

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155718	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/08/2014
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NAME OF PROVIDER OR SUPPLIER COMMUNITY NORTHVIEW CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1235 W CROSS ST ANDERSON, IN 46011
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: December 1, 2, 3, 4, 5, and 8, 2014</p> <p>Facility number: 000562 Provider number: 155718 AIM number: 100267150</p> <p>Survey team: Debra Holmes, RN-TC (December 1, 2, 3, 4, 5) Angie Stallsworth, RN (December 1, 2, 3, 4, 5) Karen Lewis, RN Ginger McNamee, RN Tina Smith-Staats, RN</p> <p>Census bed type: SNF: 4 SNF/NF: 70 Residential: 23 Total: 97</p> <p>Census payor type: Medicare: 19 Medicaid: 42 Other: 13 Total: 74</p> <p>These deficiencies reflect state findings</p>	F000000	<p>PLAN OF CORRECTION: COMMUNITY NORTHVIEW</p> <p>DATE OF COMPLIANCE: JANUARY 7, 2015</p> <p>This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by state and federal law.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F000244 SS=D	<p>cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed 12/11/14 by Brenda Marshall, RN.</p> <p>483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.</p> <p>Based on interview and record review, the facility failed to respond to and resolve grievances brought forth by the Resident Council in timely manner for 5 of 8 months reviewed.</p> <p>Findings include:</p> <p>During an interview on 12/1/14 at 11:32 A.M., the resident council president gave permission to review Resident Council meeting minutes.</p> <p>On 12/3/14 at 1:05 P.M., the Activities Director provided the Resident Council minutes from April, 2014 through November, 2014.</p> <p>Review of the Resident Council meeting</p>	F000244	<p><u>F244 LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION</u></p> <p>It is the intention and policy of this facility to listen to the views of residents and families and act upon any grievances, concerns or recommendations made by them, especially as they pertain to operational decisions affecting care and life in the facility.</p> <p>Immediate actions taken in relations to this cited deficiency:</p> <p>1) An emergency Resident Council meeting was held on 12/4/14 to hear any grievances or concerns. The meeting was conducted by the</p>	01/07/2015

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	<p>minutes was completed on 12/3/14 at 1:15 P.M. The resident council meeting minutes indicated the following:</p> <p>The resident council meets monthly.</p> <p>The grievances were voiced as follows:</p> <p>The resident council minutes, dated 11/3/14, indicated the residents voiced they would like the corrective actions explained from previous meetings. The residents indicated they did not fully understand the corrective actions from grievances which were voiced during past meetings and further indicated clarification was needed so they can choose to accept or reject the corrective actions.</p> <p>The residents requested on 10/6/14 to meet with the dietary manager and the dietician. On 11/3/14 the resident council again asked to speak with the dietary manager and the dietician. A note listed at the bottom of the minutes, dated 11/3/14, indicated that as of 11/26/14, a time has not been scheduled for the resident council to meet with the indicated staff from dietary.</p> <p>The resident council minutes, dated 9/8/14, indicated multiple concerns, including but not limited to: unclean</p>		<p>Administrator, and the DON was in attendance as well. Issues were collected as stated.</p> <p>Identification of other residents having the potential to be affected by the same cited deficiency: The facility has identified that any resident or family member that identified concerns could potentially be affected by this cited deficiency.</p> <p>The following measures will be implemented to reduce the risk of future occurrences of the cited deficiency:</p> <p>1) Every resident who resides at the facility, who is deemed as interviewable (this is a resident who has sufficient memory and comprehension to be able to answer coherently and can make day-to-day decisions in a fairly consistent and organized manner) will be visited one on one weekly by a member of the facility leadership team (Social Services/Nursing/Maintenance/Housekeeping/Dietary/Administration) to ascertain any concerns or suggestions the resident may have. These interviews will be completed with structured questions and when completed, should be turned into the Administrator</p>		

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	<p>windows in the facility, long wait times on call lights, staff changes not allowing the residents to establish routines with staff members, playing of the radio in cafe' during meals, long wait times for food at meals, substitutes not available at lunch, portions of food inconsistent, tea tastes like it has bleach in it, soup and sandwiches served too many times, fresh vegetables should be provided when in season, salad bar wanted on weekends, not enough meat provided in chicken salad and in casseroles.</p> <p>On 5/19/14, Resident #15 went to the Activity Director's office and stated, "No one else cares about this place, residents state their concerns and it doesn't do any good because no one listens to them" and further indicated she did not want to stay a member of the resident council.</p> <p>The resident council minutes, dated 5/5/14, indicated staff voiced concerns that residents aren't interested in attending meetings; Resident #15 indicated she was tired of doing all the talking and complaining when no one else cares.</p> <p>The resident council minutes, dated 4/7/14, indicated the following grievance: residents indicated they would like to eat as soon as they sit down in the dining</p>		<p>each week. Weekly interviews will begin with week ending January 2, 2015.</p> <p>2) The Administrator/designee will review the resident interview forms promptly, and facilitate any actions necessary for remedy or suggestion, and then will follow up with the resident as soon as possible, and generally, within 1 week of the interview.</p> <p>3) Grievance/Concern forms are currently in place. These are kept outside of the Social Services office, and are available 24 hours/day and 7 days/week. Any resident, staff member or family or visitor can utilize this form to document concerns. Ultimately, these forms are routed to the Administrator for review and to ensure resolution processes are being pursued.</p> <p>4) New policies on Resident Council and Resident/Family Grievances will be implemented no later than January 7, 2015.</p> <p>5) Facility staff will be inserviced on new Resident Council and Resident/Family Grievance policies no later than January 7, 2015.</p>		

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	<p>room and indicated concerns with long wait times on call lights.</p> <p>The following corrective actions were located within the meeting minutes:</p> <p>A document titled "Resident Council Items of Concern," dated 9/9/14, attached to the meeting minutes, dated 9/8/2014, indicated the following corrective actions were provided by staff, including but not limited to: note was posted in cafe indicating no radio at meal times, facility is working on getting more staff during meals to speed delivery, kitchen staff will order different type of tea-dietary doesn't use bleach, facility will talk with the kitchen staff about portion control, dietary will make changes to menu, fresh fruit ordered-came in molded, have talked about fruit order, speaking with staff about following recipes.</p> <p>Review of the Resident Council meeting minutes, dated 4/7/14, 5/5/14, 10/6/14, and 11/3/14, indicated there were no further staff responses or corrective actions to grievances voiced by the residents on those dates.</p> <p>During an interview on 12/03/14 at 2:05:44 P.M., the Facility Administrator (HFA) and the Activities Director (AD) indicated grievances were taken to the</p>			

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F000250 SS=D	<p>department heads after each resident council meeting to be addressed by each department; the department heads are given a week to respond to the grievances and any corrective actions are to be reviewed with residents at the next scheduled resident council meeting. The HFA and the AD also indicated the grievance forms were not being completed by the facility staff for any grievances voiced by the residents and further indicated the facility staff were supposed to complete the forms for all grievances voiced by the residents. The HFA also indicated there was no explanation as to why the dietary manager and the dietician have not met, to date, with the resident council. The HFA indicated the dietary manager has been working less than full time and the AD indicated the dietary manager has not requested any additional staff to attend to grievances in her absence.</p> <p>3.1-3(l)</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE 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 observation, interview and record review, the facility failed to ensure</p>	F000250	<u>F250 PROVISION OF MEDICALLY RELATED SOCIAL</u>	01/07/2015

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	<p>a system for accurately monitoring behaviors, implementing behavior reducing interventions, and evaluating efficacy of behavior interventions for 1 of 5 residents reviewed for medical social services. (Resident #69)</p> <p>Findings include: On 12/2/14 at 9:00 a.m., on 12/3/14 at 10:00 a.m., on 12/4/14 at 10:35 a.m., on 12/4/14 at 11:30 a.m., on 12/5/14 at 8:17 a.m., and on 12/5/14 at 9:30 a.m., Resident #69 was observed lying in bed with eyes closed.</p> <p>During an interview on 12/4/14 at 10:35 a.m., LPN #11 indicated Resident #69 had been sleeping during the day and up all night. She indicated this was considered a behavior of this resident, and it should be monitored on the behavior log in the medication administration record or in the computer.</p> <p>During an interview on 12/5/14 at 9:30 a.m., LPN #11 indicated behaviors were tracked on the "Behavioral Assessment (For New or Worse Behaviors) form. The LPN #11 indicated the behavioral forms were reviewed for patterns by the Social Service staff and addressed at the behavior meetings. LPN #11 indicated</p>		<p><u>SERVICE</u></p> <p>It is the practice of this facility to provide adequate medically related social services support related to behavior management and other issues.</p> <p>Immediate actions taken for resident #69: None. The resident was discharged on 12/6/2014, during the survey process. When the 2567 was ready, and identified the specific issues for the resident, she was not present in the facility any longer.</p> <p>Identification of other residents having the potential to be affected by the same cited deficiency was accomplished by the following actions: The facility determined that all residents are at risk to exhibit behaviors that may not currently appear on the behavior log/behavior intervention monthly flow record. Furthermore, any resident may exhibit any behavior at any given time that may or may not have even previously occurred.</p> <p>The following measures will be implemented to reduce the risk of future occurrences of the cited deficiency:</p> <p>1) A random audit of 10</p>				

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	<p>Resident #69's sleep pattern should have been tracked as a behavior in December 2014.</p> <p>The Social Services Director indicated on 12/5/14 at 9:30 a.m., the staff filled out a "Behavioral Assessment (For New or Worse Behaviors) form when there was a concern with a resident's behavior and placed the form in the behavior book at one of the kiosks. Social Services collected the forms and monitored the behaviors for a pattern.</p> <p>Resident #69 's clinical record was reviewed on 12/4/14 at 11:00 a.m.</p> <p>Resident #69's diagnoses included, but were not limited to, anxiety, senile dementia with delusional features, and insomnia. The annual Minimum Data Set assessment, dated August 29, 2014, indicated the Brief Interview Mental Status (BIMS) total score was 4, with a total score of 8 to 15 as interviewable.</p> <p>The "BEHAVIOR/INTERVENTION MONTHLY FLOW RECORD" for May 2014 indicated behaviors tracked were depression and anxiety. The record did not indicate the behaviors occurred.</p> <p>A "Progress Notes," dated June 13, 2014 identified behaviors of removing dentures</p>		<p>residents who are identified as residents who currently exhibit behaviors will completed by the Director of Quality Assurance (DQA). The audit components will include the following: a) chart audit for behavior documentation in December, 2014, and b) interview of multidisciplinary staff regarding behaviors observed. The audit results will be compared to the behavior logs/behavior intervention monthly flow record, and where necessary, resident specific behaviors will be added to the records for observation and documentation. This action will be completed by January 7, 2015.</p> <p>2) Nursing staff who complete monthly recap of orders for general review will work with Social Services to identify at least one specific behavior that may accompany the global diagnosis for psychoactive drugs. This action will be completed by December 31, 2014 for 100% of residents in the building, noting that not all residents are on psychoactive medications, and that regardless of medication use, residents may still experience behaviors. The DON/designee will ensure this</p>				

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	<p>after staff placed in the resident's mouth and removing and hiding string from the personal alarm on the wheel chair. Staff education was provided.</p> <p>The physician's order on June 13, 2014 indicated to increase Abilify (an anti-psychotic medication) to 5 mg daily related to a "decline in activities in daily living, inability to express self and sad facial expression."</p> <p>The pharmacist's "Note to Attending Physician/Prescriber" recommendation, dated June 24, 2014, indicated a recommendation to increase Lexapro(antidepressant) 10 mg daily and decrease Abilify from 5 mg to 2 mg. "The Abilify can contribute to decline in activities daily living and contributes to falls and lethargy." Physician on unidentified date disagreed with the recommendation and indicated Resident #69 was "much better on Abilify increase."</p> <p>The "BEHAVIOR/INTERVENTION MONTHLY FLOW RECORD" for June 2014 indicated behaviors tracked were depression and anxiety. The record did not indicate the behaviors occurred.</p> <p>The "BEHAVIOR/INTERVENTION</p>		<p>action is completed.</p> <p>3) An inservice will be held for all staff regarding that as residents exhibit behaviors the behaviors should be documented in the behavior logs or in the electronic medical record (EMR) by nursing staff, but that any staff member can report the behavior or bring it to the attention of the nursing staff, Social Services, Director of Nursing or Administrator. In addition, it will be reinforced that many times routine behaviors, while considered "normal" for the resident, really are not "normal" and should be documented. Examples of behavior scenarios will be utilized as exemplar for education. This inservice will be completed by January 7, 2015. The DQA/designee will ensure this education is completed.</p> <p>4) Reports of behaviors will be reviewed during facility morning meetings, generally held M-F business days only, with social services/nursing, and actions determined from that review. A log of these reviews will be maintained by Social Services. Social Services and the DON or designee will be responsible to ensure that action items are</p>				

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	<p>MONTHLY FLOW RECORD" for July 2014 indicated behaviors tracked were depression, anxiety, and delusions. The record indicated anxiety was present on 7/22/14 with 1 on 1 staffing as an effective intervention.</p> <p>The "BEHAVIOR/INTERVENTION MONTHLY FLOW RECORD" for August 2014 identified behaviors tracked were depression, anxiety, and delusions. The record did not indicate behaviors occurred.</p> <p>A progress note, dated September 3, 2014 at 8:00 p.m., indicated the Nurse Practioner reduced Norco (pain medication) from three times a day to two times due to lethargy (sleepiness).</p> <p>A progress note, dated September 11, 2014 at 10:16 p.m., indicated a behavior of "standing up at the foot of bed without assistance." An intervention of placing the resident at the nurse's station for closer monitoring was implemented.</p> <p>A progress note, dated September 12, 2014 at 4:52 a.m., indicated the resident had a behavior of "not going to bed" and refused to go to room. An intervention of 1 on 1 was implemented.</p> <p>A progress note, dated September 22,</p>		<p>executed timely, which could include but are not limited to: informing family/MD of behavior, adding behaviors to a behavior monitoring sheet, informing staff of interventions to manage behavior, updating of the care plan, review of resident at next behavior team meeting. This method of meeting will begin January 5, 2015 and will be ongoing.</p> <p>5) The Behavior Medication Monitoring policy will be reviewed and updated to reflect these remedies by the DQA by January 7, 2015.</p> <p>6) Audits of behavior documentation will be completed by Social Services and the DON/designee on 10 residents each, weekly, and the audits will be discussed with the Administrator in a weekly meeting. The weekly audits will be kept by the Administrator. Weekly audits will begin with the week ending Friday, January 2, 2015, and will be ongoing through the week ending March 27, 2015. Then the audit schedule will be re-evaluated by Social Services, the DON and the Administrator, and a new schedule determined.</p>				

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	<p>2014, indicated "Staff are complaining that resident is up all night."</p> <p>The "BEHAVIOR/INTERVENTION MONTHLY FLOW RECORD" for September, 2014 indicated behaviors tracked were depression and anxiety. The record indicated no tracked behaviors occurred. The record did not indicate insomnia/irregular sleep pattern was tracked and did not indicate non-pharmacological interventions to reduce symptoms of insomnia.</p> <p>A progress note, dated October 3, 2014 at 5:51 a.m., indicated a behavior of "not going to bed." The record indicated Resident #69 was not tired and was in lounge drawing and writing on papers.</p> <p>A progress note, dated October 8, 2014 at midnight, indicated a behavior of "refusal to stay in bed." Resident #69 was placed closer to the nurse's station for monitoring.</p> <p>The "BEHAVIOR/INTERVENTION MONTHLY FLOW RECORD" for October, 2014 indicated behaviors tracked were depression and anxiety. The record indicated one episode of anxiety on 10/1/14. The record indicated redirection, 1 on 1, and return to room</p>			

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	<p>were effective interventions. The record did not indicate insomnia was tracked and did not indicate non-pharmacological interventions to reduce symptoms of insomnia.</p> <p>A progress note, dated November 12, 2014, indicated the resident was eating a napkin and 1 on 1 was the intervention implemented.</p> <p>The "BEHAVIOR/INTERVENTION MONTHLY FLOW RECORD" for November, 2014 indicated behaviors tracked were depression, agitation, and insomnia. The record did not indicate behaviors occurred.</p> <p>The "BEHAVIOR/INTERVENTION MONTHLY FLOW RECORD" for December 1-5, 2014 indicated behaviors tracked were anxiety and delusions. The record did not indicate behaviors occurred.</p> <p>The physician's order on December 5, 2014 indicated to hold Abilify, Lexapro, Trazadone till 12/8/14, related to lethargy, weight gain, and history of diuretic therapy.</p> <p>The "BEHAVIOR MEDICATION MONITORING POLICY," revised 10-2014, indicated the following:</p>			

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	<p>"...Procedure:</p> <ol style="list-style-type: none"> 1. Resident who are observed displaying a mood or behavior should have documentation in the behavior logs (behavioral assessment form) placed at the nurse's stations, dining room, and each kiosk or noted in Point Click Care. The documentation should include: location, time, event, resident/staff involved, triggers, interventions attempted and signature, etc. 2. The employee should notify the charge nurse of any event. The charge nurse will take indicated action as applicable including but not limited to... Monitoring medical condition and documentation... 3. Social Service Director/designee will collect, review and sign the Behavior Assessment Form two times weekly in order to provide appropriate action when applicable... Monitor... 6. Social Services will review the targeted behavior, care plan, frequency of behaviors, frequency of PRN (as needed) medications administered, non-pharmacological measures attempted with effects for the resident, BIMS and 			

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F000282 SS=D	<p>PHQ9 (patient health questionnaire) score results, and if psychological services in place...."</p> <p>3.1-34-(a)(2)</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 observation, interview and record review, the facility failed to follow interventions in the care plan for 3 of 15 residents reviewed for care plans regarding dialysis assessment (Resident #32), lack of Gradual Dose Reduction (GDR) for psychoactive medications (Resident #15), and fall prevention (Resident #29).</p> <p>Findings include:</p> <p>1. The clinical record for Resident #32 was reviewed on 12/3/14 at 8:33 a.m. Resident #32 had a diagnosis of end stage renal disease.</p> <p>The admission Minimum Data Set assessment (MDS), dated 11/14/14, indicated the resident was cognitively</p>	F000282	<p><u>F282 SERVICES BY QUALIFIED PERSON/PER CARE PLAN</u></p> <p>It is the intention of the facility to provide care plans reflective of individualized resident care.</p> <p>Regarding dialysis:</p> <p>Immediate actions taken for resident #32: On 12/5/14, when this issue was revealed to the facility by a member of the survey team, an updated dialysis form was immediately created, which includes a pre-dialysis access site assessment to be completed by the facility's licensed nurse prior to transfer, as well as to document the post-transfer/post-dialysis dialysis access site assessment/condition. This</p>	01/07/2015
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	<p>intact.</p> <p>The care plan, dated 11/14/14, indicated a focus problem as follows: "The resident needs dialysis hemo r/t [related to] renal failure." The interventions for this focus problem, included but were not limited to, "Monitor/document, report to MD PRN [as needed] any s/sx [signs/symptoms] of infection to access site: redness, swelling, warmth or drainage."</p> <p>Nursing notes, dated from 11/6/14 to 12/3/14, lacked any documentation of monitoring the access site or checking the dressing daily as stated in the care plan. The nursing notes lacked any documentation of assessment of the resident upon return from the dialysis center.</p> <p>The Medication Administration Record (MAR) and the Treatment Administration Record (TAR) for November 2014 and December 2014, lacked any guidance for monitoring the dialysis access site.</p> <p>Resident #32 had a physician order, dated 11/6/14, for dialysis on Tuesdays, Thursdays and Saturdays.</p> <p>During an interview on 12/5/14 at 11:17</p>		<p>form is to be utilized with each dialysis treatment.</p> <p>Identification of other residents having the potential to be affected by the same cited deficiency was accomplished by the following actions: Because all residents who receive dialysis outside of the facility are potentially affected by this cited deficiency, the same remedy will go into effect for them. All residents who receive dialysis outside the facility have been identified on 12/4/14.</p> <p>The following measures will be implemented to reduce the risk of future occurrences of the cited deficiency:</p> <ol style="list-style-type: none"> 1) The new form will be used for all residents who incur dialysis treatments out of the building beginning 12/5/2014. 2) Nursing staff was educated about the new form beginning on 12/4/14. 3) The licensed staff nurse will document a pre-dialysis and post-dialysis assessment on the resident's dialysis access on the form provided, or in the EMR. 4) A policy on the general care of a resident who receives 		

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	<p>a.m., the Corporate Director of Quality Assurance indicated the facility did not have a policy related to the care of dialysis residents.</p> <p>2. The clinical record for Resident #15 was reviewed on 12/3/14 at 10:39 a.m. Resident #15 had a diagnosis of depression.</p> <p>A health care plan focus, revised on 8/20/13, indicated Resident #15 used an antidepressant medication. Interventions for this focus included, but were not limited to, "assess the resident with any Minimal Data Set (MDS) [assessment] review for a gradual dose reduction."</p> <p>Resident #15 had a signed physician order for citalopram (an antidepressant medication) 20 milligrams (mg) by mouth daily. The original date of this order was 8/19/13.</p> <p>During an interview with the Care Plan Coordinator on 12/4/14 at 10:29 a.m., she indicated a gradual dose reduction had not been attempted for Resident #15 regarding her antidepressant medication. She indicated Resident #15 had been on an antidepressant medication since August of 2013.</p> <p>3. The clinical record for Resident #29 was reviewed on 12/3/14 at 12:35 P.M.</p>		<p>hemodialysis was developed, and was put into action on 12/8/2014, with formal written policy development and full inservice to licensed nursing staff regarding the care of the dialysis resident, dialysis form, and dialysis access assessment no later than January 7, 2015.</p> <p>5) These actions meet the care plan for resident #32, and were put in place 12/4/2014.</p> <p>6) Resident #32's care plan will be reviewed entirely by January 7, 2015.</p> <p>Regarding Gradual Dose Reduction Resident #15</p> <p>1) On 12/17/14, the behavior team met to review resident's medication regimen for psychoactive medications. At that time, the team recommended a dosage reduction of Celexa, which was subsequently approved by the MD. Currently, follow up monitoring of behaviors post medication reduction is occurring.</p> <p>Regarding Falls Resident #29</p> <p>To enhance currently compliant care the resident is receiving, the resident's care plan is reflective all of</p>				

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	<p>Diagnoses included, but was not limited to, orthostatic hypertension, non insulin dependent diabetes mellitus, history of hip fracture, and Alzheimer's disease.</p> <p>The most recent Minimum Data Set (MDS) assessment, dated 9/19/14, indicated the resident required extensive assistance of two staff members for bed mobility, transfers, ambulation and toileting, had a BIMS (Brief Interview of Mental Status) score of 12, and further indicated Resident #29 had highly impaired vision and hearing. The MDS indicated the resident wore glasses and a hearing aid and also indicated the resident was able to voice his/her own needs. The fall risk assessment dated 10/28/14, indicated the resident's fall risk score to be 29 (a high risk score). The previous fall risk assessment dated 9/22/14, indicated a falls risk score of 33 (high risk fall score).</p> <p>The care plan, dated 9/13/14, indicated the resident was at risk for falls. The care plan goal related to falls, indicated the goal for Resident #29 was to remain free of falls through the next review date.</p> <p>The interventions included, but were not limited to, place call light within reach, encourage resident to participate in activities, follow facility fall protocol, low bed, physical therapy to evaluate and</p>		<p>interventions currently in place to prevent falls 12/29/2014. To be noted is that a set of interventions was being consistently implemented and followed by the nursing staff, but was not reflective in the written plan of care.</p> <p>Regarding this tag in general:</p> <p>1) A policy on development and revision of care plans will be in place by January 7, 2015.</p> <p>2) Facility staff will be inserviced on the care plan policy, care plan development and implementation, and contribution to the care plan by January 7, 2015.</p> <p>3) The Care Plan Coordinator is responsible to ensure that care plans are up to date by all disciplines, per schedule, and prn, and that care plans are reflective of changes in resident care/condition. The Care Plan Coordinator should report any challenges or failures in this process to the DON and Administrator immediately.</p> <p>4) The DON/designee will randomly audit 5 care plans/week for updates reflective of care in the last 30 days, beginning week ending January 2, 2015, and will keep a</p>	

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	<p>treat as ordered or PRN (as needed), resident will use PBA (personal body alarm) while in wheelchair and in bed, and the resident will need activities that minimize the potential for falls while providing diversion.</p> <p>The care plan had not been updated since 9/13/14 and was not revised to include new fall prevention interventions after the record indicated falls on 9/21/14, 10/22/14 and 11/17/14.</p> <p>Falls risk assessment, dated 10/28/14, indicated interventions included, but were not limited to, staff to instruct resident not to self transfer, medication reviewed by physician, lay the resident down in bed after meals, position the resident in view of staff, encourage frequent rest periods, use side rails when resident is in bed, use personal body alarm when in bed or in wheelchair, low bed and facility staff is encouraged to place the resident in the recliner after meals.</p> <p>Resident #29 was observed on 12/2/14 at 11:15 A.M., seated in a wheelchair in the lounge area with eyes closed.</p> <p>Resident #29 was observed at 8:33 A.M. on 12/3/14, sitting in a wheelchair in the lounge area, eyeglasses in place and with</p>		<p>log of audits and any recommended changes. Weekly audits will continue through February, 2015, and then 5 care plans/month will be audited ongoingly.</p>				

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	<p>eyes closed.</p> <p>Resident #29 was observed on 12/04/14 at 8:28:19 A.M., sitting in a wheelchair in the lounge area, positioned 4 feet from the TV, watching TV with eyeglasses in place.</p> <p>During an interview on 12/2/14 at 9:51 A.M., LPN #3 indicated Resident #29 had fallen 2-3 weeks ago in the lounge area by sliding out of the wheelchair. LPN #3 further indicated no injuries occurred.</p> <p>During an interview on 12/04/14 at 9:38:31 A.M., LPN #3, indicated Resident #29 is legally blind and very hard of hearing. LPN #3 further indicated when past falls occurred, the resident was trying to get to the recliner located in the lounge area. LPN #3 indicated the interventions in place to prevent falls, included the resident using the recliner while in the lounge area, taking the resident to bed when he/she was tired, and taking the resident to the restroom promptly when needed. LPN #3 indicated the resident felt alone at times, despite having someone next to him, due to his/her visual impairment. LPN #3 indicated the staff tried to include him/her in activities when possible and when the resident was</p>			

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F000309 SS=D	<p>interested in the activity.</p> <p>Falls reports received from the Director of Nursing (DON), on 12/3/14 at 3:00 P.M., indicated the resident had falls on 9/21/14, 10/22/14 and 11/17/14.</p> <p>During an interview on 12/5/14 at 11:17 A.M., the Quality Assurance nurse indicated the facility did not have a policy for the following of care plan interventions or a policy for the revising of care plans.</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 observation, interview, and record review, the facility failed to assess the dialysis access and facilitate communication with the dialysis center for 1 of 1 residents reviewed for dialysis (Resident #32).</p> <p>Findings include:</p>	F000309	<p><u>F309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</u></p> <p>Immediate actions taken for resident #32: On 12/5/14, when this issue was revealed to the facility by a member of the survey team, an updated dialysis form was created</p>	01/07/2015

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	<p>The clinical record for Resident # 32 was reviewed on 12/3/14 at 8:33 a.m. Diagnoses included, but were not limited to, pneumonia, dysphagia, constipation, end stage renal disease, diabetes uncontrolled, anemia, chronic pain and atrial fibrillation.</p> <p>Resident #32 had a physician order, dated 11/6/14, for dialysis Tuesdays, Thursdays and Saturdays.</p> <p>Nursing notes, dated from 11/6/14 to 12/3/14, lacked any documentation of monitoring of the access site or checking the dressing daily as stated in the care plan. The nursing notes lacked any documentation of assessment of the resident upon return from the dialysis center.</p> <p>The Medication Administration Record (MAR) and the Treatment Administration Record (TAR) for November 2014 and December 2014, lacked any guidance for monitoring the dialysis access site.</p> <p>The dialysis communication book was reviewed on 12/3/14 at 1:21 p.m. The book contained five pre and post dialysis communication forms: 11/13/14, which was completed, 11/18/14, which had no post dialysis information, 11/20/14,</p>		<p>immediately, which included the following components: Facility contact information; resident's pre-transfer vital signs (blood pressure, pulse, respirations, temperature), last glucose (if applicable) and weight. In addition, other components include changes since last dialysis visit for: medical condition, functional status, and medications, any swallowing or dietary concerns, behavior concerns or acute concerns. Also, for report, any medications given prior to the dialysis treatment for the day, as well as a dialysis access site assessment, if a meal was sent with the resident to dialysis, and a copy of any facility drawn labs if available. This form was sent with the resident to dialysis. In addition, on 12/5/ at 2:10 p.m., the DQA called the dialysis unit to inform them of the new form, its purpose, and for the need for the dialysis team to complete their portion of the form and send back with the resident to the facility. Lastly, when the resident returns from dialysis, the form is to be used to document the post-transfer/post-dialysis vital signs (blood pressure, pulse, respirations, temperature) along with resident general condition, and the dialysis</p>		

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	<p>which had no post dialysis information, 11/24/14, which had no post dialysis information and 12/2/14, which was complete. No dialysis communication forms were provided for 11/8/14, 11/11/14, 11/13/14, 11/15/14, 11/27/14 or 11/29/14. Resident #32 was admitted to the facility on 11/6/14.</p> <p>During an observation on 12/3/14 at 1:18 p.m., LPN #21 was observed placing papers into a three ring binder. The binder was then presented by LPN #21 as the dialysis communication book for Resident #32.</p> <p>During an interview on 12/3/14 at 1:20 p.m., LPN #21 indicated she just found the forms in the resident's room. Resident #32 had been keeping the forms in a bag because the resident did not know she was to return the forms to the facility.</p> <p>During an interview on 12/5/14 at 11:17 a.m., the Corporate Director of Quality Assurance indicated the facility did not have a policy related to the care of dialysis residents.</p> <p>The dialysis contract entitled "SNF Outpatient Dialysis Services Agreement" was provided by the Administrator on 12/1/14 at 11:15 a.m. The agreement</p>		<p>access site assessment/condition. This form is to be utilized with each dialysis treatment.</p> <p>Identification of other residents having the potential to be affected by the same cited deficiency was accomplished by the following actions: Because all residents who receive dialysis outside of the facility are potentially affected by this cited deficiency, the same remedy will go into effect for them. All residents who receive dialysis outside the facility have been identified on 12/5/14.</p> <p>The following measures will be implemented to reduce the risk of future occurrences of the cited deficiency:</p> <p>1) The new form will be used for all residents who incur dialysis treatments out of the building beginning 12/4/2014.</p> <p>2) Nursing staff was educated about the new form beginning 12/4/14.</p> <p>3) The licensed staff nurse will monitor the return/availability/completion of the forms from the dialysis unit for each visit, and will communicate with the dialysis facility as needed. Also, the</p>				

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	<p>indicated the following: "A. Obligations of Nursing Facility and/or Owner...</p> <p>2. Interchange of Information. The Nursing facility shall provide for the interchange of information useful or necessary for the care of the ESRD [end stage renal disease] Residents, including a Registered Nurse as a contact person at the Nursing Facility whose responsibilities include oversight of provision of Services to the ESRD Residents....</p> <p>B. Obligations of the ESRD Dialysis Unit and/or Company...</p> <p>1. Standards of ESRD Dialysis Unit...</p> <p>D. To provide to the Nursing Facility information on all aspects of the management of the ESRD Resident's care related to the provision of Services, including directions on management of medical and non-medical emergencies, including, but not limited to, bleeding, infection, and care of dialysis access site."</p> <p>3.1-37(a)</p>		<p>nursing staff should report to the DON/designee if there is a problem with documentation or receipt of documentation from the dialysis facility. The documentation of the dialysis site upon return to the facility will be monitored audited by the DON/designee for 100% of visits for residents who receive dialysis outside of the facility, beginning Monday, December 29, 2014, and a weekly recap will be given to the Administrator, by the DON/designee beginning the week ending Friday, January 2, 2015. This close monitoring will be completed through January 30, 2015, when twice weekly monitoring for 100% of residents who incur dialysis outside of the facility will commence with the same format and criteria as described by the DON/designee, with a weekly report given to the Administrator. This monitoring will occur ongoingly through March 31, 2015. Beginning April 1, 2015, one dialysis visit per week for 100% residents who incur dialysis outside the facility will be monitored ongoingly, by the DON/designee, and a monthly report given to the administrator of the status of this issue.</p>		

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F000323 SS=D	<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.</p> <p>Based on observation, interview and record review, the facility failed to utilize the interventions in place to prevent falls for 1 of 3 residents reviewed in a sample of 8 who met the criteria for falls. (#29)</p> <p>Findings include:</p> <p>1. During an interview on 12/2/14 at 9:51 A.M., LPN #3 indicated Resident #29 had fallen 2-3 weeks ago in the lounge area by sliding out of the wheelchair. LPN #3 further indicated no injuries occurred.</p>	F000323	<p>4) A policy on the general care of a resident who receives hemodialysis was developed, and was put into action on 12/8/2014, with formal written policy development and full inservice to licensed nursing staff regarding the care of the dialysis resident, dialysis form, and dialysis access assessment no later than January 7, 2015.</p> <p><u>F323 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</u></p> <p>It is the intention of this facility to provide an environment free of accident hazards, with supervision and devices utilized to enhance compliance in this area. A falls prevention program is currently in place, with components that include risk assessment and individualized prevention interventions, as well as consistent review of any fall-type event.</p>	01/07/2015
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	<p>The clinical record for Resident #29 was reviewed on 12/3/14 at 12:35 P.M. Diagnoses included, but were not limited to, orthostatic hypertension, non insulin dependent diabetes mellitus, history of hip fracture, and Alzheimer's disease. The most recent Minimum Data Set (MDS) assessment, dated 9/19/2014, indicated the resident required extensive assistance of two staff members for bed mobility, transfers, ambulation, and toileting; had a BIMS (Brief Interview of Mental Status) score of 12, and further indicated Resident #29 had highly impaired vision and hearing. The MDS indicated the resident wore glasses and a hearing aid and also indicated the resident was able to voice his/her own needs. The fall risk assessment dated 10/28/14, indicated the resident's fall risk score to be 29 (a high risk score). The previous fall risk assessment dated 9/22/14, indicated a falls risk score of 33 (high risk fall score).</p> <p>The care plan, dated 9/13/14, indicated the resident was at risk for falls. The care plan goal related to falls, indicated the goal for Resident #29 was to remain free of falls through the next review date. The interventions included, but were not limited to, place call light within reach, encourage resident to participate in</p>		<p>Immediate actions taken for resident #29: When 2567 arrived to facility, and specifics were revealed about this resident, his care plan related to fall prevention measures was reviewed.</p> <p>Identification of other residents having the potential to be affected by the same cited deficiency was accomplished by the following actions: All persons admitted to the facility undergo a 72 hour observation period to ascertain their risk for falls, in addition to an admission fall risk assessment being completed within 24 hours of admission. Residents currently residing in the facility are monitored in general for risky behaviors, and nurses have the liberty to place a personal alarm on the bed or chair at their discretion. They are to notify the MD and secure an order for the alarm as a secondary action, with the first intention for the resident to be safe.</p> <p>The following measures will be implemented to reduce the risk of future occurrences of the cited deficiency:</p> <p>1) To enhance currently compliant care the resident is receiving, resident #29's care</p>				

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	<p>activities, follow facility fall protocol, low bed, physical therapy to evaluate and treat as ordered or PRN (as needed), resident will use PBA (personal body alarm) while in wheelchair and in bed, and the resident will need activities that minimize the potential for falls while providing diversion.</p> <p>The care plan had not been updated since 9/13/14.</p> <p>Falls reports received from the Director of Nursing (DON), on 12/3/14 at 3:00 P.M., indicated the resident fell on 9/21/14, 10/22/14 and 11/17/14.</p> <p>A fall report, dated 9/21/14, indicated the resident was in a wheelchair in his/her room, slid out of the wheelchair onto his/her buttocks on to the floor, the fall was witnessed by the facility staff, resident's personal body alarm was in place. The report further indicated the resident was attempting to use the bathroom without assistance, no injuries were received, and the physician and the resident's family were notified.</p> <p>A fall report, dated 10/22/14, indicated the resident was in the lounge area sitting in a wheelchair, the resident leaned forward out of the wheelchair, fell to his/her knees, and then rolled onto his/her</p>		<p>plan is reflective all of interventions currently in place to prevent falls 12/29/2014, and the interventions have been communicated to facility staff, 12/29/14.</p> <p>2) A new process and form has been created in regards to the fall report. If a resident should fall, a quick root cause analysis will be done after the resident is stabilized. This root cause analysis method is called the "5 WHYS", and will be performed by the nurse and will involve other staff that may be present which could include any staff member. As a minimum requirement, at least 2 people will need to be involved in the root cause analysis questions. The addition of an initial root cause analysis will be incorporated onto the fall report, which is a paper form, separate from the EMR charting. Every business day (Monday through Friday, excluding holidays), the falls from the preceding day(s) will be reviewed by a multidisciplinary team, and changes in the resident's plan of care may be made. Minutes will be kept from this meeting, and the ADON or designee will be responsible to conduct the meeting and lead the fall review. The daily fall meeting</p>		

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	<p>left side/shoulder. The fall was witnessed by the facility staff, the resident's personal body alarm was in place, no injuries were received, and the physician and the resident's family were notified.</p> <p>A fall report dated 11/17/14, indicated the resident was in the lounge area sitting in a wheelchair, slid out of the wheelchair onto the floor. The fall was witnessed by the facility staff, the resident's personal body alarm was in place, the resident received an injury to his/her right elbow, Nurse Practitioner #1 was notified, new orders were received for treatment of the injury, and the resident's family was notified.</p> <p>Reviewed falls risk assessment, dated 10/28/14, indicated the interventions included but were not limited to, staff to instruct resident not to self transfer, medication reviewed by physician, lay the resident down in bed after meals, position the resident in view of staff, encourage frequent rest periods, use side rails when resident is in bed, use personal body alarm when in bed or in wheelchair, low bed and facility staff is encouraged to place the resident in the recliner after meals.</p> <p>Resident #29 was observed on 12/2/14 at</p>		<p>began on 12/12/14. The 5 WHYs methodology post fall will begin January 7, 2015.</p> <p>3) A new fall policy will be created that encompasses the changes detailed, and will be available January 7, 2015.</p> <p>4) Facility staff in all departments (nursing, housekeeping, maintenance, ancillary, dietary, administration and therapy) will be inserviced regarding the change in process and policy by January 7, 2015.</p> <p>5) The fall report paperwork will be reviewed by ADON/designee and if corrections in process need to occur, the ADON/designee will reach out to the staff involved within 1 business day to re-educate/coach them in the process.</p> <p>6) The new fall process, policy and paperwork will be placed in the nursing and nurse aide communication book for easy reference by January 7, 2015.</p> <p>7) A weekly summary of falls will be prepared by the ADON/designee, and submitted to the DON/Administrator for review. This weekly summary will begin with the week ending</p>		

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	<p>11:15 A.M., seated in a wheelchair in the lounge area with eyes closed.</p> <p>Resident #29 was observed at 8:33 A.M. on 12/3/14, sitting in a wheelchair in the lounge area, eyeglasses in place, and with eyes closed.</p> <p>Resident #29 was observed on 12/04/14 at 8:28:19 A.M., sitting in a wheelchair in the lounge area, positioned 4 feet from the TV, watching TV with eyeglasses in place.</p> <p>On 12/04/14 at 9:38:31 A.M. spoke with LPN #3, who indicated Resident #29 is legally blind and very hard of hearing. LPN #3 further indicated when past falls have happened, the resident was trying to get to the recliner located in the lounge area. LPN #3 indicated the interventions in place to prevent falls, included the resident using the recliner while in the lounge area, taking the resident to bed when he/she was tired, and taking the resident to the restroom promptly when needed. LPN #3 indicated the resident felt alone at times, despite having someone next to him, due to his/her visual impairment. LPN #3 indicated the staff tried to include him/her in activities when possible and when the resident was interested in the activity.</p>		<p>January 3, 2015.</p> <p>8) The DON/designee is responsible to audit up to 2 resident's falls each week, to ensure compliance with process. This audit will commence week ending January 3, 2015. Results will be forwarded to the Administrator each week.</p>				

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F000329 SS=D	<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 observation, interview, and record review, the facility failed to monitor and track behaviors to ensure efficacy, lowest possible dose, or continued need for psychoactive medications for 2 of 5 residents reviewed for unnecessary medications. (#69, #15)</p> <p>Findings include:</p>	F000329	<p><u>F329 DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</u></p> <p>It is the intention of the facility that residents' drug regimen is free from unnecessary drugs and that each medication be supported by an appropriate diagnosis/condition. It is also the intention that nursing, social services and the</p>	01/07/2015			

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	<p>1. On 12/2/14 at 9:00 a.m., on 12/3/14 at 10:00 a.m., on 12/4/14 at 10:35 a.m., on 12/4/14 at 11:30 a.m., on 12/5/14 at 8:17 a.m., and on 12/5/14 at 9:30 a.m., Resident #69 was observed lying in bed with eyes closed.</p> <p>During an interview on 12/4/14 at 10:35 a.m., LPN #11 indicated Resident #69 had been sleeping during the day and up all night. She indicated this was considered a behavior of this resident, and it should have been monitored on the behavior log in the medication administration record or in the computer.</p> <p>During an interview on 12/5/14 at 9:30 a.m., LPN #11 indicated behaviors were tracked on the "Behavioral Assessment (For New or Worse Behaviors) form. The LPN #11 indicated the behavioral forms were reviewed for patterns by the Social Service staff and addressed at the behavior meetings. LPN #11 indicated Resident #69's sleep pattern should have been tracked as a behavior in December 2014.</p> <p>Resident #69 's clinical record was reviewed on 12/4/14 at 11:00 a.m. Resident #69's diagnoses included, but were not limited to, anxiety, senile dementia with delusional features, and insomnia.</p>		<p>pharmacy consultant work together to ensure that resident medication regimens are appropriate. While all medications are important, special attention shall be given to psychoactive medications for the remedy.</p> <p>Immediate actions taken for resident #69: None. The resident was discharged on 12/6/2014, during the survey process. When the 2567 was ready, and identified the specific issues for the resident, she was not present in the facility any longer.</p> <p>Immediate actions taken for resident #15: On 12/17/14, the behavior team met to review resident's medication regimen for psychoactive medications. At that time, the team recommended a dosage reduction of Celexa, which was subsequently approved by the MD. Currently, follow up monitoring of behaviors post medication reduction is occurring.</p> <p>Identification of other residents having the potential to be affected by the same cited deficiency was accomplished by the following actions:</p> <p>The behavior management team has chosen to meet</p>	

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	<p>The physician's order on June 13, 2014 indicated to increase Abilify (an anti-psychotic medication) to 5 mg daily related to a "decline in activities in daily living, inability to express self and sad facial expression."</p> <p>The "BEHAVIOR/INTERVENTION MONTHLY FLOW RECORD" for May 2014 and June 2014 indicated behaviors tracked were depression and anxiety. The record did not indicate the behaviors occurred.</p> <p>The pharmacist's "Note to Attending Physician/Prescriber" recommendation, dated June 24, 2014, indicated a recommendation to increase Lexapro (antidepressant) 10 mg daily and decrease Abilify from 5 mg to 2 mg. "The Abilify can contribute to decline in activities daily living and contributes to falls and lethargy [pathological state of sleepiness]." Physician on unidentified date disagreed with the recommendation and indicated Resident #69 was "much better on Abilify increase." The behavioral data indicated no anxiety/depression symptoms reported prior to the increased Abilify dose, and indicated anxiety occurred one time in July 2014 and once in October of 2014 after the medication was increased.</p>		<p>weekly (beginning 12/16/14) to review as many resident's drug regimens specific to psychoactive medications, until a total of at least 60 resident medication regimens have been reviewed.</p> <p>The following measures will be implemented to reduce the risk of future occurrences of the cited deficiency:</p> <p>1) A meeting with the pharmacy regarding concerns about the consultant pharmacist's job performance was completed on December 9, 2014. At that time, the facility requested a new pharmacy consultant be put in place immediately, and laid out specific requests, including the fact that weekly behavior meetings would need to occur beginning December 16, 2014, and that the pharmacy consultant would be expected to attend each behavior meeting from December 16, 2014 forward. This meeting was conducted by the DQA with the DON in attendance. The pharmacy agreed to these conditions, and the conditions were fulfilled on time.</p> <p>2) The behavior team (which includes the consulting pharmacist) will meet weekly through mid-January (until at</p>		

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	<p>The "BEHAVIOR/INTERVENTION MONTHLY FLOW RECORD" for July 2014 indicated behaviors tracked were depression, anxiety, and delusions. The record indicated anxiety was present on 7/22/14 with 1 on 1 staffing as an effective intervention.</p> <p>The "BEHAVIOR/INTERVENTION MONTHLY FLOW RECORD" for August 2014 identified behaviors tracked were depression, anxiety, and delusions. The record did not indicate behaviors occurred.</p> <p>The "BEHAVIOR/INTERVENTION MONTHLY FLOW RECORD" for September, 2014 indicated behaviors tracked were depression and anxiety. The record indicated no tracked behaviors occurred.</p> <p>The "BEHAVIOR/INTERVENTION MONTHLY FLOW RECORD" for October, 2014 indicated behaviors tracked were depression and anxiety. The record indicated one episode of anxiety on 10/1/14. The record indicated redirection, 1 on 1, and return to room were effective interventions..</p> <p>The "BEHAVIOR/INTERVENTION MONTHLY FLOW RECORD" for</p>		<p>least 60 resident medication regimens have been reviewed as stated). Minutes will be kept for the meetings, including pharmacy recommendations about psychoactive medications and team recommendations regarding medications.</p> <p>3) The behavior team (which includes the consulting pharmacist) will meet biweekly after the 60 resident threshold is met, for 4 meetings, and then the behavior team will meet monthly to review resident's drug regimens specific to psychoactive medications. The Social Services Director and ADON will be jointly responsible to ensure that residents are reviewed and that residents who have alterations in drug regimens are re-reviewed for therapeutic effect on a timely basis.</p> <p>4) Any concerns regarding the pharmacy consultant will be reported immediately to the Administrator/designee for swift action.</p> <p>5) Residents who are on psychoactive medications will have drug regimens reviewed by the behavior management team (which includes a consultant pharmacist), specifically to psychoactive</p>		

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	<p>November, 2014 indicated behaviors tracked were depression, agitation, and insomnia. The record did not indicate behaviors occurred.</p> <p>The "BEHAVIOR/INTERVENTION MONTHLY FLOW RECORD" for December 1-5, 2014 indicated behaviors tracked were anxiety and delusions. The record did not indicate behaviors occurred.</p> <p>2. The clinical record for Resident #15 was reviewed on 12/3/14 at 10:39 a.m. Diagnoses for Resident #15 included, but were not limited to, depression, congestive heart failure and anemia.</p> <p>Resident #15 had a signed physician order for citalopram (an antidepressant medication) 20 milligrams (mg) by mouth daily. The original date of this order was 8/19/13.</p> <p>During an interview with the Care Plan Coordinator on 12/4/14 at 10:29 a.m., she indicated a gradual dose reduction had not been attempted for Resident #15 regarding her antidepressant medication. She indicated Resident #15 had been on an antidepressant medication since August of 2013.</p> <p>During an interview with the Pharmacy Consultant on 12/4/14 at 3:07 p.m., she</p>		<p>medication use, at least twice per 12 month period.</p> <p>6) The DON and Administrator are ultimately responsible for the psychoactive drug management program in the facility.</p>				

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	<p>indicated she had started reviewing the medications for Resident #15 in October of 2014. She indicated she had the records/recommendations from the previous pharmacy reviews for Resident #15 available to her. She indicated a gradual dose reduction had not been recommended for Resident #15 in any of the previous pharmacy recommendations. She further indicated she should have made a recommendation for a gradual dose reduction for Resident #15's antidepressant medication in October of 2014.</p> <p>During an interview with the Social Services Supervisor on 12/5/14 at 8:30 a.m., she indicated they were depending on pharmacy recommendations for gradual dose reductions and not tracking the need for gradual dose reductions themselves.</p> <p>Review of the current, undated facility policy, titled "GRADUAL DOSE REDUCTIONS FOR PSYCHOTROPIC MEDICATIONS", found on the table on 12/5/14 at 8:41 a.m., included, but was not limited to, the following:</p> <p>"Gradual dose reductions for anti-psychotic, anti-depressants, anxiolytics, and mood stabilizing medications will be evaluated twice the</p>			

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F000371 SS=F	<p>first year. The attempts to reduce the medication will be in two separate quarters, with at least one month in between attempts, then annually thereafter...."</p> <p>3.1-48(b)(2)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to store, prepare and serve food under sanitary conditions for 74 of 74 residents who received meals prepared in the facility kitchen.</p> <p>Findings include: During the initial kitchen tour on 12/3/14 at 9:28 a.m., with the Dietary Manager, the following concerns were observed: visible dust in vents, floor soiled with dark sticky substance, black debris noted along the base boards and brown powdered substance under the ice machine.</p>	F000371	<p><u>F371 FOOD PROCURE, STORE/PREPARE/SERVE-SANI TARY</u></p> <p>It is the intention of this facility to store, prepare, distribute and serve food under sanitary conditions.</p> <p>Immediate actions were taken for this cited deficiency as soon as the member of the survey team notified the facility of concerns about multiple issues in the kitchen. Actions taken during the afternoon/evening of 12/3/14 and day of 12/4/14 included the following:</p> <p>1. All kitchen walls were</p>	01/07/2015	

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	<p>During an interview on 12/3/14 at 9:28 a.m., the Dietary Manager indicated the floors were cleaned at night. She also indicated the cleaning was done by schedule.</p> <p>Review of the November 2014, 6:00 a.m. to 2:30 p.m., cleaning schedule indicated the following: 11/6/14, no cleaning documented, 11/10/14, no cleaning documented, 11/15/14, no cleaning documented, 11/16/14, no cleaning documented, 11/20/14, no cleaning documented. The cleaning on this schedule included "wipe down dish machine, wipe down juice machine, clean under the shelves of the juice machine, clean tray caddy and wheels, clean short prep table, clean and fill juice dispenser, clean small metal carts, clean back door and knob, sweep and mop dish room, wash the walls of the dish area and clean hall covers, and trash cans."</p> <p>Review of the November 2014, a.m. "Cook cleaning schedule", indicated the following: 11/24 through 11/28/14, no cleaning documented. The cleaning on this schedule included "clean the bottom of the steamtable, drain and refill steamtable, wipe down wall beside steamtable, clean toaster, clean kitchen sink, clean cereal cart, clean grill stovetop and drip pans, sweep kitchen</p>		<p>washed.</p> <ol style="list-style-type: none"> 2. All kitchen ceiling light fixtures were cleaned. 3. All kitchen electric outlets were cleaned. 4. All vents in the kitchen were cleaned. 5. All kitchen trash cans were cleaned inside and outside. 6. All large and small kitchen appliances were cleaned. 7. All metal racks in the kitchen were cleaned. 8. All tables in the kitchen were cleaned. 9. All doors in the kitchen were washed. 10. All door frames in the kitchen were washed. 11. All baseboards in the kitchen were washed. 12. All items on the kitchen wall were cleaned. 13. The entire salad bar was cleaned internally and externally. 	

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	<p>and mop kitchen."</p> <p>Review of the November 2014, 12:00 p.m. to 7:30 p.m. cleaning schedule indicated the following: "Wipe down wall behind steamtable" was not documented as completed from 11/24/14 through 11/30/14. On 11/25/14, the following areas had no documentation of having been completed: cleaning of the cook table, kitchen mopped and swept, slicer table cleaned, microwave cart cleaned, towels and aprons taken to laundry, the outside of the plate warmer cleaned, the inside of the dry ingredient bins wiped, the store room cleaned and mopped and the filling of the pantry. On 11/29/14 through 11/30/14, no cleaning was documented. The cleaning on this schedule included "clean hall carts/covers, straighten drawers prep table, clean long prep table, wipe down back of steamtable, check lids on storeroom containers, clean small metal carts, wipe down bus carts, clean and fill milk dispenser, clean front freezer and refrigerator."</p> <p>During an interview on 12/5/14 at 9:23 a.m., the Dietary Manager and the Housekeeping Manager indicated the kitchen floors were on a cleaning schedule. The Housekeeping Manager indicated a housekeeping staff member</p>		<p>14. All outgoing and incoming food carts were cleans.</p> <p>15. All kitchen floors were scrubbed, stripped and waxed.</p> <p>16. All kitchen sinks were cleaned.</p> <p>Identification of other residents having the potential to be affected by the same cited deficiency was accomplished by the following actions: The facility identified that all residents and staff and visitors who consume food from the kitchen have the potential for effects of this cited deficiency.</p> <p>The following measures will be implemented to reduce the risk of future occurrences of the cited deficiency:</p> <p>1) A job specific cleaning schedule has been developed for all job positions in the kitchen. Each day, the person working that particular position is responsible to complete the cleaning duties for the kitchen. New forms have been created to record completed cleaning. The dietary manager/designee is responsible to check the cleaning logs each day x 30 days (January 1-30, 2015), then twice per week through February 28, 2015, then weekly, immediately correcting any</p>				

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	<p>cleaned the kitchen floors at night to include stripping and she would inspect it the following morning. There was no set schedule for the floors to be cleaned and stripped at night. She also indicated the floors had last been stripped and cleaned 10/16/14.</p> <p>During an interview on 12/5/14 at 9:23 a.m., the Dietary Manager indicated the cleaning of the kitchen was on a schedule and kitchen staff initialed each area when completed. The cleaning schedule for the past 30 days was requested and reviewed.</p> <p>A policy dated 3/1987, titled "Sanitizing Floors", indicated the following: "Policy: Floors will be cleaned and sanitized on a regular basis. Procedure: How: 1. Sweep the floor and remove any sticky or gummy material...."</p> <p>3.1-21(i)(3)</p>		<p>deficiency on the spot. The dietary manager is ultimately responsible for the cleaning of the kitchen.</p> <p>2) A floor care schedule will be created, published, and adhered to by the housekeeping staff, and this adherence will be ensured by the Housekeeping Supervisor. This schedule will be published by January 7, 2015.</p> <p>3) The Housekeeping Supervisor and the Dietary Manager will round in the kitchen twice per month, beginning in January, with their first rounding to be completed no later than January 7th, 2015, whereby they will together establish any collaborative remedies needed. They will submit a written report to the Administrator about their findings/remedies within 1 business day after their rounds.</p> <p>4) The Administrator will make weekly rounds in the kitchen, using a checklist. These rounds will begin the week ending January 2, 2015.</p> <p>5) The Administrator will randomly spot check the dietary cleaning schedules at least twice per week, beginning</p>		

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F000428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>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 ensure the pharmacy consultant made recommendations for a gradual dose reduction of a psychoactive medication for 1 of 5 residents reviewed for pharmacy recommendations. (Resident #15)</p> <p>Findings include:</p> <p>The clinical record for Resident #15 was reviewed on 12/3/14 at 10:39 a.m. Diagnoses for Resident #15 included, but</p>	F000428	<p>with the week ending January 2, 2015.</p> <p>6) In addition, services with the Consulting Dietician will remain intact, with special emphasis on the cited deficiency, beginning with her January, 2015 visit and continuing through the entire 1st quarter of the 2015, and then as a routine part of her visit thereafter.</p> <p><u>F428 DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</u></p> <p>It is the intention of this facility to ensure that the pharmacy consultant is reviewing psychoactive medications our residents receive, at least twice per year, in addition to reviewing resident medication regimens as required and as needed. Because of this intention, the pharmacy consultant that was assigned</p>	01/07/2015

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	<p>were not limited to, depression, congestive heart failure and anemia.</p> <p>Resident #15 had a signed physician order for citalopram (an antidepressant medication) 20 milligrams (mg) by mouth daily. The original date of this order was 8/19/13.</p> <p>During an interview with the Pharmacy Consultant on 12/4/14 at 3:07 p.m., she indicated she had started reviewing the medications for Resident #15 in October of 2014. She indicated she had the records /recommendations from the previous pharmacy reviews for Resident #15 available to her. She indicated a gradual dose reduction had not been recommended for Resident #15 in any of the previous pharmacy recommendations. She further indicated she should have made a recommendation for a gradual dose reduction for Resident #15's antidepressant medication in October of 2014.</p> <p>Review of the current facility policy, dated 1/2007, titled "CONSULTANT PHARMACIST SERVICES PROVIDER REQUIREMENTS", provided by the Assistant Director of Nursing on 12/5/14 at 9:10 a.m., included but was not limited to, the following:</p>		<p>to this facility has been replaced by another, who is agreeable to be available for collaborative meetings regarding psychoactive medication, and consistent review of medication regimens for our residents.</p> <p>Immediate actions taken for resident #15: On 12/17/14, the behavior team met to review resident's medication regimen for psychoactive medications. At that time, the team recommended a dosage reduction of Celexa, which was subsequently approved by the MD. Currently, follow up monitoring of behaviors post medication reduction is occurring.</p> <p>Identification of other residents having the potential to be affected by the same cited deficiency was accomplished by the following actions: The behavior management team, which includes the consultant pharmacist, has chosen to meet weekly (beginning 12/16/14) to review as many resident's drug regimens specific to psychoactive medications, until a total of at least 60 resident medication regimens have been reviewed.</p> <p>The following measures will be implemented to reduce the risk</p>				

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	"...C. the consultant pharmacist agrees to render the required service in accordance with local, state, and federal laws, regulations, and guidelines; facility policies and procedures; community standards of practice; and professional standards of practice...." 3.1-25(i)		of future occurrences of the cited deficiency: 1) A meeting with the pharmacy regarding concerns about the consultant pharmacist's job performance was completed on December 9, 2014. At that time, the facility requested a new pharmacy consultant be put in place immediately, and laid out specific requests, including the fact that weekly behavior meetings would need to occur beginning December 16, 2014, and that the pharmacy consultant would be expected to attend each behavior meeting from December 16, 2014 forward. This meeting was conducted by the DQA with the DON in attendance. The pharmacy agreed to these conditions, and the conditions were fulfilled on time. 2) The behavior team (which includes the consulting pharmacist) will meet weekly through mid-January (until at least 60 resident medication regimens have been reviewed as stated). Minutes will be kept for the meetings, including pharmacy recommendations about psychoactive medications and team recommendations regarding medications.		

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			<p>3) The behavior team (which includes the consulting pharmacist) will meet biweekly after the 60 resident threshold is met, for 4 meetings, and then the behavior team will meet monthly to review resident's drug regimens specific to psychoactive medications. The Social Services Director and ADON will be jointly responsible to ensure that residents are reviewed and that residents who have alterations in drug regimens are re-reviewed for therapeutic effect on a timely basis.</p> <p>4) Any concerns regarding the pharmacy consultant will be reported immediately to the Administrator for swift action and can be reported by ANY member of the behavior management team, or any others with concerns.</p> <p>5) Residents who are on psychoactive medications will have drug regimens reviewed by the behavior management team (which includes a consultant pharmacist), specifically to psychoactive medication use, at least twice per 12 month period.</p> <p>6) The Administrator is ultimately responsible for ensuring that the pharmacy consultant is performing in</p>		

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F009999	<p>STATE RULE:</p> <p>3.1-14 Personnel (s) Professional staff must be licensed, certified, or registered in accordance with applicable state laws or rules.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure 1 of 44 CNA's working had a current CNA certificate. This deficient practice had the potential to affect 74 of 74 residents residing in the facility.</p> <p>Findings include:</p> <p>The employee records review was completed on 12/5/14 at 10:00 a.m. The records indicated CNA #22's Nurse Aide Certification had expired on 10/10/14.</p> <p>CNA #22's time cards were provided by the Corporate Director of Quality Assurance on 12/8/14 at 2:17 p.m. The time cards indicated the CNA worked in October, 2014, on the 13th, 14th, 16th,</p>	F009999	<p>accordance with the pharmacy agreement.</p> <p><u>F9999 Final observations</u></p> <p>It is the policy of the facility to employ professional staff that are licensed, certified or registered in accordance with applicable state laws or rules. Unfortunately, due to personnel change, there was one situation where this policy was not consistently met.</p> <p>Immediate actions taken as soon as the survey team member brought this to the facility's attention included:</p> <p>1) Notification of the Certified Nurse Aide concerned of a lapse in her Certified Nurse Aide registration.</p> <p>2) Certified Nurse Aide came right to the facility, paid her registrant fee online, and came into immediate compliance with registry certification in Indiana in good standing within an hour.</p> <p>3) An audit was immediately completed of all employed Certified Nurse Aides and Licensed Nurses for the</p>	01/07/2015			

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	<p>17th, 18th, 19th, 20th, 21st, 22nd, 23rd, 24th, 27th, 28th, 30th and 31st. CNA #22 worked 15 days in October with an expired Nurse Aide certificate.</p> <p>The time cards indicated CNA #22 worked in November, 2014, on the 1st, 2nd, 5th, 6th, 7th, 10th, 11th, 13th, 14th, 15th, 16th, 18th, 19th, 20th, 21st, 24, 25th, 27th, 28th, 29th, and 30th. CNA #22 worked 21 days in November with an expired Nurse Aide certificate.</p> <p>The time cards indicated CNA #22 worked in December, 2014, on the 2nd, 3rd and 4th with an expired Nurse Aide certificate. The CNA worked a total of 39 days with an expired Nurse Aide certificate.</p> <p>During the exit conference on 12/8/14 at 2:17 p.m., the Corporate Director of Quality Assurance indicated a previous employee always made sure licenses and certificates were current and when that employee left no one had taken over the responsibility.</p> <p>3.1-14(s)</p>		<p>facility, and none were found to be non-compliant with their licensure, registry or certification. This audit was completed within an hour of the verbal finding from the survey team.</p> <p>Identification of other residents having the potential to be affected by the same cited deficiency was accomplished by the following actions: It is the determination of the facility that all residents who were admitted to building during the certification lapse could have been potentially affected, but there no was no actual harm done, and no incident with the certified nurse aide during the time the certification fee was not paid.</p> <p>The following measures will be implemented to reduce the risk of future occurrences of the cited deficiency:</p> <p>1) Certification/registry/licensure will be verified prior to employment in the facility.</p> <p>2) The front office assistant will be responsible to track ongoing licensure/registry/certification dates, and notify the staff affected by the first week of the month prior to the month that</p>		

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			<p>the licensure/registry/certification expires.</p> <p>3) Ultimately each individual with a license/registry/certification is responsible to maintain said criteria. This information will be communicated to facility staff in an inservice, and in writing, by January 7, 2015.</p> <p>4) The Administrator is ultimately responsible to ensure that only staff that have current licensure/registry/certifications are actively employed and working in the facility.</p> <p>-</p>		