

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155507	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/24/2013
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NAME OF PROVIDER OR SUPPLIER SYCAMORE SPRINGS REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
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F000000	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Survey dates: July 17,18, 19, 22, 23, & 24, 2013</p> <p>Facility number: 000510 Provider number: 155507 AIM number: 100285440</p> <p>Survey team: Angel Tomlinson RN TC Sharon Lasher RN Leslie Parrett RN Barbara Gray RN (July 18, 19, 22, 23, & 24 2013)</p> <p>Census bed type: SNF/NF: 29 Total: 29</p> <p>Census Payor type: Medicare: 4 Medicaid: 20 Other: 5 Total: 29</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2</p> <p>Quality review 8/01/13 by Suzanne Williams, RN</p>	F000000	<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.</p> <p>This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Due to low low scope and severity of the survey finding, please find sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to follow a physician's order for thickened liquids, for 1 of 25 residents reviewed for physician's orders. (Resident #39)</p> <p>Findings include:</p> <p>On 7/19/13 at 12:47 P.M., Resident #39 was seated at the dining room table with his peers. His meal ticket laying on the table indicated a regular diet with nectar thickened liquids. His liquids available for him to drink, included 3 thickened drinks. He was observed drinking his thickened water and juice independently.</p> <p>On 7/22/13 at 10:04 A.M., Resident #39 was observed seated in his bedroom in his recliner. Resident #39's father was visiting. At that time, Resident #39's father indicated he did not know why Resident #39 could drink thin Gatorade and not drink thin water. He stated, "what's the difference." A small empty bottle of Gatorade was observed on Resident</p>	F000282	F0282 Requires the facility to ensure they follow a physician's order for thickened liquids. The facility will ensure this requirement is met through the following: 1. Resident #39 was interviewed and based upon his request the doctor was notified for the resident to consume thin liquids. The resident was educated on his need for thickened liquids and the risk of obtaining thin liquids but he still requested thin liquids. The resident signed a waiver and a physician order was obtained to allow resident to consume thin liquids. 2. All residents have the potential to be affected. All residents with physician orders for thickened liquids were reviewed to ensure the resident was consuming the right consistency of fluids. Orders were reviewed with the resident and the physician. 3. The thickened liquid policy and procedure was reviewed with no changes made. (See attachment A). The staff was inservices on the above procedure. 4. The DON or her designee will conduct room rounds to ensure that residents that have a physician order for thickened liquids are consuming	08/07/2013			

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	<p>#39's bedside table. Resident #39's father indicated the bottle was half empty when he arrived and Resident #39 finished drinking the Gatorade while he was there. At that time, Resident #39 indicated the staff allowed him to drink the thin Gatorade but provided him with thickened water.</p> <p>On 7/22/13 at 10:52 A.M., the Assistant Director of Nursing (ADON) indicated CNA #3 had informed her, Resident #39's parents brought Gatorade in for him to drink and stored it in the facility's nutrition pantry. The ADON indicated CNA #4 had informed her, she had given Resident #39 the Gatorade before to drink. The ADON indicated CNA #4 had probably seen Resident #39's parents give him the Gatorade, so she also gave it to him.</p> <p>Resident #39's record was reviewed, on 7/22/13 at 11:00 A.M. Diagnoses included but were not limited to: dysphagia (difficulty swallowing), dystharia (difficulty speaking), and seizure disorder.</p> <p>Resident #39's admission Minimum Data Set assessment, dated 7/15/13, indicated the following: Resident #39 was admitted from a local hospital.</p>		<p>the correct consistency at their bedside. The audits will be completed twice daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained for two consecutive quarters. (See attachment B). The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action will be adjusted accordingly is warranted. 5. The above corrective measures will be completed on or before August 7, 2013.</p>		

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	<p>His speech was unclear. He was able to make himself understood and understood others. He required supervision with set up help only to eat. He was provided a mechanically altered diet (change in texture of food or fluids). He showed signs and symptoms of a possible swallowing disorder (loss of liquids/solids from mouth when eating or drinking. Coughing or choking during meals or when swallowing medications). He scored 15 on his Brief Interview for Mental Status, indicating he was cognitively intact.</p> <p>An admission physician order for Resident #39, dated 7/8/13, indicated a regular consistency diet with nectar thick liquids.</p> <p>A Nutrition Care Plan for Resident #39, dated 7/8/13, indicated the following: Resident #39 would be provided a regular consistency diet with nectar thickened liquids. His goals included tolerating the diet by not displaying any signs or symptoms of choking or aspiration.</p> <p>A Nutritional Assessment Summary for Resident #39, dated 7/18/13, indicated there were no changes in his diet per Speech Therapy. Resident #39 would be provided a</p>			

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	<p>regular diet with nectar thick liquids.</p> <p>On 7/22/13 at 3:14 P.M., CNA #4 indicated she had given Resident #39 his Gatorade before out of the facility's nutrition pantry to drink. CNA #4 indicated she had given Resident #39 a Gatorade to drink that morning in the dining room before breakfast. CNA #4 indicated Resident #39 had previously been a resident at the facility and she had gotten his orders confused with his previous admission orders. CNA #4 indicated she should have realized Resident #39's orders "were all new." CNA #4 indicated she was able to determine a resident's diet by the resident's meal ticket and her CNA assignment sheet. CNA #4 was not able to provide a copy of her CNA assignment sheet at that time. She stated, "I must have laid it down somewhere."</p> <p>On 7/22/13 at 3:52 P.M., CNA #4 provided her CNA assignment sheet. CNA #4 indicated her CNA assignment sheet said thin liquids but had said thickened liquids earlier that day.</p> <p>On 7/22/13 at 3:52 P.M., the Director of Nursing (DoN) indicated she was unaware Resident #39 had been drinking thin liquids "until today." The</p>				

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	<p>DoN indicated Resident #39 had to be educated and sign a waiver prior to providing him thin liquids.</p> <p>3.1-35(g)(2)</p>			

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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 assess 1 resident with lower abdominal pain and bleeding and 1 resident with complaints of feeling sick for 2 of 2 residents reviewed for pain. (Resident #62 and #15)</p> <p>Findings include:</p> <p>1.) Resident 62's record was reviewed on 7/24/13 at 1:20 p.m. Diagnoses included, but were not limited to, diabetes, depression and fibromyalgia.</p> <p>Resident #62's MDS (Minimum Data Set), assessment, dated 5/30/13, indicated the following:</p> <ul style="list-style-type: none"> - BIMS (Brief Interview for Mental Status), 15, with a score of 13-15 indicating cognition intact - frequently incontinent of urine - always continent of bowel - been on a scheduled pain medication - received PRN (as needed) pain 	F000309	F309 Requires the facility to assess residents who have pain. The facility will ensure this requirement is met through the following: 1. Resident #62 and Resident #15 had a pain assessment completed. 2. All residents have the potential to be affected. Pain assessments were conducted on the residents. See below for corrective measures. 3. The pain management policy and procedure was reviewed with no changes made. (See attachment C). The staff was inserviced on the above procedure. 4. The DON or her designee will conduct interviews with all residents regarding pain using the Wong-Baker scale as well as review behavior sheet documentation to ensure that residents pain is addressed timely. The audits will be conducted daily times four, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100 % compliance is obtained and maintained for two consecutive quarters. (See attachment B). The audits will be	08/07/2013			

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	<p>medication</p> <ul style="list-style-type: none"> - received non-medication intervention for pain, yes - should pain assessment interview be conducted, yes - have you had pain or hurting at any time in the last 5 days, yes - how much of the time have you experienced pain or hurting, almost constantly - has pain made it hard for you to sleep at night, yes - have you limited your day-to-day activities because of pain, yes - numeric rating scale (0-10), 8 - should the staff assessment for pain be conducted, no <p>Resident #62's physician recapitulation orders, dated 7/13, indicated "5 mg (milligrams) hydrocodone (325 narcotic pain medication)/Tylenol 325 mg, by mouth, as needed, every 4 hours.</p> <p>Resident #62's nursing notes, dated 7/19/13, indicated "the resident complained of a small amount of vaginal bleeding. A scant amount of reddish secretions was on a washcloth. The resident continues to complain of cramping. Offered the resident to go to the hospital and the resident declined. The resident indicated she thought she was</p>		<p>reviewed during the facility's quarterly quality assurance meetings and the plan of action will be adjusted accordingly if warranted. 5. The above corrective measures will be completed on or before August 7, 2013.</p>		

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	<p>passing a kidney stone. The physician was notified."</p> <p>On 7/23/13 at 12:00 p.m., Resident #9 indicated, RN #2 came into her room on second shift "after I had asked for pain medication" and RN #2 stated "I gave you Lyrica (pain medication), and I told her I asked for hydrocodone (narcotic analgesic) and she took her time giving it to me and then she laid into my mom. I ask for the pain medication at 6:15 p.m., and she didn't give me the hydrocodone for a long time, around 7:15 p.m. I was having stomach and leg cramps. My left leg really hurts from prior surgery. I should not have to beg her for my pain medication. This also happened last Tuesday or Friday. My pain was a 10 on a 1 to 10 pain scale. I was doubled over in pain but she said she already gave me Lyrica and you don't need anything else; Lyrica is a pain medicine. I was prescribed the pain medication (hydrocodone) for my left leg and buddy it hurts. I am holding fluid. This problem has happened with this same nurse more than once."</p> <p>On 7/23/13 at 12:06 p.m. an interview with Resident #62's mother indicated, "Friday the way she was breathing and having pain I asked (RN #2) if</p>				

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	<p>she thought it could be a kidney stone and she stated 'I am not a doctor and it's not my job to look at her.'</p> <p>Resident #62's mother indicated, "she told me off; she (Resident #62) asked for a pain pill and (RN #2) said 'I will give it to her when I am ready to' and I told (RN #2) 'the girl is hurting.' She (RN #2) then went right outside the door to her medication cart and went back to the nursing station and I told her "the physician at Indianapolis wanted her to have this pain medication so she would not have pain if they gave it the way it was supposed to be given." Resident #62's mother indicated Resident #62 had called her on the phone at 6:15 p.m. and said she had asked RN #2 for pain medication at that time. "I got here around 8:00 p.m. or 8:30 p.m. and she was in bad pain and still had not received the pain medication."</p> <p>Resident #62's PRN (as needed) medication flow sheet for Resident #62 indicated the resident received 5 mg hydrocodone/Tylenol 325 mg on 7/20/13 at 7:00 p.m., for stomach cramps, the pain severity was 7 on a 1-10 pain scale. The medication was effective at 8:00 p.m.</p> <p>During an interview on 7/23/13 at 1:56 p.m., Resident #62 indicated, "I</p>			

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	<p>had blood in the toilet and I think it came from my rectum when I wiped there was blood on the toilet paper and there was a moderate amount of blood in the toilet. The color was strawberry bright red and (RN #2) said 'she was bleeding too.' "When I wiped my vagina there was a small amount of blood on the toilet paper and I showed her it is coming from both places but it is not normal for me. I told her I am not supposed to be bleeding; I don't have menstrual cycle. She did not do any assessment on my bowels, vitals or anything."</p> <p>During an interview on 7/23/13 at 2:20 p.m. #RN #2 indicated she was told that Resident #62 had some bloody stools and there was a consult for a colonoscopy, "she showed me a wash cloth with a quarter size blood on it, but it wasn't bright or dark but it was light red, it may have been old. I offered for her to go to the hospital and she didn't want to go and I gave her pain medication." She indicated she made a quick note and did not do an assessment because she thought it was from the stool with blood she had been having. She also indicated she gave her pain medication for abdominal cramping.</p>			

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	<p>Resident #62's progress note from the proctologist (colon specialist) for Resident #62, dated 7/24/13 at 1:30 p.m., indicated the resident had been experiencing rectal bleeding and cramping for 2-3 weeks. The resident had bright red rectal bleeding in moderate amounts. A colonoscopy would be scheduled for the resident.</p> <p>An interview with Resident #62 on 7/24/13 at 1:50 p.m., indicated yesterday the doctor said he was unsure of the cause of the rectal bleeding and went over the procedure of a colonoscopy on 8/8/13. She also indicated she will apply pressure with her hands to her stomach and that helps some, and the pain medication helps her abdominal cramps.</p> <p>2.) The record of Resident #15 was reviewed on 7/19/13 at 2:00 p.m. Resident #15's diagnoses included, but were not limited to, history of bilateral pulmonary embolism, congestive heart failure, chronic urinary tract infection and coronary artery disease.</p> <p>Resident #15's MDS (Minimum Data Set), assessment, dated 6/14/13, indicated daily decision making was moderately impaired.</p>			

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	<p>Resident #15's physician recapitulation orders, dated 7/13, indicated "Tylenol 325 mg (milligrams), give 2 tablets (650 mg) by mouth, every 6 hours as needed for pain/fever."</p> <p>Resident #15's "Mood and Behavior Communication Memo" indicated the following:</p> <ul style="list-style-type: none"> - 5/27/13, 6:00 a.m. to 2:00 p.m., possible trigger of the behavior, "not feeling good" refused her restorative programs, 3 attempts...stayed in room the whole shift saying she did not feel well, nurse aware - 5/28/13, time of incident 10:00 a.m., 11:45 a.m. and 1:00 p.m., said "she was sick" stayed in bed all day refused restorative program, 3 attempts made - 6/1/13, 11:00 a.m. to 2:00 p.m., possible trigger of the behavior "not feeling well" stayed in her room all day and was not feeling well. She refused her restorative programs, nurse aware - 7/17/13, 10:30 a.m., 12:45 p.m. and 1:10 p.m., approached 3 times to do restorative program, refused said she had a headache, she didn't get any sleep last night and she was too sick, nurse aware - 7/18/13, 10:30 a.m., 11:45 a.m. and 1:20 p.m. approached 3 times to do 						

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	<p>restorative program. She would tell me "honey I have a headache" or "honey I'm sick today."</p> <p>Resident #15's nursing notes lacked documentation of any assessments made for Resident #15's complaints of not feeling well.</p> <p>During an interview on 7/24/13 at 12:49 p.m., the DON (Director of Nursing) indicated Resident #15 does not want to go to the Restorative Program and that was the reason she was complaining of not feeling well. She also indicated on the "PRN (as needed) Medication Flow Sheet" Tylenol was given on 7/17/13 at 10:15 a.m. and there was not other documentation of Resident #15's complaints from 5/27/13 to 7/18/13 except on the 24 hour report.</p> <p>Resident #15's "PRN Medication Flow Sheet" indicated, on 7/17/13 at 10:15 a.m., Tylenol was given for a headache, 6 on the scale of 0-10. No documentation was made if the Tylenol was effective.</p> <p>Review of Resident #15's 24 hour report indicated the following; - 5/27/13, refused restorative did not feel well, blood pressure, 130/74, pulse, 74, respirations 18 and</p>			

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	<p>temperature, 97.8</p> <ul style="list-style-type: none"> - 5/28/13, refused restorative, tired and wanted to rest, no other complaints - 6/1/13, refused restorative program, stated "just not feeling well, would just like to rest" - 7/17/13, Tylenol for headache, at 12:00 p.m. - 7/18/13, refused Tylenol at 10:00 a.m. and at 12:00 p.m. no complaint of headache. <p>The "Pain Management Procedure" provided by the DON on 7/24/13 at 10:30 a.m., indicated "it is the goal of this facility to assist residents in achieving his/her optimal level of comfort by providing an effective pain management program."</p> <p>3.1-37(a)</p>				

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F000312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview and record review, the facility failed to assist a resident with a shower and with personal hygiene after an incontinent episode, for 1 resident reviewed for activities of daily living, cleanliness and grooming of 1 who met the criteria for activities of daily living, cleanliness and grooming (Resident #28).</p> <p>Finding include:</p> <p>1.) Review of the Record of Resident #28 on 7-22-13 at 11:05 a.m. indicated the resident's diagnoses included, but were not limited to, psychosis, depression, dementia with hallucinations, Parkinson, anxiety, osteoarthritis, retinal deterioration, osteoporosis, dementia with behaviors, overactive bladder and arthritis.</p> <p>The Minimum Data Set (MDS) assessment for Resident #28, dated 4-25-13 indicated the resident's BIMS (Brief Interview for Mental Status) was</p>	F000312	<p>F0312 Requires the facility to assist a resident with a shower and personal hygiene after an incontinent episode. The facility will ensure this requirement is met through the following: 1. Resident #28 had personal care provided. 2. All residents have the potential to be affected. See below for corrective measures. 3. The staff was educated on the shower schedules and the importance of providing personal care after incontinence episodes. 4. The DON or her designee will conduct daily rounds to ensure resident's showers and personal hygiene after incontinent episodes are being completed in a timely manner. The audits will be completed daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained for two consecutive quarters. (See attachment B). The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action will be adjusted accordingly if warranted. 5. The above corrective measures will be</p>	08/07/2013			

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	<p>a 15, with a range of 13-15, indicating the resident is cognitively intact, urinary continence-occasionally incontinent, transfer- extensive assistance of one person, walk in room- activity did not occur, toilet use- extensive assistance of two people, bathing- physical help in part of bathing of one person and dressing- extensive assistance of one person.</p> <p>The care plan for Resident #28 dated 5-8-13, indicated the resident had a health condition of an overactive bladder and was at risk for skin breakdown.</p> <p>The care plan for Resident #28 dated 5-8-13, indicated the resident requires two people to assist with Activities Of Daily Living. The reason for the need of assistance included, but were not limited to, Parkinson's, visual problems and weakness. The interventions included, but were not limited to, showers/bath as scheduled.</p> <p>Interview with Resident #28 on 7-22-13 at 9:30 a.m. indicated on 7-20-13 she had asked for assistance to go to the restroom at 7:30 a.m. and was not assisted to the bathroom until 9:15 a.m. The resident indicated she felt like she "wet" herself a lot. The</p>		completed on or before August 7, 2013.				

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	<p>resident indicated she laid wet with urine the entire time.</p> <p>Interview with Resident #28 on 7-23-13 at 9:30 a.m. indicated she was scheduled to have a shower on 7-22-13 but did not receive one. The resident indicated the staff told her they did not have enough time to give her, her scheduled shower. The resident indicated she had not had a shower since 7-18-13. The resident indicated she felt like her skin was irritated in her groin area from lying wet with urine on 7-20-13 and not receiving a shower on 7-22-13. The resident indicated staff did not wash her up on 7-22-13 either. The resident indicated "it does not feel good to not get a shower." The resident indicated she needed a shower bad. The resident indicated she had not felt clean since 7-20-13 when she laid in urine for a couple hours.</p> <p>Interview with CNA #10 on 7-23-13 at 10:00 a.m. indicated the facility staff were supposed to initial when they gave a resident a shower and Resident #28's shower was not initialed that she received one on Monday 7-22-13. The shower schedule indicated the resident was scheduled to have showers on Monday and Thursday of each week.</p>				

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	<p>The bathing schedule for Resident #28 dated July 2013, indicated the resident had not received a shower since July 18, 2012.</p> <p>During observation on 7-23-13 at 1:50 p.m. Resident #28's right side of her groin area was bright red and the left side of her groin area was pink. CNA #3 indicated the resident's groin area looked red and irritated. CNA #3 indicated the resident did not receive any cream or powders to that area. CNA #3 indicated he was going to report the resident's skin irritation to the nurse.</p> <p>Interview with LPN #1 on 7-24-13 at 11:36 a.m. indicated yes CNA #3 reported to her on 7-23-13 that Resident #28's groin area was excoriated, and the resident was now receiving nystatin powder to the areas two times a day and as needed to treat the excoriation.</p> <p>3.1-38(a)(2)(A)</p>				

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F000315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview and record review, the facility failed to provide care to promote normal bladder function by failing to assist a resident who required assistance to the bathroom, for 1 resident reviewed for incontinence of 1 resident who met the criteria for incontinence (Resident #28).</p> <p>Finding include:</p> <p>1.) Review of the record of Resident #28 on 7-22-13 at 11:05 a.m. indicated the resident's diagnoses included, but were not limited to, psychosis, depression, dementia with hallucinations, Parkinson, anxiety, osteoarthritis, retinal deterioration, osteoporosis, dementia with behaviors, overactive bladder and arthritis.</p>	F000315	F0315 Requires the facility to promote normal bladder function by assisting a resident who requires assistance to the bathroom. The facility will ensure this requirement is met through the following: 1. Resident #28 had personal care provided. 2. All residents have the potential to be affected. See below for corrective measures. 3. The staff was educated on the shower schedules and the importance of providing personal care after incontinence episodes. 4. The DON or her designee will conduct room rounds daily rounds to ensure resident's showers and personal hygiene after incontinent episodes are being completed in a timely manner. The audits will be completed daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained for two consecutive quarters. (See	08/07/2013	

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	<p>The Minimum Data Set (MDS) assessment for Resident #28, dated 2-15-13 indicated the resident was always continent of her bladder.</p> <p>The Minimum Data Set (MDS) assessment for Resident #28, dated 4-25-13 indicated the resident's BIMS (Brief Interview for Mental Status) was a 15, with a range of 13-15, indicating the resident is cognitively intact, urinary continence-occasionally incontinent, transfer- extensive assistance of one person, walk in room- activity did not occur, toilet use- extensive assistance of two people, bathing- physical help in part of bathing of one person and dressing- extensive assistance of one person.</p> <p>The care plan for Resident #28 dated 5-8-13, indicated the resident had a health condition of an overactive bladder and was at risk for skin breakdown.</p> <p>The scheduled toileting program for Resident #28 dated 7-20-13, indicated the resident was incontinent after breakfast.</p> <p>Interview with Resident #28 on 7-22-13 at 9:30 a.m. indicated on 7-20-13 she had asked for assistance to go to the restroom at 7:30 a.m. and</p>		<p>attachment B). The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action will be adjusted accordingly if warranted. 5. The above corrective measures will be completed on or before August 7, 2013.</p>		

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	<p>was not assisted to the bathroom until 9:15 a.m. The resident indicated she felt like she "wet" herself a lot. The resident indicated she laid wet with urine the entire time. The resident indicated she was legally blind and knew how long she laid wet with urine because her wrist watch audibly told time. The resident pushed a button on her wrist watch at this time and it audibly said the correct time. The resident indicated when she asked for assistance to get up and go to the restroom at 7:30 a.m. on 7-20-13 the staff told her they would come back and could not help her at that time because they were feeding people breakfast. The resident indicated she turned her call light back on at 7:45 a.m. and it was not answered until 9:15 a.m. The resident indicated she was tired from laying and uncomfortable. The resident indicated she felt like there should be at least one staff to help people to the bathroom during meal times.</p> <p>Interview with Resident #28 on 7-23-13 at 9:30 a.m. indicated she felt like her skin was irritated in her groin area from lying wet with urine on 7-20-13. The resident indicated she was wet with urine on 7-20-13 from 7:30 a.m. to 9:15 a.m. The resident indicated she wet herself four or five</p>						

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	<p>times while she waited for someone to help her. The resident indicated she thought about trying to go to the bathroom by herself but was afraid she would fall. The resident indicated she never requested to sleep in on 7-20-13. Interview with Resident #28's family member at this time indicated he was present on 7-20-13 when the resident was not assisted to the bathroom. The family member indicated he knew the resident was soaked with urine and went to the nursing station and told the nurse the resident needed assistance. The family member indicated the resident wanted to go to the bathroom and no one would help her. The family member indicated Resident #28 could not get around by herself anymore and the facility staff knew that. Interview with the family member indicated Resident #28 never refused to get up on 7-20-13.</p> <p>During observation on 7-23-13 at 1:50 p.m. Resident #28's right side of her groin area was bright red, and the left side of her groin area was pink. CNA #3 agreed the resident's groin area looked red and irritated. CNA #3 indicated the resident did not receive any cream or powders to that area. CNA #3 indicated he was going to report the resident's skin irritation to</p>						

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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to provide education to a resident who required thickened liquids on the possible danger of drinking thin liquids to prevent a choking and/or aspiration incident and provide him with the opportunity to sign a waiver to drink thin liquids against medical advice before providing him thin liquids, for 1 resident randomly reviewed for accidents. (Resident #39)</p> <p>Findings include:</p> <p>On 7/19/13 at 12:47 P.M., Resident #39 was seated at the dining room table with his peers. His meal ticket laying on the table indicated a regular diet with nectar thickened liquids. His liquids available for him to drink included three thickened drinks. He was observed drinking his thickened water and juice independently.</p> <p>On 7/22/13 at 10:04 A.M., Resident #39 was observed seated in his</p>	F000323	<p>F0323 Requires the facility to provide education to a resident who requires thickened liquids on the possible danger of drinking thin liquids to prevent choking and/or aspiration incident and provide the resident with an opportunity to sign a waiver to drink thin liquids against medical advice before providing liquids. 1. Resident #39 was interviewed and based upon his request the doctor was notified regarding his request for thin liquids. The resident was educated on his need for thickened liquids and the risk of obtaining thin liquids were addressed but the resident still requested thin liquids. The resident signed a waiver and an a physician order was obtained to allow resident to consume thin liquids. 2. All residents have the potential to be affected. All residents who have a physician's orders for thickened liquids were reviewed to ensure the residents are consuming the right consistency of fluids. Orders were reviewed with the resident to ensure they were educated on the need for thickened liquids and risks if thin liquids were consumed. If the resident wished</p>	08/07/2013	

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	<p>bedroom in his recliner. Resident #39's father was visiting. At that time, Resident #39's father indicated he did not know why Resident #39 could drink thin Gatorade and not drink thin water. He stated, "what's the difference." He indicated Resident #39 did not like thickened liquids. A small empty bottle of Gatorade was observed on Resident #39's bedside table. Resident #39's father indicated the bottle was half empty when he arrived and Resident #39 finished drinking the Gatorade while he was there. At that time, Resident #39 indicated the staff allowed him to drink the thin Gatorade but provided him with thickened water.</p> <p>On 7/22/13 at 10:52 A.M., the Assistant Director of Nursing (ADON) indicated CNA #3 had informed her Resident #39's parents brought Gatorade in for him to drink and stored it in the facility's nutrition pantry. The ADON indicated CNA #4 had informed her she had given Resident #39 the Gatorade before to drink. The ADON indicated CNA #4 had probably seen Resident #39's parents give him the Gatorade, so she also gave it to him.</p> <p>Resident #39's record was reviewed, on 7/22/13 at 11:00 A.M. Diagnoses</p>		<p>to change their order, the physician was notified of their request and an order obtained for thin liquids. A waiver was also signed stating their request for thin liquids and the risk factors. 3. The thickened liquid policy and procedure was reviewed with no changes made. (See attachment A). The staff was inservices on the above procedure. 4. The DON or her designee will conduct room rounds to ensure that residents that have a physician order for thickened liquids are consuming the correct consistency of liquids in their room and are educated on the risk factors of consuming thin liquids if not ordered by the physician. This audit will be completed twice daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained for two consecutive quarters. (See attachment B). The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action will be adjusted accordingly is warranted. 5. The above corrective measures will be completed on or before August 7, 2013.</p>		

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	<p>included but were not limited to: dysphagia (difficulty swallowing), dystharia (difficulty speaking), and seizure disorder.</p> <p>Resident #39's admission Minimum Data Set assessment, dated 7/15/13, indicated the following: Resident #39 was admitted from a local hospital. His speech was unclear. He was able to make himself understood and understood others. He required supervision with set up help only, to eat. He was provided a mechanically altered diet (change in texture of food or fluids). He showed signs and symptoms of a possible swallowing disorder (loss of liquids/solids from mouth when eating or drinking. Coughing or choking during meals or when swallowing medications). He scored 15 on his Brief Interview for Mental Status, indicating he was cognitively intact.</p> <p>An admission physician order for Resident #39, dated 7/8/13, indicated a regular consistency diet with nectar thick liquids.</p> <p>A Nutrition Care Plan for Resident #39, dated 7/8/13, indicated the following: Resident #39 would be provided a regular consistency diet with nectar thickened liquids. His</p>				

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	<p>goals included tolerating the diet by not displaying any signs or symptoms of choking or aspiration.</p> <p>A Nutritional Assessment Summary for Resident #39, dated 7/18/13, indicated there were no changes in his diet per Speech Therapy. Resident #39 would be provided a regular diet with nectar thick liquids.</p> <p>On 7/22/13 at 3:14 P.M., CNA #4 indicated she had given Resident #39 his Gatorade before out of the facility's nutrition party to drink. CNA #4 indicated she had given Resident #39 a Gatorade to drink that morning in the dining room before breakfast. CNA #4 indicated Resident #39 had previously been a resident at the facility and she had gotten his orders confused with his previous admission orders. CNA #4 indicated she should have realized Resident #39's orders "were all new." CNA #4 indicated she was able to determine a resident's diet by the resident's meal ticket and her CNA assignment sheet. CNA #4 was not able to provide a copy of her CNA assignment sheet at that time. She stated, "I must have laid it down somewhere."</p> <p>On 7/22/13 at 3:34 P.M., the Therapy Manager indicated the Speech</p>				

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	<p>Therapist saw delayed swallowing, coughing, and risk for aspiration, with Resident #39's last swallowing evaluation. The Therapy Manager indicated due to the Speech Therapist's observation and evaluation, she was unable to recommend a diet upgrade.</p> <p>On 7/22/13 at 3:52 P.M., CNA #4 provided her CNA assignment sheet. CNA #4 indicated her CNA assignment sheet said thin liquids, but had said thickened liquids earlier that day.</p> <p>On 7/22/13 at 3:52 P.M., the Director of Nursing (DoN) indicated she was unaware Resident #39 had been drinking thin liquids "until today." The DoN indicated she and LPN #1 had educated Resident #39 and his father on the dangers of drinking thin liquids and the importance of drinking thickened liquids today, after finding out Resident #39 had been drinking thin liquids and no longer wanted to drink thickened liquids. The DoN indicated Resident #39 signed a waiver at that time. The DoN indicated CNAs are trained to read the resident's diet card and their CNA assignment sheet, for different things they need to know regarding a resident's care. The DoN indicated</p>				

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	<p>the CNAs could also ask their nurse.</p> <p>On 7/23/13 at 12:24 P.M., LPN #1 indicated she had not been aware Resident #39 had been drinking thin liquids. LPN #1 indicated Resident #39's father had approached her yesterday (7/22/13) and informed her, Resident #39 no longer wanted to drink thickened liquids. LPN #1 indicated Resident #39 was then educated on the risk of drinking thin liquids by herself and the DoN. LPN #1 indicated Resident #39 chose to sign a waiver after being educated.</p> <p>Documentation indicated a "Waiver for Diet Non-Compliance At Risk Release" was signed by Resident #39, the DoN, and LPN #1, on 7/22/13.</p> <p>A physician's order for Resident #39, dated 7/22/13, indicated the following: Discontinue nectar thick liquids. May have thin liquids.</p> <p>The most recent Thickened Liquids policy and procedure, provided by the DoN, on 7/24/13, at 10:30 A.M., indicated the following: "Purpose: To ensure thickened liquids are provided as ordered for those residents who have been deemed unsafe to consume thin liquids. Policy: Any</p>			

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	<p>resident who suffers from dysphagia or swallowing difficulties will be referred to his/her attending physician for possible evaluation by Speech Therapy to ascertain if there is a need for liquids to be thickened. Should thickened liquids be appropriate, the facility shall ensure that the resident receives said liquids at the consistency ordered by the physician...."</p> <p>3.1-45(a)(2)</p>			

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F000329 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 observation, interview and record review, the facility failed to attempt a gradual dose reduction (GDR) for antipsychotic and antianxiety medications for 2 of 10 residents reviewed for unnecessary medication use (Resident #28 and Resident #17).</p> <p>Findings include:</p> <p>1.) Review of the record of Resident #28 on 7-22-13 at 11:05 a.m.</p>	F000329	F0329 Requires the facility to attempt a gradual dose reduction for antipsychotic and antianxiety medications. 1. Resident #28 and #17 had a gradual dose reduction attempted at this time. 2. All residents have the potential to be affected. Residents who were on an antipsychotic or antianxiety medication had their orders reviewed and a gradual dose reduction was attempted if no behaviors were noted. 3. The antianxiety drug use and antipsychotic drug use policy and procedure were reviewed with no	08/07/2013			

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	<p>indicated the resident's diagnoses included, but were not limited to, psychosis, depression, dementia with hallucinations, parkinson, anxiety, osteoarthritis, retinal deterioration, osteoporosis, dementia with behaviors, overactive bladder and arthritis.</p> <p>The Minimum Data Set (MDS) assessment for Resident #28, dated 4-25-13, indicated the resident's BIMS (Brief Interview for Mental Status) score was 15, with a range of 13-15 indicating the resident was cognitively intact, and no behaviors were indicated.</p> <p>The physician order dated July 2013 for Resident #28 indicated the resident was ordered Seroquel 12.5 milligrams (mg) at 8:00 a.m. daily and Seroquel 37.5 mg at 8:00 p.m. daily for psychosis. The resident was ordered Xanax 0.5 mg at 8:00 p.m. daily for anxiety.</p> <p>The risk-benefit acknowledgement form for antipsychotic medication for Resident #28, dated 6-21-13, indicated the resident took Seroquel. The non-pharmacological treatments/interventions utilized by staff did not improve the resident's clinical and/or functional status: social</p>		<p>changes made. (See attachment D and E). The staff was inservices on the above procedure. 4. The DON or her designee will review resident's physician orders and behaviors to ensure that a drug reduction occurs timely if resident is not displaying behaviors. This audit will be completed weekly times four weeks, then monthly for three months then quarterly thereafter until 100% compliance is obtained and maintained for two consecutive quarters. (See attachment B). The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action will be adjusted accordingly is warranted. 5. The above corrective measures will be completed on or before August 7, 2013.</p>				

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	<p>services and activities. No other non-pharmacological treatments or interventions were documented on the risk-benefit acknowledgement form. A GDR was clinically contraindicated at this time due to one or more of the following reasons: the resident is withdrawn and not going to activities of her choice. The resident was fretful and grieving over of the loss of her vision due to macular degeneration.</p> <p>The risk-benefit acknowledgement form for antianxiety medication for Resident #28, dated 6-21-13, indicated the resident took Xanax. The non-pharmacological treatments/interventions utilized by staff did not improve the resident's clinical and/or functional status: social services and activities. No other non-pharmacological treatments or interventions were documented on the risk-benefit acknowledgement form. A GDR was clinically contraindicated at this time due to one or more of the following reasons: feels anxious and nerves feels jittery.</p> <p>Interview with Resident #28 on 7-23-13 at 9:30 a.m. indicated she used to have double vision, but had lost most of her eyesight. The resident indicated at one time she did</p>			

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	<p>see things (hallucinations), but it had been a long time ago. The resident indicated her daughter had her go to a hospital in Kentucky and she had not had any problems seeing things since. The resident indicated she did not have problems feeling nervous or anxious. The resident was observed sitting in her wheelchair with dark sunglasses on; the resident did not display any abnormal behaviors during the interview.</p> <p>The record of Resident #28 indicated the hospitalization in Kentucky was on 1-27-2011.</p> <p>Interview with the Social Service Director (S.S.D.) on 7-23-13 at 11:20 a.m. indicated Resident #28 had no documented signs or symptoms of psychosis, hallucinations or anxiety since the resident started Seroquel and Xanax.</p> <p>Interview with the Pharmacist on 7-23-13 at 2:41 p.m. indicated Resident #28 had been on Seroquel since 2-3-2011 and had been on Xanax since 8-19-2011. The Pharmacist indicated she had requested a GDR on the Seroquel on 5-13-13 and the Nurse Practitioner indicated it was contraindicated, and she had requested a GDR on Xanax</p>			

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	<p>on 5-13-13 and the Nurse Practitioner indicated it was contraindicated.</p> <p>Interview with the Director Of Nursing (DON) on 7-24-13 at 9:35 a.m. indicated the facility had not attempted a GDR on Seroquel since the medication was started on 2-3-2011, and the facility had not attempted a GDR on Xanax since it was started on 8-19-2011.</p> <p>The "Nursing Spectrum Drug Handbook" 2010, indicated the indications of Seroquel were schizophrenia, acute manic episodes associated with bipolar one disorder and depression associated with bipolar. The box warning of Seroquel indicated "elderly patients with dementia-related psychosis are at increased risk for death."</p> <p>2. Review of Resident # 17's record on 7/24/13 at 8:30 a.m., indicated a physician's recapitulation (recap) orders dated 7/1/13 through 7/31/13, Zyprexa 5 mg give 1/2 tab (2.5 mg) 2 times a day. Diagnosis (DX): dementia with atypical psychosis.</p> <p>On 6/23/13 Resident # 17 returned from the hospital with discharge medication orders, which indicated Zyprexa 5 mg twice daily.</p>			

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	<p>Review of a Physician's order dated 7/10/13 at 2 p.m., indicated, "Clarification DX for Zyprexa 5 mg 1 po bid for dementia with atypical psychosis."</p> <p>An interview on 7/24/13 at 9:20 a.m. with the Director of Nursing (DON) indicated, "the medication error was due to the pharmacy recap orders were written incorrectly. When the pharmacy sent the recap orders, the medication was incorrect on the recap and was not discovered until 7/6/13, at that time it was corrected to 5 mg bid."</p> <p>"I plan on discussing with her Physician that she was doing well on the reduced medication and see if we can reduce the medication back to 2.5 mg bid."</p> <p>On 7/24/13 at 9:30 a.m. review of a new order written by the Physician indicated, change Zyprexa to 2.5 mg po bid.</p> <p>Review of the Mood and Behavior Communication Memo indicated, in April Resident # 17 had 18 documented incidents of inappropriate behaviors. On May 8, 2013 the Resident had one documented incident of an inappropriate behavior. The Mood</p>						

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	<p>and Behavior Communication Memo dated 5/8/13 indicated Resident # 17 wanted an enema then asked to talk to the Administrator, the Resident asked for her walker then began crying and indicated the staff member was making her walk. The Administrator met the Resident with her wheelchair and she was assisted into her wheelchair. The form indicated the Resident was anxious and easily agitated. Interventions attempted: time to calm/re-approach and PRN medication administered. On June 1, 2013 the Resident had one episode of anxiety with no behaviors documented. The Mood and Behavior Communication Memo indicated "ativan given anxiety." Interventions attempted: provided 1:1 with Resident, provided reassurance and comfort, PRN medication administered. There were no documented behaviors for July.</p> <p>On 6/21/13 a "Risk-Benefit Acknowledgement Form Antipsychotic Medication" indicated, Medication: Zyprexa. "This form is intended to facilitate the multidisciplinary evaluation and documentation of the use of any and/or all medications of concern identified in the Plan of Care (POC) to assure quality resident care as well as</p>						

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	<p>promoting the following medication principles: The use of non-pharmacological interventions, when applicable, to minimize the need for medications, permit use of the lowest possible dose, or allow medications to be discontinued..."</p> <p>The above medication was initiated because: Non-pharmacological treatments/interventions utilized by staff did not improve resident's clinical and/or functional status: Social Services, Activities. Gradual dose reduction (GDR) is clinically contraindicated at this time due to one or more of the following reasons: spitting on floors, tearful, crying, resists care. The form was signed by the Physician, Director of Nursing and Social Services Director.</p> <p>Review of Resident # 17's care plan for anti-psychotic medication: Zyprexa, dated 4/3/13 and reviewed on 7/11/13 indicated: Problem: The Resident requires the use of an anti-psychotic medication: Zyprexa to treat: Dementia with atypical psychosis. Goal: The Resident will have no signs or symptoms of adverse reaction associated with the use of Zyprexa thru next review. Intervention: Administer medication</p>						

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	<p>as ordered.</p> <p>Monitor for adverse side effects such as: drowsiness, sedation, somnolence, agitation, insomnia, headache, nervousness, hostility.</p> <p>Observe for changes in mood or behavior.</p> <p>Notify the charge nurse of noted problems for further evaluation and possible physician and responsible party notification.</p> <p>Refer for psychological evaluation as indicated.</p> <p>Attempt GDR per policy.</p> <p>Refer to pharmacist consultant as needed.</p> <p>Monitor for EPS (extrapyramidal side effects) per policy.</p> <p>Review of the Antipsychotic Drug Use Policy provided by the DON on 7/24/13 at 10:30 a.m., indicated, Purpose: To ensure that anti-psychotic drugs will be administered only when medically indicated to treat a specific condition and help promote or maintain the resident's highest practicable mental, physical and psychosocial well-being. Non-pharmacological interventions will be considered and used when indicated, instead of, or in addition to, medication. Gradual dose reductions will be attempted, unless clinically contraindicated, in an effort to</p>				

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	<p>discontinue these drugs...</p> <p>1. Appropriate Diagnosis or Conditions for Use</p> <p>Criteria:</p> <p>Since diagnosis alone do not warrant the use of antipsychotic medications, the clinical condition must also meet at least one of the following criteria (a or b or c):</p> <p>a. The symptoms are identified as being due to mania or psychosis (such as auditory, visual, or other hallucinations; delusions (such as paranoia or grandiosity); or</p> <p>b. The behavioral symptoms present a danger to the resident or to others; or</p> <p>c. The symptoms are significant enough that the resident is experiencing one or more of the following: inconsolable or persistent distress (e.g., fear, continuously yelling, screaming, distress associated with end-of-life, or crying); a significant decline in function; and/or substantial difficulty receiving needed care (e.g. not eating resulting in weight loss, fear and not bathing leading to skin breakdown or infection).</p> <p>D. Duration:</p> <p>1. Within the first year in which a resident is admitted on an antipsychotic medication or after the facility has initiated an antipsychotic</p>				

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	<p>medication, the facility must attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, a GDR must be attempted annually, unless clinically contraindicated. The Risk-Benefit Acknowledgement form will be complete upon initiation of any antipsychotic medication and when the resident is due to be reviewed for a GDR.</p> <p>2. For any individual who is receiving an antipsychotic medication to treat behavioral symptoms related to dementia, the GDR may be considered clinically contraindicated if:</p> <p>The resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility; and</p> <p>The physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or increase distressed behavior.</p> <p>Antianxiety Drug Use Policy Purpose: To ensure that anti-anxiety drugs will be administered only when medically indicated to treat a specific condition and help promote or maintain the</p>						

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	<p>resident's highest practicable mental, physical and psychosocial well-being. Non-pharmacological interventions will be considered and used when indicated, instead of, or in addition to, medication. Gradual dose reductions will be attempted, unless clinically contraindicated, in an effort to discontinue these drugs. Ongoing monitoring will occur to assess risk/benefit relationship of anti-anxiety drug therapy including the appropriateness of drug selection and dosage and to monitor adverse consequences related to anti-anxiety medication use - recognizing, evaluating and modifying the regimen when appropriate. Anti-anxiety drugs will not be used as a restraint...</p> <p>The Mood and Behavior Review form will be completed at least every 10 days by the interdisciplinary team.</p> <p>1. Within the first year in which a resident is admitted on an anti-anxiety medication or after the facility has initiated an anti-anxiety medication, the facility must attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, a GDR must be attempted annually, unless clinically contraindicated. The Risk-Benefit Acknowledgement form will be complete upon initiation of any</p>			

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NAME OF PROVIDER OR SUPPLIER SYCAMORE SPRINGS REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
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	<p>anti-anxiety medication and when the resident is due to be reviewed for a GDR.</p> <p>3.1-48(a)(3)</p>			

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F000514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility to document the correct time a medication was given and its effectiveness for 1 resident and to document accurate meal consumption for 1 resident, of 28 residents reviewed for documentation. (Residents #28 and #15)</p> <p>Findings include:</p> <p>1.) The record of Resident #15 was reviewed on 7/19/13 at 2:00 p.m.</p> <p>Resident #15's physician recapitulation orders, dated 7/13, indicated "Tylenol 325 mg (milligrams), give 2 tablets (650 mg) by mouth, every 6 hours as needed for pain/fever."</p>	F000514	F0514 Requires the facility to document the correct time a medication is given, its effectiveness and accurate meal consumption. 1. Resident #15 had a pain assessment completed. Resident #28 food consumption record was reviewed for accuracy. 2. All residents have the potential to be affected. All residents had a pain assessment completed. All residents had their food acceptance records reviewed for accuracy. 3. The pain management policy and procedure was reviewed with no changes made. (See attachment C). The staff was inservices on the above procedure. The staff was also educated on the importance of documenting accurate food consumptions. 4. The DON or her designee will conduct interviews with	08/07/2013			

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	<p>Resident #15's "Mood and Behavior Communication Memo" dated 7/17/13, indicated she had a headache.</p> <p>Resident #15's "PRN Medication Flow Sheet" indicated, on 7/17/13 at 10:15 a.m., Tylenol was given for a headache, with pain rated 6 on the scale of 0-10. There was no documentation if the Tylenol was effective.</p> <p>Review of Resident #15's 24 hour report indicated on 7/17/13, Tylenol was given for headache, at 12:00 p.m.</p> <p>2.) Review of the record of Resident #28 on 7-22-13 at 11:05 a.m. indicated the resident's diagnoses included, but were not limited to, psychosis, depression, dementia with hallucinations, parkinson, anxiety, osteoarthritis, retinal deterioration, osteoporosis, dementia with behaviors, overactive bladder and arthritis.</p>		<p>residents and review documentation to ensure that residents pain is being addressed timely as well as ensure the proper time and effectiveness of the pain medication is correctly documented on the prn flow sheet. The DON or her designee will monitor at least one meal service to ensure that the documentation of each resident's food consumption is accurately documented on the consumption record. These audits be completed daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained for two consecutive quarters. (See attachment B). The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action will be adjusted accordingly is warranted. 5. The above corrective measures will be completed on or before August 7, 2013</p>		

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	<p>The Minimum Data Set (MDS) assessment for Resident #28, dated 4-25-13 indicated the resident's BIMS (Brief Interview for Mental Status) was a 15, indicating no cognitive impairment.</p> <p>The mood and behavior communication memo for Resident #28 dated 7-20-13 indicated the resident refused breakfast.</p> <p>The food acceptance record for Resident #28 dated 7-20-13, indicated the resident consumed 25% of breakfast.</p> <p>Interview with Resident #28 on 7-22-13 at 9:30 a.m. indicated on 7-20-13 she did not receive breakfast.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>			