

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E209	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/07/2015
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NAME OF PROVIDER OR SUPPLIER  SUMMIT CONVALESCENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 S MAIN ST SUMMITVILLE, IN 46070
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: August 3, 4, 5, 6, and 7, 2015</p> <p>Facility number: 000373 Provider number: 15E209 AIM number: 100288730</p> <p>Census bed type: NF: 31 Total: 31</p> <p>Census Payor Type: Medicaid: 19 Other: 7 Total: 26</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	Submission of this plan of correction shall not constitute or be construed as an admission by Summit Convalescent Center that the allegations contained in the survey report are accurate or reflect accurately the provision of care and service to the residents at Summit Convalescent Center. The facility requests the following plan of correction be considered its allegation of compliance. The facility also respectfully requests paper compliance due to the low scope and severity and number of tags written	
F 0309 SS=E Bldg. 00	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and</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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	<p>psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to implement a behavior management and monitoring program for residents who had dementia and received psychoactive medications for symptoms related to dementia with behavioral disturbances for 5 of 5 residents reviewed for behavior monitoring and management associated with dementia. (Residents #14, #18, #33, #13, #27)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #14 was reviewed on 8/6/15 at 9:55 a.m. Diagnoses for the resident included but were not limited to, Dementia with behavior disturbances, anxiety, restlessness, hypertension, and depression.</p> <p>Review of the current physician orders indicated Resident #14 received the following medications:</p> <p>a. Divalproex (a mood stabilizer medication) 125 milligrams by mouth daily for diagnosis of dementia with behaviors.</p>	F 0309	<p>RESIDENT #'s 14, 18, 33, 13 &amp; 27 A new form was developed to go with the Behavior/Intervention Monthly Flow Record to include attempts to determine the underlying cause/contributing factors of the behavior.</p> <p>All residents who receive psychoactive medications or are monitored for behaviors will utilize the new form in order to determine the underlying cause/contributing factors of the behavior.</p> <p>Additionally the MDS Coordinator reviewed all HCP's (Health Care Plans) of residents on psychoactive medications to ensure the HCP accurately reflected the current psychoactive medications and behavior monitoring plan for each resident.</p> <p>The DON/designee will review the Behavior/Intervention Monthly Flow Record and accompanying documentation 2x a week for two months, then weekly for 2 months. Ongoing review of documentation will continue at the monthly behavior meeting.</p> <p>Staff in-services were held on 8/18 &amp; 8/19 to review the state survey citations and educate on new process for behavior monitoring.</p> <p>POC Date: 9/6/15</p>	09/06/2015

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	<p>b. Escitalopram (an antidepressant medication) 10 milligrams by mouth daily for diagnosis of depression.</p> <p>c. Quetiapine (an antipsychotic medication) 50 milligrams by mouth twice daily for diagnosis of dementia with behaviors.</p> <p>d. Xanax (an antianxiety medication) 0.25 milligrams 1.5 tab by mouth three times daily for diagnosis of dementia with behavior disturbance.</p> <p>The quarterly Minimum Data Set (MDS) assessment, dated 3/17/15, indicated Resident #14 had severe cognitive impairment.</p> <p>The health care assessment, dated 7/29/15, included but were not limited to the following problems:</p> <p>1a. "...Uses psychotropic medications r/t [related to] Disease process DEMENTIA WITH BEHAVIORS AND DEPRESSION...", last revised on 8/4/15, indicated Resident #14 had a problem with behaviors/mood issues exhibited by the following: "...CRYING, AGITATION, THROWING FOOD/LIQUIDS, ANXIETY, DISRUPTIVE NOISES AND RESTLESSNESS CAUSING</p>			

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	<p>INCONSOLABLE DISTRESS.... "</p> <p>Interventions for the problems included but were not limited to, "...OBSERVE/record occurrence of, for target behavior symptoms...document per facility protocol."</p> <p>1b. "...Has a behavior problem r/t [related to] DX [diagnosis] OF DEMENTIA WITH BEHAVIORS....", last revised on 3/25/15, indicated Resident #14 had a problem with behaviors exhibited by the following: "...ANXIETY, DISRUPTIVE NOISES AND SOUNDS, CURSING, AGITATION/COMBATIVE, THROWS FOOD...." Interventions for the problems included but were not limited to, "...OBSERVE behavior episodes and attempt to determine underlying cause. Consider location, time of the day, persons involved, and situations. Document behavior and potential causes...."</p> <p>A letter of contraindication for reduction of medications for Resident #14, dated 5/30/15, provided by the Administrator on 8/6/15 at 3:36 p.m., indicated the following:</p> <p>"...exhibits behaviors depression and anxiety on a daily basis. She is frequently cry[ing] and questions what</p>						

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	<p>should I do , where do I go now, will you help me? I'm afraid. She has a distressed facial appearance and sad, worried tone to her speech...."</p> <p>A review of progress notes for Resident #14 indicated the following:</p> <p>"5/14/2015 17:27 [5:27 p.m.]...Behavior...Description of behavior(s): getting into other resident's faces, making funny faces and sounds words that do not make sense...What triggered behavior: alzheimer's...Physical/Emotional Assessment: in dining room with other residents, confused going in merry walker to resident getting her face into other residents face. Agitated...removed resident from area and calmed her down...." No specific cause of behavior besides Alzheimer's [disease] had been identified.</p> <p>"5/27/2015 15:49 [3:49 p.m.] ...Social Service Note...Res [Resident] in hall in Merrywalker. Reaching out to everyone that passes asking them to stop and talk with her. SSD [Social Service Director] stopped to talk w/ [with] res [resident] very fearful, facial expression, jaw tight, furrowed brow. just [Just] kept repeating 'please help me' when asked what she needed would just repeat 'please help me'</p>			

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	<p>reassurance given rubbed her back. Increased anxiety not able to redirect...." No cause of behavior identified.</p> <p>"...5/29/2015 15:49 [3:49 p.m.]...Social Service Note...Res [Resident] in hallway yelling/screaming. Very agitated. Did quiet with offer of cookie...." No cause of behavior identified.</p> <p>"...5/31/2015 14:17 [2:17 p.m.]...Nurses Note...RES[Resident] APPEARING MORE MELLOWED BUT IS AGGITATED AT THE SAME TIME. EASILY REDIRECTED. NEEDS ALL MET AS ARISING...." No cause of behavior identified.</p> <p>"...7/10/2015 05:30 [5:30 p.m.]...Behavior...Description of behavior(s) exhibited: Res [Resident] screaming/hollaring as much as she could... What triggered behavior: 2 staff members were getting res [Resident] up for the morn...Physical/Emotional Assessment: Becomes angry and agitated...Interventions...: 1:1, res [Resident] gotten up after a little while...."</p> <p>"...7/12/2015 05:25 [5:25 p.m.]...Behavior...Description of behavior(s) exhibited: Screaming...What triggered behavior: Getting resident</p>			

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	<p>dressed and up for the day...Interventions...Attempted to talk with resident and reassure resident. Given incontinence care. Did not work. Screamed until was in chair and left alone...."</p> <p>The "BEHAVIOR/INTERVENTION MONTHLY FLOW RECORD" provided by Administrator on 8/6/15 at 11:28 a.m., indicated the following:</p> <p>1. " BEHAVIOR #1: anxiety, disruptive noises/sounds, cursing..."</p> <p>a. The month of May 2015 indicated 10 shifts did not document any behavior and/or lack of behavior. Three behaviors were documented. They were on 5/7/15, 5/13/15 and 5/27/15. No cause of the behaviors were identified on the form or in the progress notes.</p> <p>b. The month of June 2015 indicated 11 shifts did not document any behaviors and/or lack of behavior. The dates with documentation indicated no behaviors occurred.</p> <p>c. The month of July 2015 indicated 8 shifts did not document any behaviors and/or lack of behavior. Two behaviors were documented.</p>			

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	<p>d. The month of August 2015 (8/1/15 through 8/5/15) indicated 2 shifts did not document any behaviors and/or lack of behavior. One behavior was documented on 8/4/15. No cause of the behavior was identified on the form or in the progress notes.</p> <p>2. "BEHAVIOR #2: Throwing food..."</p> <p>a. The month of May 2015 indicated 10 shifts did not document any behavior and/or lack of behavior. The dates with documentation indicated no behaviors occurred.</p> <p>b. The month of June 2015 indicated 13 shifts did not document any behaviors and/or lack of behavior. The dates with documentation indicated no behaviors occurred.</p> <p>c. The month of July 2015 indicated 9 shifts did not document any behaviors and/or lack of behavior. The dates with documentation indicated no behaviors occurred.</p> <p>d. The month of August 2015 (8/1/15 through 8/5/15) indicated 2 shifts did not document any behaviors and/or lack of behavior. The dates with documentation indicated no behaviors occurred.</p>			

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	<p>3. "BEHAVIOR #3: Agitation, Combative..."</p> <p>a. The month of May 2015 indicated 20 shifts did not document any behavior and/or lack of behavior. Three behaviors were documented. They were on 5/16/15 and two on 5/27/15. No causes of the behaviors on 5/16/15 and 5/27/15 were identified on the form or the progress notes.</p> <p>b. The month of June 2015 indicated 19 shifts did not document any behaviors and/or lack of behavior. The dates with documentation indicated no behaviors occurred.</p> <p>c. The month of July 2015 indicated 14 shifts did not document any behaviors and/or lack of behavior. One behavior was documented related to ADL (Activities of Daily Living) care on 7/12/15.</p> <p>d. The month of August 2015 (8/1/15 through 8/5/15) indicated 2 shifts did not document any behaviors and/or lack of behavior. One behavior was documented on 8/4/15. No cause of the behavior was identified on the form or in the progress notes.</p> <p>2. The clinical record for Resident #18</p>			

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	<p>was reviewed on 8/6/15 at 8:53 a.m. Diagnoses for the resident included but were not limited to, senile dementia, symbolic dysfunction, dementia with psychosis and hallucination, delusions and depressive disorder.</p> <p>Review of the current physician orders indicated Resident #18 received the following medications:</p> <p>a. Quetiapine (an antipsychotic medication) 25 milligrams by mouth at bedtime for diagnosis of BPSD [behavioral and psychotic symptoms of dementia] (psychosis).</p> <p>b. Venlafaxine (an antidepressant medication) 225 milligrams by mouth every morning for diagnosis of depression.</p> <p>The annual Minimum Data Set (MDS) assessment, dated 5/19/15, indicated Resident #18 had moderate cognitive impairment.</p> <p>The health care assessment, dated 7/29/15, included but were not limited to the following problems:</p> <p>2a. "...uses psychotropic medications r/t [related to] Behavior management....", last revised on 3/25/15, indicated</p>			

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	<p>Resident #14 had a problem with behavior issues exhibited by the following: "...DELUSIONS AND HALLUCINATIONS, FABRICATIONS..." Interventions for the problems included but were not limited to, "...OBSERVE/CHART AS INDICATED ALL HALLUCINATIONS AND DELUSIONS...OBSERVE/record occurrence of for target behavior symptoms...and document per facility protocol." No interventions had been added to meet the needs of the resident or prevent the behaviors.</p> <p>2b. "...has demonstrate[d] behaviors...", last revised on 9/17/14, indicated Resident #14 had a problem with behaviors exhibited by the following: "...she fabricates stories." Interventions for the problems included but were not limited to, "...Attempt to analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document...Observe and Document any observed behavior and attempted interventions...." No updating of the interventions had been added.</p> <p>A review of progress notes for Resident #18 indicated the following:</p> <p>"...7/18/2015 13:19 [1:19 p.m.]...Behavior...Description of</p>			

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	<p>behavior(s) exhibited: Res [Resident] stated to staff that she has c/o [complained of] right leg pain and was not given med. [medication] given today @ 5:45 a.m. and 11:15 a.m. No other complaints were reported. Also stated that she was having stomach discomfort and we did nothing. No c/o stomach pain was reported...Physical/Emotional Assessment: Res [Resident] fabricates things...Interventions...Tyl [Tylenol] was given promptly...." No cause of the behavior was identified.</p> <p>"...6/11/2015 06:12 [6:12 a.m.]...Behavior...Description of behavior(s) exhibited: Res [Resident] stted [stated] she had asked for Tylenol hrs [hours] earlier and did not received [receive] it. This did not occur... Physical/Emotional Assessment: Argumentative...Interventions...1:1 and redirected, Tylenol given now. First time she had asked for it...." No cause of the behavior was identified.</p> <p>The "BEHAVIOR/INTERVENTION MONTHLY FLOW RECORD", provided by Medical Records on 8/6/15 at 9:00 a.m., indicated the following:</p> <p>1. " BEHAVIOR #1: Hallucinations..."</p> <p>a. The month of May 2015 indicated 11</p>			

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	<p>shifts did not document any behavior and/or lack of behavior. The dates with documentation indicated no behaviors occurred.</p> <p>b. The month of June 2015 indicated 11 shifts did not document any behaviors and/or lack of behavior. There was one behavior documented. It was on 6/1/15. No cause of the behavior was identified on the form or in the progress notes.</p> <p>c. The month of July 2015 indicated 7 shifts did not document any behaviors and/or lack of behavior. There were no behaviors documented.</p> <p>2. "BEHAVIOR #2: Fabricates..."</p> <p>a. The month of May 2015 indicated 11 shifts did not document any behavior and/or lack of behavior. The dates with documentation indicated no behaviors occurred.</p> <p>b. The month of June 2015 indicated 10 shifts did not document any behaviors and/or lack of behavior. Four behaviors were documented on 6/1/15, 6/5/15, 6/11/15 and 6/15/15. No cause of the behaviors were identified on the form or in the progress notes.</p> <p>c. The month of July 2015 indicated 8</p>			

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	<p>shifts did not document any behaviors and/or lack of behavior. One behavior was documented on 7/12/15.</p> <p>3. The clinical record for Resident #33 was reviewed on 8/6/15 at 11:59 a.m. Diagnoses for the resident included but were not limited to, Dementia with behavior disturbances, anxiety, and depressive disorder.</p> <p>Review of the current physician orders indicated Resident #33 received the following medications:</p> <p>a. Divalproex (a mood stabilizer medication) 125 milligrams by mouth every morning and 250 milligrams by mouth every evening for diagnosis of dementia with behaviors.</p> <p>b. Seroquel (an antipsychotic medication) 25 milligrams by mouth at bedtime for diagnosis of anxiety, agitation, hallucinations and delusions.</p> <p>c. Trazodone (an antidepressant medication) 50 milligrams by mouth at bedtime for sleep.</p> <p>d. Venlafaxine ER (extended release) (an antidepressant medication) 150 milligrams by mouth every morning for diagnosis of depression.</p>			

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	<p>e. Klonopin (an anti-anxiety medication) 0.5 milligrams by mouth four times a day for diagnosis of anxiety and 0.5 milligrams every four hours as needed for increased anxiety.</p> <p>The significant change Minimum Data Set (MDS) assessment, dated 5/19/15, indicated Resident #33 had severe cognitive impairment.</p> <p>The health care assessment, dated 7/29/15, included but were not limited to the following problems:</p> <p>3a. "...Uses antidepressant medications r/t [related to] depression...", last revised on 8/4/15, indicated Resident #33 had a problem with depression. Interventions for the problem included but were not limited to, "...OBSERVE/document s/sx (signs and symptoms) unaltered by antidepressant meds: sad, irritable, anger, ...crying, ...neg. (negative) mood or comments, ...agitation, disrupted sleep, fatigue, ...unrealistic fears, ...anxiety, ...constant reassurance...."</p> <p>3b. "...uses anti-anxiety medications r/t (related to) ANXIETY....", last revised on 4/15/15, indicated Resident #33 had a problem with anxiety. Interventions for the problems included but were not</p>			

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	<p>limited to, "...OBSERVE/record occurrence of the target behavior symptoms ...and document per facility protocol...."</p> <p>"...5/1/2015 10:10 [a.m.]...Nurses Note...INFORMED THAT RESIDENT RECENTLY HAD DECREASE IN CLONAZEPAM TO BID [twice a day], SHE IS SAD CRING [CRYING], UP AND DOWN ALL DAY AND NIGHT, CALLING FAMILY UPSET WITH FAMILY AND STAFF, AT TIMES AGITATED REQUESTED INCREASE OF CLONAZEPAM TO TID...." No cause of the behavior identified.</p> <p>"...7/27/2015 12:00 [p.m.]...Nurses Note...RESIDENT GIVEN PRN [AS NEEDED] KLONOPIN 0.5 MG [milligrams] FOR INCREASED ANXIETY, ATTEMPTED 1:1, FOOD, LIQUIDS, UNABLE TO REDIRECT...." No description of behavior or cause identified related to this timeframe.</p> <p>"...8/4/2015 14:04 [2:04 p.m.]...Nurses Note...RES [Resident] VOICING TO DON [DIRECTOR OF NURSING] THAT SHE IS SO NERVOUS AND ANXIOUS. STAFF 1:1 WITH RES, [RESIDENT] LEG RUB, TOILETING OFFERED FOOD AND FLUIDS. RES [RESIDENT] REMAINS ANXIOUS</p>			

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	<p>MED [MEDICATION] WITH PRN [AS NEEDED] KLONOPIN [AN ANTIANXIETY MEDICATION]...." No cause of behavior identified.</p> <p>The "BEHAVIOR/INTERVENTION MONTHLY FLOW RECORD", provided by Social Service Director on 8/6/15 at 10:06 a.m., indicated the following:</p> <p>1. " BEHAVIOR #1: Agitation, verbal aggression ... "</p> <p>a. The month of May 2015 indicated 11 shifts did not document any behavior and/or lack of behavior. There were 13 behaviors documented. They were on 5/1/15, 5/3/15, 5/11/15, 5/12/15, 5/13/15, 5/14/15, 5/16/15, 5/20/15 (2 behaviors), 5/21/15, 5/25/15, 5/27/15 and 5/28/15. No specific times or causes of the behaviors on 5/1, 5/11, 5/12, 5/13, 5/16, 5/20, 5/21, 5/25, and 5/27 were identified on the form or in the progress notes.</p> <p>b. The month of June 2015 indicated 11 shifts did not document any behaviors and/or lack of behavior. There was one behavior documented on 6/7/15. No cause of the behavior was identified on the form or in the progress notes.</p> <p>c. The month of July 2015 indicated 8</p>			

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	<p>shifts did not document any behaviors and/or lack of behavior. There was seven behaviors documented. They had occurred on 7/14/15, 7/23/15, 7/27/15, 7/28/15, 7/29/15, 7/30/15 and 7/31/15. No specific time or cause of the behaviors had been identified on the form or in the progress notes.</p> <p>2. "BEHAVIOR #2: Fabrication...."</p> <p>a. The month of May 2015 indicated 10 shifts did not document any behavior and/or lack of behavior. There were 5 behaviors documented. They were on 5/1/15, 5/2/15, 5/11/15, 5/21/15 and 5/25/15. No specific time or cause of the behaviors had been identified on the form or in the progress notes.</p> <p>b. The month of June 2015 indicated 11 shifts did not document any behaviors and/or lack of behavior. There were two behaviors documented. They were on 6/17/15 and 6/22/15. No specific time or cause of the behaviors had been identified on the form or in the progress notes.</p> <p>c. The month of July 2015 indicated 10 shifts did not document any behaviors and/or lack of behavior. The dates with documentation indicated no behaviors occurred.</p>			

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	<p>3. "BEHAVIOR #3: Restlessness...."</p> <p>a. The month of August 2015 (8/1/15 through 8/5/15) indicated 7 shifts did not document any behaviors and/or lack of behavior. There were three behaviors documented. They were on 8/3/15 and 8/4/15 (2 behaviors). No specific time or cause of the behaviors were identified on the form or in the progress notes.</p> <p>During an interview with the Hospice Nurse on 8/7/15 at 11:51 a.m., she indicated Resident #33 was on Seroquel (a antipsychotic medication) for anxiety, agitation, and hallucinations. The Hospice Nurse indicated Resident #33 told the nurse she had seen a man with a red hat walk past her room that had been in a car accident multiple times. The Hospice Nurse also indicated the resident was very paranoid, shaking and hiding behind the curtain. There were no "Behavior/Intervention Monthly Flow Record" related to the behaviors of hallucinations and paranoid documented.</p> <p>A "Visit Note Report", dated 7/3/15, provided by the Hospice Nurse on 8/7/15 at 11:51 a.m., indicated the following:</p> <p>"...Earlier in the week during visit PT [patient] observed having illusions</p>			
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	<p>stating 'I closed my door because I was afraid someone would come in here and choke me.' Pt [Patient] reassured and comforted. Pt [patient] observed asking about a man with a red hat that was in a car accident..."</p> <p>During an interview with the MDS Coordinator on 8/7/15 at 11:27 a.m., she indicated there was no "Behavior/Intervention Monthly Flow Record for the month of April 2015 for Resident #33.</p> <p>During an interview with the Administrator (ADM) and the Director of Nursing on 8/7/15 at 2:02 p.m., the ADM indicated she was aware of the lack of behavior monitoring documentation for residents on psychoactive medications.</p> <p>No further information was provided at exit on 8/7/15 at 3:10 p.m.</p> <p>4. Review of Resident #13's clinical record began on 8/4/15 at 9:12 a.m. Diagnoses included, but were not limited to, anxiety, dementia, and Alzheimer's dementia without behavioral disturbance. Resident #13's current physician's orders indicated the resident was prescribed the following psychotropic medications: citalopram 20 mg (an antidepressant) for</p>			

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	<p>depression and haloperidol 0.5 mg (an antipsychotic) daily at 5 p.m. for anxiety. Resident #13 had a current, 6/15/15 Minimum Data Set (MDS) assessment, which indicated the resident had severe cognitive impairment.</p> <p>A physician's exam note, performed on 6/4/15, indicated Resident #13 had a diagnosis of Alzheimer's dementia without behavioral disturbance and the resident was pleasantly confused and in no distress.</p> <p>A "Nurses Note", dated 6/25/15, indicated Resident #13 became upset regarding wanting to go home and being held against her will.</p> <p>A "Nurses Note", dated 6/30/25 at 3:51 p.m., indicated Resident #13's Nurse Practitioner was notified regarding, "Resident is having increased behaviors".</p> <p>The clinical record indicated an order was received for Haldol (haloperidol) 0.5 mg every 12 hours as needed for anxiety.</p> <p>A "Social Service Note", dated 6/30/15 at 4:34 p.m., indicated Resident #13 was "very upset and agitated with roommate" and was experiencing back pain.</p> <p>There were no other notes regarding Resident #13's behavior between 6/25/15</p>			

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	<p>and 6/30/15.</p> <p>Resident #13's Medication Administration Records (MAR), for the months of June and July 2015, indicated the resident received one dose of haloperidol 0.5 mg as needed for anxiety on 6/30/15, 7/1/15, 7/2/15, and 7/4/15.</p> <p>A "Nurses Note", dated 7/8/15, indicated an order was received from the Nurse Practitioner to increase the haloperidol to be given routinely at 5 p.m. with no documentation of behaviors or any non-pharmacological interventions having been tried.</p> <p>A form titled, "Behavioral Health Evaluation", dated 7/24/15, provided on 8/6/15 at 9 a.m. by the Medical Records nurse, indicated "7/8 Daughters wants [sic] her to be more under control-'She is verbally mean to them states she is going to run away'."</p> <p>Resident #13's MAR indicated the resident had been receiving haloperidol 0.5 mg daily at 5 p.m. since 7/8/15.</p> <p>Review of the "Behavior/Intervention Monthly Flow Record", provided by the Medical Records nurse, on 8/6/15 at 9 a.m., indicated the following:</p> <ol style="list-style-type: none"> <li>1. Behavior #1: "...agitation/verbal</li> </ol>			

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	<p>aggression [sic] ...."</p> <p>a. The month of July 2015 indicated 6 shifts did not document any behavior/lack of behavior. The record indicated no behaviors occurred on 7/4/15, when a dose of haloperidol was administered to the resident. Resident #13 had a current careplan, dated 7/2/15, for use of psychotropic medication, which indicated "...observe/record occurrence of for target behavior symptoms...and document per facility protocol...."</p> <p>During an interview, on 8/7/15 at 2:11 p.m., the Administrator indicated there should have been a proper indication for use prior to an antipsychotic medication being started and given routinely.</p> <p>5. Review of Resident #27's clinical record began on 8/3/15 at 2:28 p.m. Diagnosis included, but was not limited to, dementia with behaviors. Resident #27's current physician orders indicated the resident was prescribed the following psychotropic medications: divalproex 125 mg (a mood stabilizer) 2 capsules at bedtime for agitation related to dementia with behavioral disturbance, duloxetine 60 mg (an antidepressant) at</p>			

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	<p>bedtime, trazadone 50 mg (an antidepressant) at bedtime for insomnia, and Seroquel 50 mg (an antipsychotic) daily.</p> <p>Resident #27 had a current, 5/26/15, quarterly Minimum Data Set assessment, which indicated the resident had severe cognitive impairment.</p> <p>A review of progress notes titled "Behavior", dated 5/2/15 through 7/30/15, indicated Resident #27's behaviors included the following:</p> <ol style="list-style-type: none"> <li>1. The resident attempting to get out of bed or chair on 6 occasions in May 2015, 6 occasions in June 2015, and 3 occasions in July 2015.               <ol style="list-style-type: none"> <li>a. The documented causes of the behavior included, "...wants to get out of here..., alzheimers [sic]..., ...dementia..., ...looking for car..., and ...unknown...."</li> </ol> </li> <li>2. The resident being resistive to personal care on 6/3/15 and 6/19/15.               <ol style="list-style-type: none"> <li>a. The documented causes of the behavior were, "...Resident continues to be confused related to dementia Dx... and...getting resident in w/c [wheelchair]...."</li> </ol> </li> </ol> <p>Review of the "Behavior/Intervention Monthly Flow Record", provided by the</p>			

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	<p>Medical Records nurse, on 8/6/15 at 9 a.m., indicated the following:</p> <p>1. "...Behavior #1...Resist Care Spits hits ...."</p> <p>a. The month of May 2015 indicated 10 shifts did not document any behavior/lack of behavior.</p> <p>b. The month of June 2015 indicated 12 shifts did not document any behavior/lack of behavior.</p> <p>c. The month of July 2015 indicated 8 shifts did not document any behavior/lack of behavior.</p> <p>2. "...Behavior 2...Screams Curses.... "</p> <p>a. The month of May 2015 indicated 11 shifts did not document any behavior/lack of behavior.</p> <p>b. The month of June 2015 indicated 11 shifts did not document any behavior/lack of behavior.</p> <p>c. The month of July 2015 indicated 9 shifts did not document any behavior/lack of behavior.</p> <p>3. "...Behavior 3...Restlessness ...."</p> <p>a. The month of June 2015 indicated monitoring of this behavior began on the evening shift of 6/29/15; 2 shifts did not document any behavior/lack of behavior.</p> <p>b. The month of July 2015 had an arrow</p>			

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F 0329 SS=D Bldg. 00	<p>marked through the dates from 7/1/15 to 7/17/15. There was no documentation showing any behavior/lack of behavior for 13 shifts from 7/17/15 through 7/31/15.</p> <p>Resident #27 had a current careplan, dated 5/27/15, for use of psychotropic medication, which indicated "...OBSERVE/record occurrence for target behavior symptoms...and document per facility protocol ...."</p> <p>3.1-37(a)</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</p>			

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	<p>documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure residents who received psychopharmacological medications had identified and behavioral indicators for use, gradual dose reductions or a statement of contraindication for 3 of 5 residents reviewed for unnecessary medications. (Residents #14, #13, #27).</p> <p>Findings include:</p> <p>1. The clinical record for Resident #14 was reviewed on 8/6/15 at 9:55 a.m. Diagnoses for the resident included but were not limited to, Dementia with behavior disturbances, anxiety, restlessness, hypertension, and depression.</p> <p>The resident was currently receiving the following medication, divalproex ( a mood stabilizer medication) 125 milligrams by mouth daily for diagnosis of dementia with behaviors with a start date of 7/24/14.</p> <p>The quarterly Minimum Data Set (MDS) assessment, dated 3/17/15, indicated</p>	F 0329	<p>RESIDENT # 14 The physician reviewed Resident # 14's psychoactive medications on 8/13/15 Resident # 14's Seroquel was reduced at that time and a statement of contraindication was completed on Resident # 14's divalproex. RESIDENT # 13 The physician discontinued Resident # 13's Haldol on 8/13/15.</p> <p>RESIDENT # 27 Respectfully request Resident # 27 be removed from this citation. I feel was a miscommunication in interview with Administrator because Resident #27 does have a diagnoses to support the use of psychotropic medications. Review of Resident # 27's signed recapitulation of orders dated 7/2/15 reveal Resident # 27 has diagnoses of dementia with behaviors. Review of Resident # 27's Progress Note from visit on 7/2/15 (printed on 7/16/15) indicated Resident # 27 had Alzheimer's dementia with behavioral disturbance. In the 2567 surveyor noted Resident # 27 had a diagnosis of dementia with behaviors. Physician did review Resident # 27's current medications and diagnoses and deem them current. An audit was completed on all residents who received psychoactive</p>	09/06/2015

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	<p>Resident #14 had severe cognitive impairment.</p> <p>The "BEHAVIOR/INTERVENTION MONTHLY FLOW RECORD", provided by Administrator on 8/6/15 at 11:28 a.m., indicated the following:</p> <p>The behaviors being monitored included the following:</p> <p>1. " BEHAVIOR #1: anxiety, disruptive noises/sounds, cursing...."</p> <p>August 2015 - 1 behavior July 2015 - 2 behaviors June 2015 - 0 behaviors May 2015 - 0 behaviors</p> <p>2. "BEHAVIOR #2: Throwing food...."</p> <p>May 2015 through August 2015 - 0 behaviors</p> <p>3. "BEHAVIOR #3: Agitation, Combative...."</p> <p>August 2015 - 1 behaviors July 2015 - 1 behavior June 2015 - 1 behavior May 2015 - 3 behaviors</p> <p>During an interview with the Administrator on 8/6/15 at 3:44 p.m., she</p>		<p>medications to ensure each resident had a gradual dose reduction (GDR) or a statement of contraindicated for each of their psychoactive medications. Additionally each resident on a psychoactive mediation will have their medication regime reviewed by the behavior management team including the pharmacist on a monthly basis to determine appropriateness of psychoactive mediation and need for a GDR or statement of contraindication. At each monthly behavior management meeting the team will review each residents Behavioral/Intervention Monthly Flow Record.</p> <p>This review of all residents on a psychoactive medications will continue on an ongoing basis. At the quarterly QA meetings the pharmacist will present information regarding all residents on psychoactive mediations as part of the QA team meeting. The physician will address any recommendations at that time. Nursing in-service on 8/18 &amp; 8/19 to review the state survey citations and review importance acceptable indication for use, documentation, and GDR's for residents on psychoactive medications. POC Date: 9/6/15</p>	

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	<p>indicated no gradual dose reduction or statement of contraindication for the medication of divalproex had been completed.</p> <p>A policy titled "GDR FOR PSYCHOTROPIC MEDICATIONS" was provided by the Administrator on 8/6/5 at 9:25 a.m. and indicated the following:</p> <p>"...Any other medication given to address mood or behavioral symptoms will also be evaluated for reduction twice the first year, with attempts being made in two separate quarters, with one month in between attempts and then annually there after, or a MD (medical doctor) contraindication statement..."</p> <p>No statement of contraindication which included a risk benefit analysis or further documentation was provided by the facility at the time of exit on 8/7/15 at 3:10 p.m.</p> <p>2. Review of Resident #13's clinical record began on 8/4/15 at 9:12 a.m. Diagnoses included, but were not limited to, anxiety, dementia, and Alzheimer's dementia without behavioral disturbance. Resident #13's current physician's orders indicated the resident was prescribed the following psychotropic medications:</p>			

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	<p>citalopram 20 mg (an antidepressant) for depression and haloperidol 0.5 mg (an antipsychotic) daily at 5 p.m. for anxiety.</p> <p>Resident #13 had a current, 6/15/15, Minimum Data Set (MDS) assessment, which indicated the resident had severe cognitive impairment.</p> <p>A physician's exam note, performed on 6/4/15, indicated Resident #13 had a diagnosis of Alzheimer's dementia without behavioral disturbance and the resident was pleasantly confused and in no distress.</p> <p>A "Social Service Note", dated 6/18/15 at 11:43 a.m., indicated a care plan meeting had been held and there were no behaviors noted for this resident.</p> <p>A "Nurses Note", dated 6/25/15, indicated Resident #13 became upset regarding wanting to go home and being held against her will.</p> <p>A "Nurses Note", dated 6/30/15 at 3:51 p.m., indicated Resident #13's Nurse Practitioner was notified regarding, "Resident is having increased behaviors".</p> <p>The clinical record indicated an order was received for Haldol (haloperidol) 0.5 mg every 12 hours as needed for anxiety and was administered to the resident at</p>			

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	<p>that time. No specific behaviors or non-pharmacological interventions had been documented.</p> <p>A "Social Service Note", dated 6/30/15 at 4:34 p.m., indicated Resident #13 was "very upset and agitated with roommate" and was experiencing back pain.</p> <p>There was no other documentation of Resident #13 exhibiting behaviors between 6/25/15 and 6/30/15.</p> <p>Resident #13's Medication Administration Records (MAR) for the months of June and July 2015 indicated the resident received one dose of haloperidol 0.5 mg as needed for anxiety on the following dates: 6/30/15, 7/1/15, 7/2/15, and 7/4/15. No behaviors or other interventions having been tried had been documented.</p> <p>A "Nurses Note", dated 7/8/15, indicated an order was received from the Nurse Practitioner to increase the haloperidol to be given routinely at 5 p.m. at the request of the family for "...aggressive/anxiety they see when they visit every eve. [ning]...."</p> <p>A form titled, "Behavioral Health Evaluation", dated 7/24/15, provided on 8/6/15 at 9 a.m. by the Medical Records</p>			

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F 9999  Bldg. 00	<p>nurse, indicated the following: "7/8 Daughters wants [sic] her to be more under control-'She is verbally mean to them states she is going to run away!'" Resident #13's MAR indicated the resident had been receiving haloperidol 0.5 mg daily at 5 p.m. since 7/8/15. During an interview, on 8/7/15 at 2:11 p.m., the Administrator indicated there should have been a proper indication for use prior to an antipsychotic medication being started and given routinely. 3.1-48(a)(4)</p> <p>3.1-14 PERSONNEL (s) Professional staff must be licensed, certified, or registered in accordance with applicable state laws or rules. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure direct care staff had current certification for 1 of 36 employees reviewed for certification or licensure. Findings include: Review of employee records began on</p>	F 9999	The Indiana Professional licensing Agency was contacted immediately when the survey team identified CNA # 1's certification was expired. The CNA was removed from duty immediately until situation was resolved. On 8/7/15, the CNA was current on the registry, and a copy of her current status was provided to the surveyors at that time. An audit of all licenses and certifications was completed by the administrator. An additional back-up tracking system was implemented by the administrator. Administrator/designee will audit license and certificate book on a	09/06/2015

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	<p>8/6/15 at 11:09 a.m.</p> <p>Employee #1's Indiana nursing assistant certification had expired on 11/16/2014.</p> <p>Review of Employee #1's timecard, provided by the Administrator on 8/7/15 at 10:43 a.m., indicated Employee #1 had worked in the facility as a nursing assistant on the following dates during the survey: 8/3/15 for 8.5 hours, 8/4/15 for 8 hours, 8/5/15 for 8 hours, and on 8/6/15 for 8 hours.</p> <p>The timecard also indicated Employee #1 had worked in the facility 5 days a week since 11/16/14 with the exception of 15 days that were annotated as Paid Days Off.</p> <p>During an interview, on 8/6/15 at 2:18 p.m., the Administrator indicated Employee #1 had been employed with the facility, providing direct resident care, without current certification from 11/17/15 through 8/6/15.</p> <p>3.1-14(s)</p>		<p>monthly basis to ensure all are current. Audits will continue on an ongoing basis. POC Date: 9/6/15</p>	