

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155106	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/10/2014
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NAME OF PROVIDER OR SUPPLIER RIVERWALK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 295 WESTFIELD RD NOBLESVILLE, IN 46060
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F 000 Bldg. 00	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>This visit included the Investigation of Complaint IN00153209.</p> <p>Complaint IN00153209- Substantiated. Federal deficiencies related to the allegations are cited at F 282, F309, and F312.</p> <p>Survey dates : October 2, 3, 6, 7, 8, 9, and 10 2014.</p> <p>Facility number :000044 Provider number : 155106 AIM number : 100274940</p> <p>Survey team: Michelle Hosteter, RN-TC Michelle Carter, RN Gloria Bond, RN</p> <p>Census bed type: SNF/NF: 150 Total : 150</p> <p>Census payor type: Medicare : 14 Medicaid : 107 Other : 29 Total : 150</p>	F 000	The creation and submission of this Plan of Correction does not constitute an admission by this Provider of any conclusion set forth in the statement of deficiencies. This Provider is requesting a face to face IDR for F309 and F314 as the facility does not agree with the level of severity as cited. This Provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review for paper compliance in lieu of post survey visit on or after Nov 8, 2014.	

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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F 241 SS=D Bldg. 00	<p>Sample: 3</p> <p>These deficiencies reflect stated findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review was completed by Tammy Alley RN on October 17, 2014.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation and interview, nursing staff failed to knock at the residents door, in order to maintain dignity and respect, before entering their room, for 3 of 3 residents observed for dignity. (Resident's E, 150, & 122.)</p> <p>Findings include:</p> <p>During an observation on 10/7/14 at 11:48 A.M., CNA #10 and CNA #12 entered Resident's #150 and #122 room</p>	F 241	F 241 - Dignity and Respect of Individuality It is the consistent practice of this Provider to have staff knock at the residents door, to maintain dignity and respect, before entering the resident room. I. What action has been taken for each resident cited in the alleged deficiency? Resident 150 & 122 will have their privacy & dignity respected. Resident E no longer resides at the facility. Social Services have followed up with Resident 150 & 122 and psycho-social well being remains intact for both residents. II. How	11/08/2014

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	<p>to deliver a lunch tray to Resident #122. CNA #10 and CNA #12 did not knock or state their intention to the resident(s) upon entering. During an interview, after the lunch tray was delivered, on 10/7/14 at 11:50 A.M., CNA #10 indicated she forgot to knock. CNA #12 indicated he forgot to knock.</p> <p>During a dressing change observation on 10/8/14 at 3:10 P.M., LPN #11 entered Resident E's room without notice and without knocking. While preparing for the dressing change, at Resident E's bedside, LPN #11 indicated she forgot to knock before entering the room.</p> <p>CNA #17 failed to knock and failed to announce herself on 10/8/14 at 3:14 P.M., as she entered Resident E's room to deliver a carton of thickened liquids. During an interview at 3:51 P.M. on 10/8/14, CNA # 17 indicated she should have knocked before entering Resident E's room because that room was his home.</p> <p>3.1-3(t)</p>		<p>will the Provider identify other residents that may be affected by the same alleged deficient practice and what action taken to correct this alleged deficient practice? All residents were interviewed using the Resident QIS interview to ensure that they felt they were being treated with dignity and respect by the Customer Care Coordinator. Any concerns identified were corrected immediately. III. What systemic changes will be taken to ensure the alleged deficient practice does not recur? Staff were in-serviced by Department Managers on 10/20/14 regarding Dignity & Respect of the Residents including knocking on residents doors prior to entering a resident room. DNS/designee will conduct rounds daily on every shift to ensure staff is knocking on resident's doors and stating intent before entering a resident room. Any staff non-compliance will result in further staff education, staff performance improvement plan and/or termination. IV. How will the corrective action be monitored or what quality assurance program implemented to ensure the alleged deficient practice does not recur? Privacy & Dignity CQI tool will be completed weekly x 4, monthly x6, and quarterly thereafter. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not met then</p>				

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F 250 SS=D Bldg. 00	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on interview and record review the facility failed to provide follow up for a resident in psychological distress for 1 of 1 resident reviewed for social services. (Resident #57)</p> <p>Findings include:</p> <p>On 10/8/14 at 10:30 a.m., the record review for Resident #57 was completed. Diagnoses included but were not limited to, depression and dementia.</p> <p>The progress notes dated 7/26 indicated, "...resident up in chair today with increased agitation and anxiety. Resident became hard to redirect. Resident wanted to die. Resident stated I'll wrap the cord to blinds around my throat. Doctor was called and PRN Lorazepam was given. Resident calm down and went to sleep for the remainder of the shift. Dr. Beaver stated 'monitor resident for infections or any other issues that may precipitated change in behavior'... 9/11- 10:39 p.m. message left with social</p>	F 250	<p>an action plan will be developed.</p> <p>F250 - Social Services: It is the consistent practice of this Provider to provide medically related social services to attain or maintain the highest well being. I. What action has been taken for each resident cited in the alleged deficiency? Resident #57 - Resident was re-assessed by social services, referred to physician and mental health counselor to ensure psycho social wellbeing II. How will the Provider identify other residents that may be affected by the same alleged deficient practice and what action taken to correct this alleged deficient practice? An audit was conducted by Social Services of the resident's charts to ensure no other residents voiced any current psychological distress. Residents with report of suicide ideation, comments or threat will be immediately reported to the nursing manager and social services for follow up and appropriate response based resident assessment and need. Social Services will complete a review of nurse progress notes each business day and follow up on any documented resident</p>	11/08/2014

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F 282 SS=E Bldg. 00	<p>service #1 who states will relate message to Social Services (SS) #2 that resident continues to voice rep negative statements....."</p> <p>On 10/9/14 at 1:40 p.m., Social Services (SS) #1 indicated she was unaware of the episode on 7/26/14 in the nursing progress notes which indicated the resident had suicidal thoughts as she had stated "wrap cord around neck" and she expected nursing staff to notify the on call staff and they would follow up with her accordingly.</p> <p>The SS #1 was also unaware of the progress notes dated 9/11/14, which indicated that SS #2 was to communicate to SS #1 regarding Resident #57 continued negative comments.</p> <p>3.1-34(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 persons in accordance with each resident's written plan of care. Based on record review and interview,</p>	F 282	<p>needs. III. What systemic changes will be taken to ensure the alleged deficient practice does not recur? Social Services staff will be re-educated regarding the suicide policy including follow up by the Corporate Consultant. All nursing staff will be re-educated regarding the suicide policy including proper reporting procedures and follow up 10/21/14 Social Services completed education 10/21/14 Social Services will complete a review of nurse progress notes each business day and follow up on any documented resident needs. IV. How will the corrective action be monitored or what quality assurance program implemented to ensure the alleged deficient practice does not recur? SS/designee will complete the Suicide Policy CQI weekly times four week, monthly x 6 then quarterly to encompass until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95%</p> <p>F282 - Care plan: It is the</p>	11/08/2014			

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	<p>the facility failed to follow physician's orders and care plans for showers, nutrition, medications administration and positioning for 6 of 37 residents reviewed for physicians orders and care plans. (Resident D, #63, #96, #82, E, and #142)</p> <p>Findings include :</p> <p>1. On 10/9/14 the record review for Resident D was completed. Diagnoses included, but were not limited to, cancer of the lungs, congestive heart failure, depression and diabetes.</p> <p>The Activities of Daily Living (ADL) documentation provided by the DNS on 10/10/14 indicated the resident got a shower on the following dates: 7/9, 7/14, 7/17, 7/23, 7/26, and 7/28/2014. The documentation also indicated the resident received partial baths daily except on 7/18-7/22/2014.</p> <p>The progress notes dated 7/19/2014 indicated the resident refused shower 2 times.</p> <p>On 10/9/14 at 4:50 p.m., The Unit Manager of the Memory Care unit indicated when someone is admitted to the Memory Care Unit they explain to them showers are twice a week. They</p>		<p>consistent practice of this Provider to follow physician orders and care plans in providing care to each resident. I. What action has been taken for each resident cited in the alleged deficiency? Resident D no longer resides at the facility Resident #63 was interviewed by RD on 10/9/14 and desires weight loss. Care plan was updated to reflect this with the goal of continued weight decline without significant changes through next quarterly review. Resident #96 was assessed and has no signs and symptoms related to omissions on MAR. Resident MD was notified of omissions on MAR and nebulizer flow sheet. Resident MAR and nebulizer flow sheet reviewed 10/30/14 by DNS/designee to verify that there is no further omissions of documentation on the MAR/flow sheet. Resident #82 w/c leg rest has been replaced. Therapy screened resident #82 related to use of hand splint. Order for hand splint was reviewed. Care plan/resident profile for hand splint was reviewed and updated 10/30/14. Resident E wears off loading boots as ordered. Order was reviewed for off loading boots. Resident #142 has no signs and symptoms of hypo/hyperglycemia. MD notified of past omissions on MAR. Resident #142 MAR reviewed 10/30/14 by DNS/designee to verify that there is no further</p>				

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	<p>document the shower schedule in a book and the CNA's are to refer to this to know when to shower a resident.</p> <p>On 10/10/14 at 2:50 p.m., the Director Nursing Services (DNS) indicated the sheet for ADL had "othr" marked she indicated she did not know what type of bathing that would be. She also indicated the had gotten six showers during the month. The nursing notes documentation regarding showers for July indicated only one date where the resident refused a shower. The ADNS (Assistant Director of Nursing Services) indicated each resident should receive 2 showers a week.</p> <p>2. The record for Resident #63 was reviewed on 10/7/14 at 3:45 P.M. Diagnoses for Resident #63 included, but were not limited to, cerebral palsy, history of urinary tract infection, muscle spasms, chronic pain syndrome, delusional disorder, paraplegia, and venous thrombosis.</p> <p>A care plan, dated 11/25/12, indicated, "Resident has potential risk for altered nutrition r/t (related to) mechanically altered diet, prefers to dine in room, obese, and progression of disease process."</p>		<p>omissions of documentation. II. How will the Provider identify other residents that may be affected by the same alleged deficient practice and what action taken to correct this alleged deficient practice? Facility will obtain monthly weights and enter into electronic medical record. A monthly weight change report will then be distributed by the 7th day of each month to the Director of Nursing Services, Registered Dietitian and/or Dietary Clinician, and MDS Coordinator. Residents who have experienced significant or insidious weight loss will be brought to the attention of the Interdisciplinary Team and develops a care plan to address the resident's individual health condition. All resident's showers have been reviewed and updated to reflect current shower days as preferred and scheduled. All residents MAR/TAR reviewed 10/30/14 to ensure there were no omissions. Any concerns were corrected immediately. Nursing staff were in-serviced on 10/23/14 related to completing shower sheets and ensuring wound interventions are in place. Licensed Nurses were in-serviced on medication errors and glucometers on 10/24/14 Review of resident shower preferences was completed by DNS/designee to ensure shower preferences were reflected on the daily shower schedules. Review of all residents experience of 5%</p>	

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	<p>Goal: Resident will maintain current weight within 5%.</p> <p>Interventions:</p> <ul style="list-style-type: none"> -Follow in nutrition meeting as needed -Monitor weight -Notify MD/family of significant weight changes <p>The documented weights for this resident were:</p> <p>10/07/2014: 185 09/05/2014: 182 07/05/2014: 196 06/05/2014: 197 03/09/2014: 198</p> <p>A 7.1% (14 pounds) weight loss was noted in a 60 day period, from 7/5/14 to 9/5/14.</p> <p>The Registered Dietician's (RD) quarterly assessment note, dated 8/26/14, indicated the following: "Resident continues to receive mechanical soft diet, consuming 75 - 100% at breakfast, 75-100% at lunch, 75-100% at dinner, good fluid intake. He uses weighted utensils and divided place to enhance self-feeding, eats in room per preference. He refused weight this month, most recent weight = 196# [7/5/14] and is stable. Medications include MVI [multi-vitamin], Lasix [diuretic], Vitamin D. Will continue current plan of care and f/u [follow up] as</p>		<p>or more weight lost was completed by the RD to ensure care plan addresses residents desired weights. Review of residents with specialized wheel chair equipment and/or who experienced contractures were reviewed by MDS/RSM to ensure residents had the necessary equipment and splints per plan of care and physician orders. Review of all residents with orders for specialized boots was completed by RSM to ensure resident had the specialized boots and were applied per physician order. Chart audit was conducted by Medical Records to ensure residents were receiving medications as prescribed by the physician. Any physician order or care plan was corrected immediately. III. What systemic changes will be taken to ensure the alleged deficient practice does not recur? DNS/designee will complete rounds every shift daily to ensure wound interventions are in place per plan of care MAR/TAR/flow sheets compliance report will be ran daily to ensure there are no omissions DNS/designee will audit shower sheets daily based on schedule to ensure that showers are being completed RD/Designee will review the weight variance report weekly for significant weight loss and report the loss to the attending physician for any new orders or interventions. Any new orders will be reflected on the</p>	

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	<p>needed."</p> <p>During an interview with the RD on 10/9/14 at 4:20 P.M., she indicated Resident #63's nutritional goal was to stay within 5% of his documented weight in the last 30 days. She indicated she was not aware of Resident #63's 14 pound weight loss because the computer system did not "trigger" it. She indicated Resident #63's weight loss was not significant, since the weight loss was only 7.1% and not the 7.5% indicated in health and nutritional guidelines. He should be on a list of those residents who needed monitoring because they were very close to the potential for significant weight loss. She indicated if a resident was close to a significant weight loss, she would put the resident's name on a list of those to be monitored and give the list to the NP (nurse practitioner). The NP was the person responsible for making further decisions regarding weight loss prevention interventions. The RD indicated there were no additional preventative weight loss interventions put in place, as she had not discussed it with the NP.</p> <p>The RD indicated if a significant weight loss was noticed, she would talk with the resident, discuss potential reasons for weight loss, and discuss if the weight loss</p>		<p>care plan. Nursing staff were in-serviced on 10/23/14 related to completing shower sheets and ensuring wound interventions are in place. Licensed Nurses were in-serviced on weight gathering, medication errors and glucometers on 10/24/14 IV. How will the corrective action be monitored or what quality assurance program implemented to ensure the alleged deficient practice does not recur? Registered Dietitian or designee will complete the Weight and Nutrition-At-Risk (NAR) CQI weekly for 1 month and then monthly for 6 months. Medical Records (ongoing) CQI tool will be completed weekly x 4, then monthly x 6. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not met then an action plan will be developed. Adaptive Equipment CQI tool will be completed weekly x 4, then monthly x 6. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not met then an action plan will be developed.</p>		

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	<p>was preferred. She indicated the discussion would be documented in her notes. Documentation did not indicate weight loss was discussed and did not indicate potential weight loss was discussed.</p> <p>The RD indicated she and the nutrition team did not follow up with Resident #63 regarding the potential for weight loss and if weight loss was desired. She indicated a discussion should have been held related to weight loss.</p> <p>3. The record for Resident #82 was reviewed on 10/7/14 at 11:00 A.M. Diagnoses for Resident #82 included, but were not limited to, late effects of cerebrovascular disorder, hemiplegia/hemiparesis, psychogenic pain, Alzheimer's disease, and joint contracture.</p> <p>(a.) A care plan for the use of positioning devices, dated 11/25/13, indicated the following: Use positioning devices- seat belt, Tilt-In-Space (name of a reclining wheelchair) w/c (wheelchair) as res (resident) has difficulty maintaining positioning in chair due to pelvic thrusting/sliding related to diagnosis of CVA (cerebrovascular accident). Intervention: start date 12/16/13.</p>			

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	<p>Tilt-In-Space w/c with bilateral foot rests and seat belt for positioning.</p> <p>A physician order, dated 12/16/13, indicated, "Resident to utilize Tilt-In-Space wheelchair with bilateral foot rests and seat belts for positioning due to pelvic thrusting, every shift."</p> <p>A document used for quick reference by nursing staff that indicated resident daily activity, titled "profile", dated 12/16/13, indicated Tilt-In-Space wheelchair with bilateral foot rests and seat belt for positioning.</p> <p>At 11:40 A.M., on 10/3/14., Resident #82 was observed participating in a group activity. He was sitting in a tilted wheelchair and his legs were dangling. A foot rest for the left leg was not in place.</p> <p>During an interview on 10/3/14 at 11:44 A.M., LPN #15 indicated the reason the left foot pedal was missing was because it was broken and was out for repair at the VA (Veterans Administration) office. She indicated the facility was not responsible for Resident #82's wheelchair because it belonged to the VA. She indicated she did not know how long Resident #82 had gone without a left foot pedal.</p>			

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	<p>At 12:10 P.M., on 10/3/14, the ADON indicated Resident # 82 had a specialized wheelchair that did not belong to the facility. The left foot pedal was sent to the VA office for a repair and the facility did not have a replacement, since the wheelchair and the foot pedal were not property of the facility. She indicated there was nothing the facility could do about it and did not know how long Resident #82 had gone without a left foot pedal.</p> <p>During an interview on 10/9/14 at 11:50 A.M., the Director of Therapy confirmed the facility did not have foot rests specifically made for specialty chairs. Resident #82's wheelchair was a specialty chair provided by the VA. If a repair was needed, the therapy department must contact the VA department. She contacted the VA department to order a necessary part for Resident #82's foot rest on 8/25/14. However, his prior left foot pedal never left the facility and while the facility was waiting on the part, the resident could have used the foot rest. "It was not absolutely perfect, but it was still useable." She indicated she did not have documentation related to Resident #82 and the non-use of a left foot pedal. Additionally, she indicated she did not know how many days Resident #82 was without a left foot pedal.</p>			

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	<p>During an interview with the DON and ADON on 10/10/14 at 12:00 P.M., each nurse manager indicated documentation related to the non-use of the left foot pedal was not completed. Therefore, the length of time Resident #82 was without a left foot pedal was not known.</p> <p>(b.) A physician's order, dated 5/27/10, was included on the October 2014 TAR (treatment administration record) and indicated, "right hand splint every shift."</p> <p>On 10/10/14 at 11:50 A.M., during an observation, Resident #82 was sitting in his wheelchair, at a table, and participating in a group activity. A right hand splint was not in place.</p> <p>During an interview with LPN #15 at 11:54 A.M., on 10/10/14, she indicated he should be wearing his splint to his right hand, especially since he was up. She indicated she was not aware the splint for his right hand was not in place.</p> <p>4. The clinical record for Resident E was reviewed on 10/7/14 at 9:20 A.M. Diagnoses for Resident E included, but were not limited to, congestive heart failure, osteomalacia, chronic pain syndrome, osteoporosis, peripheral vascular disease, and pressure ulcers.</p>			

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	<p>A physician's order, dated 8/8/14, indicated, "midline boots to bilateral feet at all times, every shift. Indications-wound healing."</p> <p>During an observations on 10/7/14 at 10:05 A.M., and at 3:30 P.M., boots were not noted on Resident E's feet. The boots were noted to be stored on the top of a cabinet in his room.</p> <p>During an interview on 10/7/14, at 3:31 P.M., LPN #11 indicated he was to have the boots on at all times and did not know why the boots were not on his feet.</p> <p>5. The clinical record for Resident #96 was reviewed on 10/7/14 at 12:30 P.M. Diagnoses for Resident #96 included, but were not limited to, osteoporosis, myoclonus, closed ankle fracture, quadriplegia and quadriparesis, chronic airway obstruction, chronic pain, late effects of cerebrovascular disease, debility, high blood pressure and anoxic encephalopathy (Lance Adams syndrome).</p> <p>The physicians orders and Medication Administration Records (MAR) for September and October 2014 indicated the following:</p>			

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	<p>Olanzapine (Zyprexa, antipsychotic), 7.5 milligrams (mg), 1 tablet by mouth every day. Olanzapine was not given on 9/23, 9/30, 10/1, 10/3, and 10/6/2014.</p> <p>Forteo pen injector 20 mcg (micrograms)/dose; subcutaneous injection every day. Forteo was not given on 9/6, 9/7, 9/8/2014.</p> <p>Divalproex (anti-seizure) 500 mg 1 tablet by mouth every day. Divalproex was not given on 9/6 and 9/7/14.</p> <p>Aspirin 81 mg 1 pill by mouth every day. Aspirin was not given on 9/6/14.</p> <p>Ipratropium-Albuterol solution for nebulization, 0.5mg/3ml. 1 vial for nebulizer treatment 4 times per day, from 9/9 to 9/16/14. Observe heart rate, respiration rate and breath sounds after each nebulizer treatment, four times per day.</p> <p>Nebulizer treatment's were not administered and thus assessments were not completed on 9/13 and 9/14/14.</p> <p>Assessments were not completed after the 1:00 P.M., nebulizer treatment on 9/10, 9/11, 9/12 and 9/16/2014.</p> <p>During an interview with the ADON, on</p>			

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	<p>10/9/14 at 3:00 P.M., she indicated nursing documentation did not provide reasons related to the lack of nebulizer treatment administration and assessment. She did not know why the treatments's were not administered on 9/13 and 9/14/14.</p> <p>6. Resident #142's record was reviewed on 10/6/2014 at 12:37 P.M. Diagnoses included, but were not limited to, dementia, diabetes, and insomnia.</p> <p>The resident's physician's orders recapitulation for August of 2014 included the following: "...Diabetic orders: Accu check twice daily [blood sugar check] Special Instructions: Notify MD if blood sugar is less than 70 or greater than 250... Twice A Day; 07:00 AM, 04:00 PM"</p> <p>The resident's August MAR (Medication Administration Record) indicated: "Novolog Mix 70-30... amount to Administer: 40 units; subcutaneous Once A Day...." Time listed 9:00 A.M. The physician's order report for 6/30/14 until 8/12/14 indicated,"Order Type...Prescription...Novolog Mix 70-30...solution; ...18 units every 5pm sq; subcutaneous Special Instructions: indications: blood sugar control Once A</p>			

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	<p>Day; 05:00 PM...."</p> <p>The resident's physician order report for 8/12/14 until , "open ended," indicated, "... Novolog Mix 70-30...; 44 units every am sq; subcutaneous special Instructions; indications; blood sugar control Once a Day; 09:00 AM...."</p> <p>Resident #142's progress notes for 8/5/14 at 2:41 p.m., indicated the resident was out of Humalog and the pharmacy was notified.</p> <p>The resident's MAR indicated on 8/7/14, the resident's Accu check indicated his blood sugar at 7:00 A.M., was 208. The MAR indicated the resident was not given insulin at 9 A.M., as ordered. The record lacked an explanation as to why the resident was not given the insulin as ordered.</p> <p>The resident's MAR indicated on 9/4/14 and 9/5/14, the resident's Accu check indicated his blood sugar at 4:00 P.M., was 101 on 9/4/14 and 224 on 9/5/14. The record indicated the resident was not given insulin at 5:00 P.M., as ordered. The record lacked an explanation as to why the resident was not given the insulin as ordered.</p> <p>During an interview with LPN # 3 on</p>			

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F 309 SS=G Bldg. 00	<p>10/10/2014 at 1:43 P.M., in response to the follow up on the resident's insulin availability for 08/05/2014 and lack of administration on the August MAR, he indicated he did not remember what all occurred. He indicated he usually put a note on the MAR or in the progress notes and does not know why he did not.</p> <p>This Federal Tag relates to Complaint IN00153209.</p> <p>3.1-35(g)(2)</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 record review, observation and interview, the facility failed to ensure pain management was provided during a dressing change when a resident verbally and physically expressed pain (Resident</p>	F 309	F309 - Provide care/services for highest well being: It is the consistent practice of this Provider to ensure pain management is provided during dressing and treatment changes.	11/08/2014

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	<p>E) and failed to provided skin tear treatment (Resident D), as ordered for 2 of 2 residents reviewed for ordered treatment in a sample of 3.</p> <p>Findings include:</p> <p>1. The clinical record for Resident E was reviewed on 10/7/14 at 9:20 a.m. Diagnoses for Resident E included, but were not limited to, congestive heart failure, osteomalacia, diabetes mellitus type 2, demenita w/depression, anemia, morbid obesity, chronic pain syndrome, osteoporosis, peripheral vascular disease, and pressure ulcers.</p> <p>A physician order, dated 9/26/14, indicated the following, "Santyl ointment. Cleanse wound bed (left heel,right, medial heel, right, lateral, lower leg) with normal saline, pat dry, apply skin prep or barrier cream to periwound. Santyl to wound bed followed by hydrogel fluffed gauze, then cover with dry gauze and secure QD [daily]. Change QD."</p> <p>During an observation of the three ordered wound treatments and dressing changes on 10/8/14, Resident E was, continuously, yelling "oow" and pulling away from nurses, indicating pain, from 3:10 P.M., to 3:49 P.M.</p>		<p>This Provider is requesting a IDR for this deficiency as the facility does not agree with the level of severity currently cited. I. What action has been taken for each resident cited in the alleged deficiency? Resident E - Resident was assessed for pain and stated no pain and current pain management effective Resident D - no longer resides at facility II. How will the Provider identify other residents that may be affected by the same alleged deficient practice and what action taken to correct this alleged deficient practice? All residents have the potential to be affected. DNS/ Designee will complete a new pain assessment on all residents by 10/31/14. Any residents with identified or assessed pain will be addressed. III. What systemic changes will be taken to ensure the alleged deficient practice does not recur? ADNS/DNS in-serviced all Nursing staff on 10/22/14 on Pain Management Prior to any wound treatment or dressing change, the nurse will assess any pain. If pain is not controlled, medication will be administered per physician orders to effectively address pain. The assessment will be documented on the TAR. DNS/designee will audit the MAR/TAR daily to ensure pain is assessed and that medication and dressing changes is administered as prescribed by physician. IV. How will the</p>	

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	<p>Resident E occupied a double occupancy room. The privacy curtain was pulled. At 3:10 P.M., the dressing change to the right, lateral, lower leg was started. LPN #11 indicated she would be assisting LPN #16 with the dressing changes. Additionally, she indicated these dressing changes always required two nurses. Two family members of Resident E indicated they wanted to observe the dressing changes, too.</p> <p>LPN #11 lifted the resident's right leg and held it until the wound treatment and dressing change was completed. Resident E displayed anxious behavior and was yelling out in pain throughout the process. Upon hearing the cries of Resident E, the DON came in to the room at 3:13 P.M.</p> <p>During the right leg wound treatment, the resident continued to verbalize his discomfort.</p> <p>At 3:29 P.M., on 10/8/14, the DON asked LPN #16 if pain medication was administered. LPN #16 indicated she administered Roxanol (pain medication) 1 dose (0.25 milliliters), at 2:35 P.M. The DON indicated he could have one more and instructed LPN #16 to get another dose of pain medication.</p>		<p>corrective action be monitored or what quality assurance program implemented to ensure the alleged deficient practice does not recur? To ensure compliance TAR audits will be completed by the DNS/Designee weekly x 4 weeks then monthly x 6. The result of these audits will be reviewed by the CQI committee overseen by the ED. If a threshold of 95% is not achieved, an action plan will be developed to assure compliance.</p>	

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	<p>At 3:30 P.M., LPN #16 administered Roxanol, 0.25 ml, orally, to Resident E. LPN #16 did not assess for pain level and, at 3:32 P.M., began the dressing change to Resident E's right heel. Resident E continued to complain of pain as LPN # 11 continued to hold up the resident's right leg.</p> <p>The right leg was place on the bed and the dressing change to his right heel was completed at 3:39 P.M. Resident E continued to display anxiety and pain.</p> <p>At 3:40 P.M., the Assistant Director of Nursing (ADON) took over for LPN #11, and held up Resident E's left leg. The resident continued to yell out in pain. The dressing change for the left heel was completed at 3:49 P.M.</p> <p>At 3:56 P.M., on 10/8/14, during an interview, the DON indicated she was very upset regarding the process of the wound treatments and dressing changes. She indicated she expected nursing staff to allow time for a pain medication to take effect and assess and re-assess pain if needed. She indicated LPN #16 did not assess for pain and had to be told to provide an additional dose of pain medication. She expected LPN #16 to stop the dressing changes, administer the additional pain medication dose, and</p>			

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	<p>allow time for the pain medication to work. After the resident was assessed as comfortable, the dressing changes could be completed. Additionally, the DON indicated the process of the three wound treatments and dressing changes should not have been painful, should not have taken 45 minutes and should only require one nurse. Too many people were in his room, which, very well, may have added to his anxiety.</p> <p>2. On 10/9/14 the record review for Resident D was completed. Diagnoses included, but were not limited to, cancer of the lungs, congestive heart failure, depression and diabetes.</p> <p>The progress notes dated 7/14/14 10:54 p.m., indicated that Resident D had received of a skin tear to his upper left forearm (LUE) when he was with his daughter when he was on Leave of Absence.</p> <p>On 7/15/14 at 8:03 p.m., a progress note indicated the LUE dressing was soiled and changed.</p> <p>The Treatment Administration Record documentation indicated, "...7/14/14-Clean skin tear to left upper arm with sterile water and pat dry, apply bacitracin, cover with telfa pad</p>			

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F 312 SS=D Bldg. 00	<p>and wrap with kerlix every day...."</p> <p>The date boxes were crossed out from 7/1 through 7/14. The boxes for 7/15, 7/17, 7/18, 7/21, and 7/23 had initials inside the boxes. The date boxes of 7/16, 7/19, 7/20, 7/22, and 7/24 were empty.</p> <p>On 10/10/14 at 3:00 p.m., the DNS indicated the boxes that were empty on the TAR indicated the resident had not received the treatment.</p> <p>This Federal Tag relates to Complaint IN00153209.</p> <p>3.1-37(a)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on interview and record review, the facility failed to provide showers for 2 of 3 residents reviewed for hygiene. (Resident C and D)</p>	F 312	F 312 - ADL Care: It is the consistent practice of this Provider to provide showers and personal hygiene for all residents. 1. What action has been taken for each resident cited in the	11/08/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155106		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 10/10/2014	
NAME OF PROVIDER OR SUPPLIER RIVERWALK VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 295 WESTFIELD RD NOBLESVILLE, IN 46060			
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	<p>Findings include:</p> <p>1. On 10/9/14 the record review for Resident D was completed. Diagnoses included, but were not limited to, cancer of the lungs, congestive heart failure, depression and diabetes.</p> <p>The Activities of Daily Living(ADL) documentation provided by the DNS on 10/10/14 indicated the resident got a shower on the following dates: 7/9, 7/14, 7/17, 7/23, 7/26, and 7/28/2014. The documentation also indicated the resident received partial bath daily except on 7/18-7/22/2014 .</p> <p>The progress notes dated 7/19/2014 indicated the resident refused showers 2 times.</p> <p>2. On 10/9/14 at 1:30 p.m., the record review for Resident C was completed. Diagnoses included, but were not limited to, depression, dementia, and benign prostatic hypertrophy.</p> <p>On 10/03/2014 11:02 a.m., a family member indicated Resident C doesn't always have his hygiene done.</p> <p>The Activities of Daily Living (ADL) documentation from 8/1/14 through 10/10/14 indicated the resident received</p>		<p>alleged deficiency? Resident C/D - weekly shower schedule was updated; resident is provided 2 showers each week except upon personal preference to refuse with staff documentation of refusal. II. How will the Provider identify other residents that may be affected by the same alleged deficient practice and what action taken to correct this alleged deficient practice? All residents have the potential to be affected. DNS/Designee completed audit on all resident shower/bath days and updated on the daily shower schedule. III. What systemic changes will be taken to ensure the alleged deficient practice does not recur? ADNS/DNS in-serviced all Nursing staff on 10/23/14 on Skin/Shower Sheets. Shower sheets will be reviewed daily to ensure shower completions by the DNS/Designee IV. How will the corrective action be monitored or what quality assurance program implemented to ensure the alleged deficient practice does not recur? To ensure compliance the Accommodation of Needs CQI will be completed by the DNS/Designee weekly x 4 weeks then monthly x 6. The result of these audits will be reviewed by the CQI committee overseen by the ED. If a threshold of 95% is not achieved, an action plan will be developed to assure compliance.</p>				

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	<p>showers on the following dates: 8/3, 8/9, 8/15, 8/20, 8/27, 8/30, 9/3, 9/6, 9/13, 9/20, 9/27, 10/4, and 10/8/14.</p> <p>The progress notes were reviewed from 7/1/14 through 10/10/14 and no documentation was found regarding refusal of showers.</p> <p>On 10/10/14 at 2:50 p.m., the Director Nursing Services (DNS) indicated the sheet for ADL had "otr" documented for bath and she indicated she did not know what type of bathing that would be. She also indicated the resident had gotten six showers during the month. The nursing notes documentation regarding showers for July indicated only one date where the resident refused a shower. The ADNS (Assistant Director of Nursing Services) indicated each resident should receive 2 showers a week.</p> <p>As of the exit conference on 10/10/14 at 4:00 p.m., no further documentation was provided related to given showers for refusals.</p> <p>This federal tag relates to Complaint IN00153209.</p> <p>3.1-38(a)(2)(A)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155106	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/10/2014
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NAME OF PROVIDER OR SUPPLIER RIVERWALK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 295 WESTFIELD RD NOBLESVILLE, IN 46060
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F 329 SS=D Bldg. 00	<p>483.25(l) 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 interview and record review, the facility failed to have specific targeted behaviors defined, identified and documented for the use of antipsychotic medication for 2 of 5 residents reviewed for unnecessary medications. (Residents</p>	F 329	<p>F329 - Free from Unnecessary Drugs: It is the consistent practice of the this Provider to have a diagnosis to support the use of antipsychotic medication.</p> <p>I. What action has been taken for each resident cited in the alleged deficiency? Resident #7</p>	11/08/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155106		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 10/10/2014	
NAME OF PROVIDER OR SUPPLIER RIVERWALK VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 295 WESTFIELD RD NOBLESVILLE, IN 46060			
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	<p>#7 and #57)</p> <p>Findings include:</p> <p>1. On 10/7/14 at 3:00 p.m., the record review for Resident #7 was reviewed. Diagnoses included, but were not limited to, dementia, anxiety, and depression.</p> <p>The physician's orders indicated, "...9/15/14 discontinue current Seroquel orders change to Seroquel 25 mg by mouth three times daily related to delusional dementia. The gradual dose reduction failed and no further dose reductions...."</p> <p>Behavior flow sheets in the resident's record started at July 2014 indicated: "... Resident diagnosis of anxiety for which she takes medication. She is at risk to experience anxiety as evidenced by: repetitive questions, expressing anxiousness, pacing, etc. She may express anxiousness by feeling as though she has to entertain or be hostess to other residents as she was used to hosting guests in her earlier years (9/28/12)... she may experience delusions. She may express paranoid thoughts or talk to others who are not present (2/6/13) There were no documented episodes of paranoia for any of the shifts throughout the month of July 2014...."</p>		<p>- Resident was referred to physician services and reviewed for appropriate diagnosis for med use. Resident #57 - Resident was referred to physician services and reviewed for appropriate diagnosis for med use. II. How will the Provider identify other residents that may be affected by the same alleged deficient practice and what action taken to correct this alleged deficient practice? All residents taking anti-psychotic medications have the potential to be affected. IDT will complete a review of all residents receiving anti-psychotic medications to ensure appropriate diagnosis and documentation warranting the use of medications is present. Any concerns with indication for use will be reviewed with the physician. III. What systemic changes will be taken to ensure the alleged deficient practice does not recur? Nursing staff will be re-educated on the facility's Behavior Management Program, which includes the use of non pharmacological interventions and proper documentation. Re-education conducted by Social Services and completed by 10/21/14 Nurse Management/designee will be contacted prior to requesting any changes with anti-psychotic medication to ensure non-pharmacological interventions were attempted and monitored for effectiveness.</p>				

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	<p>The Behavior Monthly Summaries indicated: "...Feb 2014...Behavior #2: Delusions Days/Evenings/Nights : 0...Medication order #2 Seroquel 12.5 milligrams every am (8/30/12) Seroquel 12.5 mg every hour of sleep Last Gradual Dose Reducation 9/24/13...</p> <p>March 2014 Behavior symptom #2 Delusions Days, evenings and nights= 0 documented episodes... Medication Order #2: Supporting diagnosis: Delusions Specific medication and dosage : Seroquel 25 milligrams three times daily</p> <p>April 2014... Behavior symptom #2 Delusions Days=0 , evenings=3 and nights= 0 documented episodes... Medication order #1 anxiety: Xanax 0.5 mg q 9a, 3p, 9pm Date medication started : 8/20/12 Date of last AIMS : N/A Date of last GDR: N/A Date of documentation of physical clinical contraindication: N/A</p> <p>Medication Order #2: Supporting diagnosis: Delusions</p>		<p>All new/worsening behaviors will be reviewed by the interdisciplinary team for a thorough review of the behavior, assessment of potential contributing factors, root cause and recommended intervention. The interdisciplinary team will also review any antipsychotic medication orders to ensure proper use of non pharmacological interventions and documentation that warrants use of medication. IV. How will the corrective action be monitored or what quality assurance program implemented to ensure the alleged deficient practice does not recur? SS/designee will be responsible for the completion of the Psychotropic Management CQI tool weekly times 4 weeks then monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95%</p>	

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NAME OF PROVIDER OR SUPPLIER RIVERWALK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 295 WESTFIELD RD NOBLESVILLE, IN 46060
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	<p>Specific medication and dosage : Seroquel 25 milligrams three times daily...Summary : no changes... MAY summary : Behavior symptom #2 Delusions Days, evenings and nights= 0 documented episodes... Medication Order #2: Supporting diagnosis: Delusions Specific medication and dosage : Seroquel 25 milligrams three times daily Summary : No changes</p> <p>June Summary: Behavior symptom #2 Delusions Days, evenings and nights= 0 documented episodes... Medication Order #2: Supporting diagnosis: Delusions Specific medication and dosage : Seroquel 25 milligrams three times daily... Summary : no changes...."</p> <p>There was no July, August or September documentation of Behavior Monthly Summary</p> <p>The progress notes dated February 2014 through 10/9/14 indicated :</p> <p>The notes dated 3/3, 3/5, 3/6, 3/7, 3/8, 3/9, and 3/11- indicated no behaviors. 3/12/14- indicated the antipsychotic</p>			

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	<p>medication Seroquel 12.5 milligrams, had been increased to 25 milligrams twice daily on 3/5/14 due to increased confusion and agitation.</p> <p>3/17/14- "...Resident is alert with confusion called staff a bi-ch because the staff stated that resident told her that she stated that her husband died of cancer resident is now in her room no complaints of pain safety measurements in place resident thinks that staff is hiding her husband..."</p> <p>3/18/14- no new behaviors</p> <p>3/19/14- increased agitation</p> <p>3/20/14- believed she is in a hotel, wants to call husband (deceased) or father (deceased).</p> <p>5/3/14- wanted a phone book so she could call her son and call her husband.</p> <p>6/5/14- resident up until 12:30 a.m. confused, stating her husband left her here and she wanted to go find him. She stated she knew that her husband was cheating on her and she was going to kill him.</p> <p>8/1/14- Had some nights where she was up all night wanting to find her husband or tried to get ready for her wedding.</p> <p>8/24/14- Resident appeared to be less agitated with continued increased delusional behavior.</p> <p>9/3/14- Resident noted to be more agitated and restless with continued increased delusional behavior. Resident</p>			

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	<p>was given scheduled medications, which appear to be ineffective.</p> <p>During an interview on 10/8/14 at 3:25 p.m., Social Services #2 indicated the facility usually take the first week of the month or so to have the behavioral monthly summary documented in the Matrix system. He indicated the past ones would be in the chart or medical records would have them. A request was made for behavior flow sheets for August and September 2014.</p> <p>The documentation for behaviors were provided, however, the documentation had no specific information as to what the resident's delusions were.</p> <p>During interview on 10/10/14 at 11:15 a.m., Social Services #1 indicated he could not indicate what the delusions were that the resident displayed.</p> <p>2. On 10/9/14 at 3:00 p.m., the record review for Resident #57 was reviewed. Diagnoses included, but were not limited to, dementia, anxiety, and depression.</p> <p>The physician's orders indicated on 3/8/13 an antipsychotic medication of Risperidone 0.5 milligrams every evening for diagnosis of senile dementia uncomplicated.</p>			

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NAME OF PROVIDER OR SUPPLIER RIVERWALK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 295 WESTFIELD RD NOBLESVILLE, IN 46060
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	<p>The behavior monitoring documentation indicated:</p> <p>March monthly behavior symptom monthly summary form: "...behavior monitored: delirium : days, evenings and nights number of episodes... Medication order #1: acute delirium Risperidone 0.5 milligrams every hour of sleep [3/8/13]...</p> <p>May: Behavior #1 Delirium...evening episodes : 6...</p> <p>June : Behavior #1 Delirium...Days displayed : 8...</p> <p>July : Behavior #1 : Delirium...days: 4..."</p> <p>There was no August or September documentation for behaviors.</p> <p>The behavior logs dated 8/1/14 through 8/31/14 indicated the resident had no delirium displayed the entire month.</p> <p>During interview on 10/9/14 at 12:10 p.m., Social Services #1 indicated she was not aware of why the resident was on Risperdal. She indicated she thought it was delusions. A request was made for</p>			

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NAME OF PROVIDER OR SUPPLIER RIVERWALK VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 295 WESTFIELD RD NOBLESVILLE, IN 46060			
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F 428 SS=D Bldg. 00	<p>diagnosis information as well as how the delusions were displayed.</p> <p>During interview on 10/9/14 at 1:40 p.m., Social Services #1 indicated the reason for the antipsychotic medication was not clear and that just as of today the physician documented "Delusional Disorder". She indicated she was not aware of how Resident #57 displayed delirium or delusions.</p> <p>3.1-48(a)(3) 3.1-48(a)(4) 3.1-48(a)(6)</p> <p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on interview and record review, the facility failed to provide follow up after pharmacy made recommendations for 2 of 5 residents reviewed for unnecessary medications. (Residents #7 and 57)</p> <p>Findings include:</p>	F 428	F 428 - Drug Regimen Review: It is the consistent practice of the this Provider to provide follow up on pharmacy recommendations. I. What action has been taken for each resident cited in the alleged deficiency? Resident #7 - pharmacy recommendations for this resident were reviewed and followed up with physician Resident #57 - pharmacy	11/08/2014			

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NAME OF PROVIDER OR SUPPLIER RIVERWALK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 295 WESTFIELD RD NOBLESVILLE, IN 46060
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	<p>1. On 10/7/14 at 3:00 p.m., the record review for Resident #7 was reviewed. Diagnoses included, but were not limited to, dementia, anxiety, and depression.</p> <p>The documentation from the pharmacy indicated, "...Recommendation from 10/16/13...Resident is receiving the antipsychotic agent quetiapine, but lacks an allowable diagnosis to support its use...."</p> <p>There was a duplicate document with the date of 2/19/14.</p> <p>The rest of the documentation on the 10/16/13 and the 2/19/14 pharmacy form for the physicians, under the section titled "physician prescribers orders and comment section", were completely blank and undated.</p> <p>2. On 10/9/14 at 3:00 p.m., the record review for Resident #57 was reviewed. Diagnoses included, but were not limited to, dementia, anxiety, and depression.</p> <p>The documentation from the pharmacy indicated, "...Recommendation from 2/19/14...Resident is receiving the antipsychotic agent risperidone, but lacks an allowable diagnosis to support its use...No change she is stable and had been very uncomfortable prior to starting</p>		<p>recommendations for this resident were reviewed and followed up with physician II. How will the Provider identify other residents that may be affected by the same alleged deficient practice and what action taken to correct this alleged deficient practice? All residents with pharmacy recommendations have the potential to be affected by the same alleged deficient practice. Current pharmacy recommendations were reviewed by DNS/Designee to ensure appropriate and timely follow up on each resident III. What systemic changes will be taken to ensure the alleged deficient practice does not recur? Nursing staff were in-serviced on this Pharmacy recommendation follow up and processing. DNS/Designee will review the monthly consultant pharmacy report to ensure the follow up recommendations are completed and all anti psychotic medications have correlating diagnosis. IV. How will the corrective action be monitored or what quality assurance program implemented to ensure the alleged deficient practice does not recur? To ensure compliance pharmacy cqi will be completed by the DNS/Designee weekly x 4 weeks then monthly x 6. The result of these audits will be reviewed by the CQI committee overseen by the ED. If a threshold of 95% is not</p>	

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	<p>Risperdal...Delusional disorder...."</p> <p>On 10/9/14 at 1:40 p.m., SS (Social Services) #1 indicated the physician had documented "Delusional Disorder" as the diagnoses today. She indicated she did not know what the behavior was the resident displayed for delusions.</p> <p>3.1-25(i)</p>		<p>achieved, an action plan will be developed to assure compliance.</p>				