

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155824	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2015
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NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 52565 STATE ROAD 933 SOUTH BEND, IN 46637
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F000000	<p>This survey was for the Investigation of Complaint IN00164273.</p> <p>Complaint IN00164273 - Substantiated. Federal State deficiencies related to the allegations are cited at F315 and F329.</p> <p>Survey dates: February 10 and 11, 2015</p> <p>Facility number: 013302 Provider number: 155824 AIM number: N/A</p> <p>Survey team: Honey Kuhn, RN</p> <p>Census bed type: SNF: 27 Residential: 16 Total: 43</p> <p>Census payor type: Medicare 20 Other: 7 Total: 27</p> <p>Sample: 3</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed on February</p>	F000000		

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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F000314 SS=G	<p>19, 2015, by Brenda Meredith, RN.</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on record review and interviews, the facility failed to provide interventions upon admission for a dependent resident with a reddened coccyx which resulted in a Stage IV pressure area for 1 of 2 residents reviewed for pressure areas in a sample of 3. (Resident "C")</p> <p>Finding include:</p> <p>The record for Resident "C" was reviewed on 02/10/14 at 1:45 p.m. Resident "C" was admitted to the facility on 11/26/14, with diagnoses including, but not limited to, closed reduction/pinning for a (L) (Left) hip fracture, chronic UTI's (Urinary Tract Infections) with long term indwelling</p>	F000314	<p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #C has been discharge from Campus. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents & new admissions have the potential to be affected. Nursing leadership team performed a skin assessments on all Campus residents. Measures put in place and systemic changes made to ensure the alleged deficient practice does not re-occur: 1. All nursing staff, CRCA's and Licensed Nurses, in-serviced on Campus</p>	03/13/2015

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	<p>catheter and osteoarthritis. The record indicated Resident "C" was admitted with a Stage 1 pressure area (defined area of persistent redness). The resident was discharged to an ACF (Acute Care Facility: Hospital), on 01/11/15, with a Stage IV pressure area (full thickness tissue loss with exposed bone, tendon or muscle).</p> <p>The Admission MDS (Minimum Data Set) assessment, dated 12/03/14, indicated Resident "C" was cognitively intact. The resident required extensive assist of 2 for transfers, bathing, and extensive assistance of 1 for for ambulation, dressing, hygiene and toileting.</p> <p>The ACF "Patient Transfer Assessment Form," dated 11/26/14 at 10:10 a.m., indicated the resident's "Skin Condition Report," with an anatomical drawing area, a circle to the coccyx area, "...2) red area (no breakdown)."</p> <p>The ECF (Extended Care Facility: Nursing Home) "Admission Nursing Assessment," dated 11/26/14 1300 (1:00 p.m.), indicated: "DEHYDRATION RISK ASSESSMENT:...UTI...Dry mouth/tongue" "FUNCTIONAL STATUS: Total</p>		<p>guidelines regarding admission skin assessment, clinical documentation, wound and skin guidelines including interventions and prevention. 2. Per campus guidelines, Nursing Leadership Team & IDT will review the 24 hour report & all nursing notes in daily CCM (Clinical Care Meeting) 5 days a week, ongoing. This review will also include review of residents' plan of care & ensure appropriate interventions have been initiated & updated as necessary for all residents with pressure sores. 3. Per campus guidelines, Nursing Leadership Team will perform wound rounds to ensure treatment approaches and interventions are being followed through by resident care givers & all discrepancies will be corrected immediately. 4. Per campus guidelines, Nursing Leadership Team & IDT will hold CAR (Clinically At Risk) meeting weekly, in which residents with pressure sores will be reviewed & updated to ensure proper intervention, prevention of further skin breakdown are in place.</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not reoccur: 1. Audits will be conducted by the DHS or designee 5 times aweek x 4 weeks; then 2x weekly x 1months; then monthly x 4. The results of the audit and or observations will be reported to QAA. 2. QA&A will monitor</p>	

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	<p>Assist...2 person assist..." RANGE OF MOTION ASSESSMENT": Areas were checked indicating the resident had limited ROM (Range of Motion) to her lower extremities.</p> <p>The Admission "BRADEN PRESSURE ULCER RISK" (a scale to identify risk of skin breakdown), dated 11/26/14, indicated risk scores: Resident "C" was at "HIGH RISK: Score 10-12" with areas of concern noted: "Moisture"[skin] Constantly Moist... Mobility: Very Limited... Nutrition: Adequate... Friction & Shear: Problem..." with a score "TOTAL:11". The form's anatomical drawing corresponded with the ACF documentation area circled and indicated: "Red coccyx."</p> <p>A "BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK" form, initiated on 12/03/14, indicated the resident was assessed every week. The form's reference risk scores indicated: "9 </=: Very High Risk" "10-12 High Risk" "13-14 Moderate Risk" "15-18 At Risk" The risk scores for Resident "C" were: 12/03/14: 16 (at risk)</p>		<p>monthly for 6 months or until 100% compliance is obtained. QA&A will make recommendations or changes to the Plan of Correction as needed. FACILITY IDR RESPONSE 1. It is the standard of Wellbrooke of South Bend to provide a pressure reduction mattress to every resident who enters the facility. Resident "C" entered facility with a "reddened" area on coccyx. By having pressure reduction mattress in place was the first intervention to assist in decreasing pressure and avoiding further skin breakdown. Resident was also provided a pressure reduction cushion for chair to off load pressure while sitting in upright position. 2. The Admission Nursing Assessment dated 11/26/14 addresses (on page 3 of 5) Red coccyx. This is not mentioned in nursing notes as it is the standard of Wellbrooke of South Bend to not duplicate assessment information in the admission nursing note, but to add additional information that is not captured or needs further documentation in/from Admission Nursing Assessment. 3. Low loss air mattress added on 12/15/2014. 4. On going Bradens, treatments and change in treatment demonstrate attempts to maintain or retard further breakdown. 5. Resident received necessary treatment and services to promote healing,</p>		

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	<p>12/10/14: 16 (at risk) 12/17/14: 18 (at risk)</p> <p>The admission Nurse's Notes, dated 11/26/14 1300 (1:00 p.m.), did not address the reddened area. The skin area was not noted until a Nurses Note indicated: "12/09/14 2:30 p.m. During ADL's [Activities of Daily Living], CNA reported coccyx area now open, area assessed, findings documented on wound/pressure flow record. MD notified. N.O. [New Order] received...."</p> <p>The Nurses Notes addressed the coccyx wound as indicated: "12/15/14 11:30 a.m. Coccyx wound assess. See weekly record...asked daughter if she is OK c [with] ordering low air loss mattress for resident...." "12/18/14 10:00 a.m. Reassessed coccyx wound. Wound edges now necrotic. Wound bed covered c slough. Resident c/o [complains/of] pain discomfort during cleansing...low air loss mattress in place...." "12/22/14 10:30 a.m. Drsg [Dressing] order ^d [changed] to coccyx wound..." "12/25/14 1;30 p.m. ...stated the only thing that hurts is her coccyx...." "12/28/14 3:30 p.m. ...Drsg on coccyx ^d, has a lot of slough & is red around wound."</p>		however letter of unavailability could not be recovered to show that resident status compromised healing and further breakdown occurred. It is our contention that although the resident's pressure area did worsen, the scope of this citation should not actually be a level G as interventions were utilized and frequent changes of treatment were also utilized. Resident's ability to heal was compromised as evidenced by her long history of infection (UTI).				

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	<p>"12/29/14 11:50 a.m. ...Wound to coccyx has 0 [no] change...."</p> <p>"12/30/14 11:00 a.m. Treatment ^d to coccyx per order. Area stage III [full thickness tissue loss] c slough intact & very foul odor...."</p> <p>"01/04/15 11:00 a.m. ...Dressing changed to coccyx per order...."</p> <p>"01/06/15 12:00 p.m....Dressing changed per order...."</p> <p>"01/09/15 2:30 p.m....Treatment to coccyx wound continues with mod [moderate] - lg [large] amount serosanguineous drainage...."</p> <p>"01/10/15 3:50 a.m. PRN [as needed] sacral drsg ^ completed per MD order. Tolerated will. Coccyx drainage noted...."</p> <p>"01/11/15 11:30 a.m. Confused....At this time CNA reported to this writer that resident is in bed and unable to speak normally. Lying on right side and clutching positioning rail. Makes noises as if uncomfortable, but unable to verbalize....B/P 88/51...Phoned Dr back as resident seemed to be worsening....Acts as if in pain... Report called to [ACF name] ER for eval and treatment...Dressing to coccyx changed prior to discharge. Moderate amount slightly foul drainage noted with very little slough left in wound."</p> <p>A "NURSING HOME TO HOSPITAL TRANSFER FORM", dated 01/11/15,</p>			

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	<p>indicated:</p> <p>"...SKIN/WOUND CARE: Pressure Ulcers...Daily dressing change coccyx wound...Resident with stage 4 wound to coccyx which has improved. Unable to answer questions at this time."</p> <p>The "WEEKLY WOUND EVALUATION FLOW RECORD", for the resident's wound, indicated:</p> <p>"12/09/14: 2.0 cm L [Length] X [by] 0.9 cm W [Width] X 0.1 D [Depth]"</p> <p>"12/15/14: 3.0 cm L X 3.0 W X 0.2 D. ^ [Change] tx [treatment] order..."</p> <p>No other weekly wound information was provided.</p> <p>Review of the Physician's Progress Notes indicated the physician saw the resident and indicated:</p> <p>"11/28/14". No mention of a pressure area.</p> <p>"12/05/14...She is moving slowly, but improving in therapy...."</p> <p>"12/12/14 [Resident "C" name] is not doing as well this week. She is more sleepy. Nursing states she was given Tranzadone by psychiatrist for apparently due to some situational depression and some poor sleep; however, the reports [sic] she has back slid this week in therapy due to somnolence...."</p> <p>"12/19/14 {Resident "C" name} is doing fair....She came in with a stage 2 [sic]</p>			

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	<p>decubitus, now is unstageable. She is on inner mattress...."</p> <p>"12/24/14 ...Her main complaint is her sacral wound....Big issue is her sacral wound...."</p> <p>"01/09/15 ...remains confused. She still has a coccyx wound....She has been hampered some by her coccyx wound and confusion...."</p> <p>The Physician Orders indicated wound treatments, initiated on 12/09/14 were changed on: 12/15/14 12/18/14 12/22/14 12/31/14</p> <p>The Dietary interventions indicated: "12/31/14: 2 cal beverage 120 cc TID [3 time a day] c [with] med [medication] pass Record % [percentage] consumed in MAR [Medication Administration Record] MVI [Multivitamin] c Mineral once daily for wound healing."</p> <p>The "Care Conference" documentation indicated: "01/05/14 [sic] Care Conference...Members present included {Resident "C"}, therapy, SS, nursing. The POA was on speaker phone...</p>			

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	<p>[Resident "C"] then mentioned she knew she had a sore on her behind that needed to be taken care of...."</p> <p>The Care Conference minutes did not address the open area other than the concern expressed by Resident "C" on 01/05/14.</p> <p>Review of a Care Plan, initiated on admission, 11/26/14, indicated: "Problems: 11/26/14: Redness to coccyx; surgical wound 12/09/14: Pressure ulcer Stage LL [Left Lower] coccyx" "Interventions: 12/15/14: Pressure relief support surface (low air mattress) Turn & reposition every 2 hours Dressing change as ordered...."</p> <p>During an interview, on 2/11/15 at 10:30 a.m., the DNS (Director Nursing Services) indicated Resident "C" was admitted with a skin area. The DNS indicated Resident "C" was non-complaint with positioning and therapy. The DNS indicated the facility had undergone a change of ownership on 01/2015. The DNS provided, at the time, a copy of an undated Policy & Procedure, titled, "PRESSURE ULCER PREVENTION AND MANAGEMENT",</p>			

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	<p>which was in place during the previous ownership, and at the time of admission for Resident "C."</p> <p>A confidential interview, with a direct care staff person, during the survey, indicated Resident "C" was compliant with therapy.</p> <p>The "PRESSURE ULCER PREVENTION AND MANAGEMENT" Policy & Procedure indicated: "At time of Admission: 1. All residents will be assessed for pressure ulcer risk at time of admission using a Standardized Scale, i.e. Braden or Norton. 2. All risk factors are identifies....</p> <p>For an Actual Pressure Ulcer: 1. Pressure Ulcers are assessed to location, stage, size, shape, depth,...., surrounding tissue, and drainage (type, color, odor, and amount),.... 2. Initial status is documented in medical record. A narrative note or a form is acceptable.... 4. The Dietary Manager is notified and a referral is made to Registered Dietician for all Stage 2 or greater pressure ulcer. The Registered Dietician will assess for nutritional interventions and develop a plan as indicated.... 7. Within one week and then weekly, the</p>						

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F000329 SS=D	<p>IDT Risk Team reviews all new pressure ulcers and care plans....</p> <p>10. Daily monitoring is to be in place to assess the effectiveness of the plan of care and to ensure the care plan is followed i.e.: wound status pain, s/s infection or change...."</p> <p>This Federal tag related to Complaint IN00164273.</p> <p>3.1-40(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs</p>				

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	<p>receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interviews, the facility failed to review medications and monitor with behaviors onset and implement interventions related to crying and anxiety prior to obtaining a psychiatric consult and introducing an antidepressant for 1 of 3 residents in a sample of 3 reviewed for behaviors. (Resident "C")</p> <p>Finding includes:</p> <p>The record for Resident "C" was reviewed on 02/10/14 at 1:45 p.m. Resident "C" was admitted to the facility on 11/26/14 with diagnoses including, but not limited to, closed reduction/pinning for a (L) (Left) hip fracture, chronic UTI's (Urinary Tract Infections) with long term indwelling catheter and osteoarthritis. The resident had a reddened area on her coccyx at admission. The resident was transferred to a local ACF on 01/11/15.</p> <p>The Admission MDS (Minimum Data Set) assessment, dated 12/03/14, indicated Resident "C" was cognitively intact. The resident required extensive assist of 2 for transfers, bathing, and extensive assistance of 1 for for</p>	F000329	<p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident C has been discharged from the campus.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents who exhibit behaviors, signs and symptoms of depression or anxiety have the potential to be effected.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not re-occur</p> <ol style="list-style-type: none"> 1. Documentation in-service for all nursing staff & IDT, including CRCA's & licensed nurses, was completed to review signs & symptoms of anxiety and depression and implementation of appropriate interventions and documentation procedures. 2. Per campus guidelines, Nursing Leadership & IDT will review the 24 hour report & all nursing notes in daily CCM (Clinical Care Meeting) 5 days a week, ongoing. This review will include review of residents' plan of care to ensure appropriate interventions have been initiated & updated as necessary for all residents with signs and symptoms of anxiety 	03/13/2015	

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	<p>ambulation, dressing, hygiene, and toileting. The record indicated the resident was admitted for short term rehab to home.</p> <p>The Admission orders from the ACF (Acute Care Facility: Hospital), dated 11/26/14, indicated Resident "C" received medications including, but not limited to: "Tapentadol [Nucenta] 75 mg [milligrams] po [per os: by mouth] q6h [q: every] [h: hour] pain." The medication is defined as an opioid, a medication that resembles morphine (2014 Nursing Drug Handbook).</p> <p>The Physician Orders, following admission to the facility, indicated: "12/03/14 Psychological/Mental health Evaluation and Treatment by [Psych Service name]...." "12/05/14 1410 [2:10 p.m.] Trazadone 50 mg po qhs prn [as needed] sleep." "12/11/14 Trazadone 25 mg po @ [at] hs [hour sleep] prn sleep. DC [discontinue] Trazadone 50 mg."</p> <p>A "BEHAVIOR/INTERVENTION MONTHLY FLOW SHEET," undated for days 1-9 of an undetermined month, indicated crying & tearfulness on day 3 and day 5. An area noting a behavior of difficulty with sleep indicated day 3.</p>		<p>&/or depression. 3. Per campus guidelines, Nursing Leadership & IDT will hold CAR (Clinically At Risk) meeting weekly, which will include behavior monitoring of all residents with signs & symptoms of anxiety &/or depression. At that time, plan of care will be reviewed & updated to reflect appropriate documentation & interventions are in place & effective. How the corrective measures will be monitored to ensure the alleged deficient practice does not reoccur: 1. Audits will be conducted by the SSD or designee 5 times a week x 4 weeks; then 2x weekly x 1 months; then monthly x 4. SSD or designee will report the results of the audit and or observations/ findings to QA&A for 6 months or until 100% compliance is achieved 2. QAA will make recommendations or changes to the Plan of Correction as needed. Facility IDR Response Resident admitted 11/26/14. Resident BIMS dated 12/2/14 indicated: Summary Score 13-Cognitively she was alert, oriented to person, place, situation and time. That resident decision making skills –needs assistance. During resident's mood interview- (PHQ-9) "Over the past 2 weeks, have you been bothered by any of the following problems?" Resident reported the following symptom presence: 1. Feeling</p>	

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NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF SOUTH BEND			STREET ADDRESS, CITY, STATE, ZIP CODE 52565 STATE ROAD 933 SOUTH BEND, IN 46637		
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	<p>Both behavior interventions were noted as "redirected." The record did not contain a Care Plan for Behaviors.</p> <p>The Nurse's Notes indicated, 11/26/1414 - 12/12/14, the resident remained alert and oriented to time, person, and place with no episodes of confusion, tearfulness, or insomnia prior to the initiation of the Trazadone.</p> <p>The Nurse's Notes indicated: "12/13/14 [untimed] Resident is alert, confused, able to make needs known...." "12/14/14 2:00 p.m. Resident is alert, some confusion noted...." "01/02/15 1515 [3:15 p.m.] Phoned [Physician name] regarding...recent decline on BIMS [Brief Interview for Mental Status]...Explained to Dr. that [Psych Service] will see resident next week et [and] reviewed c [with] Dr her medication (Tranzadone 25 mg PRN only be [sic] taken a couple times) Doctor gave new order for Celexa 10 mg 1 po qd...."</p> <p>The Nurse's Notes indicated Resident "C" had increased episodes of confusion through the remainder of her stay. The Nurse's Notes indicated: "01/10/15 9:20 a.m. Resident presents on [sic] confusion et audible hallucinations this noc [night] shift...."</p>		<p>down, depressed, or hopeless 2. Feeling tired or having little energy 3. Poor appetite or overeating 4. Feeling bad about yourself- or that you are a failure or have let yourself or your family down 5. Moving or speaking so slowly that other people have noticed. Or the opposite being so fidgety or restless that you have been moving around a lot more than usual. Social Services notes indicate: 1. 12/4/14 Information obtained and documented during Resident interview 12/2/14 reviewed and summarized- Social Services spoke with resident who self reported symptoms over the last two weeks, these signs and symptoms were NOT documented as having been observed, intervention of the social services designee talking with resident and offering additional psychological intervention and support was explored and upon resident agreeing to having someone else (vericare) to also interview and offer interventions, attending physician contacted and orders received to involve psychological services in the care of resident. 2. 12/5/14 Summary of intervention – Resident was seen by consulting psychological services Nurse Practitioner related to residents concerns of depression. Resident was prescribed Trazadone 50 mg po q hs PRN sleep. Resident and</p>		

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	<p>"01/10/15 3:00 p.m. Resident very confused today....Resident anxious and upset at 1:45 p.m. when routine pain med taken...."</p> <p>"01/10/15 2145 11:45 p.m. Resident awake in bed moaning all shift. When asked if she was in pain, resident moaned...."</p> <p>"01/11/15 11:30 a.m....CNA reported to this writer that resident is in bed and unable to speak normally. Lying on right side and clutching positioning rail. Makes noise as if uncomfortable, but unable to verbalize...."</p> <p>The MAR (Medication Administration Record) for 11/2014, 12/2014 & 01/2015 indicated the resident received 5 doses of Trazadone 50 mg: 12/06/14, 12/07/14, 12/08/14, 12/09/14, 12/10/14.</p> <p>There was no documentation to indicate Resident "C" received Trazadone 25 mg.</p> <p>Resident "C" received 4 doses Celexa 10 mg: 01/03/15, 01/04/15, 01/05/15, 01/06/15. The medication was then discontinued.</p> <p>The DNS (Director Nursing Services) was interviewed on 02/11/15 at 11:00 a.m. The DNS was unaware if non pharmacological interventions were used with the resident and indicated Resident</p>		<p>family notified of medication and its use. Resident would need to ask for medication for not being able to sleep. 3. 12/11/14 Social services again talked with resident on 12/10/14. Resident has received 5 doses of Trazadone PRN and is now complaining of "not feeling right" and tired. Nursing requested change in dose for prn going forward. Received order for Trazadone 25 mg po hs prn insomnia. 4. 12/15/14 Resident seen by consulting psychological services Nurse Practitioner who documented~ "Alert and pleasant. Engages in conversation easily. Appears in no distress or discomfort. Affect bright. Visiting with friends and family. States she is feeling so much better. Has started sleeping better and has not used trazadone for 2 nights. Reports her husband has come to visit a few times and that she has really enjoyed seeing him. Doing well in therapy. No tearfulness or anxiety noted. 5. 12/18/14 Social services review of Nurse Practitioner recommendations 6. 12/24/14 Social services summary~ no further use of Trazadone noted at this time 7. 12/31/14- Summary of reported conversation between former ED and resident. This conversation was followed up with visit from social services. Resident exhibiting some confusion at this time as noted 8. 1/2/15~</p>		

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	<p>"C" was non-compliant with therapies. The DNS indicated the SSD (Social Service Designee) followed medications for depression and behavior monitoring. The SSD was identified as the facility liaison for coordinating and communicating with Psych Services as ordered by physicians.</p> <p>The SSD was interviewed on 02/11/15 at 11:45 a.m. The SSD provided clinical notes and indicated the resident had exhibited signs & symptoms of depression, as evidenced by crying and tearfulness, as well as anxiety.</p> <p>Review of "Clinical Notes Report" by the SSD indicated: "12/04/14 3:00 p.m. Admission....She does not take any psychotropic medications. She has shown signs of crying/tearfulness. She states this is all new to her and she wants to get better so she can go home and take care of her husband with dementia. SS offered [Resident "C" name] to have mental health services see her. She agreed to it....[Resident "C"] can make her needs known verbally...BIMS score was 13; cognitively intact....mood indicators of feeling down, feeling tired, feeling bad about herself and moving slower than usual...."</p>		Summary note of call between Social Services and resident's daughter. Resident's daughter concerned that resident may be suicidal and requested psych eval. Interventions outlined that includes NPI as well as attempting lowest dose of anti-depressant (celexa) which family and resident agrees to attempt. Each "behavior" that as indicated for treatment was "reported" either by resident or family, although there was documentation in January that resident exhibited some tearfulness, and some confusion and the Celexa was discontinued. Based on the above reports and attempts to treat the specific condition as diagnosed and documented in the clinical record as supporting documentation shows, we request that this deficiency citation be reversed.				

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	<p>"12/05/14 5:07 p.m. [Resident "C"] was seen by [Psych Services name] nurse practitioner today for concerns of depression. She was diagnosed with adjustment disorder with mixed anxiety and depression. Insomnia....Staff to monitor [Resident "C"] mood and behavior. She was put on Trazadone 50 mg po phs [sic] PRN for sleep."</p> <p>"12/10/14 12:27 p.m....[Resident "C"] continues to be involved with physical and occupational therapies. She wants to be able to go back home with her husband. The husband has dementia and has a care taker. The care taker brings him in a couple of times a week to see [Resident "C"]. [Resident "C"] was prescribed Trazadone 50 mg by [Psych Service]....Over the past two days [Resident "C"] stated to SS and the nursing staff she doesn't seem to feel right....have a call in to the doctor to see if the Trazadone can be cut in half; making her sleepy....BIMS assessment was done on 12/10/14 with a score of 12; moderately cognitively impaired....mood indicators of little interest doing things, feeling tired, trouble concentrating and moving slower than normal...."</p> <p>"12/18/14 12:23 p.m. [Resident "C"] was seen by [Psych Service] on 12/15/14 for follow up to insomnia and mood. She is</p>			

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	<p>to continue with current medications and current plan of care. Staff are to monitor her mood and behavior."</p> <p>The Regional Nurse (RRN) was interviewed on 02/11/15 at 12:30 p.m. The RRN indicated the facility had undergone a change of corporate ownership on 01/01/2015 and the RRN continued to become familiar with the new facilities. The RRN had reviewed the closed records of Resident "C" but had not assessed the resident prior to her discharge to a local ACF.</p> <p>The RRN provided a facility copy of information from the facilities drug reference book,"The 2014 Nursing Drug Handbook," for the routine pain medication Resident "C" was receiving, Nucenta 75 mg po q6 hours.</p> <p>Review of the medication, Nucynta, indicated: "tapentadol hydrochloride: Nucynta...Analgesic; ...Centrally acting synthetic opioid analgesics... INDICATIONS & DOSAGES: Moderate to severe acute pain...Adults: 5- to 100 mg po every 4 to 6 hours... ADVERSE REACTIONS: CNS [Central Nervous System]: abnormal dreams, anxiety...confusion, dizziness, fatigue, insomnia, lethargy, somnolence..</p>			

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	<p>.INTERACTIONS: Drug-drug. CNS depressants (...hypnotics, opiod analgesics,...sedatives, tranquilizers): May cause additive CNS effects. Reduce dosage of one or both drugs and monitor patient closely..."</p> <p>Review of the medication, Trazadone, from the "2014 Nursing Drug Handbook", indicated: "Trazadone hydrochloride: Trazodone. Antidepressant.</p> <p>INDICATIONS & DOSAGES: Depression</p> <p>ADVERSE REACTIONS: CNS: drowsiness, dizziness, nervousness, fatigue, confusion,...weakness, hostility, anger, nightmares, vivid dreams, ..., insomnia..."</p> <p>The DNS on 01/11/15 at 12:45 p.m., provided a Policy & Procedure, "Behavior Assessment and Monitoring: 05/2013", indicated:</p> <p>"Policy Statement: 1. Problematic behavior will be identified and managed appropriately...</p> <p>Policy Interpretation and Implementation:...</p> <p>2. The nursing staff will identify, document, and inform the physician about an individual's mental status,</p>			

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	<p>behavior, and cognition, including:</p> <p>a. Onset, duration and frequency of problematic behaviors or changes in behavior, cognition, or mood.</p> <p>b. Any precipitating or relevant factors (e.g. medications changes, ...)</p> <p>Monitoring:...</p> <p>2. The staff will document ...the following information about specific problem behaviors:</p> <p>a. Number and frequency of episodes;</p> <p>b. Preceding or precipitating factors;</p> <p>c. Interventions attempted... and</p> <p>d. Outcomes associated with interventions...."</p> <p>This Federal tag relates to Complaint IN00164273.</p> <p>3.1-48(a)(6)</p>			
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