

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155780	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/20/2015
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NAME OF PROVIDER OR SUPPLIER  MADISON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7465 MADISON AVE INDIANAPOLIS, IN 46227
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00179995.</p> <p>Complaint IN00179995 Substantiated. Federal/State deficiency related to the allegation are cited at F278.</p> <p>Unrelated deficiencies are cited.</p> <p>Survey dates: August 19 and 20, 2015</p> <p>Facility number: 012225 Provider number: 155780 AIM number: 200983560</p> <p>Census bed type: SNF/NF: 80 Total: 80</p> <p>Census payor type: Medicare: 14 Medicaid: 53 Other: 13 Total: 80</p> <p>Sample: 10</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000		
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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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F 0278 SS=E Bldg. 00	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on record review and interview, the facility failed to ensure that the Minimum Data Set assessment was accurate related to pressure ulcer assessments for 1 of 1 resident reviewed for pressure ulcers, for urinary tract assessments for 1 of 3 residents reviewed</p>	F 0278	It is the practice of Madison Healthcare Center that the MDS assessments accuracy reflect each resident status. The MDS Assessments for resident #9001 was modified and transmitted on 8/27/2015, The MDS Assessment for resident #9003 was modified	09/19/2015

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	<p>for urinary tract infections, for hospice assessments for 1 of 1 resident reviewed for receiving hospice services, for antipsychotic medication assessments for 2 of 7 residents reviewed for antipsychotic medications, and for End of Medicare stay assessments for 1 of 1 resident reviewed for discharge from Medicare in June 2015 in a sample of 10. (Residents #9001, #9003, #9005, and #9009).</p> <p>Findings include:</p> <p>1. The clinical record for Resident #9001 was reviewed on 8/20/2015 at 8:15 a.m. Diagnoses included, but were not limited to, peripheral vascular disease and renal failure.</p> <p>The quarterly Minimum Data Set (MDS) assessment, with a reference date of 6/2/2015, indicated the resident had one Stage 3 pressure ulcer that had healed since the prior assessment dated 5/13/2015.</p> <p>The Weekly Pressure Ulcer Record for 6/1/2015, indicated that one Stage 2 pressure ulcer had healed on the left buttock on 6/1/2015.</p> <p>The Prospective Payment System (PPS) 90 day MDS assessment, with a reference</p>		<p>and transmitted on 8/26/2015. The MDS assessment resident #9005 was modified and transmitted 8/24/2015. The MDS assessment resident #9009 was modified and transmitted 8/27/2015. No residents were affected by the deficient practice. The measure or systemic practices that have been put into place to assure that the deficient practice does not occur. The Regional MDS Consultant has inserviced the MDS Nurse regarding the MDS coding resident assessments. Emphasis was placed on accuracy of coding. How will the corrective action will be monitored: A performance improvement tool has been initiated. The tool will review the MDS coding for accuracy. The Regional Nurse Consultant will audit 5 MDS assessments weekly x3, 5 MDS assessment Monthly x3, then 5 MDS assessments quarterly x3. QA committee will review the tools at the schedule meetings for further recommendations. completed by 9/19/2015</p>	

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	<p>date of 7/12/ 2015, indicated the resident had no pressure ulcers that had healed since the prior assessment.</p> <p>The Weekly Pressure Ulcer Record indicated that one Stage 3 pressure ulcer had healed on the right heel on 6/5/2015.</p> <p>During an interview on 8/20/2015 at 2:45 p.m, the MDS Coordinator, indicated the Weekly Pressure Ulcer Record was used to code the MDS assessments. The quarterly MDS assessment, with a reference date of 6/2/2015, and the PPS 90 day MDS assessment with a reference date of 7/12/ 2015, were not coded accurately for healed pressure ulcers.2. The clinical record for Resident #9003 was reviewed on 8/19/2015 at 2:45 p.m. Diagnoses included, but were not limited to, anemia, depression, and hypertension.</p> <p>The quarterly Minimum Data Set (MDS) assessment, with a reference date of 6/28/2015, for Resident #9003 indicated the resident had not received any antipsychotic medications in the reference period between 6/22/2015 and 6/28/2015. The medication administration record, dated for July 2015, indicated the resident received Risperdal (antipsychotic medication) 0.5 milligrams (mg) daily from 6/1/2015 through 6/30/2015.</p>			

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	<p>The quarterly Minimum Data Set (MDS) assessment, with a reference date of 6/28/2015, for Resident #9003 indicated the last covered day for Medicare was 6/27/2015. The clinical record indicated the last covered day for Medicare was 6/26/2015.</p> <p>The Prospective Payment System (PPS) 30 day MDS assessment with a reference date of 6/13/2015, was coded for urinary tract infection (UTI). The clinical record did not indicate a significant laboratory finding or diagnosis by a licensed physician or physician representative for a UTI in the past 30 days. The clinical record did not indicate a medication or treatment for a UTI or signs and symptoms attributed to a UTI in the past 30 days.</p> <p>During an interview on 8/19/2015 at 4:25 p.m., the MDS Coordinator, indicated the quarterly MDS assessment with a reference date of 6/28/2015, for Resident #9003 was not coded accurately for antipsychotic medications, nor the last covered day of Medicare and the Prospective Payment System (PPS) 30 day MDS assessment with a reference date of 6/13/2015, was not coded accurately for UTI.</p>			

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	<p>3. The clinical record for Resident #9005 was reviewed on 8/19/2015 at 2:00 p.m. Diagnoses included, but were not limited to, anemia, congestive heart failure, diabetes mellitus, and depression.</p> <p>The Significant Change Minimum Data Set (MDS) assessment with a reference date of 7/24/2015, for Resident #9005 indicated the resident did not receive hospice services. The clinical record indicated the resident was admitted to hospice on 7/23/2015.</p> <p>During an interview on 8/20/2015 at 8:10 a.m., the MDS Coordinator, indicated the Significant Change MDS assessment with a reference date of 6/28/2015, for Resident #9005 was not coded accurately for hospice services.</p> <p>4. The clinical record for Resident #9009 was reviewed on 8/19/2015 at 4:45 p.m. Diagnoses included, but were not limited to, coronary artery disease, dementia, and chronic obstructive pulmonary disease.</p> <p>The Admission and Prospective Payment System (PPS) 5 day MDS assessment with a reference date of 7/23/2015, indicated the resident had received only one antipsychotic medication in the reference period between 7/17/2015 and 7/23/2015. The medication</p>			

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	<p>administration record, dated for July 2015, indicated the resident received Seroquel (antipsychotic medication) 75 milligrams (mg) daily from 7/17/2015 through 7/31/2015.</p> <p>The PPS 14 day MDS assessment with a reference date of 7/28/2015, indicated the resident had received only one antipsychotic medication in the reference period between 7/22/2015 and 7/28/2015. The medication administration record, dated for July 2015, indicated the resident received Seroquel (antipsychotic medication) 75 milligrams (mg) daily from 7/17/2015 through 7/31/2015.</p> <p>During an interview on 8/2/2015 at 8:10 a.m., the MDS Coordinator, indicated the Admission and PPS 5 day MDS assessment with a reference date of 7/23/2015, and the PPS 14 day MDS assessment with a reference date of 7/28/2015, were not coded accurately for antipsychotic medications.</p> <p>The Admission and PPS 5 day MDS assessment with a reference date of 7/23/2015, indicated the resident was on a turning and repositioning program for skin and ulcer treatment.</p> <p>During an interview on 8/2/2015 at 8:10 a.m., the MDS Coordinator, indicated</p>			

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F 0329 SS=D Bldg. 00	<p>the facility did not have a turning and repositioning program. The MDS Coordinator indicated the Admission and PPS 5 day MDS assessment with a reference date of 7/23/2015, was not coded accurately.</p> <p>This Federal tag relates to Complaint IN00179995.</p> <p>3.1-31(i)</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 receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue</p>			

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	<p>these drugs.</p> <p>Based on record review and interview, the facility failed to utilize non-pharmacological interventions prior to the administration of antipsychotic medication, identify and monitor behaviors associated with antipsychotic medication use, document adequate indications for the use of antipsychotic medication and determine the effectiveness of antipsychotic medication use for 2 of 7 residents reviewed for antipsychotic medications in a sample of 10. (Residents #9005 and #9009)</p> <p>Findings include:</p> <p>The clinical record for Resident #9009 was reviewed on 8/19/2015 at 4:45 p.m. Diagnoses included, but were not limited to, dementia, coronary artery disease, and chronic obstructive pulmonary disease.</p> <p>The clinical record of Resident #9009 indicated an order for Haldol (antipsychotic medication) 0.5 milligrams (mg) to be given every four hours as needed. The order did not indicate a reason the Haldol was to be given. The medication administration record (MAR), dated for July 2015, indicated the resident received the Haldol on 7/27/2015.</p>	F 0329	<p>It is the practice of this facility to assure that antipsychotic drugs be given when necessary to treat a specific condition as diagnosed, reduce as indicated with non pharmacological interventions to be utilized and appropriate with monitoring with documentation. Corrective actions taken for those resident found to be effective practice. PRN Haldol for resident #9009 has been discontinued. PRN Haldol for resident for #9005 has been discontinued. The IDT reviewed resident 9009 and #9005 present drug regime. The IDT identified and are monitoring behaviors associated with the present antipsychotic medication use and are determining the effectiveness. The residents care plans have been reviewed and revised to address the targeted behaviors identified and specific interventions to be utilized by staff. All residents could be affected the deficient practice All residents received antipsychotic medications have been review by the IDT to assure the drug therapy is necessary to treat a specific condition as diagnosed, Identify any behaviors associated with the psychotropic drug use and address the effectiveness. The care plan have been review and revised to address targeted behaviors with intervention to be utilized by staff. The measures or systemic changes that have been put into place to ensure that the</p>	09/19/2015			

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	<p>The Behavior/Intervention Monthly Flow Record for July 2015, identified behaviors of Resident #9009 as being pushing, hitting, refusing care, and running. The flow sheet did not indicate any behaviors occurred on 7/27/2015. The intervention codes on the flow sheet indicated to see the care plan. Interventions identified on the flow sheet for pushing and hitting were ambulation and call wife or family.</p> <p>The clinical record did not indicate the time the antipsychotic medication was given and did not indicate whether or not any non-pharmacological interventions were attempted prior to the administration of the antipsychotic medication. The clinical record did not specify indications for use of the antipsychotic medication, did not identify any behaviors that were present prior to the administration of the as needed antipsychotic medication and did not address the effectiveness of the antipsychotic medication.</p> <p>The clinical record did not indicate an assessment had been completed to identify and address any medical, physical, functional, psychosocial, or environmental causes of resident's behaviors that were identified on the Behavior/Intervention Monthly Flow</p>		<p>deficient practice does not reoccur, The IDT team and the attending physician has been inserviced on the policies on the antipsychotic medication usage. the IDT will insure that based on the resident's comprehensive assessments the resident will not be given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical records. Also emphasized was the monitoring for side effects and documentation in the residents clinical records. The nurses have been inserviced related to the use of medications and their appropriateness. Those residents that exhibit behaviors will be reviewed through the IDT process for root cause analysis. The IDT will review the effectiveness of the interventions and revise as indicated. How the corrective action will be monitored, A performance improvement tool has been initiated that will review 5 residents who receive antipsychotic medications to assure that . Antipsychotics are being given to treat specific conditions: Effectiveness of Medications: Monitoring for side effects: Documenting target behaviors with interventions attempted based on the care plan: reviewed by GDR/Behavior committee for reductions attempts. The QA tool will be</p>	

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	<p>Record for July 2015.</p> <p>The clinical record did not indicate a comprehensive care plan had been developed that addressed the behavior problems that were identified on the July 2015 Behavior/Intervention Monthly Flow Record.</p> <p>During an interview on 8/19/2015 at 5:30 p.m., the Director of Nursing (DON), indicated the clinical record did not indicate the time the antipsychotic medication was given and did not indicate whether or not any non-pharmacological interventions were attempted prior to the administration of the antipsychotic medication (Haldol). The DON indicated the clinical record did not specify indications for use of the antipsychotic medication, did not identify any behaviors prior to the administration of the antipsychotic medication and did not address the effectiveness of the antipsychotic medication.</p> <p>2. The clinical record for Resident #9005 was reviewed on 8/19/2015 at 2:00 p.m. Diagnoses included, but were not limited to, Alzheimer's dementia, depression, anxiety, and diabetes mellitus.</p> <p>The clinical record indicated Resident #9005 received Risperdal (antipsychotic</p>		<p>completed by the Social Services/DON or their designee, weekly x3, Monthly x3, Quarterly x3. any issues identified will be immediately corrected. The QA committee will review the tools at the schedules meetings for further recommendations. Completion Date 9/19/2015</p>	

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	<p>medication) 0.5 milligrams (mg) twice a day prior to hospitalization on 6/30/2015. The clinical record indicated upon return to the facility on 7/17/2015, the resident had an order for Seroquel (antipsychotic medication) 25 mg daily a bedtime.</p> <p>The clinical record did not address the change in antipsychotic medication, did not specify indications for use of the current antipsychotic medication, did not identify any behaviors associated with the antipsychotic medication, and did not address the effectiveness of the antipsychotic medication.</p> <p>During an interview on 8/19/2015 at 1:50 p.m., the Director of Nursing (DON), indicated the clinical record did not indicate any specific indications for use of the Seroquel, did not identify any behaviors associated with the use of the antipsychotic medication, did not address the effectiveness of the antipsychotic medication, and did not address the change in antipsychotic medication.</p> <p>On 8/20/2015 at 11:00 a.m., the DON provided a policy on Antipsychotic Medication Use, dated February 2013, and indicated that the policy was the one currently being used by the facility. The policy statement included, but was not limited to, the attending physician and</p>			

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F 0356 SS=C Bldg. 00	<p>other staff gathering and documenting information to clarify a resident's behavior, mood, function, medical condition, symptoms, and risks; the nursing staff documenting an individual's target symptom; and the attending physician identifying, evaluating and documenting, with the input from other disciplines and consultants as needed, the symptoms that warrant the use of antipsychotic medications. The policy indicated if an antipsychotic medication was administered PRN (as needed), the interdisciplinary team and the physician would discuss the situation with staff and evaluate the resident as needed to determine whether the use was appropriate and the symptoms are responding to the medication.</p> <p>3.1-48(a)(3) 3.1-48(a)(4) 3.1-48(b)(1)</p> <p>483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly</p>			

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	<p>responsible for resident care per shift:</p> <ul style="list-style-type: none"> <li>- Registered nurses.</li> <li>- Licensed practical nurses or licensed vocational nurses (as defined under State law).</li> <li>- Certified nurse aides.</li> </ul> <p>o Resident census.</p> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> <li>o Clear and readable format.</li> <li>o In a prominent place readily accessible to residents and visitors.</li> </ul> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation, record review, and interview, the facility failed to ensure that the nurse staffing information was posted daily and that the daily posted nurse staffing data was maintained for a minimum of 18 months.</p> <p>Findings include:</p> <p>Upon entrance to the facility on 8/19/2015 at 9:15 a.m., the nurse staffing information was not posted. At 11:50 a.m. on 8/19/2015, the daily nurse staffing information for 8/19/2015 was</p>	F 0356	<p>It is the practice to post the daily nurse staffing as required. The facility is posting the nurse staffing information as required on a daily basis. Corrective action taken for those resident found to be effective: No resident were found to be effective by the deficient practice. The measures or systemic changes that have been put into place to ensure that the defence does not reoccur: The facility nursing staff scheduler has been inserviced by the adminator on the policy on posting the nurse staffing information. All specific</p>	09/19/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155780	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/20/2015
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NAME OF PROVIDER OR SUPPLIER  MADISON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7465 MADISON AVE INDIANAPOLIS, IN 46227
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	<p>posted on the west wall at the entrance to the facility.</p> <p>During an interview on 8/19/2015 at 11:50 a.m., the Staffing Coordinator, indicated that today, 8/19/2015, was the first time the daily nurse staffing information had been posted since the day the facility put a mailbox up on the wall where the information had been posted. During an interview on 8/19/2015 at 12:05 a.m., the Maintenance Director indicated the mailbox was put up on 7/21/2015.</p> <p>During an interview on 8/19/2015 at 6:15 p.m., the Administrator, indicated she was unaware the daily nurse staffing information had not been posted from 7/21/2015 until 8/19/2015.</p> <p>The facility nurse staffing information sheets for the past eighteen months were reviewed on 8/19/2015 at 12:15 p.m. The daily nurse staffing information had not been retained for all days in the last 18 months. Missing daily nurse staffing information included, but was not limited to, January 19 and 26, 2015; February 2, 9, 11, 21, 22, and 25, 2015; March 7, 9, 20, 21, 22, 28, and 29, 2015; April 2, 7, 9-15, 20, 21, 25, 26, and 29, 2015, June 1-7, 10-21, 23, and 25-29, 2015, and July 1-6, 8-12, and 16-31, 2015.</p>		<p>requirements for posting reviewed including the requirements of maintaining the staffing data for a minimum of 18 months. The nurse scheduler or designee will be responsible for required posting on a daily basis after reviewed by the DON. The scheduler will be responsible for the posting are maintained for a minimum of 18 months. Monitoring : A performance improvement tool has been initiated that reviews the posting requirement. The DON or designee will complete this tool weekly x3, monthly x3, quarterly x3. The QA committee will review the tools as the scheduled meeting with further recommendations. Completion Date 9/19/2015</p>	

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	During an interview on 8/19/2015 at 6:20 p.m., the Minimum Data Set Coordinator, indicated the daily nurse staffing information had not been maintained for all days in the past 18 months.				