

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155551	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/30/2014
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NAME OF PROVIDER OR SUPPLIER ROLLING MEADOWS HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 604 RENNAKER ST LA FONTAINE, IN 46940
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: June 24, 25, 26, 27 and 30, 2014</p> <p>Facility number: 000447 Provider number: 155551 AIM number: 100289950</p> <p>Survey team: Angela Selleck, RN TC (6/24, 6/26, 6/27 and 6/30/14) Kim Davis, RN (6/24, 6/25, 6/26 and 6/27/14) Shelley Reed, RN Jason Mench, RN</p> <p>Census bed type: SNF/NF: 91 Total: 91</p> <p>Census payor type: Medicare: 9 Medicaid: 54 Other: 28 Total: 91</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F000000	<p>We at the facility are hereby respectfully requesting this agency consider paper compliance for the following plan of correction as opposed to a post survey revisit. We are willing to submit any and all documentation as requested to assure our credible compliance with the deficiencies noted in the following CMS-2567. We are hereby providing our plan of correction. Submission of this Plan of correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F000247 SS=D	<p>Quality review completed on July 2, 2014 by Randy Fry RN.</p> <p>483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on interview and record review, the facility failed to notify residents of a new roommate for 1 of 12 residents interviewed for admission, transfer or discharge. (Resident #109) Findings include: During an interview on 6/24/14 at 1:32 p.m., Resident (#109) indicated he had a roommate for a brief amount of time from January 24-30, 2014. He indicated he was not aware he was informed prior the arrival of the roommate. The Social Service Director (SSD) was then asked to provide documentation that Resident (#109) was informed prior to the receiving of a roommate.</p>	F000247	Resident #109 currently has no other residents residing in his room. Resident #109 has only had one roommate during his stay at the facility. The facility Social Services Director (SSD) talked with resident #109, the SSD asked resident #109 if he recalled the SSD making him aware that he was going to receive a roommate short term, resident #109 replied, "of course you did now that I see your face, but that was a year ago". All other residents residing in the facility that change rooms or have a roommate change have the potential to be affected by this deficient practice. Facility staff were re-inserviced by the Director of Nursing regarding Residents Rights and the right to be notified	07/14/2014

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F000250 SS=D	<p>A progress note dated 6/26/14 at 1:06 p.m., provided by the Social Service Director (SSD) on 6/26/14 at 2:15 p.m., indicated the SSD spoke to Resident (#109) to remind him that she had spoken to him prior to the roommate being admitted to his room. No additional documentation was provided prior to the 6/26/14 progress note.</p> <p>During an interview on 6/26/14 at 2:40 p.m., the (SSD) indicated she did not document Resident (#109) was informed he was getting a new roommate. She indicated during the time of admission, she was covering another position until the position was filled, but would normally document the information had been provided.</p> <p>3.1-3(v)(2)</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p>		<p>of a room change or roommate change. The SSD and/or designee will complete an audit of room/roommate changes weekly for four weeks, every other week for four weeks, then monthly thereafter. The audit will be documented on the Notice Before Room/Roommate change audit form. (Attachment A) Any concerns noted will receive immediate follow-up. Monitoring will continue until substantial compliance is achieved as determined by the Quality Assurance committee. The SSD report of monitoring will be forwarded to the Administrator for monthly Quality Assurance review and plan of action will be adjusted accordingly.</p>		

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	<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. Based on observation, interview and record review, the facility failed to ensure a behavior management plan was updated and followed to manage the behaviors of one of one resident reviewed for behavior management. (Resident # 96)</p> <p>Findings Include:</p> <p>The Initial Tour of the facility's secured unit was conducted on 6/24/14 at 9:30 a.m. During the tour, Resident #96 was observed. Resident #96 ran to the unit door as it closed. The resident then began to press the keys of the numbered panel used by staff and visitors. When the correct number code is pressed, the secured door opening to the facility, unlocks and the unit can be exited. As visitors entered the secured unit door, Resident #96 approached each, took the visitor's hand, hugged the visitors and or asked if she could kiss the visitor.</p> <p>The noon meal was observed in the secured unit on 6/24/14 at 11:45 a.m. During the observation, Resident #96 was observed running to the exit door, pushing the code panel, walking to the door which lead outside and running down the hall to her room. The resident's</p>	F000250	Resident #96 was referred for an inpatient psych evaluation and treatment. Resident #96's individualized behavior management plan was reviewed and revised as appropriate. All residents demonstrating behaviors or currently on individualized behavior management plans have the potential to be affected by this deficient practice. Behavior sheets completed within the last thirty days for residents on individualized behavior management programs were reviewed and the residents' individualized plans were updated as appropriate. The facility Behavior Management policy and procedure was reviewed with no changes indicated. Facility staff were re-inserviced on the Behavior Management policy and procedure by the Director of Nursing and the Social Service Director. Behavior sheets will be reviewed daily Monday through Friday during the morning Intradisciplinary team (IDT) clinical meeting. The Social Service Director (SSD) and/or designee will update the residents individualized behavior plan as indicated following the IDT clinical meeting. Residents on the behavior management program will be reviewed monthly by the	07/14/2014			

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	<p>room was located at the end of the hall next to another door leading outside. The resident loudly asked staff if she could go outside and see the flowers and when was her husband coming to visit. Occasionally a staff member would reply to the Resident, "go look at your picture books." Resident #96 would then run down the hall to her room.</p> <p>At 12:00 p.m., Resident #96 picked up food from a resident's plate. A resident at the same table, loudly said "get out of here".</p> <p>Resident #96's meal tray was served at 12:15 p.m., Resident #96 walked to the table, took a bite of sandwich and ran back to the front door. Staff encouraged Resident #96 to eat. The resident continued to walk to the table, take one bite or one drink of lemonade and walk back to the door.</p> <p>At 12:45 p.m., the facility psychiatrist opened a door used by staff to enter and exit the secured unit. Resident #96 ran to the door as it opened. The Social Service Director (SSD) walked to the door to meet the doctor. As she did, the SSD told Resident #96 "The Young and the Restless was on television." Resident # 96 overheard the conversation and loudly said to other residents, she will just come</p>		<p>behavior management team with new or revised interventions made to the residents individualized behavior management plan as indicated. The SSD and/or designee will complete the Behavior and Psychoactive medication review form (Attachment B) weekly for four weeks, every other week for four weeks, then monthly thereafter. Any concerns noted will receive immediate follow-up. Monitoring will continue until substantial compliance is achieved as determined by the Quality Assurance committee. The SSD report of monitoring will be forwarded to the Administrator for monthly Quality Assurance review and plan of action will be adjusted accordingly.</p>				

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	<p>back and eat other people's food.</p> <p>On 6/24/14 at 3:00 p.m., Resident #96 was observed on the secured unit. The resident continued to run to the door when it was opened. Residents were in the dining area making decorations. Resident #96 walked around the tables, up and down the hall, in and out of her room, clapping her hands and asking to go outside and see the flowers.</p> <p>On 6/25/14 at 8:30 a.m., Resident #96 was observed running to the secured unit door, pushing the code panel numbers, asking to go outside, clapping her hands, and taking the hands of visitors, asking "when can I kiss you?" or "when can I hug you?" or "when will you take me outside?" or "when can I go with you?"</p> <p>On 6/26/14 at 10:15 a.m., Resident #96 told Restorative CNA #1, she wanted to go outside. The Restorative CNA #1 told Resident #96 it was hot outside. Resident #96 then asked the Restorative CNA #1 to take her outside and see the flowers. The Restorative CNA #1 told the resident, "nope".</p> <p>On 6/27/14 at 9:00 a.m., Resident #96 was observed on the secured unit. The resident was observed running to the unit door when it opened and rushing up to</p>			

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	<p>visitors. Resident #96 was observed running up and down the hall, into her room and out again. The resident continued to request staff and visitors to take her outside and see the flowers. Staff members redirected the resident by telling her to go to her room and look at her pictures. Resident #96 would run to her room and back again to the dining room.</p> <p>The clinical record of Resident #96 was reviewed on 6/26/14. The record indicated the resident's diagnoses included, but were not limited to, psychosis, frontotemporal dementia, pseudobular affect, depressive disorder and anxiety.</p> <p>The June 2014 physician orders included, Cymbalta for depression, Depakote for frontal dementia and lorazepam as needed for agitation or anxiety.</p> <p>The care plan dated 6/3/14, indicated Resident #96 required placement on the secured unit, was a risk for elopement, required antianxiety medications and had impaired cognitive function, dementia or impaired thought process related to frontal lobe dementia. The care plan interventions included, distractions, picture books, involve in activities, redirect with diversional activities,</p>			

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	<p>administer medications, conversation, monitor and record behaviors, engage in simple structured activities and provide consistent schedule of activities and a daily routine.</p> <p>A progress note dated 6/24/14, indicated Resident # 94 was running up and down the hall clapping and repeating that she wants to go see her husband. The note indicated the resident had tried to kiss visiting men and grabbed other resident's food. The note further indicated redirection was not helpful and the as needed antianxiety medication was administered.</p> <p>There was no progress note or behavior note in the clinical record for 6/25/14 or 6/26/14.</p> <p>The facility Psychiatrist wrote progress notes on 2/3/14, 3/7/14, 4/14/14, 5/5/14 and 6/2/14. All the notes indicated continue meds (medications), support, and encourage ADLs (Activities of Daily Living).</p> <p>The facility behavior team met monthly during 2014. The 4/5/14 behavior interventions included reminisce with pictures, involve in activities and redirect with diversional activities. The 5/8/14 behavior interventions were not updated.</p>			

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	<p>The 6/10/14 interventions were not updated.</p> <p>CNA # 12 was interviewed on 6/27/14 at 9:35 a.m. During the interview, the CNA indicated Resident #94's behaviors was an everyday occurrence. The CNA indicated she attempts to help Resident #94 look at picture books, watch television and listen to her her music, but none of those interventions last very long.</p> <p>LPN #13 was interviewed on 6/26/14 at 2:00 p.m. During the interview, LPN #13 indicated Resident #96 has always been a hugger but due to the disease process, the resident has less impulse control now than before she was ill. The LPN further indicated staff try to keep Resident #96 away from male visitors and residents. LPN #13 indicated he can redirect Resident #96, but only for a short while.</p> <p>LPN #13 was interviewed on 6/27/14 at 3:00 p.m. During the interview, LPN #13 indicated Resident #96 wants to hug and kiss other residents. LPN #13 indicated Resident #96 asks residents, staff, and visitors if she can hug and kiss them. LPN #13 indicated regular visitors have learned to avoid and ignore Resident #96.</p> <p>The secured unit's Activity Director was interviewed on 6/26/14 at 2:20 p.m.</p>			

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	<p>During the interview, the Activity Director indicated she takes the unit's residents outside when Resident #96 is out of the facility. The Activity Director indicated when Resident #96 goes outside into the fenced yard, a staff member has to guard the door which leads from the fenced area into the facility's main dining room located close to the facility's main entrance. The Activity Director indicated Resident #96 doesn't want to go look at flowers, she just sees it as a way to freedom.</p> <p>The Maintenance Director was interviewed on 6/24/14 at 9:15 a.m. During the interview, the Maintenance Director indicated the front door to the facility would lock if a resident from the secured unit tried to open it.</p> <p>The Social Service Director (SSD) was interviewed on 6/27/14 at 2:15 p.m. During the interview, the SSD presented a new care plan dated 6/24/14 related to Resident #96's behaviors of hugging and kissing. The SSD indicated she had no prior training with frontal lobe dementia. The SSD indicated Resident #96 was impulsive and doesn't sit for very long. She indicated some of the behavior interventions are no longer appropriate because the resident does not have the same interests she had upon admission to</p>			

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F000329 SS=D	<p>the facility from a geriatric psychiatric unit. The SSD indicated the behavior care plan had not been updated.</p> <p>3.1-34(a)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to attempt a gradual dose reduction, and failed to obtain a letter from the Physician stating a gradual dose reduction was clinically</p>	F000329	Resident #50 and #56 have had no adverse reactions as a result of this deficient practice. Resident #50 and #56's medication were reviewed by the facility Psychiatrist and a clinically	07/14/2014

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	<p>contraindicated for psychotropic medications for 2 of 5 residents reviewed for unnecessary medications. (Residents #50 and #56)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #50 was reviewed on 6/27/14 at 1:00 p.m. Current diagnoses included, but were not limited to, Alzheimer's disease, hypertension, chronic airway obstruction, depressive disorder, anxiety, dementia unspecified with behavioral disturbance, delusional disorders and peripheral vascular disease.</p> <p>The resident was currently receiving the following medication on a daily basis Zoloft (antidepressant) 50 milligrams by mouth in the evening originally ordered on 6/30/2011 for a diagnosis of delusional disorders.</p> <p>The chart indicated no Gradual Dose Reduction (GDR) or letter of contraindication had been completed on Zoloft, being used as an antidepressant since the original order date of 6/30/11.</p> <p>A "Behavior Management Team Review" summary dated 1/10/14 was provided by LPN #2 on 6/27/14 at 4:08 p.m. and indicated Resident #50 had been</p>		<p>contraindicated statement was written at that time. All other residents residing in the facility that receive psychoactive medication have the potential to be affected by this deficient practice. All residents on psychoactive medications have been reviewed to ensure there is a schedule for gradual dose reduction in place unless clinically contraindicated by the Psychiatrist or physician. The Psychiatrist will continue with monthly review and management of residents receiving psychoactive medications. The facility policy and procedure for Psychoactive Medications and Gradual Dose Reduction was reviewed and no changes were indicated. Facility staff including the Pharmacist and Psychiatrist were re-inserviced regarding the facility policy and procedure for Psychoactive Medications and Gradual Dose Reduction. The SSD and/or designee will complete the Behavior and Psychoactive medication review form (Attachment B) weekly for four weeks, every other week for four weeks, then monthly thereafter. Any concerns noted will receive immediate follow-up. Monitoring will continue until substantial compliance is achieved as determined by the Quality Assurance committee. The SSD report of monitoring will be forwarded to the Administrator for monthly Quality Assurance</p>				

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	<p>discontinued from behavior management and the last behavior was dated 8/23/13.</p> <p>During an interview with the Social Service Director on 6/27/14 at 2:20 p.m., she indicated the medication Zoloft (antidepressant) had not been decreased because the facility was concerned with decreasing the antipsychotic medications first.</p> <p>During an interview with the Social Service Director on 6/27/14 at 3:45 p.m. she indicated no contraindication letters or attempts at a GDR since 6/30/11 for Zoloft (antidepressant) medication had been attempted.</p> <p>No further documentation was provided by the facility as of exit 6/30/14.</p> <p>2. Resident #56's clinical record was reviewed on 6/26/14 at 12:55 p.m. The resident's diagnoses included, but were not limited to, diabetes, delusional disorders, dementia with behavioral disturbance and anxiety state.</p> <p>The Resident had a current order for Lorazepam (an antianxiety medication) 0.5 milligrams (mg) by mouth every night at bedtime for anxiety. The orders indicated the Lorazepam order had originated on 8/24/12.</p>		review and plan of action will be adjusted accordingly.				

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	<p>Review of the "Behavior Management Team Review" notes, indicated the Resident was discharged from behavior management after their last meeting on 1/10/14 due to Resident #56's last behavior occurring on 9/18/13. No further behaviors were documented.</p> <p>On 6/27/14 at 10:00 a.m., the Social Service Director (SSD), Wound Nurse, and the DoN (Director of Nursing) were interviewed with the Consultant Pharmacist present during this interview via telephone. It was indicated by all parties the facility was concentrating on reducing the stronger medications and would start reducing the Lorazepam when the other medications were discontinued. The DoN, SSD and Consultant Pharmacist indicated they did not have a resident specific contraindication letter for the Lorazepam from the Physician with a justification for not attempting a gradual dose reduction.</p> <p>A policy "Psychoactive Medications/Gradual Dose Reduction Policy", dated 6/2013 and provided by the Nurse Consultant on 6/30/14 at 10:30 a.m., indicated;</p> <p>"... To ensure gradual dose reduction attempts are made unless contraindicated..."</p>			

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	<p>"...6. Based on the medication management review the pharmacist will make a recommendation to the primary physician for medication changes and/or Gradual Dose Reduction..."</p> <p>"...Considerations Specific to Psychopharmacological Medications Other than Antipsychotics and Hypnotics/Sedatives.</p> <p>During the first year in which a resident is admitted on a psychopharmacological medication, or after the facility has initiated such medication, the facility should attempt to taper the medication during at least two separate quarters (with one month between the quarters), unless clinically contraindicated. After the first year the tapering should be attempted at least annually unless contraindicated. The tapering may be considered clinically contraindicated if:</p> <p>The continued use is in accordance with relevant current standards of practice and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder..."</p>			

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F000332 SS=D	<p>3.1-48(b)(2)</p> <p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, interview, and record review, the facility failed to ensure medications were administered without error. This was evidenced by 3 medication errors during 28 attempts for 2 of 9 residents observed with 2 of 4 nurses observed resulting in an error rate of 10.71%. (Residents #99 and #53) (LPN # 10 and RN #11)</p> <p>Findings Include:</p> <p>1. The medication administration was observed after breakfast with LPN #10 and Resident #99 on 6/25/14 at 7:55 a.m. During the observation, LPN #10 administered 20 milligrams (mgs) of Omeprazol (antiulcer drug) to Resident #99.</p> <p>The clinical record of Resident # 99 was reviewed on 6/27/14 at 9:55 a.m. The record indicated the resident's diagnoses included, but were not limited to esophageal reflux and stroke. The current physician orders included an</p>	F000332	Resident #99's omeprazole was reviewed and the time was changed to administer before breakfast. Resident #53's levothyroxine and omeprazole were reviewed and the administration times were changed to before breakfast. All other residents residing in the facility that receive medication that should be administered on an empty stomach or prior to meals have the potential to be affected by this deficient practice. All residents currently residing in the facility medication was reviewed for appropriate timing and scheduling, adjustments in time administration were made as indicated. The nursing staff were re-inserviced by the Director of Nursing regarding medications that should be administered on an empty stomach or prior to meals. A random medication observation will be completed by the Director of Nursing and/or designee weekly for four weeks, every other week for four weeks, then monthly thereafter. The random audit will be documented on the Medication Administration	07/14/2014			

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	<p>order dated 8/7/13 for Omeprazol 20 mg capsule one time daily for Esophageal Reflux.</p> <p>Pages 1025 through 1027 of the 2014 "Nursing Drug Handbook" located on the facility's Birch Nurse Station provided the following information. "...Omeprazol... INDICATIONS & DOSAGES ... Symptomatic Gastroesophageal reflux disease (GERD)... 20 mg daily... ADMINISTRATION... Give drug at least 1 hour before meals..."</p> <p>2. The medication administration of Resident #53 was observed after breakfast with RN #11 on 6/25/14 at 8:08 a.m. During the observation, Resident #53 received 20 milligrams (mgs) of the antiulcer drug of Omeprazol and 50 micrograms (mcgs) of the thyroid hormone replacement drug, levothyroxine.</p> <p>The clinical record of Resident #53 was reviewed on 6/27/14 at 10:00 a.m. The record indicated the resident's diagnoses included, but were not limited to hypothyroidism, dementia, Gastroesophageal reflux disease (GERD) The current physician orders included an order dated 6/29/11 for levothyroxine 50 mcg daily for hypothyroidism and an</p>		<p>Observation form CMS-20056. Any concerns noted will receive immediate follow-up. Monitoring will continue until substantial compliance is achieved as determined by the Quality Assurance committee. The Director of Nursing report of monitoring will be forwarded to the Administrator for monthly Quality Assurance review and plan of action will be adjusted accordingly.</p>	

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	<p>order dated 2/14/14 for Omeprazol 20 mg daily for heartburn.</p> <p>Pages 1025 through 1027 of the "2014 Nursing Drug Handbook" located on the facility's Birch Nurse Station provided the following information. "Omeprazol... INDICATIONS & DOSAGES ... Symptomatic Gastroesophageal reflux disease (GERD)... 20 mg daily... ADMINISTRATION... Give drug at least 1 hour before meals..."</p> <p>Pages 829 through 831 of the "2014 Nursing Drug Handbook" provided the following information. "levothyroxine...therapeutic class: Thyroid replacement... INDICATIONS & DOSAGES...hypothyroidism 12.5 to 25 mcg daily... ADMINISTRATION...Give drug at same time each day on and empty stomach, preferably 1/2 - 1 hour before breakfast..."</p> <p>The Director of Nursing (DoN) was interviewed on 6/27/14 at 9:35 a.m. During the interview, the DoN indicated the facility was going to change the administration times of Omeprazol to 7:00 a.m. and synthroid to 6:00 a.m.</p> <p>3.1-48(c)(1)</p>			

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F000520 SS=D	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on interview and record review, the facility QAA (Quality Assessment and Assurance Committee) failed to identify deficient practice regarding GDR (Gradual Dose Reductions) of psychoactive medications resulting in continued use related to anti-anxiety (Resident #56) and anti-depressant (Resident #50) medications. The facility QAA failed to develop an action plan to address the continuing administration of psychoactive medications which had the</p>	F000520	It is the practice of the facility to maintain a Quality Assessment and Assurance (QAA) committee consisting of the Director of Nursing, the Health Facility Administrator, a physician designated by the facility, and at least three other members of the facility staff. The QAA committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of	07/14/2014

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	<p>potential to affect 79 residents in the facility receiving these medications.</p> <p>Findings include:</p> <p>During an interview on 6/30/14 at 1:40 p.m., the Administrator and Director of Nursing (DoN) were queried regarding the Quality Assessment and Assurance (QAA) process and the identified concerns of continued use of anti-anxiety and anti-depressant use without an annual Gradual Dose Reduction (GDR) within 1 year of starting the medication or a letter of contraindication which impacted Residents #50 and #56. The Administrator indicated he was the person that was overall responsible for the (QAA) committee.</p> <p>The DoN indicated from the previous annual survey plan of correction, the facility focused on anti-psychotic medications and the clinical use, as well as, the contraindication letter if needed. She indicated the need for monitoring of both anti-anxiety and anti-depressant medication use.</p> <p>The 6/24/14, facility "Resident Census and Condition of Residents" form indicated 79 of the facility's residents receive psychoactive medications. Of the 79 prescribed psychoactive medications,</p>		<p>action to correct identified quality deficiencies. The QAA committee in currently enrolled and participating in the Advancing Excellence National Campaign for anti-psychotic medication reduction. The QAA committee has documented a 38% overall reduction in antipsychotic medications during the previous three quarters. Psychoactive medications and residents receiving psychoactive medications were reviewed by the Quality Assessment and Assurance Committee. An action plan was developed for the continuing administration of psychoactive medications and review and gradual dose reduction of psychoactive medications including anti-anxiety medication and anti-depressant medication. No residents incurred any adverse reactions or negative outcomes related to this deficient practice. The QAA committee members were re-inserviced regarding the facility policy and procedure for Quality Assurance and Performance Improvement by the facility HFA and Director of Nursing. The facility will continue to conduct monthly QAA committee meetings. The QAA committee will record and maintain minutes. The facility will complete observations, assessments, and interviews a minimum of three times a year to ensure that a high standard of patient care is</p>	

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	18 residents received antianxiety medication and 40 residents received antidepressant medication. 3.1-52(b)(2)		provided. Quality Measure scores will be reviewed monthly. The QAA committee will utilize confidential facility audit tools to detect concerns so that adverse consequences can be minimized or avoided and corrective action initiated. Action plans will be identified and developed in relation to identified concerns. Action plans will be monitored and re-evaluated as needed on a continuous basis and reviewed by the QAA committee monthly.		