

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155294	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/22/2014
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NAME OF PROVIDER OR SUPPLIER FORUM AT THE CROSSING	STREET ADDRESS, CITY, STATE, ZIP CODE 8505 WOODFIELD CROSSING BLVD INDIANAPOLIS, IN 46240
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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 IN00142222</p> <p>Survey dates: January 14, 15, 16, 17, 21 & 22, 2014</p> <p>Facility number: 000191 Provider number: 155294 AIM number: N/A</p> <p>Survey team: Gloria Bond, RN Team Coordinator Janet Stanton, RN Michelle Hosteter, RN Sandra Nolder, RN</p> <p>Census bed type: SNF: 54 Residential: 24 Total: 78</p> <p>Census payor type: Medicare: 27 Other: 51 Total: 78</p> <p>Residential Sample: 7</p> <p>These deficiencies reflect state</p>	F000000	Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and/or state law.	

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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F000167 SS=C	<p>findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review was completed by Tammy Alley RN on January 28, 2014.</p> <p>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>Based on observation and interview, the facility failed to consistently maintain the results of the most recent survey conducted by the Indiana State Department of Health, Division of Long Term Care, in an area that was readily accessible to residents. The facility also failed to post a notice with the location of the survey results. This had the potential to impact 54 of 54 residents currently residing in the facility.</p> <p>Findings include:</p> <p>During the initial tour on 1/14/14 at 10:15 A.M., the results of the most</p>	F000167	F167 In response to cited findings, the following actions will be taken: F-167 483.10(g) (1) The facility makes results of the state survey available for examination by all interested parties. A) Corrective action was taken when revised notice was posted in the entry lobby pointing to the location of the survey results binder on February 1, 2014. In addition binders were prominently labeled for ease of identification. B) All residents in the facility who wish to review survey results have the potential to be affected by this alleged deficient practice. Notices will be distributed to all current residents to ensure they are aware of the location of survey results on or before February 10, 2014. C)	02/21/2014	

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	<p>recent survey, or a posted notice on the location of the survey, were not found in the facility entrance foyer, the TV/Activity lounge area, the Activity/Dining room area, in the reception area, or on either of the two resident room halls.</p> <p>In an interview on 1/21/14 at 1:15 P.M., the Resident Council President indicated she didn't know there was "such a thing." She indicated she had not seen a sign or other posted notice with the location of the survey results.</p> <p>On 1/21/14 at 1:45 P.M., the Director of Nursing Services was requested to locate the facility's "survey book," which contained the results of the most recent survey. Initially, she went into the first office around the corner from the entrance door. She indicated the book was kept in there. When asked about the accessibility of the book for the residents, she then pointed to two log books on the bottom shelf of a hall table, which was facing the entrance and was around the corner from the resident living areas. Both log books had a black leather cover, with a label of black print on a square of dark gold foil on top. One of the log books was labeled as the</p>		<p>The Health Facility Administrator will monitor for appropriate placement of survey result notice and the accompanying documents on a weekly QA tour. If the information is not found to be intact, it will be replenished as needed. D) The Executive Director will include observations of posted current ISDH survey result on his weekly environmental rounds. He will ensure the HFA maintains notices and survey results. E) Date of compliance with proposed actions: February 21 , 2014</p>		

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F000242 SS=D	<p>"Survey Report" book. At that time, the Director of Nursing Services indicated the facility used to have the books in another location in the entrance hall, and that there used to be signs with information about the location of the survey book. After looking for a posted notice, she indicated she thought the signs had not been put back up after the book was moved.</p> <p>3.1-3(b)(1)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on observation, interview and record review, the facility failed to ensure a bath tub was available and offered, for 1 resident who desired to have a tub bath, in a sample of 3 residents reviewed for Choices and Preferences that were important to them. (Resident #28)</p> <p>Findings include:</p>	F000242	<p>F242 In response to cited findings, the following actions will be taken:F-242 483.15(b) Forum residents have the right to make significant life choices A) During the survey, resident #28 was reminded she could choose a tub bath vs. a shower for bathing. B) All residents in the facility have the potential to be affected by this alleged deficient practice. Bathing preferences identified</p>	02/21/2014

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	<p>In an interview on 1/14/14 at 2:53 P.M., Resident #28, who resided on the 400 Hall, indicated she would occasionally like to take a tub bath, but the facility did not have a tub.</p> <p>On 1/16/14 at 2:10 P.M., the 400 Hall "Bathique" communal bath/shower room was observed to have only shower stalls. At 2:15 P.M., the 500 Hall "Bathique" communal bath/shower room was observed to have a special handicap-accessible tub.</p> <p>The clinical record for Resident #28 was reviewed on 1/16/14 at 2:30 P.M. Diagnoses included, but were not limited to, history of bacterial pneumonia, coronary artery disease, depressive disorder, dementia, chronic kidney disease, advanced osteoporosis, and multiple pathologic compression fractures with a Vertebroplasty.</p> <p>The Annual MDS (Minimum Data Set) assessment, dated 4/18/13, indicated the resident had a BIMS (Brief Interview for Mental Status) score of "14" (13-15=cognitively intact). In the section for an interview about Daily Preferences, the resident indicated that it was "Very Important" to her to choose</p>		<p>during creation of the multi-disciplinary set will be audited by the MDS nurse to identify any other residents who prefer tub baths vs. showers. The Activity Director or designee will interview each affected resident to determine if bathing preferences are being observed. Any findings will be directed to Charge nurse for follow-up and implementation of desired bathing options. C) Resident bathing preferences will be assessed via sample resident interview weekly by the HFA during QA tours for the next ninety (90) days. Negative results will trigger further audits, education and/or reprimands for staff members. D) Observation of resident preferences will be added to the monthly resident council agenda to gauge ongoing compliance. Subsequent findings will be addressed on an individual basis. E) Date of compliance with proposed actions: February 21, 2014</p>	

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	<p>between a tub bath, shower, bed bath or sponge bath.</p> <p>In an interview on 1/17/14 at 1:20 P.M., the MDS Coordinator indicated the Activity Director was responsible for coding and processing the MDS section for resident's individual preferences chosen during the interview on the MDS.</p> <p>In an interview on 1/17/14 at 1:25 P.M., the Activity Director indicated that after she did the resident interview and coded the MDS for their preferences, that part of the MDS was to be reviewed by each nurse. The nurses were responsible for making sure specific choices made by a resident were added to the CNA assignment sheets.</p> <p>In an interview on 1/17/14 at 1:30 P.M., RN #2 indicated each CNA had a daily "Nurse Aide Assignment" sheet, and provided one for review. The paper assignment sheet listed the rooms the CNA was assigned to for that day. No specific instructions were included on the sheet for the residents in the rooms assigned for the day. The forms indicated the CNA was to check the "Resident Profile" in the computer CareTracker system, which only gave the day and</p>						

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F000246 SS=D	<p>time for a shower. If a resident refused a shower, the CNA would indicate that on the sheet and also enter into the Care Tracker system. There was no specific information about individual residents' preferences related to a shower or tub bath.</p> <p>RN #2 indicated Resident #28 "had never asked for" a tub bath. When questioned if staff had ever offered the resident a choice between a shower or a tub bath, the nurse indicated the resident was capable of requesting one.</p> <p>3.1-3(u)(3)</p> <p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on observation, interview and record review the facility failed to ensure 1 of 30 residents' bathroom sinks were accessible for the resident to use independently in a sample of 30 resident sinks observed for accessibility. (Resident</p>	F000246	F246 In response to the cited findings the following actions will be taken: F-246 483.15(e)(1) Forum residents have reasonable accommodations of needs and preferences. A) During the survey, the plumbing leak was corrected and the related vanity obstruction was removed. B) All	02/21/2014			

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	<p>#142)</p> <p>Findings include:</p> <p>On 1/15/14 at 11:40 P.M., the bathroom sink drain trap was observed to have a slow stream of water, which was running into a trash can placed under the sink pipes.</p> <p>Resident #142's record was reviewed on 1/21/14 at 3:18 P.M. Diagnoses included, but were not limited to left ankle aftercare status post open reduction internal fixation surgery.</p> <p>The Admission Minimum Data Set Assessment dated 12/26/13 indicated the resident required extensive physical assistance from two staff for transfers, extensive physical assistance of one staff person for dressing, toileting and personal hygiene. The assessment indicated the resident had not been able to walk in her room during the assessment period.</p> <p>During an interview on 1/15/14 at 11:40 A.M., the resident indicated the sink had been leaking since she had moved into the room on 1/5/14. She indicated she had a hard time</p>		<p>residents in the facility have the potential to be affected by this alleged deficient practice. Practical access to bathroom fixtures will be visually assessed in all resident rooms by the Director of Maintenance and/or Housekeeping. Unwanted physical plant obstructions will be removed in accordance with resident preferences. Any non-physical plant obstructions will be addressed with associated personnel (example – medical equipment from nursing personnel). In all cases, residents' preferences will dictate what may or may not remain in pathways. C) Housekeeping personnel will receive special instructions and training on resident access to necessary fixtures and equipment. Related findings will be reported to charge nurses for approval or corrections. Resident Access will be assessed weekly by the HFA during QA tours for the next ninety (90) days. Negative results will trigger further education and/or reprimands for staff members. D) The Activity Direct collect related resident observations monthly as a part of the resident council agenda to ensure compliance. E) Date of compliance with proposed actions February 21, 2014</p>	

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	<p>using the sink because she could not get her legs or the wheelchair under the sink due to the trash can, which was there to catch the water. She indicated she was fearful she would get her cast on her left lower leg wet from the water leaking from the pipes. She was told by the doctor her cast was not to get wet. She indicated she had informed her therapist this morning about the leak and she was supposed to get it fixed.</p> <p>During an interview on 1/15/14 at 1:00 P.M., the Director of Nursing (DoN) and Assistant Director of Nursing (ADoN) indicated they were not aware the resident's sink had been leaking since 1/5/14 and a trash can was under the sink. They indicated they had not known she was having difficulty getting to the sink to perform her personal care.</p> <p>During an interview on 1/15/13 at 1:30 P.M., the Maintenance Utility Staff #6 indicated a work order had been put in for this sink leaking and a brand new connection had been replaced where it was leaking. He indicated he was replacing the drain trap again. He was unable to recall the date of the work order or when the pipe was fixed the first time.</p>						

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F000247 SS=D	<p>During an interview on 1/22/14 at 11:15 A.M., the Executive Director was unable to provide the date of the first work order or the date the sink pipe was fixed.</p> <p>3.1-3(v)(1)</p> <p>483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on interview and record review, the facility failed to give notice to residents or family members of a room or roommate change in a timely manner. This deficient practice affected 3 of 3 residents reviewed for intrafacility transfers in a sample of 20 residents reviewed. (Resident #30, #31, and #142)</p> <p>Findings include:</p> <p>1. During an interview on 1/15/14 at 1:43 P.M., Resident #30 indicated</p>	F000247	F247 In response to cited findings, the following actions will be taken: F247 483.15(e) (2) Residents receive notice when rooms or roommates are changed. A) The three (3) effected residents were already aware of changes of room/roommate assignments related to the finding. There was no possible corrective action. B) All residents in the facility with room changes or roommate changes scheduled have the potential to be affected by this alleged deficient practice. Henceforth all residents will be given proper notice of room or	02/21/2014

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	<p>the roommate she had at this time had been in her room for four or five days now. She indicated her room was one that frequently had roommate changes and as soon as one roommate left a new roommate was moved in. She indicated the staff would not tell her when a new roommate was being moved into her room.</p> <p>The resident's record was reviewed on 1/21/14 at 3:50 P.M. Diagnoses included, but were not limited to, depression, and debility. Resident #30's record lacked documentation regarding notification of a new roommate for 1/17/14 or 1/20/14.</p> <p>2. During an interview on 1/15/14 at 2:15 P.M., Resident #31 indicated her roommate had been moved out today and another roommate had just been moved in just a few minutes ago. She indicated she had not been given notice before this roommate was moved into her room. She stated, "They move people in and out and they don't tell anyone."</p> <p>The resident's record was reviewed on 1/21/14 at 3:36 P.M. Diagnoses included, but were not limited to, hemoptysis, gastrointestinal bleed, peripheral vascular disease and</p>		<p>roommate changes per F-247. C) The Social Worker and/or Admissions Director will ensure appropriate notice is rendered to residents for room/roommate changes when new admissions are scheduled. The requisite form will be maintained and dispatched during the daily a.m. meeting on weekdays. Weekend notices will be provided on Fridays for on-duty managers. D) The HFA will audit all of that week's related resident records weekly for the next thirty (30) days. 50% of related records will be audited bi-weekly for the subsequent thirty (30) days then monthly for the following thirty (30) days. Negative results will trigger further education and/or reprimands for staff members. E) Date of compliance with proposed actions: February 21, 2014</p>		

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	<p>chronic kidney disease. Resident #31's record lacked documentation regarding notification of a new roommate.</p> <p>3. During an interview on 1/21/14 at 3:38 P.M., Resident #142 indicated she was not informed on 1/15/14 that she was being moved back to her old room until the Admissions Marketing Staff came into her room and started packing up her belongings and she was moved.</p> <p>The resident's record was reviewed on 1/21/14 at 3:18 P.M. Diagnoses included, but were not limited to left ankle aftercare status post open reduction internal fixation surgery, osteoporosis, and peptic ulcer disease. Resident #142's record lacked documentation regarding notification that she was being moved back to her old room.</p> <p>During an interview on 1/21/14 at 2:46 P.M., the Social Worker indicated the process for a room change involved the resident who had the conflict in the room had to be the person to change rooms. She indicated a work order was placed with the receptionist to have the resident's belongings moved whenever anyone was going to be</p>						

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	<p>moved. The resident who was moved was oriented to the room and the staff on the hallway of the new room. She indicated the request for room changes was frequently for private rooms, not because there was a problem with a roommate in a room. She indicated a 24 hour notice would be given to the person being moved and to the person receiving a new roommate, unless there was an extenuating circumstance and a 24 hour notice could not be given. She indicated Social Services or Admissions would notify the resident or family of the room transfers. She indicated the notifications of the move or the new roommate should be documented in the resident's record under the Social Services notes.</p> <p>During an interview on 1/22/14 at 11:35 A.M., the Social Worker indicated she had no further information to indicate where Resident #30, #31 or #142's documentation of notifications of room changes or roommate changes could be found.</p> <p>The policy and procedure for intrafacility transfers were requested on 1/22/14 at 10:00 A.M., from the Director of Nursing and requested</p>						

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F000309 SS=D	<p>again on 1/22/14 at 11:30 A.M. No policy or procedure for intrafacility transfers were supplied by the end of the exit conference on 1/22/14.</p> <p>3.1-3(v)(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 interview and record review, the facility failed to have a coordinated Hospice care plan indicating services provided by each provider for 1 of 1 resident reviewed for Hospice. (Resident #23)</p> <p>Findings include:</p>	F000309	F309 In response to the cited findings R/T to F309, the following actions will be taken: A) There is no corrective action needed. Resident #23 is deceased and Medical Record is closed. B) All residents in facility who are receiving Hospice services have the potential to be affected by this alleged deficient	02/21/2014

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	<p>The hospice Care Plan, dated 11/5/12, indicated the resident was receiving medical care/support through Hospice secondary to failure to thrive "...SSD (Social Service Director) will invite Resident's Hospice care team to all Care Plan Meetings. SSD will serve as liaison to Hospice care support. Hospice N/SS (Nursing and Social Services)...." Revision dates were 5/30/13 and 7/18/13. Written in pen at the bottom of the care plan was the date 7/10/13-" Hospice discontinued"</p> <p>On 1/21/14 at 2 P.M., the Director of Nursing (DON) was requested to provide the current Care Plan.</p> <p>1/22/14 at 10:25 A.M., the facility provided the wound, pain, cognition, nutrition, and the catheter facility Care Plans which had "Significant change Hospice" handwritten on the top of the Care Plan.</p> <p>In an interview with the Director of Nursing and the Executive Director on 1/22/14 at 10:30 A.M., they indicated the care plans they had for wounds, pain, cognition, nutrition, and the Foley all were part of her hospice care plan. They indicated they did not have a care plan which</p>		<p>practice. C) All residents currently receiving Hospice services will be evaluated for collaborative care between facility and Hospice provider. Social Services Director and ADON will develop a collaborate care plan with current Hospice residents and respective Hospice providers. Social Services Director will initiate a collaborative plan of care for each new Hospice admission with facility staff and Hospice vendor. D) Monitoring will include review of all Hospice residents in bi-weekly Continuous Quality Improvement (CQI) meetings to ensure collaborate care plan in place and implemented. E) Date of compliance with proposed actions: February 21, 2014</p>				

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F000329 SS=E	<p>explained the facility and their role in each of these areas or the hospice provider and their role in each of these areas.</p> <p>3.1-37(a)</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 monitor specific behaviors to support the use of psychoactive medications. In addition, the facility failed to initiate</p>	F000329	F329 In response to the cited findings R/T to F329, the following actions will be taken: A) No corrective action needed for residents #28, and #23. Residents are deceased and	02/21/2014

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	<p>attempts for a GDR (Gradual Dose Reduction) of psychoactive medications, or provide specific detailed information discussing why an attempt might be clinically contra-indicated. This deficiency impacted 4 of 5 resident reviewed for Unnecessary Medication Use. (Residents #28, #23, #69, and #88)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #28 was reviewed on 1/16/14 at 2:30 P.M. Diagnoses included, but were not limited to, history of coronary artery disease, chronic kidney disease, hypothyroidism, advanced osteoporosis, multiple pathologic compression fractures with vertebroplasty, depressive disorder, and dementia.</p> <p>The annual MDS (Minimum Data Set) assessment, dated 4/18/13, indicated the resident had a BIMS (Brief Interview for Mental Status) score of "14" (13-15=cognitively intact). The resident had no behaviors and no behavioral symptoms.</p> <p>The quarterly MDS review, dated 10/18/13, indicated the resident had a BIMS of "15;" had symptoms of</p>		<p>Medical Records are closed. Corrective action for Resident #88: Behaviors sheets have been corrected to show appropriate symptoms/behaviors for corresponding psychotropic medications. Behaviors will continue to be monitored daily and interventions implemented per care plan. Corrective action for resident #69: Care plan meeting to be scheduled with resident and spouse after return from hospital to discuss options for compliance with GDR recommendations as appropriate. B) All residents in facility who are receiving psychotropic medications have the potential to be affected by this alleged deficient practice. C) Pharmacy recommendations for GDR will be followed per state/federal guidelines for all residents receiving psychotropic medications. Facility will continue to conduct monthly behavior meetings with pertinent members to review behaviors and GDR recommendations. Care plans will be scheduled with residents/responsible parties as needed to ensure education and improve compliance. Staff in-servicing to be completed re: appropriate behavior monitoring, as well as observation and documentation with GDR process to ensure optimal management with resident behaviors. D) Monitoring of GDR process and behavior management will be carried out</p>				

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	<p>feeling tired or having little energy nearly every day, and had no behaviors or behavioral symptoms.</p> <p>The January 2014 physician order recap (recapitulation) included, but was not limited to, the following medications with the original date of order: 6/4/09--Cymbalta (an anti-depressant medication) 20 mg. (milligrams)--give 2 capsules (40 mg.) by mouth daily. 6/4/09--Mirtazapine (Remeron--an anti-depressant medication) 15 mg. 1 by mouth at bedtime. 6/25/09--Risperidone (Risperdal--an antipsychotic medication) 0.5 mg. 1 by mouth daily at bedtime.</p> <p>An "Informed Consent for Psychopharmacological Medication(s)" dated 10/30/13 indicated the reason for use of the medications were: Remeron 15 mg. (depression), Cymbalta 40 mg. (depression/chronic pain), Risperdal 0.5 mg. (atypical psychosis), Ambien 2.5 mg. (insomnia). .</p> <p>An "Antipsychotic Medication Quarterly Evaluation" with dates of 4/16/13 and 10/16/13 indicated "If diagnosis is Dementing Illnesses with Associated Behavior</p>		<p>through bi-weekly CQI meetings ongoing, and monthly behavior meetings with professional staff (PharmD, MD, psychologist, NP, SSD). E) Date of compliance with proposed actions: February 21, 2014.</p>				

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	<p>Symptoms, complete target behavior." The behaviors were listed as: 1. Increase anxiety, chest pain; 2. obsessed with medical condition. No specific psychotic behavior was listed.</p> <p>Physician progress notes included, but were not limited to, the following: "1/3/13--Depression--stable on Cymbalta, Remeron 3/11/13--Chronically depressed and anxious, but has been well controlled recently with no changes in medications. 5/7/13--No significant changes in behaviors--stable on Risperdal. 9/24/13, 8/29/13-(no documentation related to behaviors or psychoactive medications) 9/25/13--(no documentation related to behavior or psychoactive medications.) 10/29/13--GDR (Gradual Dose Reduction) ; has been taking Zolipidem at 2.5 mg every HS (bedtime) since 4/10. Patient with no complaints of insomnia or behaviors in recent months. Agree with GDR, will D/C Zolipidem. 12/3/13--Dementia with psychosis--stable on Risperdal. 12/18/13, 1/8/14--(no documentation related to behavior or psychoactive medications.)"</p>			

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	<p>On 1/17/14, the Director of Nursing Services provided a "Consultant Report" form from the facility Consultant Pharmacist.</p> <p>The report indicated the resident had taken Risperidone 0.5 mg. every bedtime for atypical psychosis since 6/25/09. The recommendation was to "decrease the dose to 0.25 mg. every bedtime while concurrently monitoring for re-emergence of target and/or withdrawal symptoms. If therapy is to continue at the current dose, please provide rationale describing a dose reduction as clinically contraindicated."</p> <p>The physician responded on 7/26/13 by checking a box for a pre-printed statement that indicated "I decline the recommendation(s) above because GDR is CLINICALLY CONTRAINDICATED for this individual. The resident's target symptoms returned or worsened after the most recent GDR attempt within the facility and a GDR attempt at this time is likely to impair this individual's function or increase distressed behavior AS DOCUMENTED BELOW." There was no information related to when</p>			

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	<p>the "most recent GDR" might have occurred and the the nature of the "failure."</p> <p>In the section that indicated "Please provide CMS [Centers for Medicare Services] REQUIRED patient-specific rationale describing why a GDR attempt is likely to impair function or increase behavior in this individual," the physician had written "Adverse effects health."</p> <p>A "Consultation Report" from the Consultant Pharmacist requesting a review and GDR attempt for the two anti-depressant medications of Cymbalta and Mirtazapine were not found in the clinical record and were not provided for review.</p> <p>In an interview on 1/17/14 at 11:45 A.M., the Director of Nursing Services indicated behaviors were monitored utilizing the "Behavior/Intervention Monthly Flow Record" forms, which were located in the MAR (Medication Administration Record) book on each unit.</p> <p>The "Behavior/Intervention Monthly Flow Record " forms for Resident #28 for the months of September, October, November, and December,</p>			

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	<p>2013, were reviewed.</p> <p>The specific target behaviors for the use of the Risperdal were listed each month as "Obsessive--unfounded medical complaints," and "Paranoia." There was no description of the resident's "paranoia" to determine what behavior was displayed and monitored.</p> <p>The September record indicated that from 9/19 through 9/24, the resident experienced multiple episodes on all shifts of "obsessive--unfounded medical complaints." There was one additional episode during the day shift on 9/28/13. In October, the resident experienced several episodes of this same behavior on the day and evening shifts on 10/2 through 10/4, and 10/26/13. In November the resident had one episode of this behavior, and in December she experienced 2 episodes. The records indicated the resident had 0 (zero) episodes of the "paranoia."</p> <p>The specific target behavior for the use of the Cymbalta was listed each month as "Making negative statements." In September, the resident was documented as having</p>			

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	<p>5 episodes occurring on the same dates as the behavior documented on the sheet for the Risperdal. Episodes in October, November, and December were documented as occurring on the same days and shifts as those documented for the Risperdal.</p> <p>The specific target behaviors for the use of the Mirtazapine were listed as "Continuous crying," and "Self isolation." The Behavior Monitoring Record indicated that 0 (zero) episodes had occurred in September, October, November, and December.</p> <p>In an interview on 1/17/14 at 11:45 A.M., the Director of Nursing Services indicated facility had a monthly behavior team meeting to discuss behaviors, psychotropic medications, GDRs for each resident who had behaviors and/or were on psychoactive medications.</p> <p>On 1/22/14, the Director of Nursing Services provided the " Monthly Behavior Meeting " notes for February, May, August, and November, 2013. The agenda indicated all residents with behavioral/psych needs would be reviewed, as well as a review of</p>				

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	<p>proposed gradual dose reductions (GDRs). A "Nurses Midnight Census Report," listing all of the residents on the 400 Hall was attached. Notations related to types of medications were written in the margins.</p> <p>The February "Census Report" form had the following written in next to the resident's name: "Ambien, Cymbalta, Risperdal, Remeron. Continue all."</p> <p>The May "Census Report" form had the following written in next to the resident's name: "No GDRs due, no changes."</p> <p>The August "Census Report" form had a check mark next to the resident's name.</p> <p>The November "Census Report" form had the following written in next to the resident's name: "Not due for anything."</p> <p>There was no documentation on any of the reports related to the observed number of episodes of depression symptoms, or discussion about specific reasons a GDR would be contra-indicated for this resident.</p>						

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	<p>On 1/22/14, the attending physician provided a typed letter that indicated " ...In regards to [Resident #28], in my clinical opinion I cannot attempt to reduce two drugs at the same time. In the case of a failed attempt, I wouldn't know which drug caused the effect."</p> <p>2. The record review for Resident #23 was completed on 1/17/14 at 11:30 A.M. Diagnoses included, but were not limited to, spinal cord injury, depression, neurogenic bladder, mononeuritis, osteoporosis, severe scoliosis, muscle weakness, insomnia, osteoarthritis and constipation.</p> <p>The resident currently received Citalopram HBR 20 milligrams 1 tablet daily for depression. The physician's recapitulation for December 2013 indicated that she had been on this medication since 8/26/12. The resident was currently on Hospice for debility.</p> <p>The behavior documentation tracking form for August, September, and October 2013 for the Citalopram HBR 20 milligrams for depression indicated the behavior they were tracking for this medication was tearfulness. The documentation for October indicated</p>						

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	<p>the resident had one episode of tearfulness on 10/7/13, and that a one-on-one intervention was effective. The resident had no other episodes of tearfulness in three months prior to the request for the gradual dose reduction.</p> <p>A document dated 10/29/13, from the pharmacy indicated a request for gradual dose reduction for Citalopram 20 milligrams daily for major depressive disorder. The document indicated, "...Recommendation: Please consider documenting that gradual dose reduction (GDR) is clinically contraindicated in this individual with major depressive disorder. Should it be deemed that a GDR attempt is clinically appropriate for this individual with major depressive disorder (THIS BEING THE SECOND REQUEST IN THE FACILITY), it is recommended that the weekly dose be reduced by no greater than 25% while concurrently monitoring for re-emergence of depressive and/or withdrawal symptoms...Physician's response(check mark) denoting GDR is CLINICALLY CONTRAINDICATED for this individual because continued use is in accordance with the current</p>			

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	<p>standard of practice and a GDR attempt at this time is likely to impair this individual's function or cause psychiatric instability by exacerbating an underlying medical condition or psychiatric disorder AS DOCUMENTED BELOW. Please provide CMS required patient specific rationale describing why a GDR attempt is likely to impair function or cause psychiatric instability in this individual...."</p> <p>The physician's handwritten response, dated 10/29/13, indicated, "...Hospice benefit outweighs risk...." The physician signed the document.</p> <p>A request was made to the Director of Nursing on 1/17/14 at 2:00 P.M., regarding any attempts at reducing depression medication.</p> <p>On 1/22/14, the Director of Nursing Services provided the "Monthly Behavior Meeting" notes for February, May, August, and November, 2013. The agenda indicated all residents with behavioral / psych needs would be reviewed, as well as a review of proposed gradual dose reductions (GDRs). A "Nurses Midnight Census Report," listing all of the residents on the 400 Hall was</p>						

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	<p>attached. Notations related to types of medications were written in the margins.</p> <p>The February "Census Report" form had the following written in next to the resident's name: "Celexa 20, Trazadone 50, Ativan PRN & routine."</p> <p>The May "Census Report" form had the following written in next to the resident's name: "GDR-Hospice, Trazadone."</p> <p>The August "Census Report" form had the following written in next to the resident's name: "Ativan GDR 0.5 to [arrow down=decrease] 0.25, Trazadone 12, Celexa."</p> <p>The November "Census Report" form had the following written in next to the resident's name: "Celexa reviewed last month-no change last month. Not due for anything. Ativan PRN. Trazadone and Ativan routine."</p> <p>There was no documentation on any of the reports related observed number of episodes of depression symptoms, or discussion about specific reasons a GDR would be contra-indicated for this resident.</p>			

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	<p>On 1/22/14, the attending physician provided a typed letter that indicated "...In my clinical judgement, a further reduction in an anti-depressant for a hospice patient will affect the resident's ability to maintain their highest level of function."</p> <p>In an interview on 1/21/14 at 11 A.M., the Director of Health Services indicated she did not have any further explanation of what specific information for Resident #23 the physician used to make his determination not to attempt a GDR.</p> <p>3. Resident #88's record was reviewed on 1/21/14 at 9:57 A.M. Diagnoses included, but were not limited to, atypical psychosis, dementia without behavioral disturbances, general anxiety disorder, and depression.</p> <p>The resident's current Physicians orders included, but were not limited to, the following: 08/22/13-Lorazepam Intenso (Ativan liquid--an anti-anxiety medication) 2 mg/ml Give 0.5 ml (milliliter)/1 mg (milligrams) sublingually every 2 hours as needed for anxiety or shortness of breath. 10/08/13-Risperidone (Risperdal--an</p>						

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	<p>antipsychotic medication) 0.25 mg by mouth every evening for atypical psychosis. 12/22/13-Citalopram (Celexa--an anti-depressant medication) 20 mg by mouth daily for depression.</p> <p>A Hospice physician's progress note dated 3/21/13, indicated, "The resident requires close monitoring as he is easily agitating anxiety. Presents as safety hazard at times, requiring increased doses of Ativan." The note indicated the resident's agitation and anxiety was uncontrolled by Ativan Intensol and Risperdal was added for "psychosis."</p> <p>A Hospice physician's progress note dated 7/3/13 indicated, "1. Dementia with behaviors-stable on risperdal...4. Depression-stable on Celexa."</p> <p>A physician's progress note dated 10/2/13, indicated "Pt [patient] with long standing behaviors that have been controlled on 0.5 mg of Risperdal every bedtime." He indicated the resident was due for a gradual dose reduction (GDR) and the resident's behaviors were stable so he decreased the Risperdal to 0.25 mg at bedtime.</p>			

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	<p>A Hospice physician's progress note dated 11/19/13 indicated, 1. Dementia with behaviors-stable, no acute issues, continue Risperdal...4. Depression with anxiety-stable on Celexa and prn ativan."</p> <p>A physician's progress note dated 1/14/14, indicated the resident had a diagnosis of dementia without behavioral disturbances. He indicated, "Pt with no significant new behaviors...". His assessment indicated "dementia worsening but no behaviors that need evaluated or treated at this time. Continue comfort measures and continue safety measures."</p> <p>A Consultation Report dated 6/27/13 from the Consulting Pharmacist, indicated the resident had taken Citalopram 20 mg daily for a diagnosis of major depressive disorder since 12/22/12. The report to the Physician indicated this was the first gradual dose reduction (GDR) attempt. The Physician responded on 7/8/13 by marking a box for a pre-printed statement of "GDR is clinically contraindicated for this individual because continued use is in accordance with the current standard of practice and a GDR</p>						

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	<p>attempt at this time is likely to impair this individual's function or cause psychiatric instability be exacerbating an underlying medical condition or psychiatric disorder as documented below" The area below this statement stated, "Please provide CMS required patient-specific rationale describing why a GDR attempt is likely to impair function or cause psychiatric instability in this individual." The physician signed the form on 7/8/13, but did not provide any additional information/rationale.</p> <p>The October, November, and December 2014 "Behavior/Intervention Monthly Flow Record" was provided for review on 1/21/14 at 1:40 P.M., by the Director of Nursing (DON). These documents indicated the resident had only one behavior of "restlessness" on 12/18/13.</p> <p>During an interview on 1/21/14 at 1:40 P.M., the DON indicated the resident's diagnosis of Atypical Psychosis was being treated with Risperdal, his depression was being treated with Celexa and his anxiety was being treated with Ativan. She indicated this resident's Ativan had been routine, but was decreased to</p>			

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	<p>"PRN" (as needed) in April. She indicated the doctor was keeping the Ativan order "PRN" because the resident was on hospice. The physician preferred to make Ativan a standing order for all hospice residents. She indicated the resident's last recommended GDR for his Celexa was on 07/08/13, but the doctor had declined. The next recommendation for a GDR would be due on 01/08/14. She indicated the Risperdal was reduced on 09/25/14, and the resident's behaviors were controlled on this dose. She had indicated the doctor had not wanted the GDR for the resident's Celexa on 07/08/13 because he had marked an "X" in the box that indicated that it was clinically contraindicated. She also indicated the particular doctor was not very specific with his reasoning for not allowing GDR's.</p> <p>During an interview on 1/22/14 at 10:10 A.M., the DON indicated the facility had two ways they tracked and followed up on behaviors. The first way was the Behavioral Monitoring Team who met once a month on the last Thursday of the month. She indicated that each month a different unit was reviewed so that each unit was reviewed</p>			

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	<p>quarterly. The team consisted of the Medical Director, Clinical Psychologist, DON, Pharmacy Consultant, and Social Services. She indicated the areas that the team reviewed were any new admissions that had behaviors or were on psychotropic medications, residents who required GDR's, residents who had behaviors and residents who were on psychiatric medications. She indicated the other way behaviors were tracked was through Continuous Quality Improvement (CQI). This team consisted of the DON, Assistant Director of Nursing (ADON), Dietician, Social Services, Therapy Manager, Memory Care Director and the Minimum Data Set (MDS) Coordinator. She indicated this team met every two weeks and they evaluated any new behaviors or changes in behaviors so that a resident did not display a behavior and the behavior had not been addressed for a month before the Behavior Monitoring Team addressed it.</p> <p>During an interview on 1/22/14 at 10:23 A.M., the DON indicated the behavior being monitored for the Risperdal was "restlessness". The behavior being monitored for</p>				

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	<p>Lorazepam was restlessness and the behaviors being monitored for Celexa were negative statements and crying. She indicated the nursing staff were to use the Behavior/Intervention Monitoring Flow Records to document any behaviors the resident displayed. She indicated the resident had not displayed any behaviors presently. She indicated, "He use to be real bad with his behaviors and "yell out all the time" and he could "tear this place apart" at times, but he has not had any behaviors in awhile." She indicated, "Hospice placed him on the Risperdal for his "restlessness"."</p> <p>The policy and procedure for Behavior Monitoring and Gradual Dose Reduction was requested from the DON on 1/22/14 at 10:00 A.M., and again at 11:30 A.M. No information regarding the policies or procedures were provided by the end of the exit conference on 1/22/14.</p> <p>4. Resident #69's record was reviewed on 1/17/2014 at 10 A.M. Diagnoses included, but were not limited to, pacemaker, atrial fibrillation (fibrillation of the muscles of the atria of the heart), and depression.</p>			

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	<p>The most recent Physician's order recapitulation in the chart was for December 2013 and included, but was not limited to, the following medications and dosage: Remeron 30 mg tablet--give 1 tablet orally at bedtime for depression Risperidone 1 mg tablet--give 1 tablet 2 times a day--atypical psych</p> <p>A document titled "Case Review Note" dated 11/21/13 and written by the consultant Psychologist, indicated the Pharmacy was forwarding recommendations for the Physician to consider decreasing the antidepressant medication Remeron.</p> <p>A consultation report from the Pharmacist dated 11/21/2013, regarding Resident #69's Remeron 30 mg (milligrams) and guidance regarding gradual dose reduction if chosen, lacked a physician's response or physician's signature.</p> <p>A pharmaceutical services consultation report dated 7/25/2013, recommended Resident #69's antipsychotic medication Risperdal 0.5 mg being given 3 times per day since 6/7/11 be assessed. If therapy with this medication was to continue at the current dose, to please</p>			

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	<p>provide rationale describing a dose reduction as clinically contraindicated. The Physician responded by marking a box next to the following pre-printed statement: " I decline the recommendation(s) above because GDR (gradual dose reduction) is clinically contraindicated for this individual as indicated below. (NOTE: Please check option #1 or #2 AND provide patient-specific rationale on the lines below.)...." The Physician marked an X next to both #1 and #2. No patient-specific rationale why a GDR attempt is likely to impair function or cause psychiatric instability in this individual was written. The document was signed and dated by the Physician.</p> <p>During an interview on 1/16/2014 at 2:15 P.M., the Director of Nursing indicated the resident's spouse refused psychoactive medication changes.</p> <p>An additional record review on 1/16/2014 at 6 P.M., indicated this resident's BIMS (Brief Interview for Mental Status) was 13 out of 15 indicating the resident is cognitively intact.</p> <p>3.1-48(a)(2)</p>				

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F000371 SS=F	<p>3.1-48(a)(3) 3.1-48(a)(4) 3.1-48(a)(6) 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 ensure that food items were covered to prevent possible contamination for 1 of 1 kitchen observations. This deficient practice had the potential to affect 53 of 54 residents that received food from 1 of 1 kitchens.</p> <p>Findings include: During an observation of the kitchen on 1/14/14 at 10:15 A.M., the following was found inside the walk-in refrigerator: 10 sliced pieces of pie uncovered, 2 whole pies</p>	F000371	F-371 In response to cited findings, the following actions will be taken: F-371 483.35 (i) The facility stores and serves food under sanitary conditions. A) Food was appropriately covered for storage immediately upon discovery. No residents were adversely affected. B) All residents in the facility who participate in community meals have potential to be affected by this alleged deficient practice. The Policy & Procedure for Food Safety in Receiving & Storage was immediately re-enforced by food service management personnel. C) Dietary staff will be fully retrained with policies related to proper food coverage/storage. D) The	02/21/2014	

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	<p>uncovered, a bag of carrots open and exposed with no plastic covering on them, and a bag of salad had a visible rip in the plastic, but no plastic covering over the rip.</p> <p>The ice cream freezer had 12 dishes with ice cream. The plastic covering that was over them was pulled up on one side, leaving some of the dishes of ice cream exposed, and there were 3 ice cream sandwiches lying on top of some of the dished up ice cream.</p> <p>In an interview with the Food and Beverages Manager on 1/14/14 at 10:30 A.M., he indicated it is not usually like that and that the items should be covered.</p> <p>The dietician provided a policy dated 11/4/05, titled " Food Safety in Receiving and Storage", which indicated, "...General Food Storage Guidelines...2. Food will be stored in its original packaging as long as the packing is clean, dry, and intact...."</p> <p>3.1-21(i)(3)</p>		<p>Director of Food & Beverage, Executive Chef, and Dietitian will be responsible for observing compliance with the food storage policies. Observations will occur at least once following each meal daily for 2 weeks, then twice daily for 90 days, then twice weekly thereafter. Staff found to be non-compliant will be counseled & disciplined as indicated. The HFA will monitor compliance by supervisory staff by checking appropriate food storage on a daily basis. Ongoing success will be reported to the Quality Assurance Committee on a quarterly basis. E) Date of compliance with proposed actions: February 21, 2014</p>	

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F000431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview and record review, the facility failed to have medications labeled with the open date for 3 of 4 medication carts</p>	F000431	F431 In response to the cited findings R/T to F431, the following actions will be taken: A) Corrective action: All refrigerators in medications rooms have	02/21/2014			

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	<p>reviewed for medications labeled with open dates and ensure a narcotic medication was stored in a double locked area for 1 of 3 medication refrigerators reviewed for proper medication storage.</p> <p>Findings include:</p> <p>1. The Medication Storage Review was completed on 1/17/14 at 2:00 P.M., on the 400 B hallway, with RN #2 in attendance. There was a bottle of Nitrostat (Heart medication) observed with no open date. There were two bottles of Travatan (Glaucoma eye drops) ophthalmic solution observed opened for one resident with no open date. Two bottles of Artificial Tears (Wetting drops) were observed opened with no open date. There was a bottle of Latanoprost Ophthalmic solution (Glaucoma eye drops) observed opened with no open date. A bottle of Q-Tussin DM Syrup (Cough syrup) was observed open with no open date.</p> <p>A bottle of Lorazepam Intensole (Nerve medication) was observed in the 400 B Medication Room in the side door of the refrigerator. The refrigerator in the Medication Room did not have a lock.</p>		<p>secured with appropriate locks. Nursing staff have been in-serviced immediately re: proper storage of medications, both scheduled and non-scheduled. All medications found to be out of compliance have been re-ordered from pharmacy and labeled appropriately. Pharmacy support staff have been asked to attend a meeting with DON/ED on next scheduled visit to review expectations for pharmacy audits. B) All residents in facility who have medications administered to them have the potential to be affected by this alleged deficient practice. C) Pharmacy support staff have been asked to attend a meeting with DON/ED on next scheduled visit to review expectations for pharmacy audits. Audits of all medication carts and medication refrigerators are being conducted twice weekly (Wed, Sun) by night shift nursing staff to ensure compliance with medication storage guidelines. Weekly audit of medications carts/refrigerators will be done by DON/designee. Monthly audit by pharmacy support staff to continue with focus on current findings. Exit to be held with DON or ED to ensure compliance and discuss any noted deficiencies. Staff found to be non-compliant with corrective action will be disciplined accordingly. D) Monitoring will include review of weekly audits at bi-weekly</p>	

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	<p>During an interview at this time, RN #2 indicated the medications should have had an open date written on the label of the medication. She indicated the Lorazepam was always left in the refrigerator without a lock.</p> <p>2. The Medication Storage Review was completed on 1/17/14 at 3:09 P.M., on the Split Station Hallway, with LPN #1 in attendance. There was a bottle of Novolog Insulin (diabetic medication) observed open without an open date. There was two bottles of cough syrup observed open without an open date. There was a bottle of nasal spray observed open without an open date.</p> <p>During an interview at this time, LPN #1 indicated the medications should have had an open date written on the label of the medication.</p> <p>3. The Medication Storage Review was completed on 1/17/14 at 3:15 P.M., on the 500 Hallway, with LPN #6 in attendance. There was a Levemir Insulin Flexpen (diabetic medication) observed open without an open date.</p> <p>During an interview at this time, LPN #6 indicated the medication should</p>		<p>Continuous Quality Improvement (CQI) meetings to ensure compliance and identify any need for continued education/enforcement. E) Date of compliance with proposed actions: February 21, 2014</p>		

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	<p>have had an open date written on the label of the medication. She indicated she would place Lorazepam Intensol in the refrigerator in the Medication Room. She indicated the refrigerator in the 500 Medication Room did not have a lock.</p> <p>During an interview on 1/17/14 at 3:37 P.M., the Director of Nursing (DON) indicated the Lorazepam Intensol was to be secured with a double lock while in the refrigerator. She indicated the medications in the medication carts that were opened were to have been labeled with an opened date. She indicated any nurse had access to any of the other Medication Rooms and the unlocked refrigerators because when the nurses went on break, they gave their keys to another nurse to cover their hall while they were gone.</p> <p>A policy titled "Controlled Substances Management (Healthcare)" dated 6/1/10 was provided by the DON on 1/22/14 at 1:46 P.M., and deemed current. The policy stated, "All controlled substances ordered for residents in the facility will be dispensed and maintained according to all applicable state and federal laws...4.</p>			

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	<p>Schedule IV substances have an abuse potential less than those listed in Schedule III and more than substances in Schedule V (some examples include all benzodiazepines, diazepam, lorazepam, propoxyphene, meprobamates, etc.)... Controlled medications in Schedules II-V are subject to special handling, storage...2. Medications contained in schedules II-V must be stored in a secured/double locked area...."</p> <p>3.1-25(j) 3.1-25(n)</p>			

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F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility failed</p>	F000441	F441 In response to the cited findings R/T to F441, the	02/21/2014			

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	<p>to perform proper handwashing and to prevent cross contamination during blood glucose testing for 2 of 4 residents reviewed for blood glucose testing. (Resident #138 and #147)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During an observation on 1/17/14 at 11:32 A.M., RN #4 was observed while checking Resident #138's blood sugar. RN #4 took all her monitoring supplies and the glucometer into the resident's room. She laid her monitoring supplies on the resident's newspaper on his bed and the glucometer on the end of the resident's bed. She washed her hands, donned clean gloves, then cleansed and dried the resident's right middle finger. She laid the used supplies on the resident's newspaper on his bed. She then stuck the resident's finger and wiped the first drop of blood then checked the blood sugar. After obtaining the blood sugar reading, she placed the glucometer on the resident's newspaper on his bed while she wiped his finger with a clean alcohol pad. She gathered her trash, threw away the lancet and the strip into the sharps box on her cart. She set the used glucometer down on her 		<p>following actions will be taken: A) Corrective action: Nursing staff in-serviced immediately re: creating barrier with glucose monitoring devices to prevent cross-contamination during blood glucose testing. Corrective action: Handwashing in-servicing with specific focus on glucose monitoring and handling of glucose monitoring supplies completed with licensed staff to prevent cross-contamination during blood glucose testing. B) All residents in facility who are receiving blood glucose testing have the potential to be affected by this alleged deficient practice. C) DON/designee to monitor scheduled glucose testing on random shifts weekly x4, then monthly via visual observation. Glucose monitoring policy to be re-enforced with all newly hired licensed staff to ensure compliance. Return demonstration with post testing to validate knowledge will be done. D) Blood glucose testing observations results to be reviewed at bi-weekly CQI meetings ongoing, with focus on need for continued education and performance improvement. Employees who demonstrate continued deficient performance will be disciplined accordingly. E) Date of compliance with proposed actions: February 21, 2014.</p>				

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	<p>medication cart, and threw her trash including her used gloves away in her trash can on her cart. She donned clean gloves and cleansed the glucometer with a Sani-Cloth Bleach Wipe and sat it back in the cart. She threw the wipe and the gloves away. RN #4 took this resident down to the dining room with his newspaper from his bed she had used for her supplies and brought the next resident to do another blood sugar.</p> <p>2. During an observation on 1/17/14 at 11:50 A.M., RN #4 was observed while checking Resident #147's blood sugar. RN #4 took all her monitoring supplies and the glucometer into the resident's room. She laid all of her supplies and the glucometer on the resident's overbed table. She washed her hands, donned clean gloves, then cleansed and dried the resident's first digit on his left hand. She laid the used supplies on the resident's overbed table. She stuck the resident's finger and was unable to get blood. She gathered her trash and went to her cart to get another lancet. She left the glucometer lying on the overbed table. She gathered her new monitoring supplies and returned to the resident's room and</p>			

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	<p>obtained the blood sugar. She washed her hands, donned clean gloves, prepared her glucometer, cleansed and dried the resident's fourth digit of the left hand. She stuck his finger with a lancet, wiped the first drop of blood and placed the glucometer strip up to the resident's finger.</p> <p>She indicated to the resident she was unable to get enough blood and needed to get more supplies. She removed her gloves and left the room to get another strip. She returned to the room and removed the strip from the glucometer machine with her bare hands and laid the strip on the overbed table on her pile of trash. She washed her hands, donned clean gloves, added the new strip to the glucometer, milked the resident's finger attempted to obtain blood, but was unable to do so. She removed her gloves and left the room. She returned to the room with another strip and lancet. She washed her hands, donned clean gloves, prepared the glucometer, and cleansed and dried the fourth digit of the left hand. She stuck the resident with a lancet and wiped the first drop of blood and obtained the blood sugar. She removed her trash and</p>			

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	<p>placed her lancets and strips in the biohazard box on her medication cart and threw her trash away including her gloves. She sat her glucometer on her medication cart. She washed her hands. She cleansed the glucometer without gloves with a Sani-Cleanse Bleach Wipe.</p> <p>During an interview on 1/17/14 at 12:00 P.M., RN #4 indicated she should have placed a barrier under her glucometer and monitoring supplies when she took them into the room instead of placing them on the resident's belongings.</p> <p>During an interview on 1/17/13 at 12:10 P.M., the Director of Nursing indicated she expected the nurses to use a barrier to set their blood glucose supplies on when they went into a resident's room to prevent cross contamination.</p> <p>During an interview on 1/22/14 at 10:45 A.M., Director of Nursing indicated she expected the staff to wash their hands after they entered a resident's room, prior to and after resident care. Nurses were to wash their hands before and in between medication administrations. All staff were to wash their hands before and</p>			

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F000456 SS=C	<p>after applying gloves and if their gloves were contaminated.</p> <p>A current policy titled, "Blood Glucose Monitoring" revision date 02/03/10 was provided on 1/17/14 at 12:10 P.M., by the Director of Nursing stated, "1.0 PURPOSE: To detect or monitor resident' blood glucose levels...4.0 PROCEDURE: 13. Discard lancet in sharps container. 14. Remove gloves and wash hands...."</p> <p>3.1-18(l)</p> <p>483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Based on observation and interview, the facility failed to have an oven handle in safe functioning condition for 1 of 4 ovens in 1 of 1 kitchens. This had the potential to affect 53 of 54 residents that received food from 1 of 1 kitchens.</p> <p>Findings include: During an observation on 1/14/14 at 10:15 A.M. the handle on one of the</p>	F000456	F456 In response to cited findings, the following actions will be taken: F456 483.70(c) (2) The facility maintains essential equipment in safe operating condition. A) The oven handle was replaced shortly after the survey concluded. B) All residents in the facility have the potential to be affected by unsafe equipment. C) The facility maintains preventative maintenance programs for all substantial equipment.	02/21/2014			

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F000463 SS=D	<p>ovens appeared broken as there was several pieces of duct tape around the top and all the way to the middle bottom of the oven handle. The oven was opened and was observed to have food in it (four pans with aluminum foil on top of it), when using the handle to shut the door, one side of the oven door shut and the other door did not.</p> <p>In an interview on 1/14/14 at 10:30 A.M., the Food and Beverage Director indicated the handle was on order.</p> <p>In an interview with Cook #8 on 1/14/14 at 12:10 P.M., he indicated the oven handle had been that way for a couple of months.</p> <p>A request was made for documentation of the the oven to be fixed, and as of 1/22/14 at 4 P.M., no documentation had been provided.</p> <p>3.1-19(bb) 483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. Based on observation, interview and</p>	F000463	<p>Management personnel advise maintenance associates of repair needs in all departments when immediate needs arise. The ED will provide training to all departmental managers to ensure they understand equipment repair priorities as well as authority to call outside service personnel as necessary. D) The ED will review monthly preventative maintenance logs for the next ninety (90) days. Recorded services will be checked against equipment to affirm maintenance action was taken as appropriate. Adverse findings will result in further education and/or reprimands for staff members.</p> <p>E) Date of compliance with proposed actions: February 21, 2014</p>	02/21/2014			

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	<p>record review the facility failed to ensure 3 of 3 residents call lights were functioning properly when reviewed for properly functioning call light systems in sample of 30 residents. (Resident #80, #92 and #142)</p> <p>Findings include:</p> <p>1. During an observation on 1/15/14 at 10:10 A.M., Resident #30's red light above the inside of his door and the white dome light on the outside of his door did not come on each time the call light button was pressed. During an observation at this time, CNA #5 pressed the resident's call light button and was unable to get the red light in the resident's room above the door and the white dome light outside the resident's door to come on each time the call light was pressed.</p> <p>During an interview at this time, CNA #5 indicated the resident's call light system was not functioning properly.</p> <p>During an observation on 1/15/14 at 10:44 A.M., Environmental Service Staff #7 was unable to get the resident's call light system to function properly. During an interview at this time he indicated</p>		<p>taken: F463 483.70(f) Forum nursing stations are equipped with call systems . A) Effected residents had repairs made to their call light units as soon as problems were identified. Personnel audited lights to ensure serviceability and address low batteries and other simple problems. The service company was scheduled for a return visit to trouble shoot the call system. When the system has temporary malfunctions, alternative arrangements are implemented to ensure residents are attended on a timely basis. B) All residents in the facility have the potential to be affected by non-functional nurse call systems. C) When the system has temporary malfunctions, alternative arrangements are implemented to ensure residents are attended on a timely basis. This includes staff rounds and manual bells. A service company was re-called to trouble shoot the call system and completed work on 2-8-14. The facility maintains a preventative maintenance programs for this system. Nursing personnel advise maintenance associates of necessary repairs. D) The HFA will perform random tests of the systems weekly. Testing will include different rooms, public spaces and bathing rooms. The ED will review weekly testing logs and monthly preventative maintenance logs for the next ninety (90) days. Recorded</p>	

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	<p>the call light system was ran by a computer system and it had a battery in the box in the wall and most likely the battery needed changed. He indicated he changed the battery in the box on the wall and the call light system was functioning properly now.</p> <p>A undated document titled, "Smartcare" was provided by the Director of Nursing (DON) on 1/21/14 at 1:40 P.M. The document indicated that on 1/15/14 at 10:10 A.M., the computer had not picked up the call light when it was pressed. The resident's call light had been pressed by the Environmental Service Staff #7 at 10:44 A.M., but the document indicated that on 1/15/14 at 10:44 A.M., the computer had not picked up the call light when it was pressed.</p> <p>2. During an observation on 1/15/14 at 10:10 A.M., Resident #92's red light above the inside of his door and the white dome light on the outside of his door did not come on each time the call light button was pressed. During an observation at this time, CNA #5 pressed the resident's call light button and was unable to get the red light in the resident's room above the door and</p>		<p>services will be checked against equipment to affirm maintenance action was taken as appropriate. Adverse findings will result in further education and/or reprimands for staff members.</p> <p>E) Date of compliance with proposed actions: February 21, 2014</p>				

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	<p>the white dome light outside the resident's door to come on each time the call light was pressed.</p> <p>During an interview at this time, CNA #5 indicated the resident's call light system was not functioning properly.</p> <p>During an observation on 1/15/14 at 10:44 A.M., Environmental Service Staff #7 was unable to get the resident's call light system to function properly. During an interview at this time, he indicated he thought the call light cord was bad and he was going to change the cord. He indicated he replaced the call light cord and the resident's call light was functioning properly now.</p> <p>A undated document titled, "Smartcare" was provided by the Director of Nursing (DON) on 1/21/14 at 1:40 P.M. The document indicated that on 1/15/14 at 10:10 A.M., the computer had not picked up the call light when it was pressed. The resident's call light had been pressed by the Environmental Service Staff #7 at 10:44 A.M., but the document indicated that on 1/15/14 at 10:44 A.M., the computer had not picked up the call light when it was pressed.</p>			

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	<p>3. During an observation on 1/15/14 at 11:40 A.M., Resident #142's red light above the inside of his door and the white dome light on the outside of his door did not come on everytime the call light button was pressed. The facility staff had not responded when the call light was pressed.</p> <p>During an interview on 1/15/14 at 11:18 A.M., the resident indicated her call light had not worked last week. She indicated that one night last week her call light had not worked when she pressed it. She thought it was on and she waited two hours for someone to assist her to the bathroom. She indicated she had an incontinent episode with her bowels and she had to lay in her bowel movement for two hours waiting for someone to come down to her room to clean her. She stated, "No one should have to lay in their own bowel. That is inhumane." She indicated her call light had not worked last night and since last night it had not worked on different occasions.</p> <p>On 1/15/14 at 11:50 A.M., Environmental Service Staff #9 was informed the resident's call light was not functioning properly and he went</p>				

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	<p>to the residents room to check the function of the call light.</p> <p>A undated document titled, "Smartcare" was provided by the Director of Nursing (DON) on 1/21/14 at 1:40 P.M. The document indicated that on 1/15/14 at 11:40 A.M., the computer had not picked up the call light when it was pressed. The document indicated on the following dates and times the resident's call light was pressed, but the call was not received or responded to by staff.</p> <p>1/6/14 at 7:26 A.M. 1/7/14 at 5:05 A.M. 1/8/14 at 3:32 A.M. 1/9/14 at 8:26 A.M. 1/9/14 at 11:12 A.M. 1/9/14 at 1:55 P.M. 1/9/14 at 3:45 P.M. 1/9/14 at 5:43 P.M. 1/9/14 at 6:46 P.M. 1/9/14 at 10:24 P.M. 1/10/14 at 12:50 A.M. 1/10/14 at 11:57 A.M. 1/10/14 at 3:29 P.M. 1/12/14 at 3:52 A.M. 1/12/14 at 7:37 A.M. 1/12/14 at 11:22 A.M. 1/12/14 at 7:33 P.M. 1/12/14 at 9:17 P.M. 1/13/14 at 2:27 A.M. 1/14/14 at 3:28 A.M.</p>						

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	<p>1/14/14 at 2:55 P.M. 1/14/14 at 11:42 P.M. 1/15/14 at 8:58 A.M. 1/15/14 at 1:19 P.M.</p> <p>The Smartcare document history displayed the resident's call light history from 1/5/14 12:01 A.M., to 1/15/14 1:02 P.M. During these dates and times she had pressed her call light a total of 39 times. The call light had registered to the computer a total of 13 times that the call light had been pressed. The shortest amount of time the staff took to respond to her call light during these times were 0 minutes. The longest amount of time the staff took to respond to her call light during these times were 21 minutes to assist her.</p> <p>During an interview on 1/15/14 at 10:44 A.M., the Environmental Service Staff #7 indicated the call light system was a three part system. He indicated there was a pager that the staff received a page when the call light was pressed and the computer sent a signal to the pager, a red light in the resident's room above his or her door so the resident would know when their light was actually turned on and the white dome light outside the residents</p>			

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NAME OF PROVIDER OR SUPPLIER FORUM AT THE CROSSING				STREET ADDRESS, CITY, STATE, ZIP CODE 8505 WOODFIELD CROSSING BLVD INDIANAPOLIS, IN 46240			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>doors to allow staff walking down the hallways to acknowledge a resident needed assistance. He indicated that because the red or white lights did not come on did not mean the page did not go through to the pager.</p> <p>During an interview on 1/15/14 at 12:50 P.M., the Assistant Director of Nursing (ADoN) indicated the resident's call light was functioning according to the computer system. She indicated she thought the call button was being pushed to fast for the computer to reset or not hard enough for the computer to pick up on the signal. She indicated the red light in the resident's room and the white dome lights in the hallway was for the convenience of the residents and the staff to allow them to know the call lights were on, but the staff depended on the pagers to know when a resident's call light was on.</p> <p>During an interview on 1/15/14 at 1:00 P.M., the Director of Nursing (DoN) and the ADoN indicated the Environmental Service Worker #9 had checked the resident's call light system and he did not find anything wrong with it. They indicated her system could be working part of the time.</p>						

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	<p>During an interview on 1/21/14 at 2:00 P.M., the DoN and the Executive Director (ED) indicated the resident's light was working sporadically. The ED indicated on 1/20/14, but did not indicate a time, he had a company from Chicago come and fix the call light system. The DoN indicated since the Environmental Service Staff #7 worked on the Resident #142's call light system on 1/15/14 that her call light was being sent to the pager as the B call light on the CNA's pager. She indicated this resident had been moved to her old room on 1/15/14 and there were two new residents in that room. She indicated when the CNA's get a page for that room, they ask both residents, which one needs assistance.</p> <p>During the interview at this time the ED indicated the company from Chicago had fixed the wires that had gotten crossed last week, but the call lights in that room were not functioning properly, so he was not sure what the company had done.</p> <p>During an interview on 1/22/14 at 11:00 A.M., the ED indicated the company from Chicago had not fixed the call light system in Resident</p>				

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	#142's temporary room so that it functioned properly. 3.1-19(u)(1)			