

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155282	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2011
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO	STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: October 13, 14, 17, 18, 19, 20, 21 and 24, 2011</p> <p>Facility number: 000180 Provider number: 155282 AIM number: 100274190</p> <p>Survey Team: Terri Walters RN TC Martha Saull RN Anne Marie Crays RN (10/17, 10/18, 10/19, 10/20, 10/21, & 10/24/11)</p> <p>Census payor type: SNF/NF: 103 Residential: 13 Total: 116</p> <p>Census payor type: Medicare: 9 Medicaid: 60 Other: 47 Total: 116</p> <p>Stage 2 sample: 39</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F0000	Credible Allegation of Compliance and Correction: Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual.	

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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	Quality review 10/31/11 by Suzanne Williams, RN			
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F0159 SS=A	<p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act;</p>	F0159		

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	<p>and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>Based on interview and record review, the facility failed to ensure residents received quarterly statements of their resident fund accounts, for 2 of 2 residents reviewed for current resident fund accounts, of 3 who met the criteria for personal funds. Residents # 73, # 32</p> <p>Findings include:</p> <p>1. On 10/18/11 at 8:10 A.M., during an interview with Resident # 73, she indicated she did not know how much money she had in her personal fund account.</p> <p>On 10/20/11 at 10:30 A.M., the Business Office Manager provided a Resident Trust Account statement for Resident # 73. She indicated a monthly statement was mailed to the resident's sister, but was not given to the resident herself.</p> <p>2. On 10/18/11 at 11:25 A.M., during an interview with Resident # 32, he indicated he was unaware of how much money he had in his personal fund account. He indicated he thought his wife received a statement, but was unsure.</p>		<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; All resident's including #73 and #32 received a statement on their RTA on 11/8/11. How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All resident's with a RTA have the potential to be effected. These resident's received a statement for their RTA on 11/8/11. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; All resident's who have a RTA will receive a quarterly statement. The business office manager will print statements quarterly and will be given to residents for their review. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The business office manager will report to the QA committee quarterly that statemenst have been sent x 2 quarters. The QA committee will have on their agenda to monitor for 100% compliance. If not 100% compliance, the</p>	11/10/2011	

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	<p>On 10/21/11 at 9:00 A.M., the Business Office Manager provided a Resident Trust Account statement for Resident # 32. She indicated a monthly statement was mailed to the resident's wife, but was not given to the resident himself.</p> <p>3. On 10/20/11 at 10:30 A.M., during an interview with the Business Office Manager, she indicated the facility mails out monthly statements to the persons responsible for the residents' finances. The Business Office Manager indicated residents can receive their account balance if they ask for it.</p> <p>4. On 10/20/11 at 10:55 A.M., the Administrator provided Resident Council Minutes, dated September 6, 2011 and October 4, 2011. Both minutes included: "Told them they can get a statement at anytime if they want to know their balance...."</p> <p>At that time, the Administrator also provided the facility Admission Agreement, undated. The agreement included: "If the Resident chooses to have the Facility manage his/her personal funds...Accurate records shall be kept of all disbursements and these records shall be available to the Resident, Guardian...or other person authorized by Resident as required by government regulations...A</p>		committee will provide further recommendations and/or education.				

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	Resident Trust Account statement will be made available at least quarterly." 3.1-6(b)				

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F0160 SS=A	<p>Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.</p> <p>Based on interview and record review, the facility failed to ensure a resident trust account was refunded to the resident's estate within 30 days of death, for 1 of 3 discharged residents reviewed for refunds of resident funds, in the Stage 2 sample of 39. Resident #111</p> <p>Findings include:</p> <p>On 10/21/11 at 10:00 A.M., the Business Office Manager provided "Billing Account Information" and a "Resident Trust Checking" document for Resident #111. The documents indicated Resident #111 expired on 6/4/11, and the account was closed with the balance paid to the estate on 7/18/11. During interview with the Business Office Manager at that time, she indicated she "missed it," and the balance should have been paid within 30 days.</p> <p>On 10/20/11 at 11:00 A.M., the Administrator provided the current facility admission agreement, undated. The agreement indicated, "...The Facility shall refund any personal funds within thirty (30) days to the Resident or his/her estate</p>	F0160	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #111 was paid refund balance on 7/18/11 How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Residents with RTA who are discharged or choose to close their RTA have the potential to be effected. Residents who were discharged or closed their RTA in the last 30 days have been reviewed and assured that a refund was given. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; The business office manager has set up a tickler system on her computer to remind her to refund the RTA within 15 days of discharge to ensure compliance of within 30 days. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The business office manager will report to the QA committee monthly x3 months results of RTA accounts of</p>		11/10/2011		

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	or other entity as required by state law or regulation in the event of the Resident's death...." 3.1-6(h)		residents discharged and date of refund. The QA committee will monitor for 100% compliance and will make recommendations for further audit or education if not achieved.	

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F0250 SS=D	<p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on interview, observation, and record review, the facility failed to ensure social services were provided related to individualizing and updating behavior interventions and the administration of psychotropic medications for 2 of 10 residents reviewed for behaviors in the Stage 2 sample of 39. Resident # 101, Resident #34</p> <p>Findings include:</p> <p>1. The clinical record of Resident # 101 was reviewed on 10/19/11 at 2:20 P.M. Diagnoses included, but were not limited to, Alzheimer's Dementia.</p> <p>Nurses Notes included the following notations:</p> <p>1/18/11 at 11:20 A.M.: "...Dx [diagnosis] Alzheimer's Disease...Resident knows her family [and] self. Repeats self...Babbles @ x's [times]. Mumbles @ x's. Behavior varies...."</p> <p>1/18/11 at 11:23 A.M.: "Resident arrived via facility vehicle from [another facility]...No c/o [complaints of] pain or discomfort...."</p>	F0250	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; For resident #101 and #34 prn medications listed on 2567 were stopped. The care plans for both residents were reviewed and behavior interventions were updated. How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents on psychotropic medications have potential to be affected. On Friday, November 4th, 2011, the care plans for residents on prn psychotropic medications were reviewed and updated accordingly. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Social Services will review prn psychotropic medication use and care plans weekly to individualize and update behavior interventions. Behavior committee will meet monthly to review all residents on psychotropic meds to ensure behavior interventions have been updated and individualized. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be</p>	11/23/2011			

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	<p>1/18/11 at 8:00 P.M.: "...Resident agitated and confused. Oriented to person only. Wondering [sic]. Attempting to stand without assist. Requires 1 on 1 attention at this time. MD notified. NO [new order] Give 2 mg Haldol [anti-psychotic] IM [injection] one time only."</p> <p>1/28/11 at 3:30 P.M.: "MD called et [and] informed of residents [sic] [increased] agitation @ x's. Talked with [name] nurse. Daughter here visiting and stated they do not want her agitated et medication will be ok...."</p> <p>1/28/11 at 4:45 P.M.: "Received new order from [physician] for Ativan 0.5 mg [one] po BID [twice daily] PRN [as needed] for agitation...."</p> <p>2/1/11 at 5:30 P.M.: "Resident yelling out in dining room [and] [increased] agitation noted. Getting other residents upset [and] Ativan 0.5 mg given @ 4:20 P.M. [and] [decreased] agitation noted @ this time."</p> <p>A Comprehensive Care Plan, dated 2/3/11, indicated a problem of "Altered thought processes [with] altered mood state R/T [related to] Alzheimer's Dementia AEB [as evidenced by] short [and] long term memory loss, moderately impaired decisions. Res [resident] yells out, is physically abusive and had periods</p>		<p>put into place; Social Services/QA coordinator will perform monthly audits on psychotropic med use and behavior interventions times 3 months. Audits will be reviewed by QA committee and recommendations for further education/audits made if 100% compliance is not achieved.</p>	

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	<p>of wandering." The Interventions included: "Target Behavior: Anxiety with agitation [sic] res yells [sic] 'momma,' cries, and gets restless...Redirect to an activity: Res enjoys getting read to. Allow time to wake up. Resident is more agitated if rushed in a.m...If unable to calm, alert nurse PRN Ativan in place...Offer to take to bathroom."</p> <p>Social Service notes, dated 4/19/11 and untimed, indicated, "...Res has periods of inattention et [and] disorganized thinking...Decisions are mod. impaired as res often yells out instead of using call light...." This social service documentation did not address the resident's psychotropic medications.</p> <p>A Care Plan update, dated 4/29/11, added "Refusal of care @ x's, disorganized thinking" to the 2/3/11 care plan of "Altered Thought Processes." Different interventions were not documented.</p> <p>Nursing notes continued:</p> <p>6/14/11 at 9:00 P.M.: "Resident sitting here talking to family. Upset [with] them [and] yelling. Unable to calm. Family stated, 'I think you are going to have to give her something.' Ativan 0.5 mg given @ this time. Will cont to monitor."</p>			
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	<p>6/17/11 at 6:30 P.M.: "Resident yelling, hitting table, [increased] agitation noted. trying to push w/c [wheelchair] [and] other chairs around. tried to talk to her [and] unable to calm [down]. Ativan 0.5 mg given @ this time [and] sitting by nurses desk...."</p> <p>6/18/11 at 6:30 A.M.: "...Res appears agitated this morning [and] was given Ativan 0.5 mg... Will receive shower later this AM [and] may require medication d/t [due to] her severe reaction while being given shower. Previous shower this week resulted in res screaming [and] cursing through duration of shower...."</p> <p>6/18/11 at 3:15 P.M.: "Res extremely agitated this afternoon. res has received 1:1 attention since 1:30 P.M. this afternoon from multiple staff. Res has been yelling out, hitting/slapping table, swinging feet over side of legs of w/c. Unable to redirect resident [with] use of food, games, newspaper...Ativan 0.5 mg given po for [increased] agitation."</p> <p>6/20/11 at 11:00 A.M.: "Resident had increased agitation. tried to redirect several times. Was taken to the BR [bathroom]. Nothing helped. Ativan 0.5 mg po given...."</p> <p>6/20/11 at 8:10 P.M.: "...Resident restless</p>						

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	<p>[and] yelling out @ this time [and] Ativan 0.5 mg given...."</p> <p>6/22/11 at 9:30 P.M.: "...Resident yelling [and] trying to get out of chair [and] unable to calm @ 7:15 P.M. [and] Ativan 0.5 mg was given...."</p> <p>6/23/11 at 4:00 P.M.: "Resident restless [and] [increased] agitation noted. Unable to calm [and] Ativan 0.5 mg given. Will cont to monitor...."</p> <p>6/23/11 at 10:00 P.M.: "Resident continues to be restless. Throwing legs off side of w/c. Yelling out [and] [increased] agitation noted @ staff [with] care. Ativan 0.5 mg given @ this time...."</p> <p>6/24/11 at 10:30 A.M.: "Ativan prn given d/t [increased] agitation tried to redirect resident unable...resident was throwing legs off side of w/c."</p> <p>6/24/11 at 8:30 P.M.: "Resident very restless [and] [increased] agitation noted. Trying to throw legs to side of w/c to get [up]. Unable to calm resident or to get resident to stay in chair. Ativan 0.5 mg given @ this time...."</p> <p>6/25/11 at 2:50 P.M.: "Ativan 0.5 mg prn po given d/t [increased] agitation, toileted non effective. Ativan given prn 0.5 mg</p>			

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	<p>po...."</p> <p>6/26/11 at 4:30 P.M.: "PRN Ativan given d/t [increased] agitation, res attempted to get out of w/c numerous x's [without] assist. 1 on 1 done [with] res for while [sic]...."</p> <p>6/27/11 at 3:00 P.M.: "Resident sitting by nurses desk et [increased] agitation taken to the BR which helped. Updated [physician] that resident took Ativan 0.5 mg prn 19 x's this month et had 2 this shift ordered BID [twice daily]...."</p> <p>6/27/11 at 4:00 P.M.: "Received new orders for Ativan 0.5 mg [one] po [every 6 hours] PRN for anxiety/agitation...."</p> <p>6/28/11 at 2:00 P.M.: "Ativan 0.5 mg po given for agitation [and] yelling. Just returned from OT [occupational therapy]. Offered snack, one on one [and] toileting as intervention."</p> <p>6/28/11 at 8:15 P.M.: "PRN Ativan given for [increased] agitation et kicking at the table. Offered snack, toileted, unable to redirect."</p> <p>6/29/11 at 2:00 A.M.: "Heard yelling in res' room, [and] found res [and] her roommate bickering back [and] forth...Res is very alert [and] clear-headed this</p>			

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	<p>morning...Also given Ativan 0.5 mg...@ this time...."</p> <p>6/29/11 at 5:00 P.M.: "Resident yelling [and] trying to get out of w/c...Unable to calm. Ativan 0.5 mg given @ this time. Will con't to monitor."</p> <p>6/30/11 at 2:15 P.M.: "Resident was agitated, taken to BR...cont to be agitated trying to get out of w/c. Ativan prn 0.5 mg given po...."</p> <p>6/30/11 at 10:30 P.M.: "Resident calmer [after] Ativan above till [after] supper then became restless again. Toileted resident but did not calm [down]. [Increased] agitation noted [with] care. Ativan 0.5 mg given @ 8:15 p [and] son here...."</p> <p>7/1/11 at 1:30 P.M.: "Resident [increased] agitation tried to redirect unable taken to BR prior. Ativan 0.5 mg po prn given...."</p> <p>7/1/11 at 8:00 P.M.: "Resident has continued to be 1 on 1 [after] supper...Trying to climb out of chair. Unable to calm [with] toileting or snack. Ativan 0.5 mg given @ 7:15 P.M....."</p> <p>7/4/11 at 4:30 P.M.: "Resident attempted several x's to get out of w/c...Unable to redirect [and] Ativan 0.5 mg given @ this</p>						

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	<p>time...."</p> <p>7/6/11 at 1:00 P.M.: "Ativan 0.5 mg po given [increased] agitation, tried to redirect unable. Taken to BR. Still agitated."</p> <p>7/6/11 at 7:00 P.M.: "Resident yelling [and] trying to crawl out of w/c throwing legs off side of w/c...Ativan 0.5 mg given @ this time."</p> <p>7/7/11 at 5:45 P.M.: "Resident restless trying to crawl out of chair. Picking things up off of other residents tray...Ativan 0.5 mg given @ this time...."</p> <p>7/8/11 at 3:30 P.M.: "Resident very agitated yelling out [and] trying to get out of chair. tried to redirect [with] snack of taking to bathroom [without] success. Ativan 0.5 mg given @ this time...."</p> <p>7/11/11 at 4:30 P.M.: "Resident very agitated [and] yelling trying to climb out of chair. Unable to redirect [with] snacks, toileting. Ativan 0.5 mg given @ this time...."</p> <p>7/12/11 at 7:30 P.M.: "Resident [increased] agitation noted [and] tried to calm by toileting [and] after snack...Ativan 0.5 mg given...."</p>			
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	<p>7/13/11 at 2:00 P.M.: "...Resident had prn Ativan earlier @ 10:45 A.M. for increased agitation. Tried prior taken to toilet unable to redirect still agitated et prn given [with] effectiveness."</p> <p>7/13/11 at 4:45 P.M.: "Resident trying to crawl out of w/c. Toileted resident [and] offered snack [and] resident cont to try to get [up] out of chair. Ativan 0.5 mg given @ this time...."</p> <p>7/15/11 at 7:00 A.M.: "Resident talking loudly et [increased] agitation, unable to redirect. Ativan 0.5 mg po prn given...."</p> <p>7/15/11 at 6:00 P.M.: "Resident [with] [increased] agitation noted [after] supper. Toileting attempted but did not help to calm resident. Ativan 0.5 mg given @ this time...."</p> <p>7/18/11 at 6:30 P.M.: "Resident [with] [increased] yelling [and] agitation. Attempted to crawl out of chair several x's. Tried to redirect resident [with] toileting [and] food [without] success. Ativan 0.5 mg given @ this time...."</p> <p>7/19/11 at 3:00 P.M.: "Resident trying to get up out of w/c. Unable to redirect...Ativan 0.5 mg given."</p> <p>7/19/11 at 9:00 P.M.: "Resident [with]</p>						

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	<p>[increased] agitation @ this [sic]...Trying to crawl out of w/c to go home...Ativan 0.5 mg given @ this time...."</p> <p>7/20/11 at 7:00 P.M.: "Resident yelling [and] trying to crawl out of w/c. Resident toileted [and] offered snack...Ativan 0.5 mg given @ this time...."</p> <p>7/21/11 at 6:20 P.M.: "Resident upset [and] yelling, crawling out of w/c. Tried toileting [without] success in calming...Ativan 0.5 mg given @ this time...."</p> <p>A Care Plan, dated 7/21/11, indicated a problem of "Altered thought processes [with] altered mood state R/T [related to] Alzheimer's Dementia AEB [as evidenced by] short [and] long term memory loss, moderately impaired decisions. Res [resident] yells out, is physically abusive - more so in morning hours. Res refuses care at times and has periods of disorganized thinking." Different interventions from the earlier care plan on 4/29/11 were not present.</p> <p>7/22/11 at 4:00 P.M.: "Resident yelling [with] [increased] agitation trying to crawl out of w/c...Ativan 0.5 mg given @ this time...."</p> <p>7/23/11 at 2:00 P.M.: "Resident becoming</p>			

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	<p>agitated trying to get out of w/c...Tried to redirect unable Ativan 0.5 mg po given...."</p> <p>7/24/11 at 11:15 A.M.: "Resident agitated trying to get out of w/c, toileted tried to redirect, non effective Ativan .5 mg po given."</p> <p>7/26/11 [time illegible]: "Ativan given as prn for agitation/restlessness...."</p> <p>7/26/11 at 5:00 P.M.: "Resident [increased] agitation noted. Yelling @ people going by [and] trying to get out of chair...Ativan 0.5 mg given @ this time...."</p> <p>7/27/11 at 3:30 P.M.: "Restless today [and] did use prn Ativan [and] was effective...."</p> <p>8/2/11 at 3:30 P.M.: "Resident yelling, crawling out of chair...Ativan 0.5 mg given @ this time...."</p> <p>8/3/11 at 5:00 P.M.: "Resident yelling [and] [increased] anxiety noted...Ativan 0.5 mg given @ this time."</p> <p>8/4/11 at 4:30 P.M.: "Resident very agitated, crawling out of w/c...Ativan 0.5 mg given @ this time..."</p>						

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	<p>8/5/11 at 9:45 A.M.: "Resident trying to get out of w/c in D/R [dining room]...Ativan 0.5 mg po prn given."</p> <p>8/7/11 at 2:00 P.M.: "Resident becoming agitated...PRN Ativan given...."</p> <p>8/8/11 at 3:40 P.M.: "Resident very agitated. Trying to climb out of w/c...Ativan 0.5 mg given @ this time...."</p> <p>8/8/11 at 10:00 P.M.: "Resident still yelling [and] trying to get out of w/c...Ativan 0.5 mg given @ this time...."</p> <p>8/11/11 at 6:30 P.M.: "PRN Ativan 0.5 mg given po d/t [increased] agitation. Res yelling out repeatedly et trying to remove self from w/c."</p> <p>8/12/11 at 12:30 A.M.: "Res given Ativan 0.5 mg...for res [increase] in agitation...trying to slap this nurse...."</p> <p>8/12/11 at 12:45 A.M.: "Res' agitation continues to [increase]. Yelling, screaming, [name of physician] was paged thru [hospital] [and] updated as to res' severe agitation [and] behavior. New order received for Haldol 0.5 mg IM...."</p> <p>8/16/11 at 12:00 P.M.: "Receive new order from [physician] to D/C Ativan and order Haldol 0.5 mg po [every 6 hours]"</p>						

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	<p>prn for agitation...."</p> <p>8/18/11 at 8:00 P.M.: "Resident very agitated. Trying to crawl out of w/c...Haldol 0.5 mg po given @ this time...."</p> <p>8/31/11 at 6:15 P.M.: "Resident [with] [increased] agitation crawling out of w/c...tried to toilet and offered snack [without] effect. Haldol 0.5 mg given @ this time."</p> <p>A Rehabilitation record, dated August 2011, indicated the resident was unable to walk on 8/5, 8/9, 8/12, 8/14, 8/15, 8/28, 8/30, and 8/31 due to being "too tired" or "too sleepy."</p> <p>Nursing notes continued:</p> <p>9/8/11 at 6:20 P.M.: "Resident was yelling [with] [increased] agitation trying to crawl out of w/c. Unable to calm [with] toileting or snack. Haldol 0.5 mg given @ this time."</p> <p>9/11/11 at 2:00 A.M.: "Res cont. to sit in wheelchair next to nurses station. Keeps attempting to climb out of chair and yelling. Res given PRN Haldol po Will observe."</p> <p>The most recent Minimum Data Set</p>						

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	<p>[MDS] assessment, dated 9/27/11, indicated the resident scored a 3 out of 15 for cognitive status, with 15 indicating no cognitive impairment. The MDS assessment indicated no hallucinations or delusions, no physical behavior symptoms directed toward others, or other behavior symptoms present. The MDS assessment indicated the resident required extensive two+ persons physical assistance for transfer.</p> <p>A Care Plan, dated 10/6/11, regarding "Altered thought processes..." had the same interventions as on the previous care plan of 7/21/11.</p> <p>The clinical record of Resident # 101 was reviewed again on 10/24/11 at 9:00 A.M. The record indicated the resident received Haldol 0.5 mg po on 10/20/11 and 10/21/11 for "agitation."</p> <p>During interview with the Social Services Director [SSD] on 10/21/11 at 1:00 P.M., she indicated the resident was switched from Ativan to Haldol, because the physician thought Haldol would work better. She indicated the resident received the prn medications due to being "agitated, restless, tries to get out of chair and recliner." She indicated the nursing staff keeps her updated regarding how often the resident would receive the prn</p>			
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	<p>medication.</p> <p>2. The clinical record of Resident # 34 was reviewed on 10/19/11 at 1:45 P.M. Diagnoses included, but were not limited to, Alzheimer's Dementia, Dementia with Behavioral Disturbances/Psychosis, and Anxiety.</p> <p>A Physician's order, initially dated 3/27/06 and on the current October 2011 orders, indicated, "Ativan (Lorazepam) [an anti-anxiety medication] 0.5 mg po [by mouth] Q 4 H [every 4 hours] PRN [as needed] anxiety."</p> <p>A quarterly Minimum Data Set [MDS] assessment, dated 8/1/11, indicated the resident scored a 3 out of 15 for cognition, with 15 indicating no memory loss. The MDS assessment indicated the resident had no behaviors in the previous 7 days, and required total assistance of two+ staff for bathing.</p> <p>Interdisciplinary Progress Notes included the following notations:</p> <p>8/7/11 at 10:30 A.M.: "Ativan prn given D/T [due to] resident yelling loudly in room. Upsetting roommate. Tried to redirect, wanting red coat for her daughter [name]. Informed resident coat was found and everything was okay. Crying. Unable</p>						

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	<p>to redirect."</p> <p>8/18/11 at 11:00 A.M.: "PRN Ativan used for agitation [with] Kepo Tub bath. Med was only slightly effective...."</p> <p>8/22/11 at 10:00 A.M.: "...9:30 AM Ativan 0.5 mg po given D/T [increased] anxiety. Resident would not redirect [with] talking to her. Kept talking about [name]."</p> <p>9/10/11 at 10:00 A.M.: "Res [resident] given PRN Ativan prior to bath. Bath required 2 staff members as resident yelled out et [and] cried continuously throughout entire bath...Unable to console res [with] food, drink, or conversation...."</p> <p>A Medication Administration Record [MAR] included the following notations:</p> <p>9/1/11 at 9:30 A.M.: "Ativan 0.5 mg po [increased] agitation...."</p> <p>9/5/11 at 7:00 A.M.: Ativan 0.5 mg po prior to shower. Non effective still yelled loudly."</p> <p>9/10/11 at 9:00 A.M.: "Ativan 0.5 mg pr prior to shower. Non effective - res yelled loudly."</p> <p>9/15/11 at 2:00 P.M.: "Ativan 0.5 mg po</p>				

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	<p>given prior to shower...."</p> <p>9/24/11 at 11:00 P.M.: "Ativan 0.5 mg po [increased] agitation...."</p> <p>9/25/11 at 1:00 P.M.: "Ativan 0.5 mg po given prior to shower - agitation. Non-effective...."</p> <p>10/7/11 at 9:45 A.M.: Ativan 0.5 mg [increased] anxiety during shower. Ineffect. [sic]."</p> <p>A Comprehensive Care Plan, dated 8/2/11, indicated a problem of "ADL [activities of daily living] self care deficit R/T [related to] Dementia...AEB [as evidenced by] requires assist with ADL care, and unable to be independent [sic] with ADL's." An intervention included, "Tub bath or full bed bath two times per week per staff...."</p> <p>An additional care plan, dated 8/11/11, indicated a problem of "Alt [sic] thought process [with] altered mood state r/t [related to] Dx [diagnosis] Alz [Alzheimer's] Dementia...AEB [short term and long term] memory loss...socially disruptive beh. [behavior], phys. [physically] abusive behav...."</p> <p>Interventions included: "If agitated, ensure safety and return later. Meds as ordered...Target behavior: anxious</p>			

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	<p>behavior AEB yells out in common areas, and sings loudly...If unable to cal -alert nurse prn Ativan. Initiate positive conversation and stimulate memory by reminiscence...."</p> <p>The most recent Social Service note, dated 10/18/11, indicated, "...Often yells out instead of using call light - per nursing report. res has periods of inattention...Res often becomes agitated et change topics, or is unable to follow what is said...[No] behaviors noted in last 7 days thought resident can become agitated et curse @ staff - per nursing report...."</p> <p>On 10/21/11 at 12:10 P.M., during interview with CNA # 1, she indicated Resident # 34 "usually yells during her showers."</p> <p>On 10/21/11 at 1:00 P.M., during interview with the Social Services Director [SSD], she indicated the resident's psychotropic medications are reviewed monthly in conjunction with the behavior management meeting. The SSD indicated she would usually total up the number of prn medications the resident received at the end of the month, or at the beginning of the next month. The SSD indicated Resident # 34 received tub baths and showers. The SSD indicated she did not know if the resident preferred bed</p>				

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	<p>baths to showers, as she did not do residents' initial social histories, but "the admission coordinator does."</p> <p>On 10/24/11 at 11:45 A.M., during interview with the Administrator, she indicated Resident # 34 had other times of agitation, and not just with her showers. The Administrator indicated the resident had a history of skin issues, and needed her showers.</p> <p>3. On 10/21/11 at 1:00 P.M., during interview with the Social Services Director [SSD], she indicated a behavior management meeting is held monthly, in which behaviors and interventions are discussed. The SSD indicated the charge nurse will "usually" notify her if a resident is exhibiting new behaviors. The SSD indicated the CNAs will enter episodes of behaviors in their "palm pilots," and she tries to review those findings weekly. The SSD indicated the nurses "keep her updated" of behaviors.</p> <p>On 10/24/11 at 11:30 A.M., the SSD provided the current facility policy on "Behavior Management Committee," revised 9/10. The policy included: "...A Behavior Management Committee is formed to analyze the root cause(s) of a resident's behavior as well as provide alternatives to staff for</p>			
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	<p>solutions...Information and plans generated from this meeting will be used to update care plans on these residents...The social worker is considered to be the lead person in developing and promoting the concept of this committee and coordinating its actions...Standard Meeting Agenda...Discussion of any new admissions who need special plans...Review behavioral interventions and their effectiveness. Develop additional or modified interventions...."</p> <p>3.1-34(a)</p>			
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F0309 SS=D	<p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to ensure correct positioning for 2 of 3 sampled residents reviewed for positioning of 3 who met the criteria for positioning. Resident #101 and # 29</p> <p>Findings include:</p> <p>1. On 10/19/11 at 1:30 P.M., Resident # 29 was observed sitting in her room in her Broda chair, with her head and neck leaned over to her chest.</p> <p>On 10/20/11, the following was observed:</p> <p>9:35 A.M.: Sitting in room in broda chair. Broda chair was in the upright position. Asleep, head/neck leaning over to chest.</p> <p>10:45 A.M.: Sitting in room in broda chair. Broda chair was in the upright position. Asleep, head/neck leaning over to chest.</p> <p>On 10/20/11 at 1:00 P.M., the clinical record of Resident # 29 was reviewed. Diagnoses included, but were not limited</p>	F0309	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #101 and #29 received OT evaluation for correct positioning. Recommendations implemented. How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents who meet the criteria for positioning have the potential to be affected. OT will screen all residents who have the potential to be affected and will make recommendations if needed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; All staff will be inserviced on 11/14/11 on chair postioning and to monitor and correct when resident is noted to be leaning in their chair. OT will be contacted by nursing to conduct screening for positioning on residents when current interventions are not effective to prevent leaning. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be</p>		11/23/2011		

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	<p>to, osteoarthritis and spinal stenosis.</p> <p>A Minimum Data Set [MDS] assessment, dated 9/11/11, indicated the resident required extensive assistance of two + staff, and was totally dependent for transfers.</p> <p>A Care Plan, dated 9/20/11, indicated a problem of "Impaired Physical mobility...R/T [related to] Dx of osteoarthritis...spinal stenosis, AEB [as evidenced by] use of mechanical lift for transfers...."</p> <p>On 10/21/11 at 11:17 A.M., Resident # 29 was observed sitting in her room in Broda chair in the upright position, with her head and neck down to her chest.</p> <p>On 10/21/11 at 11:30 A.M., the DON was made aware of the resident's positioning. The DON indicated the resident was able to move her head on her own.</p> <p>2. On 10/19/11 at 2:00 P.M., Resident # 101 was observed sitting in a wheelchair in the upright position, in the tv lounge. Her head and neck was leaning to the left and down to the chest.</p> <p>On 10/20/11, Resident # 101 was observed sitting in the dining room from 9:00 A.M. to 9:30 A.M. in a wheelchair.</p>		<p>put into place; QA coordinator will do weekly positioning audit times 4 weeks, then monthly times 3 months. Audits will be reviewed by QA committee and recommendations for further education/audits made if 100% compliance not achieved.</p>		

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	<p>Her head was leaning down on her chest and to the left.</p> <p>On 10/20/11 at 11:00 A.M. and 1:30 P.M., Resident # 101 was observed sitting in the TV lounge in a reclining wheelchair. The wheelchair was in the upright position.</p> <p>On 10/20/11 at 1:40 P.M., during interview with LPN # 3, she indicated there were not instructions to the staff regarding which residents to lie down after meals.</p> <p>On 10/20/11 at 2:00 P.M., the clinical record of Resident # 101 was reviewed. Diagnoses included, but were not limited to, Alzheimer's dementia.</p> <p>A Minimum Data Set [MDS] assessment, dated 9/27/11, indicated the resident required extensive assistance of two+ for transfer and ambulation.</p> <p>A Care Plan, dated 9/20/11, indicated a problem of "Impaired Physical mobility...R/T Alzheimer's Dementia...AEB requires 2 PS [persons] for transfers..."</p> <p>On 10/21/11 at 11:20 A.M., Resident # 101 was observed sitting in her wheelchair in the TV lounge with her</p>			
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	<p>head and neck leaning down to her chest.</p> <p>On 10/21/11 at 11:30 A.M., the DON was made aware of the resident's positioning. The DON indicated Occupational Therapy [OT] recently worked with the resident regarding wheelchair positioning. The DON indicated the resident was able to raise her head by herself.</p> <p>On 10/21/11 at 12:00 P.M., the DON provided documentation of the OT evaluation, dated 10/19/11. The document included: "...Patient requires assistance to reposition self in chair...."</p> <p>On 10/24/11 at 9:00 A.M., LPN # 3 indicated she asked the resident's family to bring in a neck pillow to assist the resident in positioning.</p> <p>3.1-37(a)</p>			
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F0329 SS=E	<p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview and record review, the facility failed to have adequate indications and documentation for use of psychotropic medications, for 4 of 10 residents sampled for unnecessary medications. Residents # 101, #34, #23, #109</p> <p>Findings include:</p> <p>1. The clinical record of Resident # 101 was reviewed on 10/19/11 at 2:20 P.M. Diagnoses included, but were not limited to, Alzheimer's dementia.</p>	F0329	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Residents # 101 and #34 prn meds addressed in 2567 were stopped. Resident #23 and #109 documentation will be received from their physician to justify rationale for psychotropic meds or GDR will occur. How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents on psychotropic medications have potential to be affected. Residents on psychotropic meds will continue</p>	11/23/2011

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	<p>Nurses Notes included the following notations:</p> <p>1/18/11 at 11:20 A.M.: "...Dx [diagnosis] Alzheimers Disease...Resident knows her family [and] self. Repeats self...Babbles @ x's [times]. Mumbles @ x's. Behavior varies...."</p> <p>1/18/11 at 11:23 A.M.: "Resident arrived via facility vehicle from [another facility]...No c/o [complaints of] pain or discomfort...."</p> <p>1/18/11 at 8:00 P.M.: "...Resident agitated and confused. Oriented to person only. Wondering [sic]. Attempting to stand without assist. Requires 1 on 1 attention at this time. MD notified. NO [new order] Give 2 mg Haldol [anti-psychotic] IM [injection] one time only."</p> <p>1/28/11 at 3:30 P.M.: "MD called et [and] informed of residents [sic] [increased] agitation @ x's. Talked with [name] nurse. Daughter here visiting and stated they do not want her agitated et medication will be ok...."</p> <p>1/28/11 at 4:45 P.M.: "Received new order from [physician] for Ativan 0.5 mg [one] po BID [twice daily] PRN [as needed] for agitation...."</p>		<p>to have gradual dose reduction forms completed by physician as scheduled that will include adequate indications and documentation for use. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Gradual dose reduction form has been revised to include adequate indications and documentation by physician for use of psychotropic meds. Social Service will ensure physicians completed form and rationale or GDR was done. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Social Services will initiate and do follow-up on gradual dose reduction forms to ensure adequate indications and documentation is written by physician for psychotropic med use. Social Services/QA coordinator will do random audits monthly times 3 months and will report to QA committee who will review and make recommendations for further education/audits made if 100% compliance is not achieved.</p>				

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	<p>2/1/11 at 5:30 P.M.: "Resident yelling out in dining room [and] [increased] agitation noted. Getting other residents upset [and] Ativan 0.5 mg given @ 4:20 P.M. [and] [decreased] agitation noted @ this time."</p> <p>A Comprehensive Care Plan, dated 2/3/11, indicated a problem of "Altered thought processes [with] altered mood state R/T [related to] Alzheimer's Dementia AEB [as evidenced by] short [and] long term memory loss, moderately impaired decisions. Res [resident] yells out, is physically abusive and had periods of wandering." The Interventions included: "Target Behavior: Anxiety with agitation [sic] res yellls [sic] 'momma,' cries, and gets restless...Redirect to an activity: Res enjoys getting read to. Allow time to wake up. Resi is more agitated if rushed in a.m...If unable to calm, alert nurse PRN Ativan in place...Offer to take to bathroom."</p> <p>Social Service notes, dated 4/19/11 and untimed, indicated, "...Res has periods of inattention et [and] disorganized thinking...Decisions are mod. impaired as res often yells out instead of using call light...." This social service documentation did not address the resident's psychotropic medications.</p> <p>A Care Plan update, dated 4/29/11, added</p>			

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	<p>"Refusal of care @ x's, disorganized thinking" to the 2/3/11 care plan of "Altered Thought Processes." Different interventions were not documented.</p> <p>Nursing notes continued:</p> <p>6/14/11 at 9:00 P.M.: "Resident sitting here talking to family. Upset [with] them [and] yelling. Unable to calm. Family stated, 'I think you are going to have to give her something.' Ativan 0.5 mg given @ this time. Will cont to monitor."</p> <p>6/17/11 at 6:30 P.M.: "Resident yelling, hitting table, [increased] agitation noted. trying to push w/c [wheelchair] [and] other chairs around. tried to talk to her [and] unable to calm [down]. Ativan 0.5 mg given @ this time [and] sitting by nurses desk...."</p> <p>6/18/11 at 6:30 A.M.: "...Res appears agitated this morning [and] was given Ativan 0.5 mg... Will receive shower later this AM [and] may require medication d/t [due to] her severe reaction while being given shower. Previous shower this week resulted in res screaming [and] cursing through duration of shower...."</p> <p>6/18/11 at 3:15 P.M.: "Res extremely agitated this afternoon. res has received 1:1 attention since 1:30 P.M. this</p>			

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	<p>afternoon from multiple staff. Res has been yelling out, hitting/slapping table, swinging feet over side of legs of w/c. Unable to redirect resident [with] use of food, games, newspaper...Ativan 0.5 mg given po for [increased] agitation."</p> <p>6/20/11 at 11:00 A.M.: "Resident had increased agitation. tried to redirect sev several times. Was taken to the BR [bathroom]. Nothing helped. Ativan 0.5 mg po given...."</p> <p>6/20/11 at 8:10 P.M.: "...Resident restless [and] yelling out @ this time [and] Ativan 0.5 mg given...."</p> <p>6/22/11 at 9:30 P.M.: "...Resident yelling [and] trying to get out of chair [and] unable to calm @ 7:15 P.M. [and] Ativan 0.5 mg was given...."</p> <p>6/23/11 at 4:00 P.M.: "Resident restless [and] [increased] agitation noted. Unable to calm [and] Ativan 0.5 mg given. Will cont to monitor...."</p> <p>6/23/11 at 10:00 P.M.: "Resident continues to be restless. Throwing legs off side of w/c. Yelling out [and] [increased] agitation noted @ staff [with] care. Ativan 0.5 mg given @ this time...."</p> <p>6/24/11 at 10:30 A.M.: "Ativan prn given</p>				

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	<p>d/t [increased] agitation tried to redirect resident unable...resident was throwing legs off side of w/c."</p> <p>6/24/11 at 8:30 P.M.: "Resident very restless [and] [increased] agitation noted. Trying to throw legs to side of w/c to get [up]. Unable to calm resident or to get resident to stay in chair. Ativan 0.5 mg given @ this time...."</p> <p>6/25/11 at 2:50 P.M.: "Ativan 0.5 mg prn po given d/t [increased] agitation, toileted non effective. Ativan given prn 0.5 mg po...."</p> <p>6/26/11 at 4:30 P.M.: "PRN Ativan given d/t [increased] agitation, res attempted to get out of w/c numerous x's [without] assist. 1 on 1 done [with] res for while [sic]...."</p> <p>6/27/11 at 3:00 P.M.: "Resident sitting by nurses desk et [increased] agitation taken to the BR which helped. Updated [physician] that resident took Ativan 0.5mg prn 19x's this month et had 2 this shift ordered BID [twice daily]...."</p> <p>6/27/11 at 4:00 P.M.: "Received new orders for Ativan 0.5 mg [one] po [every 6 hours] PRN for anxiety/agitation...."</p> <p>6/28/11 at 2:00 P.M.: "Ativan 0.5 mg po</p>			

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	<p>given for agitation [and] yelling. Just returned from OT [occupational therapy]. Offered snack, one on one [and] toileting as intervention."</p> <p>6/28/11 at 8:15 P.M.: "PRN Ativan given for [increased] agitation et kicking at the table. Offered snack, toileted, unable to redirect."</p> <p>6/29/11 at 2:00 A.M.: "Heard yelling in res' room, [and] found res [and] her roommate bickering back [and] forth...Res is very alert [and] clear-headed this morning...Also given Ativan 0.5 mg...@ this time...."</p> <p>6/29/11 at 5:00 P.M.: "Resident yelling [and] trying to get out of w/c...Unable to calm. Ativan 0.5 mg given @ this time. Will con't to monitor."</p> <p>6/30/11 at 2:15 P.M.: "Resident was agitated, taken to BR...cont to be agitated trying to get out of w/c. Ativan prn 0.5mg given po...."</p> <p>6/30/11 at 10:30 P.M.: "Resident calmer [after] Ativan above till [after] supper then became restless again. Toileted resident but did not calm [down]. [Increased] agitation noted [with] care. Ativan 0.5 mg given @ 8:15 p [and] son here...."</p>			

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	<p>7/1/11 at 1:30 P.M.: "Resident [increased] agitation tried to redirect unable taken to BR prior. Ativan 0.5 mg po prn given...."</p> <p>7/1/11 at 8:00 P.M.: "Resident has continued to be 1 on 1 [after] supper...Trying to climb out of chair. Unable to calm [with] toileting or snack. Ativan 0.5 mg given @ 7:15 P.M....."</p> <p>7/4/11 at 4:30 P.M.: "Resident attempted several x's to get out of w/c...Unable to redirect [and] Ativan 0.5 mg given @ this time...."</p> <p>7/6/11 at 1:00 P.M.: "Ativan 0.5 mg po given [increased] agitation, tried to redirect unable. Taken to BR. Still agitated."</p> <p>7/6/11 at 7:00 P.M.: "Resident yelling [and] trying to crawl out of w/c throwing legs off side of w/c...Ativan 0.5 mg given @ this time."</p> <p>7/7/11 at 5:45 P.M.: "Resident restless trying to crawl out of chair. Picking things up off of other residents tray...Ativan 0.5 mg given @ this time...."</p> <p>7/8/11 at 3:30 P.M.: "Resident very agitated yelling out [and] trying to get out of chair. tried to redirect [with] snack of</p>			

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	<p>taking to bathroom [without] success. Ativan 0.5 mg given @ this time...."</p> <p>7/11/11 at 4:30 P.M.: "Resident very agitated [and] yelling trying to climb out of chair. Unable to redirect [with] snacks, toileting. Ativan 0.5 mg given @ this time...."</p> <p>7/12/11 at 7:30 P.M.: "Resident [increased] agitation noted [and] tried to calm by toileting [and] after snack...Ativan 0.5 mg given...."</p> <p>7/13/11 at 2:00 P.M.: "...Resident had prn Ativan earlier @ 10:45 A.M. for increased agitation. Tried prior taken to toilet unable to redirect still agitated et prn given [with] effectiveness."</p> <p>7/13/11 at 4:45 P.M.: "Resident trying to crawl out of w/c. Toileted resident [and] offered snack [and] resident cont to try to get [up] out of chair. Ativan 0.5 mg given @ this time...."</p> <p>7/15/11 at 7:00 A.M.: "Resident talking loudly et [increased] agitation, unable to redirect. Ativan 0.5 mg po prn given...."</p> <p>7/15/11 at 6:00 P.M.: "Resident [with] [increased] agitation noted [after] supper. Toileting attempted but did not help to calm resident. Ativan 0.5 mg given @ this</p>						

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	<p>time...."</p> <p>7/18/11 at 6:30 P.M.: "Resident [with] [increased] yelling [and] agitation. Attempted to crawl out of chair several x's. Tried to redirect resident [with] toileting [and] food [without] success. Ativan 0.5 mg given @ this time...."</p> <p>7/19/11 at 3:00 P.M.: "Resident trying to get up out of w/c. Unable to redirect...Ativan 0.5 mg given."</p> <p>7/19/11 at 9:00 P.M.: "Resident [with] [increased] agitation @ this [sic]...Trying to crawl out of w/c to go home...Ativan 0.5 mg given @ this time...."</p> <p>7/20/11 at 7:00 P.M.: "Resident yelling [and] trying to crawl out of w/c. Resident toileted [and] offered snack...Ativan 0.5 mg given @ this time...."</p> <p>7/21/11 at 6:20 P.M.: "Resident upset [and] yelling, crawling out of w/c. Tried toileting [without] success in calming...Ativan 0.5 mg given @ this time...."</p> <p>A Care Plan, dated 7/21/11, indicated a problem of "Altered thought processes [with] altered mood state R/T [related to] Alzheimer's Dementia AEB [as evidenced by] short [and] long term memory loss,</p>			
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	<p>moderately impaired decisions. Res [resident] yells out, is physically abusive - more so in morning hours. Res refuses care at times and has periods of disorganized thinking." Different interventions from the earlier care plan on 4/29/11 were not present.</p> <p>7/22/11 at 4:00 P.M.: "Resident yelling [with] [increased] agitation trying to crawl out of w/c...Ativan 0.5 mg given @ this time...."</p> <p>7/23/11 at 2:00 P.M.: "Resident becoming agitated trying to get out of w/c...Tried to redirect unable Ativan 0.5 mg po given...."</p> <p>7/24/11 at 11:15 A.M.: "Resident agitated trying to get out of w/c, toileted tried to redirect, non effective Ativan .5 mg po given."</p> <p>7/26/11 [time illegible]: "Ativan given as prn for agitation/restlessness...."</p> <p>7/26/11 at 5:00 P.M.: "Resident [increased] agitation noted. Yelling @ people going by [and] trying to get out of chair...Ativan 0.5 mg given @ this time...."</p> <p>7/27/11 at 3:30 P.M.: "Restless today [and] did use prn Ativan [and] was</p>			

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	<p>effective...."</p> <p>8/2/11 at 3:30 P.M.: "Resident yelling, crawling out of chair...Ativan 0.5 mg given @ this time...."</p> <p>8/3/11 at 5:00 P.M.: "Resident yelling [and] [increased] anxiety noted...Ativan 0.5 mg given @ this time."</p> <p>8/4/11 at 4:30 P.M.: "Resident very agitated, crawling out of w/c...Ativan 0.5mg given @ this time..."</p> <p>8/5/11 at 9:45 A.M.: "Resident trying to get out of w/c in D/R [dining room]...Ativan 0.5 mg po prn given."</p> <p>8/7/11 at 2:00 P.M.: "Resident becoming agitated...PRN Ativan given...."</p> <p>8/8/11 at 3:40 P.M.: "Resident very agitated. Trying to climb out of w/c...Ativan 0.5 mg given @ this time...."</p> <p>8/8/11 at 10:00 P.M.: "Resident still yelling [and] trying to get out of w/c...Ativan 0.5 mg given @ this time...."</p> <p>8/11/11 at 6:30 P.M.: "PRN Ativan 0.5 mg given po d/t [increased] agitation. Res yelling out repeatedly et trying to remove self from w/c."</p>						

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	<p>8/12/11 at 12:30 A.M.: "Res given Ativan 0.5 mg...for res [increase] in agitation...trying to slap this nurse...."</p> <p>8/12/11 at 12:45 A.M.: "Res' agitation continues to [increase]. Yelling, screaming, [name of physician] was paged thru [hospital] [and] updated as to res' severe agitation [and] behavior. New order received for Haldol 0.5 mg IM...."</p> <p>8/16/11 at 12:00 P.M.: "Receive new order from [physician] to D/C Ativan and order Haldol 0.5 mg po [every 6 hours] prn for agitation...."</p> <p>8/18/11 at 8:00 P.M.: "Resident very agitated. Trying to crawl out of w/c...Haldol 0.5 mg po given @ this time...."</p> <p>8/31/11 at 6:15 P.M.: "Resident [with] [increased] agitation crawling out of w/c...tried to toilet and offered snack [without] effect. Haldol 0.5 mg given @ this time."</p> <p>A Rehabilitation record, dated August 2011, indicated the resident was unable to walk on 8/5, 8/9, 8/12, 8/14, 8/15, 8/28, 8/30, and 8/31 due to being "too tired" or "too sleepy."</p> <p>Nursing notes continued:</p>						

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	<p>9/8/11 at 6:20 P.M.: "Resident was yelling [with] [increased] agitation trying to crawl out of w/c. Unable to calm [with] toileting or snack. Haldol 0.5 mg given @ this time."</p> <p>9/11/11 at 2:00 A.M.: "Res cont. to sit in wheelchair next to nurses station. Keeps attempting to climb out of chair and yelling. Res given PRN Haldol po. Will observe."</p> <p>The most recent Minimum Data Set [MDS] assessment, dated 9/27/11, indicated the resident scored a 3 out of 15 for cognitive status, with 15 indicating no cognitive impairment. The MDS assessment indicated no hallucinations or delusions, no physical behavior symptoms directed toward others, or other behavior symptoms present. The MDS assessment indicated the resident required extensive two+ persons physical assistance for transfer.</p> <p>A Care Plan, dated 10/6/11, regarding "Altered thought processes..." had the same interventions as on the previous care plan of 7/21/11.</p> <p>The clinical record of Resident # 101 was reviewed again on 10/24/11 at 9:00 A.M. The record indicated the resident received</p>			
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	<p>Haldol 0.5 mg po on 10/20/11 and 10/21/11 for "agitation."</p> <p>During interview with the Social Services Director [SSD] on 10/21/11 at 1:00 P.M., she indicated the resident was switched from Ativan to Haldol, because the physician thought Haldol would work better. She indicated the resident received the prn medications due to being "agitated, restless, tries to get out of chair and recliner." She indicated the nursing staff keeps her updated regarding how often the resident would receive the prn medication.</p> <p>2. The clinical record of Resident # 34 was reviewed on 10/19/11 at 1:45 P.M. Diagnoses included, but were not limited to, Alzheimer's dementia, dementia with behavioral disturbances/psychosis, and anxiety.</p> <p>A Physician's order, initially dated 3/27/06 and on the current October 2011 orders, indicated, "Ativan (Lorazepam) [an anti-anxiety medication] 0.5mg po [by mouth] Q4H [every 4 hours] PRN [as needed] anxiety."</p> <p>Interdisciplinary Progress Notes included the following notations:</p> <p>8/7/11 at 10:30 A.M.: "Ativan prn given</p>			

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	<p>D/T [due to] resident yelling loudly in room. Upsetting roommate. Tried to redirect, wanting red coat for her daughter [name]. Informed resident coat was found and everything was okay. Crying. Unable to redirect."</p> <p>8/18/11 at 11:00 A.M.: "PRN Ativan used for agitation [with] Kepo Tub bath. Med was only slightly effective...."</p> <p>8/22/11 at 10:00 A.M.: "...9:30 AM Ativan 0.5mg po given D/T [increased] anxiety. Resident would not redirect [with] talking to her. Kept talking about [name]."</p> <p>9/10/11 at 10:00 A.M.: "Res [resident] given PRN Ativan prior to bath. Bath required 2 staff members as resident yelled out et [and] cried continuously throughout entire bath...Unable to console res [with] food, drink, or conversation...."</p> <p>A Medication Administration Record [MAR] included the following notations:</p> <p>9/1/11 at 9:30 A.M.: "Ativan 0.5mg po [increased] agitation...."</p> <p>9/5/11 at 7:00 A.M.: Ativan 0.5mg po prior to shower. Non effective still yelled loudly."</p>			
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	<p>9/10/11 at 9:00 A.M.: "Ativan 0.5mg pr prior to shower. Non effective - res yelled loudly."</p> <p>9/15/11 at 2:00 P.M.: "Ativan 0.5mg po given prior to shower...."</p> <p>9/24/11 at 11:00 P.M.: "Ativan 0.5mg po [increased] agitation...."</p> <p>9/25/11 at 1:00 P.M.: "Ativan 0.5mg po given prior to shower - agitation. Non-effective...."</p> <p>10/7/11 at 9:45 A.M.: Ativan 0.5 mg [increased] anxiety during shower. Ineffect. [sic]."</p> <p>On 10/21/11 at 12:10 P.M., during interview with CNA # 1, she indicated Resident # 34 "usually yells during her showers."</p> <p>On 10/21/11 at 1:00 P.M., during interview with the Social Services Director [SSD], she indicated the resident's psychotropic medications are reviewed monthly in conjunction with the behavior management meeting. The SSD indicated she would usually total up the number of prn medications the resident received at the end of the month, or at the beginning of the next month. The SSD indicated Resident # 34 received tub baths</p>			

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	<p>and showers. The SSD indicated she did not know if the resident preferred bed baths to showers, as she did not do residents' initial social histories, but "the admission coordinator does."</p> <p>On 10/24/11 at 11:45 A.M., during interview with the Administrator, she indicated Resident # 34 had other behaviors of yelling out, and not just with her showers. The Administrator indicated the resident had a history of skin issues, and needed her showers.</p> <p>3. Resident #23's clinical record was reviewed on 10/20/11 at 9:00 A.M. Her diagnoses included but was not limited to: Alzheimer's disease, dementia with psychosis, and depression. Her current physician orders (9/10/11) under the diagnosis of dementia with psychosis included: Seroquel (anti-psychotic medication) 12.5 mg orally at bedtime and Klonopin (mood stabilizing medication) 0.25 mg orally four times a day. Both of these medications had order dates of 10/31/07.</p> <p>A pharmacy record dated 4/27/11 was addressed to the Resident #23's facility physician. This documentation indicated, "...In accordance with Indiana State Board of Health and Federal regulations, any nursing home resident who is receiving anti-psychotic drugs,</p>			
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	<p>benzodiazepines, hypnotics, and antidepressant drugs should receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs..."</p> <p>The drug Seroquel 12.5 mg with the diagnosis of dementia with psychosis was listed on this documentation. This documentation indicated to check the appropriate box on the form indicating to do a gradual dose reduction or that a gradual dose reduction was not appropriate at this time.</p> <p>Resident #23's physician on 5/2/11, had left both boxes unchecked. The physician indicated (5/2/11) on the comment section of the form, " Not initiated order by me. Sub specialist order ok to contact then to see if they want to d/c (discontinue)."</p> <p>Another pharmacy record dated 4/72/11, addressed to the resident's facility physician regarding the medication, Klonopin 0.25 mg with the diagnosis of dementia with psychosis. This documentation also had unchecked boxes by the physician on 5/2/11, in regard to a gradual dose reduction or that a gradual dose reduction was not appropriate at this time.</p>			

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	<p>The physician indicated (5/2/11) on the comment section of the form, " Not my order-sub specialist initiated. I believe neuro (neurology) initiated - ok to address c (with) them & d/c if they want."</p> <p>On 10/20/11 at 12:20 P.M., the Director of Nursing (DON) was made aware that documentation was lacking of a follow up to the pharmacy recommendations on 4/27/11 regarding gradual dose reduction of Klonopin and Seroquel and the physician response on 5/2/11.</p> <p>On 10/20/11 at 12:50 P.M., the DON indicated the medical director of the facility had talked to the Resident #23's facility physician regarding medication responsibility and the physician's responsibility to order consults if needed.</p> <p>4. Resident #109's clinical record was reviewed on 10/20/11 at 9:30 A.M. Her current physician orders (9/10/11) included the medication Alprazolam (Xanax) an anti-anxiety drug listed under the diagnosis of anxiety. The medication, Xanax 0.25 mg was ordered three times a day. This medication was ordered on 7/7/11, on admission to the facility.</p> <p>A pharmacy record dated 9/21/11 was addressed to Resident #109's facility physician. This documentation</p>			
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	<p>indicated,"...In accordance with Indiana State Board of Health and Federal regulations, any nursing home resident who is receiving anti-psychotic drugs, benzodiazepines, hypnotics, and antidepressant drugs should receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs..."</p> <p>The drug Alprazolam (Xanax) with the diagnosis of anxiety was listed on this documentation. This documentation indicated to check the appropriate box on the form indicating to do a gradual dose reduction or that a gradual dose reduction was not appropriate at this time.</p> <p>The "gradual dose reduction is not appropriate at this time..." was checked by Resident #109's physician. Documentation was lacking of rationale to continue this anxiety drug without gradual dose reduction.</p> <p>On 10/24/11 at 11:50 A.M., the DON was made aware of documentation lacking of rationale to continue current Xanax dosage. On 10/24/11 at 12:05 P.M., no further information was provided by the DON.</p> <p>The facility policy entitled, "Policy &</p>				

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	<p>Procedure Unnecessary Medications" dated 1/2007, was received and reviewed on 10/24/11 at 11:16 A.M. This policy included but was not limited to:</p> <p>"Purpose: To eliminate unnecessary use of medications. Policy: Each resident's drug regime must be free from unnecessary drugs. An unnecessary drug is any drug when used: a. In excessive dose (including duplicate therapy) or b. For excessive duration or c. Without adequate monitoring or d. Without adequate indications for its use or e. In the presence of adverse consequences which indicate the dose should be reduced or discontinued or f. Any combination of the reasons above..."</p> <p>3.1-48(a)(1) 3.1-48(a)(3) 3.1-48(a)(4)</p>			
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F0356 SS=C	<p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation and interview, the facility failed to ensure daily nursing staffing posting was displayed in a clear and readable manner. This had the potential to affect 103 of 103 residents.</p> <p>Findings include:</p>	F0356	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The nurse staffing information was moved and posted at wheelchair height in a prominent, easily visible place. How other resident having the potential to be affected by the same deficient practice will be</p>		11/08/2011		

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	<p>On initial tour of the building on 10/13/11 at 9 A.M., the nursing staffing posting was observed on a wall across from the nursing station of the 100, 200 and 300 halls. This nursing staff posting was not at wheelchair height but was located at approximately eye level of a 5 foot 3 inch person standing and facing the posting. The printed numbers of the staffing were no larger than 1/8 of an inch in height.</p> <p>On 10/21/11 at 1:45 P.M. the DON (Director of Nursing) was interviewed. She indicated there was a nursing staffing posting at wheelchair height. This staffing posted was observed on the far end of a 1/2 circle shaped nursing station facing down the 200 hall, not in a prominent, easily visible place.</p> <p>3.1-13(a)</p>		<p>identified and what corrective action(s) will be taken; All residents have the potential to be affected. The nurse staffing information was moved and posted at wheelchair height in a prominent, easily visible place on 10/21/2011. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; The nurse staffing information was moved and posted at wheelchair height in a prominent, easily visible place on 10/21/2011. Staffing coordinator posts nursing staffing information daily. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Staffing coordinator and DNS will monitor weekly times four weeks, then random monthly checks times six months. They report to QA committee monthly on compliance and QA committee will make recommendations if 100% compliance not achieved.</p>		

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F0425 SS=D	<p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, interview, and record review, the facility failed to ensure the pharmacy services were provided to ensure the medication Omeprazole [anti-ulcer medication] was given at the correct time, for 2 of 2 residents observed to be given Omeprazole, in a sample of 10 residents reviewed during medication pass. Resident #29, #88</p> <p>Findings include:</p> <p>1. On 10/20/11 at 9:00 A.M., LPN # 3 was observed to administer medications, including Omeprazole 20 mg, to Resident # 29. Resident # 29 was observed sitting in the dining room, with her breakfast already eaten.</p>	F0425	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The medication omeprazole doses have been changed for resident #29 and #88 to be given at least 30-60 minutes before meal. How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have potential to be affected and all residents medication regimens will be reviewed monthly per RPH. All residents on omeprazole will be reviewed by the RPH by November 23rd, 2011 to ensure correct medication administration times. What measures will be put into place or</p>		11/23/2011		

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	<p>The clinical record of Resident # 29 was reviewed on 10/19/11 at 1:00 P.M. A Physician's order, initially dated 2/21/08 and on the current October 2011 orders, indicated, "Omeprazole 20 mg daily," and the scheduled time indicated, "8:30 A.M."</p> <p>The most recent pharmacy consultant recommendation, dated October 2011, did not include the information regarding the administration time for Omeprazole.</p> <p>2. On 10/20/11 at 9:07 A.M., LPN # 3 was observed to administer medications, including Omeprazole 20 mg, to Resident # 88. Resident # 88 was observed to be sitting in the dining room, with her breakfast eaten.</p> <p>The clinical record of Resident # 88 was reviewed on 10/20/11 at 1:00 P.M. A Physician's order, initially dated 1/21/10 and on the current October 2011 orders, indicated, "Omeprazole 20 mg daily, and the scheduled time indicated, "8:30 A.M."</p> <p>3. The "Nursing Spectrum Handbook," 2010, indicated: "Omeprazole...Administration, Give 30 to 60 minutes before a meal, preferably in the morning...."</p> <p>4. On 10/24/11 at 11: 45 A.M., during</p>		<p>what systemic changes will be made to ensure that the deficient practice does not recur; Pharmacy provider updated on survey findings and regulation to monitor accurate medication administration times. The consultant Pharmacist will monitor medication monthly to assure accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; DNS/ADNs will perform random audits monthly times three months to assure the accurate acquiring, receiving, dispensing, and administering of all the drugs and biologicals meet the needs of each resident. Audit will include reviewing of recommendations by the Pharmacist and timely response to those recommendations. Findings will be reported to the QA committee monthly and recommendations for further education/audits made if 100% compliance is not achieved.</p>				

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	interview, the Administrator and Director of Nursing did not offer additional information. 3.1-25(a)				

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F0514 SS=A	<p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview, observation, and record review, the facility failed to ensure activity documentation was complete and accurate, and reflected specific activity of resident likes and dislikes, for 1 of 39 residents whose records were reviewed in the stage 2 sample of 39. Resident #39</p> <p>Findings include:</p> <p>Resident #39's clinical record was reviewed on 10/20/11 10:00 A.M. His diagnoses included, but were not limited to: Huntington's Chorea with depression and dementia.</p> <p>His current care plan with an update on 3/3/11, addressed the problem of "resident at risk for activity intolerance due to being unable to physically take part in daily activities, resident totally dependent on staff for all care, non-verbal. Needs 1:1 activity visits to promote responses..." Care plan goal was "resident to respond</p>	F0514	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The activity record for resident #39 now includes specific details of activity such as "sport shows" in the documentation. How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be effected. All activity records will include specific details of the activity that is specific to that resident. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; The activity dept. were trained on documentation requirements and the electronic health record system was up-dated to allow specific details of activity to be documented. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality</p>		11/23/2011		

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	<p>by nodding head, body movements, or moaning sounds, eye contact during 1:1 special needs visits x 90 days to maintain activity tolerance. Resident to recognize family & some staff, listen to music of interest, watch TV x 90 days to maintain activity tolerance." Interventions included but were not limited to: "...Staff to provide 1:1 special needs visits 3 x weekly. Staff to play music, turn TV to movies, sports, or other shows of interest. Provide pet visits..."</p> <p>On 10/20/11 at 10:15 A.M., Resident # 39's computer printed activity participation records from 8/2/11 to 10/19/11 were reviewed. Daily greetings 1:1 TV, music were documented on every day without a resident response. Three times weekly a 1:1 special needs activity was documented as TV, music, pet visit, reading, grooming/sensory, current events, and exercise with the resident's eye contact response documented. Responses included: opened eyes, relaxed, negative, eye contact, and no response.</p> <p>On 10/24/11 at 9:40 A.M., the Director of Activity was made aware that the "special needs 1:1 activity" provided three times a week lacked documentation of specific activities provided such as type of music or TV programming, to ensure the</p>		assurance program will be put into place; The activity director will do random audits of activity records monthly for 3 months to ensure specific documentation of the activity. She will report to the QA committee the results of audit and the committee will recommend further education or audits if not 100% compliant.				

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	<p>resident's needs and interests were being met.</p> <p>On 10/24/11 at 10:10 A.M., the Activity Director, indicated she was aware that the clinical record activity participation documentation was lacking to reflect the specific activity provided. She provided hand written 1 to 1 activity documentation that was not part of the clinical record and was not kept by the facility, but later shredded. This documentation was from 9/10/11 to 10/22/11, and included specific activities such as , reading bible devotions and a Colts(football) article, pet/bird visit, and listening to a ball game. The Activity Director indicated she had already shredded the August 2011 hand written documentation which had contained specific activities with content .</p> <p>3.1-50(a)(1)</p>			
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R0000	The following state findings are cited in accordance with 410 IAC 16.2-5.	R0000	Credible Allegation of Compliance and Correction: Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual.		

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R0299	<p>(3) The medication review, recommendations, and notification of the physician, if necessary, shall be documented in accordance with the facility ' s policy. Based on observation, interview and record review, the facility failed to ensure medications were administered according to physician orders for 1 of 6 residents observed during a medication pass. (Resident #1)</p> <p>Findings include:</p> <p>On 10/14/11 at 7:50 A.M., LPN #5 was observed passing medications to Resident #1. The MAR (medication administration record) indicated the following: 10/5/11 "Atenolol 12.5 mg...bid (twice a day); 10/5/11: Monitor vitals (blood pressure and pulse) bid, fax in one week 10/12/11." The MAR indicated the Atenolol had been started on 10/6/11. Monitoring of the vital signs began on 10/5/11. On the MAR, a line had been drawn vertically separating the dates of 10/12 and 10/13, between the squares where the Atenolol and vital signs would be documented.</p> <p>During the medication administration, LPN #5 indicated she thought the resident was on Atenolol. She reviewed the MAR again and realized the Atenolol had not been given on 10/13 and the resident had missed two doses.</p>	R0299	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The medication for Resident #1 has been re-written on the MAR on 10/14/11 and given as ordered by physician. How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected. MAR will be reviewed monthly by HIM to assure accurate transcription of medication ordered by the physician. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; MAR will be reviewed monthly by HIM director and verified with physician orders to ensure accurate transcription of orders. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; DON/ADNS will perform random audit monthly times 3 months to ensure medications were administered according to physician orders. Will report finding to QA committee and recommendations for further education/audits made</p>	11/23/2011			

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	<p>The physician order dated 10/5/11 was reviewed. The physician order, indicated the following: "Change Atenolol to 12.5 mg...bid. Monitor vitals bid and fax in 1 wk (week)..."</p> <p>On 10/14/11 at 7:57 A.M. LPN #5 was interviewed. She indicated after reviewing the physician order and the MAR for the Atenolol, the resident had missed two doses of Atenolol on 10/13/11.</p>		if 100% compliance is not achieved.	
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