

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/13/2011
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NAME OF PROVIDER OR SUPPLIER CROWNPOINTE OF CARMEL	STREET ADDRESS, CITY, STATE, ZIP CODE 11610 TECHNOLOGY DR CARMEL, IN46032
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R0000	<p>This visit was for a State Residential Licensure survey.</p> <p>Survey dates: October 12 and 13, 2011</p> <p>Facility number: 012309 Provider number: 012309 AIM number: N/A</p> <p>Survey team: Janet Stanton, R.N.--Team Coordinator Michelle Hosteter, R.N. Heather Lay, R.N.</p> <p>Census bed type: Residential--23 Total--23</p> <p>Census payor type: Other--23 Total--23</p> <p>Sample: 7</p> <p>These State Residential findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed on October 17, 2011 by Bev Faulkner, RN</p>	R0000		

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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R0154	<p>(k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24.</p> <p>Based on observation, interview and record review, the facility failed to ensure the 2 of 2 ovens and 1 of 1 walk-in refrigerators in the facility's only kitchen were maintained in a clean and sanitary condition. This deficiency had the potential to affect 23 of 23 residents that were served food from the kitchen.</p> <p>Findings include:</p> <p>The initial tour of the kitchen was done on 10/12/11 at 10:14 A.M., with Dietary Aide #2 in attendance. Each of the two ovens had a black substance on the inside floor of the ovens, underneath the cooking racks. The walk-in refrigerator had scattered small black particulate matter stuck on the ceiling near the entrance.</p> <p>In an interview at that time, Dietary Aide #2 indicated both ovens were used daily for cooking and baking. She also indicated she did not know what the black substance in the refrigerator was, and had never noticed it before.</p> <p>In an interview on 10/12/11 at 12:25 P.M., the Dietary Manager indicated she did not know what the black substance in</p>	R0154	<p>The ceiling of the walk in cooler has been cleaned of the blackened dust. The cooling fan in the cooler will be taken apart and the coils will be cleaned as well as all parts of the system that are accessible. The ovens will be cleaned of any baked on black substances will be removed. All residents have the potential of being harmed by the same deficient practices. The Kitchen Daily Cleaning Assignment Sheet has been revised to include dusting the ceiling of the walk in cooler and to clean the ovens daily immediately following any overflows or spills in the ovens. All dietary staff will be inserviced and trained on the new cleaning routine and use of the updated daily cleaning sheet. Maintenance has placed the cooling fan on their monthly preventative list and the cooling fan in the walk in cooler will be checked and cleaned by maintenance on a monthly basis. To ensure that these tasks are being completed the Dietary Manager will conduct a periodic walk through of the kitchen including the walk in cooler to ensure that all tasks are being completed. This will be conducted at least (3) times weekly. The Dietary Manager will</p>	11/18/2011			

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R0214	<p>the refrigerator was, and had never noticed it before.</p> <p>Completed cleaning schedule logs from August 29 through October 2, 2011 were provided by Dietary Manager on 10/12/11 at 2:55 P.M.</p> <p>Cleaning schedule duties included the following:</p> <p>"... Cleaning Assignment Must be Done Daily: ... Refrigerator: Clean inside and out. Throw away any leftovers that are 3 days old.... Clean ovens...."</p> <p>The Dietary Manager indicated completed cleaning tasks were identified by staff initials in the box next to the task. The boxes for the refrigerator and oven cleaning tasks had been initialed for each day, signifying the task had been completed.</p> <p>(a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident.</p>		<p>then sign at the bottom of each Daily Cleaning Assignment Sheet to verify that all tasks have been completed. Maintenance will add the cleaning of the cooling fan in the walk in cooler to their monthly preventative check list. Both lists will be monitored and signed off on monthly by the Health Facility Administrator.</p>	

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	<p>Based on record review and interview, the facility failed to ensure an evaluation of individual needs was initiated prior to admission for 1 of 5 residents admitted since the initial licensure survey in September, 2010; and failed to evaluate a fluctuating weight for 1 of 1 residents who had a recorded weight loss and gain; in a sample of 7 residents reviewed. [Residents #7, and #20]</p> <p>Findings include:</p> <p>1. The clinical record for Resident #7 was reviewed on 10/12/11 at 11:45 A.M. The resident was admitted from an acute care hospital on 3/4/11 with diagnoses included, but were not limited to, muscular dystrophy, Huntington's disease, recurrent major depressive disorder, and anxiety.</p> <p>A "Vital Sign & Weight Flow Sheet" form had the resident's weights recorded as follows:</p> <p>April, 2011=147 [pounds] May, 2011=152 June, 2011=161 July, 2011=160 August, 2011=163 September, 2011=140 October, 2011=163</p>	R0214	<p>In regards to resident #7, this resident's weight was incorrectly posted to the vital sign and weight flow sheet. The error was noted by the Health Services Director, however it was not corrected or noted in the chart at the time it was noticed. The Health Services Director has been educated on the importance of monitoring items such as weights and vitals for clerical errors and on the proper way to correct those errors in a prompt fashion. All residents have the potential to be harmed by same deficiency. The Health Services Director has been educated on the importance of monitoring items such as weights and vitals for clerical errors and on the proper way to correct those errors in a prompt fashion. A 3 month tracking log for weights and vitals has been created and placed in the communication book and is available for all clinical staff to assist in the documenting and monitoring of said weights and vitals. This tracking log will be removed from the communication book on a quarterly basis and will be kept for the purpose of tracking historical weights and for the purpose of checking for the accuracy of documentation in the residents medical records. The Health Services Director has been educated on the use of this and on the importance of monitoring the weights and vitals of all residents on a monthly</p>	11/18/2011			

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	<p>An evaluation of the resident's recorded weight gains between April and June, weight loss in September, and weight gain in October was not found.</p> <p>In an interview on 10/12/11 at 3:00 P.M., the Health & Services Director indicated that she "had noticed that" [the September weight of 140 pounds], but had not followed up because she believed it was just an error. She indicated she had not evaluated the weight gain between April and June.</p> <p>2. The record for Resident #20 was</p>		<p>basis, and the importance of properly documenting and properly following up any significant changes. Staff will be in serviced on the use and storage of the new tracking form. This practice will be monitored on a monthly basis and the Health Services Director will initial on the tracking for as each month's recorded weights and vitals are checked and evaluated. In regards to resident #20, this file is missing the pre-admission evaluation form; due to the lapse in time since her arrival we are not able to complete this form at this time. All evaluations since her admission have all been completed on schedule. In an effort to prevent this from happening with upcoming admissions, a new resident check off list has been created and will be placed in the new resident binder to be utilized for each potential new resident. The pre-admission evaluation form will be the first item on the check off list. The pre-admission evaluation will be completed by the Health Facility Administrator or her designee, the new resident check off list will be audited by both the Health Facility Administrator and the Health Services Director to ensure that all items are completed prior to the resident moving in.</p>		

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	<p>reviewed on 10/12/11 at 11:30 A.M. Diagnoses included, but were not limited to, Parkinson's disease, hypertension, and frequent falls.</p> <p>The resident's admission date was 11/9/10. An "Interdisciplinary Progress Notes," dated 11/9/10 at 3:00 P.M., included, but was not limited to, "Resident brought to facility by family..."</p> <p>A document titled "Evaluation of Needs/Service Plan" was dated 11/9/10.</p> <p>A pre-admission evaluation of the resident's needs prior to arrival at the facility was not found.</p> <p>In an interview on 10/13/11 at 9:00 A.M., the Health & Services Director indicated she was unable to locate a pre-admission evaluation of the resident's needs.</p>				

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R0217	<p>(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:</p> <p>(1) The services offered to the individual resident shall be appropriate to the:</p> <p>(A) scope; (B) frequency; (C) need; and (D) preference; of the resident.</p> <p>(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.</p> <p>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.</p> <p>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.</p> <p>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p> <p>Based on record review and interview, the facility failed to identify home health physical therapy services in the facility's Service Plan, for 1 of 2 residents reviewed who had contracted services; in a sample of 7 residents reviewed. [Resident #1]</p> <p>Findings include:</p>	R0217	In regards to Resident #1, this resident's physical therapy services were not identified on this resident's facility service plan. Traditionally the facility's service plan was intended for the purpose of identifying only the services that were to be provided to the resident by facility staff. All other services were contracted out with a third party by the resident and or their responsible	11/18/2011			

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	<p>The record for Resident #1 was reviewed on 10/13/11 at 10:20 A.M. Diagnoses included, but were not limited to, CHF [congestive heart failure], atrial fibrillation [irregular rhythm of the heart] and depression.</p> <p>On 8/24/11, the physician ordered physical therapy services to be provided by home health agency.</p> <p>A Service Plan, dated 6/3/11 and updated on 9/6/11, did not identify the physical therapy or the home health services provided to the resident.</p> <p>In an interview on 10/13/11 at 11:00 A.M., the Health & Services Director indicated Resident #1 was currently receiving home health services for physical therapy, but she had not included it on the Service Plan.</p>		<p>parties. The third party service provider traditionally gives a care plan to the resident or their responsible parties. To correct this issue, the facility has obtained a care plan from each third party contracted provider. This care plan is now included with the facility service plan. All residents have the potential of being harmed by the same deficient practice. In an effort to prevent this from happening with upcoming admissions, a new resident check off list has been created and will include care plan for contracted services. This will be placed in the new resident binder to be utilized for each new resident. The pre-admission evaluation form will be updated to include a section for any contracted services as well. The facility service plan will be updated to include contracted services. The Health Services Director will be responsible for obtaining any new care plans for any future contracted services. The Health Facility Administrator or her designee, will review all new and updated service plans quaterly and at or prior to admission to facility.</p>				

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R0243	<p>(3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the:</p> <p>(A) time;</p> <p>(B) name of medication or treatment;</p> <p>(C) dosage (if applicable); and</p> <p>(D) name or initials of the person administering the drug or treatment.</p> <p>Based on observation, interview and record review, the facility failed to ensure that 1 of 1 Q.M.A. [Qualified Medication Aide] accurately documented the administration of a resident's medications, for 5 of 5 residents observed during medication pass. [Resident #19, #17, #20, #2, and #3; Q.M.A. #1]</p> <p>Findings include:</p> <p>In an interview during the initial orientation tour on 10/12/11 at 10:45 A.M., the Executive Director indicated the medications for Residents #19, #17, #20, #2, and #3 were administered by qualified nursing staff in the facility-- either the L.P.N. or a Q.M.A.</p> <p>On 10/12/11 at 12:00 P.M., medication pass was observed with Q.M.A. #1.</p> <p>During medication pass, Q.M.A. #1 was observed charting on a document titled "Resident Medication Reminder Documentation" after giving the residents</p>	R0243	In regards to residents #17, 19 ,20, 2 and 3. A new document has been created and will be implemented into use for all residents who receive reminders or any type of assistance with their medication. This "Medication List will be individualized for each resident and will contain the basic medication information including the name of medication and dosage and description, along with the time and date medication is to be taken or administered.All residents have the potential of harm from said deficient practice.All clinical staff will be educated on the new medication list form and the proper use of this form. This form shall be kept in the resident's medication box on a monthly basis.The Director of Health Services will be responsible for monitoring the medication sheet to ensure that all documenting is being completed as directed. The Health Services Director will be required to sign off on each sheet to verify accuracy.	11/18/2011			

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	<p>their medication. The document included areas for the date, time, signature, and initials of the person administering the medications. The medications were not listed on the document. The Q.M.A. did not document the individual name or dosage of the individual medications that were administered to each resident during medication pass.</p> <p>In an interview on 10/12/11 at 3:00 P.M., the Executive Director and Health & Services Director [who was listed on the State Employee Records form as a L.P.N. and the only licensed nursing staff in the facility] indicated they were aware of how medications were documented in the facility, but not aware this practice was incorrect.</p> <p>During the daily conference on 10/12/11 at 3:00 P.M., the Executive Director and/or the Health & Services Director were given the opportunity to submit any current facility policy related to documentation of medication administration.</p> <p>On 10/13/11 at 9:30 A.M., the Executive Director provided a policy/procedure titled "Medication Administration," which she indicated was the current policy used for medication administration. The policy was dated 12/03. The facility received a</p>			

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R0246	<p>license as a Residential facility in June, 2010, when the facility became subject to the State Residential Rules.</p> <p>The policy included, but was not limited to, the following:</p> <p>"Policy: If incapable to self-administer medications with or without reminders, a licensed nurse or qualified medication aide shall be expected to administer medications as ordered by the physician...."</p> <p>The policy did not include steps for accurate documentation of medications.</p> <p>(6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact.</p> <p>Based on observation, interview and record review, the facility failed to ensure Q.M.A.s [Qualified Medication Aides] received appropriate authorization from a licensed nurse prior to administration of a P.R.N. [as needed] medication to 1 of 1</p>	R0246	In regards to resident #19, A QMA administered PRN medication without obtaining proper authorization from the nurse. The QMA and the Director of Health Services have both been re-educated on the policy of the company as well as the state	11/18/2011			

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	<p>residents, during the observation of medication pass for 5 residents. [Resident #19]</p> <p>Findings include:</p> <p>In an interview during the initial orientation tour on 10/12/11 at 10:45 A.M., the Executive Director indicated the facility's nursing staff were responsible for the administration of medication to Resident #19.</p> <p>On 10/12/11 at 12:30 P.M., Q.M.A. #1 was observed giving Resident #19 her medications. At that time, the resident complained of lower back pain, so the Q.M.A. gave the resident a dose of a physician ordered P.R.N. Naproxen Sodium [a pain medication], 1 capsule by mouth. The Q.M.A. gave the medication without seeking the authorization of the licensed nurse [the Health & Services Director--an L.P.N.], who was in the building at that time.</p> <p>In an interview immediately following the P.R.N. medication administration, Q.M.A. #1 indicated prior authorization or notification of the licensed nurse was not required when Q.M.A.'s gave any medications.</p> <p>In an interview on 10/12/11 at 3:15 P.M.,</p>		<p>regulations regarding PRN medications and on the scope of practice of the QMA. All residents have the potential of harm from said deficient practice. In an effort to prevent this from reoccurring, all clinical staff will be in-serviced on the policy of the company as well as the state regulations regarding PRN medications and on the proper documenting of all authorizations received for PRN medications and on the scope of practice of the QMA. The Director of Health Services will document in a log all authorizations given and double check to ensure accuracy of documentation and administration of PRN Medication; this will be an ongoing practice.</p>				

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	<p>the Executive Director indicated the facility followed the Indiana State Department of Health policy regarding a Q.M.A.'s scope of practice for medication administration.</p> <p>In an interview on 10/12/11 at 3:20 P.M., the Health & Services Director indicated she thought only P.R.N. Schedule II/narcotic medications required prior authorization.</p> <p>The I.A.C. [Indiana Administrative Code] 2-1-9, addressing Q.M.A. scope of practice and effective April, 2002, includes but is not limited to the following:</p> <p>"Sec. 9. (a) The following tasks are within the scope of practice for the Q.M.A. unless prohibited by facility policy:</p> <p>... (11) Administer previously ordered pro re nata (P.R.N.) medication only if authorization is obtained from the facility's licensed nurse on duty or on call.... (C) Obtain permission to administer the medication each time the symptoms occur in the resident...."</p>						

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R0272	<p>(e) All food shall be served at a safe and appropriate temperature.</p> <p>Based on observation and interview, the facility failed to monitor temperatures of foods prior to being served from 1 of 1 kitchens in the facility. This deficiency had the potential to impact 23 of 23 residents currently living in the facility.</p> <p>Findings include:</p> <p>On 10/12/11 at 12:25 P.M., the tray line service for the lunch meal was observed.</p> <p>The Dietary Manager and Dietary Aide #2 were preparing the food to be served at lunch. Dietary Aide #2 was observed to place two pizzas in the oven to be cooked for 10 minutes.</p> <p>When the pizzas had finished cooking, the Dietary Aide took one of them out of the oven, cut it into individual servings, and place them on the steam table. She then took the second pizza out of the oven, cut it into individual pieces, and placed the pieces on the steam table.</p> <p>The Dietary Manager was observed to get a container of prepared salad from the refrigerator and set it on the counter near the steam table.</p> <p>During the serving of the food, the</p>	R0272	<p>In regards to food temperatures of all hot and cold food being prepared and served at the facility. Although the dietary staff had not been maintaining a food temperature log, the food temperatures were being checked for both hot and cold food served at each meal. Food temperatures will be checked and documented at each meal. All residents have the potential of being harmed by the same deficient practice. In an effort to prevent this from occurring again, a food temperature log will be implemented into practice by all dietary staff. The log will include date and time, temperature and food being tested, initials of staff who is documenting the temperatures. All staff will be in-serviced on new food temperature log and the proper way to check and document temperatures. The dietary manager will be responsible for checking the temperature logs and verifying them for completion on a weekly basis. This will be an on going practice.</p>	11/18/2011	

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	<p>Dietary Aide was observed to place a previously cut slice of pizza on the plate, add one scoop of corn from a container on the steam table, and then use tongs to place some salad onto plate. The Dietary Manager then took each plate out to the residents waiting to be served in the dining room. This food service cycle was repeated until all of the residents were served the lunch meal.</p> <p>The temperatures of the hot and cold foods were not checked at any point during the tray line service process.</p> <p>During an interview at on 10/12/11 at 12:40 P.M., Dietary Aide #2 indicated food temperatures were checked in the morning. She indicated they do not keep a log to record the temperature checks of the food.</p> <p>In an interview on 10/12/11 at 3:05 P.M., the Dietary Manager indicated she had checked the temperatures of the food prior to the observation of the tray line service at 12:25 P.M. The Dietary Manager indicated they do not keep a log of the temperature checks of the food.</p>				

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R0273	<p>(f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.</p> <p>Based on observation and record review, the facility failed to ensure cloth oven mitts were in good repair to ensure loose strings were not brushing along hot food items during preparation for serving. This had the potential to affect 23 of 23 residents currently living in the facility and who were served food from 1 of 1 facility kitchens.</p> <p>Findings include:</p> <p>On 10/12/11 at 12:25 P.M., the tray line food service for the lunch meal was observed. The Dietary Manager and Dietary Aide #2 were preparing the food to be served at lunch.</p> <p>Dietary Aide #2 placed two pizzas in the oven, to be cooked for 10 minutes. After placing the pizzas in the oven, the Dietary Aide washed her hands, and then took a pair of oven gloves from a shelf below the prep counter, and placed them on her hands.</p> <p>With the oven mitts on, the Dietary Aide opened the oven by the oven handle, took the pizza which was on a cookie sheet out of the oven, and placed it on the counter.</p>	R0273	In regards to the oven mitts being in poor repair, said oven mitts will be discarded and replaced with new oven mitts. New oven mitts will be stored in a specific bin between uses. All residents have the potential of being harmed by this same deficient practice. In an effort to prevent this from reoccurring the daily cleaning assignment check off list will be updated to include inspecting the oven mitts for loose strings or other forms of wear and tear. The dietary manager will be responsible for maintaining equipment and tools in good condition. This will be an on going process.	11/18/2011			

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	<p>She picked up a pizza cutter with the oven mitts on her hands, and started to cut into individual pieces. There was a long string hanging from the oven gloves that brushed against the meat and cheese on the top of the pizza as she was cutting. The Dietary Manager came into the kitchen as the Dietary Aide was cutting the pizza. No verbal exchange was made between the two staff.</p> <p>The "Retail Food Establishment Sanitation Requirements" manual, effective November 13, 2004, includes, but is not limited to, the following requirements regarding glove use:</p> <p>"Section 246 (d) ... Cloth gloves may not be used in direct contact with food unless the food is subsequently cooked...."</p>				

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R0379	<p>(c) If a person is a recipient of Medicaid or federal SSI and has a major mental illness as defined by the individual needs assessment, the person will be referred to the mental health service provider for a consultation on needed treatment services. All residents who participate in Medicaid or SSI admitted after April 1, 1997, shall have a completed individual needs assessment in their clinical record. All persons admitted after April 1, 1997, shall have the assessment completed prior to the admission, and, if a mental health center consultation is needed, the consultation shall be completed prior to the admission and a copy maintained in the clinical record.</p> <p>Based on record review and interview, the facility failed to have 1 of 2 residents who were recipients of Medicaid and who had a major mental illness referred to a mental health service provider for a consultation on needed treatment prior to the admission to the facility; in a sample of 7 residents reviewed. [Resident #7]</p> <p>Findings include:</p> <p>The clinical record for Resident #7 was reviewed on 10/12/11 at 11:45 A.M. Diagnoses included, but were not limited to, muscular dystrophy, Huntington's disease, anxiety, and recurrent major depressive disorder. The resident was admitted from an acute care hospital behavioral care unit on 3/4/11 with Medicaid as a payor source.</p>	R0379	In regards to resident #7 a pre-admission mental health evaluation was not completed. Resident was referred to facility by an acute care psychiatric hospital ward. A mental health assessment that was completed by the hospital upon intake had been reviewed by facility staff but was not present in resident's chart. This item has now been placed in resident's #7's chart. All residents who are Medicaid waiver and /or SSI recipients with a major mental illness have the potential for being harmed by the same deficient practice. In an effort to prevent this oversight from happening again, the facility has enlisted a mental health services provider to provide mental health services to our clients on a continuing basis and to assist in the coordination and development of all comprehensive care plans The	11/18/2011

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	<p>The acute care hospital "Inpatient Initial Evaluation," completed on 2/25/11, indicated the resident had been brought into the hospital by the police. The resident reported "They think I need help." The report indicated the resident was having difficulty with self care, and was not following medications regularly. The resident had a history of depression, but denied current symptoms.</p> <p>The hospital discharge instruction sheet listed orders for medications which included the following psychotropic medications: Amitriptyline [an antidepressant], Trazadone [an antidepressant also used for insomnia], Zoloft [an antidepressant], and Seroquel [an antipsychotic].</p> <p>An consultation on needed treatment from a mental health service provider prior to admission was not located in the resident's clinical record.</p> <p>In an interview on 10/13/11 at 8:45 A.M., the Executive Director indicated the facility did not have a contracted mental health service provider. She indicated each resident chooses their own if such services were needed, and did not think Resident #7 was being followed by any mental health service provider.</p>		<p>facility has also updated the pre-admission assessment form to include an area pertaining to payor source and mental health assessments. This form will be completed by the Health Facility Administrator for all future potential admissions. This will be an ongoing process.</p>				

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R0382	<p>(f) Each resident with a major mental illness must have a comprehensive care plan that is developed within thirty (30) days after admission to the residential care facility. Based on record review and interview, the facility failed to ensure that 2 of 2 residents who were recipients of Medicaid and had a diagnosis of a major mental illness had a comprehensive care plan developed within 30 days after admission to the residential facility; in a sample of 7 residents reviewed. [Residents #3 and #7]</p> <p>Findings include:</p> <p>1. The clinical record for Resident #7 was reviewed on 10/12/11 at 11:45 A.M. Diagnoses included, but were not limited to, muscular dystrophy, Huntington's disease, anxiety, and recurrent major depressive disorder. The resident was admitted from an acute care hospital behavioral care unit on 3/4/11 with Medicaid as a payor source.</p> <p>The acute care hospital "Inpatient Initial Evaluation," completed on 2/25/11, indicated the resident had been brought into the hospital by the police. The resident reported "They think I need help." The report indicated the resident was having difficulty with self care, and</p>	R0382	<p>In regards to residents # 3 and #7 and the need for the development of comprehensive care plans. The comprehensive care plans will immediately be developed for all Medicaid Waiver or SSI recipients with a major mental illness. All residents who are Medicaid waiver and or SSI recipients with a major mental illness have the potential for being harmed by the same deficient practice. In an effort to prevent this oversight from happening again, the facility has enlisted a mental health services provider to provide mental health services to our clients on a continuing basis and to assist in the coordination and development of all comprehensive care plans within 30 days of admission to facility. All new residents are reassessed at 30 days after admission and the reassessment for be will updated to include and area for the completion of the comprehensive care plan. The Health Services Director will be responsible to coordinating the completion of said plan. The Health Facility Administrator or her designee will review all reassessments for completion and accuracy at reassessment</p>	11/18/2011

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	<p>was not following medications regularly. The resident had a history of depression, but denied current symptoms.</p> <p>The hospital discharge instruction sheet listed orders for medications which included the following psychotropic medications: Amitriptyline [an antidepressant], Trazadone [an antidepressant also used for insomnia], Zoloft [an antidepressant], and Seroquel [an antipsychotic].</p> <p>A "Evaluation of Needs/Service Plan" form, the standard facility service plan, was dated 3/4, 6/6, and 9/6/11. The service plan addressed daily needs by indicating with check marks that the resident needed assistance [for grooming, dressing, bathing, toileting], or was independent [for walking and eating].</p> <p>A comprehensive care plan developed within 30 days of admission, that addressed the resident's mental health needs, was not found.</p> <p>In an interview on 10/13/11 at 8:45 A.M., the Executive Director indicated the facility did not have a contracted mental health service provider. She indicated each resident chooses their own if such services were needed, and did not think Resident #7 was being followed by any</p>		<p>times which is at 30 days after admission and then again quarterly are in the event of a significant change. This will be an ongoing process.</p>				

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	<p>mental health service provider.</p> <p>2. The record for Resident #3 was reviewed on 10/12/11 at 10:45 A.M. Diagnoses included, but were not limited to, high blood pressure, depression, anxiety and seizure disorder. The resident was admitted on 11/26/10 with Medicaid as a payor source.</p> <p>A history and physical report from an outpatient visit to a local hospital, dated 6/10/10, indicated "... depression with anxiety-- I will continue the patient on his current medications. He clearly needs psychiatric help as his depression is not completely controlled and he is getting aggressive at times...."</p> <p>The facility's Service Plan was dated 11/26/10, with revision dates of 3/10/11, 6/8/11, and 9/6/11. The Service Plan did not address any issue pertaining to the resident's mental health status.</p> <p>A comprehensive care plan developed within 30 days from admission, that addressed the resident's mental health needs was not found.</p> <p>In an interview on 10/13/11 at 2:05 P.M., the Health & Services Director indicated the resident was currently seeing a counselor, but the facility had not sought</p>						

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R0383	<p>any information or coordination of services from that counselor. She indicated that they do not currently have a service plan regarding the mental health services for the resident.</p> <p>(g) The residential care facility, in cooperation with the mental health service providers, shall develop the comprehensive careplan for the resident that includes the following: (1) Psychosocial rehabilitation services that are to be provided within the community. (2) A comprehensive range of activities to meet multiple levels of need, including the following: (A) Recreational and socialization activities. (B) Social skills. (C) Training, occupational, and work programs. (D) Opportunities for progression into less restrictive and more independent living arrangements.</p> <p>Based on record review and interview, the facility failed to ensure that 2 of 2 residents who were recipients of Medicaid and had a diagnosis of a major mental illness had a comprehensive care plan developed in cooperation with the mental health service provider, and included psychosocial rehabilitation services to be provided within the community, and a comprehensive range of activities to meet multiple levels of need in a sample of 7 residents reviewed. [Residents #3 and #7]</p>	R0383	R383 In regards to residents # 3 and #7 and the need for the development of comprehensive care plans. Resident #3 notes in his file by his physician stating that is depression was stable and controlled by medication and their were no orders for follow up mental health services. Resident #7 did not have a comprehensive plan on file, but has been and is currently being treated by a mental health service provider. The comprehensive care plans will immediately be	11/18/2011

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	<p>Findings include:</p> <p>1. The record for Resident #3 was reviewed on 10/12/11 at 10:45 A.M. Diagnoses included, but were not limited to, high blood pressure, depression, anxiety and seizure disorder. The resident was admitted on 11/26/10 with Medicaid as a payor source.</p> <p>A history and physical report from an outpatient visit to a local hospital, dated 6/10/10, indicated "... depression with anxiety-- I will continue the patient on his current medications. He clearly needs psychiatric help as his depression is not completely controlled and he is getting aggressive at times...."</p> <p>The facility's Service Plan was dated 11/26/10, with revision dates of 3/10/11, 6/8/11, and 9/6/11. The Service Plan did not address any issue pertaining to the resident's mental health status.</p> <p>A comprehensive care plan, developed in cooperation with a mental health service provider and including psychosocial rehabilitation services to be provided within the community and a comprehensive range of activities- -recreational/socialization, social skills, training/occupational and work programs,</p>		<p>developed for all Medicaid Waiver or SSI recipients with a major mental illness. All residents who are Medicaid waiver and or SSI recipients with a major mental illness have the potential for being harmed by the same deficient practice. In an effort to prevent this oversight from happening again, the facility has enlisted a mental health services provider to provide mental health services to our clients on a continuing basis and to assist in the coordination and development of all comprehensive care plans within 30 days of admission to facility. All new residents are reassessed at 30 days after admission. The reassessment forms be will updated to include an area for the completion of the comprehensive care plan. The comprehensive care plan will be designed to meet all major areas of psychosocial rehabilitation services and activities for the resident. The Health Services Director will be responsible to coordinate the completion of said plan. The Health Facility Administrator or her designee will review all reassessments for completion and accuracy at reassessment times which occur 30 days after admission and then again quarterly and/or in the event of a significant change. This will be an ongoing process</p>				

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	<p>opportunities for progressing into less restrictive and more independent living arrangements--to meet multiple levels of need, was not found.</p> <p>In an interview on 10/13/11 at 2:05 P.M., the Health & Services Director indicated the resident was currently seeing a counselor, but the facility had not sought any information or coordination of services from that counselor. She indicated that they do not currently have a service plan regarding the mental health services for the resident.</p> <p>2. The clinical record for Resident #7 was reviewed on 10/12/11 at 11:45 A.M. Diagnoses included, but were not limited to, muscular dystrophy, Huntington's disease, anxiety, and recurrent major depressive disorder. The 45 year old resident was admitted from an acute care hospital behavioral care unit on 3/4/11 with Medicaid as a payor source.</p> <p>The acute care hospital "Inpatient Initial Evaluation," completed on 2/25/11, indicated the resident had been brought into the hospital by the police. The resident reported "They think I need help." The report indicated the resident was having difficulty with self care, and was not following medications regularly.</p>			

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	<p>The resident had a history of depression, but denied current symptoms.</p> <p>The hospital discharge instruction sheet listed orders for medications which included the following psychotropic medications: Amitriptyline [an antidepressant], Trazadone [an antidepressant also used for insomnia], Zoloft [an antidepressant], and Seroquel [an antipsychotic].</p> <p>A "Evaluation of Needs/Service Plan" form, the standard facility service plan, was dated 3/4, 6/6, and 9/6/11. The service plan addressed daily needs by indicating with check marks that the resident needed assistance [for grooming, dressing, bathing, toileting], or was independent [for walking and eating].</p> <p>A comprehensive care plan, developed in cooperation with a mental health service provider and including psychosocial rehabilitation services to be provided within the community and a comprehensive range of activities--recreational/socialization, social skills, training/occupational and work programs, opportunities for progressing into less restrictive and more independent living arrangements--to meet multiple levels of need, was not found.</p>						

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	In an interview on 10/13/11 at 8:45 A.M., the Executive Director indicated the facility did not have a contracted mental health service provider. She indicated each resident chooses their own if such services were needed, and did not know if Resident #7 was being followed by any mental health service provider since his hospitalization.				