

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155655	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2014
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NAME OF PROVIDER OR SUPPLIER PEABODY RETIREMENT COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 400 W SEVENTH ST NORTH MANCHESTER, IN 46962
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: December 9, 10, 11, 15, 16, and 17, 2014</p> <p>Facility number: 000485 Provider number: 155655 AIM number: 100291190</p> <p>Survey team: Shelley Reed, RN-TC Karen Lewis, RN (12/10, 12/11, 2014) Ginger McNamee, RN (12/15, 12/16, 12/17, 2014) Jason Mench, RN Angela Selleck, RN (12/9, 12/10, 12/11, 12/15, 2014) Tina Smith-Staats, RN (12/10, 12/11, 12/15, 12/16, 12/17, 2014)</p> <p>Census bed type: SNF/NF: 168 Residential: 113 Total: 281</p> <p>Census payor type: Medicare: 22 Medicaid: 118 Other: 141 Total: 281</p>	F000000		

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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F000250 SS=E	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by Debora Barth, RN.</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, record review and interview, the facility failed to ensure residents had a monitoring and management program with specific target behaviors and interventions in place for 5 of 5 residents receiving psychoactive medications. (Resident #'s 127, 1, 109, 131, 176)</p> <p>Findings include:</p> <p>1. An observation of Resident #127 was made on 12/16/2014 at 10:45:06 a.m., the resident was calm and involved in the music activity.</p> <p>Resident was observed feeding himself lunch at 12/16/2014 at 12:20 p.m.</p> <p>Resident #127's clinical record was reviewed on 12/16/14 at 8:41 a.m. The</p>	F000250	<ul style="list-style-type: none"> · Resident # 127, 1, 109, 131 and 176 Behavior management programs reviewed and updated with specific targets, behaviors and interventions, completed on 12/30/14 · All resident's have the potential to be effected by the alleged deficient practice. All resident's receiving a psychoactive medication behavior management programs reviewed and updated with specific target behaviors and interventions, effective by 1/16/15 · All Health care staff educated on updated policy and procedure for behavior tracking/monitoring/interventions, education completed by 1/16/15 · Behavior 	01/16/2015

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	<p>resident's diagnoses included, but were not limited to, dementia, depression, and anxiety.</p> <p>The resident had 12/10/14, signed physician's orders. The resident's orders included, but were not limited to, mirtazapine [an anti-depressant] 45 mg one tablet orally at bedtime; sertraline hcl [an anti-depressant] 25 mg one tablet orally at bedtime; and risperidone [an anti-psychotic] 0.25 mg one table orally at bed time for dementia with depression.</p> <p>Resident #127 had "Side Effects" monitoring sheets for risperidone, mirtazapine, and sertraline hcl. The monitoring sheets indicated the following:</p> <p>Section I: Specific Behaviors were to be identified if a resident was on a psychopharmacological (psychoactive) drug for a diagnosis of organic mental syndrome including dementia. Behaviors were to be documented per shift with the number of episodes and initialed. The section had a box to record the total number of behaviors each month.</p> <p>Section II: Side Effects area was for identifying and monitoring non-movement and movement side effects for anti-psychotics as well as side</p>		<p>tracking/intervention book will be audited by SSD/Designee daily on regular business days x 30days, weekly x 3 month and monthly for six months and ongoing thereafter until 100% threshold is achieved. The QAPI committee chaired by the Administrator will oversee compliance with the Director of Social Service having responsibility reporting.</p>		

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	<p>effects for all psychoactive drugs. The form indicated the presence of side effects were to be marked with an "X" and initialed.</p> <p>The "Side Effects" monitoring sheets for risperidone for October, November and December, 2014, were blank for Section I, with no specific identifying behaviors. The Section II: Side Effects section indicated the resident was monitored for constipation, motor restlessness, and increased agitation. There were no boxes marked with an "X".</p> <p>The "Side Effects" monitoring sheets for sertraline hcl for October, November, and December, 2014, indicated the Specific Behaviors to monitor for were refusing care and withdrawn. The Side Effects being monitored were headache and nausea. There were no boxes marked with an "X".</p> <p>The "Side Effects" monitoring sheets for mirtazapine for October, November, and December, 2014, indicated the Specific Behavior to monitor was a decreased appetite. The Side Effects being monitored were headache and falls. There were no boxes marked with an "X".</p> <p>A 11/12/14, 8:03 p.m., Nurse's Note</p>						

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	<p>indicated the resident refused his bedtime medications. The note indicated the resident stated he did not want his medications and shook his head no. The note indicated the resident was not agitated. The resident was reapproached at a later time and continued to refuse the medication.</p> <p>"Mood and Behavior Observation Forms" for Resident #127 were provided by and reviewed with the Social Service Designee #6 on 12/17/14 at 9:45 a.m. She indicated she had kept the forms in her office and reviewed them with the doctor when he came in on 12/10/14. She indicated she had not documented the behaviors in the resident's record. The forms indicated the following:</p> <p>10/22/14 at 7:00 a.m., the resident refused to shower and allow wet clothes to be changed. The form did not indicate any interventions were attempted.</p> <p>10/29/14 at 9:00 a.m., the resident refused care, refused breakfast, and refused to change his clothes. The form did not indicate any interventions were attempted.</p> <p>10/29/14 at 3:00 p.m., the resident refused to go to the toilet and to change his soiled clothes. The form did not</p>			

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	<p>indicate any interventions were attempted.</p> <p>11/12/14 at 8:30 p.m., the resident refused care. The form indicated interventions were unsuccessful.</p> <p>The resident had a 8/18/14, care plan problem of receiving an antidepressant drug on a regular basis and has a poor appetite. Intervention for this problem included, but were not limited to, "monitor for side effects of the medication. The side effects were constipation, dry mouth, anxiety, agitation, headache, and falls. Record behavior on Behavior Tracking Record. Observe for changes in mood/behavior, sleep patterns, fatigue, appetite, ability to concentrate, participation in activities, and crying."</p> <p>The resident had a 8/18/14, care plan problem of the use of antipsychotic medications, he refuses care/toileting and has a history of being combative. The goal indicated he would have decreased psychotic symptoms as evidenced by a reduction in physiological, emotional, and/or cognitive manifestation of psychosis, delusions or hallucinations and would accept care from staff. Interventions included, but were not limited to, "monitor for and document</p>				

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	<p>suspected side effects of antipsychotic medication and observation and document delusions, hallucinations, or any mood/behavioral disturbances."</p> <p>During an interview with LPN #5 on 12/16/14 at 11:05 a.m., she indicated nurses were suppose to fill out the boxes on the "Side Effects" monitoring tool every shift but they didn't always do that.</p> <p>During an interview with Social Service Designee #6 on 12/17/2014 at 10:23 a.m., she provided a 10/16/13, Physician Note that indicated the risperidone was used to treat dementia with agitation. She indicated the resident's wife wanted him to have the medication.</p> <p>2. The clinical record of Resident #131 was reviewed on 12/15/14 at 10:57 a.m. Diagnoses included, but were not limited to, senile dementia with delusions, congestive heart failure, depression, insomnia and constipation.</p> <p>During an observation on 12/9/14 at 2:35 p.m., Resident #131 was noted to be in his room. He was talking nonsensical to himself. He was observed again on 12/16/14 at 9:38 a.m. asleep in bed.</p> <p>Resident #131's Health Care Plan, dated 7/24/14, indicated he required the use of an anti-psychotic medication. The goal</p>						

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	<p>was for the resident to have decreased psychotic symptoms as evidenced by a reduction in physiological, emotional, and/or cognitive manifestation of psychosis, delusions or hallucinations through the next 90 days. Interventions included, but were not limited to, "administer medications as ordered and monitor for side effects, ongoing observation and documentation for delusions, hallucinations, or any mood/behavior disturbances and assist to reduce present level of anxiety by providing reassurance and comfort."</p> <p>Review of the current Physician Order's indicated Resident #131 received Risperdone (anti-psychotic medication) 0.5 mg at night for dementia with delusions and trazadone (anti-depressant medication) 1/2 of a 50 mg tablet as needed for insomnia.</p> <p>The October Monthly Flow Record for Side Effects monitoring indicated Risperdone was being monitored for the following side effects: "constipation, tremors, and increased agitation." No specific behavior was identified related to the use of Risperdone. 13 of 31 shifts were missing documentation related to potential side effects.</p> <p>The October Monthly Flow Record for</p>			

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	<p>Side Effects monitoring indicated trazadone was being monitored for the following side effects: "sedation/drowsiness, increased falls/dizziness, dry mouth and nausea." No specific behavior was identified related to the use of trazadone. 13 of 31 shifts were missing documentation related to potential side effects.</p> <p>The September Monthly Flow Record for Side Effects monitoring indicated Risperdone was being monitored for the following side effects: "upper respiratory infection, constipation, increased falls and increased agitation." Refusing care was the behavior identified related to the use of Risperdone. 18 of 31 shifts were missing documentation related to potential side effects.</p> <p>The September Monthly Flow Record for Side Effects monitoring indicated trazadone was being monitored for the following side effects: "skin rash, dry mouth, blurred vision, constipation, sedation and increased falls." Insomnia was the behavior identified related to the use of trazadone. 21 of 31 shifts were missing documentation related to potential side effects.</p> <p>Review of the Mood and Behavior Observation Form, provided by Social</p>				

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	<p>Service Designee (SSD) #6, indicated Resident #131 had 1 behavior in the past 3 months. Resident #131 refused a shower on 10/13/14. No non-pharmacological interventions were attempted.</p> <p>3. The clinical record of Resident #176 was reviewed on 12/15/14 at 1:42 p.m. Diagnoses included, but were not limited to, dementia with behavioral disturbances, anxiety, Alzheimer's disease with delusions and chest pain.</p> <p>During an observation on 12/16/14 at 9:17 a.m., Resident #171 was asleep in bed.</p> <p>Review of the current Physician Order's indicated Resident #176 received Zyprexa (anti-psychotic medication) 10 mg at night.</p> <p>The December Monthly Flow Record for Side Effects monitoring indicated Zyprexa was being monitored for the following side effects: "darkening of urine and suicidal behaviors." The specific behavior being monitored was "crying." 6 of 14 days were missing documentation related to potential side effects.</p> <p>Review of the Mood and Behavior</p>						

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	<p>Observation Form, provided by Social Service Designee (SSD) #6, indicated Resident #176 had 4 behaviors in the past 3 months. Resident #176 refused a shower on 11/4/14. No identified interventions were attempted.</p> <p>During an interview on 12/17/14 at 10:22 a.m., SSD #6 indicated it was hard to track behaviors without all the documentation, but relied more on the behavior sheets.</p> <p>During an interview on 12/17/14 at 1:01 p.m., SSD #6 was asked to provide specific identified behaviors being tracked and current interventions in place to decrease the behaviors.</p> <p>During an interview on 12/17/14 at 3:11 p.m., SSD #6 indicated she could not provide specific target behaviors and interventions for Resident #131, #176 and #127.</p> <p>4. Resident #1's clinical record was reviewed on 12/15/14 at 9:13 a.m. Resident #1 had current diagnoses which included, but were not limited to, dementia with delusions, diabetes, peripheral neuropathy and anxiety.</p> <p>Resident #1's medication orders included chlorpromazine (anti-psychotic medication) for dementia with delusions</p>			

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	<p>and lorazepam (anti-anxiety medication) for anxiety.</p> <p>Resident #1's clinical record provided care plans for the diagnosis of dementia with delusions and was prescribed an antipsychotic medication which was initiated during an inpatient psychiatric hospitalization. The symptoms listed were "somatic health complaints, care refusals, possible self injury (i.e. skin tears and bruises), delusions regarding care and persistent focus on bowel movements and blood sugar." The goal for this problem was as follows: "[res] will demonstrate decreased psychotic symptoms as evidenced by a reduction in physiological, emotional, and/or cognitive manifestations of psychosis, delusions or hallucinations through the next 90 days."</p> <p>The Monthly Flow Record for Behaviors/Side Effects for October, November and December, 2014 indicated no "anxiety" episodes for Resident #1. The flow record lacked any specific behaviors to describe how Resident #1 exhibited anxiety.</p> <p>The Monthly Flow Record for Behaviors/Side Effects for October, November and December, 2014 lacked any specific behaviors for the use of</p>						

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	<p>Chlorpromazine for Resident #1. The record also lacked any monitoring for hallucinations.</p> <p>The nursing notes from 10/21/14 through 12/15/14 indicated Resident #1 displayed 6 episodes of anxiety. The record lacked any documentation of hallucinations during that time frame.</p> <p>During an interview on 12/16/14 at 10:03 a.m., LPN #12 indicated Resident #1 displayed anxious behavior by yelling at staff and increased agitation. "She has good days and bad days. She gets confused at times. Sometimes she refuses her medications and she is noncompliant with her diet. This morning she was anxious, she started yelling at staff and she couldn't sit still".</p> <p>During an interview and review of the Monthly Flow Records for Resident #1 on 12/16/14 at 10:22 a.m., Unit Manager #13 confirmed the lack of specific behaviors stating "We need to list more resident specific symptoms associated with the specific behaviors being monitored." She also acknowledged the lack of monitoring Resident #1 for hallucinations.</p> <p>During an interview on 12/17/14 at 1:01 p.m., LPN #14 indicated Resident #1 had</p>						

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	<p>hallucinations. "Yes she has hallucinations. It's mainly, she sees people who aren't there. She had a conversation on Sunday with somebody who was not here. They don't last for long, just about a minute."</p> <p>During an interview on 12/17/14 at 1:30 p.m., Unit Manager #13 stated "There is no monitoring of delusions or hallucinations and there should be. The nurses are supposed to put any behaviors on the hot reports and we go over them in the jump start meetings. But I do not remember ever seeing her delusions or hallucinations on the reports. She had her last care conference in November 2014. Social Services should have reviewed her care plan then." She indicated the care conferences were held quarterly.</p> <p>During an interview on 12/17/14 at 2:17 p.m., the Director of Nursing indicated the floor nurses were to fill in the Monthly Flow Records for behaviors/side effects and the unit manager was responsible to make sure they were filled out correctly.</p> <p>5. The clinical record for Resident #109 was reviewed on 12/15/14 at 9:13 a.m. Resident #109's current diagnoses included, but were not limited to, anxiety, depression and constipation.</p>						

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	<p>Resident #109 had current physician's order for Ativan (an anti-anxiety medication) 0.5 milligrams (mg) by mouth every 8 hours as needed for anxiety with a start date of 9/12/14.</p> <p>Resident #109 had a current Minimum Data Set (MDS) assessment, dated 10/24/14 which indicated the resident was moderately cognitively intact.</p> <p>Resident #109's record did not identify the specific behavioral symptoms or target behaviors being treated by the use of the anti-anxiety medication.</p> <p>During review of "PSYCHOPHARMACOLOGIC DRUG MONTHLY FLOW RECORD" for Resident #109, provided by the Medical Records Coordinator on 12/17/14 at 1:30 p.m., indicated specific behaviors to be documented for Ativan were "General Anxiety". No behaviors were documented for the 4 months reviewed. For the month of September there were 11 days of missing documentation. For the month of October there were 5 days of missing documentation. For the month of November there were 21 days of missing documentation and for the month of December there were 10 days of missing documentation.</p>			

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NAME OF PROVIDER OR SUPPLIER PEABODY RETIREMENT COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 400 W SEVENTH ST NORTH MANCHESTER, IN 46962
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	<p>Side effects listed as being monitored for Ativan were "Disorientation and confusion, increased agitation, Loss of balance/falls, Sedation/drowsiness and Increased falls/dizziness". For the month of September there were 11 days of missing documentation. For the month of October there were 7 days of missing documentation. For the month of November there were 21 days of missing documentation and for the month of December there were 10 days of missing documentation.</p> <p>Review of the "Mood and Behavior Observation Form", provided by the Social Service Director on 12/15/14 at 1:30 p.m., indicated 6 behaviors were observed for Resident #109 in the three months reviewed. 5 of 6 behaviors observed were for "Resists/Refuses Care". 1 of 6 behaviors observed were for "Wandering, Socially inappropriate, Disrobing, Repetitive questions, Sadness/crying, and Yelling out (Nurse or Help, etc)". None of these behaviors were being tracked for the anti-anxiety medication.</p> <p>During an interview with the Social Service Director and the Social Service Designee on 12/17/14 at 2:39 p.m., both indicated the "Mood and Behavior</p>			

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	<p>Observation Form" and the "PSYCHOPHARMACOLOGIC MONTHLY FLOW RECORD" were not being used to document behaviors correctly and they could not find any notes documenting the behaviors indicated on the "Mood and Behavior Observation Form". They also indicated there was a lot of missing documentation on the "PSYCHOPHARMACOLOGIC MONTHLY FLOW RECORD" and what documentation was on the record indicated no behaviors occurred.</p> <p>6. Review of an undated policy titled "BEHAVIOR PROGRAM", provided by the Social Service Director on 12/17/14 at 3:20 p.m., indicated the following:</p> <p>"Policy It is the policy of Peabody Retirement Community to identify mood and behavior symptoms that negatively affect residents, staff, or visitors. Mood and Behavior symptoms will be investigated in order to provide, or make referral to, appropriate interventions that prevent, contain, or manage such behavior symptoms. Behavior symptoms will be addressed in the least restrictive manner possible. All Peabody retirement Community staff is responsible for reporting behavior symptoms appropriately."...</p>				

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NAME OF PROVIDER OR SUPPLIER PEABODY RETIREMENT COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 400 W SEVENTH ST NORTH MANCHESTER, IN 46962		
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	<p>"...Behavior Tracking Mood and Behavior Observation Forms are used for any and all staff to document observed incidents of maladaptive behavior and mood. The Psych Med Flowsheets are used only for tracking side effects and not for use in tracking behavior incidents...."</p> <p>Review of the Policy titled "Antipsychotic Medication Use", dated 6/2013, which was provided at entrance to facility on 12/9/14 9:00 a.m., indicated the following:</p> <p>"Highlights Policy Statement</p> <p>Antipsychotic medication therapy shall be used only when it is necessary to treat a specific condition."</p> <p>"Policy interpretation and Implementation...</p> <p>Specific Conditions for which the use of Antipsychotic medications are indicated.</p> <p>1. Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective..."</p> <p>...8. Antipsychotic medications shall only</p>				

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F000282 SS=D	<p>be used for the following conditions/diagnoses as documented in the record, consistent with the definitions in the Diagnostic and Statistical Manual of Mental Disorders (Current or subsequent editions):</p> <ul style="list-style-type: none"> a. Schizo-affective disorder; mood disorders (e.g. mania, bipolar disorder) b. Depression with psychotic features, and treatment refractory major depression. c. Psychosis NOS. d. Brief psychotic disorder. e. Schizophrenia. f. Delusional disorder g. schizophreniform disorder h. atypical psychosis i. Dementing illnesses with associated behavioral symptoms. j. Medical illnesses or delirium with manic or psychotic symptoms and/or treatment related psychosis or mania (e.g., thyrotoxicosis, neoplasms, high dose steroids)...." <p>3.1-34(a)</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. Based on record review and interview,</p> 	F000282		01/16/2015			

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	<p>the facility failed to ensure residents with daily blood pressure and pulse monitoring received those services as ordered by the physician (Resident #131)</p> <p>Findings include:</p> <p>The clinical record of Resident #131 was reviewed on 12/15/14 at 10:57 a.m. Diagnoses included, but were not limited to, senile dementia with delusions, congestive heart failure, depression, insomnia and constipation.</p> <p>Review of a current care plan, dated 10/3/14, indicated Resident #131 was at risk for respiratory distress and fluid imbalances related to a diagnosis of congestive heart failure. Interventions included, but were not limited to, "observe for s/s [signs and symptoms] of respiratory distress, dyspnea [shortness of breath], rapid breathing, excessively deep and rapid breathing, observe/record physical findings of fluid imbalance, and report negative assessment to MD."</p> <p>Record review indicated on 11/21/14, the physician ordered daily blood pressure and pulse and to report any systolic blood pressure greater than 170 or heart rate greater than 100. The physician also wrote for a cardiology consult for new onset rate controlled atrial fibrillation.</p>		<ul style="list-style-type: none"> · Resident # 131 assessed by Cardiologist on 12/18/14 and order received to discontinue daily B/P and pulse discontinued 12/18/14. · All residents have the potential to be effected by the alleged deficient practice. All residents' charts audited for daily B/P and pulse and no abnormal findings found. 12/18 /14. · All licensed nurses re-educated on Physician's order policy, education completed 1/5/15. · Physician orders will be reviewed daily by the DON/Designee on regular business days x 30 days, weekly x 3 month and monthly for six months and ongoing thereafter until 100% threshold is achieved. The QAPI committee chaired by the Administrator will oversee compliance with the Director of Nursing/Designee having responsibility reporting. 		

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F000309 SS=D	<p>Review of the daily blood pressure and pulse monitoring sheets, no pulse or blood pressure was obtained for 12/11, 12/12, 12/13 or 12/14/14.</p> <p>During an interview on 12/17/14 at 9:31 a.m., the Director of Nursing indicated the staff did miss the 4 days of blood pressure and pulse monitoring. She indicated the physician was contacted and continued the order to monitor.</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to implement and monitor a bowel program for 2 of 3 residents reviewed for unnecessary medication use (Resident #109 and #131).</p> <p>Findings include:</p> <p>1. The clinical record of Resident #131</p>	F000309	<ul style="list-style-type: none"> Resident # 109 and 131 abdomen assessment completed and no abnormal results found 12/17/14. All residents have the potential to be effected by the alleged deficient practice, all residents assessed and no abnormal findings found. 	01/16/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155655	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2014
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	<p>was reviewed on 12/15/14 at 10:57 a.m. Diagnoses included, but were not limited to, senile dementia with delusions, congestive heart failure, depression, insomnia and constipation.</p> <p>During an observation on 12/9/14 at 2:35 p.m., Resident #131 was noted to be in his room. He was talking nonsensically to himself. He was observed again on 12/16/14 at 9:38 a.m., Resident #131 was asleep in bed.</p> <p>Resident #131's Health Care Plan, dated 10/3/14, indicated he had a problem with a history of constipation. The goal was for the resident to have a bowel movement every 1-3 days thru the next review. Interventions included, but were not limited to, "administer medication as ordered by physician and monitor and document size, color and consistency of bowel movement every shift."</p> <p>Review of the current Physician Order's, Resident #131 had an order for Milk of Magnesia (liquid laxative), 30 Ml (milliliters) once daily as needed for constipation. The order was dated 8/13/13.</p> <p>Review of the ADL (Activities of Daily Living) Verification Worksheet from 10/18/14 through 12/13/14, indicated</p>		<ul style="list-style-type: none"> All Nursing staff educated on Monitoring of Bowel Movements policy and procedure, education completed by 1/16/15. Bowel report audited daily by DON/Designee on regular business days x 30 days, weekly x 3 month and monthly for six months and ongoing thereafter until 100% threshold is achieved. The QAPI committee chaired by Administrator will oversee compliance with the Director of Nursing/Designee having responsibility reporting. 		

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	<p>Resident #131 had 13 bowel movements during that time.</p> <p>Review of the Bowel and Bladder Record from November and December, Resident #131 had 4 documented bowel movements.</p> <p>During an interview on 12/17/14 at 9:31 a.m., the Director of Nursing (DON) indicated she was unable to find any additional information related to bowel monitoring. She indicated the CNA's were not documenting bowel elimination. She indicated the new plan was for staff to monitor bowel sounds every 3 days since the resident was able to take himself to the restroom.</p> <p>2. The clinical record for Resident #109 was reviewed on 12/15/14 at 9:13 a.m. Resident #109's current diagnoses included, but were not limited to, anxiety, depression and constipation.</p> <p>Review of the "Bowel and Bladder Record" for Resident #109, provided by the Medical Records Coordinator on 12/17/14 at 2:00 p.m., indicated missing documentation for the following:</p> <p>The month of September 2014, from 11:00 p.m. to 6:00 a.m. on the 28th, from 7:00 a.m. to 2:00 p.m. on the 3rd, 13th and the 23rd and from 3:00 p.m. to 10:00</p>						

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	<p>p.m on the 14th, 15th and 27th.</p> <p>The month of October 2014, from 11:00 p.m. to 6:00 a.m. on the 1st, 10th, 18th, 23rd and 30th, from 7:00 a.m. to 2:00 p.m. on the 1st and from 3:00 p.m. to 10:00 p.m. on the 10th, 11th, 12th, 15th, 20th, 24th, 27th, 30th and 31st.</p> <p>The month of November 2014, from 7:00 a.m. to 2:00 p.m. on the 12th, 18th, 20th, 24th and 28th, from 3:00 p.m. to 10:00 p.m. on the 7th, 8th, 18th, 19th, 21st, 25th and 28th.</p> <p>The month of December 2014 from 11:00 p.m. to 6:00 a.m on the 9th, from 3:00 p.m. to 10:00 p.m. on the 4th, 9th, 10th, 11th, 12th and 14th.</p> <p>Review of the computer generated "Elimination Record", provided by the Clinical Nurse Manager, indicated Resident #109 had 4 bowel movements from 9/17/14 to 10/18/14, 1 bowel movement from 10/19/14 to 11/12/14, 3 bowel movements from 11/14/14 to 12/4/14 and 1 bowel movement from 12/6/14 to 12/12/14.</p> <p>During an interview with CNA #10 and #11 on 12/17/14 at 1:13 p.m., they indicated the residents were checked on every hour and toileted or changed as</p>						

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NAME OF PROVIDER OR SUPPLIER PEABODY RETIREMENT COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 400 W SEVENTH ST NORTH MANCHESTER, IN 46962		
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	<p>needed and then they documented any urine or bowel movement amount and size in the computer charting system if it was working or on the "Bowel and Bladder Record" if the computer charting system was not working.</p> <p>During an interview with the Clinical Nurse Manager on 12/17/14 at 1:25 p.m., she indicated their computer charting system for the CNA's to chart bowel movements had not been working correctly and the CNA's had been charting in the computer program and on paper when the computer program was not working. The night shift nurse reviewed the computer generated "Elimination Record" and compared the names of the residents on the computer generated "Elimination Record" and the CNA paper documentation to see who had a bowel movement in the last three days. Those residents that had not had a bowel movement in the last 3 days after comparing both documentation records were then offered an intervention.</p> <p>3. Review of a current facility policy dated 12/07 and revised 12/09, titled "Monitoring of Bowel Movements", provided by the DON on 12/17/14 at 11:08 a.m., indicated the following;</p> <p>"Policy: It is the policy of Peabody</p>				

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NAME OF PROVIDER OR SUPPLIER PEABODY RETIREMENT COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 400 W SEVENTH ST NORTH MANCHESTER, IN 46962		
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F000371 SS=D	<p>Retirement Community (PRC) to monitor bowel function of all residents routinely and as needed for signs of constipation.</p> <p>PROCEDURE:..</p> <p>2. All BM's will be documented in the kiosk or on paper in the residents medical record every shift.</p> <p>3. A Bowel Movement (BM) report will be run nightly...</p> <p>4. The BM report will be audited for each resident to identify any resident who has had either no BM or a small BM within the previous 72 hours for further intervention.</p> <p>5. Any resident identified as having no BM or only small BM within the previous 72 hours will have a complete assessment...</p> <p>7. If no results noted in 24 hours,...the physician will be updated according the the Physician Notification of Resident's Change in Condition Policy."</p> <p>3.1-37(a)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p>				

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NAME OF PROVIDER OR SUPPLIER PEABODY RETIREMENT COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 400 W SEVENTH ST NORTH MANCHESTER, IN 46962			
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	<p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, record review and interview, the facility failed to serve food under sanitary conditions for 2 of 2 dining observations and for 1 of 4 flat top grills not free from debris in 1 of 4 satellite kitchens observed. This deficiency had the potential to affect 42 of 42 residents who dined in the Pine Dining Room out of 168 total residents that resided in the facility.</p> <p>Findings include:</p> <p>1. During a dining observation on 12/9/14 at 12:06 p.m., a family member of a resident was observed to assist herself to a serving of jello and cheesecake from two large multi-serving containers. The handle of the spoon was observed resting in the dish of cheesecake and a spatula was observed resting on the lid of the jello container.</p> <p>During an interview with the Dietary Cook #4 on 12/9/14 at 12:12 p.m., she indicated it was cross contamination when the family members of the residents' served themselves. She indicated it was a problem. She further</p>	F000371	<p>· There where no residents adversely affected by this alleged deficient practice. · As all residents have the potential to be affected, grills were thoroughly cleaned, food placed in single serve dishes and covered 12/9/14. · All dining staff educated on Infection Control policy and procedure 12/22/14 · The Food and Beverage Director or designee will visually monitor and record findings of infection control/sanitation audit daily x 30 days, weekly x 1 month and monthly for six months and ongoing thereafter until 100% threshold is achieved. The QAPI committee chaired by the Administrator will oversee compliance with the Food and Beverage Director/Designee reporting.</p>	01/16/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155655	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2014
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	<p>indicated a solution would have been to have the food out of the reach of residents and their family members.</p> <p>2. During a dining observation on 12/11/14 at 11:17 a.m., the following were observed in ready to serve but uncovered containers:</p> <p>Eight jello, four cottage cheese, two applesauce and five mixed fruit. All of the items were in four ounce bowls and placed next to the steam table. The Dining Service Coordinator #3 was observed leaning over a bowl of jello to reach into a large plastic container of pudding, which was placed on a shelf above the jello. Dietary Cook #4 was present and observed the Dining Service Coordinator #3 lean over the bowls of jello.</p> <p>During an interview with the Dietary Cook #4, she indicated she witnessed the Dining Service Coordinator lean over the jello. She further indicated it was a potential for cross contamination.</p> <p>During an interview with the Dietary Service Coordinator #3, she indicated she had leaned over the jello in an angle to reach the pudding.</p> <p>3. During a kitchen observation on</p>			

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	<p>12/9/14 at 12:40 p.m. in the Pine Dining room with the Food and Beverage Director, the front cover of the flat top grill was down and a large amount of a greasy substance was noted around and under the drip pan.</p> <p>During an interview with the Food and Beverage Director on 12/9/14 at 12:40 p.m., she indicated the staff was to be cleaning the flat top grill on a daily basis and after each meal. She also indicated it looked like this grill had not been cleaned in at least a week. The Food and Beverage Director indicated this grill should not look like this.</p> <p>During an interview with the Food and Beverage Director on 12/11/14 at 10:30 a.m., she provided "Kitchen Sanitation Survey" audits which had been done on a weekly basis by each kitchen manager. She indicated each kitchen manager performed the audits at the end of each week to monitor kitchen sanitation. The Food and Beverage Director indicated they did not have a daily kitchen cleaning record the staff signed to show they had maintained kitchen sanitation.</p> <p>4. Review of a policy, titled "USAGE AND CLEANING OF GRILLS", dated December 2010 and revised November 2012, provided by the Food and Beverage</p>				

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NAME OF PROVIDER OR SUPPLIER PEABODY RETIREMENT COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 400 W SEVENTH ST NORTH MANCHESTER, IN 46962			
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	<p>Director on 12/11/14 at 12:15 p.m., indicated the following:</p> <p>"FREQUENCY: Daily</p> <p>POLICY: It is the policy of Peabody Retirement Community to have all staff trained to use the stove top grills to ensure safety and proper food preparation practices.</p> <p>PROCEDURE:...</p> <p>...34. Check grill for any debris before turning on and wipe with clean cloth if need be...</p> <p>...CLEANING:...</p> <p>...4. Remove drip pan under the grill and wash with hot soapy water and replace."</p> <p>Review of a policy, titled "General infection Control in Dining Services", dated December 2010 and revised December 2014, provided by the Food and Beverage Director on 12/15/14 at 7:55 a.m., indicated the following:</p> <p>"...PROCEDURE:</p> <p>Food Preparation Areas:...</p> <p>...6. Interior and exterior of all appliances</p>						

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F000431 SS=D	<p>should be clean and free from grease, food, or mineral build-up..."</p> <p>3.1-21(i)(3)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the</p>			

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	<p>quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation and interview, the facility failed to properly ensure medication carts were free of loose pills for 1 of 12 carts observed during medication storage (Memory North).</p> <p>The facility also failed to ensure topical medications were properly labeled in a treatment cart for 1 of 6 treatment carts observed (Memory South).</p> <p>Findings include:</p> <p>1. During observation on 12/16/14 at 2:46 p.m., the Memory South treatment cart was found to have had a tube of Bacitracin Zinc (topical medication used to prevent infections), 2 bottles of Nystop (topical powder anti-fungal antibiotic), a tube of Bacitracin (topical antibiotic) and a tube of Triple Anti-biotic (topical anti-biotic). All 5 bottles and/or tubes had been opened. No resident label was noted on any of the items.</p> <p>During observation of the Memory North medication cart on 12/16/14 at 2:54 p.m., 1 unidentified pill was found in medication cart D. The pill was loose inside the cart.</p> <p>During observation medication cart C, 1 unidentified pill was found in the</p>	F000431	<ul style="list-style-type: none"> · There were no residents adversely affected by the alleged deficient practice. · All medication and treatment carts cleaned and all medications and treatments properly labeled and stored in carts 12/29/14. · All licensed Nurses and QMAs educated on Medication storage policy and procedure, education completed by 1/5/14. · All Medication and Treatment carts to be visually audited by Director of Nursing/Designee daily on regular business days x 30 days, weekly x 3 month and monthly for six months and ongoing thereafter until 100% threshold is achieved. The QAPI committee chaired by the Administrator will oversee compliance with the Director of Nursing/Designee having responsibility reporting. 	01/16/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155655		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2014	
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	<p>medication cart. The pill was loose inside the cart.</p> <p>During an interview on 12/16/14 at 3:00 p.m., LPN #5 indicated the medication should have been disposed of by 2 nurses by being flushed down the toilet. She attempted to pick up the pill from medication cart D and indicated "I busted it."</p> <p>The pill from medication care D was picked up by LPN #5 and disposed of.</p> <p>2. Review of a current facility policy, dated 5/1/10 and revised 1/1/13, titled "Storage and Expiration of Medication, Biologicals, Syringes and Needles", which was provided by the Director of Nursing on 12/17/14 at 11:08 a.m., indicated the following:</p> <p>"Applicability: Procedure:...</p> <p>6. Facility should destroy and reorder medications and biologicals with soiled, illegible, worn, makeshift, incomplete, damaged or missing labels...</p> <p>17. Facility personnel should inspect nursing station storage areas for proper storage compliance on a regular scheduled basis."</p> <p>3.1-25(k)</p>						

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R000000	<p>3.1-25(o)</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: December 9, 10, 11, 15, 16, and 17, 2014</p> <p>Facility number: 000485 Provider number: 155655 AIM number: 100291190</p> <p>Survey team: Shelley Reed, RN TC Karen Lewis, RN (12/10, 12/11, 2014) Ginger McNamee, RN (12/15, 12/16, 12/17, 2014) Jason Mench, RN Angela Selleck, RN (12/9, 12/10, 12/11, 12/15, 2014) Tina Smith-Staats, RN (12/10, 12/11, 12/15, 12/16, 12/17, 2014)</p> <p>Census bed type: SNF/NF: 168 Residential: 113 Total: 281</p> <p>Census payor type: Medicare: 22</p>	R000000					

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R000241	<p>Medicaid: 118 Other: 141 Total: 281</p> <p>Sample: 8</p> <p>These state findings are cited in accordance with 410 IAC 16.2-5.</p> <p>410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident 's physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.</p> <p>Based on record review and interview, the facility failed to ensure a resident who self administered medications had a physician's order to self administer medications for 1 of 4 residents reviewed for self administration of medications in a sample of 8. (Resident #R19)</p> <p>Findings include:</p> <p>The clinical record for Resident #R19 was reviewed on 12/10/14 at 1:59 p.m. Diagnoses for Resident #R19 included, but was not limited to, diabetes, hypertension, and hyperlipidemia.</p>	R000241	<ul style="list-style-type: none"> · Resident #R19 assessed by clinical staff for self administration of medication, physicians order for self administration of medications received 12/11/14. · All residents who currently self administer medications have the potential to be affected. All residential residents' charts reviewed and updated as needed. January 15, 2015. · All licensed nurses staff educated on self administration of medications policy and procedure, 	01/16/2015	

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	<p>An "EVALUATION OF RESIDENT'S ABILITY TO SELF-MEDICATE", dated 6/18/14, was in Resident #R19's clinical record. The clinical record for Resident #R19 lacked a signed physician order to self-administer medications.</p> <p>During an interview with RN #2 on 12/11/14 at 8:05 a.m., additional information was requested related to a physician order for self administration of medications for Resident #R19.</p> <p>During an interview with the Director of Residential Services on 12/11/14 at 8:53 a.m., he provided a physician order for Resident #R19 to self administer medications dated 12/11/14. He indicated Resident #R19 had not had a physician order to self administer medications in his clinical record.</p> <p>Review of the current facility policy, revised 12/2009, titled "ASSISTED LIVING-MEDICATION SELF ADMINISTRATION", provided by the Director of Residential Services on 12/11/14 at 9:36 a.m., included, but was not limited to, the following:</p> <p>"...3. Any resident identified as being able to Self Administer Medications will have a physician order to do so...."</p>		<p>completed by 1/5/15.</p> <p>The Director of Residential Services/Designee will audit self administration assessments/ self administration physician orders weekly for one month and monthly for six months and ongoing thereafter until 100% threshold is achieved. The QAPI committee chaired by the Administrator will oversee compliance with the Director of Residential Services/Designee having responsibility reporting.</p>	

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R000410	<p>410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance</p> <p>(e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read.</p> <p>(f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>(g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p> <p>Based on record review and interview, the facility failed to ensure residents received a Mantoux test for tuberculosis (TB test) prior to or upon admission for 1 of 8 residents reviewed for TB testing in a sample of 8. (Resident #R19)</p> <p>Findings include:</p> <p>The clinical record for Resident #R19 was reviewed on 12/10/14 at 1:59 p.m.</p>	R000410	<ul style="list-style-type: none"> · Resident #R19 Tuberculin skin test administered. · All residents have the potential to be affected by the alleged practice and an audit of all residents Tuberculin test completed and all residents have current TBs on chart. · The licensed nurses were educated on Resident Tuberculin 	01/16/2015

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	<p>The resident had a Nurse's Note, dated 8/5/13 8:28 p.m., indicating the resident was a new admit to the facility.</p> <p>The "Peabody Retirement Community TB documentation form", indicated Resident #R19 had a TB test placed on 8/6/13.</p> <p>During an interview with RN #2 on 12/11/14 at 8:05 a.m., additional information was requested related to the 8/6/13 TB test for Resident #R19.</p> <p>During an interview with the Director of Residential Services on 12/11/14 at 8:53 a.m., he indicated he had no further information to provide related to the 8/6/13 TB test for Resident #R19. He further indicated Resident #R19 should have had a TB test prior to or upon admission to the facility.</p>		<p>policy and procedure, education completed by 1/5/15.</p> <p>The Director of Residential Services/Designee will audit Tuberculin skin tests on all new admits weekly for one month and monthly for six months and ongoing thereafter until 100% threshold is achieved. The QAPI committee chaired by the Administrator will oversee compliance with the Director of Residential Services having responsibility reporting.</p>		