

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155368	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/29/2013
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NAME OF PROVIDER OR SUPPLIER TODD DICKEY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 712 W 2ND ST LEAVENWORTH, IN 47137
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: August, 21, 22, 26, 27, 28, and 29, 2013</p> <p>Facility number: 000490 Provider number: 155368 AIM number: 100291320</p> <p>Survey team: Gloria J. Reisert, MSW - TC Nicole Wright, RN (8/21/13 and 8/22/13) Gwen Pumphrey, RN (8/22, 8/26, 8/27, 8/28, 8/29/13) Joan Laux, RN</p> <p>Census bed type: SNF/NF: 49 Total: 49</p> <p>Census payor type: Medicare: 8 Medicaid: 33 Other: 8 Total: 49</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on</p>	F000000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	September 11, 2013 by Cheryl Fielden, RN.				

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F000156 SS=A	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>			

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	<p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits,</p>			

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	<p>and how to receive refunds for previous payments covered by such benefits. Based on interview and record review, the facility failed to provide the "General Notice of Medicare Non-Coverage" to 1 of 3 Medicare A residents upon discharge to home although Medicare benefit days were still available. (Resident #45)</p> <p>Findings included:</p> <p>During a review of the " Medicare Notice" on 8/28/13 at 9:00 a.m., Resident #45 was discharged to home on 3/22/13 per her choice. A "Notice of Medicare Denial" letter had not been issued.</p> <p>During an interview with the Bookkeeper on 8/28/13 at noon , she indicated "We don't issue Medicare denial notices when residents go home by their own choice"</p> <p>At 2:28 p.m., the Bookkeeper indicated "The grid we got from CMS [Center for Medicare/Medicaid Services] says if the beneficiary chose to go home even she still had days left, then its AMA {Against Medical Advice} and we do not have to issue any notices. That's how we look at it."</p>	F000156	<p>This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report. Resident #45 was notified by telephone and followed with a General Notice of Medicare Non-Coverage statement showing the number of Medicare days she has left. A one time audit of current Medicare residents was performed and letters to inform them of their days left, if any, will be presented at the time of discharge. Business office personnel and appropriate staff have been in-serviced on Rights, Rules, Services and Charges policy and procedure. The administrator/designee will monitor discharges weekly for 30 days to insure notice is given. Failure to comply will lead to additional monitoring, training and disciplinary action, as needed. The Quality Assurance committee will review the results of these audits for any changes or updates, as indicated.</p>	09/28/2013			

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	3.1-4(l)(1)			

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F000272 SS=D	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on observation, interview and record review the facility failed to complete a comprehensive assessment of the resident's need for a foley catheter. This deficient</p>	F000272	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of	09/28/2013

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	<p>practice affected 1 of 3 residents with urinary catheters. (Resident #67)</p> <p>Findings include:</p> <p>Resident #67 was observed with a foley catheter on multiple observations on 8/22/13, 8/26/13, 8/27/13, 8/28/13, and 8/29/13.</p> <p>Review of the medical record on 8/28/13 at 9:34a.m., indicated Resident #67 had diagnosis including but not limited to, dementia, dyslipidemia, seizures, fluid retention, acid reflux, toxic metabolic encephalopathy, and hypertension.</p> <p>Resident #67 was readmitted to the facility on 5/2/13 with orders "f/c[foley catheter] to bsd[bedside]". Review of the medical record lacked documentation of an assessment of the need to for a foley catheter.</p> <p>Review of the urologist progress note indicated Resident #67 had a foley catheter placed on 7/23/13. The progress note lacked evidence of the need to place the foley catheter. The medical record does not indicate when the resident had previous foley catheter discontinued.</p> <p>In an interview on 8/29/13 at</p>		<p>or agreement with the deficiencies or conclusions contained in the Department's inspection report. Resident #67 has been assessed for the need for a Foley catheter by the IDT members and appropriate documentation was included in the comprehensive assessment. Residents with Foley catheters have been assessed for the need of a Foley catheter by IDT members, as well as a review of documentation in each of those resident's medical records. Licensed nursing staff has been in-serviced on appropriate diagnosis and on the facility's policy and procedure for Foley catheter usage. The DON/designee will review Foley catheter usage weekly for 30 days for appropriate assessment and usage of Foley catheters. The Quality Assurance committee will review the results of these audits on a monthly basis for any change or updates, as indicated.</p>	

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	<p>1:30p.m., LPN #2 indicated Resident #67 had a history urinary retention. LPN#2 indicated the resident did not have a foley catheter before being admitted to the hospital in May 2013. LPN#2 indicated the resident was readmitted to the facility with a foley catheter. LPN#2 was unable to provide documentation of the need to continue the foley catheter when readmitted to the facility.</p> <p>LPN#2 indicated the foley catheter observed on 8/22/13-8/29/13 was placed on 7/22/13. LPN#2 was unable to provide indication for foley catheter use.</p> <p>3.1-31(c)(6)</p>			

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review, observation and interviews, the facility failed to develop a care plan which addressed bladder incontinence for 1 of 30 residents' care plans reviewed. (Resident #51)</p> <p>Findings include:</p> <p>Residen #51 ' s record review on 8/28/13 at 10:30 a.m. included an MDS (Minimum Data Set) dated 3/28/13 and indicated resident #51 was "always continent." The 30 day scheduled assessment dated 4/22/13</p>	F000279	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report. Resident #51 has been care planned for urinary incontinence. A one time 100% audit has been conducted for resident's urinary incontinence status. Care plans have been reviewed for urinary incontinence. Licensed nursing staff have been provided with	09/28/2013

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	<p>indicated resident #51 was "always continent." The 90 day scheduled assessment dated 6/21/13 indicated resident #51 was "occasionally incontinent (less than 7 episodes of incontinence). "</p> <p>A review of the physician's orders dated 8/1/31 to 8/31/13 indicated diagnosis of dementia, benign prostrate hyperplasia, hyperlipidemia, anxiety, glaucoma, hypertension, myocardial infarction, cardiac stent, headaches, confusion, and depression.</p> <p>A review of the history of resident #51's present illness dated 3/13/13 from a local psychiatric hospital indicated "...he has been incontinent, wetting in the pants, hangs them to dry then without cleaning them."</p> <p>A review of the physician's orders dated 8/1/13 to 8/31/13 indicated an order for flomax 0.4 mg 1 by mouth daily.</p> <p>A review of a local urologist history and physical dated 4/11/13 indicated "urgency and incontinence and on flomax twice a day."</p> <p>On 8/28/13 at 2:08 p.m., during an interview with CNA #8, she indicated</p>		<p>in-servicing on communication and care for incontinent residents. The DON/designee will audit 10 resident medical records weekly for two months to ensure accurate urinary incontinence care plans. The Quality Assurance committee will review the results of these audits on a monthly basis for any changes or updates, as indicated.</p>	

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	<p>that resident # 51 "was incontinent since his admit. A few episodes due to his pneumonia, when he was very sick, about 2 months ago. He was having trouble with his legs, hard to get around. Most of the time he cleans himself up. We fill out stop and watch forms for when there is a change."</p> <p>On 8/28/13 at 2:10 p.m., during an interview with RN #2, he indicated resident #51 was "incontinent from time of admit. It wasn't very often. Some stress incontinence. This has continued since admit."</p> <p>On 8/28/13 at 2:15 p.m., during an observation and interview with the resident # 51 he indicated "I have to go bad, can you shut the door for me?" On coming out of the restroom in his room, he indicated that he has had accidents for a long time, before he ever came in to this facility. He has had good and bad days. "Sometimes I can go a long time, days without having an accident, sometimes when i'm sick or something, it can get worse. That's all I know." The call light is within reach and has a walker close by. His room is uncluttered.</p> <p>On 8/28/13 at 2:22 p.m. during an interview with the DON (Director of</p>			

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	<p>Nursing) indicated that "he was functional when he got here. He got cellulitis on his leg that impaired his mobility and he had more episodes of incontinence." The DON also indicated at this time that she could not find a stop and watch form for this resident.</p> <p>On 8/28/13 at 2:27 p.m. during an interview with the MDS (Minimum Data Set) co-coordinator/float, she indicated that resident #51 was admitted on 3/21/13. The look back period dates from 3/22/13 to 3/28/13. A 7 day look back period indicated he had no incontinent episodes. "This look back period is what they base the initial MDS on. That is why he was coded as continent as he had no incontinent periods during this 7 days. The 90 day was 6/21/13 indicated an occasional incontinent episode. The 7 day look back for the 90 day evaluation dated 6/15/13 to 6/21/13 that this resident had 3 episodes of incontinence."</p> <p>On 8/28/13 at 2:48 p.m., during an interview with the DON she indicated that no care plan for urinary incontinence had been written for this resident.</p> <p>On 8/28/13 at 2:57 p.m., during an</p>			

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	<p>interview with the DON she indicated that any nurse or administrator can write a care plan. "When someone becomes incontinent they would do that. Take it to our daily clinical meeting. I don ' t think it was evident to me or the ADON that he was incontinent." The DON indicated that " 1 doesn ' t indicate a pattern, more than 1 would indicate a pattern and then the care plan should be made. When we have a change in condition we use a 3 day pattern and assess it. If it indicates a problem, we initiate a bladder assessment. This pattern at admission, it showed no incontinence. On the re-admit 3 day, he had 1 episode out of a 72 hour tracking period." The DON indicated that resident #51 is now continent.</p> <p>On 8/28/13 at 2:43 p.m., the bladder and bowel report dated between 6/15/13 to 6/21/13 indicated resident #51 had 3 episodes of urinary incontinence and on 7/20/13; he had 1 episode of urinary incontinence.</p> <p>On 8/28/13 at 3:55 p.m., the " Policy and Procedure for Documentation " indicated " The comprehensive care plan should be an interdisciplinary communication tool that must have measureable objectives with time frames and describes the services to</p>			

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	<p>be provided to maintain the resident 's highest practicable physical, mental, and psychosocial well-being ...the care plan is driven ...by identified resident issues. The care plan is to be oriented towards: managing risk factors. This policy indicated one of the care plans as: " Alteration in Urinary Continence Care Plan. "</p> <p>3.1-35(a) 3.1-35(b) (1) 3.1-35(b) (2)</p>			

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to provide a complete physician's order for residents with a foley catheter. This deficient practice affected 2 of 3 residents reviewed for foley catheters. (Resident #67 and Resident #44)</p> <p>Findings include:</p> <p>1. Resident #67 was observed on 8/22/13, 8/26/13, 8/27/13, 8/28/13, and 8/29/13 with a foley catheter.</p> <p>A review of the medical record on 8/28/13 at 9:34a.m., indicated Resident #67 had a previous diagnosis of dementia, dyslipidemia, seizures, fluid retention, COPD, acid reflux, cholecystectomy, toxic metabolic encephalopathy, and hypertension.</p> <p>A review of the physician order dated 7/22/13 indicated "FC(foley catheter) to BSD(bedside) bag". The physician order indicated urinary retention as the need for a foley cathete. The physician order lacked the catheter</p>	F000282	<p>This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report. Resident #67 and #44 now have correct physician's orders for Foley catheters, including catheter size, bulb size with how much to inflate the bulb and when to change the Foley catheter. Residents with Foley catheters have been assessed for correct physician's orders for Foley catheter placement and care. Licensed nursing staff have been provided in-servicing on Foley catheter orders including diagnosis for use, catheter size, bulb size and fluid in bulb and also when to change the Foley catheter. The DON/designee will review Foley catheters weekly for 30 days for correct physician's orders. The Quality Assurance committee will review the results of these audits on a monthly basis for any changes or updates, as indicated.</p>	09/28/2013

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	<p>size, bulb size with how much fluid to inflate the bulb, and when to change the foley catheter.</p> <p>2. A record review on 8/27/13 at 11:07 a.m., of the physician's orders dated 7/31/13 indicated diagnosis of mild mental retardation, hypertension, type 2 diabetes, gastro esophageal reflux disease, depression, psychosis, muscle spasms, hyperlipidemia, benign prostate hyperplasia, constipation, and cerebral palsy.</p> <p>A review of the catheter care plan dated 7/22/13 indicated that the use of a catheter, when the resident has urinary retention that cannot be corrected surgically or medically, will have a goal of remaining free of UTI's (urinary tract infections) and other related catheter complications. Interventions included assuring that the catheter and drainage bag are below the level of the bladder, emptying the urine bag every shift and as needed, maintaining a closed drainage system, striving to keep the residents catheter free of feces, changing the catheter and system as directed by a provider, and to check for patency and integrity.</p> <p>A review of the MDS (minimum data set) dated 7/28/13 indicated the use</p>				

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	<p>of an indwelling catheter. Active diagnoses include, but not limited to: cerebral palsy, depressive disorder, and intellect disability.</p> <p>A review of the physician ' s order dated 7/8/13 indicated "Place foley cath (catheter) for possible retention." A physician's order dated 8/1/13 indicated "foley cath to bedside, cath care every shift."</p> <p>On 8/27/13 at 11:57 a.m., during an interview with the DON (Director of Nursing) she indicated " with foley catheter's you need the appropriate diagnosis, the size, the cc for the balloon. I know a lot of orders are just written for foley catheter for bedside drainage."</p> <p>On 8/27/13 at 12:00 p.m., a review of the " Policy and Procedure of Indwelling Urinary Catheter ' s " indicated " residents admitted to the center with an indwelling catheter that was placed elsewhere, need a provider order and medical justification for the catheter to remain in place. "</p> <p>On 8/27/13 at 1:19 p.m., during an interview with LPN #3, she indicated that what was needed in a physician's order for a foley catheter should</p>			

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	<p>contain "the size of catheter, the inflate, how much we put in the balloon, peri-care, flush per facility policy, how often to change per facility policy, which is usually a month. When they see a urologist, it is usually changed by the urologist. We call urologist for orders when we have to. This resident came to us from the hospital with a foley in place."</p> <p>During a review of the nurse's notes dated between 7/8/13 to 8/1/13, documentation was lacking on placement of a foley catheter.</p> <p>During a review of the physician's orders dated between 7/8/13 to 8/1/13 documentation on size of foley catheter, how many cc's to inflate bulb with was lacking.</p> <p>On 8/27/13 at 2:17 p.m., during an interview with DON, she indicated "the Doctors usually order to have a catheter, we get a diagnosis, generally an order to change or if it is dislodged. If we don ' t have orders to occlude or irrigate, we call and get the order for that. If a need to change it, we set up a urologist to see the resident and the urologist takes care of this. I know our policy is very vague, it's all we got, it 's all we got."</p>			

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	<p>On 8/27/13 at 2:25 p.m., a record review of instructions from a local hospital indicated "continue with foley catheter for urinary retention."</p> <p>On 8/27/13 at 2:25 p.m., the DON gave this surveyor a copy of a nurse's note dated 7/8/13 to demonstrate that catheter care is being documented. The nurse's note indicated "When cath (catheter) placed, got 400 cc (cubic centimeter) output."</p> <p>On 8/28/13 at 9:28 a.m., the DON indicated the original order for a catheter to be placed was on 7/8/13. The physician order, dated 7/8/13 indicated "Place foley cath (catheter) for possible retention."</p> <p>On 8/28/13 at 9:45 a.m., resident #44 was observed sleeping in his room, catheter attached to the side of bed and catheter bag was covered.</p> <p>A review of the treatment record on 8/28/13 at 10:30 a.m., dated 8/1/13 to 8/31/13 indicated that the foley catheter was signed off for being done by the nursing staff.</p> <p>3.1-35(g) (2)</p>			

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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <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 record review and interview, the facility failed to ensure anti-psychotropic medications had adequate indications for use prior to initiating or increasing the dosage for 1 of 5 residents reviewed for unnecessary medications. (Resident #39)</p> <p>Finding includes:</p> <p>Review of the clinical record for</p>	F000329	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report. Resident #39 has been reviewed by IDT members for psychotropic drug usage and care plans have been updated appropriately. A one time 100% audit was performed by IDT members for psychotropic	09/28/2013

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	<p>Resident #39 on 8/29/13 at 9:00 a.m., indicated the resident was admitted from the hospital on 4/26/13 and had diagnoses which included, but were not limited to: traumatic brain injury due to a motor vehicle accident, vascular dementia with delirium (severe frontal lobar), and depressive disorder.</p> <p>Review of the 5/13/13 14 day Admission MDS [Minimum Date Set] Assessment indicated the resident's BIMS [Brief Interview Mental Status] score was a 3 - poor short/long term memory; had no mood issues; and had 1-3 days of yelling out for help in a 7 day period.</p> <p>Review of the 7/11/13 Quarterly MDS Assessment indicated the resident's BIMS score was a 3 - poor short/long term memory; had frequent trouble concentrating; occasional little interest in things with poor appetite; 1 day of feeling down and depressed; was tired with little energy and feeling bad about self and had 1-3 days of yelling out for help in a 7 day period</p> <p>During an interview with the Social Worker on 8/29/13 at 11:56 a.m., she indicated that any behaviors a resident might experience would be coded into the Care Tracker system</p>		<p>drug use and appropriate documentation to support use and dosage adjustments.Licensed nursing staff have been provided with in-servicing on psychotropic drug use, including supportive documentation for dosage adjustments. The DON/designee will audit 10 medical records weekly for two months on psychotropic drug use and supportive documentation. The Quality Assurance committee will review the results of these audits on a monthly basis for any changes or updates, as indicated.</p>		

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	<p>and that was how she would follow up on what had been entered and to see if goals and approaches needed to be changed. IDT [Interdisciplinary Team] meetings were also held when changes occurred with the resident, i.e. Medication changes.</p> <p>Review of the 4/26/13 Admission medications during the clinical record review, indicated the resident had the following orders: Depakote [used for mood and behavior] 500 mg [milligrams]- 1 Q [every] HS [every night] - mood disorder and Lexapro [anti-depressant] 20 mg - 1 QD [every day] depression.</p> <p>On 4/29/13, a new physician order was received to increase the Depakote to 500 mg - 1 tab BID [twice daily] and add Risperdal [anti-psychotic] 0.25 mg - 1 Q HS.</p> <p>Documentation from the Care Tracker [computer system in which each episode of behaviors were recorded] provided by the Social Worker on 8/29/13 at 10:20 a.m., was lacking of the resident having experienced any behavior issues between 4/26 to 4/28/13, which required the need to add or increase his meds.</p> <p>On 5/14/13, a new physician order</p>						

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	<p>was received to increase the Risperdal to 0.5 mg Q AM [morning] and 0.25 mg Q HS for psychosis and agitation/</p> <p>Documentation was lacking in the Care Tracker system of the resident having experienced any behavior issues between 5/2/13 to 5/14/1313, which required the need to add or increase his meds. The resident did have 1 episode of resistance of care and verbal abuse towards staff during toileting at night with inappropriate touching of a staff member on 4/29/13 and 5/1/13.</p> <p>On 7/17/13, a new physician order for Wellbutrin XR [anti-depressant] 150 mg - 1 TAB QD was received.</p> <p>On 8/13/13, a new order was received to increase the Risperdal to 0.5 mg BID - per the psychiatrist, due to increased agitation and disorientation during her visit; not understanding what was happening around him, poor sleep, appetite and increased pain in legs.</p> <p>A review of the Care Tracker on 8/29/13 at 10:20 a.m., lacked documentation of the resident having experienced any other behavior issues between 7/18/13 and 8/13/13,</p>			

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	<p>which required the need to add or increase his medications. The resident did have 1 episode of resistance of care and verbal abuse towards staff during toileting at night with inappropriate touching of a staff member on 7/18/13 and 8/13/13.</p> <p>During an interview with the Administrator, Director of Nursing and the Social Worker on 8/29/13 at 5:30 p.m., the Social Worker indicated that the reason the Risperdal was increased on 8/13/13 was because he acted up during the psychiatrist's visit and she thought an increase was needed. When queried if any assessment had been made to determine why the resident was having the occasional behavior issues at night and when the psychiatrist visited, they had replied that they had not.</p> <p>Policy and Procedure titled "Psychoactive Medication" was presented by the Social Worker on 8/29/13 at 5:00 p.m. Review of the policy at this time included but was not limited to: "Policy: Extencicare Health Services, Inc. (EHSI) requires a review of residents prescribed psychoactive medication upon admission, annually, quarterly, and with a significant change in</p>			

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	<p>condition...Procedure:...13. Complete a progress note in the Progress Notes section of the medical record that indicates the Interdisciplinary Team (IDT) met, reviewed identified issues and initiated/updated the Plan of Care as necessary."</p> <p>3.1-48(a)(3) 3.1-48(a)(4)</p>			

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F000431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review the facility failed to ensure medications were properly</p>	F000431	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of	09/28/2013

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	<p>stored and labeled. This deficient practice affected 3 of 4 medication carts and 1 of 2 medication storage rooms observed for medication storage.(Resident #11 and Resident #63)</p> <p>Findings include:</p> <p>1. During an observation of the medication storage room on the 100 unit on 8/27/13 at 3:15p.m., the medication refrigerator was found to be unlocked. Inside the refrigerator the Emergency Drug Kit(EDK) was found to be unlocked.</p> <p>During an interview on 8/27/13 at 3:30p.m., RN#2 indicated the medication refrigerator is only locked if there are narcotic medications in it.</p> <p>In an interview on 8/28/13 at 3:14p.m., the Director of Nursing (DON) indicated the refrigerator in the medication storage room is only locked if there are narcotic medications stored in it.</p> <p>2. During an observation of the medication cart on the 400 hall on 8/27/13 at 4:05p.m., the following was observed:</p> <p>a. A glucaGen Hypokit was found with no pharmacy label.</p>		<p>correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report.The EDK in the East Wing medication room has been properly secured, including refrigerated EDK. The medication cart on 400 Hall has been cleaned and unlabeled medications and hype kits were destroyed. Resident #63 now has OTC medications that are properly labeled. Medication on the 200 Hall medication cart is refrigerated per manufacturer's guidelines. A one time 100% audit has been conducted to secure EDK in the facility, including refrigerated EDK. The medication carts have been cleaned and audited for unlabeled medications, refrigerated medications and OTC unlabeled medications.The licensed nursing staff have been in-serviced on EDK storage, medication cart storage, refrigerated medication storage and OTC labeling. The DON/designee will audit one medication cart weekly for two months to ensure storage and labeling compliance. The Quality Assurance committee will review the results of these audits on a monthly basis for changes or updates, as indicated.</p>		

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	<p>b. A vial of lantus insulin was found with no pharmacy label, with Q handwritten "Named Resident".</p> <p>c. Loose sediment and sticky substance in bottom drawers.</p> <p>3. On 8/28/13 at 3:47p.m., an observation of the medication cart on the 300 unit indicated 4 bottles of an over the counter medication "Clear Tract Urinary Tract Formula" cranberry concentrate. On each bottle top was handwritten Resident #63's name. On 2 of the 4 bottles was handwritten "see mar".</p> <p>In an interview on 8/27/13 at 4:00p.m., LPN #4 indicated, "This is how we label them(over the counter medications) and we go by the MAR".</p> <p>In an interview on 8/28/13 at 3:14p.m., the DON indicated she was told only the pharmacy could label medications and she believed the resident's name was sufficient labeling.</p> <p>4. During an observation on 8/28/13 at 2:15p.m., of the medication cart on the 200 unit a medication desmopressin 0.01% spray was found in the drawer of the medication</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155368	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/29/2013
NAME OF PROVIDER OR SUPPLIER TODD DICKEY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 712 W 2ND ST LEAVENWORTH, IN 47137		
(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>cart. The medication had a pharmacy label which indicated the medication was to be refridgerated. The label indicated this medication belonged to Resident #11 .</p> <p>In an interview on 8/28/13 at 2:30p.m., RN#1 indicated this medication was stored similar to insulin. RN#1 indicated the medication could be stored at room temperature once opened.</p> <p>According to the manufactureres instructions, the medication is to be stored in the refrigerator.</p> <p>A review of the policy for medication storage and labeling received from the DON on 8/28/13 at 3:44p.m., indicated the facility should ensure medications are stored at the proper temperatures. The policy does not indicate how medications should be labeled.</p> <p>3-1-25(j)(k)(l)(n)</p>				