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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155795 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 08/28/2013 |
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| NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS | STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383 |
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| F000000 | <p>This visit was for a Post Survey Revisit (PSR) to a Recertification and State Licensure Survey completed on 07/02/13. This visit included the PSR to the Investigations of Complaints IN00128508, IN00128614, IN00128738, and IN00130059.</p> <p>This visit was in conjunction with the Investigation of Complaints IN00132541, IN00132978, and IN00134933.</p> <p>Complaint IN00128508-corrected.</p> <p>Complaint IN00128614-corrected.</p> <p>Complaint IN00128738-corrected.</p> <p>Complaint IN00130059-corrected</p> <p>Survey dates: August 26, 27, and 28, 2013</p> <p>Facility number: 012766 Provider number: 155795 AIM number: 201051640</p> <p>Survey team: Regina Sanders, RN, TC Heather Hite, RN (August 26 and 27, 2013)</p> | F000000 | <p>This plan of correction is submitted by Avalon Springs Health Campus in order to respond to the alleged deficiencies sited during the Complaint/ PSR survey which was conducted on August 28, 2013. Preparation or execution of this plan of correction does not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the position of Federal and State law. Please accept this plan of correction as the provider's credible allegation of compliance effective September 16, 2013. Considering the volume, scope, and severity of the alleged deficient practice noted in the CMS-2567, Avalon Springs Health Campus respectfully requests a desk review for this survey. If approved, we would be willing to provide all documentation requested including, but not limited to: education records, policies and procedures, checklists, and forms that have been completed, revised, or implemented as part of this Plan of Correction.</p> | |

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

TITLE

(X6) DATE

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

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| | <p>Caitlyn Doyle, RN Jennifer Redlin, RN</p> <p>Census bed type: SNF: 39 SNF/NF: 19 Residential: 55 Total: 113</p> <p>Census Payor type: Medicare: 34 Medicaid: 10 Other: 69 Total: 113</p> <p>Residential sample: 3</p> <p>There deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on September 2, 2013, by Janelyn Kulik, RN.</p> | | | | | | |

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| F000329 SS=D | <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 residents' were free of unnecessary medications related to an increased dosage of Seroquel (antipsychotic), a cardiac medication not held for a resident, who's blood pressure was lower than the parameter to give, and the incorrect amount of insulin administered to a resident for 2 of 4 residents reviewed for unnecessary medications. (Resident #7 and #52)</p> | F000329 | <p>F 329 1. Resident #7 record was reviewed on 8-27-13 for any adverse side effects related to the Insulin and Coreg. No adverse side effects were noted and correct dosage has been administered per the MD orders.</p> <p>Resident #52 was assessed for any adverse side effects related to the Seroquel with no adverse side effects noted. The behavior profile for the resident was updated to reflect non-pharmacological interventions and behaviors exhibited. 2. Residents records</p> | 09/16/2013 | |

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| | <p>Findings include:</p> <p>1) Resident #7's record was reviewed on 08/27/13 at 1:30 p.m. The resident's diagnoses included, but were not limited to, hypertension and diabetes mellitus.</p> <p>A) Resident #7's re-admission orders, dated 8/7/13, indicated an order for glucometer checks (blood sugar checks) three times a day before meals, and an order for Novolog insulin sliding scale (insulin given by results of the glucometer results): 150-200-4units (u) 201-250-8u 251-300-12 u 301-350-16u 351-400-20u above 400 or below 60 call the physician.</p> <p>The Medication Administration Record (MAR), dated 08/13, indicated the resident's blood sugar on 08/07/13 at supper time was 227 and four units of Novolog insulin was given. The resident's blood sugar on 08/09/13 at supper time was 268 and eight units of Novolog insulin was given.</p> <p>During an interview on 08/27/13, the Unit Manager indicated the incorrect</p> | | <p>with Insulin, orders for B/P parameters and behavior profiles were reviewed. Behavior profiles were updated with non-pharmacological interventions if applicable. Social Service behavioral documentation reviewed and updated if applicable. 3. Licensed Nurses will have a Directed In-service by 9/13/2013 related to following physician orders, appropriate documentation of medication, the Five "R's" of medication administration, the monitoring of vital sign parameters, behavior monitoring, documentation of triggers, non-pharmacological approaches/interventions by the outside Pharmacy Nurse Consultant. Director of Health Services (DHS) or designee will monitor residents to ensure License Nurses will follow the MD orders related to Insulin, B/P parameters, the use of anti-psychotic medications and behavior monitoring 5x weekly x 2 months, then 3x weekly x 2 months, then 1x weekly thereafter until QAA states otherwise. DHS or designee will report findings to QAA monthly. 4. QAA will monitor findings monthly for any trends and make recommendations to the plan of correction as needed. The QAA will monitor for 6 months then quarterly until 100% compliance is achieved. 5. Completion date: 9/16/13</p> | | |

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| | <p>dose of insulin had been given. She indicated the resident should have received eight units on 08/07/13 and 12 units of insulin on 08/09/13.</p> <p>B) Resident #7's hospital discharge orders indicated an order for Coreg (cardiac medication) 3.125 mg (milligrams) twice a day-hold if systolic blood pressure less than 140.</p> <p>The re-admission orders, dated 8//7/13, indicated an order for Coreg 3.125 mg twice a day, hold if systolic blood pressure was less than 140 until systolic blood pressure is over 130 and notify the physician before giving.</p> <p>Resident #7's MAR, dated 08/13, indicated the Coreg had been administered to the resident with the following morning blood pressures:</p> <p>8/12/13-134/78 8/13/13-138/80 8/18/13-126/72 8/19/13-132/78 8/21/13-136/72 8/22/13-134/78 8/23/13-122/82 8/26/13-126/70</p> <p>There was a lack of documentation to indicate the resident's physician had</p> | | | | | | |

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| | <p>been notified prior to the administration of the Coreg on 8/12/13, 08/13/13, 08/19/13, 08/21/13, and 08/22/13.</p> <p>The MAR, dated 08/13, indicated the Coreg had been administered to the resident with the following evening blood pressures:</p> <p>8/13/13-130/72 8/17/13-128/60 8/18/13-130/72 8/23/13-132/70</p> <p>There was a lack of documentation to indicate the resident's physician had been notified prior to the administration of the Coreg on 08/13/13, 08/18/13, and 08/23/13.</p> <p>During an interview on 8/27/13 at 2:04 p.m., the Unit Manager indicated the Coreg should not have been given if the resident's systolic blood pressure was under 140. She indicated the Coreg had been administered to the resident on the above dates and times.</p> <p>During an interview on 08/27/13 at 2:06 p.m., LPN #1 indicated the order should have just been written to indicate the Coreg should have been held if the systolic blood pressure was</p> | | | | |

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| | <p>under 140. She indicated the order to give the Coreg if the systolic blood pressure was over 130 after the physician was called, was an order prior to the resident being admitted into the hospital.</p> <p>2. Resident #52's record was reviewed on 08/26/13 at 2:21 p.m. The resident's diagnoses included, but were not limited to, dementia with behaviors and insomnia.</p> <p>The resident's care plan, dated 06/06/13 indicated the resident had a behavior of yelling out continuously in the evening and night. The interventions included, anticipate care needs and provide them before the resident becomes overly stressed, reduce the following stressors that may be contributing to the resident's inappropriate behaviors (area left blank), observe behavior episodes, attempt to determine underlying cause. If observed, document in Behavior log/kiosk. Attempt the following to assist in redirection: toilet, snack, drink, reassurance, validations of feelings/support, rub back/arm, give incontinence care, use humor, redirect as needed, distract with activities.</p> <p>The Physician's Recapitulation</p> | | | | |

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| | <p>Orders, dated 08/13, indicated an order for Seroquel 200 mg (milligrams) with 50 mg (total 250 mg) daily at bedtime for dementia (originally ordered 5/20/13) and Seroquel 25 mg with 50 mg (total 75 mg) daily every morning (originally ordered 5/20/13)</p> <p>A Physician's Order, dated 8/21/13, indicated to give Seroquel 25 mg now (one time).</p> <p>A Physician's Order, dated 8/23/13, indicated to give Seroquel 100 mg every morning, which was increased by 25 mg, for behaviors.</p> <p>The Behavior Detail Log, dated 08/02/13 through 08/27/13, indicated the resident had a socially inappropriate behavior/other (no definition of the behavior documented) on 08/08/13 at 5:15 p.m., diversion activities (no explanation what activities) completed and were not effective and redirection was given but was not effective.</p> <p>The log indicated there were no other behaviors until 08/22/13 at 10:15 p.m., when the resident had socially inappropriate behaviors (no definition of the behavior documented), there was a lack of documentation to</p> | | | |

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| | <p>indicate what interventions were attempted and there was a lack of documentation to indicate the behavior was assessed. The log indicated the resident had no further behaviors from 08/23/13 through 08/27/13.</p> <p>A, "Change in Condition" form, dated 08/21/13 at 1:30 p.m., indicated the resident was yelling out continuously, was agitated and restless, and had increased confusion. There was a lack of documentation to indicate what interventions were attempted to decrease the behaviors and an assessment for possible stressors which may have caused the behavior.</p> <p>The back of the "Change in Condtion" form, indicated: 08/21/13-evening shift-no yelling 08/22/13-night shift-resident became combative (no interventions or assessment of stressors documented) 08/22/13- day shift-no behaviors 08/22/13-night shift-resident continued to have "bouts" of yelling (no interventions or assessment of stressors documented) 08/23/13-no behaviors 08/23/13- evening shift-behavior continue but stopped after evening meal (no interventions or assessment</p> | | | | |

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| | <p>of stressors documented) 08/24/13-night shift-no behaviors 08/24/13-no shift documented-no behaviors</p> <p>The last Social Service note was on 03/01/13.</p> <p>There was a lack of documentation in the Nurses' Notes, dated 08/08/13 through 08/14/13 to indicate the resident had behaviors.</p> <p>During an interview on 8/27/13 at 8:34 a.m., the Social Service Director indicated she was unaware of the Seroquel being increased, and had just found out this morning. She indicated she would have to try and talk to the staff to find out what behavior interventions were attempted. She indicated there had been no documentation of what interventions were completed prior to the increase of the medication. She indicated there was no explanation given on what the socially inappropriate behavior was.</p> <p>During an interview on 08/27/13 at 8:49 a.m., RN #2 indicated yelling out was normal for the resident. She indicated if the resident had behaviors a "Change in Condition" form should have been filled out.</p> | | | | | | |

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| | <p>A facility policy, dated 09/12, titled, "Psychoactive Drug Monitoring", received from the Director of Health Services as current, indicated, "...Nonpharmacological interventions such as behavior modification or social services and their effects are documented as a part of the care planning process, and are utilized by the prescriber (sic) in assessing the continued need for psychoactive medication...Residents receive anti-psychotic medication only for behaviors that are persistent, that are not caused by preventable reasons..."</p> <p>This deficiency was cited on 07/02/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-48(a)(6) 3.1-48(b)(2)</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 record review and interview, the facility failed to identify and implement a plan of action to correct a quality deficiency related to unnecessary medications for 2 of 3 residents reviewed for unnecessary medications, which had the potential to effect 58 of 58 residents who reside in the healthcare facility. (Residents #7 and #52)</p> | F000520 | F520 1. Resident #7 record was reviewed on 8-27-13 for any adverse side effects related to the Insulin and Coreg. No adverse side effects were noted and correct dosage has been administered per the MD orders. Resident #52 was assessed for any adverse side effectes related to the Seroquel with no adverse side effects noted. The behavior profile was updated to reflect non-pharmacological interventions and behaviors | 09/16/2013 | | | |

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| | <p>Finidngs include:</p> <p>The facility failed to ensure residents were free from unnecessary medications related to an increased dosage of Seroquel (antipsychotic) for Resident #52 and Resident #7's cardiac medication was not held as ordered by the physician due to systolic blood pressure lower than 140 and the incorrect dose of insulin was administered to Resident #7.</p> <p>During an interview on 08/28/13 at 8:27 a.m., the Director of Health Services (DHS) indicated Resident #7's blood pressure medication and insulin were audited by the Nursing staff. She indicated the audits were completed three times a week and the resident's blood pressures and medications were reviewed for every day and shift. She indicated the audits indicated the blood pressure was obtained and physician's orders for the medication were followed. She indicated the resident's sliding scale and blood sugar were audited and the audits indicated the physician's orders were followed. She indicated she had just began checking to ensure the audits were correct on 08/25/13 evening. She indicated she had, "checked the Checker" on 08/27/13 and had called</p> | | <p>exhibited. 2. Residents records with Insulin, orders for B/P parameters and behavior profiles were reviewed. Behavior profiles were updated with non-pharmacological interventions if applicable. Social Service behavioral documentation reviewed and updated if applicable. 3. Audit forms were revised to include the vital sign parameters, and non-pharmacological inteventions tried before starting an anti-psychotic medication. The administrative staff and Nursing staff will receive a Directed Inservice by 9/13/2012 by outside consultant related to the audit and QA process. The Executive Director/Designee will monitor audits to ensure all items are checked and the data is accurate 5x weekly x 2 weeks, then 1x weekly thereafter until QAA states otherwise. ED/Designee will report findings to QAA monthly. 4. QAA will monitor monthly for any trends and make recommendations for corrections or modifications as needed. QAA will monitor for six months then quarterly until 100% compliance is achieved. 5. Complete date: 9/16/13</p> | | |

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| | <p>the physician and received different parameters. She indicated the facility had not caught the error quick enough.</p> <p>The DHS also indicated the Seroquel increase for Resident #52 had happened over the week-end (occurred on Wednesday 8/21/13 and Friday 08/23/13) and the facility would have looked at it on Monday (08/26/13). She indicated someone was supposed to be monitoring the psychotropic medications.</p> <p>This deficiency was cited on 07/02/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-52(b)(2)</p> | | | |

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| R000000 | | R000000 | This plan of correction is submitted by Avalon Springs Health Campus in order to respond to the alleged deficiencies sited during the Complaint/ PSR survey which was conducted on August 28, 2013.Preparation or execution of this plan of correction does not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the position of Federal and State law.Please accept this plan of correction as the provider's credible allegation of compliance effective September 16, 2013.Considering the volume, scope, and severity of the alleged deficient practice noted in the CMS-2567, Avalon Springs Health Campus respectfully requests a desk review for this survey. If approved, we would be willing to provide all documentation requested including, but not limited to: education records, policies and procedures, checklists, and forms that have been completed, revised, or implemented as part of this Plan of Correction. | | |