

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E209	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SUMMIT CONVALESCENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 S MAIN ST SUMMITVILLE, IN 46070
--	---

(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
F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: August 18, 19, 20, and 21, 2014</p> <p>Facility number: 000373 Provider number: 15E209 AIM number: 100288730</p> <p>Survey team: Angela Selleck, RN TC Shelley Reed, RN Jason Mench, RN</p> <p>Census bed type: NF: 31 Total: 31</p> <p>Census payor type: Medicaid: 22 Other: 9 Total: 31</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by Debora Barth, RN.</p>	F000000	Submission of this plan of correction shall not constitute or be construed as an admission by Summit Convalescent Center that the allegations contained in the survey report are accurate or reflect accurately the provision of care and service to the residents at Summit Convalescent Center The facility requests the following plan of correction be considered its allegation of compliance The facility also respectfully requests paper compliance due to the low scope and severity of the tags written	
F000279	483.20(d), 483.20(k)(1)			

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E209	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SUMMIT CONVALESCENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 S MAIN ST SUMMITVILLE, IN 46070
--	---

(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
SS=D	<p>DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to develop comprehensive care plans regarding the diagnosis for the use of psychoactive medications for 3 of 5 residents reviewed for unnecessary medications. (Resident #10, # 22, & # 23)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #10 was reviewed on 8/19/14 at 11:59 a.m. The record indicated the resident's diagnoses included, but were not limited to, depressive disorder, insomnia and</p>	F000279	<p>RESIDENT # 10 Resident # 10 had a Health Care Plan (HCP) developed on 8/20/14 to address her anxiety and antianxiety medication use.</p> <p>RESIDENT # 22 Resident # 22 had a HCP revised on 8/28/14 to include the target behaviors being treated by the use of antipsychotic medications.</p> <p>RESIDENT # 23 Resident # 23 had a HCP revised on 8/28/14 to include her history of hallucination and delusions which included target behaviors and interventions. All other residents who received psychoactive medications have the potential to be affected by this</p>	09/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E209	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2014
NAME OF PROVIDER OR SUPPLIER SUMMIT CONVALESCENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 701 S MAIN ST SUMMITVILLE, IN 46070		
(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>anxiety.</p> <p>The August 2014 Physician rewrite orders included a medication order, with a start date of 7/11/14, for Lorazepam (an anti-anxiety medication) 0.5 milligrams one tablet by mouth three times daily for anxiety and agitation.</p> <p>Review of Resident #10's current care plans indicated there was no care plan to monitor the side effects of Lorazepam use or for the diagnosis of anxiety.</p> <p>During an interview with the MDS (Minimum Data Set) coordinator on 8/20/14 at 10:24 a.m., she indicated there was no care plan for Resident #10 related to a diagnosis of anxiety and the resident should have a care plan for the diagnosis of anxiety and for the use of the medication Lorazepam.</p> <p>During an interview with the D.o.N. (Director of Nursing) on 8/20/14 at 1:43 p.m., she indicated care plans are updated within 24 to 48 hours or as quickly as they can be if there are any changes.</p> <p>No further information was presented at exit on 8/21/14 at 5:45 p.m.</p> <p>2. The clinical record for Resident #22 was reviewed on 8/20/14 at 9:45 a.m.</p>		<p>alleged deficient practice.</p> <p>The HCP's of all residents who receive psychoactive medications were reviewed and updated as indicated to reflect their psychoactive medication use, diagnoses for use, target behaviors, and interventions. The procedure for reviewing the HCP's was revised to ensure all HCP's are reviewed by the interdisciplinary team (IDT) during the HCP meeting a minimum of upon admission, annually, quarterly, and with any significant change. During these meetings the team will determine the continued appropriateness of the HCP and make any revisions as indicated. The Director of Nursing (DON)/designee will review/audit all HCP'S of residents on psychoactive medications on a quarterly basis to ensure resident psychoactive medication use is care planned as required. The results of the audits will be discussed at the next 3 QAA meetings and the team will determine the need for continued audits. The team may determine provided there is 100% compliance that the audits may be stopped or decreased in frequency. MDS/HCP Coordinator and HCP IDT will be in serviced on HCP review procedure by 9/20/14 POC Date- 9/20/14</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E209	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SUMMIT CONVALESCENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 S MAIN ST SUMMITVILLE, IN 46070
--	---

(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>Resident #22's current diagnoses included, but were not limited to, dementia with confusion, delusional disorder, Parkinson's disease and depression.</p> <p>Resident #22 had current physician's orders for Seroquel (anti-psychotic medication) 25 mg, 1 tablet at night.</p> <p>Resident #22 had a current, 7/1/14, significant change, Minimum Data Set (MDS) assessment which indicated the resident had hallucinations with no delusions.</p> <p>Resident #22 was assessed as cognitively intact. The current diagnoses on the MDS included, but were not limited to, dementia, depression and anxiety.</p> <p>Resident #22 did not have a care plan to address the specific behavioral symptoms or targeted behaviors being treated by the use of anti-psychotic medication. The current monthly behavior monitoring included anxiety and agitation. No monthly behavior monitoring was noted for hallucinations and/or delusions related to the use of Seroquel.</p> <p>Resident #22's record indicated she had not received any form of mental health services.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E209	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SUMMIT CONVALESCENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 S MAIN ST SUMMITVILLE, IN 46070
--	---

(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>Review of Resident #22's Nurses Notes dated 4/6/14, resident indicated someone was up on the wall. On 4/1/14, staff reported resident had episodes of hallucinations of seeing people, causing fighting in her room and causing trouble. On 3/16/14, Nurses Notes indicated resident often saw children and babies in the toilet. On 2/27/14, resident indicated she was fearful to go into her room because she thought the drug cartel were in there.</p> <p>3. The clinical record for Resident #23 was reviewed on 8/19/14 at 2:48 p.m. Resident #23's current diagnoses included, but were not limited to, senile dementia with delusional features, other persistent disorder and depressive disorder.</p> <p>Resident #23 had current physician's orders for, dated 5/14/14, Seroquel 25 mg (an anti-psychotic medication) - 1 tablet daily.</p> <p>Resident #23 had a current, 5/26/14, admission, Minimum Data Set (MDS) assessment which indicated the resident had delusions and no hallucinations. Resident #23 was assessed as cognitively intact. The current diagnoses on the MDS included, but were not limited to, dementia and depression.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E209	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SUMMIT CONVALESCENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 S MAIN ST SUMMITVILLE, IN 46070
--	---

(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>Resident #23's record did not identify the specific behavioral symptoms or target behaviors being treated by the use of an anti-psychotic medication.</p> <p>Resident #23's record indicated she had not received any form of mental health services.</p> <p>During review of a current care plan dated 5/20/14, Resident #23 had a current problem with the use of psychotropic medication related to behavior management. Interventions for this problem included, but were not limited to, observe/record occurrence for target behaviors symptoms disrobing, inappropriate response to verbal communication and aggression towards staff.</p> <p>The care plan did not include any hallucinations and/or delusions problems or interventions.</p> <p>During an 8/21/14 at 1:15 p.m. interview, the Social Service Designee indicated Resident #22 and #23 were not currently being followed by mental health services. She indicated the Social Service Director was in the facility 4 hours per month but could provide no documentation related to Resident #22 or #23.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E209		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2014	
NAME OF PROVIDER OR SUPPLIER SUMMIT CONVALESCENT CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 701 S MAIN ST SUMMITVILLE, IN 46070			
(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			
F000280 SS=D	<p>During an interview on 8/21/14 at 3:00 p.m., the Minimum Data Set (MDS) Coordinator indicated Resident #23 had a history of hallucinations and delusions. She indicated the resident has accused staff of stealing her husband and having an affair with him. She indicated the resident was receiving Seroquel related to a history of delusions.</p> <p>4. A review of the undated "Care Plan Procedure" policy provided by the D.o.N. on 8/20/14 at 1:43 p.m. indicated the following:</p> <p>"MDS coordinator updates care plans as applicable when new orders are written, when there is a change in the plan of care and on quarterly, annual, or a significant change MDS."</p> <p>3.1-35(a)</p> <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</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E209		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2014	
NAME OF PROVIDER OR SUPPLIER SUMMIT CONVALESCENT CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 701 S MAIN ST SUMMITVILLE, IN 46070			
(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>of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interview, the facility failed to update the plan of care related to risk of falls for 2 of 3 residents reviewed for accidents. (Resident #10 and #16)</p> <p>1. The clinical record of Resident #10 was reviewed on 8/19/14 at 11:59 a.m. The record indicated the resident's diagnoses included, but were not limited to, right sided hemiparesis related to cerebrovascular accident, anemia, depressive disorder, insomnia, diabetes mellitus type II, hypertension, expressive language disorder, and chronic airway obstruction.</p> <p>During an interview with the D.o.N. (Director of Nursing) and Administrator on 8/21/14 at 4:05 p.m., the D.o.N. indicated the care plan interventions should be updated when interventions are changed or added.</p> <p>A review of Resident #10's fall</p>	F000280	<p>RESIDENT # 10 Resident # 10's Health Care Plan (HCP) interventions were updated on 8/28/14 to include all her fall prevention interventions.</p> <p>RESIDENT # 16 Resident # 16's HCP interventions were updated on 8/20/14 to include all her fall prevention interventions. All residents with special fall prevention interventions HCP'S were reviewed to ensure all individualized interventions are included on the HCP. After fall investigation for any resident the Director of Nursing (DON)/ Designee will ensure individualized fall interventions are added to the HCP. All HCP's are reviewed by the interdisciplinary team (IDT) during the HCP meeting a minimum of upon admission, annually, quarterly, and with any significant change. During these meetings the team will determine the continued appropriateness of the HCP and make any revisions as indicated. The Director of Nursing (DON)/designee with audit/review each resident's HCP</p>	09/20/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E209	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SUMMIT CONVALESCENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 S MAIN ST SUMMITVILLE, IN 46070
--	---

(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>occurrences and investigations indicated the following interventions were to be implemented:</p> <p>a. Fall on 5/4/14: new interventions added included concave mattress to bed and mat to floor.</p> <p>b. Fall on 5/10/14: new interventions added included low bed and moved resident closer to nurse's station.</p> <p>c. Fall on 5/12/14: new interventions added included physical therapy, occupational therapy and speech therapy.</p> <p>d. Fall on 7/29/14: new interventions added included hourly checks when resident in bed if restless.</p> <p>Review of Resident #10's current care plans indicated the following:</p> <p>"...is moderate risk for falls r/t (related to) RT (right) hemiparesis. Date initiated: 3/4/2014..."</p> <p>Interventions included:</p> <p>a. "...needs a safe environment with: a working and reachable call light, personal items within reach. Date initiated: 3/4/2014 Revision on 8/20/2014."</p>		<p>on a quarterly basis to ensure resident's HCP is updated with individualized fall prevention interventions. The results of the audits will be discussed at the next 3 QAA meetings and the team will determine the need for continued audits. The team may determine provided there is 100% compliance that the audits may be stopped or decreased in frequency. MDS/HCP Coordinator and HCP IDT will be in serviced on HCP review procedure by 9/20/14. POC Date- 9/20/14</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E209	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SUMMIT CONVALESCENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 S MAIN ST SUMMITVILLE, IN 46070
--	---

(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>b. "...needs activities that minimize the potential for falls while providing diversion and distraction. Date initiated: 3/4/2014."</p> <p>c. "Anticipate and meet (Resident's) needs. Date initiated: 3/4/2014 Revision on 3/5/2014."</p> <p>d. "Be sure (Resident's) call light is within reach and encourage HER to use it for assistance as needed. SHE NEEDS prompt response to all requests for assistance. Date initiated: 3/4/2014."</p> <p>e. "Ensure that (Resident) is wearing appropriate footwear NON SLIP bedroom slippers, non-skid socks when mobilizing in w/c (wheelchair). Date initiated: 3/4/2014."</p> <p>f. "Follow facility fall protocol. Date initiated: 3/4/2014." There was no indication of the interventions added on the Fall investigation forms.</p> <p>No further information was presented at exit on 8/21/14 at 5:45 p.m. 2. Resident #16's clinical record was reviewed on 8/19/14 at 11:34 a.m. The Resident's diagnoses included, but were not limited to, dementia, depressive disorder and anxiety state.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E209	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SUMMIT CONVALESCENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 S MAIN ST SUMMITVILLE, IN 46070
--	---

(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>Resident #16 had a 7/29/14, annual Minimum Data Set assessment indicating the resident had severe cognitive impairment, required the assistance of one for ambulation and transfers and had a history of falls.</p> <p>Review of the "Fall Risk Assessment," dated 7/29/14, indicated the resident had a history of falls, used psychotropic medications, had poor memory recall, was frequently incontinent of bowel and bladder, exhibited loss of balance while standing, and required hands on assistance to move from place to place.</p> <p>Interventions included: "call light in place, non skid shoes on when up, lay down after meals, wheelchair, bed and chair alarms and use of a low bed."</p> <p>Review of Resident #16's care plan for fall's, dated 12/8/2011, interventions included:</p> <p>"...1. Needs a safe environment with: even floors free from spills and/or clutter; adequate, glare free light; a working and reachable call light, handrails on walls, personal items easily accessible.</p> <p>2. Needs activities that minimize the potential for falls while providing</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E209	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SUMMIT CONVALESCENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 S MAIN ST SUMMITVILLE, IN 46070
--	---

(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>diversion and distraction. Staff to assist with ambulation to activities, with learning new routines.</p> <p>3. Anticipate and meet needs.</p> <p>4. Be sure call light is within reach and encourage to use it for assistance as needed. Resident #16 needs prompt response to all requests for assistance. instruct on the use of call light as needed.</p> <p>5. Ensure that Resident #16 is wearing appropriate foot wear non-skid socks/slippers when ambulating."</p> <p>The Fall Risk care plan, dated 12/8/2011, did not include updates of bed and chair alarms, low bed, laying down after meals and use of wheelchair.</p> <p>During an interview with the Director of Nursing (DoN) and the Administrator on 8/20/14 at 3:30 p.m., both indicated the care plan should have been updated to include the new interventions.</p> <p>3. An undated facility policy "POLICY AND PROCEDURE FOR FALL PREVENTION," provided by the DoN on 8/20/14 at 12:00 p.m., included, but was not limited to, the following:</p> <p>"PURPOSE: To provide a means to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E209		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2014	
NAME OF PROVIDER OR SUPPLIER SUMMIT CONVALESCENT CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 701 S MAIN ST SUMMITVILLE, IN 46070			
(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			
F000282 SS=D	<p>determine those residents at risk for falls and implement the least restrictive measures to prevent injuries.</p> <p>POLICY: It is the policy of this facility to provide for the safety of our residents while utilizing the least restrictive means possible to help maintain their dignity and highest quality of life..."</p> <p>" PROCEDURE...</p> <p>2) The interventions determined will be added to the resident's plan of care..."</p> <p>An undated facility policy "CARE PLAN PROCEDURE", provided by the DoN on 8/20/14 at 1:43 p.m., included, but was not limited to, the following:</p> <p>"MDS Coordinator updates care plans as applicable when new orders are written, when there is a change in the plan of care and on quarterly, annual, or significant change MDS...."</p> <p>3.1-35(a)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E209	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SUMMIT CONVALESCENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 S MAIN ST SUMMITVILLE, IN 46070
--	---

(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>persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to ensure the fall interventions for 1 of 3 residents reviewed for accidents were implemented. (Resident #10).</p> <p>Findings include: The clinical record of Resident #10 was reviewed on 8/19/14 at 11:59 a.m. The record indicated the resident's diagnoses included, but were not limited to, right sided hemiparesis related to cerebrovascular accident, anemia, depressive disorder, insomnia, diabetes mellitus type II, hypertension, expressive language disorder, and chronic airway obstruction.</p> <p>During an observation on 8/18/14 at 11:31 a.m., Resident #10 was sitting in her high back wheelchair in the dining room and wearing socks without anti-slip soles.</p> <p>During an observation on 8/20/14 at 11:51 a.m., Resident #10 was sitting in her highback wheelchair in the dining room and wearing socks without anti-slip soles.</p> <p>During an interview with the D.o.N. (Director of Nursing) and Administrator on 8/21/14 at 4:05 p.m., the D.o.N.</p>	F000282	<p>RESIDENT # 10 Resident # 10 will wear shoes or socks with anti slip soles when the resident is up in the wheelchair. All other residents with fall prevention interventions of anti slip socks or shoes when up were reviewed and determination made if this intervention is appropriate. Director of Nursing (DON)/ designee will monitor a minimum of 3 residents 3 times a week for 2 months, then 2 times a week for 2 months, then weekly for 2 months to ensure fall prevention intervention are utilized correctly. The results of monitoring will be discussed at the next 3 QA meetings, and provided there is 100% compliance for at least 2 months in the monitoring of fall prevention interventions the QA team will determine the need for continued monitoring. Nursing staff will be in serviced by 9/20/14 to ensure their understanding of fall prevention interventions. POC Date 9/20/14</p>	09/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E209	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SUMMIT CONVALESCENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 S MAIN ST SUMMITVILLE, IN 46070
--	---

(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>indicated the care plan interventions should be followed.</p> <p>Review of Resident #10's current care plans indicated the following:</p> <p>"...is (at) moderate risk for falls r/t (related to) RT (right) hemiparesis. Date initiated: 3/4/2014..."</p> <p>Interventions included but were not limited to: "Ensure that (Resident) is wearing appropriate footwear NON SLIP bedroom slippers, non-skid socks when mobilizing in w/c (wheelchair). Date initiated: 3/4/2014."</p> <p>Review of "Policy and Procedure for Fall Prevention" provided by DON on 8/20/14 at 12 noon indicated the following:</p> <p>"Purpose: To provide a means to determine those resident's at risk for falls and implement the least restrictive measures to prevent injuries.</p> <p>Policy: It is the policy of this facility to provide for the safety of our residents while utilizing the least restrictive possible to help maintain their dignity and highest quality of life.</p> <p>Procedure:</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E209	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SUMMIT CONVALESCENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 S MAIN ST SUMMITVILLE, IN 46070
--	---

(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
F000309 SS=D	<p>...5) The DNS (Director Nursing Services) will then assure that the intervention are implemented..."</p> <p>No further information was presented at exit on 8/21/14 at 5:45 p.m.</p> <p>3.1-35(g)(1)</p> <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 observation, interview and record review, the facility failed to develop and implement a behavior management and monitoring program for residents who had dementia and received psychoactive medication for symptoms related to dementia with behavioral disturbances for 2 of 5 residents reviewed for behavior monitoring and management associated with dementia (Residents #22 and #23).</p> <p>Findings include:</p> <p>1. The clinical record for Resident #22</p>	F000309	RESIDENT # 22 Resident # 22's behavior intervention monthly flow record document was revised to include target behavior of anxiety and hallucinations. RESIDENT # 23 Resident # 23's behavior intervention monthly flow record document was revised to include hallucinations and delusions as target behavior for use of antipsychotic medication. All residents on mood altering medications behavior intervention monthly flow record document was reviewed and revised to ensure all target behaviors are tracked. The DON/designee will review/monitor the behavior	09/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E209	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SUMMIT CONVALESCENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 S MAIN ST SUMMITVILLE, IN 46070
--	---

(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>was reviewed on 8/20/14 at 9:45 a.m. Resident #22's current diagnoses included, but were not limited to, dementia with confusion, delusional disorder, Parkinson's disease and depression.</p> <p>Resident #22 had current physician's orders for the following psychoactive medications:</p> <p>a) 10/15/13, Alprazolam (an anti-anxiety medication) - 0.25 mg (1/2 tablet) by mouth twice daily.</p> <p>b) 10/15/13, Alprazolam 0.25 mg - 1 tablet at night.</p> <p>Resident #22 had a current, 7/1/14, significant change, Minimum Data Set (MDS) assessment which indicated the resident had hallucinations with no delusions. Resident #22 was assessed as cognitively intact. The current diagnoses on the MDS included, but were not limited to, dementia, depression and anxiety.</p> <p>Resident #22's record did not identify the specific behavioral symptoms or target behaviors being treated by the use of an anti-anxiety medication.</p> <p>Resident #22's record indicated she had</p>		<p>intervention monthly flow records on a monthly basis to ensure residents target behaviors are noted as indicated on the document.</p> <p>The QA team will review the results of the monitoring at the quarterly meetings on an ongoing basis. Nursing staff in-service by 9/20/14. POC Date: 9/20/14</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E209	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SUMMIT CONVALESCENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 S MAIN ST SUMMITVILLE, IN 46070
--	---

(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>not received any form of mental health services.</p> <p>Review of Resident #22's Nurses Notes, dated 4/6/14, indicated resident indicated someone was up on the wall. On 4/1/14, staff reported resident had episodes of hallucinations of seeing people, causing fighting in her room and causing trouble. On 3/16/14, Nurses Notes indicated resident often saw children and babies in the toilet. On 2/27/14, resident indicated she was fearful to go into her room because she thought the drug cartel were in there. None of these behaviors had been included in the resident's care plan or were being tracked for effectiveness of the medication.</p> <p>2. The clinical record for Resident #23 was reviewed on 8/19/14 at 2:48 p.m. Resident #23's current diagnoses included, but were not limited to, senile dementia with delusional features, other persistent disorder and depressive disorder.</p> <p>Resident #23 had current physician's orders, dated 5/14/14, for Seroquel 25 mg (an anti-psychotic medication) - 1 tablet daily.</p> <p>Resident #23 had a current, 5/26/14, admission, Minimum Data Set (MDS)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E209	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SUMMIT CONVALESCENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 S MAIN ST SUMMITVILLE, IN 46070
--	---

(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>assessment which indicated the resident had delusions and no hallucinations. Resident #23 was assessed as cognitively intact. The current diagnoses on the MDS included, but were not limited to, dementia and depression.</p> <p>Resident #23's record did not identify the specific behavioral symptoms or target behaviors being treated by the use of an anti-psychotic medication.</p> <p>Resident #23 did not have a care plan to address the specific behavioral symptoms or targeted behaviors being treated by the use of the anti-psychotic medication.</p> <p>Resident #23's record indicated she had not received any form of mental health services.</p> <p>During an interview 8/21/14 at 1:15 p.m., the Social Service Designee indicated Resident #22 or #23 was not currently being followed by mental health services. She indicated the Social Service Director was in the facility 4 hours per month but could provide no documentation related to Resident #22 or #23.</p> <p>3.1-37(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E209	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SUMMIT CONVALESCENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 S MAIN ST SUMMITVILLE, IN 46070
--	---

(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
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 observation, interview, and record review, the facility failed to ensure Gradual Dose Reductions were completed for 2 of 5 residents reviewed for the use of unnecessary medication use. (Residents #16 and #22)</p> <p>Findings Include:</p> <p>1. The clinical record for Resident #22 was reviewed on 8/20/14 at 9:45 a.m. Resident #22's current diagnoses included, but were not limited to,</p>	F000329	RESIDENT # 22 Resident # 22'S physician was contacted regarding either a Xanax reduction or contraindication on 9/3/14. Resident # 16 had a statement of contraindication for a reduction in her Xanax on 8/21/14, and a statement of contraindication for a reduction in her Lexapro on 8/28/14. All resident's records who take a psychoactive medications were reviewed to determine if they had a gradual dose reduction or a statement of contraindication from the physician for the dose	09/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E209		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2014	
NAME OF PROVIDER OR SUPPLIER SUMMIT CONVALESCENT CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 701 S MAIN ST SUMMITVILLE, IN 46070			
(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>dementia with confusion, delusional disorder, Parkinson's disease, anxiety and depression.</p> <p>Resident #22 had current physician's orders for the following psychoactive medications:</p> <p>a) 10/15/13, Alprazolam (an anti-anxiety medication) - 0.25 mg (1/2 tablet) by mouth twice daily.</p> <p>b) 10/15/13, Alprazolam 0.25 mg - 1 tablet at night.</p> <p>Resident #22 had a current, 7/1/14, significant change, Minimum Data Set (MDS) assessment which indicated the resident had hallucination with no delusions. Resident #22 was assessed as cognitively intact. The current diagnoses on the MDS included, but were not limited to, dementia, depression and anxiety.</p> <p>Resident #22's record indicated she had not received any form of mental health services.</p> <p>During review of the monthly Behavior Monitoring sheets from 5/1/14-7/31/14, Resident #22 had no observed anxiety behaviors.</p>		<p>reduction. The Director of Nursing (DON)designee/will review the" Psychoactive & Sedative Hypnotic Utilization By Resident" report provided by the Consultant Pharmacist on a monthly basis to ensure each resident on a psychoactive medication has either received a GDR, or the physician has completed a statement of contraindication. All residents on psychoactive medications will be reviewed at least quarterly during behavior management meetings to determine the residents appropriateness for a GDR or need for statement of contraindication. During quarterly QA meetings consultant pharmacist will present information on residents psychoactive medications. DON will present information from her reviews of the Psychoactive & Sedative Hypnotic Utilization by resident report to the QA team for review and discussion to ensure GDR or statements of contraindication are completed on a timely basis. This will continue on an ongoing basis. POC Date: 9/20/14</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E209		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2014	
NAME OF PROVIDER OR SUPPLIER SUMMIT CONVALESCENT CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 701 S MAIN ST SUMMITVILLE, IN 46070			
(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>A pharmacy recommendation log dated 9/30/13-8/5/14, indicated there had been no reduction of Alprazolam (Xanax). During review of a chronological Gradual Dose Reduction (GDR) sheet, provided by the Business Office Manager on 8/20/14 at 10:59 a.m., the physician noted to review reducing the Xanax dose in September to allow for adequate time for adjustment to Seroquel reduction.</p> <p>During an interview on 8/21/14 at 10:44 a.m., the Director of Nursing found no additional information related to any GDR to have been attempted for Resident #22. 2. Resident #16's clinical record was reviewed on 8/19/14 at 11:34 a.m. The Resident's diagnoses included, but were not limited to, dementia, depressive disorder and Anxiety state.</p> <p>Resident #16 had a 7/29/14 annual Minimum Data Set assessment indicating the resident had severe cognitive impairment.</p> <p>Resident #16 had current order for Xanax (an anti-anxiety medication) 0.25 milligrams (mg), 1 tablet by mouth three times a day for anxiety with a start date of 1/4/12 and a dose reduction date of 11/28/12 and Lexapro (an anti-depressant medication) 20mg, 1 tablet by mouth daily for depression with a start date of</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E209	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2014
NAME OF PROVIDER OR SUPPLIER SUMMIT CONVALESCENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 701 S MAIN ST SUMMITVILLE, IN 46070		
(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>4/29/13. No Gradual Dose Reductions (GDR's) had been attempted on these medications since these dates and a Letter of Contraindication could not be provided.</p> <p>In an interview with the Director of Nursing (DoN) and the Administrator on 8/20/14 at 3:30 p.m., both indicated the Xanax had not been reduced since 11/28/12 and the Lexapro had not been reduced since it started on 4/29/14 and did not have a Letter of Contraindication for either medication.</p> <p>3. A policy, dated January 2007, and titled "Medication Monitoring and Management," provided by the DoN on 8/21/14 at 2:40 p.m., indicated the following:</p> <p>"...c. Other Psychopharmacologic Medications. During the first year in which a resident is admitted on a psychopharmacological medication (other than antipsychotic or a sedative/hypnotic), or after the facility has initiated such medication, the facility attempts a GDR during at least two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, a tapering should be attempted annually, unless clinically contraindicated..."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E209	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SUMMIT CONVALESCENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 S MAIN ST SUMMITVILLE, IN 46070
--	---

(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>"B. If a medication seems unnecessary or harmful to the resident, the Director of Nursing or consultant pharmacist requests the prescriber to evaluate the resident for the continued need for the medication and/or to consider tapering the medication. If the prescriber deems the medication necessary, a documented clinical rationale for the benefit of, or necessity for, the medication is documented in the resident's active record..."</p> <p>3.1-48(a)(4)</p>			