

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155042	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/26/2015
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NAME OF PROVIDER OR SUPPLIER WILLOW MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 3801 OLD BRUCEVILLE RD BOX 136 VINCENNES, IN 47591
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00180588.</p> <p>Complaint IN00180588 - Unsubstantiated, due to lack of evidence.</p> <p>Unrelated deficiency cited.</p> <p>Survey dates: August 25 and 26, 2015</p> <p>Facility number: 000016 Provider number: 155042 AIM number: 100291500</p> <p>Census bed type: SNF/NF: 130 Total: 130</p> <p>Census payor type: Medicare: 15 Medicaid: 95 Other: 20 Total: 130</p> <p>Sample: 5</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our record of compliance effective 9/2/2015 to the complaint survey conducted 8/26/2015.	

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

TITLE

(X6) DATE

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

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F 0279 SS=D Bldg. 00	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview, and record review, the facility failed to develop a care plan and interventions, and/or revise interventions, for a resident with a history of illegal drug activity and misuse of her medications, for 1 of 5 residents reviewed with plans of care, in a sample of 5. Resident D</p> <p>Findings include:</p> <p>The clinical record of Resident D was reviewed on 8/26/15 at 10:30 A.M.</p>	F 0279	<p>F 279 What Correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice: An order was received for the resident D to have her medications crushed and placed in applesauce or pudding. Resident D was placedon 15 minute checks. Residents D's Careplans were updated to reflect these interventions How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective</p>	09/02/2015

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	<p>Diagnoses included, but were not limited to, muscular dystrophy.</p> <p>Physician orders, dated August 2015, indicated the resident's medications included: Seroquel [an antipsychotic medication], Prozac [an antidepressant], Elavil [an antidepressant], Norflex [a pain medication], Xanax [an antianxiety medication], Hydro/Apap [a pain medication], Oxycodone [a pain medication], and Neurontin [a type of pain medication].</p> <p>An additional physician order, initially dated 1/31/15 and on the August 2015 orders, indicated, "May crush medications & place in applesauce."</p> <p>A Social Service Progress Note, dated 10/23/14, indicated, "Unit Nurse [name] made Social Services aware that CNA had found her pain medication crushed up in her drawer today. Meds were confiscated and resident was spoke to about the issue today...we discussed a Psych consult...."</p> <p>A "Doctor's Progress Note," dated 5/21/15 and signed by the Nurse Practitioner (NP), indicated, "Nursing staff continue to voice concern with patient snorting pain/anxiety medicines. One nurse states patient voiced the reason</p>		<p>action(s) will be taken: Residents who use illegal drugs or misuse their medications could be affected by this deficient practice. There were no other residents identified to be using illegal drugs or misusing their current medications in this facility.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Staff will be educated that when a resident is identified as misusing medication that they will need to notify the Physician to get an order to crush medications so that staff can verify that the medications are being taken as ordered. Staff will be trained on utilizing a "Drug Error Medication Report" when a resident is identified as taking a medication illegally or by the wrong route.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The "Drug Error Medication Report" will be reviewed upon submission and interventions will be developed as needed for the Careplan. This will continue on an ongoing basis.</p> <p>By what date the systemic changes will be completed: 9/2/2015</p>				

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	<p>for snorting was because it worked faster. I talked with patient we discussed this. She denied it...."</p> <p>Nurses Notes included the following notations:</p> <p>5/22/15 at 9:00 P.M.: "When this Nurse gave Res. [resident] 2100 [9:00 P.M.] meds, res tried to hide Xanax, Norflex et [and] Norco under left hand - when this nurse asked if she had any under her hand, Res. stated, 'No.' This Nurse discovered meds. Res said, 'If you report me, I am signing myself out, that is the only joy I have et you've taken it from me.' Incident reported to DON [Director of Nursing] et MD."</p> <p>5/23/15 [sic] at 11:45 P.M.: "Res yelling for help. Staff arrived to Res room to find resident falling out of scooter. Staff assisted Res back up right in seat et noticed pills in a Ziploc between res legs...This nurse took bag, asked Res where pills came from....Res was slurring words et lethargic during conversation. This nurse confiscated 9 vicodin [pain medication] et 3 Xanax in a small Ziploc bag."</p> <p>5/23/15 at 9:30 A.M.: "N.O. [new order] received to crush all meds et place in applesauce or pudding. Res notified of</p>			

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	<p>N.O. et not pleased."</p> <p>5/23/15 at 11:45 A.M.: "[Illegible] to meds crushed but refused applesause [sic] or pudding."</p> <p>5/23/15 at 10:30 A.M. ["Late Entry"]: "Received call from DON to start 15 min [checks] on res."</p> <p>5/23/15 at 5:00 P.M.: "CNA reported to this nurse that res states that's fine that they took my pills 'I still have \$150.00 to buy more pills [with].' Res states she spent \$1000 on drugs...."</p> <p>5/26/15 at 6:30 P.M.: "Called to res room...While changing res clothes/linens...noted small plastic baggie stuck to res. abdomen. Baggie contained a white powdery substance. Res stated, 'My brother brought that in for me.' Contact made [with] Admin et [police agency] - Officer [name] @ facility, tested the substance - was positive for methamphetamine...."</p> <p>5/27/15 at 6:00 A.M.: "When aide clean res. [sic] a clear small bag was noted in vaginal area. The bag had a white powder noted in it. Bag was placed in a cup et turned into administration...."</p> <p>A Social Service Progress Note, dated</p>			

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	<p>5/27/15, indicated, "Social Services made aware - that nursing found a small bag believed to be methamphetamine [sic] in resident room...Resident denied and said she was holding it for her brother - resident was offered to be sent to treatment for drugs and refused...."</p> <p>A Nurses Note, dated 5/28/15 at 3:00 A.M., indicated, "Resident up in chair took 2100 [9:00 P.M.] meds [without] difficulty, however when doing 15 min check at 2230 [10:30 P.M.] noticed pt had Xanax and Oxycodone on bedside table and pt [patient] was slumped over in w/c [wheelchair] with head dangling forward. Pt took meds on bedside table and nurse observed...."</p> <p>A "Doctor's Progress Note," dated 5/28/15 and signed by the NP, indicated, "Patient was recently caught doing meth. We had a heart to heart...."</p> <p>The resident was transferred to the Emergency Room on 5/29/15, and returned the same date.</p> <p>Nurses Notes continued:</p> <p>6/1/15 at 2:00 P.M.: "Cont 15 min [checks]...."</p> <p>6/1/15 at 3:00 P.M.: "N.O. received to</p>			

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	<p>change PRN [as needed] pain meds to liquid x 7 days...."</p> <p>A "Doctor's Progress Note," dated 6/10/15 and signed by the NP, indicated, "Have had several drug issues this month including getting meth into facility...Her drug screen was + for meth, benzos [and] barbiturates...."</p> <p>Nurses Notes continued:</p> <p>6/24/15 at 3:00 P.M.: "15 min [checks] dc'd [discontinued] due to res improvement [with] mood [and] [decreased] behaviors."</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 7/26/15, indicated the resident scored a 13 out of 15 for cognition, with 15 indicating no memory impairment. The MDS assessment indicated the resident required total assistance of two+ staff for transfer, did not ambulate, and had exhibited no behaviors in the previous 7 days. The MDS assessment indicated the resident had a range of motion impairment on both sides of the upper extremity and lower extremity.</p> <p>Nurses Notes continued:</p> <p>7/27/15 at 2:00 A.M.: "This nurse et</p>			

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	<p>CNA arrived to Res room to transfer Res to bed et noted Res leaning forward on Res scooter...Res had thick green mucus [sic] coming from her left nostril. This nurse washed off nose et noted green powder substance on Res upper lip et inside [left] nostril. Res lethargic et unable to hold head up. This nurse got tissues et instructed Res to blow her nose [with] the assist of this nurse...asked Res if she snorted anything up her nose et Res stated 'Yes' et slowly shook her head up et down. This nurse asked Res if she snorted a Xanax et Res again stated 'Yes.'...."</p> <p>8/6/15 at 1:20 A.M.: "This Nurse observed Res et visitor outside et appeared to be hiding something. This Nurse assisted Res et visitor [with] door to enter building. Res eyes barely open et speech slurred. Visitors [sic] eyes barely open et walked into a wall, slurred speech. This nurse reported to Administrator that Res et visitor appeared to be under the influence. This nurse was instructed to call [police department]."</p> <p>8/15/15 at 1:30 A.M.: "Resident requesting pain meds. Rec'd [sic] pain meds @ 0030 [12:30 A.M.]. Resident in room slumped over in scooter and talking incoherently...."</p>			

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	<p>8/18/15 at 1:00 A.M.: "Res given PRN pain meds as req [sic] @ 2200 [10:00 P.M.]. Staff attempting to put Res to bed. Res eyes rolling back in head et in et out of alertness et unintelligible sleep. Res requested pain meds et this nurse held dose d/t [due to] Res [decreased] consciousness."</p> <p>8/22/15 at 10:00 A.M.: "Notified by Environmental Aid [sic] of res. possibly having illegal substance in her room. Stated it was in a cigarette pack in her drawer. Administrator notified. Entered res room [with] CNA staff - found cigarette pack containing a lighter, a straw cut to about 4 inches long, and a plastic card [with] a dried yellowish powdery substance on it. [Police department] notified. [Police department] responded...."</p> <p>A Care Plan, dated 9/19/14, indicated: "Focus: Resident is at risk for self harm related to self medicating when leaving facility. Interventions: Explain risks of behavior. Refer to mental health as ordered. Remind resident she has agreed to comply with not medicating self when LOA [leave of absence]. Remind resident when she leave [sic] facility with her narcotics and returns stating she lost them that they will not be replaced. Report any unusual behavior to MD. Staff to explain</p>			

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	<p>to resident that she cannot hoard up medications to either give to her friends or take @ once. M.D. and family are fully aware that resident does this. Staff to monitor closely and room sweeps are often performed to look for hoarded medications. 5/8/15 Res may not take narcs when LOA [with] family/friends per M.D."</p> <p>An additional Care Plan, dated 1/22/15, indicated, "Focus: Non-Compliance with: Medication administration, Treatment, Safety, ...Often hoards medications in room/hides meds from staff. Interventions: Accept resident's right to refuse and show respect for resident's decisions...Provide education to correct knowledge deficit..." There were no additional interventions dated after 1/22/15.</p> <p>On 8/26/15 at 10:45 A.M., during an interview with the Director of Nursing (DON), she indicated the resident did have a history of illegal drug activity. She indicated the resident had been known to also "snort" her prescribed medication. The DON indicated the staff search the resident's room at least twice a week. The DON indicated the resident refused drug rehab because, "She says she doesn't have a problem."</p>			

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	<p>During a confidential interview with Staff # 1, the staff member indicated, "They have found meth in her [Resident D] room a couple of times. The police come in but they don't do anything. The boyfriend was arrested a couple of weeks ago. She goes out, gets drug tested, and then comes back. She can do whatever she wants."</p> <p>During a confidential interview with Staff # 2, the staff member indicated, "[Resident D] has been found with meth in her room a couple of times. The police were called."</p> <p>On 8/26/15 at 2:15 P.M., during an interview with Resident D, she indicated, "They think I do drugs. I don't. They can test me." Resident D indicated, "I didn't know my brother had dope on him one time." Resident D indicated that if the nurses crush her medications, she will "just throw them up."</p> <p>On 8/26/15 at 2:20 P.M., Medical Records Staff # 1 provided the current facility policy on "Care Planning," undated. The policy included: "All Residents will have a plan of care addressing the actual problems and potential problems as identified through the assessment data on the MDS and other accompanying assessments...The</p>			

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	<p>care plan should be a comprehensive and include measurable objectives and timetables to meet a Resident's medical, nursing and psychosocial needs that are identified in the comprehensive assessment...."</p> <p>On 8/26/15 at 2:20 P.M., Medical Records Staff # 1 provided the current facility policy on "Administering Medications." The policy included: "Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely."</p> <p>3.1-35(a) 3.1-35(d)(2)(B)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/08/2015
FORM APPROVED
OMB NO. 0938-0391

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