

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155121	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/08/2015
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NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE AT LAFAYETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 1903 UNION ST LAFAYETTE, IN 47904
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F 0000 Bldg. 00	<p>This visit was for Recertification and State Licensure survey.</p> <p>Survey dates: June 1, 2, 3, 4, 5, and 8, 2015</p> <p>Facility Number: 000051 Provider Number: 155121 AIM Number: 100275490</p> <p>Census bed type: SNF: 12 SNF/NF: 111 Total: 123</p> <p>Census payor type: Medicare: 17 Medicaid: 91 Other:15 Total: 123</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1</p>	F 0000	Rosewalk Village of Lafayette respectfully requests desk review for this survey	
F 0250 SS=D Bldg. 00	<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.</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	<p>Based on record review and interview the facility failed to provide services to maintain mental well being of 1 of 1 resident reviewed for Preadmission Screening and Resident Review (PASSR). (Resident #202)</p> <p>Findings include:</p> <p>The record review for Resident #202 was completed on 6/8/15 at 9:00 a.m. Diagnoses included but not limited to, hemorrhagic brain bleed, schizophrenia, depressive disorder, anxiety, COPD (Chronic Obstructive Pulmonary Disease).</p> <p>A review of the social service progress notes dated 5/29/15 at 3:28 p.m., indicated a MDS(Minimum Data Set Assessment) was completed. The Resident was alert and oriented. The Resident had a diagnoses of severe depression, schizoaffective disorder. The resident was not stable on his medication and stated he still heard voices that told him to kill himself. The resident had been referred to (name of behavioral health inpatient facility) for evaluation and treatment on 6/1/15.</p> <p>A review of Care Plans on 6/8/15 at 10:00 a.m., did not indicate a care plan</p>	F 0250	Resident #202 was discharged to a behavioral health inpatient facility and not returned to this facility so therefore no corrective action is possible for this resident. All residents with suicidal ideation have the potential to be affected. All residents with suicidal ideation will have a care plan initiated for suicidal ideation. Social Services and Interdisciplinary team inserviced on Suicidal Precautions Policy to ensure any resident who verbalizes an intent to attempt suicide will have a care plan per policy CQI tool will be completed per social services for all residents with suicidal ideation weekly x 4 weeks, then monthly x 6 months, then quarterly thereafter for one year. Results of the CQI tool will be shared with the CQI committee for evaluation for minimum of 1 year. If 95% threshold is not achieved, an action plan will be developed to ensure compliance. All corrective actions will be completed on or before 6/29/15	06/29/2015			

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	<p>for suicidal ideation. The resident discharged to an inpatient behavioral health facility on 6/1/15 at 1:25 p.m.</p> <p>During an interview with Social Service Personnel on 6/8/15 at 10:00 a.m., she indicated she was present in the care plan meeting and was aware of the statement of hearing voices to kill himself. She indicated she did not initiate a care plan for monitoring the resident for suicidal ideation.</p> <p>A review of the policy titled "Suicidal Precautions Policy" dated 3/2010, obtained from Social Service on 6/8/15 at 2:00 p.m., indicated "Policy: It is the policy of this facility to provide for the safety of all residents and to prevent injury/harm from suicide attempts...III. Residents who verbalizes an intent to attempt suicide and is not actively harming him/herself or verbalizing a definitive plan...if based on the interview there is not definitive plan to cause harm to self continue with the following steps. e. document in the Social Service or nursing progress notes; quoting the exact questions asked and the resident actual response. f. the resident is not to be left alone during the immediate period of time the threat of suicide has been made. Once the resident is no longer verbalizing intent of suicide they will be placed on 15</p>			

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F 0278 SS=D Bldg. 00	<p>minute checks that may be extended to greater period of time with the physician guidance/direction or IDT [interdisciplinary team] recommendations...."</p> <p>3.1-34(a)(1)</p> <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</p>			

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	<p>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 correctly identify and accurately assess the residents status regarding Hospice for 1 out of 1 resident reviewed for Hospice (Resident #48).</p> <p>Findings include:</p> <p>The record for Resident #48 was reviewed on 6/4/2015 at 9:00 a.m. Diagnoses included but were not limited to Alzheimer's disease, chronic kidney disease, venous insufficiency, heart disease, atrial fibrillation, anemia, congestive heart failure, adult failure to thrive, and dementia.</p> <p>A Physician's order, dated 5/9/2015, indicated, admission to Hospice with diagnosis of Alzheimer's disease and dementia, and resident had prognosis of six months or less.</p> <p>A significant change Minimum Data Set Assessment (MDS), dated 5/18/2015, indicated Resident #48 was on hospice and did not have a prognosis of six months or less.</p> <p>During an interview with the MDS</p>	F 0278	<p>A Minimum Data Set (MDS) was modified for resident #48 and resubmitted on 6/4/15 to include a prognosis of six months or less. All residents with hospice services have the potential to be affected. All residents with hospice services will include a prognosis of six months or less on the Minimum Data Set (MDS).MDS nurses inserviced on the RAI manual regarding coding for residents with hospice services to ensure that all residents with hospice services will be coded with prognosis of six months or less on the (MDS).CQI tool will be completed per MDS nurses for all residents with hospice services weekly x 4 weeks, then monthly x 6 months, then quarterly thereafter for one year. Results of the CQI tool will be shared with the CQI committee for evalutaion for minimum of 1 year. If 95% threshold is not achieved, an action plan will be developed to ensure compliance. All corrective actions will be completed on or before 6/29/15</p>	06/29/2015

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F 0280 SS=D Bldg. 00	<p>coordinator on 6/4/2015 at 1:45 p.m., regarding the hospice status of Resident #48, she indicated that hospice was noted on the MDS, but that Resident #48 did not have a prognosis of less than six months indicated on the MDS.</p> <p>3.1-31(a) 3.1-31(d)(3)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interview the facility failed to revise the care plan to address suicidal ideation for 1 of 1 resident reviewed for Preadmission</p>	F 0280	Resident #202 was discharged to a behavioral health inpatient facility and not returned to this facility so therefore no corrective action is possible for this	06/29/2015			

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	<p>Screening and Resident Review (PASSR). (Resident #202)</p> <p>Findings include:</p> <p>The record review for Resident #202 was completed on 6/8/15 at 9:00 a.m. Diagnoses included but not limited to: hemorrhagic brain bleed, schizophrenia, depressive disorder, anxiety, COPD (Chronic Obstructive Pulmonary Disease).</p> <p>A review of the social service progress notes dated 5/29/15 at 3:28 p.m., indicated a MDS(Minimum Data Set Assessment) was completed. The resident was alert and oriented. The resident had a diagnoses of severe depression, schizoaffective disorder. The resident was not stable on his medications and stated he still heard voices that told him to kill himself. The resident had been referred to a (name of behavioral health inpatient facility) for evaluation and treatment on 6/1/15.</p> <p>A review of Care Plans on 6/8/15 at 10:00 a.m., did not indicate a care plan for suicidal ideation. The resident discharged to an inpatient behavioral health facility on 6/1/15 at 1:25 p.m.</p> <p>During an interview with Social Service</p>		<p>resident.All residents with suicidal ideation have the potential to be affected. All residents with suicidal ideation will have a care plan initiated for suicidal ideation. Social Services and Interdisciplinary team inserviced on Suicidal Precautions Policy to ensure any resident who verbalizes an intent to attempt suicide will have care plan initiated per policy.CQI tool will be completed per social services for all residents with suicidal ideation weekly x 4 weeks, then monthly x 6 months, then quarterly thereafter for one year.Results of the CQI tool will be shared with the CQI committee for evaluation for minimum of 1 year. If 95% threshold is not achieved, an action plan will be developed to ensure compliance.All corrective actions will be completed on or before 6/29/15</p>	

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	<p>on 6/8/15 at 10:00 a.m., she indicated she was present in the care plan meeting and was aware of the statement of hearing voices to kill himself. She indicated she did initiate a care plan for suicidal monitoring.</p> <p>A review of the policy titled "Care Plan Review and Maintenance Process" dated 8/11, received from Director of Nursing (DON), it indicated "Policy: it is the policy of this facility that each resident will have a care plan developed based on comprehensive assessment... resident needs... Care plan problems, goals and interventions will be updated based on changes in resident assessment/condition, resident preferences or family input...."</p> <p>A review of the policy titled "Suicidal Precautions Policy" dated 3/2010, obtained from Social Service on 6/8/15 at 2:00 p.m., noted "Policy: It is the policy of this facility to provide for the safety of all residents and to prevent injury/harm from suicide attempts...III. Residents who verbalizes an intent to attempt suicide and is not actively harming him/herself or verbalizing a definitive plan...if based on the interview there is not definitive plan to cause harm to self continue with the following steps. e. document in the Social Service or nursing progress notes; quoting the exact questions asked and the</p>			

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F 0431 SS=D Bldg. 00	<p>resident actual response. f. the resident is not to be left alone during the immediate period of time the threat of suicide has been made. Once the resident is no longer verbalizing intent of suicide they will be placed on 15 minute checks that may be extended to greater period of time with the physician guidance/direction or IDT [interdisciplinary team] recommendations...."</p> <p>3.1-35(a) 3.1-35(b)(1) 3.1-35(e)</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>In accordance with State and Federal laws,</p>			

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	<p>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 expired Prilosec (omeprazole magnesium) oral solution was destroyed or returned to the dispensing pharmacy, located in the refrigerator of 1 of 2 medication storage rooms and medication was properly labeled for 1 of 12 residents observed during medication pass. (Resident #3)</p> <p>Findings include:</p> <p>1. During an observation of the medication storage room located on the second floor of the facility on 6/5/2015 at 2:01 p.m., it was observed that the refrigerator contained a bottle of expired Prilosec (omeprazole magnesium) oral solution for heartburn, with an expiration date of 6/3/2015.</p>	F 0431	<p>Prilosec (omeprazole magnesium) was immediately destroyed. A change of direction label was placed on the tramadol medication package container for resident #3. All residents who receive medication have the potential to be affected. All medications were audited for expiration dates and correct administration directions which match the current MD order. Licensed nurses have been inserviced on the policies for expired medication destruction and Medication Pass Guidelines. Change of direction labels are available on all medication carts for use as appropriate. A CQI tool will be completed to audit for expired medications and appropriate use of direction change labels daily x 1 week, weekly x 4 weeks and monthly x 6 months, then quarterly thereafter for one year. Results of the CQI</p>	06/29/2015

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	<p>During an interview with LPN #1 on 6/5/2015 at 2:05 p.m., he indicated the medication had expired and should have been destroyed.</p> <p>During an interview with the Director of Nursing (DON), on 6/5/2015 at 2:30 p.m., she indicated the expired bottle of Prilosec should have been destroyed.</p> <p>A policy titled "Medication Returns, Credits, & Destruction", dated 2/2014, provided by the DON on 6/5/2015 at 8:50 a.m., The policy indicated "...1. When a medication is discontinued the facility should evaluate medication for return to the pharmacy for credit or destruction and disposal at the facility..."</p> <p>2. The clinical record for Resident #3 was reviewed on 6/5/2015 at 6:00 p.m., Diagnoses included but not limited to anemia, depression, osteoarthritis and rheumatoid arthritis.</p> <p>During a medication pass observation on 6/4/15 at 5:12 p.m., the following was observed, a current physician medication order dated 5/25/2015, indicated an order for Tramadol 50 milligrams (mg) for pain, three times a day by mouth.</p> <p>The Medication Administration Record</p>		<p>audit will be shared with the CQI committee for evaluation for a minimum of 1 year. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance. All corrective actions will be completed on or before 6/29/15</p>				

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	<p>(MAR) for June 2015 indicated Tramadol 50 milligrams (mg), three times a day by mouth.</p> <p>The medication package container from the pharmacy indicated Tramadol 50 milligrams (mg), four times a day.</p> <p>The MAR history for May 2015 and June 2015 indicated, since 5/26/2015 Resident #3 was given the medication three times a day</p> <p>During an interview on 6/5/2015 at 5:12 p.m., RN #1 indicated the medication package container from the pharmacy was incorrect and that Resident #3 had received the medication three times a day since the order change on 5/25/2015.</p> <p>During and interview on 6/5/2015 at 8:50 a.m., the DON indicated Resident #3 had a medication change on 5/25/2015 but the medication card from the pharmacy was not changed to indicate the new order, and the resident had received the medication three times a day as the order change indicated.</p> <p>A policy titled " Med Pass General Guidelines," dated 2/2014, provided by the DON on 6/5/2015 at 8:50 a.m., indicated "...3.0 The Nurse should check the medication(s) three (3) times with the</p>			

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	Medication Administration Record (MAR) in order to verify the order with the label...." 3.1-25 (j) 3.1-25(k)(5) 3.1-25(o)				