

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155796	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  10/30/2015
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NAME OF PROVIDER OR SUPPLIER  CEDARS THE	STREET ADDRESS, CITY, STATE, ZIP CODE 14409 SUNRISE CT LEO, IN 46765
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00184044.</p> <p>Complaint IN00184044 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: October 26, 27, 28, 29, 30, 2015</p> <p>Facility number: 001215 Provider number: 155796 AIM number: 100450890</p> <p>Census bed type: SNF/NF: 46 Residential: 11 Total: 57</p> <p>Census payor type: Medicare: 2 Medicaid: 17 Other: 27 Total: 46</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000		

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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F 0279 SS=D Bldg. 00	<p>QR completed by 11474 on November 2, 2015.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to develop an individualized care plan with non-pharmacological interventions to be implemented prior to administering an anti-anxiety medication for 1 of 5 residents reviewed for unnecessary medications (Resident #55).</p> <p>Findings include:</p>	F 0279	F-279 The facility will provide an individualized care plan that address the DX: Anxiety with individualized interventions before administration of PRN anti-anxiety medication. 1. A care plan with individualized interventions was created for Resident # 55. These interventions were updated on the Medication administration record to match the interventions on the care plan. See exhibit A. 2. No other resident was found to be	11/16/2015

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	<p>The record for Resident #55 was reviewed on 10/28/2015 at 10:30 A.M. Diagnoses included, but were not limited to, anxiety disorder.</p> <p>A physician's order monthly re-cap, signed by the physician on 10/19/2015, indicated Resident #55 was prescribed alprazolam (medication used to treat anxiety) 0.5 mg (milligrams) to be administered three times daily as needed for anxiety. The monthly re-cap indicated the alprazolam had been prescribed since 9/20/2015.</p> <p>The Medication Administration Record (MAR) for October 2015 indicated Resident #55 had been administered the alprazolam thirty different times on the following dates and times during the month of October:</p> <p>10/03/2015 at 04:29 P.M. 10/03/2015 at 09:58 P.M. 10/04/2015 at 04:12 P.M. 10/04/2015 at 11:24 P.M. 10/05/2015 at 09:03 A.M. 10/05/2015 at 07:26 P.M. 10/06/2015 at 01:24 P.M. 10/07/2015 at 09:19 P.M. 10/08/2015 at 03:49 P.M. 10/08/2015 at 09:06 P.M. 10/09/2015 at 04:08 P.M. 10/10/2015 at 01:01 P.M.</p>		<p>effected by this deficient practice. An audit was conducted of all residents to assure care plans were in place. See exhibit B. 3. An in-service will be performed with all the licensed nursing staff, MDS Coordinator and Social Service Director of the systemic changes to ensure the deficient practice does not recur. See exhibit C. 4. The MDS Coordinator (or designee) will monitor monthly X3 months in the chemical restraint meeting, then quarterly. This process will be reviewed through the QA monthly meeting. The QA Officer will monitor for the effectiveness of the changes and the need of continuation of monitoring.</p>	

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	<p>10/11/2015 at 08:11 A.M. 10/14/2015 at 08:37 P.M. 10/16/2015 at 03:01 P.M. 10/16/2015 at 08:39 P.M. 10/17/2015 at 08:25 P.M. 10/18/2015 at 10:03 P.M. 10/20/2015 at 09:11 A.M. 10/20/2015 at 08:11 P.M. 10/21/2015 at 09:19 A.M. 10/22/2015 at 12:58 P.M. 10/23/2015 at 09:14 A.M. 10/23/2015 at 03:30 P.M. 10/24/2015 at 06:58 P.M. 10/25/2015 at 06:37 P.M. 10/26/2015 at 10:05 A.M. 10/26/2015 at 06:20 P.M. 10/27/2015 at 08:37 P.M. 10/28/2015 at 04:58 A.M.</p> <p>A review of Resident #55's record indicated a care plan for anxiety with non-pharmacological interventions to be attempted prior to administering the alprazolam had not been developed.</p> <p>LPN #1 was interviewed on 10/29/2015 at 10:40 P.M. During the interview, LPN #1 indicated each resident with PRN (as needed) anti-anxiety medications had a sticker indicating interventions to be attempted prior to administering any PRN anti-anxiety medication. The list was attached to the Controlled Substances Record. LPN #1 indicated all</p>			

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	<p>residents with PRN anti-anxiety medications had the same interventions listed on the stickers and the interventions were not individualized for each resident.</p> <p>A Controlled Substance Record for alprazolam for Resident #55 had a sticker attached with the following interventions:</p> <ol style="list-style-type: none"> <li>1. Offer food</li> <li>2. Toilet</li> <li>3. Give drink</li> <li>4. 1 on 1</li> <li>5. Redirect</li> <li>6. Change position</li> </ol> <p>The facility Director of Nursing (DON) was interviewed on 10/29/15 at 10:45 A.M. During the interview, the DON indicated the interventions on the sticker attached to Resident #55's Controlled Substance Record were not individualized specifically for the resident. The DON further indicated any resident receiving a PRN medication for anxiety should have a care plan with non-pharmacological interventions to be attempted prior to administering the medication. The DON indicated the interventions should be based on assessment of the resident and should be individualized for each resident. The DON indicated Resident #55 did not</p>			

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F 0280 SS=D Bldg. 00	<p>have a care plan with non-pharmacological interventions to be implemented prior to administering the alprazolam. The DON further indicated the facility did not a policy which addressed care plans for residents receiving of PRN psychotropic (medications used to treat mood and behavior).</p> <p>3.1-35(a)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on interview and record review, the facility failed to revise, update, and implement a nursing care plan to prevent</p>	F 0280	F-280 The facility must revise, update, and implement a nursing care plan to prevent dehydration.	11/16/2015

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	<p>dehydration for 1 of 1 resident who was reviewed for dehydration. (Resident #28)</p> <p>Findings include:</p> <p>The clinical record for Resident #28 was reviewed on 10/28/15 at 2:45 PM. A nursing care plan for alteration in fluid/hydration related to self help deficit due to left hemiparesis was initiated on 3/4/15. The care plan goals included but were not limited to: "...No signs or symptoms of dehydration..." The interventions included, but were not limited to: "...labs, intakes...supplements as ordered..." There were no additional care plan interventions to address the resident's risk for dehydration until 7/23/15. On 7/23/15 the nursing care plan was updated to include the following problem: "IV (intravenous) started due to decrease in oral intakes diagnosis dehydration and UTI (urinary tract infection). A physician's order dated 7/23/15 included: "D5 and 1/2 NS ( dextrose and normal saline) IV 60cc per hour times 3 days for dehydration."</p> <p>Review of a nutrition risk assessment, dated 2/27/15, indicated Resident #28 had an estimated fluid need of 1425 ml (milliliters) or cc (cubic centimeters) daily.</p> <p>Review of the fluid intake detail reports</p>		<p>1. Resident #28 care plan was updated and the following has been implemented. As a nursing measure, the licensed staff will offer 240cc of additional fluids with each shift. If the resident refuses the additional fluids, the MDS Coordinator will be notified to update the care plan and offer additional interventions, if applicable. The nutritional supplements will be update with the % to be recorded on the MAR with each one given. See exhibit I. 2. No other resident was found to have deficient practices related revision, update, or implementation of nursing care. An audit was performed to assure all applicable residents at risk for dehydration had a current care plan. See exhibit J. 3. An in-service will be performed with all licensed nursing staff and the MDS Coordinator to assure all systemic changes are implemented and the deficient practice does not recur. See Exhibit K. 4. The MDS Coordinator or (designee) will audit for compliance with each new systemic change to prevent dehydration, monthly X 3 months, then quarterly. This will be monitored through the QA process for compliance and need for continuation of monitoring. QA Officer will make the decision when to discontinue.</p>				

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	<p>indicated the following fluid intakes on these dates for Resident #28:</p> <p>June 23, 2015: 420 cc</p> <p>June 24: 120 cc</p> <p>June 25: 600 cc</p> <p>June 26: 240 cc</p> <p>June 27: 240 cc</p> <p>June 28: 240 cc</p> <p>June 29: 360 cc</p> <p>June 30: 360 cc</p> <p>July 1, 2015: 360 cc</p> <p>July 2: 200 cc</p> <p>July 3: 345 cc</p> <p>July 4: 380 cc</p> <p>July 5: 200 cc</p> <p>July 6: no fluid intake documented</p> <p>July 7: 540 cc</p> <p>July 8: 360 cc</p> <p>July 9: 380 cc</p> <p>July 10: 480 cc</p> <p>July 11: 480 cc</p> <p>July 12: 120 cc</p> <p>July 13: 480 cc</p> <p>July 14: 480 cc</p> <p>July 15: 240 cc</p> <p>July 16: 360 cc</p> <p>July 17: 480 cc</p> <p>July 18: Resident was out of the facility</p> <p>July 19: 180 cc</p> <p>July 20: 720 cc</p> <p>July 21: 225 cc</p> <p>July 22: 540 cc</p> <p>July 23: 420 cc</p>			

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F 0282 SS=D Bldg. 00	<p>An interview with the Director of Nursing (DoN), on 10/29/15 at 11:05 A.M., indicated Resident #28 could receive up to 270 cc additional fluids each day with medication administration but the facility nursing staff did not document the amount of actual fluid intake for this resident each day. The Don indicated the resident's additional fluid intake varied significantly each day, and there were no new care plan interventions developed and implemented to prevent dehydration from 3/4/15 through 7/22/15.</p> <p>3.1-35(d)(2)(B)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to follow physician's orders for 1 of 5 residents (#35) reviewed for unnecessary medications.</p> <p>Findings include:</p> <p>Resident #35's clinical record was reviewed on 10/27/15 at 9:30 A.M. On</p>	F 0282	The facility will provide services by qualified persons in accordance with each resident's written plan of care. 1. Resident # 35 was placed on a medication that needed to be updated in 2 weeks. The medication was update to the physician. No unwanted side effects noted. The physician gave a continuation for the order. the resident is doing	11/16/2015

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F 0327 SS=D Bldg. 00	<p>10/1/15, a physician's order was received to start Risperdal 0.25 milligrams (mg) at bedtime for anxiety and to re-evaluate in 2 weeks.</p> <p>A physician's progress note of 10/22/15 did not mention the use of Risperdal.</p> <p>An interview with LPN #3 on 10/29/15 at 9:45 A.M. indicated no re-evaluation of Risperdal use was noted in Resident #35's record.</p> <p>An interview with LPN #3, on 10/29/15 at 9:54 A.M. indicated she was the rounding nurse for Resident #35's physician. She indicated, on 10/22/15 during the physician visit, Risperdal use was discussed but not documented by the physician or herself. LPN #3 did indicate the Risperdal use should have been re-evaluated on 10/15/15.</p> <p>3.1-35(g)(2)</p> <p>483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. Based on interview and record review, the facility failed to provide the recommended amount of fluids to</p>	F 0327	<p>much better and having less anxiety with the present medication. 2. No other resident were affected by the deficient practice. An audit was conducted to assure all other residents medications were followed up by the MD if noted. See exhibit D 3. An in-service will be conducted for all licensed staff and the rounding nurse to ensure the deficient practice does not recur. See exhibit E. 4. The rounding nurse will monitor monthly X 3 months, then quarterly. The results will be reviewed in the QA meeting for the need for continuation and to monitor the effectiveness of the audit.</p> <p>F-327 the facility must provide the resident with sufficient fluid intake to maintain proper hydration and health. 1.</p>	11/16/2015	

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	<p>prevent dehydration for 1 of 1 resident who was reviewed for dehydration. (Resident #28)</p> <p>Findings include:</p> <p>The clinical record for Resident #28 was reviewed on 10/28/15 at 2:45 PM. A laboratory test for BUN (blood urea nitrogen to assess kidney function and rule out dehydration), dated 12/1/14, indicated a BUN of 21 (normal parameters 7-18) which indicated the resident was at risk for dehydration. A nursing care plan for alteration in fluid/hydration related to a self help deficit due to left hemiparesis was initiated on 3/4/15. The care plan goals included but were not limited to: "...No signs or symptoms of dehydration...." The interventions included, but were not limited to: "...labs, intakes...supplements as ordered...." There were no additional care plan interventions to address the resident's risk for dehydration until 7/23/15. On 7/23/15 the nursing care plan was updated to include the following problem: "IV (intravenous) started due to decrease in oral intakes diagnosis dehydration and UTI (urinary tract infection). A physician's order dated 7/23/15 included: "D5 and 1/2 NS ( dextrose and normal saline) IV 60cc per hour times 3 days for dehydration."</p>		<p>Resident #28 Care Plan was updated and the following has been implemented. As a nursing measure, the licensed staff will offer 240cc of fluids each shift in addition to the resident's daily fluid intakes. If the resident refuses the additional fluids the MDS Coordinator will be notified so the care plan can be updated. The nutritional supplements will have the % of fluids taken and documented on the MAR. See exhibit F. 2. No other resident was found to have deficient practices related to updating care plans. An audit was completed to assure that all applicable residents at risk for dehydration had a current care plan. See exhibit G. 3. An in-service will be performed with all the licensed nursing staff and the MDS Coordinator of the systemic changed to insure the deficient practice does not recur. see Exhibit H. 4. The MDS Coordinator (or designee) will monitor monthly X 3 months, then quarterly. All results will be addressed in the QA monthly meeting. The QA Officer will monitor for the effectiveness of the changes and for the need of continuation of audit.</p>	

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	<p>The most Recent MDS (Minimum Data Set) quarterly assessment, dated 8/03/2015, indicated Resident #28 had become dehydrated prior to the date of the assessment.</p> <p>Review of a nutrition risk assessment, dated 2/27/15, indicated Resident #28 had an estimated fluid need of 1425 ml (milliliters) or cc (cubic centimeters) daily.</p> <p>Review of the fluid intake detail reports indicated the resident received 705 cc to 1305 cc less fluid than recommended. The daily fluid intakes were recorded on these dates for Resident #28:</p> <p>June 23, 2015: 420 cc            June 24: 120 cc            June 25: 600 cc            June 26: 240 cc            June 27: 240 cc            June 28: 240 cc            June 29: 360 cc            June 30: 360 cc            July 1, 2015: 360 cc            July 2: 200 cc            July 3: 345 cc            July 4: 380 cc            July 5: 200 cc            July 6: no fluid intake documented            July 7: 540 cc            July 8: 360 cc            July 9: 380 cc</p>			

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	<p>July 10: 480 cc July 11: 480 cc July 12: 120 cc July 13: 480 cc July 14: 480 cc July 15: 240 cc July 16: 360 cc July 17: 480 cc July 18: Resident was out of the facility July 19: 180 cc July 20: 720 cc July 21: 225 cc July 22: 540 cc July 23: 420 cc</p> <p>An interview with the Director of Nursing (DoN), on 10/29/15 at 11:05 A.M., indicated Resident #28 could receive up to 270 cc additional fluids each day with medication administration but the facility nursing staff did not document the amount of actual fluid intake for this resident each day. The Don indicated the resident's additional fluid intake varied significantly each day and there were no new interventions added to the nursing care plan from 3/4/15 through 7/22/15 to prevent dehydration.</p> <p>3.1-46(b)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155796	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  10/30/2015
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NAME OF PROVIDER OR SUPPLIER  CEDARS THE	STREET ADDRESS, CITY, STATE, ZIP CODE 14409 SUNRISE CT LEO, IN 46765
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000  Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Residential Census: 11</p> <p>Sample: 5</p> <p>The Cedars was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Survey.</p>	R 0000		