

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155400	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/27/2014
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NAME OF PROVIDER OR SUPPLIER LIBERTY VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 4600 E JACKSON ST MUNCIE, IN 47303
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00141860.</p> <p>Complaint IN00141860 - Substantiated, Federal/State deficiencies related to the allegations are cited at F323.</p> <p>Survey dates: January 21, 22, 23, 24, 27, 2014</p> <p>Facility number: 000269 Provider number: 155400 AIM number: 100267720</p> <p>Survey Team: Toni Maley, BSW, TC Ginger McNamee, RN Karen Lewis, RN Tina Smith-Staats, RN</p> <p>Census bed type: SNF: 9 SNF/NF: 67 Total: 76</p> <p>Census payor type: Medicare: 9 Medicaid: 53 Other: 14 Total: 76</p>	F000000	<p>Submission of this Plan of Correction does not constitute an admission to or an agreement with facts alleged on the survey report. Submission of this Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies.</p> <p>The Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance.</p>	

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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F000241 SS=E	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed by Debora Barth, RN.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview and record review, the facility failed to ensure dependent residents were served meals in a manner to preserve their dignity regarding lengthy meal waits for 4 of 4 residents reviewed for dignified dining experience (Resident #24, #12, #30 and #28).</p> <p>Findings include:</p> <p>1.) During the 1/22/13 Rosewood Dining Room lunch observation from 11:30 a.m. to 12:03 p.m. (33 minutes), twelve dependent residents sat facing a table as if ready to dine. The residents were not offered any form of diversionary</p>	F000241	<p>1. Resident #24, #12, #30, and #28 are currently beingserved meals in a dignified manner. Residents are being providedactivities, such as music and television, while in the dining room prior tomeals and are not left sitting for long periods lacking stimulation.2. Allother residents have been observed during meal services and are being servedmeals in a dignified manner. Residents are being provided activities, such asmusic and television, while in the dining room prior to meals and are not leftsitting for long periods lacking stimulation.3. Residents' rights have beenreviewed (See Attachment K) and the facility staff have been re-educated onthese rights with a special focus on the dignified dining</p>	02/17/2014			

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	<p>materials, the room was void of music, television or any form of audio visual stimulation. The residents did not converse with one another. For the first 20 minutes of waiting for the meal, no staff were present in the dining room. Residents #24, #12, #30 and #28 were in the group of twelve residents who sat at the table without any form of stimulation for 33 minutes preceding the meal.</p> <p>2.) During the,1/24/14, Rosewood Dining Room lunch observation from 11:10 a.m. to 12:06 p.m., residents were escorted into the dining room by staff members. The Activity Director offered individualized one on one ball toss with the majority of the residents in the room. The ball toss game lasted 1 to 2 minutes per resident. The other residents in the room did not watch their cohorts toss the ball, cheer or encourage them or converse about the ball game. The majority of residents sat facing the table as if ready to dine. The activity director moved their chairs away from the table and tossed the ball with them. Following the ball toss she returned them to their dining room table.</p> <p>Resident #24 was escorted to the</p>		<p>experience (SeeAttachment A). A Dining Monitoring Form has been initiated (SeeAttachment B).4. The Activity Director or Designee will complete the DiningMonitoring Form to ensure residents are not sitting for longperiods lacking stimulation on scheduled work days as follows: Daily for two weeks, one time weekly for two weeks, then monthlythereafter. Should a concern be found, immediate corrective action willoccur. Results of these reviews and any corrective actions taken will bediscussed in the facility's quarterly QA meetings for a minimum of six monthsand the plan adjusted accordingly, if indicated</p>				

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	<p>dining area at 11:10 a.m. and participated in two minutes of ball toss activity. After the ball toss, she sat at her dining room table awaiting her meal until 12:06 p.m. when meals were served. The resident did at times ask who was going to feed her lunch and spoke with staff who answered her question.</p> <p>Resident #12 was escorted into the dining room at 11:12 a.m. and participated in a two minute ball toss activity. After the ball toss, she sat at her dining room table awaiting her meal until 12:06 p.m. when meals were served. While waiting, the resident did not converse with staff, other residents, or interact with her environment.</p> <p>Resident #30 was escorted to the dining area at 11:15 a.m. and participated in a two minute ball toss activity. After the ball toss, she sat at her dining room table awaiting her meal until 12:06 p.m. when meals were served. While waiting, the resident did not converse with staff or other residents. She did move her legs in her chair.</p> <p>Resident #28 was escorted into the dining area at 11:31 a.m. and participated in a two minute ball toss</p>			

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	<p>activity. After the ball toss, she sat at her dining room table awaiting her meal unit 12:06 p.m. when meals were served. While waiting, the resident did not converse with staff or other residents. She did not interact with her environment.</p> <p>3.) Resident #24's record was reviewed on 1/27/14 at 12:10 p.m.</p> <p>Resident #24's current diagnoses included, but were not limited to, severe hearing loss, Alzheimer's disease and anxiety.</p> <p>Resident #24 had a current, 10/12/13, quarterly, Minimum Data Set (MDS) assessment which indicated the resident was cognitively impaired and rarely or never made decisions and required staff assistance for locomotion (purposeful movement from one location to another).</p> <p>Resident #24 had a current, 1/22/14, care plan problem regarding anxiety. Approaches to this problem included, but were not limited to, encourage the resident to attend activities.</p> <p>Resident #24 had a current, 1/22/14, care plan problem regarding calling</p>				

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	<p>out due to blindness. Approaches to this problem included, but was not limited to, provide activities of interest.</p> <p>4.) Resident #12's record was reviewed on 1/27/14 at 12:15 p.m.</p> <p>Resident #12's current diagnoses included, but were not limited to, dementia with depressive and psychotic features and chronic pain.</p> <p>Resident #12 had a current, 12/14/13, quarterly, Minimum Data Set (MDS) assessment which indicated the resident was cognitively impaired and rarely or never made decisions and required staff assistance for locomotion (purposeful movement from one location to another).</p> <p>Resident #12 had a current, care plan problem regarding dementia with depressive and psychotic features. Approaches to this problem included, but were not limited to, encourage activities of interest.</p> <p>5.) Resident #30's record was reviewed on 1/27/14 at 9:50 a.m. Resident #30's current diagnoses included, but were not limited to, end</p>				

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	<p>stage dementia, Alzheimer's disease, dementia with delusions and psychotic features and wasting syndrome.</p> <p>Resident #30 had a current, 12/23/13, quarterly, Minimum Data Set (MDS) assessment which indicated the resident was cognitively impaired and rarely or never made decisions; required staff assistance for locomotion (purposeful movement from one location to another) and displayed no maladaptive behaviors during the assessment period.</p> <p>Resident #30 had a current, 1/16/14, care plan problem regarding depression. Approaches to this problem included, but were not limited to, encourage attendance in activities of interest.</p> <p>6.) Resident #28's record was reviewed on 1/27/14 at 9:00 a.m. Resident #28's current diagnoses included, but were not limited to, vascular dementia with delusions, depressive disorder and anxiety.</p> <p>Resident #28 had a current, 11/26/13, significant change, Minimum Data Set (MDS)</p>						

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	<p>assessment which indicated the resident was cognitively impaired and rarely or never made decisions; and required staff assistance for locomotion (purposefully movement from one location to another); and displayed no maladaptive behaviors during the assessment period.</p> <p>Resident #28 had a current, 11/7/13, care plan problem regarding depression. Approaches to this problem included, but were not limited to, encourage activities of choice and interest.</p> <p>Resident #28 had a current, 11/7/13, care plan problem regarding anxiety. Approaches to this problem included, but were not limited to, encourage activities of choice and interest.</p> <p>7. During a 1/27/13, 1:30 p.m., interview, the Administrator in training indicated each resident should be offered some form or activity or diversion when awaiting meals. He indicated no resident should wait for 30 minutes at the table before a meal. Review of the undated facility policy, titled "Residents Rights", provided by the Administrator in</p>			

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F000250 SS=D	<p>Training 1/27/14 at 10:45 a.m., included, but was not limited to, the following:</p> <p>"...(a) DIGNITY A facility must care for its residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality..."</p> <p>3.1-3(t)</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to ensure a resident with the diagnoses of schizophrenia and anxiety, and being treated by the use of psychoactive and anti-anxiety medications, had a behavior monitoring and management program in place for 1 of 5 residents reviewed for behavior monitoring and management. (Resident #5)</p> <p>Findings include:</p>	F000250	<p>1. A behavior monitoring and management program has been initiated for Resident #5 to include specific behaviors for tracking . 2.All other residents receiving psychoactive medications have been reviewed and a behavior monitoring and management program has been initiated as indicated to include specific behaviors for tracking. 3. The facility has initiated a new Behavior Management Program (See Attachment C). The SSD and facility staff have been educated on the new behavior program (See Attachment A). A Behavior</p>	02/17/2014			

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	<p>The clinical record for Resident #5 was reviewed on 1/23/14 at 12:20 p.m.</p> <p>Diagnoses for Resident #5 included, but were not limited to, paranoid schizophrenia, depression, anxiety, diabetes mellitus, and multiple sclerosis.</p> <p>The clinical record lacked documentation of any specific behavioral symptoms associated with the diagnoses of schizophrenia and anxiety. The "MOOD AND BEHAVIOR FLOW RECORD" for November and December 2013, and January 2014 did not contain any specific behaviors for tracking and had broad behavioral symptoms as follows: signs and symptoms of depression, signs and symptoms of anxiety and insomnia.</p> <p>Current physician's orders for Resident #5 included, but were not limited to, the following orders:</p> <p>a. Seroquel (an antipsychotic medication) 100 milligrams (mg) 1 tablet by mouth every morning. The original date of this order was 8/21/08.</p> <p>b. Seroquel (an antipsychotic</p>		<p>Management Review form has been initiated (See Attachment D) to ensure continued implementation of the Behavior Management Program. 4. The SSD or designee will complete the Behavior Management Review form for five residents and any residents with new orders for psychoactive medications to ensure behavior management plans are in place on scheduled work days as follows: daily for two weeks, two times weekly for two weeks, weekly for four weeks, then monthly thereafter. Should concerns be found, immediate corrective action will be completed. Results of these reviews and any corrective actions taken will be discussed during the facility's quarterly QA meetings for a minimum of six months and the plan adjusted accordingly, if indicated.</p>				

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	<p>medication) 300 mg 1/2 tablet (150 mg) by mouth daily at bedtime. The original date of this order was 9/4/13.</p> <p>c. Zolof (an anti-depressant medication) 25 mg 1 tablet by mouth once daily. The original date of this order was 12/4/13.</p> <p>d. Clonazepam (an anti-anxiety medication) 0.5 mg 1 tablet by mouth two times a day. The original date of this order was 8/22/13.</p> <p>During an interview with the Social Services Director and the East Unit Manager on 1/27/14 at 8:18 a.m., additional information was requested related to the lack of identified specific behaviors for the diagnoses of schizophrenia and anxiety requiring the use of psychoactive medications for Resident #5.</p> <p>During an interview with the Social Services Director (SSD) and the Director of Nursing (DoN) on 1/27/14 at 1:12 p.m., the SSD indicated she did not know the specific behaviors for the diagnoses of schizophrenia and anxiety. The DoN further indicated she had never observed any behaviors of Resident #5. The July, 2010, updated "Mood and</p>				

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	<p>Behavior Program Procedures" was provided by the Administrator in Training on 1/27/14 at 1:30 p.m. The procedure indicated a written plan of care would be developed to address the moods and/or behaviors, including interventions to address any noted intrinsic and/or extrinsic factors precipitating the moods and/or behaviors by the social service and/or the interdisciplinary team. The procedure further indicated a "Mood and Behavior Monthly Flow Record" would be implemented by the social service and/or appointed designee and placed in the Mood and Behavior Monthly Flow Record notebook. The notebook would be user-friendly and maintained by social service and/or appointed designee. Social service and/or appointed designee would ensure that three months of Mood and Behavior Monthly Flow Records were maintained in the notebook. A copy of the resident's Mood and Behavior Care Plan would be placed in the notebook so it could be easily accessible to all staff.</p> <p>3.1-34(a)</p>			

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to ensure residents who received psychoactive medications had care plans which identified and addressed target behaviors being treated by the psychoactive medications for 3 of 4 residents reviewed for care planing regarding behavioral symptoms and the use of psychoactive medications (Resident #30, #28 and #5).</p> <p>Findings include:</p> <p>1.) Resident #30's record was</p>	F000279	.1. Resident #30, #28, and #5 currently have care plans addressing specific targeted behaviors which are being treated with psychoactive medications. 2. All other residents receiving psychoactive medications have the potential to be affected. Their clinical records have been reviewed and care plans addressing specific targeted behaviors have been implemented. 3. The facility has initiated a new Behavior Management Program (See Attachment C). The facility has reviewed it's current policy for Care Plan Development with no	02/17/2014	

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	<p>reviewed on 1/27/14 at 9:50 a.m. Resident #30's current diagnoses included, but were not limited to, end stage dementia, Alzheimer's disease, dementia with delusions and psychotic features and wasting syndrome.</p> <p>Resident #30 had current physician's orders for the following psychoactive medications: a.) 11/12/13, Seroquel 50 mg (an antipsychotic medication) - 1 tablet two times daily. This medication was a dose increase. b.) 1/4/13, Cymbalta 30 mg (an anti-depressant medication) - 1 tablet daily c.) 6/23/13, Xanax 0.5 mg (an anti-anxiety medication) - 1 tablet four times daily.</p> <p>Resident #30 had a current, 12/23/13, quarterly, Minimum Data Set (MDS) assessment which indicated the resident was cognitively impaired, rarely or never made decisions, and displayed no maladaptive behaviors during the assessment period.</p> <p>Resident #30's record did not identify the specific behavioral symptoms or target behaviors being treated by the use of an</p>		<p>changes indicated (See Attachment E). The SSD and facility staff has been educated on the new behavior program and care plan development with a special focus on targeted behaviors (See Attachment A). A Behavior Management Review form has been initiated (See Attachment D) in an effort to confirm ongoing compliance with addressingspecific target behaviors for which psychoactive medications are ordered forthe applicable resident.. 4. The SSD or designee will complete theBehavior Management Review form for five residents and any residents with neworders for psychoactive medications to ensure specific behaviors are careplanned on scheduled work days as follows: daily for two weeks, two timesweekly for two weeks, weekly for four weeks, then monthly thereafter. Should concerns be found, immediate corrective action will be completed. Results of these reviews and any corrective actions taken will bediscussed during the facility's quarterly QA meetings for a minimum of sixmonths and the plan adjusted accordingly, if warranted.</p>		

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	<p>antipsychotic medication, an anti-depressant medication or an anti-anxiety medication.</p> <p>Resident #30 did not have a care plan to address the specific behavioral symptoms or targeted behaviors being treated by the use of an antipsychotic medication, an anti-depressant medication or an-anxiety medication.</p> <p>During an 1/27/14, 12:55 p.m. interview, the Director of Nursing and Social Service Director indicated Resident #30 did not have identified targeted behaviors for the use of the psychoactive medications and did not have a care plan regarding target behaviors.</p> <p>2.) Resident #28's record was reviewed on 1/27/14 at 9:00 a.m. Resident #28's current diagnoses included, but were not limited to, vascular dementia with delusions, depressive disorder and anxiety.</p> <p>Resident #28 had current physician's orders for the following psychoactive medications: a.) 12/6/12, Seroquel 50 mg (an antipsychotic medication) - 1 tablet two times daily b.) 9/11/13, Xanax 0.25 mg (an</p>			

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	<p>anti-anxiety medication) - 1 tablet daily</p> <p>c.) 9/11/13, Celexa 20 mg (an anti-depressant medication) - 1 tablet daily. This medication was a dose increase.</p> <p>Resident #28 had a current, 11/26/13, significant change, Minimum Data Set (MDS) assessment which indicated the resident was cognitively impaired, rarely or never made decisions, and displayed no maladaptive behaviors during the assessment period.</p> <p>Resident #28 did not have a care plan to address the specific behavioral symptoms or targeted behaviors being treated by the use of an antipsychotic medication, an anti-depressant medication or an-anxiety medication.</p> <p>Resident #28's record indicated she had not received any form of mental health services in the year 2013 and was not currently receiving mental health services.</p> <p>During an 1/27/14, 12:55 p.m. interview, the Director of Nursing and Social Service Director indicated Resident #30 did not have identified targeted behaviors for the use of the</p>						

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	<p>psychoactive medications and did not have a care plan regarding target behaviors.</p> <p>3. The clinical record for Resident #5 was reviewed on 1/23/14 at 12:20 p.m.</p> <p>Diagnoses for Resident #5 included, but were not limited to, paranoid schizophrenia, depression, anxiety, diabetes mellitus, and multiple sclerosis.</p> <p>Current physician's orders for Resident #5 included, but were not limited to, the following orders:</p> <p>a. Seroquel (an antipsychotic medication) 100 milligrams (mg) 1 tablet by mouth every morning. The original date of this order was 8/21/08.</p> <p>b. Seroquel (an antipsychotic medication) 300 mg 1/2 tablet (150 mg) by mouth daily at bedtime. The original date of this order was 9/4/13.</p> <p>c. Zoloft (an anti-depressant medication) 25 mg 1 tablet by mouth once daily. The original date of this order was 12/4/13.</p> <p>d. Clonazepam (an anti-anxiety</p>				

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F000309 SS=D	<p>medication) 0.5 mg 1 tablet by mouth two times a day. The original date of this order was 8/22/13.</p> <p>Resident #5 lacked a care plan with specific behaviors related to her diagnosis of schizophrenia and use of an antipsychotic medication.</p> <p>Resident #5 lacked a care plan with specific behaviors related to her diagnosis of anxiety and use of an anti-anxiety medication.</p> <p>3.1-35(a)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview and record review, the facility failed to develop and implement a behavior management and monitoring program for residents who had dementia and received psychoactive medication for symptoms related to dementia with behavioral disturbances for 2 of 2 residents reviewed for behavior monitoring and management associated with</p>	F000309	<p>1. Resident #30 and #28 currently have a behavior monitoring and management program including care plans for specific targeted behaviors</p> <p>2. All other residents receiving psychoactive medications have the potential to be affected. Their clinical records have been reviewed and a behavior monitoring and management program including care plans for specific targeted behaviors have been initiated as</p>	02/17/2014

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	<p>dementia (Residents #30 and #28).</p> <p>Findings include:</p> <p>1.) Resident #30's record was reviewed on 1/27/14 at 9:50 a.m. Resident #30's current diagnoses included, but were not limited to, end stage dementia, Alzheimer's disease, dementia with delusions and psychotic features and wasting syndrome.</p> <p>Resident #30 had current physician's orders for the following psychoactive medications:</p> <p>a.) 11/12/13, Seroquel 50 mg (an antipsychotic medication) - 1 tablet two times daily. This medication was a dose increase.</p> <p>b.) 1/4/13, Cymbalta 30 mg (an anti-depressant medication) - 1 tablet daily</p> <p>c.) 6/23/13, Xanax 0.5 mg (an anti-anxiety medication) - 1 tablet four times daily.</p> <p>Resident #30 had a current, 12/23/13, quarterly, Minimum Data Set (MDS) assessment which indicated the resident was cognitively impaired, rarely or never made decisions, and displayed no maladaptive behaviors during the assessment period.</p>		<p>indicated. 3. The facility has initiated a new Behavior Management Program (See Attachment C). The facility has reviewed it's current policy for Care Plan Development with no changes indicated (See Attachment E). The facility staff has been educated on the new behavior management program and care plan development with a special focus on targeted behaviors (See Attachment A). A Behavior Management Review form has been initiated (See Attachment D) in an effort to ensure ongoing compliance with the behavior management and monitoring program. 4. The SSD ordesignee will complete the Behavior Management Review form for five residents and any residents with new orders for psychoactive medications to ensure behavior management plans are in place and specific behaviors are care planned on scheduled work days as follows: daily for two weeks, two times weekly for two weeks, weekly for four weeks, then monthly thereafter. Should concerns be found, immediate corrective action will be completed. Results of these reviews and any corrective actions taken will be discussed during the facility's quarterly QA meetings for a minimum of six months and the plan adjusted accordingly, if warranted.</p>				

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	<p>Resident #30's record did not identify the specific behavioral symptoms or target behaviors being treated by the use of an antipsychotic medication, an anti-depressant medication or an anti-anxiety medication.</p> <p>Resident #30 did not have a care plan to address the specific behavioral symptoms or targeted behaviors being treated by the use of an antipsychotic medication, an anti-depressant medication or an-anxiety medication.</p> <p>Resident #30's record indicated she had not received any form of mental health services since January 2013.</p> <p>Review of Resident #30's Nurses Notes and behavior record for November and December 2013 and January 2014 indicated she had displayed one behavior of saying help me during this three month period. The behavior was repeat verbalization of "help me." The 11/17/13 "Mood and Behavior Communication Memo" indicated when the Social Services Director offered one to one comfort the behavior stopped.</p>			

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	<p>During an 1/27/14, 12:55 p.m. interview, the Director of Nursing and Social Service Director indicated Resident #30 did not have identified targeted behaviors for the use of the psychoactive medications; did not have a care plan regarding target behaviors; had not received mental health services since January 2013; and did not have ongoing maladaptive behaviors which could not be redirected or calmed with one to one interaction. The facility did not have statements of contraindication which included evaluations for the use for any of the psychoactive medications and the facility believed gradual dose reduction was not required for residents receiving hospice services.</p> <p>2.) Resident #28's record was reviewed on 1/27/14 at 9:00 a.m. Resident #28's current diagnoses included, but were not limited to, vascular dementia with delusions, depressive disorder and anxiety.</p> <p>Resident #28 had current physician's orders for the following psychoactive medications: a.) 12/6/12, Seroquel 50 mg (an antipsychotic medication) - 1 tablet two times daily b.) 9/11/13, Xanax 0.25 mg (an</p>						

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	<p>anti-anxiety medication) - 1 tablet daily</p> <p>c.) 9/11/13, Celexa 20 mg (an anti-depressant medication) - 1 tablet daily. This medication was a dose increase.</p> <p>Resident #28 had a current, 11/26/13, significant change, Minimum Data Set (MDS) assessment which indicated the resident was cognitively impaired, rarely or never made decisions, and displayed no maladaptive behaviors during the assessment period.</p> <p>Resident #28's record did not identify the specific behavioral symptoms or target behaviors being treated by the use of an antipsychotic medication, an anti-depressant medication or an anti-anxiety medication.</p> <p>Resident #28 did not have a care plan to address the specific behavioral symptoms or targeted behaviors being treated by the use of an antipsychotic medication, an anti-depressant medication or an-anxiety medication.</p> <p>Resident #28's record indicated she had not received any form of mental health services in the year 2013 and</p>						

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	<p>was not currently receiving mental health services.</p> <p>During an 1/27/14, 12:55 p.m. interview, the Director of Nursing and Social Service Director indicated Resident #30 did not have identified targeted behaviors for the use of the psychoactive medications; did not have a care plan regarding target behaviors; had not received mental health services during the year 2013; did not have ongoing maladaptive behaviors; and did not have a current behavior tracking log. The facility did not have statements of contraindication which included evaluations for the use for any of the psychoactive medications and the facility believed gradual dose reduction was not required for residents receiving hospice services.</p> <p>The July, 2010, updated "Mood and Behavior Program Procedures" was provided by the Administrator in Training on 1/27/14 at 1:30 p.m. The procedure indicated a written plan of care would be developed to address the moods and/or behaviors, including interventions to address any noted intrinsic and/or extrinsic factors precipitating the moods and/or behaviors by the social service and/or the</p>				

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F000323 SS=D	<p>interdisciplinary team. The procedure further indicated a "Mood and Behavior Monthly Flow Record" would be implemented by the social service and/or appointed designee and placed in the Mood and Behavior Monthly Flow Record notebook. The notebook would be user-friendly and maintained by social service and/or appointed designee. Social service and/or appointed designee would ensure that three months of Mood and Behavior Monthly Flow Records were maintained in the notebook. A copy of the resident's Mood and Behavior Care Plan would be placed in the notebook so it could be easily accessible to all staff.</p> <p>31.1-37(a) 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to ensure residents who were transferred using a mechanical lift were transferred with sufficient staff assistance to prevent accident and injury for 1 of 3 residents reviewed</p>	F000323	<p>1. Resident B no longer resides at the facility. 2. All residents requiring utilization of a mechanical lift for transfer have been identified to ensure staff is aware of need for use of the lift. Additionally, observations were completed for each resident identified to confirm two</p>	02/17/2014
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	<p>for safety during transfers (Resident B)</p> <p>Finding include:</p> <p>Resident #B's closed record was reviewed on 1/14/14 at 12:45 p.m. Resident #B's diagnoses included, but were not limited to, hypertension, post cerebral vascular accident, Alzheimer's disease and osteoporosis.</p> <p>Resident #B had a, 10/23/13, quarterly, Minimum Data Set (MDS) assessment which indicated the resident was cognitively impaired, rarely or never made decisions, and required total assistance from two staff members for physical transfers.</p> <p>Resident #B had a 12/23/13, 4:30 a.m., Nursing Note which indicated a CNA was transferring the resident to the wheelchair with a mechanical lift and the lift arm hit the resident in the left eyebrow causing a laceration. The laceration was cleaned and steri-strips were applied.</p> <p>A 12/23/13, 4:30 a.m., "Incident and Accident Report and Investigation" indicated a CNA was transferring Resident #B using the mechanical lift by herself. In response the CNA</p>		<p>staff members were present during the transfer. If a concern was found, immediate corrective action was completed. 3. The facility's policy for utilizing a mechanical lift has been reviewed and no changes are indicated (See Attachment F). Nursing staff have been re-educated on mechanical lift transfers (See Attachment A) with emphasis on the necessity of two staff members. A transfer observation form has been implemented (See Attachment G), 4. The DON or designee will be responsible to observe two residents transferred via mechanical lift and complete the transfer observation form to ensure transfers are done appropriately on scheduled workdays as follows: Daily for two weeks, weekly for two weeks, then monthly thereafter. If a concern is noted, immediate corrective action will occur. Results of these reviews and any corrective action taken will be discussed during the facility's quarterly QA meetings for a minimum of six months and the plan adjusted accordingly, if warranted.</p>		

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	<p>was re-educated about using a mechanical lift with 2 staff members and all staff were inserviced and reminded to use 2 persons when transferring with a mechanical lift.</p> <p>During a 1/24/13, 10:00 a.m., interview the Administrator in Training indicated Resident #B should have been transferred with a mechanical lift and two staff members. The facility re-educated all staff to ensure mechanical lifts were operated by 2 staff members to ensure resident safety. Review of the current facility policy, dated June 2006, titled "Hoyer Lift", provided by the Administrator in Training 1/24/14 at 10:00 a.m., included, but was not limited to, the following:</p> <p>"PURPOSE: A Hoyer lift enables nursing personnel to lift and transfer a resident to and from bed.</p> <p>...POLICY: A Hoyer lift is to be used for residents who are too heavy to be lifted by one staff member or seriously disabled. A Hoyer lift must always be used with two (2) staff members present...."</p> <p>This Federal tag relates to Complaint IN00141860.</p>				

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F000329 SS=D	<p>3.1-45(a)(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 resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview and record review, the facility failed to ensure, residents who received psychoactive medications had behavior indicators for the use of the medication, behavioral monitoring, and or dose reductions or statements of contraindication for 3 of 5 residents reviewed for</p>	F000329	1.Resident #30, #28, and #5currently have behavior management programs whichfocus on monitoring of specific targeted behaviors and the care planningof such behaviors. Dose reductions or statements ofcontraindication have been obtained for the psychoactive medications in use, asindicated. 2. All other residents	02/17/2014

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	<p>unnecessary medications (Resident #30, #28 and #5).</p> <p>Findings include:</p> <p>1.) Resident #30's record was reviewed on 1/27/14 at 9:50 a.m. Resident #30's current diagnoses included, but were not limited to, end stage dementia, Alzheimer's disease, dementia with delusions and psychotic features and wasting syndrome.</p> <p>Resident #30 had current physician's orders for the following psychoactive medications:</p> <p>a.) 11/12/13, Seroquel 50 mg (an antipsychotic medication) - 1 tablet two times daily. This medication was a dose increase.</p> <p>b.) 1/4/13, Cymbalta 30 mg (an anti-depressant medication) - 1 tablet daily</p> <p>c.) 6/23/13, Xanax 0.5 mg (an anti-anxiety medication) - 1 tablet four times daily.</p> <p>Resident #30 had a current, 12/23/13, quarterly, Minimum Data Set (MDS) assessment which indicated the resident was cognitively impaired, rarely or never made decisions, and displayed no maladaptive behaviors during the</p>		<p>receiving psychoactive medications have been reviewed and a behavior management program including the monitoring and care planning of specific targeted behaviors has been initiated. Dose reductions or statements of contraindication have been obtained for the psychoactive medications in use, as indicated. 3. The facility has initiated a new Behavior Management Program (See Attachment C). The SSD and facility staff has been educated on the new behavior program with special focus on monitoring and care planning of targeted behaviors and the need for dose reductions or statements of contraindication (See Attachment A) as per regulation. A Behavior Management Review form has been initiated (See Attachment D) to ensure ongoing compliance. A Psychoactive tracking form has been implemented (See Attachment H) in an effort to track timely review for potential dose reduction. 4. The SSD or designee will complete the Behavior Management Review form for five residents and any residents with new orders for psychoactive medications to ensure behavior management plans including, the monitoring and care planning of specific behaviors, and the gradual dose reductions or statements of contraindication are in place on</p>				

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	<p>assessment period.</p> <p>Resident #30's record did not identify the specific behavioral symptoms or target behaviors being treated by the use of an antipsychotic medication, an anti-depressant medication or an anti-anxiety medication.</p> <p>Resident #30 did not have a care plan to address the specific behavioral symptoms or targeted behaviors being treated by the use of an antipsychotic medication, an anti-depressant medication or anti-anxiety medication.</p> <p>Resident #30's record indicated she had not received any form of mental health services since January 2013.</p> <p>Resident #30 had a, 6/24/13, pharmacy recommendation which requested a reduction in Xanax or a statement of contraindication. The physician had placed check marks under disagree. The contraindication did not include an evaluation of the residents medical condition; a statement of how this medication was currently treating a medical symptom or condition; indication of how this medication maintained the resident's quality of</p>		<p>scheduled workdays as follows: daily for two weeks, two times weekly for two weeks, weekly for four weeks, then monthly thereafter. Results of these reviews and any corrective actions taken will be discussed during the facility's quarterly QA meetings on an ongoing basis and the plan adjusted accordingly, if indicated. The DON will complete the Psychoactive tracking form and update with any new or changed orders with psychoactive medications on scheduled work days on an ongoing basis. Results of these reviews will be discussed during the facility's quarterly QA review on an ongoing basis and the plan adjusted accordingly if indicated</p>		

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	<p>life and/or quality of care, or indication of how a decrease in these medications would negatively impact the resident's quality of life or quality of care.</p> <p>Resident #30 had a 8/26/13 pharmacy recommendation which requested a reduction in Seroquel or a statement of contraindication. The physician had placed check marks under disagree. The contraindication did not include an evaluation of the resident's medical condition; a statement of how the medication was currently treating a medical symptom or condition; indication of how the medication maintained the resident's quality of life and/or quality of care; nor indication of how a decrease in the medication would negatively impact the resident's quality of life or quality of care.</p> <p>Resident #30 had a 10/30/13 "Mood and Behavior Monitoring Summary" which indicated her psychoactive medications would not be decreased because she was receiving hospice services. The summary did not contain an evaluation of the residents medical condition; a statement of how these medication were currently treating a medical</p>			

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	<p>symptom or condition; indication of how these medications maintained the resident's quality of life and/or quality of care; nor indication of how a decrease in these medications would negatively impact the resident's quality of life or quality of care.</p> <p>Review of Resident #30's Nurses Notes and behavior record for November and December 2013 and January 2014 indicated she had displayed one behavior of saying help me during this three month period. The behavior was repeat verbalization of "help me." The 11/17/13 "Mood and Behavior Communication Memo" indicated when the Social Services Director offered one to one comfort the behavior stopped.</p> <p>The record lacked documentation of any maladaptive behaviors prior to the increase of Seroquel on 11/12/13.</p> <p>During an 1/21/14, 11:35 a.m. to 12:00 p.m., lunch meal observation, the resident did not display any maladaptive behaviors.</p> <p>During an 1/24/14, 11:15 a.m. to 12:00 p.m., lunch meal observation,</p>			

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	<p>the resident did not display any maladaptive behaviors.</p> <p>During an 1/27/14, 12:55 p.m. interview, the Director of Nursing and Social Service Director indicated Resident #30 did not have identified targeted behaviors for the use of the psychoactive medications; did not have a care plan regarding target behaviors; had not received mental health services since January 2013; and did not have ongoing maladaptive behaviors which could not be redirected or calmed with one to one interaction. The facility did not have statements of contraindication which included evaluations for the use for any of the psychoactive medications and the facility believed gradual dose reduction was not required for residents receiving hospice services.</p> <p>2.) Resident #28's record was reviewed on 1/27/14 at 9:00 a.m. Resident #28's current diagnoses included, but were not limited to, vascular dementia with delusions, depressive disorder and anxiety.</p> <p>Resident #28 had current physician's orders for the following psychoactive medications: a.) 12/6/12, Seroquel 50 mg (an</p>			

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	<p>antipsychotic medication) - 1 tablet two times daily</p> <p>b.) 9/11/13, Xanax 0.25 mg (an anti-anxiety medication) - 1 tablet daily</p> <p>c.) 9/11/13, Celexa 20 mg (an anti-depressant medication) - 1 tablet daily. This medication was a dose increase.</p> <p>Resident #28 had a current, 11/26/13, significant change, Minimum Data Set (MDS) assessment which indicated the resident was cognitively impaired, rarely or never made decisions, and displayed no maladaptive behaviors during the assessment period.</p> <p>Resident #28's record did not identify the specific behavioral symptoms or target behaviors being treated by the use of an antipsychotic medication, an anti-depressant medication or an anti-anxiety medication.</p> <p>Resident #28 did not have a care plan to address the specific behavioral symptoms or targeted behaviors being treated by the use of an antipsychotic medication, an anti-depressant medication or anti-anxiety medication.</p>			

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	<p>Resident #28 had a, 6/24/13, pharmacy recommendation to decrease Celexa and Seroquel or provide a statement of contraindication. On 7/3/13, the physician indicated he disagreed with a dose reduction and indicated "de-stabilization by exacerbating an underlying psychiatric disorder." The contraindication did not include an evaluation of the resident's medical condition; a statement of how these medication were currently treating a medical symptom or condition; indication of how these medications maintained the resident's quality of life and/or quality of care, nor indication of how a decrease in these medications would negatively impact the resident's quality of life or quality of care.</p> <p>Resident #28 had a, 8/26/13, pharmacy recommendation to decrease Celexa and Seroquel or make a statement of contraindication. On 9/4/13, the doctor indicated he desired to decrease Celexa to 10 mg daily. The physician indicated no changes in Seroquel but did not provide a statement of contraindication.</p> <p>Resident #28 had a, 9/11/13, 12:30</p>						

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	<p>p.m., Nursing Note which indicated the resident had a change in anxiety and was stating "I feel like I am going to die" and her anti-anxiety medication was restarted on this date. The record did not indicate why the antidepressant was restarted.</p> <p>From 9/4/13 when the anti-depressant was decreased until 9/11/13 when it was increased to it's previous dose, the one, 9/11/13, 12:30 p.m., note listed was the only behavioral symptom documented in the seven day period.</p> <p>Resident #28 had a 10/30/13 "Mood and Behavior Monthly Monitoring Summary" which indicated the resident's psychoactive medications did not need a gradual does reduction because the resident had recently begun receiving hospice services. The summary did not contain an evaluation of the resident's medical condition; a statement of how these medication were currently treating a medical symptom or condition; indication of how these medications maintained the resident's quality of life and/or quality of care, nor indication of how a decrease in these medications would negatively impact the</p>			

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	<p>resident's quality of life or quality of care.</p> <p>Resident #28's record indicated she had not received any form of mental health services in the year 2013 and was not currently receiving mental health services.</p> <p>Review of Resident #28's Nurses Notes for November and December 2013 and January 2014 indicated the resident had displayed no maladaptive behaviors during this period. Resident #28 had no behavior tracking record for the three month period.</p> <p>During an 1/21/14, 11:35 a.m. to 12:00 p.m., lunch meal observation, the resident did not display any maladaptive behaviors.</p> <p>During an 1/24/14, 11:35 a.m. to 12:00 p.m., lunch meal observation, the resident did not display any maladaptive behaviors.</p> <p>During an 1/27/14, 12:55 p.m. interview, the Director of Nursing and Social Service Director indicated Resident #30 did not have identified targeted behaviors for the use of the psychoactive medications; did not have a care plan regarding target</p>						

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	<p>behaviors; had not received mental health services during the year 2013; did not have ongoing maladaptive behaviors; and did not have a current behavior tracking log. The facility did not have statements of contraindication which included evaluations for the use for any of the psychoactive medications and the facility believed gradual dose reduction was not required for residents receiving hospice services.</p> <p>3. The clinical record for Resident #5 was reviewed on 1/23/14 at 12:20 p.m.</p> <p>Diagnoses for Resident #5 included, but were not limited to, paranoid schizophrenia, depression, anxiety, diabetes mellitus, and multiple sclerosis.</p> <p>Current physician's orders for Resident #5 included, but were not limited to, the following orders:</p> <p>a. Seroquel (an antipsychotic medication) 100 milligrams (mg) 1 tablet by mouth every morning. The original date of this order was 8/21/08.</p> <p>b. Seroquel (an antipsychotic medication) 300 mg 1/2 tablet (150 mg) by mouth daily at bedtime. The</p>			

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	<p>original date of this order was 9/4/13.</p> <p>c. Zoloft (an anti-depressant medication) 25 mg 1 tablet by mouth once daily. The original date of this order was 12/4/13.</p> <p>d. Clonazepam ((an anti-anxiety medication) 0.5 mg 1 tablet by mouth two times a day. The original date of this order was 8/22/13.</p> <p>The clinical record lacked documentation of any specific behavioral symptoms for the use of the antipsychotic and the anti-anxiety medications. The "MOOD AND BEHAVIOR FLOW RECORD" for November and December 2013, and January 2014 did not contain any specific behaviors for tracking and had broad behavioral symptoms as follows: signs and symptoms of depression, signs and symptoms of anxiety and insomnia.</p> <p>During an interview with the Social Services Director and the East Unit Manager on 1/27/14 at 8:18 a.m., additional information was requested related to the lack of identified specific behaviors for the use of the antipsychotic and the anti-anxiety</p>				

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	<p>medications for Resident #5.</p> <p>During an interview with the Social Services Director (SSD) and the Director of Nursing (DoN) on 1/27/14 at 1:12 p.m., the SSD indicated she did not know the behavior indicators for the antipsychotic and the anti-anxiety medications. The DoN further indicated she had never observed any behaviors of Resident #5.</p> <p>4. Review of the current facility policy, dated 5/09, titled "Antipsychotic Drug Use Policy ", provided by the Administrator in Training 1/27/14 at 10:56 a.m., included, but was not limited to, the following:</p> <p>"PURPOSE: To ensure that anti-psychotic drugs will be administered only when medically indicated to treat a specific condition and help promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being. Non-pharmacological interventions will be considered and used when indicated, instead of, or in addition to medication. Gradual dose reductions will be attempted, unless clinically contraindicated, in an effort to discontinued these drugs.</p>						

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	<p>... Since diagnosis alone do not warrant the use of antipsychotic medications, the clinical condition must also meet at least one of the following criteria (a or b or c):</p> <p>b. The behavioral symptoms present a danger to the resident or to others; OR</p> <p>c. The symptoms are significant enough that the resident is experiencing one or more of the following: inconsolable or persistent distress (e.g., fear, continuously yelling, screaming, distress associated with the end-of-life, or crying); a significant decline in function; and/or substantial difficulty receiving needed care (e.g., not eating resulting in weight loss, fear and not bathing leading to skin breakdown or infection)..."</p> <p>Review of the current facility policy, dated 3/07, titled "Antidepressant Drug Use Policy", provided by the Administrator in Training 1/27/14 at 10:56 a.m., included, but was not limited to, the following:</p> <p>"PURPOSE: To ensure that anti-psychotic drugs will be administered only when medically indicated to treat a specific condition</p>						

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	<p>and help promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being. Non-pharmacological interventions will be considered and used when indicated, instead of, or in addition to medication..."</p> <p>Review of the current facility policy, dated 5/09, titled "Antianxiety Drug Use Policy", provided by the Administrator in Training 1/27/14 at 10:56 a.m., included, but was not limited to, the following:</p> <p>"PURPOSE: To ensure that anti-psychotic drugs will be administered only when medically indicated to treat a specific condition and help promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being.</p> <p>...Evidence exists that other possible reasons for the individual's distress have been considered; and Use results in maintenance or improvement in the individual's mental, physical, or psychosocial well-being (e.g., as reflected on the MDS or other assessment tools)..."</p> <p>3.1-48(a)(6)</p>			

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F000332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation, record review and interview, the facility failed to ensure medication administration was free of a medication error rate of greater than 5% for 3 of 27 opportunities observed. This resulted in a medication error rate of 11%. This deficient practice impacted 3 residents (Resident #55, Resident #54 and Resident #62)</p> <p>Findings include:</p> <p>1. During a medication administration observation on 1/21/14 at 11:29 a.m., Resident #55 was given a subcutaneous injection of 12 units of Novolog insulin (rapid acting insulin to lower blood sugar levels) by LPN #1. Resident #55 was then seated in the dining room and served lunch at 12:09 p.m., 39 minutes after receiving the insulin injection.</p> <p>2. During a medication administration observation on 1/24/14 at 11:18 a.m., Resident #54 was given a subcutaneous injection</p>	F000332	<p>1. Resident #55, #54, and #62 experienced no negative outcomes and are currently receiving their insulin as ordered by the physician. 2. All residents receiving sliding scale insulin have the potential to be affected. These residents have been reviewed and are currently receiving their insulin as ordered by the physician. 3. The facility's policy for insulin administration has been reviewed and no changes are indicated at this time (See Attachment I). The nurses have been re-educated on the policy with a focus on timeframe for short acting insulin (See Attachment A). An insulin administration observation form has been implemented (See Attachment J). 4. The DON or designee will be responsible to observe 5 residents receiving sliding scale insulin to ensure adherence to administering insulin as per the manufacturer's instructions and complete the insulin administration observation form on scheduled work days as follows: daily for two weeks, weekly for two weeks, then monthly thereafter. Should a</p>	02/17/2014
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	<p>of 10 units of Novolog insulin (rapid acting insulin to lower blood sugar levels) by LPN #1. Resident #54 was then seated in the dining room and served lunch at 12:15 p.m., 57 minutes after receiving the insulin injection.</p> <p>3. During a medication administration observation on 1/24/14 at 11:35 a.m., Resident #62 was given a subcutaneous injection of 6 units of Novolog insulin (rapid acting insulin to lower blood sugar levels) by LPN #1. Resident #62 was then seated in the dining room and served lunch at 12:08 p.m., 33 minutes after receiving the insulin injection.</p> <p>4. Manufacturer's directions from the "2010 Nursing Spectrum Drug Handbook," included but were not limited to: "Give 5 to 10 minutes before start of meal by subcutaneous injection in the abdominal wall, thigh, or upper arm."</p> <p>5. During an interview on 1/27/14 at 10:56 a.m., the Director of Nursing indicated the glucometers and the sliding scale insulin injections were administered at 11:30 a.m. "We do our blood sugars and insulins on the half hour and lunch is served at</p>		<p>concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions taken will be discussed during the facility's quarterly QA meeting for a minimum of 6 months and the plan adjusted accordingly.</p>				

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	<p>12:00 p.m." She further indicated that residents should eat within 30 minutes of receiving insulin.</p> <p>6. The medication observation had 27 opportunities for error with 3 resulting timing errors. The resulting error rate was 11%.</p> <p>Review of the current facility policy, dated 9/05, titled "INJECTIONS, INSULIN," provided by the Director of Nursing on 1/27/14 at 10:21 a.m., included, but was not limited to, the following:</p> <p>"PURPOSE: Insulin is injected to aid oxidation and utilization of the blood sugar by the tissues, and to control blood sugar levels in residents with Diabetes Mellitus....</p> <p>...POLICY: Insulin is administered by licensed personnel as ordered by the physician.</p> <p>...PREPARING THE INSULIN: 1. Check the physician's order..."</p> <p>3.1-48(c)(1)</p>				