

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155434	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/11/2012
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT CONNERSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 2600 N GRAND AVE CONNERSVILLE, IN 47331
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F0000	<p>This visit was for the investigation of Complaint number IN00106471.</p> <p>Complaint number IN00106471 substantiated, Federal/State deficiency related to the allegation is cited at F-323.</p> <p>Unrelated deficiencies cited at F-157, F-222 & F-329</p> <p>Survey dates: April 10 & 11 2012</p> <p>Facility number: 000319 Provider number: 155434 AIM number: 100286530</p> <p>Survey team: Angel Tomlinson RN Leslie Parrett RN</p> <p>Census bed type: SNF/NF: 33 Total: 33</p> <p>Census payor type: Medicare: 2 Medicaid: 21 Other: 10 Total: 33</p> <p>Sample: 4</p>	F0000		

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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	<p>These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 4/15/12 Cathy Emswiller RN</p>			

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F0157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to notify the Physician of the multiple doses administered PRN [as needed] of an anti-anxiety medication (Ativan) over an extended period of time</p>	F0157	This Plan of Correction constitutes the written allegation of compliance for deficiencies cited. However, submission of this Plan of Correction is not an admission	05/10/2012

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	<p>for 1 of 4 residents reviewed for medications. (Resident # B)</p> <p>Findings include:</p> <p>On 4/10/12 at 10:45 a.m. review of Resident # B's record indicated she was admitted to the facility on 11/8/11. The resident's diagnoses included, but were not limited to: Alzheimer's dementia with behavioral disturbance, arthritis, hypertension, anxiety and kidney disease.</p> <p>Resident # B's Physicians recapitulation orders dated 4/2012 indicated the Resident was receiving Ativan 0.5 mg take 1 tablet by mouth twice daily as needed for anxiety.</p> <p>Review of a timeline provided by the DON on 4/11/12 at 9:15 a.m. and the Medication Administration Record, nursing notes, behavior log, PRN (as needed) Anti-Anxiety Medication Flow sheet indicated from February 1, 2012 to April 11, 2012 the resident received 68 doses of Ativan 0.5 mg out of 71 days. The record did not contain documentation of the resident's physician being notified of multiple Ativan doses being administered.</p> <p>On 4/11/12 at 1:50 p.m. interview with the DON indicated the medication had not</p>		<p>that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law. F157</p> <p>It is the policy of this facility to notify the physician when multiple doses of PRN medication are given over an extended period of time, including anti-anxiety medications.</p> <p><i>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</i></p> <p>Resident B's physician has been updated regarding the multiple doses of PRN Ativan that has been given. After consideration, the physician has now ordered the Ativan to be given routinely.</p> <p>All licensed nurses have been re-educated regarding the facility policy for physician notification for frequent administration of PRN drugs.</p> <p><i>1. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</i></p>		

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	been effective. 3.1-5(a)(3)		<p>All residents receiving PRN anxiety and hypnotic medications have the potential to be affected by this practice. All residents with PRN orders for anti-anxiety medication have been reviewed. The attending physician has been notified for any resident that was noted to be receiving frequent PRN doses of anti-anxiety medication. For those residents, the physician(s) have ordered that the anti-anxiety medications be given routinely.</p> <p>If the DON or SSD find that PRN anti-anxiety medications are being given frequently and the physician has not been notified, she will make sure that the physician is contacted as soon as possible and notified of the situation. Once physician orders are received and the resident status is taken care of, the DON will retrain the nurses involved regarding the facility's policy and procedure. Progressive disciplinary action will be given for continued lack of compliance.</p> <p><i>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</i></p>		

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			<p>The SSD is reviewing the MARs for documentation of administration of PRN anti-anxiety medications at least 5 days a week during her tour of duty. She is bringing the results of her reviews to the next scheduled morning management meeting, consisting of the interdisciplinary team, which occurs at least 5 days a week.</p> <p>In addition the interdisciplinary team will meet with the consultant pharmacist at least monthly to review all residents receiving psychoactive medications. Any recommendations made, including those involving residents receiving anti-anxiety medications will be forwarded to the physician for consideration. His response and subsequent orders, if any, will be recorded in the residents' medical records.</p> <p>Identified areas of concern will be followed up as indicated in question #2.</p> <p><i>1.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</i></p>	

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			<p>The SSD will bring the results of her reviews and the monthly psychoactive medication review to the monthly QA Committee meeting for further review and recommendation. Any recommendations made will be followed up by the SSD or DON and the results of those recommendations will be brought back to the QA Committee at its next scheduled meeting for further consideration as needed.</p> <p>Correction date: 5/10/12</p>	

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F0222 SS=D	<p>483.13(a) RIGHT TO BE FREE FROM CHEMICAL RESTRAINTS</p> <p>The resident has the right to be free from any chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>Based on record review and interview, the facility failed to provide interventions 54 times out of 68 times prior to administering an anti-anxiety medication for 1 of 4 residents reviewed for medications. (Resident # B)</p> <p>Findings include:</p> <p>On 4/10/12 at 10:45 a.m. review of Resident # B's record indicated she was admitted to the facility on 11/8/11. The resident's diagnoses included, but were not limited to: Alzheimer's dementia with behavioral disturbance, arthritis, hypertension, anxiety and kidney disease.</p> <p>Resident # B's Physicians recapitulation orders dated 4/2012 indicated the Resident was receiving Ativan 0.5 mg take 1 tablet by mouth twice daily as needed for anxiety.</p> <p>Review of a timeline provided by the DON on 4/11/12 at 9:15 a.m. and the Medication Administration Record, nursing notes, behavior log, PRN (as needed) Anti-Anxiety Medication Flow sheet indicated from February 1, 2012 to</p>	F0222	<p>F222</p> <p>It is the policy of this facility to provide interventions prior to administering anti-anxiety medication to residents.</p> <p>1. <i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</i></p> <p>Resident B's physician has been updated regarding the multiple doses of PRN Ativan that has been given. After consideration, the physician has now ordered the Ativan to be given routinely.</p> <p>All licensed nurses have been re-educated regarding the facility policy for physician notification for frequent administration of PRN anti-anxiety drugs, including the required documentation of attempts made to use other non-pharmacological interventions before administering the medication. They have also been retrained</p>	05/10/2012	

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	<p>April 11, 2012 the resident received 68 doses of Ativan 0.5 mg with no prior interventions attempted 54 of the times she received the medication.</p> <p>Review of the Behavior log dated 2/5/12, 2/14/12, 2/28/12 and 3/6/12 indicated resident received Ativan for wandering into other residents rooms.</p> <p>On 4/11/12 at 11:00 a.m. interview with the Social Services Director indicated she added the PRN Anti-Anxiety Medication Flow sheet to encourage the nurses to use interventions prior to medication administration.</p> <p>On 4/11/12 at 11:20 a.m. the administrator provided a document titled "Restraints, Chemical" "Policy: Each resident has the right to be free from any chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. Each resident's drug regimen must be free from unnecessary drugs"...</p> <p>"Definitions: Chemical Restraint - any drug that is used for discipline or convenience and not required to treat medical symptoms.</p> <p>3.1-3(w) 3.1-26(o)</p>		<p>in the documentation of PRN medications, including documentation of the effectiveness of the drug once it is given.</p> <p>2. <i>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</i></p> <p>All residents receiving PRN anti-anxiety medications have the potential to be affected by this practice. All residents with PRN orders for anti-anxiety medication have been reviewed to ensure medication is being documented according to facility policy which includes the documentation of interventions and alternatives being tried prior to giving the medication to the resident. In addition, the effectiveness of the PRN dose of medication should be documented after it has been administered.</p> <p>The attending physician has been notified for any resident that was noted to be receiving frequent PRN doses of anti-anxiety medication. For those residents, the physician(s) have ordered that the anti-anxiety medications be</p>				

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			<p>given routinely.</p> <p>If the DON or SSD find that PRN anxiety medications are being given without documentation that staff has attempted other non-pharmacological interventions first, she will retrain the nurse(s) involved regarding the facility policy and will administer progressive disciplinary action at that time.</p> <p>In addition, if the DON or SSD find that PRN anti-anxiety medications are being given frequently and the physician has not been notified, she will make sure that the physician is contacted as soon as possible and notified of the situation. Once physician orders are received and the resident status is taken care of, the DON will retrain the nurses involved regarding the facility's policy and procedure. Progressive disciplinary action will be given for continued lack of compliance.</p> <p><i>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</i></p> <p>The SSD is reviewing the MARs for documentation of</p>	

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			<p>administration of PRN anxiety medications, including documentation of attempts to provide non-pharmacological interventions before giving the medication and effectiveness of the medication, when given, at least 5 days a week during her tour of duty. She is bringing the results of her reviews to the next scheduled morning management meeting, consisting of the interdisciplinary team, which occurs at least 5 days a week.</p> <p>In addition the interdisciplinary team will meet with the consultant pharmacist at least monthly to review all residents receiving psychoactive medications. Any recommendations made, including those involving residents receiving anti-anxiety medications will be forwarded to the physician for consideration. His response and subsequent orders, if any, will be recorded in the residents' medical records.</p> <p>Identified areas of concern will be followed up as indicated in question #2.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance</p>	

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			<p><i>program will be put into place?</i></p> <p>The SSD will bring the results of her reviews and the monthly psychoactive medication review to the monthly QA Committee meeting for further review and recommendation. Any recommendations made will be followed up by the SSD or DON and the results of those recommendations will be brought back to the QA Committee at its next scheduled meeting for further consideration as needed. This will continue on an ongoing basis.</p> <p>Correction date: 5/10/12</p>		

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F0323 SS=G	<p>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.</p> <p>Based on observation, interview and record review, the facility failed to assist a dependent resident with bed mobility in a safe manner resulting in the resident falling out of bed, acquiring a closed head wound that required 20 sutures and right side facial and eye contusions for 1 of 4 residents sampled for accidents in a total sample of 4 (Resident #A).</p> <p>Finding include:</p> <p>Review of the record of Resident #A on 4-10-12 at 10:30 a.m. indicated the resident's diagnoses included, but were not limited to, congestive heart failure, diabetes mellitus, depression and obesity.</p> <p>The Minimum Data Set (MDS) assessment for Resident #A dated, 3-29-12 indicated the following: bed mobility- total dependence of two people, transfer- total dependence of two people, walk in room- did not occur and toileting- total dependence of two people.</p> <p>The nurses note for Resident #A dated,</p>	F0323	<p>F323It is the policy of this facility to ensure that each resident receives adequate supervision and assistance to prevent accidents.1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?The incident was thoroughly investigated. The investigation did not reveal any policy or procedure errors made by CNA #1 or by CNA #4 who were assisting the resident at the time of the fall. The immediate interventions put into place were the use of facility provided cotton sheets versus the polyester sheets the family had been providing; blanket rolls and three assist for 1st and 2nd shift. On 3/30/12 assist bars were placed on the resident's bed. Hospice has also provided a wider bariatric bed that has ½ rails as an enabler as an added precaution. Resident A's plan of care has been reviewed and updated.Facility management was not made aware of any issues related to the</p>	05/10/2012			

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	<p>3-29-12 at 9:15 p.m. indicated the resident was on the floor face down with blood around the head. The resident had an laceration to the top of the head and a skin tear to the left hand. The emergency personal was called and pressure was applied to the resident's head.</p> <p>The nurses note for Resident #A dated, 3-29-12 at 9:25 p.m. indicated the emergency personal took the resident to the emergency room.</p> <p>The local hospital emergency room record for Resident #A dated, 3-29-12 at 9:50 p.m. indicated the resident was placed on an backboard and c-collar was placed on the resident's neck. The resident had a peri orbital hematoma and a head laceration. The resident's pain level was maximum at a level 10.</p> <p>The local hospital emergency room record for Resident #A dated, 3-29-12 at 11:05 p.m. indicated the resident had a 6 centimeter scalp laceration and an right eye orbit contusion. The resident's pain level was moderate.</p> <p>The interpretive imaging report for Resident #A dated, 3-29-12 indicated the history was pelvis injury and pain. The findings was no acute fracture.</p>		<p>“slickness” of the resident’s sheets which were being provided to the resident by the family. CNA #1 and CNA # 4 have been interviewed to determine who they reported the “slick” sheets to. Staff has been educated regarding the need to report any safety concern to the DON for immediate intervention. CNA #2 and CNA #3 have been counseled regarding not providing care with three assist and with blanket rolls on 4/10/12 during observation by the State Surveyor. Please note CNA #2 and CNA #3 both stated that blanket rolls were in use at the time of the Surveyor’s observation of care. The CNAs stated that the blanket rolls were under the fitted sheets during care. All nursing staff will be inserviced by 5/11/12 regarding prevention of resident accidents, including precautions to take when turning residents in bed. Staff will also be informed of the need for them to report any change in resident equipment, including use of different bedsheets, to the DON immediately.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be</p>	

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	<p>The Computed Tomography (CT) (x-ray procedure) of the facial bones for Resident #A dated, 3-29-12 indicated the history was head and neck injury and pain. The findings were bone window images show no fracture. There were fluid in the sphenoid sinuses. There were no mass effect, midline shift or evidence of hemorrhage.</p> <p>The cervical CT for Resident #A dated, 3-29-12 indicated the history was head and neck injury. The findings were no fractures or dislocations were seen.</p> <p>The CT of facial bones for Resident #A dated, 3-30-12 indicated the history was facial injury and pain. The findings were mucosal thickening in the left maxillary sinus. There was fluid in the sphenoid sinuses. There were no fractures seen.</p> <p>The local hospital physician order for Resident #A dated, 3-29-12 indicated the resident was to return back to the nursing home. The diagnoses was closed head injury, scalp laceration and facial right eye orbit contusion. The resident was ordered neurological checks every two hours for 24 hours and then discontinue if they were stable. Notify the resident's physician of the resident's fall and scalp laceration. The sutures to be removed in 10 days.</p>		<p>taken. Residents who are at risk for falling have the potential to be affected by this practice. All residents will be assessed for fall risk by 5/11/12, including assessment for any bed mobility issues that might present at the time of the assessment. The DON and interdisciplinary team will review the results of the fall assessments and current interventions in place. Any recommendations for additional or revised interventions will be added to the resident's care plan and to the CNA assignment sheets at the time of the review. All resident beds have been inspected for use of family provided sheets to ensure that safety issues do not exist with the sheets. All residents have also been assessed for the possible need of assist bars. If the DON or any member of the interdisciplinary team observes that a resident is being placed in a precarious position during care or treatment, he/she will intervene immediately to make sure that the resident is safe. Once that is done and the care has been completed in a safe manner, the DON, designee, or Administrator will re-train the staff involved at that time regarding the facility policy and the what precautions to take in</p>		

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	<p>The episodic care plan falls for Resident #A dated, 3-29-12 indicated the cause of the fall was slick sheets were on the bed.</p> <p>The assessment of other skin abnormalities for Resident #A dated, 3-29-12 indicated the resident had a 6 centimeter laceration to the top of the head, moderate amount of bleeding, sent to the emergency room for evaluation. Twenty sutures intact upon return.</p> <p>The care plan for Resident #A dated, 3-30-12 indicated the resident was at risk for falls. The interventions were as follows: "inform me of what you are going to do", "place hoyer sling under me", "converse with me during transfer to assure me that I am safe", "talk to hospice about assist rails for my bed", "use standard cotton sheets on my bed", "place a star outside my door to alert staff of my fall risk", do a fall risk assessment for me quarterly and as needed. The intervention added on 3-31-12 was assist rails to bilateral side of the resident's bed.</p> <p>The "ATTENTION NURSING STAFF" documentation for Resident #A dated, 3-30-12 included, but were not limited to, Nurses please check every two hours and document well regarding the resident's condition. The first sign of any problem,</p>		<p>the future to provide safe care for the resident. If staff involved has been trained previously but continues to show noncompliance, the DON will render progressive disciplinary action, up to and including termination. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?The interdisciplinary team will observe for the care of residents in bed as part of their Guardian Angel rounds that are done during each tour of duty, in addition to the routine rounds that are done each shift as part of their normal work day. The DON or designee will complete daily care observations to include monitoring care of residents while in bed. The DON or designee will also compare the care rendered to the interventions outlined in the residents' care plans and CNA assignment sheets. Any identified or observed concerns will be addressed as indicated in question #2. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?The DON and Administrator will bring the</p>				

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	<p>call the doctor and hospice, On first and second shift please use 3 staff for bed care, Please use a blanket roll as an extra barrier on the side of the bed away from the wall, please be mindful of the resident's soreness and get her up as tolerated, please assist the resident to use the grab bar now on her bed when turning side to side, provide plenty of reassurance due to her anxiety.</p> <p>The nurses notes for Resident #A dated, 3-30-12 at 1:00 a.m. indicated the resident returned by ambulance to the facility. The resident was assisted back to bed with the assist of 3 people. The resident had a large purple bruise to the right eye and the eye was swollen shut. The resident's scalp was clean. The resident had sutures in place. The left hand had an bandage on it. The resident had multiple bruising noted to the upper body.</p> <p>During observation on 4-10-12 at 11:15 a.m. Resident #A was laying in bed. The resident had an air mattress on the bed and had quarter grab bars on each side of the bed. The resident had bruising to the right side of the face and right ear. The resident had a large deep laceration on the right side of her head with dried dark drainage on it, the laceration had steri strips across it. The resident indicated she fell out of bed and was unable to</p>		<p>results of the Guardian Angel rounds and the daily DON observations to the monthly QA Committee for review and recommendation. Any recommendations made will be followed up by the DON and the results of those recommendations will be brought back to the QA Committee at its next scheduled meeting for further consideration as needed. This will continue on an ongoing basis. Completion Date: 5/10/12</p>	

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	<p>remember what happened. The resident indicated her head was sore.</p> <p>During observation on 4-10-12 at 11:30 a.m. CNA #2 and CNA #3 assisted Resident #A from side to side in her bed to apply an hoyer lift pad under the resident for an transfer. Resident #A was able to grab the assist bars on her bed while being assisted with turning. Interview with CNA #2 and CNA #3 at this time indicated the resident had always had an air mattress and did not have assist bars until the resident fell out of bed. CNA #2 and CNA #3 indicated they had not had any problems with Resident #A sliding due to slick sheets. CNA #2 provided a set of sheets that the resident's family had provided, and the label on the sheets indicated 100% polyester. CNA #3 indicated she had not experienced any problems with Resident #A grabbing out for things during bed mobility until after the resident fell out of the bed. CNA #3 indicated the resident was fearful being turned from side to side now after she fell out of bed. During observation there were no roll blanket used during care.</p> <p>Interview with family member #1 of Resident #A on 4-10-12 at 12:50 p.m. indicated the resident had rolled out of bed. Family member #1 indicated the</p>			

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	<p>resident had felt insecure about being so close to the edge of the bed. Family member #1 indicated he was told by the facility the resident was reaching for something and the sheets were slick was the cause of the resident falling out of bed. Family member #1 indicated there had not been any problems brought to the family regarding the sheets they had provided until after the resident had fallen out of the bed. Family member #1 indicated the resident had been using the sheets for several months. Family member #1 indicated the resident had voiced concerns about being too close to the edge and was afraid she would fall. Family member #1 indicated he was told there were two staff and they rolled the resident to her side to clean her up and the resident reached for something and fell out of bed.</p> <p>Interview with Family member #2 of Resident #A on 4-10-12 at 1:15 p.m. indicated when she arrived to the hospital on 3-29-12 after the resident had fell out of bed, the resident indicated to her she had told those girls not to roll her so close to edge of the bed, that she was going to fall. Family member #2 indicated the resident's right side of her face was black and blue and her right eye was swollen shut. Family member #2 indicated the resident was not able to roll herself in bed by herself. Family member #2 indicated</p>			

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	<p>the resident had been using the sheets the family had bought for 8-9 months. Family member #2 indicated there had not been any problems with the sheets until after the resident fell out of bed.</p> <p>Interview with the Director Of Nursing (DON) on 4-10-12 at 2:25 a.m. indicated the "ATTENTION NURSING STAFF" documentation for Resident #A dated, 3-30-12 was an inservice the Administrator had done with staff after Resident #A had fell out of bed. The DON indicated the interventions should have been added to the resident's care plan. The DON indicated the blanket roll was added for support.</p> <p>Interview with CNA #1 on 4-10-12 at 2:30 p.m. indicated she and CNA #4 was caring for Resident #A on 3-29-12 when she fell out of the bed. CNA #1 indicated she had rolled the resident toward her so CNA #4 could clean the resident. CNA #1 indicated the resident attempted to grab for the oxygen tank and she instructed the resident to hold on to her scrub top. CNA #1 indicated the resident did hold onto her top for a minute. CNA #1 indicated the resident kept saying "I'm gonna fall" "I am gonna fall". CNA #1 indicated the resident's bed cannot be raised up for care so she was bending down trying to hold</p>			

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	<p>on to the resident. CNA #1 indicated she went to reposition her back from bending over and when she moved her knees, that was when the resident fell out of bed. CNA #1 indicated the resident had sheets on her bed the family had brought in and that she had told the nurses in the past the sheets were too slick. CNA #1 indicated she had told the nurses when the resident had the sheets on her bed it was too easy for the resident to move when trying to hold onto her.</p> <p>Interview with CNA #4 on 4-10-12 at 2:35 p.m. indicated she was assisting Resident #A on 3-29-12 when the resident fell out of the bed. CNA #4 indicated she was cleaning the resident at the time of the fall. When queried if Resident #A was close to the edge of the bed when she fell out of bed, CNA #4 indicated the resident was always kind of on the edge of the bed because of the resident's size. CNA #4 indicated the sheets did not help the situation and the resident not having side rails made the situation difficult. CNA #4 indicated she had reported the sheets were too slippery. CNA #4 indicated when she would try to hold onto the resident during care, the resident would move easily due to the sheets. CNA #4 indicated when staff would assist the resident to reposition and be pulled up in the bed, the resident would slide down because the</p>			

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	<p>sheets were slick. CNA #4 indicated she had reported the sheets being too slippery a few times.</p> <p>The CNA assignment sheet provided by the DON on 4-10-12 at 2:45 p.m. indicated Resident #A should have assist bars, blanket roll and the assistance of two people for turning.</p> <p>Interview with the Administrator on 4-11-12 at 1:50 p.m. indicated the staff were instructed to use three people during Resident #A's care when possible. The Administrator indicated the three staff during care and the blanket roll were immediate interventions the facility had put in place and were never added to the resident's care plan. The Administrator indicated the grab bars placed on the resident's bed were the main intervention put in place after the resident's fall on 3-29-12.</p> <p>This federal tag relates to complaint IN00106471.</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p>			

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F0329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to provide adequate indications for the use of an anti-anxiety medication (Ativan) for 1 of 4 residents reviewed for medications. (Resident # B)</p> <p>Findings include:</p> <p>On 4/10/12 at 10:45 a.m. review of Resident # B's record indicated she was admitted to the facility on 11/8/11. The resident's diagnoses included, but were not limited to: Alzheimer's dementia with</p>	F0329	<p>F329It is the policy of this facility to make sure that each resident's drug regimen is free from unnecessary drugs, including anti-anxiety drugs.1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?Resident B's physician has been updated regarding the multiple doses of PRN Ativan that has been given. After consideration, the physician has now ordered the Ativan to be given routinely.All licensed nurses have been re-educated regarding</p>	05/10/2012

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	<p>behavioral disturbance, arthritis, hypertension, anxiety and kidney disease.</p> <p>Resident # B's Physicians recapitulation orders dated 4/2012 indicated the Resident was receiving Ativan 0.5 mg take 1 tablet by mouth twice daily as needed for anxiety.</p> <p>Review of a timeline provided by the DON on 4/11/12 at 9:15 a.m. from February 1, 2012 to April 11, 2012 indicated Resident # B received Ativan 0.5 mg with no documentation for the use of the medication 58 out of 68 times it was given.</p> <p>Review of the Medication Administration Record(MAR), nursing notes, behavior log, PRN (as needed) Anti-Anxiety Medication Flow sheet from February 1, 2012 to April 11, 2012 indicated the MAR was not signed that the medication was given 53 of the 68 times. Nursing notes indicated for 60 doses of Ativan given there was no documentation for the use and 67 doses given with no documentation of effectiveness of the medication.</p> <p>Review of the Behavior log dated 2/5/12, 2/14/12, 2/28/12 and 3/6/12 indicated Resident # B received Ativan for wandering into other residents rooms.</p> <p>Review of the PRN (as needed) Anti-Anxiety Medication Flow sheet</p>		<p>the facility policy for physician notification for frequent administration of PRN anti-anxiety drugs, including the required documentation of attempts made to use other non-pharmacological interventions before administering the medication. They have also been retrained in the documentation of PRN medications, including documentation of the effectiveness of the drug once it is given.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?All residents receiving PRN anxiety medications have the potential to be affected by this practice. All residents with PRN orders for anti-anxiety medication have been reviewed to ensure medication is being documented according to facility policy which includes the documentation of interventions and alternatives being tried prior to giving the medication to the resident. In addition, the effectiveness of the PRN dose of medication should be documented after it has been administered.The attending physician has been notified for any resident that was noted to be receiving frequent PRN doses of anti-anxiety medication. For those residents, the physician(s) have ordered that the anti-anxiety medications be given routinely.If</p>	

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	<p>indicated no interventions were done prior to medication administration 51 of the 68 times the Resident received the medication.</p> <p>On 4/11/12 at 11:00 a.m. interview with the Social Services Director indicated she added the PRN Anti-Anxiety Medication Flow sheet to encourage the nurses to use interventions prior to medication administration.</p> <p>On 4/11/12 at 11:25 a.m. the Administrator provided a document titled "Unnecessary Medications" "Policy: 1. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used"... "For excessive duration; or without adequate monitoring; or without adequate indications for its use; or "... "Any combination of the reasons above."</p> <p>3.1-48(a)(2) 3.1-48(a)(3) 3.1-48(a)(4) 3.1-48(a)(6)</p>		<p>the DON or SSD find that PRN anti-anxiety medications are being given without documentation that staff has attempted other non-pharmacological interventions first, she will retrain the nurse(s) involved regarding the facility policy and will administer progressive disciplinary action at that time. In addition, if the DON or SSD find that PRN anti-anxiety medications are being given frequently and the physician has not been notified, she will make sure that the physician is contacted as soon as possible and notified of the situation. Once physician orders are received and the resident status is taken care of, the DON will retrain the nurses involved regarding the facility's policy and procedure. Progressive disciplinary action will be given for continued lack of compliance.3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The SSD is reviewing the MARs for documentation of administration of PRN anxiety medications, including documentation of attempts to provide non-pharmacological interventions before giving the medication and effectiveness of the medication, when given, at least 5 days a week during her tour of duty. She is bringing the results of her reviews to the next</p>				

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			<p>scheduled morning management meeting, consisting of the interdisciplinary team, which occurs at least 5 days a week. In addition the interdisciplinary team will meet with the consultant pharmacist at least monthly to review all residents receiving psychoactive medications. Any recommendations made, including those involving residents receiving anti-anxiety medications will be forwarded to the physician for consideration. His response and subsequent orders, if any, will be recorded in the residents' medical records. Identified areas of concern will be followed up as indicated in question #2.4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?The SSD will bring the results of her reviews and the monthly psychoactive medication review to the monthly QA Committee meeting for further review and recommendation. Any recommendations made will be followed up by the SSD or DON and the results of those recommendations will be brought back to the QA Committee at its next scheduled meeting for further consideration as needed. This will continue on an ongoing basis. Correction date: 5/10/12</p>	