

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155236	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/07/2015
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NAME OF PROVIDER OR SUPPLIER AVON HEALTH & REHABILITATION CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 4171 FOREST POINTE CIR AVON, IN 46123
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00186985.</p> <p>This visit was in conjunction with Complaint IN00188020.</p> <p>Complaint IN00186985- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: November 30 and December 1, 2, 3, 4, & 7, 2015.</p> <p>Facility number: 000141 Provider number: 155236 AIM number: 100283860</p> <p>Census bed type: SNF/NF: 111 Total: 111</p> <p>Census payor type: Medicare: 14 Medicaid: 79 Other: 18 Total: 111</p> <p>These deficiencies reflect State findings in accordance with 410 IAC 16.2-3.1.</p>	F 0000		

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

TITLE

(X6) DATE

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

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F 0157 SS=G Bldg. 00	<p>Quality review completed December 13, 2015 by 29479.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of</p>			

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	<p>the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to assess and immediately notify a physician of a resident's change in condition related to concerns of lethargy and dehydration voiced by the family member, which resulted in hospitalization for dehydration. This deficient practice affected 1 of 3 residents reviewed for physician notification (Resident B).</p> <p>Findings include:</p> <p>Resident B's record was reviewed on 12/3/2015 at 3:45 p.m. Resident B had diagnoses which included, but were not limited to, dysphagia, vascular dementia, cognitive communication deficit, and hypernatremia (high concentration of sodium in the blood). The record lacked indication of a system for ensuring fluids were increased and the resident was monitored for signs of dehydration.</p> <p>A physician's progress report, dated 11/24/2015, indicated the Nurse Practitioner had evaluated Resident B for hypernatremia with regard to her sodium level of 150 drawn on 11/12/2015. The Nurse Practitioner indicated the facility was to encourage Resident B to drink oral fluids and recheck her BMP on</p>	F 0157	<p>The following plan of correction constitutes our written allegation of compliance for the deficiencies cited. Submission of this plan of correction is not an admission that the deficiency exists or that one was cited correctly. This plan of correction is submitted to meet the requirements established by State and Federal law. This facility respectfully requests paper compliance for the deficiencies cited. Corrective action: Physician was notified of Resident B's change of condition and an assessment completed. Other residents with potential to be affected: Residents with a change of condition have the potential to be affected. Progress notes were reviewed from the past week to ensure any residents with a change of condition had been assessed and physicians had been notified. Systematic changes: 1:1 education was provided to staff member who failed to make appropriate notification. An in-service was presented to staff on the facility 'Physician/Family/Responsible Party Notification' policy and the e-interact Change of Condition Assessment. IDT will review progress notes during clinical meeting for changes of condition and audit for appropriate notification (no less than 5 days/week excluding holidays and</p>	01/06/2016			

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	<p>11/30/2015.</p> <p>A nurse's note, dated 11/25/2015 at 9:06 p.m., indicated Resident B's daughter called the facility twice during the shift and expressed concerns regarding her mother's lethargy during the afternoon and requested her anti-anxiety medication be placed on hold. This note indicated Resident B's anti-anxiety medication had been placed on hold and the resident had been put on the doctor's board for assessment during his next visit to the facility.</p> <p>A nurse's note, dated 11/26/2015 at 6:29 p.m., indicated Resident B's routine pain medication had not been administered because the resident appeared tired.</p> <p>A nurse's note, dated 11/26/2015 at 8:00 p.m., indicated Resident B's daughter arrived at the facility at 7 p.m. and expressed concern regarding her mother's lethargy, decreased responsiveness and lack of eating and drinking. She requested the facility transfer her mother to the Emergency Room for evaluation. This note indicated the ambulance transported Resident B to the Emergency Room at 7:50 p.m.</p> <p>A review of Resident B's November 2015 Vital Signs Report, dated 12/7/2015,</p>		weekends) . Staff members who fail to comply will be subject to re-education and/or disciplinary action. Monitoring: Results of the audits will be forward to QA for review monthly X3 then quarterly. Date of completion: 1/6/16	

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	<p>indicated Resident B's blood pressure, temperature, pulse, respirations and oxygen level had not been assessed during the month of November until 11/26/2015 at 7 p.m.</p> <p>A Physician's Progress Note, dated 11/26/2015 at 11:29 p.m., indicated Resident B had a critically high sodium level of 182 and would be admitted to the hospital from the Emergency Department for further evaluation.</p> <p>An Admission History and Physical Note, dated 11/27/2015 at 2:58 a.m. indicated Resident B was admitted to the hospital with pronounced dehydration, severe hypernatremia and altered mental status.</p> <p>During an interview on 12/7/2015 at 11:23 a.m., the Director of Nursing (DON) indicated she could not provide documentation of a nursing assessment on Resident B after her family voiced concerns of the resident's condition.</p> <p>During an interview on 12/7/2015 at 12:07 p.m., the DON indicated Resident B had an order to encourage oral fluids due to her high sodium levels and to increase hydration. She indicated the facility encouraged and monitored oral fluid intake with documentation. No</p>			

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	<p>other assessments were in place to assess hydration.</p> <p>During an interview on 12/7/2015 at 12:25 p.m., the DON indicated she expected her staff to perform an assessment of a resident when a family member voiced concerns regarding a change in the resident's condition.</p> <p>During an interview on 12/7/2015 at 2:49 p.m., Licensed Practical Nurse (LPN) #7 indicated non-emergent concerns regarding a resident are placed on the doctor's board. The physicians visit the facility at least twice a week and will review the doctor's board in the facility. Emergency concerns regarding a resident should be called into the physician.</p> <p>During an interview on 12/7/2015 at 3:55 p.m., the DON indicated an assessed change of condition should be reported to the physician immediately.</p> <p>A policy titled "Physician/Family/Responsible Party Notification for Change in Condition, dated 8/2013, and identified as current by the Nurse Consultant on 12/7/2015 at 3:35 p.m., indicated, ...Purpose: To ensure that medical care problems are communicated to the attending physician and family/responsible party in a timely,</p>			

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F 0223 SS=D Bldg. 00	<p>efficient, and effective manner...Policy: Physician and family/responsible party notification is to include, but is not limited to: ...change in level of consciousness, change in condition that may warrant a change in current treatment...Physician and Family/Responsible Party notification will be documented in the progress notes, it should contain information regarding the resident condition, physician notification, and any physician orders obtained...."</p> <p>3.1-5(a)(1)</p> <p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on record review and interview, the facility failed to ensure a resident was free from verbal and physical abuse for 1 of 1 abuse allegations reviewed (Resident #36).</p> <p>Finding includes:</p>	F 0223	<p>Corrective action: Facility followed abuse protocol per company policies and state regulations. Administrator and DON immediately notified, employee immediately suspended pending investigation to ensure resident safety. Employee terminated following investigation. Other residents having potential to be affected:</p>	01/06/2016

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	<p>During an interview on 12/1/15 at 11:11 a.m., Resident #207 indicated she had observed Certified Nursing Assistant (CNA) #6 verbally and physically abuse Resident #36. Resident #207 indicated CNA #6 was rough when assisting Resident #36 into her wheelchair. She indicated CNA #6 kept loudly saying, "stand up, stand up," despite the resident stating she was unable to stand without assistance. CNA #6 then grabbed the resident, pulled her up roughly and caught her foot on the foot pedal. She indicated CNA #6 jerked the resident's foot from under the foot pedal and dropped her on the bed. She indicated the resident was in tears.</p> <p>During an interview on 12/1/15 at 1:56 p.m., Resident #36 indicated Certified Nursing Assistant (CNA) #6 was rough with her and spoke harshly to her.</p> <p>During an interview on 12/01/15 at 3:21 p.m., the Executive Director (ED) indicated the abuse allegation regarding Resident #36 was reported to the Indiana State Department of Health (ISDH) and the employee was terminated.</p> <p>The investigative report, dated 11/9/15, for the abuse allegation was reviewed on 12/1/15 at 3:27 p.m. The investigation included a written interview from</p>		<p>Resident and staff interviews were conducted upon the allegation of abuse and no other residents were identified. Systematic changes: Our facility will continue to provide abuse training during orientation and ongoing throughout the year through staff in-services and on-line training. Facility will provide abuse training to all departments by 1/6/15. QAPI nurse will continue to address during stage 1 Abaqis with resident and family reviews quarterly, with Administrator to follow up on any concerns. Abuse reporting education will be provided monthly during resident council. (ongoing) Education/information regarding abuse will continue to be provided upon admission to resident/and/or family member through the admission process Monitoring: Administrator and/or designee will monitor abuse training via on-line training system and in-house training monthly x 3 months then quarterly thereafter, ongoing unless otherwise determined by the QA committee. Stage 1 Abaqis involves resident and/or family interviews that will allow both alert and cognitively impaired residents the opportunity to be assessed for potential abuse. Any positive response during this interview process will be immediately reported to the Administrator and an investigation will be initiated.</p>				

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	<p>Resident #36 stating CNA #6 was rough with her, and pushed her in bed. The report stated, " she became tearful and the aide said 'quit that baby stuff.'"</p> <p>Resident #36 indicated her foot got stuck in wheel of walker and the CNA #6 jerked her foot out. The report included a written interview from the night shift supervisor stating the resident was very upset and had stated one of the CNAs was very rough with her. The night shift supervisor indicated Resident #207 had witnessed the incident and both residents were scared of CNA #6 and of her taking care of them. The report included a written interview with CNA #6. CNA #6 indicated she had cared for Resident #36 on 11/8/15.</p> <p>The follow-up report of alleged abuse submitted to ISDH, dated 11/13/15, stated Resident #36, "consistently repeated the details of the situation." The report indicated CNA #6 admitted to providing care at the time of the incident, but denied allegations of abuse. The report stated CNA #6's, "employment was terminated for not meeting care standards."</p> <p>Resident #36's record was reviewed on 12/2/15 at 2:30 p.m. Resident #36's 30 day minimum data set (MDS) assessment, dated 11/27/15, indicated the</p>		<p>Results of the training and Abaqis reviews will be brought to monthly QA ongoing unless otherwise determined by the QA committee Date of completion: 1/6/15</p>				

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	<p>resident's brief interview for mental status (BIMS) score was 15 and the resident was cognitively intact, the resident had adequate hearing, and was able to make her understood.</p> <p>Resident #207's record was reviewed on 12/2/15 at 3:30 p.m. Resident #207's 14 day MDS, dated 11/2/15, indicated she had a BIMS score of 15 and was cognitively intact, had adequate hearing, and was able to make herself understood.</p> <p>The staff in-service titled, "All Staff inservice related to abuse and reporting abuse," dated 1/28/15, stated, "It is mandatory if a resident reports to you that someone is 'rough', 'aggressive', or reports any form of abuse, this MUST be reported to the ADMINISTRATOR, and DON IMMEDIATELY!!!" The inservice stated, "Any negative comments while in a resident's room could be perceived as abuse...Any 'Man-handling' or excessive roughness or force could be considered abuse."</p> <p>On 12/3/15 at 11:33 a.m., the ED provided by the current abuse policy titled, "Abuse, Neglect, and Misappropriation of Resident Property." The policy stated, "resident has the right to be free from verbal, sexual, physical and mental abuse, involuntary seclusion,</p>			

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F 0226 SS=D Bldg. 00	<p>corporal punishment and misappropriation of resident property...The staff will not commit verbal, mental, sexual or physical abuse, including corporal punishment or involuntary seclusion.</p> <p>3.1-27(a)(1) 3.1-27(b)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to implement its policies and procedures to prevent abuse to a resident for 1 of 1 abuse allegations reviewed (Resident #36).</p> <p>Finding includes:</p> <p>During an interview on 12/1/15 at 11:11 a.m., Resident #207 indicated she had observed Certified Nursing Assistant (CNA) # 6 verbally and physically abuse Resident #36. Resident #207 indicated CNA #6 was rough when assisting Resident #36 into her wheelchair. She indicated CNA #6 kept loudly saying, "stand up, stand up," despite the resident stating she was unable to stand without</p>	F 0226	<p>Corrective Action: Facility provided the ISDH survey team with abuse policies and procedures in accordance with state regulations. Per policy, the Administrator and DON were notified immediately, employee was immediately suspended pending investigation and facility ensured resident safety. Employee terminated following investigation. Other residents having potential to be affected: Resident and staff interviews were conducted upon the allegation of abuse and no other residents were identified. Systematic changes: facility will continue to provide abuse training during orientation and ongoing throughout the year through staff in-services and</p>	01/06/2016

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	<p>assistance. CNA #6 then grabbed the resident, pulled her up roughly and caught her foot on the foot pedal. She indicated CNA #6 jerked the resident's foot from under the foot pedal and dropped her on the bed. She indicated the resident was in tears.</p> <p>During an interview on 12/1/15 at 1:56 p.m., Resident #36 indicated Certified Nursing Assistant (CNA) #6 was rough with her and spoke harshly to her.</p> <p>During an interview on 12/01/15 at 3:21 p.m., the Executive Director (ED) indicated the abuse allegation regarding Resident #36 was reported to the Indiana State Department of Health (ISDH) and the employee was terminated.</p> <p>The investigative report, dated 11/9/15, for the abuse allegation was reviewed on 12/1/15 at 3:27 p.m. The investigation included a written interview from Resident #36 stating CNA #6 was rough with her, and pushed her in bed. The report stated, " she became tearful and the aide said 'quit that baby stuff.'" Resident #36 indicated her foot got stuck in wheel of walker and the CNA #6 jerked her foot out. The report included a written interview from the night shift supervisor stating the resident was very upset and had stated one of the CNAs</p>		<p>on-line training. Facility will provide abuse training to all departments by 1/6/15. QAPI nurse will continue to address during stage 1 Abaqis with resident and family reviews quarterly, with Administrator to follow up on any concerns. Abuse reporting education will be provided monthly during resident council. (ongoing) Education/information regarding abuse will continue to be provided upon admission to resident/and/or family member through the admission process. Monitoring: Administrator and/or designee will monitor abuse training via on-line training system and in-house training monthly x 3 months then quarterly thereafter, ongoing unless otherwise determined by the QA committee. Stage 1 Abaqis involves resident and/or family interviews that will allow both alert and cognitively impaired residents the opportunity to be assessed for potential abuse. Any positive response during this interview process will be immediately reported to the Administrator and an investigation will be initiated. Results of the training and Abaqis reviews will be brought to monthly QA ongoing unless otherwise determined by the QA committee Date of completion: 1/6/16</p>	

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	<p>was very rough with her. The night shift supervisor indicated Resident #207 had witnessed the incident and both residents were scared of CNA #6 and of her taking care of them. The report included a written interview with CNA #6. CNA #6 indicated she had cared for Resident #36 on 11/8/15.</p> <p>The follow-up report of alleged abuse submitted to ISDH, dated 11/13/15, stated Resident #36, "consistently repeated the details of the situation." The report indicated CNA #6 admitted to providing care at the time of the incident, but denied allegations of abuse. The report stated CNA #6's, "employment was terminated for not meeting care standards."</p> <p>Resident #36's record was reviewed on 12/2/15 at 2:30 p.m. Resident #36's 30 day minimum data set (MDS) assessment, dated 11/27/15, indicated the resident's brief interview for mental status (BIMS) score was 15 and the resident was cognitively intact, the resident had adequate hearing, and was able to make her understood.</p> <p>Resident #207's record was reviewed on 12/2/15 at 3:30 p.m. Resident #207's 14 day MDS, dated 11/2/15, indicated she had a BIMS score of 15 and was</p>			

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F 0279	<p>cognitively intact, had adequate hearing, and was able to make herself understood.</p> <p>The staff in-service titled, "All Staff inservice related to abuse and reporting abuse," dated 1/28/15, stated," It is mandatory if a resident reports to you that someone is 'rough', 'aggressive', or reports any form of abuse, this MUST be reported to the ADMINISTRATOR, and DON IMMEDIATELY!!!" The inservice stated, "Any negative comments while in a resident's room could be perceived as abuse...Any 'Man-handling' or excessive roughness or force could be considered abuse."</p> <p>On 12/3/15 at 11:33 a.m., the ED provided by the current abuse policy titled, "Abuse, Neglect, and Misappropriation of Resident Property." The policy stated, "resident has the right to be free from verbal, sexual, physical and mental abuse, involuntary seclusion, corporal punishment and misappropriation of resident property...The staff will not commit verbal, mental, sexual or physical abuse, including corporal punishment or involuntary seclusion.</p> <p>3.1-28(a) 483.20(d), 483.20(k)(1)</p>			

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SS=E Bldg. 00	<p>DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to develop individualized and measurable goals for residents' care plans for 3 of 27 residents reviewed for care plans (Residents #134, #15, and #122).</p> <p>Findings include:</p> <p>1. Resident 134's record was reviewed on 12/02/2015 at 11:14 a.m. Resident #134 had a diagnoses which included, but were limited to, agitation and dementia. The record lacked indication the facility's behavioral monitoring system was</p>	F 0279	<p>Corrective Action: identified residents were reviewed and behavior care plans were updated to reflect individualized with measureable goals Other residents having potential to be affected: all residents who require a behavioral care plan have the potential to be affected Systematic changes: Social Services and Care Plan Coordinator will provide an audit of all behavioral care plans– any identified care plans will be reviewed to ensure individualized with measureable goals. Care plans will be reviewed and/or updated during behavior management meeting(s) and as</p>	01/06/2016	

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	<p>utilized for tracking behaviors.</p> <p>Behavior care plans, dated 9/16/15, indicated Resident #134 exhibited hallucinations which caused her distress and required reassurance, validation, and understanding. A goal indicated the symptoms would be managed with her "care plan interventions." Interventions indicated staff would allow her to choose not to have care, reproach at a later time, administer medications as ordered, change care giver, offer alternative interventions. The care plan lacked indication of a measurable goal to assess the efficacy of the interventions implemented to address Resident #134's behaviors.</p> <p>During an interview with the Director of Nursing (Director of Nursing) and the SSD on 12/04/2015 at 1:54 p.m., the DON indicated a care plan which indicated measurable goals to assess the the efficacy of the interventions implemented to address Resident #134's behaviors was not available..</p> <p>2. Resident #15's record was reviewed on 12/4/2015 at 10:30 a.m. Resident #15 had a diagnosis which included, but was not limited to, dementia. The record lacked indication the facility's behavioral monitoring system was utilized for</p>		<p>needed to reflect resident status on an ongoing basis Monitoring: Behaviors will be reviewed during clinical/IDT meeting (no less than 5 days/week excluding holidays and weekends) and the care plans will be reviewed to reflect changes as needed . Social Services will audit behavioral care plans monthly to ensure goals are measureable and that the care plans are individualized – results of the audit will be brought to monthly QA X3 months then quarterly ongoing unless otherwise determined by the QA committee. Date of completion: 1/6/16</p>		

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	<p>tracking behaviors.</p> <p>A care plan, dated 9/17/15, indicated Resident #15 had behavioral symptoms which included "potential for resistance to care such as showers changing clothing or having hair washed, delusion." The care plan indicated her behaviors would be managed through her "care plan interventions." The interventions included staff were to allow her to express her feelings and participate in her delusions if they were not distressing to her, provide her reassurance if they were distressing to her, allow her to refuse care, attempt care at a later time, and offer alternative choices for care. The care plan lacked indication of a measurable goal to ensure the efficacy of the mood stabilizer medication or indication the use of the medication would be routinely reviewed and gradual dose reductions would be attempted if not contraindicated.</p> <p>During an interview with the Director of Nursing (Director of Nursing) and the SSD on 12/04/2015 at 1:54 p.m., the DON indicated a care plan which indicated measurable goals to assess the the efficacy of the interventions implemented to address Resident #15's behaviors was not available.</p>						

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	<p>3. Resident #122's record was reviewed on 12/02/2015 at 4:10 P.M. Resident #122 had a diagnosis which included, but was not limited to, anxiety. The record lacked indication the facility's behavioral monitoring system was utilized for tracking behaviors.</p> <p>A care plan dated 10/2/15, indicated Resident #122 had anxiety. A goal indicated her anxiety would be managed by her "care plan interventions." Interventions included staff were to allow her to verbalize her anxiety, administer medication as needed, remind her to use relaxation strategies such as massage, talking in a soothing voice, soft music, sounds, aroma therapy deep breathing, and spiritual support The care plan lacked indication of a measurable goal to assess the efficacy of the interventions to address Resident #122's anxiety.</p> <p>During an interview with the Director of Nursing (Director of Nursing) and the SSD on 12/04/2015 at 1:54 p.m., the DON indicated a care plan which indicated measurable goals to assess the the efficacy of the interventions implemented to address Resident #122's anxiety was not available.</p> <p>A Care Area Assessment Process and Care Planning policy identified as current</p>			

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	<p>by 12/7/15 at 9:07 a.m., indicated, "... The care delivery system in a nursing home is complex yet critical to successful resident care outcomes and is guided by both professional standards of practice and regulatory requirements. The delivery of care to meet the needs of resident is based upon the completion of a comprehensive assessment and the development of a care plan based upon the assessment. Documentation of this assessment process is necessary to assure continuity of care and to identify declines, improvements, or maintenance of a resident's condition of a resident's condition... CAA [Care Area Assessments] documentation should include the underlying causes, contributing factors, and unique risk factors related to the care area condition for the specific resident. A risk factor increased the chance of having a negative outcome or complication...The plan of care then addresses these factors with the goal of promoting the resident's highest practicable level of functioning" (improvements where possible or () maintenance and prevention of avoidable declines... When the IDT [Interdisciplinary Team]The existence of a care planning issue (i.e., a resident problematic issue/condition, need, or strength) should be documented a part of the CAA review documentation.</p>			

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	<p>Documentation may be done by individual staff members who have completed assessments or have participated in care planning, or as a summary note by members of the IDT. The resident, family, or resident representative should be part of the team discussion or join the care planning process when desires. The individual team members may have already discussed preliminary care plan ideas with the resident, family, or resident representative in order to get suggestions, confirm agreement, or clarify reasons for developing specific goals and approaches. In some cases, a resident may refuse particular services or treatments that the IDT believes may assist him or her to meet the highest practicable level of well-being. The resident's wishes should be documented in the clinical record. When the IDT has identified problematic issues/conditions, limitation, maintenance levels, improvement possibilities, and so forth, the IDT should state these items, to the extent possible, in functional or behavioral terms (e.g., how the condition is a problem for the resident; how the condition limits or jeopardizes the residents' ability to complete the tasks of daily life; or how the condition affects the resident's well-being in some way). The IDT agrees on intermediate goal(s) that</p>			

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F 0309 SS=G Bldg. 00	<p>will lead to an outcome objective. The intermediate goal(s) should be measurable and have a time frame for completion or evaluation. The parts of the goal statement should include" The subject, the verb, modifiers, and the time frame...Depending upon the conclusions of the assessment, types of goals may include improvements goals, prevention goals, palliative goals, or maintenance goals. Specific, individualized steps or approaches that the staff will take to assist the resident to achieve the goal(s) will be identified. These approaches serve as instructions for resident care and provide for continuity of care by all staff...."</p> <p>3.1-35(a)</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. Based on interview and record review,</p>	F 0309	Corrective action: Physician was notified of Resident B's change of	01/06/2016

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	<p>the facility failed to complete an immediate assessment of a resident following a family member's voiced concerns of a change in condition, which resulted in a hospitalization of the resident due to critical sodium lab values and severe dehydration (Resident B).</p> <p>Findings include:</p> <p>Resident B's record was reviewed on 12/3/2015 at 3:45 p.m. Resident B had diagnoses which included, but were not limited to, dysphagia, vascular dementia, cognitive communication deficit, and hypernatremia (high concentration of sodium in the blood). The record lacked documentation of a nursing assessment performed for Resident B on 11/25/2015, following the concerns of the resident's family member. The record lacked indication of a system for ensuring fluids were increased and the resident was monitored for signs of dehydration.</p> <p>A Basic Metabolic Panel (BMP) lab report, dated 11/12/2015, indicated Resident B had a high sodium level of 150 milliequivalents per liter (mEq/L). The reference range for sodium levels is between 135- 145 mEq/L.</p> <p>A Basic Metabolic Panel (BMP) lab report, dated 11/12/2015, indicated</p>		<p>condition and an assessment completed. Other residents having potential to be affected: Residents with a change of condition have the potential to be affected. Progress notes were reviewed from the past week to ensure any residents with a change of condition had been assessed and physicians had been notified. Systematic changes: 1:1 education was provided to staff member who failed to make appropriate notification. An in-service was presented to staff on the facility 'Physician/Family/Responsible Party Notification' policy and the e-interact Change of Condition Assessment. IDT will review progress notes during clinical meeting for changes of condition and audit for appropriate notification and a completed assessment (no less than 5 days/week excluding holidays and weekends). Staff members who fail to comply will be subject to re-education and/or disciplinary action. Monitoring: Results of the audits will be forward to QA for review monthly X3 then quarterly unless otherwise noted by the QA committee Date of completion: 1/6/16</p>		

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	<p>Resident B had a high sodium level of 150 milliequivalents per liter (mEq/L). The reference range for sodium levels is between 135- 145 mEq/L.</p> <p>A physician's progress report, dated 11/24/2015, indicated the Nurse Practitioner had evaluated Resident B for hypernatremia with regard to her sodium level of 150 drawn on 11/12/2015. The Nurse Practitioner indicated the facility was to encourage Resident B to drink oral fluids and recheck her BMP on 11/30/2015.</p> <p>A nurse's note, dated 11/25/2015 at 9:06 p.m., indicated Resident B's daughter called the facility twice during the shift and expressed concerns regarding her mother's lethargy during the afternoon and requested her anti-anxiety medication be placed on hold. This note indicated Resident B's anti-anxiety medication had been placed on hold and the resident had been put on the doctor's board for assessment during his next visit to the facility.</p> <p>A nurse's note, dated 11/26/2015 at 1:00 p.m., indicated Resident B's routine pain medication had not been administered per her daughter's request.</p> <p>A nurse's note, dated 11/26/2015 at 6:29</p>			

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	<p>p.m., indicated Resident B's routine pain medication had not been administered because the resident appeared tired.</p> <p>A nurse's note, dated 11/26/2015 at 8:00 p.m., indicated Resident B's daughter arrived at the facility at 7 p.m. and expressed concern regarding her mother's lethargy, decreased responsiveness and lack of eating and drinking. She requested the facility transfer her mother to the Emergency Room for evaluation. This note indicated the ambulance transported Resident B to the Emergency Room at 7:50 p.m.</p> <p>A review of Resident B's November 2015 Vital Signs Report, dated 12/7/2015, indicated Resident B's blood pressure, temperature, pulse, respirations and oxygen level had not been assessed during the month of November until 11/26/2015 at 7 p.m.</p> <p>A Physician's Progress Note, dated 11/26/2015 at 11:29 p.m., indicated Resident B had a critically high sodium level of 182 and would be admitted to the hospital from the Emergency Department for further evaluation.</p> <p>An Admission History and Physical Note, dated 11/27/2015 at 2:58 a.m. indicated Resident B was admitted to the</p>			

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	<p>hospital with pronounced dehydration, severe hypernatremia and altered mental status.</p> <p>During an interview on 12/7/2015 at 11:23 a.m., the Director of Nursing (DON) indicated she could not provide documentation of a nursing assessment on Resident B after her family voiced concerns of the resident's condition.</p> <p>During an interview on 12/7/2015 at 12:07 p.m., the DON indicated Resident B had an order to encourage PO fluids due to her high sodium levels and to increase hydration. She indicated the facility encouraged and monitored oral fluid intake with documentation. No other assessments were in place to assess hydration.</p> <p>During an interview on 12/7/2015 at 12:25 p.m., the DON indicated she expected her staff to perform an assessment of a resident when a family member voiced concerns regarding a change in the resident's condition.</p> <p>During an interview on 12/7/2015 at 12:45 p.m., the DON indicated the facility had no numeric parameters for fluid to maintain Resident B's hydration.</p> <p>During an interview on 12/7/2015 at 2:49</p>			

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	<p>p.m., Licensed Practical Nurse (LPN) #7 indicated non-emergent concerns regarding a resident are placed on the doctor's board. The physicians visit the facility at least twice a week and will review the doctor's board in the facility. Emergency concerns regarding a resident should be called into the physician.</p> <p>During an interview on 12/7/2015 at 3:55 p.m., the DON indicated an assessed change of condition should be reported to the physician immediately.</p> <p>During an interview on 12/7/2015 at 4:00 p.m., the DON indicated she could not provide a facility policy regarding nursing assessments of a resident for a change in condition.</p> <p>A policy titled "Physician/Family/Responsible Party Notification for Change in Condition, dated 8/2013, and identified as current by the Nurse Consultant on 12/7/2015 at 3:35 p.m., indicated, ...Purpose: To ensure that medical care problems are communicated to the attending physician and family/responsible party in a timely, efficient, and effective manner...Policy: Physician and family/responsible party notification is to include, but is not limited to: ...change in level of consciousness, change in condition that</p>			

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F 0314 SS=G Bldg. 00	<p>may warrant a change in current treatment...Physician and Family/Responsible Party notification will be documented in the progress notes, it should contain information regarding the resident condition, physician notification, and any physician orders obtained...."</p> <p>3.1-37(a)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview, and record review, the facility failed to ensure pressure ulcer prevention interventions were evaluated and revised to prevent a resident who was admitted without a pressure ulcer to his coccyx from developing an unstageable (full thickness tissue loss in which actual depth of the ulcer is completely observed by slough and/or eschar in the wound bed) pressure</p>	F 0314	<p>Corrective action: Resident #158's pressure ulcer preventative interventions were reviewed and revised immediately upon finding coccyx ulcer. Other residents having potential to be affected: All residents with hip fractures and have the potential to be affected. An audit was completed to evaluate and revise preventative interventions for residents with fractures. Systematic changes: The DON</p>	01/06/2016

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	<p>ulcer that later became a stage 3 (full thickness skin loss) for 1 of 3 residents reviewed for pressure ulcers (Resident #158).</p> <p>Findings include:</p> <p>During an interview on 11/30/2015 at 2:56 p.m., Licensed Practical Nurse (LPN) #1 indicated Resident #158 had a stage 3 pressure ulcer (full thickness skin loss) to his coccyx.</p> <p>During an observation on 12/4/2015 at 1:46 p.m., Wound Nurse #2 changed a dressing to Resident #158's stage 3 pressure ulcer to his coccyx, that had been measured as 1 centimeter (cm) by 0.5 cm by 0.1 cm during a wound assessment on 12/2/2015. The wound had two small areas of sloughing visible at the edges of the wound. The old dressing had a scant amount of serosanguinous (containing or relating to both blood and the liquid part of blood) drainage. Resident was observed lying on a composure mattress.</p> <p>Resident #158's record was reviewed on 12/3/2015 at 9:45 a.m. Resident #158's diagnoses included, but were not limited to, dementia with behavioral disturbances, muscle weakness, and closed fracture of the femur.</p>		<p>and Wound Care Certified (WCC) Nurse presented an in-service on wound prevention to staff that included identifying residents that are at high risk for skin break down; immediate notification to wound nurse and/or DON of residents identified with change in skin condition; inspecting the entire body for any areas with redness or open areas; inspecting dry skin, moist skin, or break down of skin; monitoring restrictive devices such as splints, wraps, etc. New admissions will be reviewed during clinical meeting (no less than 5 days/week excluding holidays and weekends) and WCC Nurse/designee will ensure that residents admitted at risk for skin breakdown will receive appropriate pressure ulcer preventative interventions. WCC Nurse will implement turning and repositioning schedules for residents at risk for skin break down. WCC Nurse/designee will evaluate and revise pressure ulcer prevention interventions weekly on identified residents who are at risk for skin break down. WCC nurse/designee will make rounds at various times to assess proper utilization of wound preventative measures (no less than 5 days/week excluding days off). Staff members who fail to comply will be subject to re-education and/or disciplinary action. Monitoring: Results of the audits will be forwarded to QA</p>				

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	<p>A Skin observation sheet, dated 6/3/2015, indicated a Certified Nursing Assistant (CNA) discovered Resident #158's open area to his coccyx on 6/3/2015 at 9:04 p.m. This document indicated the open area to Resident #158's coccyx was new and acquired after his admission to the facility.</p> <p>An Initial Pressure Ulcer Report, dated 6/4/2015, indicated Resident #158 had an unstageable pressure ulcer to his coccyx, that had been measured as 3.2 cm by 1.3 cm by 0.1 cm. This pressure ulcer was not present on his admission to the facility. The wound report comments indicated Resident #158 had a recent surgery to his right hip. The pressure ulcer to his coccyx occurred due to repeated exposure to pressure while in bed and chair. The mattress was changed to composure on 6/2/2015 and a Roho cushion had been placed in his wheelchair.</p> <p>A Braden Scale for Predicting Pressure Sore Risk on Admission assessment, dated 6/10/2015, indicated Resident #158 had a mild risk of pressure ulcer development with a score of 15 out of 23.</p> <p>A skin integrity care plan, dated 6/10/2015, indicated Resident #158 was</p>		for review monthly X3 then quarterly. Date of completion: 1/6/16		

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	<p>at risk for developing pressure ulcers related to his immobility. The care plan goal indicated his risk for pressure ulcer development would be minimized through his care plan interventions. The interventions included: cushion in chair, turn and reposition frequently, observe skin weekly and as needed, remind resident to turn and reposition when choosing not to, and rest on a special support surface.</p> <p>A pressure ulcer care plan, dated 6/10/2015, indicated Resident #158 had a stage 3 wound to his coccyx that was previously noted as unstageable. The interventions included: will have a cushion in chair for pressure redistribution, receive treatments as ordered, rest on a composure mattress, assist with incontinence care, and assist with turning and repositioning every two hours and more frequently as needed.</p> <p>A Minimum Data Set assessment (MDS), dated 12/2/2015, indicated Resident #158 was at risk for developing pressure ulcers, and had one stage 3 pressure ulcer that had not been present on admission. Resident #158 required extensive assistance of at least 2 staff to assist him with bed mobility, transfers, and toileting. The resident required extensive assistance of 1 staff member for</p>			

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	<p>locomotion on the unit in his wheelchair.</p> <p>Pressure Ulcer Progress Reports for Resident #158's pressure ulcer to his coccyx indicated the resident's pressure ulcer to his coccyx was identified and measured as an unstageable pressure ulcer on 6/4/2015 with measurements of 3.2 cm by 1.3 cm by 0.1 cm. Resident #158's pressure ulcer progressed to a stage 3 pressure ulcer on 6/10/2015 with measurements of 2 cm by 1.3 cm by 0.1 cm. Resident #158's pressure ulcer to his coccyx remained at a stage 3 on 12/4/2015 with measurements of 1.8 cm by 0.5 cm by 0.1 cm.</p> <p>During an interview on 12/3/2015 at 3:35 p.m., Wound Nurse #2 indicated Resident #158 developed his pressure ulcer to his coccyx after his admission. She indicated the resident was encouraged to lay down after meals to relieve pressure from his coccyx. She indicated the pressure ulcer development to his coccyx was due to the lack of staff turning and repositioning him frequently.</p> <p>During an interview on 12/4/2015 at 11:31 a.m., LPN #3 indicated staff encouraged Resident #158 to lay down after meals and he often refused. He sat up in his wheelchair for meals and with locomotion on the unit.</p>			

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	<p>During an interview on 12/7/2015 at 10:56 a.m., Wound Nurse #2 indicated Resident #158 had dementia and had periods when he would not comply with the intervention of laying in bed after meals to alleviate pressure to his coccyx. She indicated Resident #158 received too much pressure to his coccyx sitting up in his wheel chair for long periods of time and a Roho cushion had been placed in his wheelchair after the unstageable pressure ulcer to his coccyx developed.</p> <p>During an interview on 12/7/2015 at 11:51 a.m., the Director of Nursing (DON) indicated Resident #158 was identified at risk for the development of pressure ulcers on admission. She indicated his care plan interventions for the prevention of pressure ulcers had not been individualized. She indicated after the facility identified the resident's non-compliance with laying down and after meals and repositioning, additional pressure reducing devices and a specialized turning and repositioning schedule should have been implemented before the development of his unstageable pressure ulcer to his coccyx.</p> <p>A Wound Prevention Protocol policy, dated 4/2012, and identified as current by the DON on 12/7/2015 at 10:00 a.m.,</p>			

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F 0315 SS=D Bldg. 00	<p>indicated the following, "...Identify residents that are high risk for developing pressure areas using the Braden scale. Relieve or remove pressure to prevent tissue trauma. Initiate nursing interventions along with medical orders to prevent tissue trauma...Resident specific interventions will be care planned..."</p> <p>3.1-40(a)(1)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, record review, and interview, the facility failed to obtain a physician order and justification for a resident's urinary catheter for 1 of 2 residents reviewed for urinary catheters (Resident #214).</p> <p>Finding includes:</p>	F 0315	<p>Corrective action: A physician's order and justification for the resident's urinary catheter was obtained for Resident # 214. Other residents having potential to be affected: All residents with catheters have the potential to be affected. An audit was completed to ensure physician orders and</p>	01/06/2016

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	<p>On 12/2/15 at 10:00 a.m., Resident #214 was observed lying in bed on her back with a urinary catheter bag hung on the bed frame.</p> <p>On 12/3/15 at 12:59 p.m., Resident #214 was observed sitting in her wheelchair with a urinary catheter bag hung on the side of the wheelchair.</p> <p>On 12/3/15 at 2:46 p.m., Resident #214's record was reviewed. The admission minimum data set (MDS) assessment, dated 11/13/15, indicated Resident #214 had a brief interview for mental status (BIMS) score of 13 out of 15 and had an indwelling urinary catheter.</p> <p>The hospital consultation report, dated 11/9/15, stated, "We will watch her closely for signs and symptoms of acute volume overload, and a Foley catheter will be anchored to accurately document her urine output."</p> <p>The physician order, dated 11/14/15, ordered urinary catheter care every shift and staff to record urinary output. The record lacked documentation of a physician order for the urinary catheter including: the size of the catheter, the amount of fluid to inflate the balloon, and how often to change the catheter and</p>		<p>justification for the urinary catheters were in place. Systematic changes: A catheter in-service was presented to nursing staff. DON/designee will review all new catheter placements during clinical meeting to ensure physician orders and justification for the urinary catheter is in place (no less than 5 days/week excluding holidays and weekends) . Monitoring: Results of the audits will be forward to QA for review monthly X3 then quarterly. Date of completion: 1/6/16</p>		

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	<p>catheter collection bag. The record lacked documentation of a diagnosis for the urinary catheter.</p> <p>The care plan, dated 11/20/15, indicated Resident #214 had an indwelling urinary catheter.</p> <p>The admission catheterization evaluation, dated 11/13/15, indicated the urinary catheter was inserted on 11/13/15. The catheterization evaluation, dated 11/18/15, stated, "Foley catheter was placed in the hospital with no plan for removal. No attempt with failure was made. Will talk to the doctor about removal."</p> <p>During an interview on 12/1/15 at 1:48 p.m., Licensed Practical Nurse (LPN) #4 indicated Resident #214 had an indwelling urinary catheter to promote wound healing for her bilateral leg wounds.</p> <p>During an interview on 12/4/15 at 12:10 p.m., Resident #214 indicated her urinary catheter was inserted in the hospital to monitor her urine output.</p> <p>During an interview on 12/7/15 at 10:03 a.m., the Director of Nursing (DON) indicated Resident #214's urinary catheter was inserted in the hospital for accurate</p>			

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	<p>urine output. She indicated the resident still had the catheter for the same reason. She indicated there was no physician order documented for the urinary catheter. She indicated the resident was taking diuretics and had severe edema, so the catheter was used to accurately monitor urine output.</p> <p>During an interview on 12/7/15 at 3:15 p.m., the DON indicated during the physician rounds the physician ordered the catheter to remain to monitor urine output. The DON indicated the reason for the Resident #214's urinary catheter was not documented and the catheterization assessment was unclear on the reason the catheter's benefits outweighed the risks.</p> <p>During a telephone interview on 12/7/15 at 4:00 p.m., Physician #5 indicated she had kept Resident #214's urinary catheter to accurately monitor urine output. She indicated the urinary catheter was the only way to accurately monitor urine output due to the being bedridden and incontinent of urine. She indicated it was medically necessary to accurately monitor the resident's urine output due to diagnoses of leukemia and severe edema, and the use of diuretics.</p> <p>On 12/7/15 at 3:35 p.m., the Nurse</p>			

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F 0329 SS=E Bldg. 00	<p>Consultant provided the current policy on documentation. The policy stated, "Each health care professional shall be responsible for making their own prompt, factual, concise, entries that are complete, appropriate, and readable... Verbal and telephone communication will all parties concerning the care and treatment of the resident will be entered in the clinical record."</p> <p>3.1-50(a)(1)</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>			

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	<p>Based on interview and record review, the facility failed to review and consider a dose reduction when documentation did not indicate residents displayed behaviors for which the medications were prescribed, failed to ensure residents were free from unnecessary medications, and failed to attempt non-pharmacological interventions prior to the administration of as needed anti-anxiety medications for 3 of 5 residents reviewed for unnecessary medication (Resident #134, #15, and #122).</p> <p>Findings included:</p> <p>1. Resident 134's record was reviewed on 12/02/2015 at 11:14 a.m. Resident #134 had a diagnoses which included, but were not limited to, agitation and dementia. A Minimum Data Set (MDS) assessment tool, dated 9/10/15, indicated Resident #134 had cognitive impairment with a Brief Interview Mental Status (BIMS) score of 6 out of 15 and was unable to answer questions regarding preferences for daily activities.</p> <p>A physician's order, dated 1/16/15, indicated Ativan (anti-anxiety) 0.5 milligrams (mg) 1/2 tab on Tuesday and Wednesday one hour prior to showers.</p>	F 0329	<p>Corrective Action: Resident #134's Ativan 0.5mg ½ tab on Tuesday and Wednesday one hour prior to showers was discontinued and behavior care plan was reviewed and updated as necessary. Resident #15's Divalproex 1250mg daily was reduced and behavior care plan reviewed and updated as necessary. Resident #122's Alprazolam 0.25mg every morning as needed was discontinued and care plan reviewed and updated as necessary. Other residents having potential to be affected: All residents receiving psychoactive medication prior to showers have the potential to be affected. Any residents identified had their behavior care plan reviewed and updated as needed and necessity of medication use reviewed with physician. All residents receiving a mood stabilizer for behavioral intervention have the potential to be affected. An audit was completed for residents receiving mood stabilizer for behavioral intervention to ensure gradual dose reductions occurred unless clinically contraindicated within the last quarter. All residents receiving as needed anti-anxiety medication have the potential to be affected. An audit was completed on residents receiving as needed anti-anxiety medication to identify if non-pharmacological interventions were attempted prior to use over the past 30 days and care plans</p>	01/06/2016			

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	<p>Behavior care plans, dated 9/16/15, indicated Resident #134 exhibited hallucinations which caused her distress and required reassurance, validation, and understanding. A goal indicated the symptoms would be managed with her care plan interventions. Interventions indicated staff would allow her to choose not to have care, reproach at a later time, administer medications as ordered, change care giver, offer alternative interventions.</p> <p>During an interview on 12/03/2015 at 3:32 p.m., Nurse Supervisor #1 indicated Resident #134 was showered twice a week and had a bed bath daily. She indicated she became very agitated during showers</p> <p>During an interview on 12/03/2015 at 4:12 p.m., the Social Service Director (SSD) indicated Resident #134 was "anxious by nature" however, her anxiety increased during showers. She indicated she was unable to find documentation which indicated why she didn't want a shower and did not have an explanation as to why she was being medicated for showers when other options for bathing were available.</p> <p>During an interview with the Director of Nursing (Director of Nursing) and the</p>		<p>updated as necessary. Systematic changes: The Regional Director of Quality Assurance presented an in-service to the Social service staff and interdisciplinary team over behavior management and psychoactive medication/ gradual dose reduction policy and procedures. Social Service Director presented an in-service to staff members on the behavior management program. The Administrator, Director of Nursing and Social Service Director will meet with the Psychiatrist to discuss the need for gradual dose reductions and clinically contraindicated statements within long term care to elicit his support with attempting gradual dose reductions as indicated. The Social Service Director/designee will pull a behavior alert and PRN medication report prior to clinical meeting to ensure non-pharmacological interventions were attempted prior to administration of PRN anti-anxiety medication. Brightly colored labels will be placed on all PRN anti-anxiety medication cards to alert the nurse of the need to provide at least 3 non-pharmacological interventions prior to the administration of the medication. Monitoring: IDT will review all behavior sheets during clinical meeting to ensure appropriate follow up and intervention was provided as necessary. IDT will review all</p>	

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	<p>SSD on 12/04/2015 at 1:54 p.m., the DON indicated residents had the right to refuse care and Resident #134 should not have been medicated for showers when other options were available.</p> <p>2. Resident #15's record was reviewed on 12/4/2015 at 10:30 a.m. Resident #15 had a diagnosis which included, but was not limited to, dementia.</p> <p>A physician's order, dated 8/29/11, indicated divalproex 1250 Milligrams (mg) daily for vascular dementia with delusions. The record lacked indication a gradual dose reduction of this medication had been attempted, or a failed gradual dose reduction, or indication the facility's behavioral monitoring system was utilized for tracking behaviors for evaluation of behavioral data for consideration of GDRs.</p> <p>A care plan, dated 9/17/15, indicated Resident #15 had behavioral symptoms which included "potential for resistance to care such as showers changing clothing or having hair washed, delusion." The care plan indicated her behaviors would be managed through her "care plan interventions." The interventions included staff were to allow her to express her feelings and participate in her delusions if they were not</p>		<p>resident's receiving mood stabilizer for behavioral intervention monthly to ensure gradual dose reduction completed unless clinically contraindicated. IDT will review the administration of as needed anti-anxiety medication during clinical meeting to ensure non-pharmacological interventions were utilized prior to its use. All findings of audits will be reviewed in QA meeting monthly for three months then quarterly for a total of six months. Date of Compliance: 1/6/16</p>		

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	<p>distressing to her, provide her reassurance if they were distressing to her, allow her to refuse care, attempt care at a later time, and offer alternative choices for care. The care plan lacked indication of a measurable goal to ensure the efficacy of the mood stabilizer medication or indication the use of the medication would be routinely reviewed and gradual dose reductions would be attempted if not contraindicated.</p> <p>A psychiatric progress note, dated 5/6/15, indicated staff reported resident had not exhibited symptoms of delusions or agitation. The note indicated the last documented behavior was on 12/31/14. The note lacked indication the physician reviewed and/or considered a gradual dose reduction of the divalproex. The note lacked indication a gradual dose reduction of the divalproex was contraindicated.</p> <p>A psychiatric progress note, dated 8/5/15, indicated staff reported Resident #15 exhibited "bossy" behaviors and was "chronically delusional" that her kids were young. The note indicated the physician declined a gradual dose reduction of the divalproex because Resident #15 was "just manageable" on current medications.</p>			

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	<p>A psychiatric progress note, dated 10/8/15, indicated staff reported Resident #15 remained delusional regarding having young children but had not exhibited agitation or aggression. The note indicated she continued to be "bossy." The note indicated the physician declined to decrease her medication because she was "well controlled" on current medication.</p> <p>During an interview on 12/4/15 at 11:23 a.m., the Social Service Director (SSD) indicated Resident #15 was on divalproex for "bossy behavior" and a gradual dose reduction had not been attempted since the medication was started in 2005. She indicated she doesn't currently exhibit "bossy behaviors." The SSD indicated psychotropic medications were routinely reviewed and if residents were not having behaviors gradual dose reductions would be attempted. She indicated only recorded when behaviors occurred and documentation which indicated Resident #15 had exhibited behaviors was not available. She indicated if a physician continued to refuse gradual dose reductions in the absence of documented behaviors the Executive Director would be notified.</p> <p>During an interview with the Director of Nursing (DON) and the Social Service</p>			

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	<p>Director on 12/4/15 at 2:04 p.m., the DON indicated Resident #15 was on divalproex for "not wanting to wash her hair, being anxious about her kids getting to school, and being bossy." She indicated Resident #15 had originally started on divalproex 250 milligrams twice a day and in August of 2011 it was increased to 1250 milligrams daily. She indicated a gradual dose reduction had not been attempted because she was "so well adjusted where she was." She further indicated documentation of a failed gradual dose reduction of the divalproex was not available.</p> <p>3. Resident #122's record was reviewed on 12/02/2015 at 4:10 P.M. Resident #122 had a diagnosis which included, but was not limited to, anxiety. The record lacked indication the facility's behavioral monitoring system was utilized for tracking behaviors for evaluation of the efficacy of the anti-anxiety medications.</p> <p>A physician's order dated 10/2/15, indicated alprazolam (anti-anxiety medication) 0.25 milligrams (mg) every am (morning) as needed (prn) for anxiety.</p> <p>A care plan dated 10/2/15, indicated Resident #122 had anxiety. A goal indicated her anxiety would be managed by her "care plan interventions."</p>			

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	<p>Interventions included staff were to allow her to verbalize her anxiety, administer medication as needed, remind her to use relaxation strategies such as massage, talking in a soothing voice, soft music, sounds, aroma therapy deep breathing, and spiritual support The care plan lacked indication of a measurable goal to ensure the efficacy of the interventions.</p> <p>Medication Administration Records, dated for October, November, and through December 4, 2015, were reviewed on December 4, 2015 at 11:25 a.m. The records indicated the prn anti-anxiety medication was administered on October 6, 10, 12, 23, November 19, 26, and December 2, 2015. The record lacked indication non pharmacological interventions were attempted prior to giving the "as needed" anti-anxiety medication.</p> <p>During an interview on 12/4/15 at 11:28 a.m., the Social Service Director indicated documentation which indicated non pharmacological interventions were attempted prior to the administration of the anti-anxiety medication was not available. She indicated because Resident #122 was alert and oriented the medication was administered when requested.</p>			

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	A Psychoactive Medications/Gradual Dose Reduction Policy identified as current by the Administrator 12/7/15 at 9:07 a.m., indicated, "It is the policy of this facility that a resident will receive psychoactive medications only when it is necessary to improve the resident's overall psychosocial health status. To ensure the resident is receiving the necessary medication at the lowest effective dose with an appropriate diagnosis. To ensure gradual dose reduction attempts are made unless contraindicated... Residents receiving psychoactive medications will have their medical record reviewed for appropriate diagnosis. If a diagnosis is not located in the resident's medical recorded, nursing will contact the primary physician for either a diagnosis or discontinuation of medications(S). Residents receiving psychoactive medications will have a care plan initiated that contains interventions regarding the target behaviors and possible adverse side effects of the medications(S)...Gradual dose reductions will be attempted, unless clinically contraindicated... Prior to the administration of a prn psychoactive medication, the nurse will attempt non-pharmacological interventions document the interventions attempted and outcomes of the intervention. Within the first year in which a resident is			

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F 0371 SS=D Bldg. 00	<p>admitted on an antipsychotic medication or after the physician has initiated an antipsychotic medication, the IDT must attempt a gradual dose reduction in two separate quarters (with at least one month between attempts) unless clinically contraindicated. After the first year, a gradual dose reduction must be attempted annually, unless contraindicated. The GDR may be considered clinically contraindicated if: target symptoms returned or worsened after the most recent attempt at a GDR within the facility; and The physician has documented the clinical rationale for why an additional attempted dose reduction would likely impair the resident's functioning, increase distressed behavior or cause psychiatric instability...."</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</p>	F 0371	Corrective action: the box of cake mix and creamy wheat were	01/06/2016

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	<p>record review, the facility failed to ensure foods were labeled with open dates for 1 of 2 kitchen observations. This deficient practice had the potential to affect 110 of 110 residents who received food from the kitchen.</p> <p>Finding includes:</p> <p>During the initial kitchen observation on 11/30/15 from 10:09 a.m. to 10:29 a.m., with the Dietary Manager (DM) present, a box of white cake mix and a container of creamy wheat hot cereal were observed open and stored in the dry storage area.</p> <p>During an interview on 11/30/15 at 10:17 a.m., the Dietary Manager indicated the container of cereal and the box of cake mix were open without an open date label. She indicated opened food items should have been labeled with an opened date.</p> <p>A policy titled "Leftovers" identified as current by the Nurse Consultant on 12/3/15 at 11:16 a.m., stated, "All foods stored for later use shall be covered, labeled with the food name, and dated with the current date as the open date (OP)..."</p> <p>3.1-21(i)(3)</p>		<p>removed. A review of all items in dry storage was completed to ensure label and dated Other residents having the potential to be affected: no other items were identified that would affect the residents Systematic changes: An in-service will be provided to dietary staff regarding labeling and dating of food items. A daily review of dry storage will be completed by the Dietary Manager and/or designee to ensure all opened items are labeled and dated, ongoing, unless otherwise noted by the QA committee (but no less than 3 months) Monitoring: A daily review of dry storage will be completed by the Dietary Manager and/or designee to ensure all opened items are labeled and dated, ongoing, unless otherwise noted by the QA committee (but no less than 3 months). Results of the review(s) will be brought to monthly QA x 3 months, then quarterly ongoing unless otherwise noted by the QA committee Date of completion: 1/6/16</p>	

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F 0441 SS=E Bldg. 00	<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</p>			
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	<p>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 to ensure adequate hand sanitation between resident to resident contact. This deficient practice had the potential to affect 3 of 3 residents observed for infection control (Residents #218, #3, and #197).</p> <p>Finding includes:</p> <p>On 12/7/15 from 9:10 a.m. through 9:18 a.m., Certified Nursing Assistant (CNA) #1 was observed on the 300 hall providing care. CNA #1 was not observed to sanitize her hands during the observation.</p> <p>CNA #1 was observed with bare hands adjusting Resident #218's bed covers, shutting off her light, and then exiting the room. She proceeded to push the meal tray cart down the hall, unlock the clean linen closet, remove clean linen, and then enter Resident #3's room. She placed the clean linen in Resident #3's room, exited the room and entered Resident #197's room. She was observed transporting Resident #197 to the restroom via his wheel chair.</p>	F 0441	<p>Corrective action: Facility was unable to correct as incident happened during the survey Other residents having the potential to be affected: all residents could potentially be affected Systematic changes: 1:1 education was provided to staff member who failed to utilize adequate hand sanitation between resident to resident contact. An in-service on hand washing was presented to staff. DON/designee will complete return demonstrations on hand hygiene completed by staff initially and then will conduct spot checks weekly. Monitoring: Results of the audits will be forward to QA for review monthly X3 then quarterly. Date of completion: 1/6/16</p>	01/06/2016			

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	<p>During an interview on 12/7/15 at 9:35 a.m., CNA #1 indicated she wasn't aware she needed to sanitize her hands unless she touched "dirty" items.</p> <p>During an interview on 12/7/15 at 10:00 a.m., the Director of Nursing indicated CNA #1 should have sanitized her hands after touching residents' belongings and before touching clean linen.</p> <p>A policy titled "Hand Washing" identified as current by the Director of Nursing on 10/12/15, indicated, "...To ensure proper hand washing before and after procedures/and or resident care to prevent the spread of infection... after contact with inanimate objects in the residents'/patients immediate environment..."</p> <p>3.1-18(1)</p>			