STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155414	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINTON NURSING AND REHABILITATION CENTER	1501 A ST LINTON, IN 47441

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: July 7, 8, 9, 10, and 13, 2015. Facility number: 000333 Provider number: 155414 AIM number: 100288370 Census bed type: SNF/NF: 28 Total: 28 Census Payor type: Medicare: 6 Medicaid: 17 Other: 5 Total: 28 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	Preparation and/or exercution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies This plan of correction is prepared and/or executed solely because required July 28, 2015 Dear Ms,. Rhoades, On July 10, 2015, a Recertification and State Licensure Survey was conducted at Linton Nursing and Rehab by the ISDH Long Term Care Division Please consider this letter and plan of correction to be the facility's credible allegation of compliance I am requesting a desk review to verify that the facility has achieved substantial compliance with the applicable requirements as of the date set forth in the plan of correction of August 9th 2015 Please call me with any further questions at 812-847-4426 or directly at 812-296-0695 Respectfully, Charlotte Wagoner, HFA	
F 0280 SS=D Bldg. 00	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.			
	Based on observation, interview, and record review, the facility failed to ensure the fall careplan was revised for a resident with history of falls for 1 of 2 residents reviewed for accidents. (Resident #9) Findings include: Resident #9's clinical record was reviewed on 7/13/15 at 12:42 p.m. Diagnosis include but were not limited to: profound weakness, depression, and diabetes type 2. The current comprehensive Minimum data Set (MDS) assessment dated 5/31/15, indicated Resident #9 was severely cognitively impaired and not interviewable.	F 0280	I) Resident #9 was assessed and no negative outcomes identified Resident also screened by therapy for additional needs. The care plan and goal was reviewed for resident #9 and updated II) All residents have the potential to be affected by this practice. The Director of Nursing audited all residents care plans and goals for those residents identified as being at a risk for falls. Also, All residents Care Plans and Goals were reviewed by D.O.N. and updated if applicable. III) Policy for "Care Plans" reviewed and found to appropriate. D.O.N./Designee to re-educate nursing staff on the Care Plan Policy and the timeliness of updating the care plans with any falls or change in condition. The Care plans will be updated quarterly and with any change in condition. IV) The	08/09/2015

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	On 7/7/15 at 11:43 a.m., interview with LPN #1 indicated Resident #9 fell on 7/7/15. "[Resident #9] was found on the floor yelling by the doorway. [Resident #9] slid off the bed and crawled to the doorway." Resident #9's alarm was found wrapped up and on the bed. Resident #9 had on non-skid socks. "We put a bed alarm in place." The current care plan dated 12/28/14, indicated "The resident has potential for falls r/t [related to]: Unaware of safety needs, Gait/balance problems, ...Goal [dated through 2/27/15]: The resident will be free of fall, ...Intervention ... Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed, the resident needs prompt response to all requests for assistance, ... pull pin alarm in chair, floor mat alarm, bed alarm, keep alarm boxes out of resident reach, room closes to nurses station to aide in fast response time of staff to prevent unsafe resident safe transfer." Fall Risk Assessment dated 2/26/15, indicated a score of 14, when 10 or more represents high risk for falls. On 7/13/15 at 2:26 p.m., the DON indicated the fall careplan goal (dated		Director of Nursing/Designee will audit all care plans including falls, for timeliness of updates 5xweekly x2 weeks, weekly x2. ,monthly x5. Any discrepancies will be reported to the administrator and results will also be monitored via Q.A. Committee quarterly x4 for any further recommendations	

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	2/27/15) had not been reviewed and revised for Resident #9 and should have been updated on 7/7/15, after the fall. There was no revised careplan provided for Resident #9 indicating updated goal and interventions for fall prevention provided. 3.1-35(d)(2)(B)			
F 0282 SS=D Bldg. 00	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, the facility failed to ensure care plans were followed for weekly skin assessment for a resident with edema and bruising for 1 of 25 residents observed for skin condition during stage 1 (Resident #10) and to ensure care plans were followed in regard to monitoring antidepressant and antipsychotics medications for 2 of 5 residents reviewed for unnecessary medication use (Resident	F 0282	I) Resident #10, 22, and 9 were assessed with no negative outcomes identified The care plan, goals and monitoring tools were reviewed and updated for these 3 residents A new tool was implemented for monitoring Staff was educated on the tools and documentation by D.O.N. to ensure the care plans are to be followed in regard to the daily monitoring of anti depressants and anti psychotic medications for side effects and effectiveness of	08/09/2015

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	#9, Resident #22). Findings include: 1). Resident #10's clinical record was reviewed on 7/10/15 at 9:43 a.m. Diagnosis included, but were not limited to: obesity, arteriosclerotic heart disease (thickening and hardening of the walls of the coronary arteries), and anemia. The current comprehensive Minimum Data Set (MDS) assessment dated 5/9/15, indicated " ...Skin and Ulcer Treatment ...H. Applications of ointments/medications ..." Care Plan dated 2/5/15, "Non Compliant with Nursing Measure" indicated "...Approach 1. Monitor skin weekly for complications from not using padding on stool. ..." Care plan dated 7/15/15, "Resident has potential for impaired skin related to immobility. Goal:... will have intact skin free of redness, blister or discoloration, ...Intervention: administer medications as ordered. Monitor/document for ...effectiveness, ... Follow facility policies/protocols for the prevention/treatment of skin breakdown, ..." On 7/8/15 at 12:06 p.m., Resident #10		medication II) All residents have the potential to be affected by this practice An audit was conducted of all current residents receiving antidepressants and antipsychotic meds with no negative side effects being identified to those residents All care plans and goals and monitoring tools reviewed and updated Staff re-educated on the policy for care plans and tools to monitor side effects and effectiveness III) Licensed nursing will be re-educated on daily monitoring of antidepressant and antipsychotic medication side effects and effectiveness for residents receiving these meds and the importance of following care plans. Licensed nurses and CNA's will be re-educated on following care plans and monitoring tool for residents assessed and identified for having wounds by the wound nurse IV) The DON/designee will monitor skin sheets and care plans 5xweely x2 weeks and weekly x2, monthly x5. Reports will be taken to the QA Committee quarterly x4 for review and further recommendations. The D.O.N/Social Services will monitor the tracking tool for daily charting of side effects and effectiveness of the anti/depressive and antipsychotic medications 5xweekly x2 and weekly x2, monthlyx5. Any discrepancies will be reported to the Administrator. A report will	

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	was observed to have bilateral lower leg purplish bruising with edema (swelling). On 7/13/15 at 2:53 p.m., the DON provided "WEEKLY SKIN REVIEW" sheets for the past 3 months dated 6/22/15, 6/29/15, and 7/6/15. There were no other weekly skin review sheets provided. On 7/13/15 at 3:06 p.m., the DON provided documentation labeled "SKIN ASSESSMENT" and indicated the form was currently used by the Certified Nursing Assistants on shower days to document skin concerns identified. The forms dated: 5/4/15, 5/7/15, 5/11/15, 5/14/15, 5/21/15, 5/25/15, 5/28/15, 6/1/15, 6/4/15, and 6/11/15 lack documentation indicating identified skin conditions the C.N.A.'s were monitoring for on Resident #10's bilateral lower legs. The forms indicated buttocks. On 7/13/15 at 2:48 p.m., an interview with the Director of Nursing (DON) indicated they are (staff) encouraging resident to lift up her feet. 2.a.) Resident #22's clinical record was reviewed on 7/13/15 at 10:01 a.m. Diagnosis included but were not limited		presented to the QA Committee quarterly x4 for review and any additional recommendations	

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	to: psychosis and depression. The current physician's order dated July 2015, indicated Resident #22 received Risperdal 0.5 mg (milligram) daily for psychosis since 4/21/15, and Effexor 75 mg three times a day for depression. Care plan dated 2/3/15, indicated "...psychotropic medications r/t [related to] Behavior management, Goal: ...will reduce the use of psychoactive medication, ...Monitor/document for ... effectiveness. ... Monitor/record/report to MD [Medical Doctor] prn [as needed] side effects and adverse reactions of psychoactive medications: ... depression, ... behavior symptoms not usual to the person, ..." Care plan dated 2/3/15,indicated " Resident uses antidepressant medication r/t [related to] Poor adjustment to admission, Depression. ...Goal: ...will be free from discomfort or adverse reactions related to antidepressant therapy, ...Intervention ...Monitor/document ... suicidal ideation, neg. [negative] mood/comments ...unrealistic fears, ... anxiety. ..." Review of the following "BEHAVIOR/MOOD SYMPTOM TRACKING TOOL" assessment			

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	indicated the following: April 2015, indicated no documentation of behaviors for which the medication was prescribed (effectiveness) being monitored for antipsychotic medications Risperdal, nor antidepressant Effexor. May 2015, indicated no documentation of behaviors for which the medication was prescribed (effectiveness) being monitored for antipsychotic medications Risperdal, nor antidepressant Effexor. June 2015, indicated no documentation of behaviors for which the medication was prescribed (effectiveness) being monitored for antipsychotic medications Risperdal, nor antidepressant Effexor. July 2015, indicated a behavior documented on 7/2/15 of refusing care. There were no other documented behaviors for which the medication was prescribed (effectiveness) Risperdal nor antidepressant Effexor. Review of the Medication Administration Record dated April, May, June and July, 2015, lack documentation of monitoring behaviors for antidepressant and antipsychotic medications. On 7/13/15 at 12:04 p.m., interview with			

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	the Director of Nursing (DON) indicated, Resident #22 had a behavior on 7/11/15, and the behavior should have been documented on the behavior/mood symptom tracking tool form. On 7/10/15 at 3:25 p.m., the Social Service Director indicated that targeted behaviors are not routinely documented for the residents. She indicated the staff would document a behavior after the resident exhibited a behavior. During an interview, on 7/10/15 at 3:35 p.m., the DON (Director of Nursing) indicated the facility charts behaviors only when the resident displayed a behavior. On 7/13/15 at 12:02 p.m., the DON provided the facility's policy, "Psychotropic Management," dated March 2015, and indicated it was the policy currently being used by the facility. The policy indicated, ".... The Licensed Nurse will institute the appropriate Behavior Monitoring form associated with the drug category ... To identify specific/target behaviors ... To document number of episodes of behaviors and ... To document interventions and outcomes... " 2.b.) Resident #9's clinical record was			

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	reviewed on 7/13/15 at 12:42 p.m. Diagnosis include but were not limited to: depression. The current physician's order dated July 2015, indicated Resident #9 received 20 mg of Celexa daily for depression since 8/21/14. Care plan dated 2/17/15, indicated "antidepressant medication (Celexa) r/t [related to] Depression, ...Goal: ...show decreased episodes of s/sx of depression, ...Intervention: ...Monitor /document/report to MD [Medical Doctor] prn [as needed] ongoing s/sx of depression unaltered by antidepressant meds: Sad, irritable, anger, ...crying, ...lethargy, does not enjoy usual activities, ..." Review of the following "BEHAVIOR/MOOD SYMPTOM TRACKING TOOL" assessment indicated the following: April 2015, indicated no documentation of behaviors for which the medication was prescribed (effectiveness) being monitored for antidepressant medication Celexa. May 2015, indicated no documentation of behaviors for which the medication was			

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	prescribed (effectiveness) being monitored for antidepressant medication Celexa. June 2015, indicated no documentation of behaviors for which the medication was prescribed (effectiveness) being monitored for antidepressant medication Celexa. July 2015, indicated no documentation of behaviors for which the medication was prescribed (effectiveness) being monitored for antidepressant medication Celexa. On 7/10/15 at 3:25 p.m., the Social Service Director indicated targeted behaviors are not routinely documented for the residents. She indicated the staff would document a behavior after the resident exhibited a behavior. During an interview, on 7/10/15 at 3:35 p.m., the DON (Director of Nursing) indicated the facility charts behaviors only when the resident displayed a behavior. On 7/13/15 at 12:02 p.m., the DON provided the facility's policy, "Psychotropic Management," dated March 2015, and indicated it was the policy currently being used by the			

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	facility. The policy indicated, ".... The Licensed Nurse will institute the appropriate Behavior Monitoring form associated with the drug category ... To identify specific/target behaviors ... To document number of episodes of behaviors and ... To document interventions and outcomes... " 3.1-35(g)(2)			
F 0329 SS=E Bldg. 00	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. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			

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	Based on interview and record review, the facility failed to ensure residents who received a psychotropic medication were monitored for targeted behaviors and for effectiveness of medications for 5 of 5 residents reviewed for unnecessary medication use. (Resident #14, Resident #30, Resident #24, Resident #9, and Resident #22) Findings include: 1. The clinical record was reviewed for Resident #14 on 7/10/15 at 3:16 p.m. Diagnoses included, but were not limited to: depression and dementia. The physician's June 2015, orders for Resident #14 indicated the following: On 1/11/13 (start date), the resident was ordered Zoloft (antidepressant medication) 50 mg (milligrams) daily. On 10/16/14 (start date), the resident was ordered Zyprexa (antipsychotic medication) 5 mg every morning. The clinical record lacked documentation which indicated targeted behaviors for which the medications were prescribed were monitored for Resident #14's Zoloft and Zyprexa.	F 0329	I) Residents #'s 14, 30,24,9, and 22 have been assessed with no adverse signs or symptoms from psychotropic medications Daily monitoring for adverse side effects and/or effectiveness has been initiated. II) Residents receiving antipsychotic drugs have potential to be affected by this practice. A new pharmacy behavior monitoring form has been placed in the MAR book. Professional nursing staff in-serviced on the use of this monitoring tool. This tool will be used for the following: To identify specific target behaviors for the med To identify # of episodes of behavior To document interventions To document outcomes/effectiveness III) The systemic change is the new pharmacy form placed in the MAR book for the profession nurses to use daily. IV) The D.O.N./Designee will monitor behavior tool for compliance 5x weekly and weekly x2, monthly x5. Thereafter, Social Services will monitor monthly ongoing and report in discrepancies to the D.O.N . A report will be given to the Q.A. Committee quarterly x4 for review and recommendations.	08/09/2015

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	The Wolters Kluwer Nursing 2014 Drug Handbook, 34th edition, copyright 2015, Black Box Warning for Zoloft indicated, but was not limited to: " .... closely observe patient for increased suicidal thinking and behavior... " On 7/10/15 at 3:25 p.m., the Social Service Director indicated targeted behaviors are not routinely documented for the residents. The staff would document a behavior after the resident exhibited a behavior. During an interview, on 7/10/15 at 3:35 p.m., the DON (Director of Nursing) indicated the facility charts behaviors only when the resident displayed a behavior. On 7/13/15 at 12:02 p.m., the DON provided the facility's policy, "Psychotropic Management," dated March 2015, and indicated it was the policy currently being used by the facility. The policy indicated, ".... The Licensed Nurse will institute the appropriate Behavior Monitoring form associated with the drug category ... To identify specific/target behaviors ... To document number of episodes of behaviors and ... To document interventions and outcomes... "			

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	2. The clinical record was reviewed for Resident #30 on 7/13/15 at 10:35 a.m. Diagnoses included, but were not limited to: dementia and depression. The physician's July 2015, orders for Resident #30 indicated the following: On 6/24/13 (start date) the resident was ordered Cymbalta (antidepressant medication) 60 mg (milligrams) daily. On 11/10/14(start date) the resident was ordered Zyprexa (antipsychotic medication) 10 mg every night at bedtime. The clinical record lacked documentation which indicated targeted behaviors for which the medications were prescribed were monitored for Resident #30's Cymbalta and Zyprexa. The Wolters Kluwer Nursing 2014 Drug Handbook, 34th edition, copyright 2015, Black Box Warning for Cymbalta included: " ... Monitor patient closely for worsening of depression or suicidal behavior..." On 7/10/15 at 3:25 p.m., the Social Service Director indicated that targeted behaviors are not routinely documented for the residents. She indicated the staff			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155414	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/13/2015

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	would document a behavior after the resident exhibited a behavior. During an interview, on 7/10/15 at 3:35 p.m., the DON (Director of Nursing) indicated the facility charts behaviors only when the resident displayed a behavior. On 7/13/15 at 12:02 p.m., the DON provided the facility's policy, "Psychotropic Management," dated March 2015, and indicated it was the policy currently being used by the facility. The policy indicated, ".... The Licensed Nurse will institute the appropriate Behavior Monitoring form associated with the drug category ... To identify specific/target behaviors ... To document number of episodes of behaviors and ... To document interventions and outcomes... " 3. Resident #24's clinical record was reviewed on 7/10/2015 at 11:00 a.m. Diagnosis included, but were not limited to anxiety, depression and Alzheimer's disease with behavioral disorder. The current Minimum Data Set (MDS) assessment dated 6/27/2015, assessed Resident #24 as taking an anti-anxiety medication the last 7 out of 7 days, an anti-depressant medication the last 7 out of 7 days and an anti-psychotic			

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NAME OF PROVIDER OR SUPPLIER LINTON NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1501 A ST LINTON, IN 47441	

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	medication the last 5 out of 7 days. Physician's order dated July 2015, indicated Resident #24's medications included, but were not limited to: Ativan tablet (an anti-anxiety) 2 milligrams (mg) every night at bedtime for anxiety. Ativan tablet 2 mg as needed every 6 hours for anxiety. Trazodone tablet (an anti-depressant) 50 mg every night at bedtime for depression. Zoloft tablet (an anti-depressant) 50 mg every morning for depression. Risperdal (an anti-psychotic) 1 mg twice a day for Alzheimer's with behavioral disorder. The original start date of the Ativan, Trazodone, Zoloft and Risperdal is unknown however, Resident #24 was re-admitted to the facility on 5/2/2015 after a previous admit date of 10/3/13, and was on the medication at that time. A care plan initiated on 2/3/2015, indicated a focus of: "[Resident #24] uses psychotropic medications (Zoloft, Ativan, Risperdal,Trazodone) related to			

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NAME OF PROVIDER OR SUPPLIER LINTON NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1501 A ST LINTON, IN 47441	

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	Alzheimer's, depression, insomnia and anxiety ... monitor and document for side effects and effectiveness ... educate the resident, family and caregivers about the risks, benefits and the side effects and or toxic symptoms of psychoactive medication drugs being given ..." The Wolters Kluwer Nursing 2015 Drug Handbook, 35th edition, copyright 2015, Black Box Warning for Risperdal include: "... Elderly patients with dementia related psychosis treated with anti-psychotics are at increased risk for death. ..." On 7/13/2015 at 11:20 a.m., the Social Service Director (SSD) provided the document titled, "Behavior/Mood Symptom Tracking Tool" for May, June and July, 2015. The documents were blank and lacked evidence which indicated behaviors for which the medication was prescribed and the effectiveness of the medication were being monitored for Resident #24's Ativan, Zoloft, Trazodone and Risperdal since his re-admit date of 5/2/2015. On 7/10/2015 at 1:59 p.m., an interview with the SSD indicated, they only chart if the resident is exhibiting a behavior. On 7/10/2015 at 2:00 p.m., an interview			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155414	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 07/13/2015

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	with the Director of Nursing (DON)indicated, she is not sure how they are monitoring for side effects and effectiveness of Resident #24's psychotropic medications. The nurses will notice a change in the resident and they will chart if there is a behavior that day. On 7/13/2015 at 12:02 p.m., the DON provided the facility's policy, "Psychotropic Medication Management Program dated March 2015, and indicated the policy was the one currently being used by the facility and the only policy used for psychotropic medications. The policy indicated, " ... 6. As needed in accordance with state regulation: the licensed nurse will institute the appropriate behavior monitoring form associated with the drug category ... a. To identify specific/target behaviors b. To document number of episodes of behaviors c. To document interventions and outcomes. ... " 4). Resident #22's clinical record was reviewed on 7/13/15 at 10:01 a.m. Diagnosis included but were not limited to: psychosis, and depression. The current physician's order dated July 2015, indicated Resident #22 received Risperdal 0.5 mg (milligram) daily for psychosis since 4/21/15, and Effexor 75			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155414		07/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINTON NURSING AND REHABILITATION CENTER	1501 A ST LINTON, IN 47441

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	mg three times a day for depression. Care plan dated 2/3/15, indicated "...psychotropic medications r/t [related to] Behavior management, Goal: ...will reduce the use of psychoactive medication, ... will remain free of drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment, ...Monitor/document for side effects and effectiveness. ... Monitor/record/report to MD prn side effects and adverse reactions of psychoactive medications: unsteady gait, tardive dyskinesia, EPS [shuffling gait, rigid muscles, shaking], frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, ... behavior symptoms not usual to the person, ..." Care plan dated 2/3/15,indicated " Resident uses antidepressant medication r/t [related to] Poor adjustment to admission, Depression. ...Goal: ...will be free from discomfort or adverse reactions related to antidepressant therapy, ...Intervention ...Monitor/document ... suicidal ideation, neg. [negative] mood/comments ...unrealistic fears, ... anxiety. ..."			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	Wolters Kluwer Nursing 2015 Drug Handbook, 35th edition, copyright 2015, Black Box Warning for Risperdal include: "... Elderly patients with dementia related psychosis treated with anti-psychotics are at increased risk for death. ..." Review of the following "BEHAVIOR/MOOD SYMPTOM TRACKING TOOL" assessment indicated the following: April 2015, indicated no documentation of behaviors for which the medication was prescribed (effectiveness) being monitored for antipsychotic medications Risperdal, nor antidepressant Effexor. May 2015, indicated no documentation of behaviors for which the medication was prescribed (effectiveness) being monitored for antipsychotic medications Risperdal, nor antidepressant Effexor. June 2015, indicated no documentation of behaviors for which the medication was prescribed (effectiveness) being monitored for antipsychotic medications Risperdal, nor antidepressant Effexor. July 2015, indicated a behavior documented on 7/2/15 of refusing care. There were no other documented			

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	behaviors for which the medication was prescribed (effectiveness) Risperdal nor antidepressant Effexor. Review of the Medication Administration Record dated April, May, June and July, 2015, lack documentation of monitoring behaviors for antidepressant and antipsychotic medications. On 7/13/15 at 12:04 p.m., interview with the Director of Nursing (DON) indicated, Resident #22 had a behavior on 7/11/15, and the behavior should have been documented on the behavior/mood symptom tracking tool form. On 7/10/15 at 3:25 p.m., the Social Service Director indicated that targeted behaviors are not routinely documented for the residents. She indicated the staff would document a behavior after the resident exhibited a behavior. During an interview, on 7/10/15 at 3:35 p.m., the DON (Director of Nursing) indicated the facility charts behaviors only when the resident displayed a behavior. On 7/13/15 at 12:02 p.m., the DON provided the facility's policy, "Psychotropic Management," dated March 2015, and indicated it was the			

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	policy currently being used by the facility. The policy indicated, ".... The Licensed Nurse will institute the appropriate Behavior Monitoring form associated with the drug category ... To identify specific/target behaviors ... To document number of episodes of behaviors and ... To document interventions and outcomes... " 5). Resident #9's clinical record was reviewed on 7/13/15 at 12:42 p.m. Diagnosis include but were not limited to: depression. The current physician's order dated July 2015, indicated Resident #9 received 20 mg (milligram) of Celexa daily for depression since 8/21/14. Care plan dated 2/17/15, indicated "antidepressant medication (Celexa) r/t [related to] Depression, ...Goal: ...show decreased episodes of s/sx of depression, ...Intervention: ...Monitor /document/report to MD [Medical Doctor] prn [as needed] ongoing s/sx of depression unaltered by antidepressant meds [medication]: Sad, irritable, anger, ...crying, ...lethargy, does not enjoy usual activities, ..." Review of the following "BEHAVIOR/MOOD SYMPTOM			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINTON NURSING AND REHABILITATION CENTER	1501 A ST LINTON, IN 47441

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	TRACKING TOOL" assessment indicated the following: April 2015, indicated no documentation of behaviors for which the medication was prescribed (effectiveness) being monitored for antidepressant medication Celexa. May 2015, indicated no documentation of behaviors for which the medication was prescribed (effectiveness) being monitored for antidepressant medication Celexa. June 2015, indicated no documentation of behaviors for which the medication was prescribed (effectiveness) being monitored for antidepressant medication Celexa. July 2015, indicated no documentation of behaviors for which the medication was prescribed (effectiveness) being monitored for antidepressant medication Celexa. On 7/10/15 at 3:25 p.m., the Social Service Director indicated that targeted behaviors are not routinely documented for the residents. She indicated the staff would document a behavior after the resident exhibited a behavior.			

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	155414		07/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINTON NURSING AND REHABILITATION CENTER	1501 A ST LINTON, IN 47441

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	During an interview, on 7/10/15 at 3:35 p.m., the DON (Director of Nursing) indicated the facility charts behaviors only when the resident displayed a behavior. On 7/13/15 at 12:02 p.m., the DON provided the facility's policy, "Psychotropic Management," dated March 2015, and indicated it was the policy currently being used by the facility. The policy indicated, ".... The Licensed Nurse will institute the appropriate Behavior Monitoring form associated with the drug category ... To identify specific/target behaviors ... To document number of episodes of behaviors and ... To document interventions and outcomes... " 3.1-48(a)(3)			
F 0441 SS=D Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -			

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NAME OF PROVIDER OR SUPPLIER LINTON NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1501 A ST LINTON, IN 47441	

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	(1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, interview, and record review, the facility failed to ensure staff hand washed for 20 seconds as indicated by the facility policy and Center for Disease Control. (Resident #6, Resident #5, Resident #24, Resident #26) Findings include: On 7/10/15 at 11:34 a.m., RN #1 was observed to handwash for 5 seconds after administering medication to Resident #6.	F 0441	I) It is the practice of this facility to assure that all procedures are conducted in a manner that is in accordance with infection control guidelines Residents # 6,5, 24, and 26 now receive services within acceptable parameters of infection control including proper hand washing II) All residents have the potential to be affected by this practice. All residents are receiving services within acceptable parameters of infection control including proper hand washing. The facility will	08/09/2015

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	RN #1 walked to the medication cart and prepared medication for Resident #5, walked into Resident #5's room, and no handwashing was observed nor hand sanitizer use. RN #1 administered pills to Resident #5 and used hand sanitizer afterward. RN #1 indicated she should have hand washed for 30 seconds. RN #1 was unsure of the facility policy on handwashing. On 7/13/15 at 11:44 a.m., RN #2 was observed to enter Resident #24's room to administer medication. No handwashing nor hand sanitizer was observed. RN #2 administered medication to Resident #24 and handwash for 5 seconds, walked to the medication cart and retrieved the medication for Resident #26. RN #2 entered Resident #26's room, no handwashing nor hand sanitizing was observed, administered the medication and handwash for 15 seconds. RN #2 indicated she should have handwashed for 20 seconds. RN #2 indicated she used the "Happy Birthday" song to calculate the 20 seconds. On 7/10/15 at 12:00 p.m., Registered Nurse #1 provided policy "HAND HYGIENE" dated 2009, and indicated the policy was the one currently used by the facility. The policy indicated, " ...HANDWASHING ...C. Wash well		randomly observe staff that are providing services to assure that proper hand washing is followed in accordance with the facility policy. A performance improvement tool has been initiated that will be used to randomly observe 5 residents during provision of services related to proper hand washing techniques This observation will be conducted randomly to include all shifts by D.O.N./Designee. IV) The DON/Designee will monitor 5x weekly x2, then weekly x2, and monthlyx5. The monitoring tool will be used randomly on all shifts. Any issues will immediately corrected and additional training will immediately occur. The results will be taken to the QA Committee quarterly x4 for review and any further recommendations	

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	under running water for a minimum of 15 seconds, ... WATERLESS HANDWASHING PRODUCTS: If hands are not visibly soiled, use an alcohol-based hand rub for routinely decontaminating hands, ..." On 7/13/15 at 1:48 p.m., the Director of Nursing (DON) provided "Center for Disease Control and Prevention documentation, Wash You Hands" dated 12/11/13. The documentation indicated, "....Scrub your hands for at least 20 seconds. Need a timer? Hum the "Happy Birthday" song from beginning to end twice. ..." On 7/14/15 at 11:58 a.m., review of the Centers for Disease Control and Prevention at www.cdc.gov/handwashing dated December 16, 2013, indicated" How should you wash your hands? ... apply soap. Scrub your hands for at least 20 seconds. Need a timer? Hum the "Happy Birthday" song from beginning to end twice. ... " 3.1-18(l)			