

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155694	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  04/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  BETZ NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 116 BETZ RD AUBURN, IN 46706
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: April 22, 23, 24, 27, and 28, 2015.</p> <p>Facility number: 000306 Provider number: 155694 AIM number: 100273860</p> <p>Census bed type: SNF/NF: 97 Total: 97</p> <p>Census payor type: Medicare: 10 Medicaid: 51 Other: 36 Total: 97</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a post survey revisit on or after May 11,2015	
F 176 SS=D Bldg. 00	<p>483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE</p> <p>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>Based on observation, record review, and Interviews, the facility</p>	F 176	F176 Resident Self-Administer Drugs if deemed safe Residents	05/11/2015

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155694	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  04/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  BETZ NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 116 BETZ RD AUBURN, IN 46706
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>failed to ensure an assessment for self-administration of medications was completed, and a physician's order was obtained for 1 of 35 residents (Resident #28) who was observed to have medications left at bedside.</p> <p>Findings include:</p> <p>Resident #28 was observed eating breakfast, in her room, at 9:47 A.M., on 4/23/15. There were 2 medications on the tray on her bedside table. The resident did not respond when an interview was attempted, and there was no one else observed in the room.</p> <p>LPN #1 was interviewed, on 4/23/15, at 9:52 A.M., regarding the medication observed on the resident's bedside table. She indicated she normally left the resident's morning medications on the bedside table because the resident would not take her medications if the LPN was watching her. The LPN indicated she checked the resident frequently after giving her medications to see if the resident had taken the medications.</p> <p>The record for Resident #28 was</p>		<p>affected by the alleged deficient practice – One resident(#28) was found to have been affected by the alleged deficient practice. All residents with a care plan to allow medication to be self administered have the potential to be affected. What corrective actions will be taken for the resident found to have been affected by the deficient practice – A medication self-administration assessment was completed by DNS for Resident 28 on 4-27-2015. Physician order was secured to self-administer on 4-27-2015 How will facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken – All residents care plans will be reviewed for self-administration approaches. If any are identified, DNS/designee will do an updated self-administration assessment and secure a physician order for the same. DNS/designee will in-service all licensed nursing staff regarding residents must have assessment, physician order, and care plan in place to self-administer medications on or before 5/11/15. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not re-occur – DNS/Designee will in-service and educate all licensed nursing staff</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155694	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/28/2015
NAME OF PROVIDER OR SUPPLIER  BETZ NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 116 BETZ RD AUBURN, IN 46706		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>reviewed, on 4/24/15 at 10:15 A.M. Diagnoses included, but were not limited to: dysphagia, hypothyroidism, dementia, senile with delusions, insomnia, anxiety state, and depression.</p> <p>Current Physician orders for April, 2015 indicated orders for the following medications: B complex vitamins, 1 tablet, daily docusate sodium 100 milligrams, twice daily (a laxative) Lasix 20 milligrams daily (a diuretic-water pill) levothyroxine 50 mcg daily (for thyroid hormone replacement) lopressor 100 milligrams daily (for high blood pressure) Miralax 17 grams daily (a laxative) naproxen sodium 220 milligrams twice daily (non-steroid anti-inflammatory medication) omeprazole 20 milligrams daily (for acid reflux) vitamin D3 2000 IU (International units) daily clonazepam 0.5 milligrams daily at 8:00 A.M. (medication for anxiety) clonazepam 0.25 milligrams daily at 5:00 P.M. Restoril 15 milligrams at bedtime daily (medication for insomnia) zoloft 50 milligrams twice daily</p>		<p>on the importance of having self-administration assessment, physician order, and careplan in place for all appropriate residents. Medical records will be reviewed for all appropriate residents to ensure all have the correct documentation. Any new admission will be assessed for self administration of medication by the DNS/Designee. If appropriate, the DNS/Designee will obtain a physician's order and the resident care plan will be developed accordingly. Any resident assessed for appropriate self medication will be reassessed quarterly or with a significant change to ensure appropriateness of the self administration of the medication. How will the corrective action be monitored to ensure the deficient practice will not recur, ie, what QA program will be put into place –A CQI Care Plan updating tool will be implemented weekly per DNS/designee then monthly times 6 months. Data will be collected by DNS/designee and submitted to the CQI committee. If threshold of 95% is not met, an action plan will be developed. Date of Compliance will be 5-11-2015</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155694	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BETZ NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 116 BETZ RD AUBURN, IN 46706
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>(medication for depression.</p> <p>The current Medication Administration Record (MAR) for April, 2015, indicated the following medications were given, on 4/23/15, at 8:00 A.M., by LPN #1: B complex vitamins, 1 tablet Docusate sodium 100 milligrams Lasix 20 milligrams Lopressor 50 milligrams Naproxen sodium 220 milligrams Vitamin C 500 milligrams Vitamin D3 2000 IU clonazepam 0.5 milligrams zoloft 50 milligrams.</p> <p>The Minimum Data Set (MDS), annual assessment, dated 1/8/15, indicated the Brief Interview for Mental Status (BIMs) score was 15 out of 15 indicating the resident was alert and oriented.</p> <p>A care plan for ADL (activities of daily living)/Rehabilitation potential for self care deficit related to dementia, depression, and anxiety, with a problem start date of 1/28/14, and most recent goal date of 5/5/15, indicated, "Resident will be able to with limited assistance after set-up" with approaches including but not limited to: "Does not like for nurses to stand</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155694		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/28/2015	
NAME OF PROVIDER OR SUPPLIER  BETZ NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 116 BETZ RD AUBURN, IN 46706			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>next to res (resident) when takes pills. Nurses to frequently check to see if res has taken medications."</p> <p>There were no physician orders to indicate the resident could self medicate, and no documentation to indicate an assessment had been completed regarding self-administration of medications.</p> <p>The Director of Nursing Services (DNS) was interviewed, on 4/27/15, at 11:17 A.M., and indicated she was aware Resident #28 would not take medications if someone was watching her, so she was aware the nurses would leave the medications for the resident to take, then would go back and check to make sure the resident had taken the medications. She indicated there was no assessment completed to ensure the resident was safe to take her medications without the nurses present and there was no physician order for the resident to self-medicate. She indicated there was a care plan documented under Activity of Daily Living (ADL) care, which indicated the resident did not like to be watched when taking her medications.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155694	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BETZ NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 116 BETZ RD AUBURN, IN 46706
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>RN #2 was interviewed on 4/27/15, at 3:30 P.M. She indicated Resident #28 received medications at 8:00 P.M., and 9:00 P. M daily. She indicated she gave the resident medications at 8:00 P.M., and the resident would take the medications while RN #2 was in the room. She indicated she left the 9:00 P.M. medication for sleep in the resident's room when she took her 8:00 P.M. medications to the resident. She indicated the resident would then take the sleeping medication at 9:00 P.M., on her own. The RN indicated she would go back and check at 9:00 P.M., to make sure the resident had taken her sleeping pill.</p> <p>A policy for medication pass was requested on 4/28/15 at 10:00 A.M. from the DNS. The DNS indicated there was not an actual policy for medication pass, but the facility used a skills validation for the medication pass.</p> <p>The Skills Validation for Medication Pass Procedure, dated originally on 2/2010, with review dates of 9/2012 and 03/2013, was provided by the Regional Nurse Consultant, on 4/28/15, at 10:20 A.M. The Medication Pass Procedure</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155694		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/28/2015	
NAME OF PROVIDER OR SUPPLIER  BETZ NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 116 BETZ RD AUBURN, IN 46706			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F 282 SS=D Bldg. 00	<p>was reviewed, on 4/28/15, at 10:30 A.M., and indicated the following: "6. Identified resident prior to administering. 7. Observed taking medications – not left at bedside. "</p> <p>3.1–11(a)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observations, interviews, and record reviews, the facility failed to follow a Physician's Order for a personal alarm for 1 of 3 residents reviewed for falls (Resident #101).</p> <p>Findings include:  Review of the clinical record for Resident #101 on 4/27/15 at 11:00 A.M. indicated the following: diagnosis included, but were not limited to, acute myocardial infarction, septicemia, Parkinson's disease, hypopotassemia, reflux, dysphagia, pneumonia, hypertension, hyperlipidemia, senile dementia, and</p>	F 282	F282 Services by Qualified Persons/Per Care Plan Residents affected by the alleged deficient practice – One resident (#101) was found to have been affected by the alleged deficient practice. All residents with a physician order for a personal alarm have the potential to be affected by the alleged deficient practice What corrective actions will be taken for the resident found to have been affected by the deficient practice – Resident #101 had personal alarm replaced per physician order On 4-27-15. How will facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken –	05/11/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155694	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/28/2015
NAME OF PROVIDER OR SUPPLIER  BETZ NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 116 BETZ RD AUBURN, IN 46706		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>depression.</p> <p>The fall investigation report dated 3/28/15 at 9:48 AM indicated Resident #101 was found on the floor next to his wheelchair. The resident was unable to tell the staff how the fall had occurred. The resident continues to receive intravenous antibiotics for possible aspiration pneumonia.</p> <p>The Physician's Order dated 3/30/15 indicated Resident #101 was to have a "canary" alarm on at all times.</p> <p>The at risk for falls Care Plan for Resident #101 dated 4/12/13 indicated the resident is at risk for fall due to: balance deficit, cognitive deficit, receiving antidepressant, antihypertensive, diuretic medications, Parkinson's disease, vision impairment, and incontinence. The Care Plan was updated on 3/30/15 to include a canary alarm to apply to the resident at all times.</p> <p>On 4/28/15 at 10:00 A.M. the resident was observed with CNA #4 in the lounge on the 500 hall sitting in his wheelchair and there was no alarm present. An interview with CNA #4 indicated Resident #101 alarm had been discontinued.</p>		<p>All residents with personal alarm orders will be reviewed by DNS/designee. A full house sweep will be completed to ensure all ordered alarms are in place. DNS/designee will in-service all nursing staff regarding residents with personal alarms. There must be a physician order, a care plan, and resident profiles in place. This will be completed on or before 5/11/15. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not re-occur – DNS/Designee will in-service and educate all licensed nursing staff on the importance of following physician orders, care plans, and care-giver profiles. Care plans and care-giver profiles will be reviewed by the IDT team to ensure physician orders are appropriately implemented. How will the corrective action be monitored to ensure the deficient practice will not recur, ie, what QA program will be put into place –A Care Plan updating CQI tool and a fall management CQI tool will be implemented weekly per DNS/designee then monthly times 6 months. Data will be collected by DNS/designee and submitted to the CQI committee. If threshold of 95% is not met, an action plan will be developed. Date of Compliance will be 5-11-2015</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155694		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/28/2015	
NAME OF PROVIDER OR SUPPLIER  BETZ NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 116 BETZ RD AUBURN, IN 46706			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F 329 SS=D Bldg. 00	<p>On 4/28/15 at 1:00 P.M. the resident was observed in the main dining room eating lunch. Resident #101 was sitting in his wheelchair with no alarm present.</p> <p>On 4/28/15 at 1:10 P.M. an interview with the Assistant Director OF Nursing (ADON) in regard to Resident #101's alarm indicated she would have to check on the alarm and in the meantime an alarm was applied to the resident.</p> <p>On 4/28/15 at 1:30 P.M. an interview with CNA #4 indicated she had removed Resident #101's alarm because she had thought the alarm had been discontinued.</p> <p>3.1-35(g)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155694	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BETZ NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 116 BETZ RD AUBURN, IN 46706
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to ensure 1 of 5 residents (#123) reviewed for medications had non-pharmacological interventions attempted before administering an as needed (PRN) medication (Ambien for insomnia) on 5 occasions in March 2015.</p> <p>Findings include:</p> <p>Resident # 123's clinical record was reviewed on 4/24/15 at 12:00 P.M.. The Physician's orders indicated on 2/22/15 Resident #123 received an order for Ambien 5 milligrams(mg) PRN for insomnia.</p> <p>Review of Resident #123's Medication Administration Record (MAR) for March and April 2015 indicated Ambien 5 mg PRN was administered on 3/1/15, 3/2/15, 3/4/15, 3/14/15 and 3/15/15. The March MAR indicated on each of the 5 Ambien administration dates, the indication for</p>	F 329	<p>F329 Drug Regimen is Free from Unnecessary Drugs Residents affected by the alleged deficient practice – One resident (#123) was found to have been affected by the alleged deficient practice. All residents with a physician order for a PRN antipsychotic medication have the potential to be affected by the alleged deficient practice What corrective actions will be taken for the resident found to have been affected by the deficient practice – Resident #123 had the Ambien d/c'd as it had not been given/needed for over 30 days How will facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken – All residents with PRN antipsychotic medications ordered were reviewed by DNS/designee to ensure applicable nonpharmacological interventions were documented. DNS/designee will in-service all licensed nursing staff regarding the documentation of failure for at</p>	05/11/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155694		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/28/2015	
NAME OF PROVIDER OR SUPPLIER  BETZ NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 116 BETZ RD AUBURN, IN 46706			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>use was sleep and on 3/1/15, 3/2/15, 3/4/15, 3/14/15, the medication was effective. On 3/15/15, the medication was documented as somewhat effective. The MAR did not indicate any non-pharmacological interventions were attempted before administration of Ambien 5 mg PRN.</p> <p>Review of the progress notes for Resident #123 on 3/1/15, 3/2/15, 3/4/15, 3/14/15 and 3/15/15/15 did indicate any non-pharmacological interventions attempted before administration of Ambien 5 mg PRN.</p> <p>Review of a care plan started 2/17/15 for Resident #123 indicated the problem as: Behavior: Resident is at risk for insomnia as evidenced by not being able to sleep during normal night hours, sleeping during the day and awake at night. Interventions included: #1. Staff will encourage resident to stay awake during day time hours; #2. Staff will encourage resident to participate in activities; #3. Staff will offer toileting, food, fluid and help resident to get comfortable when awake at night; #4. Staff will provide quiet, dark, calm environment for resident to sleep.</p> <p>An interview with the Director of Nursing Services (DNS) on 4/28/15 at</p>		<p>least 3 nonpharmacological interventions prior to administration of the PRN antipsychotic medication. This will be completed on or before 5/11/15. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not re-occur – DNS/Designee will in-service and educate all licensed nursing staff on the importance of nonpharmacological interventions prior to administering PRN antipsychotic medications. Medical records will be reviewed for all residents to identify the PRN antipsychotic orders and verify the need going forward. DNS/Designee will review the resident medical record to ensure non pharmacological interventions are attempted and documented indicating the ineffectiveness of the intervention, prior to administering the antipsychotic medication. How will the corrective action be monitored to ensure the deficient practice will not recur, ie, what QA program will be put into place –A Behavior Management CQI tool and an Unnecessary Medication CQI tool will be implemented weekly per DNS/designee then monthly times 6 months. Data will be collected by DNS/designee and submitted to the CQI committee. If threshold of 95% is not met, an action plan will be</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155694	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  04/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  BETZ NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 116 BETZ RD AUBURN, IN 46706
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>2:23 P.M. indicated there was no documentation of non-pharmacological interventions attempted before administration of Ambien 5 mg PRN on the dates of 3/1/15, 3/2/15, 3/4/15, 3/14/15 and 3/15/15/15.</p> <p>The DNS provided a current policy titled Behavior Management Policy dated 7/14, on 4/28/15 at 2:45 P.M.. The policy did not address non-pharmacological interventions before administration of PRN medications. The DNS indicated the facility did not have a policy addressing non-pharmacological interventions before administration of PRN medications.</p> <p>3.1-48(b)(1)</p>		developed. Date of Compliance will be 5-11-2015	