

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155077	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/08/2012
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NAME OF PROVIDER OR SUPPLIER LAKEVIEW MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 45 BEACHWAY DR INDIANAPOLIS, IN 46224
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: October 31, November 1, 2, 5, 7, and 8, 2012</p> <p>Facility number: 000032 Provider number: 155077 AIM number: 100273330</p> <p>Survey team: Karina Gates, BHS TC Courtney Mujic, RN Beth Walsh, RN</p> <p>Census bed type: SNF: 4 SNF/NF: 123 Total: 127</p> <p>Census payor type: Medicare: 12 Medicaid: 100 Other: 15 Total: 127</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 11/16/12 Cathy Emswiller RN</p>	F0000	<p>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 as a requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. *We are requesting paper review for deficiencies.</p>	

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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F0157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to notify a resident's doctor when as needed pain medication was consistently used for 1 of 10 residents reviewed</p>	F0157	1. Resident #99's pain was being controlled with said PRN pain medication which was utilized less than daily. His physician was aware of the frequency of PRN pain	11/26/2012			

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	<p>for unnecessary medications. (Resident #99)</p> <p>Findings include:</p> <p>The clinical record for Resident #99 was reviewed on 11/5/12 at 11:00 a.m.</p> <p>The diagnoses for Resident #99 included, but were not limited to: osteoarthritis.</p> <p>The November, 2012 physician's recapitulation orders indicated a Norco 5-325 Tablet to be given by mouth every 6 hours as needed for pain effective 9/18/12.</p> <p>Review of the October and November, 2012 PRN (as needed) Medication Flow Sheet indicated Norco (a pain medication) was given to Resident #99 on the following days:</p> <p>10/2/12 10/5/12 10/8/12 10/9/12 10/11/12 10/14/12 10/16/12 10/17/12 10/19/12</p>		<p>medication use, he continued the pain medication PRN in an effort to prevent increased side effects. 2. All residents requiring PRN pain medication(s) have the potential to be affected. All residents receiving PRN pain medication were reviewed for frequency and adequacy of pain management with applicable physicians notified, as indicated in an effort to identify a resident who might benefit from a routine medication regimen versus PRN. 3. As a means to ensure ongoing compliance, all nurses will be re-educated on the facility's policy on PRN Medication Administration and Physician Notification should consistent PRN use be observed. The DON or designee will complete an audit of MARs weekly for three months then monthly ongoing to ensure the physician is notified, as indicated, regarding consistently administered PRN pain medication, (please see attachment A). Any findings will be addressed immediately. 4. As a means of quality assurance the DON or designee will review any findings from the ongoing audits and subsequent corrective action in the facility's quarterly Quality Assurance meetings, and interventions revised accordingly, as warranted. Response: The facility will observe for PRN use on at least three consecutive days at the maximum frequency</p>		

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	<p>10/20/12</p> <p>10/22/12</p> <p>10/23/12</p> <p>10/24/12</p> <p>10/27/12</p> <p>10/30/12</p> <p>10/31/12</p> <p>11/1/12</p> <p>11/2/12</p> <p>11/3/12</p> <p>11/5/12</p> <p>11/6/12</p> <p>11/8/12</p> <p>During an interview with LPN #12 on 11/8/12 at 11:30 a.m. regarding Resident #99's continuous Norco usage, she indicated, "He's really confused. He yells out in the morning and says he hurts all over. I give him the norco and he's good for the day. I'm not sure if it's the arthritis or what. He's pretty stiff. Usually, he yells out after a transfer."</p> <p>During an interview with LPN #11 on 11/8/12 at 11:46 a.m., she indicated if residents are using a prn pain medication everyday, she would call to get it scheduled. She stated, "I haven't called on (name of Resident #99). I did not know he was using his prn daily. No one has told me about (name of Resident #99). We should call and get it scheduled. A person</p>		<p>indicated (for example, if the resident can receive a pain medication every 4 hours PRN, the facility would consider it consistent if the resident utilized the pain medication every 4 hours for three consecutive days; OR, for example if a resident could receive a PRN pain medication every 12 hours and the resident received the pain medication every 12 hours for three consecutive days) this would be consistent PRN use.</p>				

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	could be in pain and not say anything, and then he wouldn't get it." 3.1-5(a)(3)			

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F0224 SS=D	<p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATE</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 observation, interview and record review, the facility failed to identify a suspicious injury to a resident as potential abuse, to notify the Administrator immediately, and report it to the Indiana State Department of Health as outlined in the facility policy for 1 of 3 residents reviewed who met the criteria for abuse. (Resident #61)</p> <p>Findings include:</p> <p>On 11/1/12 at 12:00 p.m., an interview was conducted with Resident #61 regarding whether she had ever been treated roughly by staff. Resident #61 indicated yes, she had been treated roughly by staff. She stated, "I got a scar on my left hip. I was wet and she snatched the brief to change me and I got a skin tear. It was in my room in the stand up lift. She was in a hurry and took the brief off me while I was in the lift. She snatched it. I should have been in the bed. It was (name of CNA #5),</p>	F0224	<p>1. Resident #61 has a BIM score of 15 on her most recent MDS, the highest possible score indicating she is cognitively intact. Neither resident #61 nor her responsible party alleged any type of abuse. The injury was initially an injury of unknown origin which was investigated accordingly per facility policy and was not suspected or reported to be any type of abuse. 2. Any resident with an abuse allegation or an injury of unknown origin has the potential to be affected, thus the following corrective actions were taken. A shift to shift in-service was conducted to address the facility's policy on Abuse Prohibition, including but not limited to notifying the Administrator immediately of a suspicious injury to a resident. 3. As a means to ensure ongoing compliance, all staff will be re-educated on the facility's policy on Abuse Prohibition and investigation of injuries of unknown origin. The Administrator or designee will be responsible to review all incident/accident reports, grievances and reports of</p>	11/26/2012	

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	<p>a CNA (Certified Nursing Assistant). She still works here." She further indicated the incident happened the previous week and she knew her skin tore when CNA #6 gave her a shower on 10/27/12 and saw it. Resident #61 stated, "It was down to the meat. The Administrator talked to me on Monday (10/29/12). (Name of CNA #5) saw it yesterday and she said she didn't do it."</p> <p>The 10/1/12 quarterly MDS (minimum data set) assessment indicated Resident #61 had a BIMS (Brief Interview for Mental Status) score of 15, the highest possible score indicating resident is cognitively intact.</p> <p>The Incident & Accident Report and Investigation completed by LPN #7 regarding the above incident was provided by the Administrator on 11/1/12 at 1:30 p.m. The report indicated, "Date of Incident: 10/27/12. Time: 3 pm. Location: Res (resident) Rm (room). Thorough Description of Incident: aide informed nurse that Res had tear to upper left leg aprox (approximately) 3 in. aide nor resident aware of what happen (sic), dr and sister notified. Please provide measurements of any areas identified on the above diagram:</p>		<p>concern to ensure injuries of unknown origin are addressed per facility policy and the same documented. Any concerns in regard to adherence with policy will be addressed immediately. 4. As a means of quality assurance the Administrator or designee will review any findings from the ongoing reviews and subsequent corrective action taken, if warranted, in the facility's quarterly Quality Assurance meetings, and interventions revised accordingly, as warranted.</p>		

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	<p>aprox 3 in long. (The diagram indicated an area below the left buttock circled with the measurement 7 x 1 cm written next to it.) Any equipment involved? Explain: Not there at time of incident. Resident Interview: Resident unaware what happen. Immediate Action or Keep-Safe Intervention implemented to prevent any recurrence: called dr." The report was signed by LPN #7 on 10/27/12. The report was signed by the DON on 10/29/12 at which time, per the DON in an interview on 11/5/12 at 10:55 a.m., she added the word "Brief" to the report under the "Any equipment involved" section as well as "Res to be reassessed for proper brief size CNA educated on taking brief off properly" under the "Immediate Action or Keep-Safe Intervention" section.</p> <p>The statements from LPN #7 and CNA #6 were provided by the Administrator on 11/1/12 at 1:30 p.m. The statement from LPN #7 dated 10/27/12 indicated, "aide informed nurse of Res having skin tear, Nurse went in Res room and seen skin tear it's on the back of Res left upper leg right beneath bottom, aprox 3 in long, Informed dr and sister who was in room at the time tear was found". The statement from CNA #6 dated</p>			

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	<p>10/27/12 indicated, "I (name of CNA #6) came in at 11 am, (name of Resident #61) was up and dry went to lunch. Came back from lunch went to change (room #). Was wet but thought her pant was wet pulled them down and I seen a skin tear on her left inner leg, call the nurse (name of LPN #7) to come and look at it ask (name of Resident #61) what happen couldn't tell me."</p> <p>An interview was conducted with LPN #7 regarding the incident on 11/1/12 at 1:51 p.m. She stated, "One of the aides, (name of CNA #6), came and got me and said (name of Resident #61) had a skin tear. I went into her room and she had her on stand up hoyer. She pointed it out to me and I saw it. (Name of Resident #61) said it happened on day shift. She said (Name of CNA #5) was changing her brief, the day before, probably. She didn't go into detail at the time, but around the time I was leaving, she told me (Name of CNA #5) was changing her brief and it happened then. She said she pulls it to the side. (At this time, LPN #7 moved her arms in a sideways motion.) I called the doctor. Her sister was already present in the facility and knew. I told (name of RN#8) that day." LPN #7 indicated she did not tell the</p>			

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	<p>Administrator or the DON that about the incident. She stated, "I wrote a statement and gave it to (name of RN#8).</p> <p>During another interview with LPN #7 on 11/7/12 at 12:38 p.m., she indicated Resident #61 did not tell her about the incident with the brief when she first asked, thus the reason she filled out the "Incident & Accident Report and Investigation" the way she did, to indicate Resident #61 was unaware of what happened. LPN #7 indicated it took "about an hour" for Resident #61 to inform her of the incident with the brief. LPN #7 indicated she never perceived Resident #61's skin tear as a situation of potential abuse.</p> <p>The statement from RN #8 dated 10/29/12 was provided by the Administrator on 11/1/12 at 1:30 p.m. The statement indicated, "Nurse on staff notified me on Sat. 10/27/12 of a skin tear on (name of Resident #61) left posterior thigh of unknown origin. Res who is A&Ox3 (alert and oriented times 3) was questioned and was unsure of when and how it happened. Incident report completed by staff nurse."</p> <p>The "Injury of Unknown Origin or</p>			

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	<p>Significant Injury Investigation Worksheet" dated 10/27/12 at 3:00 p.m. was provided by the Administrator on 11/1/12 at 1:30 p.m. The worksheet indicated, "Injury reported to ISDH (Indiana State Department of Health) within 24 hours after discovery of injury." The "No" box was checked. The "Conclusion of investigation" section was completed by the DON on 10/29/12 per the DON in an interview on 11/5/12 at 10:55 p.m. and indicated "Improper brief size; CNA pulling brief out from behind res while on stand up lift".</p> <p>During an interview with the Administrator and DON on 11/5/12 at 10:42 a.m. regarding whether the above situation was investigated as potential abuse, the Administrator indicated, "With it being a skin tear and the resident being asked and not indicating that it was abuse, we then did not investigate it as potential abuse." She also indicated she expected to be notified right away of an injury that required medical treatment and that injuries of unknown origin should be followed up on right away. She indicated, the first she heard of the incident was on 10/29/12. Regarding the incident involving Resident #61, the</p>			

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	<p>Administrator stated, "I personally, should not have been notified right away. I've not been called for skin."</p> <p>During an interview with the DON on 11/5/12 at 10:55 a.m., she indicated, "If I was a nurse on the floor, I would not have looked at this as potential abuse."</p> <p>During another interview with the Administrator on 11/8/12 at 2:27 p.m., she indicated even if she would have received a call on 10/27/12, she still wouldn't have considered that potential abuse.</p> <p>During an interview with Consultant #1 on 11/8/12 at 2:30 p.m. regarding whether the incident involving Resident #61 should have been investigated as potential abuse, she indicated, "It was never an allegation of abuse and doesn't fit the criteria for reporting. The area was not suspicious. Initially, it was an injury of unknown origin but it still did not meet the criteria for reporting because it was not suspicious. The area was on the back of her thigh."</p> <p>An observation of Resident #61's skin tear was made on 11/8/12 at 2:40 p.m. with CNA #9 and LPN #10. Resident #61 was lying on her right</p>			

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	<p>side. CNA #9 spread Resident #61's buttocks apart so wound could be observed. The wound was located on the very bottom part of her inner left buttock and could not be seen without cheeks being physically spread apart. The wound was up and down, at a diagonal angle, approximately 4 inches in length. The width was approximately 3/4 of a centimeter. The inner part of the wound was a bright red in color and the outer edge of the wound was pink in color.</p> <p>The Abuse Prohibition, Reporting and Investigation Policy and Procedure provided by the Administrator on 10/31/12 at 2:00 p.m. indicated, "1. This facility will ensure that all alleged violations, including mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility...3. This facility will report all unusual occurrences, which includes abuse, within 24 hours of discovery, to the Long Term Care Division of the Indiana State Department of Health."</p> <p>3.1-28(a)</p>				

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NAME OF PROVIDER OR SUPPLIER LAKEVIEW MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 45 BEACHWAY DR INDIANAPOLIS, IN 46224			
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F0225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on observation, interview and</p>	F0225	1. Resident #61 has a BIM score	11/26/2012			

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	<p>record review, the facility failed to identify a suspicious injury to a resident as potential abuse, to notify the Administrator immediately, and report it to the Indiana State Department of Health as outlined in the facility policy for 1 of 3 residents reviewed who met the criteria for abuse. (Resident #61)</p> <p>Findings include:</p> <p>On 11/1/12 at 12:00 p.m., an interview was conducted with Resident #61 regarding whether she had ever been treated roughly by staff. Resident #61 indicated yes, she had been treated roughly by staff. She stated, "I got a scar on my left hip. I was wet and she snatched the brief to change me and I got a skin tear. It was in my room in the stand up lift. She was in a hurry and took the brief off me while I was in the lift. She snatched it. I should have been in the bed. It was (name of CNA #5), a CNA (Certified Nursing Assistant). She still works here." She further indicated the incident happened the previous week and she knew her skin tore when CNA #6 gave her a shower on 10/27/12 and saw it. Resident #61 stated, "It was down to the meat. The Administrator talked to me on Monday (10/29/12). (Name of CNA #5) saw it</p>		<p>of 15 on her most recent MDS, the highest possible score indicating she is cognitively intact. Neither resident #61 nor her responsible party alleged any type of abuse. The injury was initially an injury of unknown origin which was investigated accordingly per facility policy and was not suspected or reported to be any type of abuse. 2. Any resident with an abuse allegation or an injury of unknown origin has the potential to be affected, thus the following corrective actions were taken. A shift to shift in-service was conducted to address the facility's policy on Abuse Prohibition, including but not limited to notifying the Administrator immediately of a suspicious injury to a resident. 3. As a means to ensure ongoing compliance, all staff will be re-educated on the facility's policy on Abuse Prohibition and investigation of injuries of unknown origin. The Administrator or designee will be responsible to review all incident/accident reports, grievances and reports of concern to ensure injuries of unknown origin are addressed per facility policy and the same documented. Any concerns in regard to adherence with policy will be addressed immediately. 4. As a means of quality assurance the Administrator or designee will review any findings from the</p>		

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	<p>yesterday and she said she didn't do it."</p> <p>The 10/1/12 quarterly MDS (minimum data set) assessment indicated Resident #61 had a BIMS (Brief Interview for Mental Status) score of 15, the highest possible score indicating resident is cognitively intact.</p> <p>The Incident & Accident Report and Investigation completed by LPN #7 regarding the above incident was provided by the Administrator on 11/1/12 at 1:30 p.m. The report indicated, "Date of Incident: 10/27/12. Time: 3 pm. Location: Res (resident) Rm (room). Thorough Description of Incident: aide informed nurse that Res had tear to upper left leg aprox (approximately) 3 in. aide nor resident aware of what happen (sic), dr and sister notified. Please provide measurements of any areas identified on the above diagram: aprox 3 in long. (The diagram indicated an area below the left buttock circled with the measurement 7 x 1 cm written next to it.) Any equipment involved? Explain: Not there at time of incident. Resident Interview: Resident unaware what happen. Immediate Action or Keep-Safe Intervention implemented</p>		ongoing reviews and subsequent corrective action taken, if warranted, in the facility's quarterly Quality Assurance meetings, and interventions revised accordingly, as warranted.		

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	<p>to prevent any recurrence: called dr." The report was signed by LPN #7 on 10/27/12. The report was signed by the DON on 10/29/12 at which time, per the DON in an interview on 11/5/12 at 10:55 a.m., she added the word "Brief" to the report under the "Any equipment involved" section as well as "Res to be reassessed for proper brief size CNA educated on taking brief off properly" under the "Immediate Action or Keep-Safe Intervention" section.</p> <p>The statements from LPN #7 and CNA #6 were provided by the Administrator on 11/1/12 at 1:30 p.m. The statement from LPN #7 dated 10/27/12 indicated, "aide informed nurse of Res having skin tear, Nurse went in Res room and seen skin tear it's on the back of Res left upper leg right beneath bottom, aprox 3 in long, Informed dr and sister who was in room at the time tear was found". The statement from CNA #6 dated 10/27/12 indicated, "I (name of CNA #6) came in at 11 am, (name of Resident #61) was up and dry went to lunch. Came back from lunch went to change (room #). Was wet but thought her pant was wet pulled them down and I seen a skin tear on her left inner leg, call the nurse (name of LPN #7) to come and look at it ask</p>			

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	<p>(name of Resident #61) what happen couldn't tell me."</p> <p>An interview was conducted with LPN #7 regarding the incident on 11/1/12 at 1:51 p.m. She stated, "One of the aides, (name of CNA #6), came and got me and said (name of Resident #61) had a skin tear. I went into her room and she had her on stand up hoyer. She pointed it out to me and I saw it. (Name of Resident #61) said it happened on day shift. She said (Name of CNA #5) was changing her brief, the day before, probably. She didn't go into detail at the time, but around the time I was leaving, she told me (Name of CNA #5) was changing her brief and it happened then. She said she pulls it to the side. (At this time, LPN #7 moved her arms in a sideways motion.) I called the doctor. Her sister was already present in the facility and knew. I told (name of RN#8) that day." LPN #7 indicated she did not tell the Administrator or the DON that about the incident. She stated, "I wrote a statement and gave it to (name of RN#8).</p> <p>During another interview with LPN #7 on 11/7/12 at 12:38 p.m., she indicated Resident #61 did not tell her about the incident with the brief when</p>			

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	<p>she first asked, thus the reason she filled out the "Incident & Accident Report and Investigation" the way she did, to indicate Resident #61 was unaware of what happened. LPN #7 indicated it took "about an hour" for Resident #61 to inform her of the incident with the brief. LPN #7 indicated she never perceived Resident #61's skin tear as a situation of potential abuse.</p> <p>The statement from RN #8 dated 10/29/12 was provided by the Administrator on 11/1/12 at 1:30 p.m. The statement indicated, "Nurse on staff notified me on Sat. 10/27/12 of a skin tear on (name of Resident #61) left posterior thigh of unknown origin. Res who is A&Ox3 (alert and oriented times 3) was questioned and was unsure of when and how it happened. Incident report completed by staff nurse."</p> <p>The "Injury of Unknown Origin or Significant Injury Investigation Worksheet" dated 10/27/12 at 3:00 p.m. was provided by the Administrator on 11/1/12 at 1:30 p.m. The worksheet indicated, "Injury reported to ISDH (Indiana State Department of Health) within 24 hours after discovery of injury." The "No" box was checked. The "Conclusion</p>			

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	<p>of investigation" section was completed by the DON on 10/29/12 per the DON in an interview on 11/5/12 at 10:55 p.m. and indicated "Improper brief size; CNA pulling brief out from behind res while on stand up lift".</p> <p>During an interview with the Administrator and DON on 11/5/12 at 10:42 a.m. regarding whether the above situation was investigated as potential abuse, the Administrator indicated, "With it being a skin tear and the resident being asked and not indicating that it was abuse, we then did not investigate it as potential abuse." She also indicated she expected to be notified right away of an injury that required medical treatment and that injuries of unknown origin should be followed up on right away. She indicated, the first she heard of the incident was on 10/29/12. Regarding the incident involving Resident #61, the Administrator stated, "I personally, should not have been notified right away. I've not been called for skin."</p> <p>During an interview with the DON on 11/5/12 at 10:55 a.m., she indicated, "If I was a nurse on the floor, I would not have looked at this as potential abuse."</p>				

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	<p>During another interview with the Administrator on 11/8/12 at 2:27 p.m., she indicated even if she would have received a call on 10/27/12, she still wouldn't have considered that potential abuse.</p> <p>During an interview with Consultant #1 on 11/8/12 at 2:30 p.m. regarding whether the incident involving Resident #61 should have been investigated as potential abuse, she indicated, "It was never an allegation of abuse and doesn't fit the criteria for reporting. The area was not suspicious. Initially, it was an injury of unknown origin but it still did not meet the criteria for reporting because it was not suspicious. The area was on the back of her thigh."</p> <p>An observation of Resident #61's skin tear was made on 11/8/12 at 2:40 p.m. with CNA #9 and LPN #10. Resident #61 was lying on her right side. CNA #9 spread Resident #61's buttocks apart so wound could be observed. The wound was located on the very bottom part of her inner left buttock and could not be seen without cheeks being physically spread apart. The wound was up and down, at a diagonal angle, approximately 4 inches in length. The</p>			

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	<p>width was approximately 3/4 of a centimeter. The inner part of the wound was a bright red in color and the outer edge of the wound was pink in color.</p> <p>The Abuse Prohibition, Reporting and Investigation Policy and Procedure provided by the Administrator on 10/31/12 at 2:00 p.m. indicated, "1. This facility will ensure that all alleged violations, including mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility...3. This facility will report all unusual occurrences, which includes abuse, within 24 hours of discovery, to the Long Term Care Division of the Indiana State Department of Health."</p> <p>3.1-28(c) 3.1-28(e)</p>			

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F0226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on observation, interview and record review, the facility failed to identify a suspicious injury to a resident as potential abuse, to notify the Administrator immediately, and report it to the Indiana State Department of Health as outlined in the facility policy for 1 of 3 residents reviewed who met the criteria for abuse. (Resident #61)</p> <p>Findings include:</p> <p>On 11/1/12 at 12:00 p.m., an interview was conducted with Resident #61 regarding whether she had ever been treated roughly by staff. Resident #61 indicated yes, she had been treated roughly by staff. She stated, "I got a scar on my left hip. I was wet and she snatched the brief to change me and I got a skin tear. It was in my room in the stand up lift. She was in a hurry and took the brief off me while I was in the lift. She snatched it. I should have been in the bed. It was (name of CNA #5), a CNA (Certified Nursing Assistant).</p>	F0226	<p>1. Resident #61 has a BIM score of 15 on her most recent MDS, the highest possible score indicating she is cognitively intact. Neither resident #61 nor her responsible party alleged any type of abuse. The injury was initially an injury of unknown origin which was investigated accordingly per facility policy and was not suspected or reported to be any type of abuse. 2. Any resident with an abuse allegation or an injury of unknown origin has the potential to be affected, thus the following corrective actions were taken. A shift to shift in-service was conducted to address the facility's policy on Abuse Prohibition, including but not limited to notifying the Administrator immediately of a suspicious injury to a resident. 3. As a means to ensure ongoing compliance, all staff will be re-educated on the facility's policy on Abuse Prohibition and investigation of injuries of unknown origin. The Administrator or designee will be responsible to review all incident/accident reports, grievances and reports of concern to ensure injuries of</p>	11/23/2012			

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	<p>She still works here." She further indicated the incident happened the previous week and she knew her skin tore when CNA #6 gave her a shower on 10/27/12 and saw it. Resident #61 stated, "It was down to the meat. The Administrator talked to me on Monday (10/29/12). (Name of CNA #5) saw it yesterday and she said she didn't do it."</p> <p>The 10/1/12 quarterly MDS (minimum data set) assessment indicated Resident #61 had a BIMS (Brief Interview for Mental Status) score of 15, the highest possible score indicating resident is cognitively intact.</p> <p>The Incident & Accident Report and Investigation completed by LPN #7 regarding the above incident was provided by the Administrator on 11/1/12 at 1:30 p.m. The report indicated, "Date of Incident: 10/27/12. Time: 3 pm. Location: Res (resident) Rm (room). Thorough Description of Incident: aide informed nurse that Res had tear to upper left leg aprox (approximately) 3 in. aide nor resident aware of what happen (sic), dr and sister notified. Please provide measurements of any areas identified on the above diagram: aprox 3 in long. (The diagram</p>		<p>unknown origin are addressed per facility policy and the same documented. Any concerns in regard to adherence with policy will be addressed immediately. 4. As a means of quality assurance the Administrator or designee will review any findings from the ongoing reviews and subsequent corrective action taken, if warranted, in the facility's quarterly Quality Assurance meetings, and interventions revised accordingly, as warranted.</p>		

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	<p>indicated an area below the left buttock circled with the measurement 7 x 1 cm written next to it.) Any equipment involved? Explain: Not there at time of incident. Resident Interview: Resident unaware what happen. Immediate Action or Keep-Safe Intervention implemented to prevent any recurrence: called dr." The report was signed by LPN #7 on 10/27/12. The report was signed by the DON on 10/29/12 at which time, per the DON in an interview on 11/5/12 at 10:55 a.m., she added the word "Brief" to the report under the "Any equipment involved" section as well as "Res to be reassessed for proper brief size CNA educated on taking brief off properly" under the "Immediate Action or Keep-Safe Intervention" section.</p> <p>The statements from LPN #7 and CNA #6 were provided by the Administrator on 11/1/12 at 1:30 p.m. The statement from LPN #7 dated 10/27/12 indicated, "aide informed nurse of Res having skin tear, Nurse went in Res room and seen skin tear it's on the back of Res left upper leg right beneath bottom, aprox 3 in long, Informed dr and sister who was in room at the time tear was found". The statement from CNA #6 dated 10/27/12 indicated, "I (name of CNA</p>			

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	<p>#6) came in at 11 am, (name of Resident #61) was up and dry went to lunch. Came back from lunch went to change (room #). Was wet but thought her pant was wet pulled them down and I seen a skin tear on her left inner leg, call the nurse (name of LPN #7) to come and look at it ask (name of Resident #61) what happen couldn't tell me."</p> <p>An interview was conducted with LPN #7 regarding the incident on 11/1/12 at 1:51 p.m. She stated, "One of the aides, (name of CNA #6), came and got me and said (name of Resident #61) had a skin tear. I went into her room and she had her on stand up hoyer. She pointed it out to me and I saw it. (Name of Resident #61) said it happened on day shift. She said (Name of CNA #5) was changing her brief, the day before, probably. She didn't go into detail at the time, but around the time I was leaving, she told me (Name of CNA #5) was changing her brief and it happened then. She said she pulls it to the side. (At this time, LPN #7 moved her arms in a sideways motion.) I called the doctor. Her sister was already present in the facility and knew. I told (name of RN#8) that day." LPN #7 indicated she did not tell the Administrator or the DON that about</p>				

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	<p>the incident. She stated, "I wrote a statement and gave it to (name of RN#8).</p> <p>During another interview with LPN #7 on 11/7/12 at 12:38 p.m., she indicated Resident #61 did not tell her about the incident with the brief when she first asked, thus the reason she filled out the "Incident & Accident Report and Investigation" the way she did, to indicate Resident #61 was unaware of what happened. LPN #7 indicated it took "about an hour" for Resident #61 to inform her of the incident with the brief. LPN #7 indicated she never perceived Resident #61's skin tear as a situation of potential abuse.</p> <p>The statement from RN #8 dated 10/29/12 was provided by the Administrator on 11/1/12 at 1:30 p.m. The statement indicated, "Nurse on staff notified me on Sat. 10/27/12 of a skin tear on (name of Resident #61) left posterior thigh of unknown origin. Res who is A&Ox3 (alert and oriented times 3) was questioned and was unsure of when and how it happened. Incident report completed by staff nurse."</p> <p>The "Injury of Unknown Origin or Significant Injury Investigation</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155077	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/08/2012
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	<p>Worksheet" dated 10/27/12 at 3:00 p.m. was provided by the Administrator on 11/1/12 at 1:30 p.m. The worksheet indicated, "Injury reported to ISDH (Indiana State Department of Health) within 24 hours after discovery of injury." The "No" box was checked. The "Conclusion of investigation" section was completed by the DON on 10/29/12 per the DON in an interview on 11/5/12 at 10:55 p.m. and indicated "Improper brief size; CNA pulling brief out from behind res while on stand up lift".</p> <p>During an interview with the Administrator and DON on 11/5/12 at 10:42 a.m. regarding whether the above situation was investigated as potential abuse, the Administrator indicated, "With it being a skin tear and the resident being asked and not indicating that it was abuse, we then did not investigate it as potential abuse." She also indicated she expected to be notified right away of an injury that required medical treatment and that injuries of unknown origin should be followed up on right away. She indicated, the first she heard of the incident was on 10/29/12. Regarding the incident involving Resident #61, the Administrator stated, "I personally,</p>			

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	<p>should not have been notified right away. I've not been called for skin."</p> <p>During an interview with the DON on 11/5/12 at 10:55 a.m., she indicated, "If I was a nurse on the floor, I would not have looked at this as potential abuse."</p> <p>During another interview with the Administrator on 11/8/12 at 2:27 p.m., she indicated even if she would have received a call on 10/27/12, she still wouldn't have considered that potential abuse.</p> <p>During an interview with Consultant #1 on 11/8/12 at 2:30 p.m. regarding whether the incident involving Resident #61 should have been investigated as potential abuse, she indicated, "It was never an allegation of abuse and doesn't fit the criteria for reporting. The area was not suspicious. Initially, it was an injury of unknown origin but it still did not meet the criteria for reporting because it was not suspicious. The area was on the back of her thigh."</p> <p>An observation of Resident #61's skin tear was made on 11/8/12 at 2:40 p.m. with CNA #9 and LPN #10. Resident #61 was lying on her right side. CNA #9 spread Resident #61's</p>			

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	<p>buttocks apart so wound could be observed. The wound was located on the very bottom part of her inner left buttock and could not be seen without cheeks being physically spread apart. The wound was up and down, at a diagonal angle, approximately 4 inches in length. The width was approximately 3/4 of a centimeter. The inner part of the wound was a bright red in color and the outer edge of the wound was pink in color.</p> <p>The Abuse Prohibition, Reporting and Investigation Policy and Procedure provided by the Administrator on 10/31/12 at 2:00 p.m. indicated, "1. This facility will ensure that all alleged violations, including mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility...3. This facility will report all unusual occurrences, which includes abuse, within 24 hours of discovery, to the Long Term Care Division of the Indiana State Department of Health."</p> <p>3.1-28(a)</p>				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155077	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/08/2012
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F0241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview and record review, the facility failed to maintain a resident's dignity by knocking/announcing themselves when entering a resident's room, not explaining procedure/care being done, and failed to ensure a resident's dignity was maintained during a random observation. This affected 2 of 4 residents reviewed for dignity. (Resident #109 and #2)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #109 was reviewed on 11/5/12 at 11:30 a.m. The diagnoses for Resident #109 included, but were not limited to: congestive heart failure.</p> <p>During a resident interview, on 11/1/12 at 12:11 p.m., RT (Respiratory Therapist) #7 was observed walking into Resident #109's room, without knocking on door or asking to come into room. RT#7 then was observed taking off Resident #109's nasal canula from</p>	F0241	<p>1. The residents did not exhibit harm or anguish as a result of the two observations described. The involved staff members were addressed immediately following observations. One should note that resident #2 has a license plate on the back of his wheel chair with the nick name he prefers to be called imprinted on it. 2. All residents have the potential to be affected, thus the following corrective actions were taken. All staff were re-educated on knocking before entering a resident's room, explaining care to be provided, and on providing dignity by addressing residents appropriately.3. As a means to ensure ongoing compliance, all staff will be re-educated on providing dignity to residents, including knocking before entering resident's rooms, interacting with the resident, explaining care and addressing a resident by the preferred name/title. The DON or designee will complete random observations on all shifts at least five times weekly for three months, then weekly thereafter ongoing to ensure staff members are providing residents with</p>	11/26/2012

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	<p>over Resident #109's ears and under their nose, replacing it with a new nasal canula tubing, and changing the water on an oxygen tank. RT#7 then walked out of the room after they were queried about their name. RT#7 did not speak/talk to Resident #109 during the entire observation, while RT#7 was in Resident #109's room</p> <p>In an interview with the Administrator, on 11/7/12 at 1:10 p.m., she indicated all staff, including any type of therapy, received training on resident's rights and dignity.</p> <p>At 12:50 p.m., on 11/8/12, the Administrator indicated all staff was expected to treat the residents with dignity and were supposed to knock/announce themselves before entering a resident's room. She also indicated all staff was expected to explain procedures/care to residents before/when staff provides care.</p> <p>2. LPN #6 observed on the c-hall in front of the nurses station and was assisting Resident #2 by pushing him in his wheelchair after he asked to be wheeled down to the dining room. LPN #6 said, "come on you old fart." There was no verbal response from Resident #2. There were five other residents in the hallway present at the time.</p>		<p>dignity, (please see attachment C). Any concerns observed will be addressed immediately. 4. As a means of quality assurance the DON or designee will review any findings from ongoing observations and subsequent corrective action, if warranted, in the facility's quarterly Quality Assurance meetings, and interventions revised accordingly, as warranted.</p>	

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	<p>Interview with the Administrator on 11/8/2012 at 12:50 indicated that term used by LPN #6 is not appropriate, she expects staff to address residents by their name.</p> <p>Interview with the Administrator and Nurse Consultant #1 on 11/8/2012 at 2 pm indicated Resident #2 "likes to be called that, it is a nickname for him." No explanation, just silence was the response given when asked about whether it was appropriate to use this term in front of other residents.</p> <p>3.1-3(t)</p>			

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NAME OF PROVIDER OR SUPPLIER LAKEVIEW MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 45 BEACHWAY DR INDIANAPOLIS, IN 46224			
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F0280 SS=D	<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 interview and record review, the facility failed to revise a behavior care plan to include monitoring of potential side effects for a mood stabilizer drug for 1 of 10 residents reviewed for unnecessary medications. (Resident #34)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #34 was reviewed on 11/5/12 at 11:25 p.m. The diagnoses for Resident #34 included, but were not limited to: delusional disorder and depression. Resident #34 was admitted on 9/21/07.</p>	F0280	<p>1. The care plan for resident # 34 was updated to include an intervention to monitor for potential side effects of Depakote.2. All residents with mood stabilizing medications (such as Depakote) in their medication regimen have the potential to be affected. Thus, the care plans for all residents utilizing mood stabilizing medications for which side effects should be monitored were audited to ensure that the care plan addresses possible side effects for which to monitor.3. As a means to ensure ongoing compliance, all nurses will be re-educated on care plan</p>	11/26/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155077	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/08/2012
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	<p>A recapitulation of the November, 2012 Physician's Orders indicated Resident #34 received 1 capsule of Depakote 125 mg (milligram) Sprinkles (mood stabilizer) twice a day. The Physician's Orders indicated the medications was initiated on 3/21/12. A Physician's Order dated 11/1/12, indicated a GDR (gradual dose reduction) was initiated to have the medication to be given once a day.</p> <p>The McGraw Hill 2010 Nursing Spectrum Drug Handbook, copyright 2010, indicated dizziness, paresthesia (numbness), tremor, sedation, dyspnea (labored breathing), blurred vision, hepatotoxicity (liver damage), anorexia, pancreatitis, and thrombocytopenia (low platelet count) were some of the side effects of Depakote Sprinkles. The handbook also indicated neurological and GI status should be monitored closely.</p> <p>A review of the care plan for delusions due to diagnosis of delusional disorder, initially dated 11/17/11 (last revision date indicated-10/18/12), indicated the following interventions: approach from the front, make eye contact, speak in</p>		<p>development to include side effect monitoring. The DON or designee will complete a random audit of at least ten careplans of those residents utilizing mood stabilizing medications for which side effects must be monitored weekly for three months, then ten monthly ongoing to ensure all residents utilizing said medications have a care plan in place that addresses possible side effects to be monitored, (Please see attachment D). Any findings/concerns will be addressed immediately. 4. As a means of quality assurance, the DON or designee will review any findings from ongoing audits and subsequent corrective action in the facility's quarterly Quality Assurance meetings, and interventions revised accordingly, if warranted.</p>		

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	<p>a calm low tone of voice at a volume easily heard by the resident, gently explain that their belief is false, and introduce evidence to prove why it is not true, attempt to ascertain the potential for harm to self or others, notify the charge nurse and social service director for further evaluation and possible physician and responsible party notification, ensure resident's safety, administer medications as ordered, and monitor labs as indicated.</p> <p>During an interview with Unit Manager #8, on 11/5/12 at 11:55 a.m., she indicated side effects from Depakote Sprinkles should be monitored closely and should be on the behavior/delusions care plan. She also indicated she did not see side effect monitoring for Depakote, on any of the care plans for Resident #34.</p> <p>At 2:10 p.m., on 11/5/12, the Facility Consultant indicated there was not always a specific care plan for Depakote but the side effects that should be monitored, along with labs needed, medication to be administered, all should be on/added to the behavior care plan.</p> <p>3.1-35(d)(2)(B)</p>			

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F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review, the facility failed to ensure neurological checks were completed on a resident after an unwitnessed fall for 1 of 3 residents reviewed who met the criteria for accidents. (Resident #99)</p> <p>Findings include:</p> <p>The clinical record for Resident #99 was reviewed on 11/5/12 at 11:00 a.m.</p> <p>The diagnoses for Resident #99 included, but were not limited to: seizure disorder.</p> <p>The 9/28/12 fall risk assessment indicated Resident #99 was at risk for falls due to seizure disorder, confusion, weakness, unsteady gait, and poor vision/blind.</p> <p>The 10/26/12 fall care plan indicated an intervention was to do neurological checks as indicated.</p>	F0309	The facility is requesting this citation be reviewed via the informal dispute resolution process. 1. Resident #99 was not suspected or known to have hit his head or face and had no adverse effects to the incident. An appropriate assessment was completed at the time of the incident per the facility policy. 2. Any resident that experiences an unwitnessed fall has the potential to be affected, thus the following corrective actions were taken. Incident reports from the past 30 days were reviewed to confirm appropriate assessment was conducted and appropriate monitoring initiated as per facility policy. 3. As a measure to ensure ongoing compliance, all nursing staff will be re-educated on the facility's policy on Incidents and Accidents and Neurological checks. The DON or designee will be responsible to review all incident/accidents on scheduled days of work to confirm appropriate assessment was completed following a fall/incident, as per facility policy. Should non-compliance be noted,	11/26/2012	

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	<p>The 10/23/12 Incident & Accident Report and Investigation indicated Resident #99 was found at 6:30 a.m. by a restorative aide on the side of his bed on his knees with his right arm resting atop his bed. The report indicated, "Staff involved: None, Witness Interviews: unwitnessed, and Resident Interview: I asked what happened his response was "nothing help me up". The report did not indicate neurological checks were initiated.</p> <p>The 10/23/12 post fall investigation worksheet indicated, "Were staff present at the time? no".</p> <p>The 10/23/12 and 10/24/12 nurses notes regarding the 10/23/12 fall were reviewed and did not indicate any neurological checks were completed on either day.</p> <p>During an interview with LPN #12 on 11/7/12 at 2:30 p.m., the nurse who made the 10/24/12 nurses notes for Resident #99, she indicated, "I didn't do neuro (neurological) checks."</p> <p>During an interview with LPN #11 on 11/7/12 at 3:05 p.m., she indicated it was unusual for Resident #99 to fall. She stated, "I don't see where we did</p>		<p>the same shall be addressed with the applicable nurse. 4. As a means of quality assurance, the DON or designee will report ongoing compliance with facility policy, as observed per ongoing incident/accident review, and subsequent corrective action (if applicable) in the facility's quarterly Quality Assurance meetings, and interventions revised accordingly, as warranted.</p>				

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	<p>neuro checks on him."</p> <p>The fall policy provided by the Director of Nursing on 11/5/12 at 2:00 p.m. indicated, "In all cases of an incident-accident, the following must be observed and documented: Vital signs and any other appropriate assessment information (blood sugar, neuro checks, mental status changes, etc)."</p> <p>3.1-37(a)</p>			

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F0329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview the facility failed to adequately monitor a resident who was on a medication by not obtaining labs and failed to ensure indications for the use of the medication as no assessments were completed for 1 of 10 residents reviewed for unnecessary medications. Resident #126.</p> <p>Findings included:</p>	F0329	<p>1. Resident #126 is taking a low dose of Depakote to treat disinhibited agitation. The physician of Resident #126 has been addressed as to desire for liver function testing2. All residents utilizing Depakote have the potential to be affected. All residents with Depakote ordered have been identified to ensure routine liver function tests are ordered, as indicated, if desired by the attending physician. Should the physician decline, the same shall be documented. 3. As a means to</p>	11/23/2012			

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	<p>Resident #126's clinical record was reviewed on 11/5/2012 at 10:10 am. Diagnoses included but were not limited to; osteoporosis, hypertension, hypothyroidism, insomnia, psychosis, dementia, depressive disorder, anxiety.</p> <p>A neuro psychology and behavioral health agency note dated 8/27/2012 indicated, "Recommendations for attending physician: 1. In view of disinhibited agitation, you may wish to consider the medical appropriateness of starting Depakote (a seizure medication also sometimes used for agitation) 250 mg at bed time, for better control of agitation."</p> <p>An MD order dated 8/27/2012 indicated, "Depakote 250 mg."</p> <p>Review of the MD lab orders indicated no orders for a liver function test had been ordered from August through current.</p> <p>Interview with Nurse Consultant #1 on 11/5/2012 at 1:45 pm indicated there is no specific care plan created for Depakote use if its used for behaviors, its just a general behavior care plan that will indicate to monitor for signs and symptoms of side effects. No labs are drawn for</p>		<p>ensure ongoing compliance, all nurses will be educated on Depakote use and appropriate laboratory monitoring. The DON or designee will be responsible to review all newly ordered medications on scheduled days of work in an effort to monitor for Depakote use and audit for compliance with corresponding laboratory testing. Additionally, the consultant pharmacist will be advised to include in monthly medication review compliance with appropriate laboratory testing/monitoring in an effort to ensure Hepatic function tests and or Depakote levels are monitored as indicated. Any findings will be addressed immediately. 4. As a means of quality assurance, the DON or designee will review any findings from the ongoing reviews/audits and subsequent corrective action in the facility's quarterly Quality Assurance meetings, and interventions revised accordingly, as warranted. Response: The physician had not ordered a liver function test prior to the initiation of Depakote 250mg on 8/27/12 and has not since ordered liver function testing. Upon notification and inquiry, the physician declined liver function testing at this time relative to the use of Depakote.</p>		

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	<p>residents who are on Depakote for behaviors. If they are on Depakote for seizures then they will have levels drawn.</p> <p>3.1-48(a)(3) 3.1-48(a)(4)</p>			

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F0469 SS=C	<p>483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM</p> <p>The facility must maintain an effective pest control program so that the facility is free of pests and rodents.</p> <p>Based on observation and interview the facility failed to ensure a door was completely sealed in order to prevent possible entrance of pests for one door in the kitchen. This had the potential to affect all 127 residents in the facility who are served food and or beverage out of the kitchen.</p> <p>Findings included:</p> <p>Observation of the kitchen on 11/8/2012 at 12:40 am indicated a small dime-sized area of sunlight coming through on the lower left hand corner of the door directly leading to the outside.</p> <p>Interview with Administrator on 11/8/12 at 1:22 pm indicated no pest problems have been reported recently. The maintenance man has to check the doors weekly. There was an issue with a different door that was fixed in October.</p> <p>A 'work request' was provided on 11/8/12 at 1:30 pm which indicated, "Department: Dietary. Time: 12:35 pm. Description of Problem: Back</p>	F0469	<p>1. The kitchen door was immediately repaired. 2. All doors have the potential to be affected. All doors throughout the facility were checked with no further problems noted. 3. As a means to ensure ongoing compliance, the Maintenance Director will complete preventative maintenance audits twice weekly for 3 months, then weekly ongoing to ensure all doors are in good repair and proper working order, (please see attachment F) . 4. As a measure of quality assurance the Maintenance Director or designee will review any findings from ongoing audits and subsequent corrective action in the facility's quarterly Quality Assurance meeting, and interventions revised accordingly, as warranted.</p>	11/23/2012	

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	<p>door needs sealed has an opening."</p> <p>A 'weekly check off schedule: All doors and kitchen' was provided by the Administrator on 11/8/2012 at 1:36 pm indicated, "This schedule is done weekly. Check each door to ensure the smoke seals are properly placed; door is closing, completely latching and any vents are closed." The most recent date listed was, "11/4/2012, comment: working good."</p> <p>Interview with the Maintenance Director on 11/8/2012 at 2:30 pm indicated he fixed the hole with a sweep, he doesn't know exactly when the hole occurred, all the outside doors are checked weekly. Most likely this was a very recent problem. He will keep a close eye on the door to make sure the sweep holds, but it is on there good now.</p> <p>3.1-19(f)(4)</p>				