

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/16/2013
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NAME OF PROVIDER OR SUPPLIER WATERS OF SCOTTSBURG THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1350 N TODD DR SCOTTSBURG, IN 47170
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00126260 and Complaint IN00126331.</p> <p>Complaint IN00126260 - Substantiated - Federal/state deficiencies related to the allegations are cited at F225 and 226.</p> <p>Complaint IN00126331 - Substantiated - Federal/state deficiencies related to the allegations are cited at F431.</p> <p>Survey dates: April 2, 3, 4, 5, 11, 12, 15 and 16, 2013</p> <p>Facility number: 000478 Provider number: 155494 AIM number: 100290430</p> <p>Survey team: Gloria J. Reisert MSW - TC Debbie Peyton, RN Gwen Pumphrey, RN</p> <p>Census bed type: SNF/NF: 69 Total: 69</p> <p>Census payor type:</p>	F000000	Preparation and or execution of this plan of correction in general, or this correction action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.	

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>Medicare: 3 Medicaid: 60 Other: 6 Total: 69</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 4/23/13 by Suzanne Williams, RN</p>				

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F000155 SS=D	<p>483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES</p> <p>The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. Based on record review and interview, the facility failed to ensure a resident had the right to refuse incontinence care. This deficient practice affected 1 of 2 residents reviewed for right to refuse care of 2 residents who met the criteria for choices (Resident #55).</p> <p>Finding includes:</p> <p>Review of the clinical record for Resident #55 on 4/16/13 at 9:20 a.m., indicated the resident was admitted on 6/20/12. Diagnoses included, but were not limited to: dementia with behaviors, alcohol persistent</p>	F000155	<p>F 155 RIGHT TO REFUSE: FORMULATE ADVANCED DIRECTIVES It is the intent of this facility to ensure that a resident has their rights respected when they refuse treatment/care.1. Action taken: A. Staff in service conducted on residents rights and refusal of care. B. Resident #55 had care plan updated per SS for behaviors with new interventions. C. MDS dated 1-30-13 was modified to include that the resident was frequently incontinent.2. Others identified: No other residents identified as being affected.3. Measures taken: A. 100 percent audit was completed on all residents identified as resisting</p>	05/02/2013			

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	<p>dementia, and depressive disorder with mixed dementia.</p> <p>Review of the Nursing Notes between 3/1 and 4/15/13 indicated that during the 3/5 and 3/7/13 evening incontinence checks, the resident became very combative and resistive to having his brief changed. The notes indicated that on 3/5/13, it took 3 CNAs [certified nursing assistants] to change the resident's brief due to his combative behavior. The notes also indicated that on 3/7/13, it took 4 CNAs to attempt to change his brief as the resident spit, kicked, scratched at staff and was so resistive, that the staff had to leave the room in order for him to calm down and had been unsuccessful in getting the brief changed.</p> <p>Review of the 1/30/13 Quarterly Minimum Data Set [MDS] Assessment indicated the resident had severe cognitive impairment; had no mood issues but did have delusions with occasional physical behaviors of hitting, kicking, scratching; and frequently rejected care. He also was always continent of bowel and bladder and required supervision for toilet use.</p> <p>During an interview with the DoN</p>		<p>care to ensure that care plan reflects interventions that do not violate a residents rights. B. Staff in service was conducted on residents rights.4. How Monitored: A. SS/Designee to audit behavior logs daily for residents who have been coded to resist care to ensure appropriate interventions are being used. This will be an ongoing process. B. DON/Designee will watch care on 2 residents a day, 5 days a week for 4 weeks, then 1 resident a day, 3 days a week for 4 weeks, then PRN weekly to ensure resident rights are not being violated. This will continue until QA reports compliance. C. The CEO will review these daily in QA stand up meeting; monthly with the QA team; then quarterly with the medical director at the quarterly QA meeting.5. This plan of correction constitutes our credible allegation of compliance with all regualtory requirements. Our date of compliance is: May 2, 2013.</p>		

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	<p>[Director of Nursing] on 4/16/13 at 3:00 p.m., and again with the DoN, Administrator in Training and MDS Coordinator [Minimum Data Set] at 6:50 p.m. during the final exit meeting, they indicated that although the documentation said 3-4 CNAs, they did not believe all of them went in at the same time to do care. They indicated although the resident was frequently combative when it came to incontinence care, they did not feel the resident could be left soiled as they might be accused of poor care and that the odor from the resident if left too long, could affect others.</p> <p>3.1-4(d)</p>				

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F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record</p>	F000225	F 225 INVESTIGATE/REPORT	05/02/2013

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	<p>review, the facility failed to ensure an allegation of abuse was immediately reported to the administrator and state survey and certification agency, and also report the results of their investigation within 5 working days of the incident to the State survey and certification agency, affecting 1 of 6 residents reviewed for abuse. (Resident A)</p> <p>Findings include:</p> <p>Record review for Resident A, on 4/12/13, at 10:45 a.m., indicated diagnoses including, but not limited to, senile delusion, polyarthritis, macular degeneration, dementia with behavior, congestive heart failure, Alzheimer's, seizure disorder, and degenerative joint disease. The MDS (minimum data set) assessment, dated 3/7/13, indicated the resident was totally dependent of 2 persons for bed mobility and transfers and was cognitively severely impaired and never or rarely made decisions.</p> <p>Nurses notes, dated 3/15/13, at 1:00 a.m., indicated Resident A was found "sitting on floor." Resident A indicated she did not know how she got onto the floor.</p> <p>During an interview on 4/12/13, at</p>		<p>ALLEGATIONS/INDIVIDUALS It is the intent of this facility to report any allegations of abuse to a resident to the CEO and other officials in occurrence with state law through established procedures.1. Action taken: A. Investigation had already been completed. B. DON immediately reported allegation while surveyors were in the building.2. Others identified: No other resident identified as being at risk.3. Measures taken: A. CEO of company inserviced managers on abuse allegations and proper reporting. B. Staff in service conducted related to abuse allegations and proper reporting.4. How monitored: A. CEO/DON/Designee will investigate and report all allegations of abuse. This process will be on going. B. Abuse in service will be conducted every three months per social services. This process will be on going. C. All allegations will be discussed in daily QA meeting.5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is: May 2, 2013.</p>		

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	<p>11:00 a.m., the DON (Director of Nursing) and AIT (Administrator In Training) both indicated that they were notified by the ADON (Assistant Director of Nursing) on 3/20/13 of an allegation of Resident A being pulled out of bed and being raped by another resident on 3/15/13. They also indicated on 3/20/13 they conducted a full investigation with both residents and all staff involved.</p> <p>A review of the facility's investigative report, dated 3/20/13, and provided by the AIT on 4/12/13, at 11:00 a.m., indicated she and the DON were not notified of the allegation until the morning of their investigation. The report indicated that a note was presented to the ADON on the morning of 3/20/13 by CNA #3 and CNA #7 indicating other staff members were alleging "a resident was raped over the weekend." Both of the CNAs indicated they had received the information from CNA #5 during shift report. CNA #5 indicated that she received the information from CNA #7 during shift report. CNA #7 indicated that she received the information from CNA #2 and CNA #4 during shift report, who then indicated they had never made the allegation. CNA #2 and CNA #4 both indicated they only told CNA #7 that there was</p>			

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	<p>a lock on Resident A's bathroom door to keep the other resident out of Resident A's room. CNA #7 indicated she must have misunderstood the information given to her. The DON indicated she asked CNA #7 if she had reported the allegation to a nurse, and she said "no."</p> <p>The Investigative report also indicated the ADON interviewed Resident A on 3/20/13. Resident A indicated no male resident had ever been in her room and she did not know how she had gotten out of bed. It also indicated the resident was able to raise both legs and hold them above the mattress on her own. The ADON also interviewed Resident A's roommate, who indicated she was in the room when Resident A fell out of bed and no one else was in the room at that time.</p> <p>The investigative report also indicated that LPN #1 had completed a physical assessment of Resident A's trunk and peri/anal area, bilateral lower extremities and bilateral upper extremities, and no redness or bruising were noted. Resident A's skin was intact and she did not complain of any pain in these areas. The DON indicated that the medical director was notified of the allegation.</p>			

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	<p>The AIT, DON, and ADON indicated that in conclusion of their investigation, "there was no evidence of any abuse between the accused residents in the situation...there is no abuse substantiated. These allegations were fabricated and taken to extremes."</p> <p>During an interview on 4/12/13, at 11:00 a.m., the DON and AIT both indicated they did not report the allegation as they felt that after their investigation, the incident did not happen.</p> <p>A policy and procedure for "Abuse Prohibition" dated 7/1/11 was provided by the medical records clerk on 4/12/13, at 2:05 p.m., and identified as their current policy. The guidelines indicated, but was not limited to, "This facility shall comply with all federal and state requirements to screen, train, prevent, identify, investigate, protect and report, if applicable, any event that is not consistent with the usual operation of nursing facility or the standard care for certain resident."</p> <p>This Federal tag is related to Complaint IN00126260.</p> <p>3.1-28(c)</p>			

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	3.1-28(e)				

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F000226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F000226	F 226 DEVELOP/IMPLEMENT/ ABUSE/NEGLECT, ETC POLICIES It is the intent of this facility to report any allegations of abuse to a resident to the CEO and other officials in occurance with state law through established procedures.1. Action taken:A. Investigation had already been completed.B. DON immediately reported allegation while surveyors were in the building.2. Others identified: No other resident identified as being at risk.3. Measures taken:A. CEO of company inserviced managers on abuse allegations and proper reporting.B. Staff in service conducted related to abuse allegations and proper reporting.4. How monitored:A. CEO/DON/Designee will investigate and report all allegations of abuse. This processwill be on going.B. Abuse in service will be conducted every three months per social services. This processwill be on going.C. All allegations will be discussed in daily QA meeting.5. This plan of correction constitutes our credible allegation of compliance with all regualtoryrequirements. Our date of compliance is: May 2, 2013.	05/02/2013	

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	<p>Based on interview and record review, the facility failed to implement written policies and procedures to report an allegation and an investigation of abuse to the State Survey and Certification agency, affecting 1 of 6 residents reviewed for allegations of abuse. (Resident A)</p> <p>Findings include:</p> <p>Record review for Resident A, on 4/12/13, at 10:45 a.m., indicated diagnoses including, but not limited to, senile delusion, polyarthritis, macular degeneration, dementia with behavior, congestive heart failure, Alzheimer's, seizure disorder, and degenerative joint disease. The MDS (minimum data set) assessment, dated 3/7/13, indicated the resident was totally dependent of 2 persons for bed mobility and transfers and was cognitively severely impaired and never or rarely made decisions.</p> <p>Nurses notes, dated 3/15/13, at 1:00 a.m., indicated Resident A was found "sitting on floor." Resident A indicated she did not know how she got onto the floor.</p> <p>During an interview on 4/12/13, at 11:00 a.m., the DON (Director of Nursing) and AIT (Administrator In</p>				

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	<p>Training) both indicated that they were notified by the ADON (Assistant Director of Nursing) on 3/20/13 of an allegation of Resident A being pulled out of bed and being raped by another resident on 3/15/13. They also indicated on 3/20/13 they conducted a full investigation with both residents and all staff involved.</p> <p>A review of the facility's investigative report, dated 3/20/13, and provided by the AIT on 4/12/13, at 11:00 a.m., indicated she and the DON were not notified of the allegation until the morning of their investigation. The report indicated that a note was presented to the ADON on the morning of 3/20/13 by CNA #3 and CNA #7 indicating other staff members were alleging "a resident was raped over the weekend." Both of the CNAs indicated they had received the information from CNA #5 during shift report. CNA #5 indicated that she received the information from CNA #7 during shift report. CNA #7 indicated that she received the information from CNA #2 and CNA #4 during shift report, who then indicated they had never made the allegation. CNA #2 and CNA #4 both indicated they only told CNA #7 that there was a lock on Resident A's bathroom door to keep the other resident out of</p>			

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	<p>Resident A's room. CNA #7 indicated she must have misunderstood the information given to her. The DON indicated she asked CNA #7 if she had reported the allegation to a nurse, and she said "no."</p> <p>The Investigative report also indicated the ADON interviewed Resident A on 3/20/13. Resident A indicated no male resident had ever been in her room and she did not know how she had gotten out of bed. It also indicated the resident was able to raise both legs and hold them above the mattress on her own. The ADON also interviewed Resident A's roommate, who indicated she was in the room when Resident A fell out of bed and no one else was in the room at that time.</p> <p>The investigative report also indicated that LPN #1 had completed a physical assessment of Resident A's trunk and peri/anal area, bilateral lower extremities and bilateral upper extremities, and no redness or bruising were noted. Resident A's skin was intact and she did not complain of any pain in these areas. The DON indicated that the medical director was notified of the allegation. The AIT, DON, and ADON indicated that in conclusion of their</p>				

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	<p>investigation, "there was no evidence of any abuse between the accused residents in the situation...there is no abuse substantiated. These allegations were fabricated and taken to extremes."</p> <p>During an interview on 4/12/13, at 11:00 a.m., the DON and AIT both indicated they did not report the allegation as they felt that after their investigation, the incident did not happen.</p> <p>A policy and procedure for "Abuse Prohibition" dated 7/1/11 was provided by the medical records clerk on 4/12/13, at 2:05 p.m., and identified as their current policy. The guidelines indicated, but was not limited to, "This facility shall comply with all federal and state requirements to screen, train, prevent, identify, investigate, protect and report, if applicable, any event that is not consistent with the usual operation of nursing facility or the standard care for certain resident."</p> <p>This Federal tag is related to Complaint IN00126260.</p> <p>3.1-28(a)</p>			

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F000250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>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> <p>Based on record review, observations and interview, the facility failed to provide medically related Social Services to 1 resident who experienced hallucinations/delusions of her clothes being poisoned and would only wear a hospital gown and failed to provide follow-up monitoring to 2 residents after being involved in separate resident to resident conflicts. This deficient practice affected 3 of 3 residents reviewed for Social Services. (Residents #55, 56 and 57)</p> <p>Findings include:</p> <p>1. Review of the clinical record for Resident #55 on 4/16/13 at 9:20 a.m., indicated the resident had diagnoses which included, but were not limited to: dementia with behaviors, alcohol persistent dementia, and depressive disorder with mixed dementia.</p> <p>A Social Work note, written by Social Worker #2 on 2/17/13 at 11:30 am, indicated "This resident seen pushing another resident. Immediately separated. This resident placed on</p>	F000250	<p>F 250 PROVISION OF MEDICALLY RELATED SOCIAL SERVICES It is the intent of this facility to provide adequate medically related social services to all residents that reside in this facility. 1. Actions taken: A. Resident # 55 has been discharged from this facility. B. Resident # 57 immediately had care plan re written to reflect resident specific delusions and resisting care. C. Resident # 56 had all charting updated and completed per social services during survey process. D. SS reviewed and made any other updates needed to the three residents charts who were identified. 2. Others identified: No other residents identified. 3. Measures taken: A. CEO in serviced SS employees related to follow up charting and updating care plans. B. 100 percent audit completed and care plans updated on any resident who experiences delusions to reflect specific delusion. 4. How monitored: A. SS/Designee to audit 5 charts a week of residents identified as having delusions for 4 weeks. Then 3 charts a week for 4 weeks. Then ongoing on a PRN basis for any new or</p>	05/02/2013	

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	<p>one-to one- at this time. No injury noted."</p> <p>A new physician's order dated 2/17/13 at 7:00 p.m. was noted "1. UA C & S [urine culture and sensitivity], 2. TSH [thyroid stimulating hormone] CBC [complete blood count] CMP [comprehensive metabolic profile] to be done in AM; 3. Psych consult as soon as available, 4. Ativan 0.5 mg [for agitation/anxiety] 1 tab at night x [times] 3 days."</p> <p>During an interview with SW #2 on 4/16/13 at 11:35 a.m., he indicated he did not remember who the resident was that Resident #55 pushed on 2/17/13 as it was his first week working in the facility. Documentation was lacking of any follow-up by Social Services after the incident.</p> <p>2. Review of the clinical record for Resident #57 on 4/12/13 at 10:45 a.m., indicated the resident had diagnoses which included, but were not limited to: paranoid schizophrenia, generalized anxiety, insomnia, and chronic pain.</p> <p>During random observations of the resident during initial tour on 4/2/13 at 9:30 a.m. and on 4/3/13 at noon, Resident #57 was observed in bed in</p>		<p>worsening behaviors to ensure care plans identify any new or specific Delusion. B. The CEO will review these daily in QA stand up meeting, monthly with QA team and quarterly with MD at quarterly QA meeting.5. This plan of correction constitutes our credible allegation of compliance with all regualtoryrequirements. Our date of compliance is: May 2, 2013.</p>				

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	<p>a hospital gown. Resident was unable to say why she was in bed nor why she wasn't dressed.</p> <p>On 04/03/2013 at 11:54 a.m., during an interview with RN #1, she indicated "The resident has a tendency to refuse to wear her clothes as she feels her clothes are poisoned. Will wear the hospital gowns. Did refuse to get dressed today or get up. She would frequently pull all her clothes out of the closet and throw them into the laundry saying they were full of poison and try to get rid of them. Sometimes she would wear this one sweat outfit for days and refuse to change it because she thought all her other clothes were poisoned by the staff. She seems to have no problems with wearing a hospital gown - so we figured at least she was dressed in that."</p> <p>A Care Plan, dated 2/15/13 with a review date of 4/10/13, indicated the resident was at risk for behavioral disturbances r/t [related to] dx [diagnoses] of paranoid schizophrenia with increased paranoia, delusions and hallucinations. Approaches included: medications monitoring with considerations of GDRs [gradual dose reductions], observe for behaviors, explain care and approach</p>						

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	<p>in non-threatening manner.</p> <p>During an interview with Social Worker #1 and the MDS [Minimum Data Set] Coordinator on 4/12/13 at 12:05 p.m., they indicated the resident was care planned for having hallucination/delusions but did not address the specific hallucination the resident had about refusing to wear her own clothes as they were poisoned. They did acknowledge that it could be a dignity issue if it was not specifically addressed.</p> <p>During the interview, they indicated the resident had episodes of saying "her drinks were poisoned even after asking for something to drink, people are out to get me, a man tried to stab me." The Social Worker indicated the resident was not being monitored for behaviors of refusal of care nor was she aware of the resident refusing to get dressed because her clothes were poisoned.</p> <p>Review of Nursing notes between 2/12/13 and 4/12/13 and Social Work notes between 11/14/12 and 4/11/13, indicated documentation was lacking of the resident's refusals to get dressed and of refusing to wear her own personal clothing and wanting hospital gowns only.</p>				

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	<p>During an observation on 4/12/13 at 11:58 a.m., the resident was in bed dressed in a hospital gown.</p> <p>During an interview with CNA #1 on 4/12/13 at 4:00 p.m., she indicated "the resident from day one has always told us her clothes were poisoned and will not let us get her dressed. She may sometimes put her clothes on but then later takes them all off as she believes they are poisoned. She also refuses to get out of bed. For some reason, she will tolerate a hospital gown and will leave that on."</p> <p>3. Review of the clinical record for Resident #56 on 4/16/13 at 11:00 a.m., indicated the resident had diagnoses which included, but were not limited to: dementia with behaviors, Alzheimer's disease, generalized anxiety, and depressive psychosis.</p> <p>Review of the Social Work notes dated 4/1/13 11:15 a.m. indicated "Involved in altercation with peer on 3/31/13. [Resident name] was not the aggressor, he has no recall of the event and showing no s/s of increased anxiety/depression/fear. Will f/u [follow up] PRN [as needed]."</p>				

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	<p>Documentation was lacking to indicate the Social Worker had followed up on the resident regarding the incident.</p> <p>During the final exit meeting on 4/18/13 at 7:00 p.m. with Social Worker #1, she indicated she had not followed up as the resident didn't seem to be aware the incident occurred.</p> <p>On 4/16/13 at 3:00 p.m., the Business Office Manager presented copies of the signed Job Descriptions for both Social Worker #1, dated 1/29/13, and #2, dated 2/4/13. Review of these Job Descriptions at this time indicated they were both the same "Director of Social Services."</p> <p>The Job Description duties included, but were not limited to: "...C Role Responsibilities - Documentation:...5. Maintains significant social service progress notes on the resident's medical chart on a timely basis and, at least quarterly, completes a progressive assessment note...."</p> <p>3.1-34(a)</p>				

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS 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 record review, observations and interview, the facility failed to develop a care plan which addressed a resident's hallucinations of her clothing being poisoned and refusal to wearing anything other than a hospital gown most days. This deficient practice affected 1 of 34 residents reviewed for care plans. (Resident #57).</p> <p>Finding includes:</p> <p>1. Review of the clinical record for Resident #57 on 4/12/13 at 10:45</p>	F000279	F279 DEVELOP COMPREHENSIVE CARE PLANS It is the intent of this facility to develop a care plan for each resident that includes measurable objectives to meet a residents medical, mental and psychosocial needs. 1. Actions taken: A. Resident # 57 immediately had care plan re written to reflect resident specific delusions and resisting care. 2. Others identified: No other residents identified 3. Measures taken: A. CEO in serviced SS employees related to follow up charting and updating care plans. B. 100 percent audit	05/02/2013
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	<p>a.m., indicated the resident had diagnoses which included, but were not limited to: paranoid schizophrenia, generalized anxiety, insomnia, and chronic pain.</p> <p>Review of the 1/24/13 Quarterly Minimum Data Set [MDS] Assessment indicated the resident had severe cognitive impairment; occasionally felt down; frequently had trouble concentrating; had occasional behaviors of cursing others with occasional disrobing in public; and frequently rejected ADL [Activities of Daily Living] assistance.</p> <p>During random observations of the resident during initial tour on 4/2/13 at 9:30 a.m. and on 4/3/13 at noon, Resident #57 was observed in bed in a hospital gown. Resident was unable to say why she was in bed nor why she wasn't dressed.</p> <p>On 04/03/2013 at 11:54 a.m., during an interview with RN #1, she indicated "The resident has a tendency to refuse to wear her clothes as she feels her clothes are poisoned. Will wear the hospital gowns. Did refuse to get dressed today or get up. She would frequently pull all her clothes out of the closet and throw them into the laundry</p>		<p>completed and care plans updated on any resident who experiences delusions to reflect specific delusion.4. How monitored:A. SS/Designee to audit 5 charts a week of residents identified as having delusions for 4 weeks. Then 3 charts a week for 4 weeks. Then ongoing on a PRN basis for any new or worsening behaviors to ensure care plans identify any new or specific Delusion.B. The CEO will review these daily in QA stand up meeting, monthly with QA team and quarterly with MD at quarterly QA meeting.5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is: May 2, 2013.</p>		

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	<p>saying they were full of poison and try to get rid of them. Sometimes she would wear this one sweat outfit for days and refuse to change it because she thought all her other clothes were poisoned by the staff. She seems to have no problems with wearing a hospital gown - so we figured at least she was dressed in that."</p> <p>A Care Plan, dated 2/15/13 with a review date of 4/10/13, indicated the resident was at risk for behavioral disturbances r/t [related to] dx [diagnoses] of paranoid schizophrenia with increased paranoia, delusions and hallucinations. Approaches included: medications monitoring with considerations of GDRs [gradual dose reductions], observe for behaviors, explain care and approach in non-threatening manner.</p> <p>During an interview with Social Worker #1 and the MDS [Minimum Data Set] Coordinator on 4/12/13 at 12:05 p.m., they indicated the resident was care planned for having hallucination/delusions but did not address the specific hallucination the resident had about refusing to wear her own clothes as they were poisoned. They did acknowledge that it could be a dignity issue if it was not specifically addressed.</p>				

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	<p>During the interview, they indicated the resident had episodes of saying "her drinks were poisoned even after asking for something to drink, people are out to get me, a man tried to stab me." The Social Worker indicated the resident was not being monitored for behaviors of refusal of care nor was she aware of the resident refusing to get dressed because her clothes were poisoned.</p> <p>During an interview with CNA #1 on 4/12/13 at 4:00 p.m., she indicated "the resident from day one has always told us her clothes were poisoned and will not let us get her dressed. She may sometimes put her clothes on but then later takes them all off as she believes they are poisoned. She also refuses to get out of bed. For some reason, she will tolerate a hospital gown and will leave that on." 3.1-35(a) 3.1-35(b)(1)</p>				

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F000280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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, observation and interview, the facility failed to update the care plan with a new intervention after a resident returned from the hospital after scrotal surgery and regarding redness, burning and itching around the right eye of another resident . This deficient practice affected 2 of 34 residents whose care plans were reviewed. (Residents #54 and A)</p> <p>Findings include:</p> <p>1. Review of the clinical record for Resident #54 on 4/15/13 at 2:00 p.m., indicated the resident was admitted to</p>	F000280	F280 RIGHT TO PARTICIPATE PLANNING CARE-REVISE CPit is the intent of this facility to develop a plan of care with the ID team and/or resident and family to provide the highest quality of care for an individual.1. Actions taken: A. Resident #54 care plans updated to reflect current status. B. Resident A care plan was produced to surveyors at exit interview. 2. Others identified: No other residents identified.3. Measures taken: A. CEO in serviced department heads related to care plan initiation and revision. B. Nursing staff in services was conducted related to care plan initiation and revision. C. 100 percent audit done per ID	05/02/2013	

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	<p>the facility on 11/1/12 and had diagnoses which included, but were not limited to: status post hydrocele repair, dementia, diabetes, and mood behavior.</p> <p>Review of a 1/22/13 hospital out-patient surgery note indicated the resident had undergone a hydrocelectomy [removal of fluid and soft swelling in the membrane surrounding the testes].</p> <p>A 1/22/13 1:50 p.m. nursing note indicated "...Drsg [dressing] et [and] sling [scrotal support] in place..."</p> <p>Review of the care plans indicated there was a care plan originally dated 9/12/12 regarding the resident's scrotal swelling and left hydrocele and that it was updated on 1/22/13 due to his surgery to repair the hydrocele with new interventions to include: "Antibiotics per order, observe surgical incision, report abnormal findings to MD." Documentation of the intervention regarding the use of the scrotal support after surgery was not included.</p> <p>On 1/25/13, the resident was directly re-admitted to the hospital from the Urologist's office due to developing a scrotal hematoma that the Urologist</p>		<p>team to ensure all care plans updated and revised to reflect residents current status.4. How monitored: A. DON/Designee will audit charts daily Monday through Friday to ensure residents with any new orders or change in condition had an updated care plan in place. B. All change in condition, new orders, or new behaviors will be discussed by ID team in AM during clinical meeting and care plans updated as needed. C. The CEO will review these daily in QA stand up meeting, monthly with QA team and quarterly with MD at quarterly QA meeting.5. This plan of correction constitutes our credible allegation of compliance with all regualtoryrequirements. Our date of compliance is: May 2, 2013.</p>		

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	<p>presumed developed as a result of the resident not wearing his scrotal support sling.</p> <p>During an interview on 4/16/13 at 3:30 p.m. with the Administrator in Training, Director of Nursing and the MDS [Minimum Data Set] Coordinator, they indicated "the Physician did not indicate on his orders whether he wanted to continue the sling when he came back. They may have just put it on him after surgery and didn't want to continue it. We did not clarify with the Urologist nor his Primary Physician if it was to be continued here at the facility and for how long. We talked with his primary Physician as to what was going on with him and gave us some orders but not specifically about the sling. The urologist was assuming he didn't wear the sling - that's not to say the nurses didn't have it on him. They may have just forgot to chart it. Can't say if it should have been put on the Care Plan as an intervention as we didn't know if the Urologist wanted to continue it or not."</p> <p>On 4/16/13 at 12:12 p.m., the MDS Coordinator presented a copy of the facility's current policy titled "Care Plans". Review of this policy at this time indicated, but was not limited to:</p>			

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	<p>"...Procedure:...7. All goals and approaches are to be reviewed and revised as appropriate by a team of qualified persons after each assessment and upon a significant change of condition..."</p> <p>2. On 4/3/13 at 2:15 p.m., Resident A was observed to have a reddened area around and above the right eye, and she complained of burning.</p> <p>Record review on 4/11/13, at 9:45 a.m., indicated diagnoses including, but not limited to, senile delusion, esophageal reflux, anemia, polyarthritis, macular degeneration, dementia with behaviors, congestive heart failure, atherosclerosis, diabetes mellitus type 2, dysphagia, Alzheimer's, seizure disorder, neurogenic bladder, constipation, chronic urinary tract infections, agitation, history of myocardial infarction, gastric ulcer, and degenerative joint disease.</p> <p>During an observation on 4/11/13, at 10:00 a.m., Resident A was sitting up in her geri chair asleep. The area around her right eye was less reddened, with some yellowish crusty areas observed around her eye lid.</p> <p>During an observation on 4/12/13, at</p>			

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	<p>9:30 a.m., Resident A was sitting up in her geri chair. Area around her right eye remained reddened, and she was requesting a wash cloth to hold over her eye.</p> <p>During an observation on 4/16/13, at 8:30 a.m., Resident A was sitting up in her geri chair at the nurses desk. The area around her right eye remained reddened with yellowish crusty areas around her eye lid.</p> <p>A record review on 4/15/13, at 2:19 p.m., indicated a nurses note, dated 3/27/13, stating the doctor was notified through a fax, of the right eye being reddened and burning. A nurses note, dated 3/28/13, indicated the doctor was notified of the resident's eye being reddened, edematous and warm to touch. Also, redness was noted to the forehead and scalp area above the right eye. The note indicated an order to send the resident to the emergency room was received. A physician's progress note, dated 3/29/13, indicated, "sent to ER (Emergency Room) earlier this week, staff reported red swollen right eye with evidence of pus, she c/o (complains of) pain. Looks suspicious for shingles, treated with ATB (antibiotic) for cellulitis. There are no shingles-like pustules."</p>			

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	<p>No care plan was observed in the resident's chart regarding a skin condition around the resident's eye.</p> <p>During an interview on 4/16/13, at 7:00 p.m., the DON indicated the cellulitis had been care planned through antibiotic use. She did produce a care plan for cellulitis of the right eye, but it had been marked through, labeled as "resolved", and removed from the resident's chart.</p> <p>3.1-35(d)(2)(B)</p>			

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>A. Based on interview and record review, the facility failed to ensure a doctor's order was followed to discontinue a medication for 1 of 10 residents reviewed for unnecessary medications. (Resident # 37)</p> <p>B. Based on observation, interview, and record review, the facility failed to ensure an intervention was implemented for turning and repositioning on a resident's care plan for 1 of 34 residents reviewed for care plans. (Resident # 41)</p> <p>Findings include:</p> <p>A. Record review for Resident #37 on 4/3/13, at 1:40 p.m., indicated diagnoses including, but not limited to, dementia with behaviors, acute kidney failure, benign prostatic hypertrophy, lack of coordination, dysphagia, urine retention, degenerative joint disease, and Alzheimer's. A doctor's order dated 3/22/13, indicated to decrease Lexapro (antidepressant medication) to 2.5 mg</p>	F000282	<p>F 282 SERVICES BY QUALIFIED PERSONS/PER CARE PLAN It is the intent of this facility that services must be provided by qualified persons in accordance with each residents written plan of care. 1. Actions taken: A. Resident #37 medication was immediately D/C'd , MD and family notified and resident assessed. B. resident # 41, care plan was updated to reflect resident to be turned and repositioned every two hours as verified by MD.2. Others identified: No other residents identified.3. Measures taken: A. Nursing staff in serviced on providing care to a resident per their individualized care plan. B. 100 percent audit was done on all care plans to reflect residents current status.4. How monitored: A. DON/Designee will audit charts daily Monday through Friday to ensure residents with any new orders or change in condition had an updated care plan in place. B. All change in condition, new orders, or new behaviors will be discussed by ID team in AM during clinical meeting and care plans updated as needed. C. The CEO will review these daily in QA</p>	05/02/2013

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	<p>(milligrams) by mouth, daily for 7 days, then to discontinue. The MAR (medication administration record) dated 3/1/13 through 3/31/13, indicated Lexapro 5 mg was discontinued on 3/22/13 and Lexapro 2.5 mg was given 3/23/13 through 3/29/13, and then was discontinued. The MAR dated 4/1/13 through 4/30/13, indicated the resident began receiving Lexapro 5 mg by mouth, daily on 4/1/13 through 4/3/13.</p> <p>During an interview on 4/3/13, at 1:40 p.m., LPN #1 indicated she did not know why the Lexapro 5 mg had been transferred to the April MAR. She did indicate that the Lexapro should have been discontinued on 3/29/13. A nurses note dated 4/3/13, and signed by DON, indicated that the doctor was notified.</p> <p>B. Record review for Resident #41 on 4/15/13, at 10:30 a.m., indicated diagnoses including, but not limited to, left rib fractures (1-8), chronic infrarenal dissection, right subdural hematoma, epidural hematoma, stroke with watershed effect, pneumothorax, ileostomy, hypertension, diabetes mellitus, and pressure ulcers.</p> <p>On 4/15/13, at 3:00 p.m., the resident</p>		stand up meeting, monthly with QA team and quarterly with MD at quarterly QA meeting.5. This plan of correction constitutes our credible allegation of compliance with all regualtoryrequirements. Our date of compliance is: May 2, 2013.		

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	<p>was observed lying on his back in bed.</p> <p>A review of the MDS (Minimum Data Set) assessment dated 3/19/13 indicated that resident was totally dependant of 2 plus persons for bed mobility, transfers, and most ADL's (Activities of Daily Living).</p> <p>Record review on 4/16/13, at 10:30 a.m., indicated a care plan last updated on 3/12/13. The care plan indicated that the resident had a problem of pressure ulcers to back, and buttocks. Interventions included, but were not limited to, provide treatment as ordered, provide pressure relieving devices to reduce pressure to affected area, and turn and reposition every 1 hour (dated 12/11/12).</p> <p>During observations on 4/16/13, at 8:38 a.m., and 9:05 a.m., the resident was observed lying on his back in bed.</p> <p>During an interview on 4/16/13, at 10:40 a.m., QMA #1 and CNA #7 indicated they were turning and repositioning the resident every 2 hours and propping with pillows to keep the resident off of his back, but he manages to wiggle off of the pillow</p>			

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	<p>and onto his back in between times.</p> <p>During an interview on 4/16/13, at 11:05 a.m., LPN #2 indicated the resident should be turned every 1 hour, and she would let the CNAs know.</p> <p>Record review of ADL (Activities of Daily Living) sheets on 4/16/13, at 11:20 a.m., and dated and initialed for dates 12/1/12 through 4/16/13, indicated the resident was turned and repositioned every 2 hours.</p> <p>3.1-35(g)(2)</p>				

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F000309 SS=G	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to provide the necessary care to maintain the highest practical well-being after recent surgery in that the resident developed a scrotal hematoma 3 days after surgery due to not wearing his scrotal support sling. This resulted in the resident being re-admitted to the hospital for further treatment. This deficient practice affected 1 of 1 resident reviewed for after surgery care. (Resident #54)</p> <p>Finding includes:</p> <p>Review of the clinical record for Resident #54 on 4/15/13 at 2:00 p.m., indicated the resident was admitted to the facility on 11/1/12 and had diagnoses which included, but were not limited to: status post hydrocele repair, dementia, diabetes, and mood behavior.</p> <p>Review of a 1/22/13 hospital out-patient surgery note indicated the</p>	F000309	<p>F 309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEINGIt is the intent of this facility to provide the necessary care and services to maintain the highest practicable physical, mental and psychosocial well being in accordance with the care plan.1. Actions taken: A. Resident # 54 has had no complications after re admit to facility from hospital. B. Resident #54 care plan had been revised to show current status.2. Others identified: no other residents identified.3. Measures taken: A. 100 percent audit conducted of care plans to reflect residents current condition and updates. B. Nursing staff in service conducted on continuity of resident care.4. How monitored: A. DON/Designee will audit charts of any surgical resident to clarify all treatments that are needed by that resident. B. DON/Designee will review from the 24 hour shift sheets any change in residents condition and discuss in morning QA meeting. C. The CEO will review these daily in QA stand up</p>	05/02/2013	

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	<p>resident had undergone a hydrocelectomy [removal of fluid and soft swelling in the membrane surrounding the testes].</p> <p>Review of the out-patient instructions indicated the only instructions the physician gave upon return was to change the dressing as needed.</p> <p>A 1/22/13 1:50 p.m. nursing note indicated "...Drsg [dressing] et [and] sling [scrotal support] in place...." Further documentation of the resident wearing his scrotal support sling was lacking.</p> <p>Review of the care plans indicated there was a care plan originally dated 9/12/12 regarding the resident's scrotal swelling and left hydrocele. This care plan was updated on 1/22/13 due to his surgery to repair the hydrocele with new interventions to include: "Antibiotics per order, observe surgical incision, report abnormal findings to MD." Documentation of the intervention regarding the use of the scrotal support after surgery was not included.</p> <p>Documentation was also lacking of the physician having been contacted to clarify use of the sling.</p>		<p>meeting, monthly with QA team and quarterly with MD at quarterly QA meeting.5. This plan of correction constitutes our credible allegation of compliance with all regualtoryrequirements. Our date of compliance is: May 2, 2013.This facility respectfully requests a face to face IDR as the facility does not believe the resident's hematoma was a result of any fault of the facility. The facility followed up as per protocol on all MD orders, Md notifications, ETC.</p>	

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	<p>On 1/25/13, documentation indicated the resident had a follow-up appointment with the Urologist, per primary physician recommendation, due to scrotal swelling and low grade temperature. The Urologist noted on the visit note that the resident was having pain after surgery from his left testicle. He further noted "Never wore scrotal support." He then sent the resident back to the hospital as a direct re-admit and diagnosed the resident as having a left scrotal hematoma.</p> <p>Review of the 1/25/13 hospital admitting note indicated, "...He underwent a left hydrocele repair on 1/22/13 and really went fine. He apparently went home to his nursing home and no one applied the mesh panties/scrotal support and he subsequently developed a hematoma...given his exam, I thought he needed to be admitted for IV [intravenous fluid] antibiotics. He is aware that if the hematoma infects or this gets worse, he may need a scrotal orchiectomy [removal of the testicle]...."</p> <p>On 1/28/13, the resident was re-admitted back the facility after receiving antibiotics in the hospital for three days. No further surgery was</p>			

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	<p>necessary.</p> <p>During an interview on 4/16/13 at 3:30 p.m. with the Administrator in Training, Director of Nursing and the MDS [Minimum Data Set] Coordinator, they indicated "the Physician did not indicate on his orders whether he wanted to continue the sling when he came back. They may have just put it on him after surgery and didn't want to continue it. We did not clarify with the Urologist nor his Primary Physician if it was to be continued here at the facility and for how long. We talked with his primary Physician as to what was going on with him and gave us some orders but not specifically about the sling. The urologist was assuming he didn't wear the sling - that's not to say the nurses didn't have it on him. They may have just forgot to chart it. Can't say if it should have been put on the Care Plan as an intervention as we didn't know if the Urologist wanted to continue it or not."</p> <p>3.1-37(a)</p>				

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F000329 SS=E	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure the residents' drug regimen was free from unnecessary anti-psychotics, anti-depressants and excessive diabetic medications. This deficient practice affected 4 of 10 residents reviewed for unnecessary medications. (Residents #1, 24, 54 and 37)</p> <p>Findings included:</p>	F000329	<p>F 329 UNNECESSARY DRUGS It is the intent of this facility to only use drug therapy as deemed necessary to a specific diagnosis and titrate and reduce as needed. 1. Actions taken: A. Resident #1- Diagnosis was obtained for Trazadone and a GDR was done on both medications in question. B. Resident #24- GDR was done on medication in question. C. Resident #54- Reviewed again diabetic regimen with MD and MD still wants to continue current regimen. D. Res</p>	05/02/2013			

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	<p>1. Review of the clinical record for Resident #1 on 4/15/13 at 10:52 a.m., indicated the resident had diagnoses which included, but were not limited to: alcohol cirrhosis, alcohol persistent dementia, mental disorder, and alcohol dependence.</p> <p>Review of the April 2013 Monthly Physician Orders indicated the resident had orders for Trazadone [for depression/insomnia] 100 mg [milligrams] dated 7/17/12 - one tablet every night and for Seroquel [an antipsychotic medication] 50 mg dated 10/17/11 - one tablet every 12 hours.</p> <p>Documentation was lacking of any indications for the use of the Trazadone or of gradual dose reductions having been attempted on the Seroquel since started.</p> <p>Review of nursing notes between 9/7/12 and 4/7/13, indicated the resident had only one episode of agitation noted on 10/30/12 due to smoking.</p> <p>The Psychiatrist saw the resident on 8/8/12, 11/5/12 and on 2/18/13 with no documentation of the resident having any behavior of mood issues that needed to be addressed.</p>		<p>#37- Medication was D/C'd , MD and family notified and resident assessed with no issues.2. Others identified: No other residents affected.3. Measures taken: A. 100 percent audit of antipsychotics completed fro GDR review.4. How monitored: A. GDR's will be audited per SS every three months with MDS schedule and PRN with behaviors. B. DON/Designee will audit any new orders in daily clinical meetings for proper DX and use. C.DON/Designee will review pharmacy recs monthly with MD D. The CEO will review these daily in QA stand up meeting, monthly with QA team and quarterly with MD at quarterly QA meeting.5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is: May 2, 2013.</p>		

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	<p>Documentation was also lacking in the Social Worker notes of the resident having had any behavior issues.</p> <p>Behavior logs were implemented in February 2013 to monitor the resident's behaviors and insomnia and indicated the resident had occasional repetitive questions on 3 of 31 days in March and 9 of 9 days in February and only 1 day of insomnia in March and none in February.</p> <p>A 2/19/13 care plan was implemented to address the resident being at risk for decline in mood r/t [related to] DX [diagnosis] Depression and on an anti-depressant. Approaches included, but were not limited to: " 10. GDR [gradual dose reduction] per guidelines".</p> <p>A 12/30/11 care plan was implemented with a last review date of 2/11/13 to address the resident being at risk for behavioral disturbances R/T DX: Dementia with behavioral disturbances and HX [history] of mood and behavior disturbances. resident on anti-psychotic med R/T closed head injury with mood and behavior</p>			

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	<p>disturbance and psychosis. Approaches included, but were not limited to: "9. GDR per guidelines."</p> <p>During an interview with Social Worker #1 on 4/18/13 at 10:00 a.m., she indicated it was a "toss up" which medication should have been reduced and she chose the Ativan [for anxiety] instead of the Trazadone and the Seroquel.</p> <p>2. Review of the clinical record for Resident #24 on 4/12/13 at 3:37 p.m., indicated the resident had diagnoses which included, but were not limited to: dementia with behavior, recurrent depressive psychosis, anxiety, and paralysis.</p> <p>During the Consultant Pharmacist's visit on February 19, 2013, a recommendation was made for the physician to evaluate the resident's current usage of Trazadone [an anti-depressant] 50 mg every bedtime ordered 11/4/11.</p> <p>During an interview with the Director of Nursing on 4/15/13 at 9:25 a.m., the Director of Nursing indicated she was not aware of the Trazadone being evaluated for reduction per the recommendation in February 2013 by the pharmacist.</p>						

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	<p>During an interview on 4/15/13 at 9:26 a.m., the Social Worker indicated she was not aware of there being a recommendation for the Trazadone to be evaluated for possible reduction.</p> <p>Review of the psychiatrist's notes indicated the resident was seen every 3 months and has had no need for psychiatric interventions since May 2012 as behavior had remained stable.</p> <p>On 4/15/13 at 8:15 a.m., the Director of Nursing [DoN] presented a copy of the facility's current policy titled "Behavior Management/Psychotropic Medication Committee Agenda". Review of this policy at this time included, but was not limited to: "...Meeting Format:...5. the committee will recommend gradual dose reductions of anti-psychotic, anxiolytic and sedative/hypnotic medications at a minimum of Quarterly, unless clinically contraindicated in an effort to decrease or discontinue these drugs..."</p> <p>3. Review of the clinical record for Resident #54 on 4/15/13 at 1:50 p.m., indicated the resident had diagnoses that included, but were not limited to:</p>						

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	<p>diabetes.</p> <p>A 3/26/13 Pharmacist recommendation indicated "[name of resident] diabetic regimen is quite complicated for an elderly person; Lantus 40 units Q [every] AM Metformin 500 mg Q AM Lispro Insulin 10 units with each meal Sliding Scale Insulin QID [4 times a day] - starting coverage at 101</p> <p>His Metformin has been greatly reduced recently. I'm not sure why.</p> <p>1. I would recommend we at least give Metformin 500 mg BID [twice a day] (unless he couldn't tolerate it)</p> <p>2. As he is already getting short acting insulin routinely with each meal, I think the sliding scale should be much more conservative to avoid hypoglycemic events: Consider reducing his fingersticks to TID [3 times a day] (avoid giving short acting insulin at bedtime) Consider a more conservative sliding scale: 250-300 = 4 units 301-350 = 6 units > 350 = 8 units."</p> <p>Review of the resident's blood sugar readings for January, February, and March 2013, indicated the resident</p>						

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	<p>had not experienced any low blood sugar readings.</p> <p>On 4/12/13, the physician signed the recommendation and indicated "Disagree". Documentation by the physician was lacking as to the reasoning he/she did not want to change the resident's diabetic medications.</p> <p>4. Record review for Resident #37 on 4/3/13, at 1:40 p.m., indicated diagnoses including, but not limited to, dementia with behaviors, acute kidney failure, benign prostatic hypertrophy, lack of coordination, dysphagia, urine retention, degenerative joint disease, and Alzheimer's.</p> <p>A doctor's order dated 3/22/13, indicated to decrease Lexapro to 2.5 mg (milligrams) by mouth, daily for 7 days, then to discontinue. The MAR (medication administration record) dated 3/1/13 through 3/31/13, indicated that Lexapro 5 mg was discontinued on 3/22/13 and Lexapro 2.5 mg was given 3/23/13 through 3/29/13, and then was discontinued.. The MAR dated 4/1/13 through 4/30/13, indicated that the resident began receiving Lexapro 5 mg by mouth, daily on 4/1/13 through 4/3/13.</p>						

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	<p>During an interview on 4/3/13, at 1:40 p.m., LPN #1 indicated that she did not know why the Lexapro 5 mg had been transferred to the April MAR. She did indicate that the Lexapro should have been discontinued on 3/29/13.</p> <p>A nurses note dated 4/3/13, and signed by DON, indicated that the doctor was notified.</p> <p>3.1-48(a)(3) 3.1-48(a)(4)</p>			

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F000371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to store food under sanitary conditions. This deficient practice potentially affected 69 of 69 residents currently residing in facility and eating food served from the kitchen.</p> <p>Findings include:</p> <p>During the initial tour of the kitchen with Dietary Manager (DM) on 4/2/13 at 8:22 a.m., the walk-in refrigerator had a tub of pickles had an expiration date of 5/2012. In the dry storage area: a gallon sized baggie of seasoning had no label or open date. A bag of noodles and penne pasta had no labeling or date to indicate when it expired. There was a gallon sized baggie of white substance with no label and no date. When asked what it was, the DM responded thickener. The DM immediately disposed of the items.</p> <p>During an observation of the</p>	F000371	<p>F 371 FOOD PROCURE, STORE/PREPARE/SERVE-SANITARY It is the intent of this facility to store, prepare and serve food under sanitary conditions.1. Actions taken: A. All items were immediately disposed of. B. A temp. log was immediately implemented on the open up freezer.2. Others identified: No other issues identified.3. Measures taken: A. All dietary staff in serviced on proper food storage. B. 100 percent audit conducted on all food for correct labeling, dates and storage4. How monitored: A. DM to audit freezer temps, this will be an on going process. B. DM to audit labeling and dates on foods daily. This will be an ongoing process. C. The CEO will review these daily in QA stand up meeting, monthly with QA team and quarterly with MD at quarterly QA meeting.5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is: May 2, 2013.</p>	05/02/2013			

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	<p>nourishment room on 4/15/13 at 3:00 p.m., 3 bags of unopened corn nuggets were not labeled with an expiration date in the chest freezer.</p> <p>During an interview with the DM on 4/15/13 at 3:15 p.m., indicated the facility does not keep freezer logs in the nourishment room. The DM discarded the 3 bags of corn nuggets.</p> <p>3.1-21(i)(3)</p>			

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F000428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on record review and interview, the facility failed to ensure the consultant pharmacist made recommendations for gradual dose reductions of anti-psychotics and had indications for use of anti-depressants. The facility also failed to ensure the physician listed reasoning for refusing to follow the consultant pharmacist's recommendations to modify a resident's diabetic regimen and to consider reduction of a resident's anti-depressant. This deficient practice affected 3 of 10 residents review ed for unnecessary medications. (Residents #1, 54 and 24)</p> <p>Findings include:</p> <p>1. Review of the clinical record for Resident #1 on 4/15/13 at 10:52 a.m., indicated the resident had diagnoses which included, but were not limited to: Alcohol cirrhosis, alcohol</p>	F000428	<p>F 428 DRUG REGIMEN REVIEW, REPORT, ACT ON It is the intent of this facility to act upon any drugs reviewed by a pharmacist with MD as soon as possible.1. Actions taken:A. Resident #1- Diagnosis was obtained for Trazadone and a GDR was done on both medications in question.B. Resident #24- GDR was done on medication in question.C. Resident #54- Reviewed again diabetic regimen with MD and MD still wants to continue current regimen.D. Resident# 37- Medication was D/C'd , MD and family notified and resident assessed with no issues.2. Others identified: No other residents affected.3. Measures taken:A. 100 percent audit of antipsychotics completed for GDR review.4. How monitored:A. GDR's will be audited per SS every three months with MDS schedule and PRN with behaviors.B. DON/Designee will audit any new orders in daily clinical meetings for proper DX and use.C. DON/Designee will</p>	05/02/2013	

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	<p>persistent dementia, mental disorder, and alcohol dependence. No documentation of a diagnosis of depression was noted.</p> <p>Review of the April 2013 Monthly Physician Orders indicated the resident had orders for Trazadone [for depression/insomnia] 100 mg [milligrams] dated 7/17/12 - one tablet every night and for Seroquel [antipsychotic medication] 50 mg dated 10/17/11 - one tablet every 12 hours.</p> <p>Review of the Consultant Pharmacist's visit notes between January 2012 and March 2013 failed to locate documentation of any recommendations for doing a gradual dose reduction on Seroquel and a indication for use for the Trazadone.</p> <p>During an interview with the Director of Nursing [DoN] on 4/15/13 at 11:30 a.m., she indicated that unless it was indicated on the pharmacist's monthly review, then no recommendations for reductions were made.</p> <p>2. Review of the clinical record for Resident #24 on 4/12/13 at 3:37 p.m., indicated the resident had diagnoses which included, but were not limited to: dementia with behavior, recurrent</p>		<p>review pharmacy recs monthly with MDD. The CEO will review these daily in QA stand up meeting, monthly with QA team and quarterly with MD at quarterly QA meeting.5. This plan of correction constitutes our credible allegation of compliance with all regualtoryrequirements. Our date of compliance is: May 2, 2013</p>		

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	<p>depressive psychosis, anxiety, and paralysis.</p> <p>During the Consultant Pharmacist's visit on February 19, 2013, a recommendation was made for the physician to evaluate the resident's current usage of Trazadone [an anti-depressant] 50 mg every bedtime ordered 11/4/11.</p> <p>During an interview with the Director of Nursing on 4/15/13 at 9:25 a.m., the Director of Nursing indicated she was not aware of the Trazadone being evaluated for reduction per the recommendation in February 2013 by the pharmacist.</p> <p>During an interview on 4/15/13 at 9:26 a.m., the Social Worker indicated she was not aware of there being a recommendation for the Trazadone to be evaluated for possible reduction.</p> <p>Review of the consultant pharmacist's monthly report also failed to make a follow-up recommendation during the 3/26/13 visit to the 2/19/13 request to evaluate the Trazadone for reduction.</p> <p>3. Review of the clinical record for Resident #54 on 4/15/13 at 1:50 p.m., indicated the resident was admitted to</p>						

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	<p>the facility on 8/23/12 and subsequently re-admitted on 11/1/12 with diagnoses that included, but were not limited to: diabetes.</p> <p>A 3/26/13 Pharmacist recommendation indicated "[name of resident] diabetic regimen is quite complicated for an elderly person; Lantus 40 units Q [every]AM Metformin 500 mg Q AM Lispro Insulin 10 units with each meal Sliding Scale Insulin QID [4 times a day] - starting coverage at 101</p> <p>His Metformin has been greatly reduced recently. I'm not sure why.</p> <p>1. I would recommend we at least give Metformin 500 mg BID [twice a day] (unless he couldn't tolerate it)</p> <p>2. As he is already getting short acting insulin routinely with each meal, I think the sliding scale should be much more conservative to avoid hypoglycemic events: Consider reducing his fingersticks to TID [3 times a day] (avoid giving short acting insulin at bedtime) Consider a more conservative sliding scale: 250-300 = 4 units 301-350 = 6 units > 350 = 8 units."</p>			

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	<p>On 4/12/13, the physician signed the recommendation and indicated "Disagree". Documentation was lacking as to a reasoning for declining the recommendation.</p> <p>On 4/16/13 at 3:10 p.m., the Business Office Manager presented a copy of the Consultant Pharmacist's current Job Responsibilities. Review of the Job Description at this time included, but was not limited to: "...Procedures:...Communicating to the responsible physician potential or actual problems detected relating to medication therapy...Consult with attending physicians and nurses to ensure compliance with the Geriatric Pharmaceutical Care Guidelines...Submitting a written report of findings and recommendations resulting from the review of medications regimen and nursing documentation records to the attending physician and director of nursing.."</p> <p>3.1-25(i)</p>			

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F000431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>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, 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, record review and interview, the facility failed to store and label medications properly. This deficient practice affected 4 of 5</p>	F000431	F 431 DRUG RECORDS/LABEL/STORE DRUGS It is the intent of this facility to store and label medications as accordance with	05/02/2013			

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	<p>medication carts observed (Residents #10, #36, #54), 1 of 1 medication storage room observed and potentially affected 69 residents currently residing in the facility.</p> <p>Findings include:</p> <p>During an observation of the medication cart located on Ruby hall on 4/15/13 at 8:45 a.m., 2 bottles of opened liquid medication were not properly labeled with an open date. Each medication was labeled with a resident's name. An interview with LPN #1 indicated medications should be labeled with an open date when opened. LPN#1 immediately discarded the medications.</p> <p>During an observation of the medication cart on Emerald hall on 4/15/13 at 9:15 a.m., Resident #36 had 2 Levimir FlexPens (Insulin). Both FlexPens were labeled with Resident #36's name only. 1 FlexPen was open and 1 FlexPen was unopened. During the same observation Resident #54 had 2 Humalog FlexPens(Insulin). The FlexPens had a label from the pharmacy that indicated refrigeration was needed. In an interview on 4/15/13 at 9:30 a.m., RN #1 indicated the pharmacy staff recommended the insulin could</p>		<p>facility and pharmacy protocol.1. Actions taken: A. Medications in question on all carts were discarded immediately. B. 100 percent audit on all carts to substantiate compliance were conducted. C. Resident # 36, 54, 10- had medication discarded and re ordered.2. Others identified: No other issues identified.3. Measures taken: A. 100 percent cart audit conducted to substantiate compliance. B. Nursing in service conducted on all medications, proper storage and lables.4. How monitored: A. DON/Designee will audit carts one time per week for compliance. This will be ongoing.5. This plan of correction constitutes our credible allegation of compliance with all regualtoryrequirements. Our date of compliance is: May 2, 2013</p>	

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(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
	<p>be stored without refrigeration for 28 days.</p> <p>During an observation of QMA #1's medication cart on 4/15/13 at 10:15 a.m., a Lantus FlexPen and a Novolog FlexPen had no resident identifier on it. When asked who the medication belonged to, QMA#1 indicated it belonged to Resident #10. When QMA #1 was asked how a medication could be identified without a label, QMA#1 indicated was "pretty sure" it belonged to Resident #10. At this time, 3 bottles of opened liquid medication were also found to be without a open date in the same medication cart.</p> <p>A copy of the policy and procedure on Insulin storage, received on 4/15/13 at 11:25 a.m. from the DON, indicated unopened vials and cartridge systems should be stored in a refrigerator. The policy also indicated open vials and cartridges should be discarded after 28 days.</p> <p>During an observation of the medication storage area on 4/15/13 at 11:40 a.m., nine 8.45 ounce cans of Diabetisource AC tube feeding with an expiration date of 01/08/13 were found. At this time, LPN#3 indicated these were floor stock. In the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/16/2013
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	<p>refrigerator used for medication storage, one unopened box of Bisacodyl 10 mg was observed with no resident label, and one opened vial of Tuberculin/PPD Diluted/Aplisol 5TU/0.1m I(Vaccine) was observed with an expiration of 02/2013.</p> <p>During an observation of medication cart located on the Onyx Unit on 4/15/13 at 2:00 p.m., 8 bottles of opened liquid medications were not properly labeled with an open date: four bottles of miralax (laxative), two bottles of lactulose (laxative), one bottle of Robafen (cough syrup), and 1 bottle of milk of magnesia (laxative). An interview with LPN #2 at this time indicated the medications should be labeled with an open date when opened. LPN #2 immediately discarded the medications.</p> <p>An interview with the DON on 4/15/13 at 3:00 p.m. indicated staff were being re-educated on proper labeling and storage of medications.</p> <p>This Federal tag is related to Complaint IN00126331.</p> <p>3.1-25(j)</p>			