

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/04/2015
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R000000	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: February 2 & 3, 2015</p> <p>Facility number: 010889 Provider number: 010889 AIM number: N/A</p> <p>Survey team: Heather Tuttle RN-TC Janet Adams RN 2/2/15</p> <p>Census bed type: Residential: 38 Total: 38</p> <p>Census payor type: Other: 38 Total: 38</p> <p>Sample: 10</p> <p>These State findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed on February 4, 2015 by Jodi Meyer, RN</p>	R000000	<p>Plan of correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or the proposed administrative penalty (with right to correct) on the community. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation or finding. We have not presented all contrary factual or legal arguments, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy the objective.</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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R000055	<p>410 IAC 16.2-5-1.2(y)(1-4) Residents' Rights - Deficiency (y) Residents have the right to be treated as individuals with consideration and respect for their privacy. Privacy shall be afforded for at least the following: (1) Bathing. (2) Personal care. (3) Physical examinations and treatments. (4) Visitations.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the resident's privacy was maintained during medication pass related to resident's personal information left on top of the medication cart for 2 of 5 residents reviewed for medication pass. (Residents #2 and #8)</p> <p>Findings include:</p> <p>On 2/3/15 at 8:20 a.m., LPN #1 was observed preparing and pouring medication for Resident #2. At that time, she removed a white opaque plastic bag from the medication cart. The outside of the white bag had the resident's name and all of the medications that were in the bag listed on the front. The LPN opened the bag and removed the resident's medications. She then opened each dose pack and placed them in a plastic med</p>	R000055	<ul style="list-style-type: none"> · LPN #1 received immediate re-education from the Health and Wellness Director/Licensed Nurse regarding adherence to resident privacy as well as proper medication administration procedures to be followed to ensure resident privacy. · Rounds were immediately made by the Executive Director/Nurse Designee to audit for the presence of private information in unauthorized areas of the community · Associate re-education was completed by the Executive Director/ Nurse Designee regarding privacy and adherence to HIPAA guidelines within the community for the protection of resident protected health information. This re-education was provided on 2/3/15 and 2/4/15. 	02/20/2015
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	<p>cup. The LPN then closed her medication book, but left the white plastic bag on top of the medication with the resident's name and medications in clear view. She then walked into the resident's room and closed the door. The LPN returned to the cart after administering the medication and threw the white plastic bag away in the garbage can on the side of the cart.</p> <p>Continued observation on 2/3/15 at 8:25 a.m., LPN #1 was observed preparing and pouring medication for Resident #8. At that time, she removed a white opaque plastic bag from the medication cart. The outside of the white bag had the resident's name and all of the medications that were in the bag listed on the front. The LPN opened the bag and removed the resident's medications. She then opened each dose pack and placed them in a plastic med cup. The LPN then closed her medication book, but left the white plastic bag on top of the medication with the resident's name and medications in clear view. She then walked into the resident's room and closed the door. The LPN returned to the cart after administering the medication and threw the white plastic bag away in the garbage can on the side of the cart.</p> <p>Continued observation at that time,</p>		<ul style="list-style-type: none"> · The Executive Director will direct routine rounds to be completed by each shift to audit for the presence of unauthorized resident information in public areas. Results will be reviewed in stand up meetings. · Staff has been authorized to properly secure such material immediately if found, and individuals not adhering to the policy will receive corrective action, which may include disciplinary action, up to and including termination, at the discretion of the Executive Director. 	

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R000092	<p>indicated there was a Resident roster located under a clear plastic cover on top of the medication cart. The roster contained a list of all the residents living at the facility as well as their room numbers. The roster was in plain view to see. The LPN also had another Resident roster in which she was personally using to cross off names as she passed their medication. The LPN had left this in plain view on top of the medication each time she had walked into the resident rooms to administer medication.</p> <p>Interview with LPN #1 on 2/3/15 at 8:30 a.m., indicated she was not to leave the white plastic bag on top of the medication cart after she removed the resident's medications from it. She further indicated she was unaware the Resident roster was even on top of the medication cart under the plastic cover.</p> <p>Interview with the Director of Health and Wellness on 2/3/15 at 9:00 a.m., indicated the nurses were to discard the white plastic bag after they removed the medication or they were to tear off the resident's name at the top of the bag and throw that away.</p> <p>410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance</p>						

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	<p>(i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows:</p> <p>(1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms.</p> <p>(2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.</p> <p>Based on record review and interview, the facility failed to ensure at least one fire drill was completed in conjunction with the local Fire Department once every 6 months.</p> <p>Findings include:</p> <p>Records of the facility's monthly fire drills were reviewed on 2/2/15 at 12:00 p.m. There were monthly fire drills conducted 11/2013 through 12/2014. There were no records of any attempts to have the local Fire Department involved in any of the fire drills conducted during</p>	R000092	<p>· Fire Drill in conjunction with Fire department has been scheduled. · Monthly audits will be performed by Executive Director or Designee to assure compliance with Monthly Fire Drill/ expectations of Fire Department Involvement.</p>	02/20/2015			

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R000273	<p>2014.</p> <p>When interviewed on 2/2/15 at 12:25 p.m., the Administrator currently covering the facility indicated the last fire drill conducted with the local Fire Department was completed in 11/2013 per review of the logs.</p> <p>When interviewed on 2/2/15 at 12:28 p.m., the Maintenance Director indicated the last fire drill conducted with the local Fire Department was completed in 11/2013. The Maintenance Director indicated he had not contacted the local Fire Department to participate in any drills since then.</p> <p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to ensure food storage and preparations areas were clean and utensils were stored in clean drawers and cabinets for 1 of 1 Kitchen areas. (Main Kitchen)</p>	R000273	<p>Items observed on 2/2/14- 1, 2,3, and 4 were immediately corrected on 2/4/15. The accumulation of grease and dust on the hoods above the stove were cleaned. The wooden bottoms of</p>	02/20/2015			

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	<p>Findings include:</p> <p>During Kitchen Sanitation Tour on 2/2/15 at 11:05 a.m., the following was observed in the Main Kitchen:</p> <ol style="list-style-type: none"> 1. There was an accumulation of grease and dust on the hoods above the stove. 2. The wooden bottoms of the four drawers under the counter under the serving window were dusty and peeling. There was no liner on the bottom of the drawers. There were serving utensils in each of the drawers. 3. Uncovered clean plates and bowls were stored on a three tiered gray cart next to the oven. There was debris and crumbs around the handle used to push the cart. 4. The wooden bottom of four cabinets under the food prep island counter had accumulations of dust and debris. There were no liners on the bottom of the drawers. There were pans and bowls in each of the cabinets. 5. There was red spillage on the floor of the reach in cooler. <p>When interviewed on 2/2/15 during the Kitchen Sanitation tour, the Dietary</p>		<p>the four drawers under the counter under the serving window were dusted and cleaned A liner in the bottom drawers was placed inside drawer. Gray carts were cleaned and sanitized and plates and bowls were removed from the cart . Plates and bowels were stored in the cupboard. The wooden bottom of four cabinets under the food prep island were cleaned and sanitized. Liners were placed on the bottom of the drawers. Spillage on the floor near the cooler was cleaned immediately</p> <ul style="list-style-type: none"> · The Dining Services Director or designee will complete sanitation rounds daily for 30 days to monitor compliance and then weekly thereafter. · Dietary associates will be re-educated on food service sanitation and standards. · Weekly sanitation audits will be completd by Executive Director for 6 months to monitor compliance. 		

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R000349	<p>Manager indicated the above areas were in need of cleaning. The Dietary Manager also indicated the dishes and bowls were washed after breakfast and stored uncovered on the gray cart by the oven.</p> <p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p> <p>Based on record review and interview, the facility failed to ensure the resident's clinical record was complete and accurate related to adequate indications for the use of antipsychotic and hypnotic medication for 2 of 5 residents reviewed for medications in the sample of 10. (Resident #3 and #5)</p> <p>Findings include:</p> <p>1. The record for Resident #3 was reviewed on 2/2/15 at 2:35 p.m. The resident's diagnoses included, but were not limited to, high blood pressure, pacemaker, coronary artery disease, arrhythmia, depression and Alzheimer's</p>	R000349	<ul style="list-style-type: none"> · Resident #3 and Resident #5 received psychiatric consults the week of 2/17/15. · Medication review was completed by the psychiatric consultant at the time of evaluation. · The appropriate diagnosis was obtained for each, warranting utilization for chronic psychiatric diagnoses. · Diagnosis list was updated to reflect the current psychiatric need for medications. · Pharmacy was updated regarding the addition of the new diagnosis and the resident information sheet has been updated to reflect the additional diagnoses. · Nurse Designee will complete 	02/20/2015

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	<p>disease.</p> <p>Physician Orders dated 12/4/14 and on the current 2/2015 recap indicated Risperidone (an antipsychotic medication) .5 milligrams (mg) 1 tablet daily at 6:00 p.m. Another Physician Order dated 12/4/14, indicated Risperidone .5 mg as needed for agitation. The resident also had another Physician Order dated 11/3/14, for Restoril (a hypnotic) 30 mg at bedtime.</p> <p>Nursing Progress Notes for the months of 8/2014, 9/2014, 10/2014, 11/2014, 12/2014, and 1/2015, indicated there was no evidence of any documented behaviors from the resident. There was also no evidence of any documented episodes of insomnia or the resident having trouble falling asleep.</p> <p>Nursing Progress notes dated 11/3/14 at 10:00 a.m., indicated "Son requesting sleeping pill for resident. Resident sleeps all day and is up all night. Called MD (Medical Doctor) and new order for 30 mg Restoril at hs (bedtime)."</p> <p>The Psychotropic Med Review dated 11/18/14, indicated the resident received Risperdal .5 mg 1 tablet twice a day. The targeted behavior was listed as agitation.</p>		<p>audits on medical records for all residents who have an order for antipsychotic medication to request from the physician an appropriate diagnosis for said medication.</p> <ul style="list-style-type: none"> · Nurse Designee will respond to pharmacy consultant recommendations following each pharmacy review. · Nurse Designee will provide the appropriate nursing staff with re-education on the need for antipsychotic medications to have an appropriate medical or antipsychotic medications to have an appropriate medical or psychiatric diagnosis warranting use of such medications. · Nurse Designee will complete audits of new orders on a weekly basis for the presence of any new antipsychotic medications without an appropriated diagnosis. · In the event residents have received new orders that do not include the appropriate diagnosis warranting the use of such a medication, the nurse designee will contact the prescribing physician to (a) obtain an appropriate diagnosis or (b) ask for medication to be discontinued or (c) develop a plan of care that ensures medication is being utilized in the lowest, most effective dose possible, through quarterly reviews and pharmacy oversight. · Med Reviews for antipsychotic and benzodiazepine use will be completed by Nurse Designee on a 				

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	<p>The Medication Administration Records for the months of 12/2014 and 1/2015, indicated the resident had received the Risperidone .5 mg daily and the Restoril 30 mg at night time.</p> <p>Interview with the Health and Wellness Director on 2/2/15 at 3:15 p.m., indicated the resident had been on the Risperidone for a long time. She indicated it was twice a day and since then they had reduced the medication. She further indicated there was no supporting diagnosis for the Risperdal. She indicated the resident's record was lacking documentation of any insomnia episodes and again there was no diagnosis for the use of the Restoril.</p> <p>2. The record for Resident #5 was reviewed on 2/2/15, at 12:30 p.m. The resident's diagnoses included, but were not limited to, falls, anemia, dementia, dehydration, legally blind, hypothyroidism, and light headedness.</p> <p>Physician Orders dated 6/22/14 and on the current 2/2015 recap, indicated Depakote (a mood stabilizer) 250 milligrams (mg) 1 tablet daily. Another Physician Order dated 6/22/14 indicated Risperidone (an antipsychotic medication) .5 mg 1 tablet twice a day as needed for agitation.</p>		<p>quarterly basis. Request for changes, including reductions or discontinuance of inappropriate medications will be documented in the clinical record, along with the physician response.</p>				

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	<p>Nursing Progress Notes dated 10/2014, 11/2014, 12/2014, and 1/2015 indicated there was no evidence of any indication for the use of the Depakote or the Risperidone.</p> <p>The Medication Administration Record for 12/2014 and 1/2015 indicated the resident had received the Depakote everyday. The resident had not received the as needed Risperidone.</p> <p>Interview with the Health and Wellness Director on 2/2/15 at 3:15 p.m., indicated the resident had behaviors months ago and was hospitalized for them. She further indicated there were no diagnosis or indication for the use of the Depakote and Risperidone.</p>			