

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155428	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/30/2015
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NAME OF PROVIDER OR SUPPLIER  MERIDIAN NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2102 S MERIDIAN ST INDIANAPOLIS, IN 46225
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00163365.</p> <p>Survey dates: January 26, 27, 28, 29, and 30, 2015.</p> <p>Facility number: 000386 Provider number: 155428 AIM number: 100286820</p> <p>Survey team: Dorothy Plummer, RN-TC Marsha Smith, RN Patsy Allen, LSW Diana Zgonc, RN (January 28 and 29, 2015)</p> <p>Census bed type: SNF/NF: 39 Total: 39</p> <p>Census payor type: Medicare: 4 Medicaid: 27 Other: 8 Total: 39</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC</p>	F000000	<p>Indiana Department of Health ATTN: Kim Perigo Supervisor Re: Annual Recertification Survey Meridian Nursing and Rehab 2102 S Meridian St Indianapolis, IN 46225</p> <p>On 1-30-15 a survey team from the Indiana StateDepartment of Health completed an annual recertification survey. Enclosed please find the statement of Deficiencies with the facility's plan of correction for these alleged deficiencies.</p> <p>Please consider this letter and plan of correction to be the facility's credible allegation of compliance. This letter is our request for a desk review to verify the facility has achieved substantial compliance with the applicable requirements as of the date set forth in the plan of correction as of March 1, 2015.</p> <p>Please feel free to call with any further questions Respectfully submitted,</p> <p>April England Administrator 317-786-9426</p>	

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

TITLE

(X6) DATE

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

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F000248 SS=D	<p>16.2-3.1.</p> <p>Quality review completed on February 06, 2015; by Kimberly Perigo, RN.</p> <p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, record review, and interview, the facility failed to ensure 1:1 activities were provided for a resident according to their plan of care for 1 of 9 residents who met the criteria for review of activities. (Resident #7)</p> <p>Findings include:</p> <p>The clinical record of Resident #7 was reviewed on 1/30/15 at 8:41 a.m. Diagnoses for the resident included, but were not limited to, Huntington's disease, dementia, and altered mental status.</p> <p>A current care plan for Resident #7, initiated 5/29/14 and revised 9/17/14, indicated she was dependent on staff for</p>	F000248	<p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.</p> <p><b>F248 Activities Meet Interest of Each Resident</b></p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice:</p> <p>Resident 7 is now schedule for 1:1 with the activities department fifteen (15) minutes 3 times per week for atotal of forty-five (45) minutes per week and only when the resident is the facility.</p> <p><b>1. How you will identify other residents having potential to</b></p>	03/01/2016

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	<p>activities due to physical limitations, immobility, and cognitive deficits. The goal was, "The resident will attend/participate in activities via 1:1 with activities director two times a week for 30 minutes at a time." Interventions included, "The resident needs 1 to 1 bedside/in-room visits and activities..."</p> <p>A significant change Minimum Data Set assessment, dated 9/16/14, indicated Resident #7 enjoyed music, family or significant other involvement, religious activities and going outdoors.</p> <p>Activity Logs for weeks in September, October, and November, 2014, indicated the following:</p> <p>9/21-9/29: total of 50 minutes documented as provided 9/28-10/4: total of 30 minutes documented as provided 10/5-10/11: total of 45 minutes documented as provided 10/12-10/18: total of 37 minutes documented as provided 10/19-10/25: no minutes documented as provided 10/26-11/1: no minutes documented as provided 11/2-11/8: total of 30 minutes documented as provided 11/9-11/15: total of 15 minutes</p>		<p><b>be affected by the same practice and what corrective action will be taken:</b></p> <p>Three (3) other residents on the 1:1 program as of 1-30-15 had the potential to be affected. All care plans have been updated to reflect an accurate amount of 1:1 time.</p> <p><b>2. What measures will be put into place or what systematic changes you will make to ensure that the practice does not reoccur:</b></p> <p>Activity Director educated on providing 1:1 activities in compliance with the care plan of each resident requiring 1:1 activity programming</p> <p><b>3. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:</b></p> <p>The Administrator or designee will audit the 1:1 programming each week times eight (8) weeks for accuracy of 1:1 programming minutes. The Facility Risk Manager will report results at the next QA/Risk Management meeting and monthly thereafter until substantial compliance has been achieved and then quarterly monitoring by the RDO is</p>	

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F000279 SS=D	<p>documented as provided 11/16-11/22: total of 30 minutes documented as provided 11/23-11/29: no minutes documented as provided</p> <p>Activity Logs for December, 2014, and January and February, 2015, were not provided.</p> <p>On 1/30/14, the Activities Director indicated she does 1:1 therapy with Resident #7, "Two times per week for at least 15 minutes per session."</p> <p>Resident #7 was not observed being involved in any activities during the survey week.</p> <p>3.1-33(a)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS 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</p>		<p>recommended to maintain compliance</p> <p><b>4.Date of compliance: 3-1-2015</b></p>		

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	<p>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 record review and interview, the facility failed to ensure care plans were developed for hospice care (Resident #7), dental care (Resident #26), and incontinence care (Resident #33).</p> <p>Findings include:</p> <p>1. The clinical record of Resident #7 was reviewed on 1/30/15 at 8:41 a.m. Diagnoses for the resident included, but were not limited to, Huntington's disease, dementia, and altered mental status.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 12/16/14, indicated Resident #7 had a condition which might result in a life expectancy of less than six months.</p> <p>A physician's order, dated 11/30/14, indicated Resident #7 was to receive Hospice care. The resident's terminal diagnosis was Huntington's disease. This</p>	F000279	<p><b>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. F279: Develop Comprehensive Care Plans</b></p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice: 1.) Res #7's care plan was updated to include Hospice care on 1/30/15 by the MDS coordinator Res #26's care plan was updated to include oral and dental needs 1/29/15 by the MDS coordinator Res #33's care plan was updated to reflect resident incontinence status 1/29/15 by the MDS coordinator. <b>b. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</b></p>	03/01/2015	

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	<p>is a genetic disease causing degeneration of brain cells, leading to uncontrolled movements, impaired cognitive function and emotional disturbances.</p> <p>A care plan dated 11/30/14, created by Hospice, when care for the resident was initiated, was reviewed. Interventions, including communication with facility staff regarding resident's condition, were reviewed.</p> <p>A care plan, created by the facility regarding Resident #7 receiving Hospice care, was not found in the resident's record.</p> <p>On 1/30/15 at 2:51 p.m., the MDS Coordinator indicated Resident #7 did not have a care plan regarding Hospice care. She indicated she would create one.</p> <p>2. The clinical record review, completed on 1/28/15 at 2:15 p.m., indicated Resident #26 had diagnoses including, but not limited to, left foot infection.</p> <p>An Admission Minimum Data Set (MDS) assessment completed 12/30/14, assessed Resident #26 as having obvious or likely cavity or broken natural teeth. The resident was assessed as having a BIMS (Brief Interview for Mental Status) of 13 out of 15, indicating the resident</p>		<p>2.) All residents are at risk for this deficiency. <b>C Whatmeasures will be put into place or what systematic changes you will make to ensure that the practice does not reoccur:</b> 3.) The MDS Coordinator and DON will be reinserviced by the Director of Clinical Operations 2/18/15 on developing comprehensive care plans. The MDS coordintator will be responsible for updating quarterly, annual and significant change care plans that are reflective of the resident MDS. DON will be responsible to ensure care plans are updated with any change of condition between MDS completion. The DON or designee will inservice nursing staff on the change of condition audit tool to ensure care plans are updated timely with new changes of condition. <b>D. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:</b> 4.) The DON or designee will complete change of condition audit 3 times per week ongoing to ensure resident current status is reflected on the resident care plan. The Admin will complete random audit weekly for three months that MDS comprehensive care plans are updated and reflect resident current status. MDS coordinator will establish a schedule to ensure that all residents have</p>		

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	<p>was capable of making decisions regarding care.</p> <p>During a Stage 1 interview on 1/26/15 at 2:23 p.m., Resident #26 reported experiencing problems with some teeth and indicated the dentist had recommended extraction of the teeth.</p> <p>A Dental Referral Form dated 1/6/14 sic (1/6/15), indicated the resident was being referred to an oral surgeon for removal of retained roots for teeth #18, #29, and #31 and was signed by the facility dentist.</p> <p>Resident #26's records lacked a written plan of care to address oral care for the resident including care of the broken teeth and recommendation for extraction of the roots.</p> <p>During an interview with the MDS coordinator on 1/29/15 at 4:30 p.m., the MDS coordinator indicated Resident #26's care plans were not complete and needed to be updated.</p> <p>3. The clinical record review, completed on 1/29/15 at 9:33 a.m., indicated Resident #33 had diagnoses including, but not limited to, multiple sclerosis ( a debilitating disease affecting the central nervous system).</p>		<p>updated care plans within 90 days, and maintain this schedule on a quarterly basis and with significant changes. Findings will be reviewed by the Administrator and DON in QAPI monthly for three months and then quarterly thereafter. 5)Date of Compliance-3-1-15</p>				

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	<p>An Annual Minimum Data Set (MDS) assessment completed 11/13/14, assessed Resident #33 as having occasional urinary incontinent episodes (unable to hold urine at times). The MDS assessment indicated the resident had been tried on a toileting program since admission to the facility, but lacked an improvement in incontinence. The resident was assessed as having a BIMS (Brief Interview for Mental Status) of 15 out of 15, indicating the resident was capable of making decisions regarding care.</p> <p>A Quarterly Nursing Assessment completed 1/7/15, assessed the resident as having being incontinent at times of urine.</p> <p>During a Stage 1 interview on 1/27/15 at 3:20 p.m., the resident reported having urinary incontinence and occasionally requiring assistance from the staff to change incontinent pads.</p> <p>On 1/29/15 at 2:43 p.m., the Administrator provided a copy of the CNA (Certified Nursing Assistant) assignment sheet and indicated the sheet was the one currently used by the staff. Resident #33 was listed on the sheet as being incontinent of urine and requiring the use of incontinent briefs.</p>			

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F000280 SS=D	<p>A review of the plans of care for Resident #33 lacked a plan of care addressing urinary incontinence.</p> <p>During an interview with the MDS coordinator on 1/29/15 at 4:30 p.m., the MDS coordinator indicated Resident #33's care plans were not complete and needed to be updated.</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 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 ensure fall care plans were updated with new interventions for</p>	F000280	F280: Right to Participate Planning Care-Revise Care Plan 1.What corrective action(s) will	03/01/2015
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	<p>2 of 6 residents who met the criteria for review of accidents. (Residents #7 and #48)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #7 was reviewed on 1/30/15 at 8:41 a.m. Diagnoses for the resident included, but were not limited to, Huntington's disease, altered mental status, aggressive behaviors, and dementia.</p> <p>A significant change Minimum Data Set (MDS) assessment, dated 9/16/14, indicated Resident #7 was severely cognitively impaired and totally dependent on staff for transfers, bed mobility and locomotion.</p> <p>An Incident/Accident Report, dated 1/6/15, indicated Resident #7 fell out of her chair. The report indicated her lap tray was not properly secured. New interventions included, "Staff educated on proper placement [of lap tray] &amp; aware to notify [Hospice] for adjustments."</p> <p>A care plan, initiated 7/30/13, and current through 3/1/15, indicated, "The resident has had an actual fall with no injury..." Interventions on the care plan were not updated from the 1/6/15</p>		<p>be accomplished for those residents found to have been affected by the practice: Res # 27's care plan was updated to include new interventions post fall 1/6/15 Res # 48's care plan was updated to include new interventions post fall 1/1/15</p> <p><b>B. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</b> All residents who have had a fall in January were audited and care plan was updated to include new intervention implemented post fall.</p> <p><b>C. What measures will be put into place or what systematic changes you will make to ensure that the practice does not reoccur:</b> Don/designee will re-in service all nursing staff on new Chosen fall guidelines and paperwork. The fall incident and accident form will be reviewed by the Interdisciplinary Team the following work day to ensure a new intervention was implemented, that the intervention is appropriate for the resident and that the care plan was updated.</p> <p><b>D. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:</b> The DON/designee will complete a condition audit 3 times per week to ensure care plans have been</p>	

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	<p><b>Incident/Accident Report.</b></p> <p>On 1/30/15 at 10:00 a.m., the MDS Coordinator indicated she would add these interventions to Resident #7's fall care plan.</p> <p>2. The clinical record of Resident #48 was reviewed on 1/27/15 at 2:36 p.m. Diagnoses for the resident included, but were not limited to, schizophrenia, anxiety, and depression.</p> <p>An Incident/Accident Report and Investigation, dated 1/1/15, indicated Resident #48 fell in the bathroom. "Actions taken to prevent recurrence" included, "Assist res[ident] to restroom. Advise to always use walker."</p> <p>A care plan for Resident #48, initiated 10/29/14, and current through 1/22/15, indicated he was at risk for falls. The goal was he would remain fall free. Interventions included bed in lowest position, pharmacy consult to evaluate medications, proper nonskid footwear at all times, and physical and occupation therapy referrals as ordered. New interventions from 1/1/15, of assisting resident to restroom and advising him to always use his walker were not added to the care plan.</p>		<p>revised post fallongoing. The Regional Nurse consultant willcomplete a random audit bi-monthly for three months to ensure facility isfollowing Chosen fall guidelines and care plans are updated. Findings will bereviewed by the DON at QAPI monthly for three months and then quarterlythereafter. E- Date of compliance 3-1-15</p>	

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F000282 SS=E	<p>On 1/30/15 at 10:00 a.m., the Minimum Data Set coordinator indicated the resident's fall care plan had not been updated with new interventions, and she would do so.</p> <p>On 1/26/15 at 12:55 p.m., the Regional Director of Operations provided a policy, dated 11/2014, titled, "Fall Management," and indicated it was the policy currently used by the facility. The policy indicated, "The IDT [interdisciplinary team] will review all resident falls...to evaluate circumstances and probably cause for fall. The IDT modifies and implements a Care Plan and treatment approach to minimize repeat falls. The Care Plan will be reviewed/revised as indicated..."</p> <p>3.1-35(d)(2)(B)</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.</p> <p>Based on record review, observation, and interview, the facility failed to ensure plans of care were followed for a resident receiving hemodialysis (Resident #19), 5 residents receiving antipsychotic medications, (Residents #6, #21, #15,</p>	F000282	<p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.</p> <p>1. What corrective action(s) will</p>	03/01/2015	

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	<p>#55, and #33), a resident dependent on staff for her activity involvement (Resident #7), and a resident requiring behavior monitoring. (Resident #55)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #19 was reviewed on 1/29/15 at 11:34 a.m. Diagnoses for the resident included, but were not limited to, acute renal failure, congestive heart failure and edema.</p> <p>Hemodialysis is a process by which blood flows through a tube out of the body, goes through a machine filter for cleaning, and then is returned to the body. The resident's blood is accessed through a fistula, which is a surgically created connection between a vein and an artery. Resident #19 had a fistula in her left arm.</p> <p>A current recapitulated physician's order for December, 2014, indicated Resident #19 was to have her fluids restricted to 1500 milliliters (ml) per day, 180 ml every shift for medications, and 960 ml daily for meals.</p> <p>A care plan for Resident #19, initiated 2/11/13, and current through 1/30/15, indicated the resident needed hemodialysis due to acute renal failure. A goal was the resident would have no</p>		<p>be accomplished for those residents found to have been affected by the practice:</p> <p>A. Policy for hemodialysis was reviewed and revised for "resident will wear a band of color to shunt site arm to indicate no BP" to read (optional). There were no adverse outcomes to resident #19 for not wearing a band to wrist. B. AIMS was updated for resident #6, 21, 15, 55 and 33. No signs of EPS were noted.</p> <p><b>B. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</b></p> <p>A. No other residents were affected, no other residents receive hemodialysis B. All residents that utilize psychotropic medications had their AIMS updated 1/29/15.</p> <p><b>C. What measures will be put into place or what systematic changes you will make to ensure that the practice does not reoccur:</b></p> <p>A. DON will insert service nurses on the hemodialysis policy to include, guidelines, pre/post assessment and fluid restriction. B. Don or designee will be inserted on completion of AIMS.</p> <p><b>D How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:</b> A. Don or designee will complete audit 3 times per week</p>				

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	<p>signs or symptoms of complications from dialysis. Interventions included monitoring, documenting and reporting any signs or symptoms of bleeding, infection to the access site, monitor intake [of food and fluids], monitor vital signs per protocol.</p> <p>A current care plan initiated 2/11/13, indicated the resident had renal failure due to kidney disease. Interventions included, "Fluids as ordered. Restrict or give as ordered."</p> <p>On 1/26/15 at 12:55 p.m., the Regional Director of Operations (RDO) provided a policy titled, "Hemodialysis, Care of Residents," dated June 2008, and indicated it was the policy currently used by the facility. The policy indicated, "Do not take blood pressure on arm with dialysis [access site]...Place a colored armband that indicates, 'No [blood pressure] this arm' on the residents arm that has the [access site]..Provide routine [access site] care and monitoring...Upon return from dialysis... the nurse will assess the condition of the access site for bleeding, redness, tenderness or swelling." A bruit is abnormal whooshing sound heard when placing a stethoscope over the fistula. A thrill is a vibration felt around the fistula access site.</p>		<p>on residents who receive hemodialysis to ensure pre/post dialysis assessment is complete for 1 month, then weekly for 1 month, then monthly.B. DON or designee will audit residents who have orders for fluid restriction 3 times per week to ensure that fluids are being monitored per physician order for one month, then weekly for one month and then monthly. C. DON or designee will set a calendar schedule for AIMS to be completed a minimum of every 6 months per regulations. Regional Nurse Consultant will audit to ensure completion. D. DON or designee will ensure all residents with new orders for a psychotropic medication has an AIMS initiated and added to the calendar for continued monitoring utilizing the change of condition tool.</p> <p>The DON will report findings to QAPI monthly for three months and then quarterly thereafter.</p> <p>E Date of Compliance 3-1-2015</p>	

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	<p>A review of Dialysis Assessments, to be completed before and after dialysis with vital signs, signs of swelling, bleeding or infection, indicated no post dialysis assessments were done on 12/2, 12/16, and 12/29, 2014. No preassessment was done on 12/18/14.</p> <p>A Fluid Intake Record for December, 2014, indicated fluid amounts per shift and total fluid intake were not completed for shifts on December 2, 4, 8, 10, 11, 12, 13, 14, 15, 16, 18, 20, 21, 22, 23, 25, 26, 29, and 30, 2014.</p> <p>On 1/30/15 at 3:17 p.m., the RDO indicated, for December, 2014, according to the Fluid Intake Record, Resident #19's fluids were not adequately monitored.</p> <p>On 1/30/15 at 9:32 a.m., Resident #19 was observed to be not wearing a bracelet. The resident indicated she had never worn a bracelet to remind staff she had a fistula in her left arm. On 1/30/15 at 12:25 P.M., the Regional Director of Clinical Operations indicated the resident did not have a bracelet on.</p> <p>2.a. The clinical record of Resident #6 was reviewed on 1/28/15 at 1:59 p.m. Diagnoses for the resident included, but</p>						

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	<p>were not limited to, dementia with behaviors, schizophrenia, anxiety and major depressive disorder.</p> <p>A current physician's order, initiated 10/13/14, indicated Resident #6 was to receive Zyprexa 20 milligrams every day at bedtime. Zyprexa is an antipsychotic medication used to treat schizophrenia. Adverse side effects can include abnormal involuntary movements.</p> <p>A current care plan for Resident #6, dated 12/7/12, and revised on 9/22/14, indicated the resident was at risk for adverse effects of antipsychotic medications. Interventions included, "AIMS [abnormal involuntary movement scale] quarterly [every 3 months] and prn [as needed]..."</p> <p>An AIMS assessment for Resident #6 was done on 3/25/14. No other assessments for abnormal involuntary movements were found in the resident's record.</p> <p>On 1/29/15 at 2:00 p.m., the Regional Director of Operations indicated she was unable to find any assessments for abnormal involuntary movements after 3/25/14.</p> <p>2.b. The clinical record of Resident #21</p>			

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	<p>was reviewed on 1/28/15 at 3:03 p.m. Diagnoses for the resident included, but were not limited to, major depressive disorder and suicidal ideation.</p> <p>A current physician's order, dated 4/4/13, indicated Resident #21 was to receive risperidone, 2 mg (milligram) twice a day. Risperidone is an antipsychotic medication used to treat depression. Adverse side effects can include abnormal involuntary movements.</p> <p>A current care plan for Resident #21, dated 3/27/13, indicated she used psychotropic medications and was at risk for "drug related complications, including movement disorder..." Interventions included monitoring for side effects.</p> <p>Resident #21 was assessed for abnormal voluntary movements (AIMS) on 3/25/14. No other AIMS was found in the resident's record.</p> <p>On 1/29/15 at 9:06 a.m., the Regional Director of Operations indicated no AIMS assessments on the resident had been done since 3/25/14.</p> <p>2.c. The clinical record of Resident #15 was reviewed on 1/29/15 at 8:27 a.m. Diagnoses for the resident included, but were not limited to, major depressive</p>			

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	<p>disorder, paranoid, dementia of the Alzheimer's type with behavioral disturbances.</p> <p>A current physician's order, initiated 11/4/13, indicated Resident #15 was to receive Latuda, 80 milligrams (mg) daily, and risperidone 1 mg twice a day. Latuda is an antipsychotic medication used to treat depression. Risperidone is an antipsychotic medication used to treat schizophrenia and bipolar depression. Adverse side effects of both of these medications can include abnormal involuntary movements.</p> <p>A care plan for Resident #15, dated 12/7/12, and current through March, 2015, indicated the resident was at risk for adverse reactions related to taking antipsychotic medications. Interventions included, "Monitor for possible signs and symptoms of adverse drug reaction..."</p> <p>No assessments for abnormal involuntary movements were found in Resident #15's record.</p> <p>On 1/29/14 at 1:49 p.m., the Regional Director of Operations indicated she was unable to find any assessments for abnormal involuntary movements in Resident #15's record.</p> <p>2. d. The clinical record review,</p>			

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	<p>completed on 1/30/15 at 9:28 a.m., indicated Resident #55 had diagnoses including, but not limited to, dementia. The resident was admitted to the facility on 9/14/14.</p> <p>A Quarterly Minimum Data Set (MDS) assessment completed 12/19/14, assessed the resident as receiving an antipsychotic medication each day of the assessment period.</p> <p>The recapitulation of physician's orders dated 1/1/15 - 1/31/15, indicated the resident should receive risperidone (an antipsychotic medication) 0.25 mg (milligrams) in the morning and 0.5 mg in the evening for the treatment of increased agitation/dementia. The start date for this dosage was 10/22/14. The resident was receiving risperidone upon admission to the facility. Abnormal involuntary movements have been identified as an adverse side effect of antipsychotic medications.</p> <p>The clinical record of Resident #55 lacked an assessment for abnormal involuntary movements.</p> <p>During an interview with the Regional Director of Clinical Operations (RDCO) on 1/29/15 at 9:30 a.m., the RDCO indicated the AIMS (Abnormal</p>			

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	<p>Involuntary Movements Scale) had not been completed for Resident #55.</p> <p>2. e. The clinical record review, completed on 1/29/15 at 9:33 a.m., indicated Resident #33 had diagnoses including, but not limited to, multiple sclerosis ( a debilitating disease affecting the central nervous system).</p> <p>An Annual Minimum Data Set (MDS) assessment completed 11/13/14, assessed Resident #33 as having a BIMS (Brief Interview for Mental Status) of 15 out of 15, indicating the resident was capable of making decisions regarding care. The resident was assessed as receiving psychotropic medications 7 out of 7 days during the assessment period.</p> <p>A current care plan dated 2/18/13, indicated the resident used psychotropic medications. The goal of the care plan was to have the resident remain free of drug related complications including movement disorders. An intervention included monitoring/documenting for side effects and effectiveness.</p> <p>The recapitulation of physician's orders dated 1/1/15 - 1/31/15, indicated the resident was receiving divalproex 500 mg (milligrams) at bedtime for insomnia. The start date for the divalproex was</p>			

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	<p>7/15/14. A side effect of the medication included abnormal movements.</p> <p>The clinical record contained an AIMS (Abnormal Involuntary Movement Scale) dated 8/4/13.</p> <p>During an interview with the Regional Director of Clinical Operations (RDCO) on 1/29/15 at 9:30 a.m., the RDCO indicated the AIMS had not been updated since 8/4/13, for Resident #33.</p> <p>On 1/29/15 at 10:10 a.m., the RDCO provided the policy Psychoactive Medications dated 05/2013, and indicated the policy was the one currently used by the facility. The policy indicated, "...10... a. AIMS testing will be completed prior to the initiation of any antipsychotic medications. b. AIMS testing will be completed no less frequently than every six months for those residents receiving antipsychotic medications..."</p> <p>3. The clinical record of Resident #7 was reviewed on 1/30/15 at 8:41 a.m. Diagnoses for the resident included, but were not limited to, Huntington's disease, dementia, and altered mental status.</p> <p>A current care plan for Resident #7, initiated 5/29/14 and revised 9/17/14, indicated she was dependent on staff for</p>						

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	<p>activities due to physical limitations, immobility, and cognitive deficits. The goal was, "The resident will attend/participate in activities via 1:1 with activities director two times a week for 30 minutes at a time." Interventions included, "The resident needs 1 to 1 bedside/in-room visits and activities..."</p> <p>Resident #7 was not observed being in involved in any activities or 1:1 activities during the survey week.</p> <p>A significant change Minimum Data Set assessment, dated 9/16/14, indicated Resident #7 enjoyed music, family or significant other involvement, religious activities and going outdoors.</p> <p>Activity Logs for weeks in September, October, and November, 2014, indicated the following:</p> <p>9/21-9/29: total of 50 minutes documented as provided 9/28-10/4: total of 30 minutes documented as provided 10/5-10/11: total of 45 minutes documented as provided 10/12-10/18: total of 37 minutes documented as provided 10/19-10/25: no minutes documented as provided 10/26-11/1: no minutes documented as</p>						

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	<p>provided 11/2-11/8: total of 30 minutes documented as provided 11/9-11/15: total of 15 minutes documented as provided 11/16-11/22: total of 30 minutes documented as provided 11/23-11/29: no minutes documented as provided</p> <p>Activity Logs for December 2014, and January and February 2015, were not provided by the facility.</p> <p>On 1/30/14, the Activities Director indicated she does 1:1 therapy with Resident #7 for, "2 times per week for at least 15 minutes per session."</p> <p>4. The clinical record review, completed on 1/30/15 at 9:28 a.m., indicated Resident #55 had diagnoses including, but not limited to, dementia. The resident was admitted to the facility on 9/14/14.</p> <p>A Quarterly Minimum Data Set (MDS) assessment completed 12/19/14, assessed the resident as receiving an antipsychotic medication each day of the assessment period. The resident was not assessed as having any behaviors on the MDS.</p> <p>A current plan of care dated 9/26/14,</p>						

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	<p>indicated the resident had physical behaviors of hitting the staff related to dementia. Interventions included, but were not limited to, monitor and document danger to self and others.</p> <p>A current plan of care dated 9/29/14, indicated the resident wandered aimlessly. Interventions included, but were not limited to, distract the resident from wandering and provide structured activities.</p> <p>Another plan of care dated 9/30/14, and current as of 1/30/15, indicated the resident demonstrated abusive behaviors related to dementia. Interventions included, but were not limited to, analyze key time, places, circumstances, triggers, and what de-escalated the behavior and document.</p> <p>A review of the Behavior/Mood Symptom Tracking Tools for Resident #55 indicated the resident had 4 episodes of hitting, yelling, wandering, refusing care, and verbally threatening in the month of September 2014. One episode of the behavior was documented for October 2014. One episode of yelling, wandering, and verbally threatening was documented for November 2014. The behavior tracking tool for December 2014 and January 2015 were blank.</p>				

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	<p>A review of the Behavior Summary for 9/1/14 - 10/31/14 and 11/1/14 - 11/30/14, lacked Behavior Committee Review.</p> <p>A nursing progress note dated 12/9/14 10:30 p.m., indicated the resident had refused to have vital signs taken and refused to use rolling walker for ambulation.</p> <p>A note on 12/10/14 11:30 a.m., indicated the resident was redirected multiple times due to wandering.</p> <p>A note on 1/17/15 4:02 a.m., indicated the resident required supervision when ambulating due to wandering.</p> <p>During an interview with the MDS coordinator on 1/27/15 5:19 p.m., the MDS coordinator indicated the resident had difficulty finding his room and frequently wandered into the rooms of other residents. The MDS coordinator indicated the resident did not always understand what was being said to him and would become agitated when other residents would try to get him out of their rooms.</p> <p>On 1/29/15 at 4:30 p.m., the resident was observed wandering into the therapy room. The resident was unable to</p>			

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	<p>verbalize wants and needs to staff and was redirected into the hallway.</p> <p>During an interview with the Social Services Director (SSD) on 1/30/15 at 11:30 a.m., the SSD indicated daily behavior tracking should be done by the nursing staff on the behavior monitoring sheets. The SSD indicated no Behavior Summary was available for December 2014, as no behaviors were documented on the monitoring log.</p> <p>On 1/30/15 at 12:30 p.m., the SSD provided the undated Behavior Management Policy and indicated the policy was the one currently used by the facility. The policy indicated, "The facility will treat (sic) will provide or make referrals to provide appropriate interventions in establishing a plan of treatment for those residents identified as needing 'Behavior Management'...Examples may include: physical behavioral symptoms directed toward others, verbal behavioral symptoms directed toward others,...rejection of care and wandering...8. Effectiveness of interventions will be monitored by review of documentation on the behavior tracking record by Social Service Department...."</p>			

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F000309 SS=D	<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 observation, record review, and interview, the facility failed to ensure a resident receiving dialysis treatments was assessed and monitored according to their policy, for 1 of 1 residents reviewed for dialysis care. (Resident #19)</p> <p>Findings include:</p> <p>The clinical record of Resident #19 was reviewed on 1/29/15 at 11:34 a.m. Diagnoses for the resident included, but were not limited to, acute renal failure, congestive heart failure and edema.</p> <p>Hemodialysis is a process by which blood flows through a tube out of the body, goes through a machine filter for cleaning, and then is returned to the body. The resident's blood is accessed through a fistula, which is a surgically created connection between a vein and an artery.</p>	F000309	<p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice: Policy for hemodialysis was reviewed and revised for "resident will wear a band of color to shunt site arm to indicate no BP" to read (optional). There were no adverse outcomes to resident #19 for not wearing a band to wrist</p> <p><b>B. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</b> No other residents were affected, no other residents receive hemodialysis</p> <p><b>C. What measures will be put into place or what systematic changes you will make to ensure that the</b></p>	03/05/2015			

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	<p>Resident #19 had a fistula in her left arm.</p> <p>A current recapitulated physician's order for December 2014, indicated Resident #19 was to have her fluids restricted to 1500 milliliters (ml) per day, 180 ml every shift for medications, and 960 ml daily for meals.</p> <p>A care plan for Resident #19, initiated 2/11/13, and current through 1/30/15, indicated the resident needed hemodialysis due to acute renal failure. A goal was the resident would have no signs or symptoms of complications from dialysis. Interventions included monitoring, documenting and reporting any signs or symptoms of bleeding, infection to the access site, monitor intake [of food and fluids], monitor vital signs per protocol.</p> <p>A current care plan initiated 2/11/13, indicated the resident had renal failure due to kidney disease. Interventions included, "Fluids as ordered. Restrict or give as ordered."</p> <p>On 1/26/15 at 12:55 p.m., the Regional Director of Operations (RDO) provided a policy titled, "Hemodialysis, Care of Residents," dated June 2008, and indicated it was the policy currently used by the facility. The policy indicated, "Do</p>		<p><b>practice does not reoccur:</b> DON will inservice nurses on thehemodialysis policy to include, guidelines, pre/post assessment and fluidrestriction</p> <p><b>D. How thecorrective action(s) will be monitored to ensure the practice will not recur,i.e., what quality assurance program will be put into place:</b></p> <p>A. Don or designee will complete audit 3times per week on residents who receive hemodialysis to ensure pre/postdialysis assessment is complete for 1 month, then weekly for 1 month, thenmonthly.</p> <p>B. DON or designee will audit residents whohave orders for fluid restriction 3 times per week to ensure that fluids arebeing monitored per physician order for one month, then weekly for one month,and then monthly for 2 months. DONwill report findings to QAPI monthly for three months and then quarterly thereafter.</p> <p>E Date of compliance 3-1-15</p>	

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	<p>not take blood pressure on arm with dialysis [access site]...Place a colored armband that indicates, 'No [blood pressure] this arm' on the residents arm that has the [access site]..Provide routine [access site] care and monitoring...Upon return from dialysis... the nurse will assess the condition of the access site for bleeding, redness, tenderness or swelling." A bruit is abnormal whooshing sound heard when placing a stethoscope over the fistula. A thrill is a vibration felt around the fistula access site.</p> <p>A review of Dialysis Assessments, to be completed before and after dialysis with vital signs, signs of swelling, bleeding or infection, indicated no post dialysis assessments were done on 12/2, 12/16, and 12/29, 2014. No preassessment was done on 12/18/14.</p> <p>A Fluid Intake Record for December, 2014, indicated fluid amounts per shift and total fluid intake were not completed for shifts on December 2, 4, 8, 10, 11, 12, 13, 14, 15, 16, 18, 20, 21, 22, 23, 25, 26, 29, and 30, 2014.</p> <p>On 1/30/15 at 3:17 p.m., the RDO indicated, for December, 2014, according to the Fluid Intake Record, Resident #19's fluids were not adequately</p>			

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F000323 SS=D	<p>monitored.</p> <p>On 1/30/15 at 9:32 a.m., Resident #19 was observed to be not wearing a bracelet. The resident indicated she had never worn bracelet to remind staff she had a fistula in her left arm. On 1/30/15 at 12:25 P.M., the Regional Director of Clinical Operations indicated the resident did not have a bracelet on.</p> <p>3.1-37(a)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure a positioning device (lap tray), placed on a resident's chair, was securely attached to prevent falls for 1 of 6 residents who met the criteria for review of accidents. (Resident #7)</p> <p>Findings include:</p> <p>The clinical record of Resident #7 was reviewed on 1/30/15 at 8:41 a.m. Diagnoses for the resident included, but were not limited to, Huntington's disease,</p>	F000323	<p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required</p> <p>F323: Free of Accidents and Hazards A What corrective action(s) will be accomplished for those residents found to have been affected by the practice: Res # 27's care plan was updated to include new interventions post fall 1/6/15 Res # 48's care plan was updated to include new interventions post fall 1/1/15 B How you will identify other</p>	03/01/2015

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	<p>altered mental status, aggressive behaviors, and dementia.</p> <p>A significant change Minimum Data Set (MDS) assessment, dated 9/16/14, indicated Resident #7 was severely cognitively impaired and totally dependent on staff for transfers, bed mobility and locomotion.</p> <p>A nurse's note dated 1/5/15 at 8:40 a.m., indicated, "Called to res[ident's] room. Res[ident] lying on [right] side on top of floor mat next to her bed. Lap tray was not secured. Res[ident] has [no] injuries..."</p> <p>An Incident/Accident Report, dated 1/6/15, indicated Resident #7 fell out of her chair. The report indicated her lap tray was not properly secured. New interventions included, "Staff educated on proper placement [of lap tray] &amp; aware to notify [Hospice] for adjustments."</p> <p>A care plan, initiated 7/30/13, and current through 3/1/15, indicated, "The resident has had an actual fall with no injury..." Interventions included, "...fall 3/7/14 - no injury: staff education on proper placement of lap tray..." The care plan had not been updated regarding the resident's fall on 1/5/15.</p>		<p><b>residentshaving potential to be affected by the same practice and what corrective actionwill be taken:</b></p> <p>All residents who have had a fall in January were audited and care plan was updated to include new interventionimplemented post fall.</p> <p><b>C What measures will be put into place orwhat systematic changes you will make to ensure that the practice does not reoccur:</b></p> <p>Don/designee will re-inservice all nursing staff onnew Chosen fall guidelines and paperwork.</p> <p><b>D How the corrective action(s) will bemonitored to ensure the practice will not recur, i.e., what quality assuranceprogram will be put into place:</b></p> <p>The fall incident and accident form will bereviewed by the Interdisciplinary Team the following work day to ensure a newintervention was implemented, that the intervention is appropriate for theresident and that the care plan was updated.</p> <p>The DON/designee will complete change ofcondition audit 3 times per week to ensure care plans have been revised postfall ongoing.</p> <p>The Regional Nurse consultant willcomplete a random audit bi-monthly for three months to ensure facility isfollowing Chosen fall guidelines and care plans are updated.</p> <p>Findings will be reviewed by the DON at QAPI monthlyfor three months and then quarterly</p>	

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F000329 SS=E	<p>On 1/30/15 at 10:00 a.m., the MDS Coordinator indicated she would add these interventions to Resident #7's fall care plan.</p> <p>3.1-45(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to adequately monitor</p>	F000329	<p>thereafter. E Date of Compliance 3-1-2015</p> <p><b>A. What corrective action(s) will be accomplished for those residents found to have been</b></p>	03/01/2015	

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	<p>for abnormal involuntary movements for 5 of 5 residents receiving psychoactive medications (Resident #6, Resident #21, Resident #15, Resident #33, and Resident #55), and failed to complete behavior monitoring for a resident exhibiting behaviors who was receiving antipsychotic medications. (Resident #55)</p> <p>Findings include:</p> <p>1. a. The clinical record review, completed on 1/30/15 at 9:28 a.m., indicated Resident #55 had diagnoses including, but not limited to, dementia. The resident was admitted to the facility on 9/14/14.</p> <p>A Quarterly Minimum Data Set (MDS) assessment completed 12/19/14, assessed the resident as receiving an antipsychotic medication each day of the assessment period.</p> <p>The recapitulation of physician's orders dated 1/1/15 - 1/31/15, indicated the resident should receive risperidone (an antipsychotic medication) 0.25 mg (milligrams) in the morning and 0.5 mg in the evening for the treatment of increased agitation/dementia. The start date for this dosage was 10/22/14. The resident was receiving risperidone upon</p>		<p><b>affected by the practice:</b> AIMS was updated for resident #6, 21, 15, 55 and 33. No signs of EPS were noted Resident 55 has d/c from Meridian Nursing and Rehab <b>B. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</b> All residents receiving psychotropic medications or who have behaviors as of 1-30-15 were at risk of being affected <b>C. What measures will be put into place or what systematic changes you will make to ensure that the practice does not reoccur:</b> DON or designee will be in-serviced on completion of AIMS All staff in-serviced on documenting behaviors as they occur on the behavior tracking log Social Services Director in-serviced on follow up for behaviors to include checking the behavior books daily, bringing logs to morning meeting on dates when morning meeting is held, and reviewing each week at behavior meetings. <b>D. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:</b> DON or designee will set a calendar schedule for AIMS to be completed a minimum of every 6 months per regulations. Regional Nurse Consultant will</p>				

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	<p>admission to the facility. Abnormal involuntary movements have been identified as an adverse side effect of antipsychotic medications.</p> <p>The clinical record of Resident #55 lacked an assessment for abnormal involuntary movements.</p> <p>During an interview with the Regional Director of Clinical Operations (RDCO) on 1/29/15 at 9:30 a.m., the RDCO indicated the AIMS (Abnormal Involuntary Movements Scale) had not been completed for Resident #55.</p> <p>1. b. The clinical record review, completed on 1/29/15 at 9:33 a.m., indicated Resident #33 had diagnoses including, but not limited to, multiple sclerosis ( a debilitating disease affecting the central nervous system).</p> <p>An Annual Minimum Data Set (MDS) assessment completed 11/13/14, assessed Resident #33 as having a BIMS (Brief Interview for Mental Status) of 15 out of 15, indicating the resident was capable of making decisions regarding care. The resident was assessed as receiving psychotropic medications 7 out of 7 days during the assessment period.</p> <p>A current care plan dated 2/18/13,</p>		<p>audit to ensure completion. DON or designee will ensure all residents with new orders for a psychotropic medication has an AIMS initiated and added to the calendar for continued monitoring utilizing the change of condition tool. The Administrator or designee will audit the behavior tracking daily for documentation of behaviors x 8 weeks. Audit will include checking that behaviors are documented, that follow up is made, and that those residents exhibiting behaviors are reviewed in the weekly behavior meetings. The Facility Risk Manager will report results at the next QA/Risk Management meeting and monthly thereafter until substantial compliance has been achieved and then quarterly monitoring by the RDO is recommended to maintain compliance <b>E. Date of compliance: 3-1-2015</b></p>	

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	<p>indicated the resident used psychotropic medications. The goal of the care plan was to have the resident remain free of drug related complications including movement disorders. An intervention included monitoring/documenting for side effects and effectiveness.</p> <p>The recapitulation of physician's orders dated 1/1/15 - 1/31/15, indicated the resident was receiving divalproex 500 mg (milligrams) at bedtime for insomnia. The start date for the divalproex was 7/15/14. A side effect of the medication included abnormal movements.</p> <p>The clinical record contained an AIMS (Abnormal Involuntary Movement Scale) dated 8/4/13.</p> <p>During an interview with the Regional Director of Clinical Operations (RDCO) on 1/29/15 at 9:30 a.m., the RDCO indicated the AIMS had not been updated since 8/4/13, for Resident #33.</p> <p>1. c. The clinical record of Resident #15 was reviewed on 1/29/15 at 8:27 a.m. Diagnoses for the resident included, but were not limited to, major depressive disorder, paranoid, dementia of the Alzheimer's type with behavioral disturbances.</p> <p>A current physician's order, initiated</p>			

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	<p>11/4/13, indicated Resident #15 was to receive Latuda, 80 milligrams (mg) daily, and risperidone 1 mg twice a day. Latuda is an antipsychotic medication used to treat depression. Risperidone is an antipsychotic medication used to treat schizophrenia and bipolar depression. Adverse side effects of both of these medications can include abnormal involuntary movements.</p> <p>A care plan for Resident #15, dated 12/7/12, and current through March, 2015, indicated the resident was at risk for adverse reactions related to taking antipsychotic medications. Interventions included, "Monitor for possible signs and symptoms of adverse drug reaction..."</p> <p>No assessments for abnormal involuntary movements were found in Resident #15's record.</p> <p>On 1/29/14 at 1:49 p.m., the Regional Director of Operations indicated she was unable to find any assessments for abnormal involuntary movements in Resident #15's record.</p> <p>1. d. The clinical record of Resident #21 was reviewed on 1/28/15 at 3:03 p.m. Diagnoses for the resident included, but were not limited to, major depressive disorder and suicidal ideation.</p>			

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	<p>A current physician's order, initiated 4/4/13, indicated Resident #21 was to receive risperidone 2 mg (milligram) twice a day. Risperidone is an antipsychotic medication used to treat depression. Adverse side effects can include abnormal involuntary movements.</p> <p>A current care plan for Resident #21, dated 3/27/13, indicated she used psychotropic medications and was at risk for "drug related complications, including movement disorder..." Interventions included monitoring for side effects.</p> <p>Resident #21 was assessed for abnormal voluntary movements (AIMS) on 3/25/14. No other AIMS was found in the resident's record.</p> <p>On 1/29/15 at 9:06 a.m., the Regional Director of Operations indicated no AIMS assessments on the resident had been done since 3/25/14.</p> <p>1. e. The clinical record of Resident #6 was reviewed on 1/28/15 at 1:59 p.m. Diagnoses for the resident included, but were not limited to, dementia with behaviors, schizophrenia, anxiety and major depressive disorder.</p>			

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	<p>A current physician's order, initiated 10/13/14 indicated Resident #6 was to receive Zyprexa 20 milligrams every day at bedtime. Zyprexa is an antipsychotic medication used to treat schizophrenia. Adverse side effects can include abnormal involuntary movements.</p> <p>A current care plan for Resident #6, dated 12/7/12, and revised on 9/22/14, indicated the resident was at risk for adverse effects of antipsychotic medications. Interventions included, "AIMS [abnormal involuntary movement scale] quarterly (every 3 months) and prn [as needed]..."</p> <p>An AIMS assessment for Resident #6 was done on 3/25/14. No other assessments for abnormal involuntary movements were found in the resident's record.</p> <p>On 1/29/15 at 2:00 p.m., the Regional Director of Operations indicated she was unable to find any assessments for abnormal involuntary movements after 3/25/14.</p> <p>2. The clinical record review, completed on 1/30/15 at 9:28 a.m., indicated Resident #55 had diagnoses including, but not limited to, dementia. The resident was admitted to the facility on</p>			

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NAME OF PROVIDER OR SUPPLIER  MERIDIAN NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2102 S MERIDIAN ST INDIANAPOLIS, IN 46225
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	<p>9/14/14.</p> <p>A Quarterly Minimum Data Set (MDS) assessment completed 12/19/14, assessed the resident as receiving an antipsychotic medication each day of the assessment period. The resident was not assessed as having any behaviors on the MDS.</p> <p>A current plan of care dated 9/26/14, indicated the resident had physical behaviors of hitting the staff related to dementia. Interventions included, but were not limited to, monitor and document danger to self and others.</p> <p>A current plan of care dated 9/29/14, indicated the resident wandered aimlessly. Interventions included, but were not limited to, distract the resident from wandering and provide structured activities.</p> <p>Another plan of care dated 9/30/14, and current as of 1/30/15, indicated the resident demonstrated abusive behaviors related to dementia. Interventions included, but were not limited to, analyze key time, places, circumstances, triggers, and what de-escalated the behavior and document.</p> <p>A review of the Behavior/Mood Symptom Tracking Tools for Resident</p>			

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	<p>#55 indicated the resident had 4 episodes of hitting, yelling, wandering, refusing care, and verbally threatening in the month of September 2014. One episode of the behaviors was documented for October 2014. One episode of yelling, wandering, and verbally threatening was documented for November 2014. The behavior tracking tools for December 2014 and January 2015 were blank.</p> <p>A review of the Behavior Summary for 9/1/14 - 10/31/14 and 11/1/14 - 11/30/14, lacked Behavior Committee Review.</p> <p>A nursing progress note dated 12/9/14 10:30 p.m., indicated the resident had refused to have vital signs taken and refused to use rolling walker for ambulation.</p> <p>A note on 12/10/14 11:30 a.m., indicated the resident was redirected multiple times due to wandering.</p> <p>A note on 1/17/15 4:02 a.m., indicated the resident required supervision when ambulating due to wandering.</p> <p>During an interview with the MDS coordinator on 1/27/15 5:19 p.m., the MDS coordinator indicated the resident had difficulty finding his room and frequently wandered into the rooms of</p>			

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	<p>other residents. The MDS coordinator indicated the resident did not always understand what was being said to him and would become agitated when other residents would try to get him out of their rooms.</p> <p>On 1/29/15 at 4:30 p.m., the resident was observed wandering into the therapy room. The resident was unable to verbalize wants and needs to staff and was redirected into the hallway.</p> <p>During an interview with the Social Services Director (SSD) on 1/30/15 at 11:30 a.m., the SSD indicated daily behavior tracking should be done by the nursing staff on the behavior monitoring sheets. The SSD indicated no Behavior Summary was available for December 2014 as no behaviors were documented on the monitoring log.</p> <p>On 1/30/15 at 12:30 p.m., the SSD provided the undated Behavior Management Policy and indicated the policy was the one currently used by the facility. The policy indicated, "The facility will treat (sic) will provide or make referrals to provide appropriate interventions in establishing a plan of treatment for those residents identified as needing 'Behavior Management'...Examples may include:</p>			

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F000458 SS=D	<p>physical behavioral symptoms directed toward others, verbal behavioral symptoms directed toward others,...rejection of care and wandering...8. Effectiveness of interventions will be monitored by review of documentation on the behavior tracking record by Social Service Department...."</p> <p>3.1-48(a)(3)</p> <p>483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. Based on record review, observation, and interview, the facility failed to provide at least 80 square feet (sq ft) per resident in multiple resident rooms. This was evidenced in 2 of 20 resident rooms in the facility. (Rooms 9 and 10)</p> <p>Finding include:</p> <p>Facility documentation of room size dated 01/26/15 and 01/29/15, provided by the Administrator on 1/29/15 at 2:00 p.m., indicated the following room sizes of observed rooms:</p> <p>* 1. Room #9 3 beds 20 sq ft x 11 1/2 sq</p>	F000458	<p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.</p> <p>F458 Bedrooms Measure atleast 80 square feet per resident <b>What corrective action(s) will be accomplished for those residents found to have been affected by the practice:</b></p> <p>Room waiver requested by facility staff during annual survey</p> <p><b>How you will identify other residents having potential to be affected by the same practice and</b></p>	03/01/2015			

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	ft SNF/NF 73.75 sq ft per resident  * 2. Room #10 3 beds 20 sq ft x 11 1/2 sq ft SNF/NF 73.75 sq ft per resident.  3.1-19(I)(2)		<b>what corrective action will be taken:</b>  Three (3) other residents had thepotential to be affected  <b>What measures will be put into place or what systematic changes youwill make to ensure that the practice does not reoccur:</b>  Measurements are available at anytime for these rooms  <b>How the corrective action(s) will be monitored to ensure the practicewill not recur, i.e., what quality assurance program will be put into place:</b>  Obtaining the room waiver fromISDH will show compliance in this area. Room waiver will be requested annually  <b>Date of compliance: 3-1-2015</b>		