

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155799	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/12/2015
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NAME OF PROVIDER OR SUPPLIER MARION REHABILITATION AND ASSISTED LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 614 WEST 14TH STREET MARION, IN 46953
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: January 5, 6, 7, 8, 9 and 12, 2014</p> <p>Facility number: 012809 Provider number: 155799 AIM number: 201136580</p> <p>Survey team: Jason Mench, RN-TC Shelley Reed, RN Deb Barth, RN</p> <p>Census bed type: SNF: 29 SNF/NF: 18 Residential: 32 Total: 79</p> <p>Census payor type: Medicare: 19 Medicaid: 18 Other: 10 Total: 47</p> <p>Residential Sample: 7</p> <p>These deficiencies reflect state findings</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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F000156 SS=B	<p>cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review was completed by Tammy Alley RN on January 16, 2015.</p> <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and</p>				

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	<p>periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the</p>						

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	<p>name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. Based on observation, record review, and interview, the facility failed to verbally inform residents of their rights upon admission and failed to post the State agency complaint number. This potentially affected 47 of 47 residents residing in the facility.</p> <p>Findings include:</p> <p>1. The family of Resident # 40 was interviewed on 1/6/15 at 1:45 p.m. He indicated he did not believe he had been informed of the Residents' Rights.</p> <p>During an interview with the Admissions Coordinator, on 1/7/15 at 9:45 a.m., she indicated she gave the residents and family members a copy of the Residents' Rights, as part of the admission packet. She indicated she did not review the written information unless there was a question presented.</p> <p>Review of the admission packet, on 1/7/15 at 10 a.m., indicated a written</p>	F000156	<p>This plan of correction is prepared and executed because the provision of state and federal law require it and not because Marion Rehabilitation & Assisted Living Center agrees with the allegations made in the cited deficiencies. The facility maintains that the deficiencies do not jeopardize the health and safety of guests, nor are they of such character so as to limit our capability to render adequate care. F 156 Family of resident #40 will be notified of the center's Resident Rights verbally and in writing by 2-5-15. Resident #8 was informed of the location of the toll free direct telephone number to file a complaint with the State Department of Health. Resident Council meeting was held on 1-29-15 and 1-30-15 to verbally and in writing notify residents of Residents Rights. Also, residents were informed during the resident council meeting the location of the toll free direct telephone number to file a complaint with the State Department of Health. A copy of the center's resident rights will</p>	02/11/2015			

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	<p>copy of the Residents' Rights were included.</p> <p>2. During a Resident Council interview with Resident #8 on 1/8/15 at 1:38 p.m., when asked if resident had been informed of and given information on how to formally complain to the State for any grievances they might have she indicated the information was on a blue sheet that was handed out.</p> <p>Upon review of an undated blue sheet titled, "Marion Rehabilitation and Assisted Living Center: Grievance/Complaint Resolution Report," provided by the Administrator on 1/8/15 at 1:50 p.m., no State complaint phone numbers were listed on this sheet. Upon review of all posted signage in the facility, the direct complaint number to the State Department of Health was not available.</p> <p>During an interview with the Administrator on 1/8/15 at 3:00 p.m., he indicated the complaint phone number posted on all signs in the building was the main switchboard number to the Indiana State Department of Health and not the direct complaint phone number. He indicated that some residents might no be able to manage the instructions when calling the switchboard to file a complaint with the State and the direct</p>		<p>be mailed by 2-5-15 to the responsible partyfor those residents unable to sign acknowledgement. AdmissionsCoordinator and Business Office employees will be educated byAdministrator/designee regarding the requirement of resident/responsible partyreceiving notification of Resident Rights upon admission, verbally and inwriting. The ActivitiesDirector will audit Resident Rights acknowledgment sheets monthly for 3 monthsand will review Resident Rights monthly for 3 months in resident councilmeetings. The Activities Director willensure appropriate toll free telephone number is posted weekly for 3 months. Results of audits will be reviewed at the monthly QA&A for 3 months or until a consistent pattern of compliance is achieved. Date ofCompliance: 2-11-15</p>				

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F000159 SS=B	<p>number should be posted and will be added to the signs.</p> <p>3.1-4(a)</p> <p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p>						

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	<p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>Based on interview and record review, the facility failed to make resident funds available to residents 24 hours a day. This potentially affected 7 of 7 residents who had resident funds accounts and might want their money between the hours of 5:00 p.m. and 8:00 a.m.</p> <p>Findings include:</p> <p>The business office manager was interviewed on 1/8/15 at 2:15 p.m. She indicated the front desk was staffed from 8 a.m. to 5 p.m. She indicated the residents could get money from their accounts seven days a week during those hours, but the monies were not available unless through front desk staff.</p> <p>The computer print-out was reviewed and indicated there were seven residents who</p>	F000159	<p>F 159</p> <p>The 7 identified residents with a resident trust account were notified of being able to have access to monies from his/her account 24 hours a day.</p> <p>Resident Council meeting was held on 1-29-15 and 1-30-15 to inform residents of the availability of funds 24 hours a day through the use of a resident trust account that can be set up with the business office. The center put in place a lock box with monies available for residents who have a resident trust account after normal business hours (8 am – 5 pm). The lock box will be placed in a secure location after normal business hours.</p> <p>Licensed nurses and the business office staff will be educated by the Administrator /designee regarding the institution and use of the lock box to be used after normal business hours.</p>	02/11/2015

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F000246 SS=D	<p>had resident fund accounts with the facility.</p> <p>3.1-6(f)(1)</p> <p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on observation, interview and record review, the facility failed to provide adaptive equipment related to receiving an over-the-bed table for 1 of 1 residents reviewed in regards to room accommodations. (Resident #80)</p> <p>Findings include:</p> <p>During an observation on 1/5/15 at 2:13 p.m., Resident #80 was in bed, with a long side table on the right of her bed and a short side table on the left side of her bed. Several food items and person hygiene items were noted on both tables.</p> <p>During an observation on 1/9/15 at 11:18 a.m., Resident #80's table was not over</p>	F000246	<p>The business office manager will audit the resident trust lock box 5 X week for 4 weeks and then 3 X week for 8 weeks. Results of audits will be reviewed at the monthly QA&A for 3 months or until a consistent pattern of compliance is achieved. Date of Compliance: 2-11-15</p> <p>F 246 Resident #80 was provided an over-the-bedtable with wheels. Facility residents will be audited to ensure residents' equipment needs are met. Any adaptive equipment found to be needed during the audit will be provided to the resident for reasonable accommodation of needs. Center Department Managers will have education by the Administrator/designee regarding residents having their right and need monitored for proper equipment accommodations. The Department Managers will audit resident equipment needs utilizing Manager Quality Rounds form. This audit will be done 5 X week for 4 weeks and then 3 X week for 8 weeks. Results of audits will be reviewed at the monthly QA&A for 3 months or</p>	02/11/2015

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	<p>the bed and the resident was wearing a cervical collar. The table was not adjustable and did not have any wheels.</p> <p>During an interview on 1/9/15 at 9:06 a.m., Resident #80 indicated she was still having trouble with the table and her neck was sore. RN #1 came into the room and indicated the table would fit over the bed and he would talk to the staff who brought her meals and have them set the table up over her bed so she could eat more easily.</p> <p>During an interview on 1/9/15 at 11:18 a.m., Resident #80 indicated she did not understand how the side table would fit over her bed. She indicated she felt like she would be stuck under the table until someone came and removed it. She indicated she was wearing the cervical collar because the radiation was around her neck and head and her neck was very sore. She indicated she could hardly move her neck from side to side. She indicated she did not get out of bed unless she had radiation therapy.</p> <p>The clinical record for Resident #80 was reviewed on 1/9/15 at 2:30 p.m. Diagnoses for the resident included, but were not limited to, multiple myeloma and immunoproliferative neoplasms, anxiety, pain and effects of radiation.</p>		until a consistent pattern of compliance is achieved. Date of Compliance: 2-11-15				

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F000248 SS=D	<p>The Admission Minimum Data Set (MDS) assessment, dated 11/19/14, indicated Resident #80 was cognitively intact. Resident #80 received the following Activities of Daily Living (ADL) assistance; transfer-extensive assistance with two person assist, ambulation-extensive assistance with two person assist, hygiene and dressing-extensive assistance with one person assist and eating-limited assistance with one person assist.</p> <p>A current health care plan assessment dated 11/13/14 and updated 12/18/14, indicated Resident #80 required one person physical assist for eating.</p> <p>3.1-3(v)(1)</p> <p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview and record review, the facility failed to provide an activity program for 2 of 3 cognitively impaired residents reviewed for activities. (Residents #40 and #69)</p>	F000248	F 248 The Activities Director willcreate an individualized activity program for residents #40 and #69 by 2-5-15. Current residents and newresidents upon admission (within 72 hours of admission) will be assessed	02/11/2015			

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	<p>Findings Include:</p> <p>1. On 1/7/15 at 9:19 a.m., Resident #69's door was closed.</p> <p>The resident was observed in the bed, on her back on 1/7/15 at 9:32 a.m. She indicated to staff she wanted to get up.</p> <p>Resident #69 was observed in bed, on her back on 1/8/15 at 12:51 p.m. Resident was yelling out and moaning.</p> <p>Resident #69 was observed on her back, in bed on 1/8/15 at 10:39 a.m., asleep with the television on.</p> <p>Resident #69 was observed on her back, in bed on 1/9/15 at 9:16 a.m., awake in bed with the television on.</p> <p>The clinical record of Resident #69 was reviewed on 1/7/15 at 9:12 a.m. The record indicated the resident's diagnoses included, but were not limited to, cerebral artery occlusion with infarct, diabetes mellitus, depressive disorder, episodic mood disorder and metabolic encephalopathy.</p> <p>The Quarterly Minimum Data Set Assessment, dated 12/12/14, indicated the resident was severely cognitively impaired.</p>		<p>forlevel of cognition. Appropriateactivities will be planned and care plan will reflect appropriate cognition andactivities. The Activities staff will beeducated by the DON/designee regarding appropriate activities for residentswith varying levels of cognition. To prevent recurrence allresidents will be monitored as follows: an audit will be performed for level of cognitive impairment and uponadmission for new residents. This auditwill be done monthly X 3 months. Resultsof audit will be reviewed at the monthly QA&A for 3 months or until aconsistent pattern of compliance is achieved. Date of Compliance: 2-11-15</p>				

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	<p>The care plan, dated 3/19/14, indicated Resident #69 was assessed to being content with sitting just outside the nurses' station and conversing/greeting others. She enjoyed regular visits from family and views television on a daily basis. She would accept 1:1 visits from staff at times. The interventions included, but were not limited to, document attendance and level of participation, try activities that are short and repetitive and that can be stopped if the resident becomes overwhelmed.</p> <p>The Quality of Life Annual Assessment, dated 3/20/14, indicated it was somewhat important for the resident to have books, newspapers, music and to go outside when the weather was good.</p> <p>The Activity Director (AD) was interviewed on 1/8/15 at 10:24 a.m. During the interview, the AD indicated activity was provided for cognitively impaired residents on a 1:1 basis. The activities may be from a past interest, family visits, nail care, walks and music twice weekly. She indicated Resident #69 was not offered twice weekly activities and was more interested in television.</p> <p>Review of the One to One Activity Log</p>						

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	<p>Sheet for December 2014, Resident #69 was offered nail painting, reading of newspaper, sensory stimulation and lotion rub. The resident declined 2 of the 4 offered activities. The Independent Activity Log indicated Resident #69 had 30 television activities and 1 exercise during the month of December.</p> <p>The January 2015 Log Sheet, indicated Resident #69 had 1 visit with conversation and 7 television activities.</p> <p>2. On 1/7/15 at 9:10 a.m., Resident #40 was asleep in her room.</p> <p>The resident was observed in the bed, asleep on 1/8/15 at 10:40 a.m. The television was not on.</p> <p>Resident #40 was observed in bed, asleep on 1/8/15 at 1:21 p.m. The television was not on.</p> <p>Resident #40 was observed in bed on 1/9/15 at 9:02 a.m., asleep with the television off.</p> <p>The clinical record of Resident #40 was reviewed on 1/7/15 at 10:00 a.m. The record indicated the resident's diagnoses included, but were not limited to, heart failure, dementia and depression.</p>						

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	<p>The Quarterly Minimum Data Set Assessment, dated 9/2/14, indicated the resident was severely cognitively impaired.</p> <p>The care plan, dated 8/29/14, indicated Resident #40 was assessed with having a hearing impairment and cannot understand activity program content in some settings. She became confused at times requiring cueing and assistance completing tasks. The interventions included, but were not limited to, provide small group activity options, speak in a lower tone and decrease background noise.</p> <p>The Quality of Life Annual Assessment, dated 8/29/14, indicated it was very important for the resident to keep up with the news, going outside when the weather is good and family visits.</p> <p>The Activity Director (AD) was interviewed on 1/8/15 at 10:24 a.m. During the interview, the AD indicated activity was provided for cognitively impaired residents on a 1:1 basis. The activities may be from a past interest, family visits, nail care, walks and music twice weekly. She indicated she had only been in the position for about 1 month and was working on the activity program.</p>				

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F000250 SS=E	<p>Review of the Independent Activity Log for December 2014, Resident #40 was noted to have 30 days of television activity and 1 family visit. She also participated in 1 snack cart activity. During the month of January 2015, Resident #40 had 6 television activities, 1 nail painting session and 1 ice cream social activity.</p> <p>The January 2015 Log Sheet, indicated Resident #69 had 1 visit with conversation.</p> <p>A policy on activities for cognitively impaired residents was not provided.</p> <p>3.1-33(a) 3.1-33(b)(8)</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to assure residents who displayed maladaptive behaviors had those behaviors tracked for effective nonpharmacological interventions prior to the use of "routine" and "prn"</p>	F000250	F 250 Residents #110, #42, #49, and #56 will be audited by 2-5-15 of their resident drug regime to include psychotropic drugs, verification of proper diagnosis, behavior tracking, and nonpharmacological interventions with effectiveness.	02/11/2015			

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	<p>psychoactives in order to prevent the recurrence of those behaviors. This deficiency affected 4 of 5 residents reviewed for unnecessary medications. (Resident #110, #42, #49 and #56)</p> <p>Findings include:</p> <p>1. The clinical record for Resident # 110 was reviewed on 1/7/15 at 2:30 p.m. The resident had diagnoses which included, but were not limited to: malignant neoplasm without specified site, pulmonary embolism, mood disorder and dementia.</p> <p>The physician orders indicated the resident received the following psycho-active medications: trazadone - an antidepressant - 50 mg. (milligrams), Ativan - an antianxiety- 0.25 mg tid (three times daily) prn (as needed) and Haldol - an antipsychotic - 5 mg. q6h (every 6 hours) prn. The Ativan had originally been ordered on 12/5/14. The Haldol had been ordered on 11/25/14 and discontinued on 12/15/14. The trazadone had been started on 12/24/14.</p> <p>Review of the Medication Administration Records (MAR) for December, 2014 indicated the resident was being tracked for "fear of paranoia, being verbally aggressive toward others, functional</p>		<p>The care plan for these residents coincides with the above. An audit of residents with psychotropic drug use is being done to ensure appropriate diagnosis, appropriate behavior tracking, documentation of nonpharmacological interventions and effectiveness. The care plan will be reviewed for accuracy. Licensed nurses and Social Services will be educated by the DON/designee regarding appropriate psychotropic drug use, documentation and care planning. To prevent recurrence residents currently on psychotropic medications will be audited for diagnosis, behavior tracking, documentation of nonpharmacological intervention and accuracy of care plan. New orders for psychotropic drug use will be audited in the morning clinical meeting 3 X per week for 12 weeks. Ongoing monitoring of psychotropic compliance will be done by the Pharmacist consultant each month during monthly drug regimen reviews. Results of audits will be reviewed at the monthly QA&A for 3 months or until a consistent pattern of compliance is achieved. Date of Compliance: 2-11-15</p>		

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	<p>impairment, resists care/therapy, and crying" for the use of the Haldol. The MAR indicated the resident was being tracked for restlessness, fidgeting, unrealistic fear, and resisting care for the use of the antianxiety.</p> <p>The December MAR indicated a 2 hour increment for each shift for documenting the behaviors, i.e. 2:00 to 4:00 a.m., 12:00 p.m. to 2:00 p.m. Each increment had a nurse's initials in it. There was no indication of which behavior had been demonstrated, if any. A similar tracking had been recorded for the Ativan use but without having identified any specific behavior demonstrated.</p> <p>The MAR indicated "non-drug interventions" for the use of psychotropics included: "one on one, ambulate, activities, toilet, music/talking books, give food/drink, change position, encourage rest, return to room, backrub/massage, aromatherapy, and other."</p> <p>The MAR indicated the resident received a dose of prn Haldol on 12/3/14 at 12:12 a.m. There was no specific behavior identified as to which one he had demonstrated. There was no entry for any "non-drug" interventions having been tried prior to the administration of the</p>						

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	<p>Haldol.</p> <p>The MAR also indicated the resident received the Haldol at 1:12 a.m. on 12/4/14. There were no "non-drug" interventions indicated has having been tried.</p> <p>The MAR indicated the resident had received Haldol prn on 4 different occasions. None of the administrations identified any "non-drug" interventions having been tried prior to the use of the prn medication.</p> <p>In addition, the MAR indicated the resident had received Ativan on 12/17/14 at 1:13 a.m., on 12/18/14 at 2:25 a.m., and 12/18/14 at 8:56 p.m. with no identified behavior for which the resident was being treated. No "non-drug" interventions were identified as having been tried prior to the use of the drug.</p> <p>Trazadone was identified as having been given on 12/30/14 at 8:24 p.m. with no "non-drug" interventions having been tried prior to the medication having been given. No specific behavior had been identified for which the resident was being treated.</p> <p>Interview with the Social Services Director, on 1/8/15 at 9:30 a.m.,</p>						

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	<p>indicated she kept behavior sheets in a book in her office. Anyone could complete the behavior sheets. She would then review them and file them in the book.</p> <p>There were only two behavior sheets for Resident# 110 for December, 2014 provided by the SSD. The behavior sheets were as follows: Dated 12/17/14, no time identified as having occurred, "resident will ask inappropriate questions such as 'Why can't we get an apartment together,' 'Can I get your address and phone number, resident has verbally made these statements and is beginning to become agitated when explained the therapist/patient behavior and relationship that is appropriate." The behavior sheet was signed by the speech therapist. There were no interventions listed as having been tried, as being successful or not. The second behavior sheet was dated 12/20/14 at 9:20 am "alarm sounding. entered room and guest had pull tab alarm in hands. placed [unable to read] over sensor. threatened to throw alarm out window. then threw it across room into wall." This sheet was signed by a CNA whose signature was illegible. Interventions listed were "tlc [tender loving care] reassurance and remove source of agitation." The effectiveness of the interventions was not</p>				

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	<p>charted.</p> <p>The care plan indicated the resident had the problem of behavior disturbances demonstrated by behaviors of "inappropriate sexual comments, throws safety alarm, yelling, cursing, aggressive/threatening, making false statements." Interventions included "provide reassurance, provide a structured and familiar daily routine, explain procedures prior to implementation, encourage to make choices in adls (activities of daily living), provide pain intervention as needed - assess for pain, encourage to express feelings, remove from situation when argumentative or combative, provide calm, quiet environment, interdisciplinary team quarterly review, medications as ordered, 2 person assist with adls." Both the behaviors and the interventions differed somewhat from the listings on the MAR.</p> <p>Interview with the SSD, on 1/9/15 at 10:00 a.m., indicated she was unaware of any precursor of the resident's behaviors. She also indicated there was no way, by the tracking being done, to identify what behavior had occurred, what interventions were effective, and why the medication had been needed.</p> <p>2. During an observation on 1/8/15 at</p>			

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	<p>1:50 p.m., Resident #56 was in his room. Resident was able to move about his room in his wheelchair.</p> <p>The clinical record for Resident #56 was reviewed on 1/8/15 at 1:57 p.m. Diagnoses included, but were not limited to, other persistent mental disorder, congestive heart failure, hypertension, myocardial infarction, dementia and depression. The Admission Minimum Data Set dated 11/19/14, indicated Resident #56 was moderately cognitively impaired.</p> <p>Resident #56 had a current order for risperidone (anti-psychotic medication) 0.25 mg daily for a diagnosis of other persistent mental disorder.</p> <p>Resident #56 had a current care plan dated 11/21/14. The care plan listed a problem/need which indicated the resident used a psychotropic medication related to his disease process of dementia. Monitoring targeted behaviors that included, delusions, fear of paranoia, verbally aggressive towards others, resists meds/treatments, resists care/therapy and crying. Interventions to the problem included, but were not limited to, administer antidepressant, monitor/document/report PRN (as needed) adverse reactions to</p>						

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	<p>antidepressant therapy, consult with pharmacy, MD (medical director) to consider dosage reduction when clinically appropriate at least quarterly.</p> <p>Review of the December 2014 and January 2015 Administration Documentation History Detail Report, the only documented comment related to any monitoring was on 12/23/14, 12/24/14, 1/1/15, 1/8/15 and 1/9/15.</p> <p>Review of a Social Service Progress Note dated 12/26/14, indicated the only behavior was the resident was wandering in and out of other resident rooms, but had no exit seeking behaviors and was pleasant and cooperative during care.</p> <p>No additional behaviors and/or monitoring notes were provided during the exit conference.</p> <p>3. During an observation on 1/7/15 at 12:53 p.m., Resident #49 was asleep in bed.</p> <p>During an observation on 1/8/15 at 10:39 a.m., Resident #49 was asleep in his chair.</p> <p>The clinical record for Resident #49 was reviewed on 1/8/15 at 9:46 a.m. Diagnoses included, but were not limited</p>			

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	<p>to, chronic airway obstruction, anxiety, malignant neoplasm, pain, shortness of breath and pruritic disorder. The Admission Minimum Data Set dated 12/20/14, indicated Resident #49 was cognitively intact.</p> <p>Resident #49 had a current order for hydroxyzine (to treat anxiety and allergic reactions) 10 mg three times daily as needed. He also had an order for alprazolam (anti-anxiety medication) 0.25 mg 4 times daily as needed.</p> <p>Resident #49 had a current care plan dated 1/1/15. The care plan listed a problem/need which indicated the resident used an anti-depressant medication related to adult failure to thrive, weakness and pain related to cellulitis. The intervention for this problem included, but were not limited to, monitor/document/report PRN any s/sx (signs or symptoms) of depression, including: hopelessness, anxiety, sadness, insomnia, anorexia, verbalize negative statements or tearfulness.</p> <p>Review of the December 2014 and January 2015 Administration Documentation History Detail Report, the only documented comment related to any monitoring was on 12/15/14, 12/20/14, 12/21/14, 12/24/14 and 1/7/15.</p>				

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	<p>Alprazolam was given at least 1 time daily from 12/14/-12/31/14. Hydroxyzine was given all but 1 day in January 2015.</p> <p>During an interview on 1/8/15 at 2:12 p.m., RN #6 indicated when staff gave a PRN [as needed] medication, they were to write the reason for giving the medication in the system.</p> <p>No additional behaviors and/or monitoring notes were provided during the exit conference. 4. The clinical record for Resident #42 was reviewed on 1/8/15 at 8:20 a.m. The resident had diagnoses which included, but were not limited to: Alzheimer's and depression.</p> <p>The physician orders indicated the resident received the following psycho-active medication: citalopram 10 mg (milligrams) by mouth one time daily with a start date of 4/14/14. The Medication Administration Records (MAR) for December, 2014 indicated the resident received his daily dose as per order.</p> <p>Resident was care planed for depression and the use of citalopram, but no behaviors were recognized on the care plan.</p>				

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	<p>Review of the MAR for December, 2014 indicated the resident was being tracked for "stays to self, stays in room" and "sad facial expressions/mood" for the use of the citalopram.</p> <p>The December MAR indicated a 2 hour increment for each shift for documenting the behaviors, i.e. 4:00 to 6:00 a.m. and 4:00 to 6:00 p.m. Each increment had a nurse's initials in it. There was no indication of which behavior had been demonstrated, if any.</p> <p>The MAR indicated "non-drug interventions" for the use of psychotropics included: "one on one, ambulate, activities, toilet, music/talking books, give food/drink, change position, encourage rest, return to room, backrub/massage, aromatherapy, and other." The MAR also indicated a 2 hour increment for each shift for documenting any interventions used, i.e. 4:00 to 6:00 a.m., 12:00 to 2:00 p.m., and 8:00 to 10:00 p.m. Each increment had a nurse's initials in it. There was no indication of which intervention had been used, or whether any had been successful or unsuccessful.</p> <p>During an interview with the SSD and Director of Nursing (DON), on 1/8/15 at 2:28 p.m., The DON indicated Resident</p>			

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F000314 SS=D	<p>#42 did not have any behaviors that were being tracked. The facilities computer charting system requires them to pick a behavior to track and monitor for every psychoactive drug that is entered, even if they do not have any behaviors. The SSD and the DON indicated there was no documentation or tracking of non-pharmacological interventions and whether those interventions were effective or ineffective.</p> <p>5. Review of a policy titled "Psychoactive Medication Management", dated August, 2014, provided by the Administrator on 1/8/14 at 8:20 a.m., indicated the following:</p> <p>"...8. Medication effects will be monitored and documented on the medication administration record, to include targeted behavior monitoring, and monitoring for adverse effects when the medications are used..."</p> <p>3.1-34(a)</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</p>						

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	<p>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.</p> <p>Based on observation, interview and record review, the facility failed to ensure dressing changes were preformed as ordered for 1 of 3 residents reviewed for pressure sores (Resident #78)</p> <p>Findings include:</p> <p>The clinical record for Resident #78 was reviewed on 1/7/15 at 8:38 a.m. The resident had diagnoses which included, but were not limited to: pressure ulcer stage IV, tracheostomy, depression and protein calorie malnutrition.</p> <p>Resident #78 had a current Physicians order for a dressing change to the stage IV pressure sore on his coccyx, dated 1/5/14, and indicated the following. "Cleanse area to sacrum; pat dry. Apply Iodosorb to a piece of foam. place medication side into wound bed covering completely. Change every 2 days and PRN." This was reflected on the Resident's current care plan.</p> <p>Resident #78 had a current care plan for a dressing change to his lower back as a preventative treatment for a previous</p>	F000314	F 314 Resident #78 has current dressingchanges as ordered by physician. Center performed a complete skinassessment for all residents currently in the facility on 1-8-15. Any identified issue during skin assessments wereaddressed at the time of the assessment. Licensed nurses will be educated byDON/Staff Development/designee coordinator regarding dressing placements andmonitoring for placement daily as ordered by physician. CNAs are to report to the licensed nurse anyresident dressing that is missing or dislodged. To prevent recurrence currentresidents with dressing treatment orders will be audited to ensuredocumentation, to check placement of dressing daily as indicated in theresident treatment record. This auditwill be performed on 3 residents 3 X week for 4 weeks and then 3 residentsweekly for 8 weeks. Results of auditswill be reviewed at the monthly QA&A for 3 months or until a consistentpattern of compliance is achieved. Date of Compliance: 2-11-15	02/11/2015			

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	<p>pressure sore resolved on 9/1/14 and reviewed on 12/8/14. This treatment consisted of a foam dressing over the area on the lower back and to change weekly.</p> <p>During an observation on 1/7/15 at 10:09 a.m., with RN #7 present, RN #6 organized supplies to change the coccyx wound dressing. The staff turned the Resident onto his right side while he was lying in bed. A small amount of stool was visible in the residents brief and no dressing was present on the coccyx wound. The pressure wound was clean and free from stool. RN #6 proceeded to clean, measure the wound, with the wound measuring 3.5 cm long by 3.0 cm wide and 0.5 cm in depth and 1.5 cm of undermining at 11 O'clock, and dress wound per Physician order. RN #6 proceeded to wash her hands and change gloves and change the dressing on the lower back. The lower back dressing was dated 12/29/14 and was due to be changed on 1/5/15. When the dressing was removed, the skin was clear with no sign of a wound. RN #6 proceeded to replace the foam dressing on the lower back and both dressings were dated and signed.</p> <p>During review of "Wound Care Specialist Evaluation" form, on 1/7/15 at 10:15 a.m., provided by RN #6 on 1/7/15 at</p>			

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F000329 SS=E	<p>10:10 a.m., indicated the coccyx dressing was last completed on 1/5/15 per the Physician with documentation of no change in the wound</p> <p>3.1-4(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 receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to assure 1 of 5 resident reviewed for unnecessary medications had a diagnosis for the use of an anti-psychotic medication, in addition,</p>	F000329	F 329 Residents #110, #42 and #56 willbe audited by 2-5-15 their resident drug regime to include psychotropic drugs, verification of proper diagnosis, behavior tracking, and nonpharmacological interventions	02/11/2015	

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	<p>the facility failed to track behaviors and effective interventions for 2 of 5 residents reviewed for the use of psychoactive medications. (Resident #110, #42 and #56)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #110 was reviewed on 1/7/15 at 2:30 p.m. The resident had diagnoses which included, but were not limited to: malignant neoplasm without specified site, pulmonary embolism, mood disorder and dementia.</p> <p>The physician orders indicated the resident received the following psycho-active medications: trazadone - an antidepressant - 50 mg. (milligrams), Ativan - an antianxiety- 0.25 mg tid (three times daily) prn (as needed) and Haldol - an antipsychotic - 5 mg. q6h (every 6 hours) prn. The Ativan had originally been ordered on 12/5/14. The Haldol had been ordered on 11/25/14 and discontinued on 12/15/14. The trazadone had been started on 12/24/14.</p> <p>Review of the Medication Administration Records (MAR) for December, 2014 indicated the resident was being tracked for "fear of paranoia, being verbally aggressive toward others, functional</p>		<p>with effectiveness. The care plan for these residents coincides with the above. An audit of residents with psychotropic drug use is being done to ensure appropriate diagnosis, appropriate behavior tracking, documentation of nonpharmacological interventions and effectiveness. The care plan will be reviewed for accuracy. Licensed nurses and Social Services will be educated by the DON/designee regarding appropriate psychotropic drug use, documentation and care planning. To prevent recurrence residents currently on psychotropic medications will be audited for diagnosis, behavior tracking, documentation of nonpharmacological intervention and accuracy of care plan. New orders for psychotropic drug use will be audited in the morning clinical meeting 3 X per week for 12 weeks. Ongoing monitoring of psychotropic compliance will be done by the Pharmacist consultant each month during monthly drug regimen reviews. Results of audits will be reviewed at the monthly QA&A for 3 months or until a consistent pattern of compliance is achieved. Date of Compliance: 2-11-15</p>		

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	<p>impairment, resists care/therapy, and crying" for the use of the Haldol. The MAR indicated the resident was being tracked for restlessness, fidgeting, unrealistic fear, and resisting care for the use of the antianxiety.</p> <p>The December MAR indicated a 2 hour increment for each shift for documenting the behaviors, i.e. 2:00 to 4:00 a.m., 12:00 p.m. to 2:00 p.m. Each increment had a nurse's initials in it. There was no indication of which behavior had been demonstrated, if any. A similar tracking had been recorded for the Ativan use but without having identified any specific behavior demonstrated.</p> <p>The MAR indicated "non-drug interventions" for the use of psychotropics included: "one on one, ambulate, activities, toilet, music/talking books, give food/drink, change position, encourage rest, return to room, backrub/massage, aromatherapy, and other."</p> <p>The MAR indicated the resident received a dose of prn Haldol on 12/3/14 at 12:12 a.m. There was no specific behavior identified as to which one he had demonstrated. There was no entry for any "non-drug" interventions having been tried prior to the administration of the</p>						

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	<p>Haldol.</p> <p>The MAR also indicated the resident received the Haldol at 1:12 a.m. on 12/4/14. There were no "non-drug" interventions indicated has having been tried.</p> <p>The MAR indicated the resident had received Haldol prn on 4 different occasions. None of the administrations identified any "non-drug" interventions having been tried prior to the use of the prn medication.</p> <p>In addition, the MAR indicated the resident had received Ativan on 12/17/14 at 1:13 a.m., on 12/18/14 at 2:25 a.m., and 12/18/14 at 8:56 p.m. with no identified behavior for which the resident was being treated. No "non-drug" interventions were identified as having been tried prior to the use of the drug.</p> <p>Trazadone was identified as having been given on 12/30/14 at 8:24 p.m. with no "non-drug" interventions having been tried prior to the medication having been given. No specific behavior had been identified for which the resident was being treated.</p> <p>Interview with the Social Services Director, on 1/8/15 at 9:30 a.m.,</p>						

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	<p>indicated she kept behavior sheets in a book in her office. Anyone could complete the behavior sheets. She would then review them and file them in the book.</p> <p>There were only two behavior sheets for Resident #110 for December, 2014 provided by the SSD. The behavior sheets were as follows: Dated 12/17/14, no time identified as having occurred, "resident will ask inappropriate questions such as 'Why can't we get an apartment together,' 'Can I get your address and phone number, resident has verbally made these statements and is beginning to become agitated when explained the therapist/patient behavior and relationship that is appropriate." The behavior sheet was signed by the speech therapist. There were no interventions listed as having been tried, as being successful or not. The second behavior sheet was dated 12/20/14 at 9:20 am "alarm sounding. entered room and guest had pull tab alarm in hands. placed [unable to read] over sensor. threatened to throw alarm out window. then threw it across room into wall." This sheet was signed by a CNA whose signature was illegible. Interventions listed were "tlc [tender loving care] reassurance and remove source of agitation." The effectiveness of the interventions was not</p>			

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	<p>charted.</p> <p>The care plan indicated the resident had the problem of behavior disturbances demonstrated by behaviors of "inappropriate sexual comments, throws safety alarm, yelling, cursing, aggressive/threatening, making false statements." Interventions included "provide reassurance, provide a structured and familiar daily routine, explain procedures prior to implementation, encourage to make choices in adls (activities of daily living), provide pain intervention as needed - assess for pain, encourage to express feelings, remove from situation when argumentative or combative, provide calm, quiet environment, interdisciplinary team quarterly review, medications as ordered, 2 person assist with adls." Both the behaviors and the interventions differed somewhat from the listings on the MAR.</p> <p>Interview with the SSD, on 1/9/15 at 10:00 a.m., indicated she was unaware of any precursor of the resident's behaviors. She also indicated there was no way, by the tracking being done, to identify what behavior had occurred, what interventions were effective, and why the medication had been needed.</p> <p>2. During an observation on 1/8/15 at</p>						

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	<p>1:50 p.m., Resident #56 was in his room. Resident was able to move about his room in his wheelchair.</p> <p>The clinical record for Resident #56 was reviewed on 1/8/15 at 1:57 p.m. Diagnoses included, but were not limited to, other persistent mental disorder, congestive heart failure, hypertension, myocardial infarction, dementia and depression. The Admission Minimum Data Set dated 11/19/14, indicated Resident #56 was moderately cognitively impaired.</p> <p>Resident #56 had a current order for risperidone (anti-psychotic medication) 0.25 mg daily for a diagnosis of other persistent mental disorder. The medication had been decreased from .5 mg to the current dose on 12/15/14.</p> <p>Resident #56 had a current, 11/21/14, care plan problem/need which indicated the resident used a psychotropic medication related to his disease process of dementia. Monitoring targeted behaviors that included, delusions, fear of paranoia, verbally aggressive towards others, resists meds/treatments, resists care/therapy and crying. Interventions to the problem included, but were not limited to, administer antidepressant, monitor/document/report PRN (as</p>						

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	<p>needed) adverse reactions to antidepressant therapy, consult with pharmacy, MD (medical director) to consider dosage reduction when clinically appropriate at least quarterly.</p> <p>Review of a current History and Physical dated 11/3/14, the report indicated the resident was well known and followed as an outpatient. The report indicated the resident had depression and was being treated for it. He had no history of psychiatric hospitalization or self-harm behaviors. The diagnoses included dementia with multiple etiologies-advanced and depression and agitation, under control with medication.</p> <p>A psychological consult was obtained on 12/9/14. The physician indicated no hallucination or delusions were observed and suicidal thoughts were denied. The report indicated no psychosis was observed and recommended to decrease the risperidone to 0.25 mg daily. The order was decreased on 12/15/14.</p> <p>During review of a Pharmacy Consult dated 12/12/14, the pharmacist indicated Resident #56 was admitted to the facility on risperidone 0.5 mg daily. The physician indicated the order for the medication was "per psych" and signed 12/15/14.</p>						

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	<p>A second pharmacy consult dated 12/12/14, indicated there was no diagnosis and/ or documentation in the resident's record to support the use of risperidone. The physician signed the consult with a diagnosis of "depression".</p> <p>Review of the December 2014 and January 2015 Administration Documentation History Detail Report, the only documented comment related to any monitoring was on 12/23/14, 12/24/14, 1/1/15, 1/8/15 and 1/9/15.</p> <p>Review of a Social Service Progress Note dated 12/26/14, indicated the only behavior was the resident was wandering in and out of other resident rooms, but had no exit seeking behaviors and was pleasant and cooperative during care.</p> <p>During an interview on 1/9/15 at 10:03 a.m, the Director of Nursing indicated the facility did not have any additional diagnoses for the use of risperidone.</p> <p>During an interview on 1/9/15 at 10:03 a.m, the Director of Nursing indicated the facility did not complete an Abnormal Involuntary Movement Scale(AIMS) Assessment. 3. The clinical record for Resident #42 was reviewed on 1/8/15 at</p>						

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	<p>8:20 a.m. The resident had diagnoses which included, but were not limited to: Alzheimer's and depression.</p> <p>The physician orders indicated the resident received the following psycho-active medication: citalopram 10 mg (milligrams) by mouth one time daily with a start date of 4/14/14. The Medication Administration Records (MAR) for December, 2014 indicated the resident received his daily dose as per order.</p> <p>Resident was care planed for depression and the use of citalopram, but no behaviors were recognized on the care plan.</p> <p>Review of the MAR for December, 2014 indicated the resident was being tracked for "stays to self, stays in room" and "sad facial expressions/mood" for the use of the citalopram.</p> <p>The December MAR indicated a 2 hour increment for each shift for documenting the behaviors, i.e. 4:00 to 6:00 a.m. and 4:00 to 6:00 p.m. Each increment had a nurse's initials in it. There was no indication of which behavior had been demonstrated, if any.</p> <p>The MAR indicated "non-drug</p>						

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	<p>interventions" for the use of psychotropics included: "one on one, ambulate, activities, toilet, music/talking books, give food/drink, change position, encourage rest, return to room, backrub/massage, aromatherapy, and other." The MAR also indicated a 2 hour increment for each shift for documenting any interventions used, i.e. 4:00 to 6:00 a.m., 12:00 to 2:00 p.m., and 8:00 to 10:00 p.m. Each increment had a nurse's initials in it. There was no indication of which intervention had been used, or whether any had been successful or unsuccessful.</p> <p>During an interview with the SSD and Director of Nursing (DON), on 1/8/15 at 2:28 p.m., The DON indicated Resident #42 did not have any behaviors that were being tracked. The facilities computer charting system requires them to pick a behavior to track and monitor for every psychoactive drug that is entered, even if they do not have any behaviors. The SSD and the DON indicated there was no documentation or tracking of non-pharmacological interventions and whether those interventions were effective or ineffective.</p> <p>4. Review of a policy titled "Psychoactive Medication Management", dated August, 2014, provided by the Administrator on</p>			

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F000356 SS=C	<p>1/8/14 at 8:20 a.m., indicated the following:</p> <p>"...3. When psychoactive medications are prescribed for a specific condition or targeted behavior, the clinical record will be reflective of the diagnosis, reasons for use [functional impairment]..."</p> <p>"...5. Medications should be prescribed within federal guidelines..."</p> <p>"...6. Psychoactive drugs may be ordered on a PRN basis and should have a very clear and specific indication for use. Special attention should be given to attempt non-drug approaches outlined in residents' plan of care prior to using a PRN medication to control behavior or promote sleep..."</p> <p>"...8. Medication effects will be monitored and documented on the medication administration record, to include targeted behavior monitoring, and monitoring for adverse effects when the medications are used..."</p> <p>3.1-48(a)(6)</p> <p>483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following</p>						

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	<p>information on a daily basis:</p> <ul style="list-style-type: none"> 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 responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <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"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <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, interview and record review, the facility failed to ensure posted nursing staff information was accurate and up to date for 1 of 6 days of the survey (1/5/15). This practice had the potential to affect 79 of 79 residents who resided in the facility.</p> <p>Findings include:</p>	F000356	F 356 The facility ensured that all remaining days of the survey had appropriately posted nursing staff information. No further issues were identified. Facility residents have the potential to be affected by the above alleged citation. The Restorative Aide/Staffing Coordinator/Nursing Supervisor/ or Unit Manager Monday through Sunday. The	02/11/2015			

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F000431 SS=E	<p>During initial tour on 1/5/15 at 9:00 a.m., the nursing staff information was found to be posted with the date of 1/4/15.</p> <p>During an interview on 1/12/15 at 4:15 p.m., the Director of Nursing indicated the task of posting the current staff census was assigned to a person who worked Monday thru Friday and arrived to work early. She was unsure why the staff posting had not been completed.</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p>		<p>front office receptionist will monitor daily. The Restorative Aide, Staffing Coordinator, Nursing Supervisor, Unit Manager, ADON and business office staff will be educated by DON/designee on the daily staffing information posting in the front lobby of the facility. The front office receptionist will monitor daily. The front office receptionist/designee will audit/monitor the staffing information posting 5 X week for 4 weeks and then 3 X week for 8 weeks. Results of audits will be reviewed at the monthly QA&A for 3 months or until a consistent pattern of compliance is achieved. Date of Compliance: 2-11-15</p>	

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	<p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview and record review, the facility failed to ensure medicated lotions, medicated packets and dressing change trays were properly disposed of following expiration dates for 1 of 2 treatment carts observed. (Hall E). The facility also failed to properly ensure medication carts were free of loose pills for 3 of 3 carts observed during medication storage (Cart E1, E2 and North D Hall)</p> <p>Findings include:</p> <p>1. During observation of the treatment cart for E Hall on 1/7/15 at 3:45 p.m., 4 dressing change trays were found with an expiration date of 10/14. Two packets of Vitamin A & D ointment were found</p>	F000431	F 431 The identified medication carts and treatment cart was audited on 1-8-15 for any loose pills and expired treatments. Any issues identified were taken care of during the audit. Facility medication and treatment carts were audited on 1-8-15 for any loose pills and expired treatments. Any issues identified were taken care of during the audit. Licensed nursing staff was educated by the Staff Development coordinator/designee on accountability for monitoring medication carts and treatment carts for expired and loose medications and treatments. A facility Nurse Manager will audit for loose/expired medications and treatments 3 X week for 4 weeks and weekly for 8 weeks. Results of audits will be	02/11/2015

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	<p>with an expiration date of 10/14. A bottle of ammonium lactate was found with an expiration date of 12/14.</p> <p>During an observation of medication storage on 1/7/15 at 3:58 p.m., RN #3 unlocked the cart for E2 Hall for observation. The medication cart was found to contain 7 unidentified loose pills throughout the cart. 3 of the 7 pills were found at the bottom of the cart not secured in any drawer. RN #3 indicated the loose pills were to have been disposed of.</p> <p>During observation of the E1 medication cart, 1 unidentified, loose pill was found at the bottom of the cart.</p> <p>During observation of the North D Hall medication cart on 1/7/15 at 4:05 p.m., 2 unidentified, loose pills were found in the cart.</p> <p>2. A review of a current facility policy titled "Storage and Expiration of Medications, Biologicals, Syringes and Needles" dated 1/1/13, which was provided by the Administrator on 1/8/15 at 8:20 a.m. indicated the following:</p> <p>"Procedure:</p> <p>1. Facility should ensure...</p>		<p>reviewed at the monthly QA&A for 3 months or until a consistent pattern of compliance is achieved. Date of Compliance: 2-11-15</p>				

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F000441 SS=D	<p>4. Facility should ensure that medications and biologicals:</p> <p>4.1 Have an Expiration Date on the label;</p> <p>4.2 Have not been retained longer than recommended by manufacturer or supplier guidelines; or,</p> <p>4.3 Have not been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier...</p> <p>6. Facility should destroy and reorder medications and biologicals with soiled, illegible, worn, makeshift, incomplete, damaged or missing labels."</p> <p>3.1-25(o)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as</p>			

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	<p>isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation and record review, the facility failed to ensure gloves were applied during medication administration of a enteral medication for 1 of 3 residents and 1 of 5 staff members observed providing direct care. (Resident #69) (LPN #5)</p> <p>Findings include:</p> <p>During medication administration observation on 1/7/15 at 9:24 a.m., LPN #5 removed a medication from her cart for Resident #69. LPN #5 checked the order for Augmentin (oral antibiotic) 875</p>	F000441	F 441 There was no harm or ill effectfor resident #69. LPN #5 was educated bythe Staff Development coordinator/designee on 1-15-15 regarding standardprecautions. Residents and licensed nursingstaff have the potential to be affected by above alleged citation. Facility licensed nursing staff was educatedregarding standard precautions. Licensed nursing staff waseducated by the Staff Development coordinator/designee regarding standardprecautions to prevent the transmission of infections. The Clinical Managers (ADON,	02/11/2015			

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	<p>mg and crushed the pill per physician orders. She poured the powder into 40 mL of water, gathered her supplies for the administration of the medication.</p> <p>Resident #69 was observed laying in bed. LPN #5 washed her hands, placed a washcloth around the gasterostomy tube and checked for bowel sounds with her stethoscope. She opened up the port and some gastric fluids came out of the tubing and spilled onto her hands. She then wiped her hands on the washcloth and administered the medication and flushed with additional water. She then washed her hands following the procedure. She was not observed to wear gloves during the administration of an enteral medication.</p> <p>2. A review of a current facility policy titled "Enteral Feeding Tube, Care of" dated 2006, which was provided by the Administrator on 1/8/15 at 8:20 a.m. indicated the following:</p> <p>"EQUIPMENT Medication as ordered. Dressing for Enteral tube site, if necessary. Tape. Waterproof pad, if required. Wash cloth and towels. Appropriate container for soiled dressing.</p>		UnitManager) will audit for the practice of Standard Precautions 5 X week for 4weeks and 3 X week for 8 weeks. Results of audits will be reviewed at themonthly QA&A for 3 months or until a consistent pattern of compliance is achieved. Date of Compliance: 2-11-15				

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R000000	<p>Paper towels. Scissors. Disposable gloves.</p> <p>PROCEDURE</p> <ol style="list-style-type: none"> 1. Position resident... 2. Put on gloves... 8. Apply medication as ordered" <p>3.1-18(j)</p>						
R000245	<p>These state findings are cited in accordance with 410 IAC 16.2-5.</p> <p>410 IAC 16.2-5-4(e)(5) Health Services - Offense (5) Injectable medications shall be given only by licensed personnel. Based on record review and interview, the facility failed to ensure injectable medications were given by licensed personnel only for 1 of 7 residents reviewed. (Resident B2)</p> <p>Findings include:</p> <p>The clinical record for Resident #B2 was reviewed on 1/12/15 at 1:20 p.m. Diagnoses for Resident #B2 included, but were not limited to, diabetes, hypertension, generalized pain and anxiety.</p>	R000000	R 245 QMA is no longer practicing in the facility as of 1-12-15. QMAs are not employed by the facility at this time. Therefore, no other residents may be affected by the alleged deficient practice. Licensed nursing staff will be educated by the Staff Development coordinator/designee regarding injectable medications are to be given only by licensed nursing personnel. QMAs will complete orientation to include scope of practice and medication pass observation upon hire and annually thereafter.	02/11/2015			

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	<p>During review of "Administration Documentation History Detail Report", it was indicated QMA #8 documented subcutaneous insulin as follows:</p> <p>Novolog 100 unit/ml subcutaneous solution "2u per self" on 12/3/14 at 4:40 p.m., 12/6/14 at 11:00 a.m., 12/6/14 at 4:00 p.m., 12/9/14 at 4:00 p.m., 12/13/14 at 11:00 a.m., 12/14/14 at 11:00 a.m., 12/14/14 at 4:00 p.m., 12/17/14 at 4:00 p.m., 12/20/14 at 11:00 a.m., 12/20/14 at 4:00 p.m., 12/21/14 at 11:00 a.m., 12/21/14 at 4:00 p.m., 12/21/14 at 8:00 p.m., 12/25/14 at 11:00 a.m., 12/27/14 at 11:00 a.m., 12/28/14 at 11:00 a.m. and 12/28/14 at 4:00 p.m. "4u per self" on 12/24/14 at 4:00 p.m. and 12/27/14 at 4:00 p.m.</p> <p>Levemir 100 unit/ml subcutaneous solution "25u per self" on 12/3/14 at 8:00 p.m., 12/6/14 at 8:00 p.m., 12/7/14 at 8:00 p.m., 12/9/14 at 8:00 p.m., 12/13/14 at 8:00 p.m., 12/14/14 at 8:00 p.m., 12/17/14 at 8:00 p.m., 12/20/14 at 8:00 p.m., 12/21/14 at 8:00 p.m., 12/27/14 at 8:00 p.m. and 12/28/14 at 8:00 p.m.</p> <p>During review of Resident #B2 "EVALUATION FOR SELF-ADMINISTRATION OF MEDICATIONS" assessment, dated</p>		<p>DON/designee will complete arandom medication pass observation audit 3 X week for 12 weeks. Results of audits will be reviewed at themonthly QA&A for 3 months or until a consistent pattern of compliance is achieved. Date of Compliance: 2-11-15</p>	

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	<p>12/30/14, and provided by RN #6 on 1/12/14 at 3:30 p.m., indicated the resident was unable to administer her own medications, including being unable to demonstrate administration of subcutaneous injections. The assessment form indicated "nursing to admin all meds".</p> <p>During an interview with LPN #9 and RN #6 on 1/12/15 at 4:11 p.m., LPN #9 and RN #6 indicated the charting indicated QMA #8 was letting Resident #B2 administer her own insulin when Resident #B2 was unable to administer her own medications. LPN #9 and RN #6 indicated the nursing staff administered all of Resident #B2's medications.</p> <p>During an interview with RN #6 and the Nurse Consultant on 1/12/15 at 4:50 p.m., RN #6 and the Nurse Consultant indicated Resident #B2 was administering her own insulin after QMA #8 has drawn up the medication into an insulin syringe for her.</p> <p>During an interview with the Administrator on 1/12/14 at 5:00 p.m., he indicated Resident #B2 had stated to them QMA #8 was drawing up her insulin had handing it to her to administer herself.</p>						

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R000304	<p>410 IAC 16.2-5-6(e) Pharmaceutical Services - Deficiency (e) Medicine or treatment cabinets or rooms shall be appropriately locked at all times except when authorized personnel are present. All Schedule II drugs administered by the facility shall be kept in individual containers under double lock and stored in a substantially constructed box, cabinet, or mobile drug storage unit.</p> <p>Based on observation, interview and record review, the facility failed to ensure medication carts were properly locked for 1 of 2 carts observed. (C Hall cart for rooms 109-126)</p> <p>Findings include:</p> <ol style="list-style-type: none"> During the initial tour on 1/5/15 at 9:07 a.m., a medication cart was observed to have been unlocked. A nurse was administering medication at the other end of the hall with another cart. <p>LPN #4 returned to the nurses' station and the unlocked cart was shown to her. She indicated she must have forgot to lock the cart and the medications were for the residents in rooms 109-126. She indicated there were harmful medications in the cart. No resident was observed in the area.</p> <ol style="list-style-type: none"> A review of a current facility policy titled "Storage and Expiration of 	R000304	<p>R 304 The medication cart cited was not found to be unlocked at anytime during the rest of the survey process. In addition, no other facility medication carts were found to be unlocked or unattended while unlocked. Facility residents have the potential to be affected by the alleged citation. No additional medication carts were found to be unlocked or unattended while unlocked during the rest of the survey and since the survey concluded. Licensed nursing staff was educated by the Staff Development coordinator/designee regarding storage of medications and biologicals in a safe manner – ensuring that the medication carts remain locked while unattended. The DON/designee will audit the medication carts to ensure that they are properly locked 3 X week for 4 weeks and weekly for 8 weeks. Results of audits will be reviewed at the monthly QA&A for 3 months or until a consistent pattern of compliance is achieved. Date of Compliance: 2-11-15</p>	02/11/2015			

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R000349	<p>Medications, Biologicals, Syringes and Needles" dated 1/1/13, which was provided by the Administrator on 1/8/15 at 8:20 a.m. indicated the following:</p> <p>"Procedure:</p> <p>1. Facility should ensure...</p> <p>3.3 Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room...."</p> <p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure records were complete and accurate for 1 of 7 resident</p>	R000349	R 349 Current residents' records on the Assisted Living unit to include #G7 were audited for completeness by 2-6-15.	02/11/2015	

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	<p>records reviewed. (Resident #G7)</p> <p>Findings include:</p> <p>1. During record review on 1/12/15 at 2:15 p.m., the closed record of Resident #G7 was missing the following information:</p> <p>Service plan Pre-admission evaluation Semi-annual evaluation Weight on admission and semi-annually Self-administration evaluation Tuberculin test on admission</p> <p>During an interview on 1/12/15 at 4:00 p.m., the Director of Nursing indicated she could not find a signed service plan for Resident #G7. She continued to look for the missing information.</p> <p>No additional information was provided during the exit conference for Resident #G7.</p> <p>2. A review of a current facility policy titled "LTC Health Information Practice and Documentation Guidelines" dated August 2001, which was provided by the Administrator on 1/8/15 at 8:20 a.m. indicated the following:</p> <p>"4.0 PRACTICE GUIDELINES FOR</p>		<p>Pertinent information that was able to be updated and completed was done. The Assisted Living unit Coordinator was educated by DON/designee regarding the completeness and accuracy of the content of the clinical record. The Assisted Living unit Coordinator will audit current residents on the Assisted Living unit for record completeness and accuracy. New admissions will be audited for clinical record accuracy within 72 hours of admission. The DON/designee will audit the completeness and accuracy of new admissions 72 hours upon admission and monthly for 3 months. Results of audits will be reviewed at the monthly QA&A for 3 months or until a consistent pattern of compliance is achieved. Date of Compliance: 2-11-15</p>				

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NAME OF PROVIDER OR SUPPLIER MARION REHABILITATION AND ASSISTED LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 614 WEST 14TH STREET MARION, IN 46953			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
R000351	<p>LTC HEALTH INFORMATION AND RECORD SYSTEMS</p> <p>4.1 RECORD SYSTEMS, ORGANIZATION AND MAINTENANCE:</p> <p>A medical record must be maintained for every resident in a long term care facility. With varying levels of automation, there may be some records maintained electronically and some in paper format...</p> <p>It is critical that every facility have formalized system in place for the maintenance of the records. Records should be systematically organized and readily accessible.</p> <p>410 IAC 16.2-5-8.1(c)(d) Clinical Records - Noncompliance (c) The facility must safeguard clinical record information against loss, destruction, or unauthorized use. (d) The facility must keep confidential all information contained in the resident ' s records, regardless of the form or storage method of the records, and release such records only as permitted by law.</p> <p>Based on observation and interview, the facility failed to ensure the residents' clinical records were stored to prevent against loss, destruction or unauthorized use.</p> <p>Findings include:</p>	R000351	R 351 The unapproved "shredder box" was removed by 1-28-15 from the area and replaced with a locked "shredder box" to ensure the residents' clinical records were stored to prevent against loss, destruction or unauthorized use. Facility residents have the potential to be affected by the	02/11/2015			

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	<p>During an initial tour on 1/5/15 at 9:10 a.m., a box was observed on the floor of the nurses' station. The box had a lid with a sign that stated "shredder box". The contents of the box contained used medication labels and resident clinical information.</p> <p>During an interview on 1/5/15 at 9:17 a.m., LPN #4 indicated it was a shredder box because the other shredder box was in the copy room. She indicated the contents were shredded about 1-2 times per week.</p> <p>2. A review of a current facility policy titled "LTC Health Information Practice and Documentation Guidelines" dated August 2001, which was provided by the Administrator on 1/8/15 at 8:20 a.m. indicated the following:</p> <p>"4.0 PRACTICE GUIDELINES FOR LTC HEALTH INFORMATION AND RECORD SYSTEMS</p> <p>4.1 RECORD SYSTEMS, ORGANIZATION AND MAINTENANCE:</p> <p>4.3 For healthcare campuses or continuums...</p>		<p>alleged citation. A locked "shredder box" replaced the unapproved "shredder box". No other area in the facility had a "shredder box" that did not meet safeguarding specifications. Facility personnel were educated by the Administrator/DON/designee on how to safeguard resident clinical information by placing discarded clinical/HIPAA information in the appropriate locked "shredder box" to ensure the resident's clinical records were stored to prevent against loss, destruction or unauthorized use. The facility Maintenance Director/designee will audit the facility for approved locked "shredder boxes" 5 X week for 4 weeks and weekly for 8 weeks. Results of audits will be reviewed at the monthly QA&A for 3 months until a consistent pattern of compliance is achieved. Date of Compliance: 2-11-15</p>				

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	Health information staff should oversee record management, storage, retention, and destruction for the medical records...."				