

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/07/2015
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NAME OF PROVIDER OR SUPPLIER  APERION CARE TOLLESTON PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2350 TAFT ST GARY, IN 46404
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00176573.</p> <p>This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaint IN00173090 completed on 05/21/15.</p> <p>This visit was in conjunction with a PSR to the Investigation of Complaint IN00173606 completed on 06/9/15.</p> <p>Complaint IN00176573-Substantiated. Federal/State deficiencies related to the allegations were cited at F-157, F-250, F-279, and F-329.</p> <p>Survey dates: July 6 &amp; 7, 2015</p> <p>Facility number: 008505 Provider number: 155580 AIM number: 200064830</p> <p>Census bed type: SNF/NF: 101 Total: 101</p> <p>Census Payor type: Medicare: 08 Medicaid: 79 Other: 14</p>	F 0000		
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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>Total: 101</p> <p>Sample: 7</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>			
F 0157 SS=D Bldg. 00	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in</p>			

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	<p>§483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to notify a resident's Responsible Party, related to medication and condition changes, for 1 of 3 resident's reviewed for condition changes in a total sample of 7. (Resident #B)</p> <p>Finding includes:</p> <p>Resident #B's record was reviewed on 07/07/15 at 9:26 a.m. The resident's diagnoses included, but were not limited to, dementia and congestive heart failure. The resident's information sheet indicate Family Member #1 was the resident's Responsible Party and the First Emergency Contact.</p> <p>Physician's Orders, dated 06/08/15, indicated Ativan (anti-anxiety) 1 mg (milligram), take one tablet, three times daily and Lorazepam (hypnotic) 15 mg, take one tablet at bedtime.</p> <p>A Nurses' Progress Note, dated 06/08/15 at 3:35 p.m., indicated Family Member #2 was aware of the change in orders.</p>	F 0157	<p>F 157</p> <p><b>The facility requests paper compliance for this citation.</b></p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p><b>1) Immediate actions taken for those residents identified:</b></p> <p>Resident # B has been discharged</p>	07/22/2015	

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	<p>The note did not indicate the Responsible Party had been notified of the medication change.</p> <p>A Physician's Order, dated 06/10/15, indicated Lorazepam (Ativan), give 2 mg, three times a day for anxiety.</p> <p>A Nurses' Progress Note, dated 06/10/15 at 2:11 p.m., indicated the Nurse attempted to notify the resident's Physician due to the resident's alertness, and there was no answer from the Physician.</p> <p>A Nurses' Progress Note, dated 06/10/15 at 4:21 p.m., indicated the 4 p.m. dose of Lorazepam 2 mg had been held due to lethargy.</p> <p>A Nurses' Progress Note, dated 06/10/15 at 6:08 p.m., indicated the Nurse had spoke with the Nurse Practitioner in regards to the Lorazepam dose and received an order to hold the third dose of Ativan until the resident exhibited signs of agitation.</p> <p>The Nurses' Progress Notes, dated for 06/10/15, had not indicated the resident's Responsible Party or other family members had not been notified of the medication change and the resident's lethargy.</p>		<p>from facility</p> <p><b>2) How the facility identified other residents:</b></p> <p>An audit will be completed of orders for all current residents received since 7/1/15 to ensure responsible parties were notified as indicated.</p> <p><b>3) Measures put into place/ System changes:</b></p> <p>Licensed nurses will be in-serviced regarding notification of responsible parties of behaviors and new medication orders.</p> <p>Progress notes and physician orders will be reviewed at least 3 times per week to ensure that the responsible parties have been notified.</p> <p>The Director of Nursing or designee is responsible of the oversight of these audits.</p>	

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	<p>A Nurses' Progress Note, dated 06/11/15 at 10:35 p.m., written by the resident's Emergency Contact #2, who works at the facility, indicated the Physician had been notified of the families concern in regards to the higher dose of Lorazepam, changes in the resident's activities of daily living functions, sleepiness and a new order for Lorazepam 2 mg in the afternoon and to decrease in Seroquel (anti-psychotic) from 25 mg, twice a day and 75 mg at bedtime, to Seroquel 75 mg at bedtime.</p> <p>The Emergency Contact #2 had received and written the Physician's Order for the medication changed. The Nurses' Progress Notes did not indicated the Responsible Party had been notified of the condition change and the medication change.</p> <p>A Physician's Order, dated 06/12/15, indicated Lorazepam 2 mg, give in the afternoon (changed from three times daily to daily) and to give Seroquel 75 mg at bedtime.</p> <p>A Nurses' Progress Note, dated 06/16/15 at 11:35 a.m., indicated the Nurse Practitioner was notified due to the resident being lethargic and a new order for Lorazepam 1 mg three times daily had</p>		<p><b>4) How the corrective actions will be monitored:</b></p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3</p> <p>Months, then quarterly x1 for a total of 6 months.</p> <p><b>5) Date of compliance: 7/22/15</b></p>	

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	<p>been received. The note indicated the resident's Emergency Contact #2 was in the facility and aware. The note did not indicated the resident's Responsible Party had been notified of the lethargy and the new orders from the Physician.</p> <p>A Physician's Order, dated 06/16/15, indicated Lorazepam 1 mg three times a day for anxiety.</p> <p>A facility policy, dated 08/13, received from the ADoN (Assistant Director of Nursing) as current on 07/06/15 at 5:17 p.m., titled, "Physician/Family/Responsible Party Notification for Change in Condition", indicated, "Purpose: To ensure that medical care problems are communicated to the attending physician and family/responsible party in a timely, efficient, and effective manner...to include...Change in condition that may warrant a change in current treatment...notification will be documented in the progress notes..."</p> <p>During an interview on 07/07/15 at 2:12 p.m. the ADoN indicated the policy stated family or Responsible Party were to be notified. The ADoN indicated the resident's Emergency Contact #2 was aware of the changes.</p>			

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F 0250 SS=D Bldg. 00	<p>During an interview on 07/07/15 at 5:14 p.m., the ADoN indicated the policy stated "family slash (/) Responsible Party". The ADoN further indicated either could be notified.</p> <p>This Federal Tag relates to Complaint IN00176573.</p> <p>3.1-5(a)(2) 3.1-5(a)(3)</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE 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 record review and interview, the facility failed to provide medically-related social services to attain or maintain the highest practicable mental and psychosocial well-being of each resident, related to identifying behaviors, thoroughly assessing behaviors, implementing behavioral interventions, reviewing psychotropic</p>	F 0250	<p>F 250</p> <p>The facility requests paper compliance for this citation.</p>	07/22/2015

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	<p>medications, and evaluating the outcome of the interventions to support the residents' individual needs, for 1 of 3 residents reviewed for psychoactive medications in a total sample of 7. (Resident #B)</p> <p>Finding includes:</p> <p>Resident #B's record was reviewed on 07/07/15 at 9:26 a.m. The resident's diagnoses included, but were not limited to, dementia and congestive heart failure.</p> <p>A Care plan, dated 08/01/14, indicated the resident had a diagnosis of insomnia. The interventions were to administer medications as ordered, encourage the resident to go to bed at the same time daily, evaluate the resident's room for noise, darkness, temperature, and comfort.</p> <p>There were no care plans to indicate the resident had behaviors.</p> <p>A Physician's Order, dated 03/10/15, indicated Lorazepam (Ativan) (anti-anxiety) by mouth. 1 mg (milligram) every six hours as needed for anxiety.</p> <p>A Physician's Order, dated 03/10/15, indicated Lorazepam (hypnotic) 15 mg,</p>		<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p><b>1) Immediate actions taken for those residents identified:</b></p> <p>Resident # B has been discharged from the facility.</p> <p><b>2) How the facility identified other residents:</b></p> <p>Behavior documentation and new psychotropic medication orders on all current residents will be reviewed from 7-1-15 to present to identify any other residents affected.</p>	

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	<p>one capsule as needed for insomnia.</p> <p>A Physician's Order, dated 03/10/15, indicated Ambien (hypnotic) 5 mg, as needed for insomnia.</p> <p>A Physician's Order, dated 03/11/15, indicated an order for Quetiapine (Seroquel) (anti-psychotic) 25 mg, twice a day at 8 a.m. and 8 p.m. for dementia with behavioral disturbance.</p> <p>A Physician's Order, dated 03/12/15, indicated Lorazepam, intramuscularly (IM), 2 mg every six hours as needed for anxiety.</p> <p>A Physician's Order, dated 03/13/15, indicated an order for Seroquel 75 mg at bedtime for dementia with behavioral disturbance.</p> <p>A Nurses' Progress Note, dated 06/01/15 at 1:42 p.m., indicated the resident was in the dining room, cursing, yelling, and threatening staff. The staff attempted redirections, snacks and the family was called and all interventions were unsuccessful. The note indicated Lorazepam 2 mg IM had been given.</p> <p>The Medication Administration Record (MAR), dated 06/15, indicated 2 mg of Lorazepam IM was given at 3:11 p.m. on</p>		<p><b>3) Measures put into place/ System changes:</b></p> <p>Social Services, Licensed nurses and CNA's will be educated regarding behavior reporting and documentation.</p> <p>Behavior documentation and new psychotropic medication orders will be reviewed at least 3x/week to ensure appropriate documentation was completed with appropriate follow-up and interventions put in place as needed.</p> <p>Social Services Director will be responsible for oversight.</p> <p><b>4) How the corrective actions will be monitored:</b></p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3</p> <p>Months, then quarterly x1 for a total of 6 months.</p>	

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	<p>06/01/15, and was effective.</p> <p>The Mar, dated 06/15/15, indicated on 06/03/15 at 8:06 p.m., the Lorazepam was given for insomnia and was effective.</p> <p>A Nurses' Progress Note, dated 06/04/15 at 2:39 p.m. indicated there were no concerns with the resident's mood or behaviors.</p> <p>A Nurses' Progress Note, dated 06/05/15 at 7:26 p.m., indicated the resident was uncooperative, resisted care and had socially inappropriate behavior.</p> <p>The MAR, dated 06/15, indicated on 06/05/15 at 7:45 p.m. Ambien 5 mg for insomnia had been administered and was effective.</p> <p>The MAR, dated 06/15, indicated on 06/05/15 at 7:46 p.m., Lorazepam (Ativan) (anti-anxiety) 1 mg (milligram) was given.</p> <p>The Mar, dated 06/15, indicated on 06/07/15 at 7:03 p.m., Lorazepam 15 mg had been administered to the resident for insomnia and was effective.</p> <p>A Physician's Progress Note, dated 06/08/15, indicated medications were</p>		<p><b>5) Date of compliance: 7/22/15</b></p>	

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	<p>reviewed and the resident had aggressive behavior, required medication changes and behavior modifying.</p> <p>Physician's Orders, dated 06/08/15, indicated Ativan (anti-anxiety) 1 mg (milligram), take one tablet, three times daily and Lorazepam (hypnotic) 15 mg, take one tablet at bedtime and to discontinue the Ambien.</p> <p>A Physician's Order, dated 06/10/15, indicated Lorazepam (Ativan), give 2 mg, three times a day for anxiety.</p> <p>A Nurses' Progress Note, dated 06/10/15 at 2:11 p.m., indicated the Nurse attempted to notify the resident's Physician due to the resident's alertness, and there was no answer from the Physician.</p> <p>A Nurses' Progress Note, dated 06/10/15 at 4:21 p.m., indicated the 4 p.m. dose of Lorazepam 2 mg had been held due to lethargy.</p> <p>A Nurses' Progress Note, dated 06/10/15 at 4:47 p.m., indicated there were no concerns with the resident's mood or behavior.</p> <p>A Nurses' Progress Note, dated 06/10/15 at 6:08 p.m., indicated the Nurse had</p>			

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	<p>spoke with the Nurse Practitioner in regards to the Lorazepam dose and received an order to hold the third dose of Ativan until the resident exhibited signs of agitation.</p> <p>Nurses' Progress Notes, dated 06/11/15 at 1:29 a.m. and 1:57 P.M., indicated there were no concerns with the resident's mood or behavior.</p> <p>A Nurses' Progress Note, dated 06/11/15 at 10:35 p.m., indicated the Physician had been notified of the families concern in regards to the higher dose of Lorazepam, and changes in the resident's activities of daily living functions, and sleepiness and a new order for Lorazepam 2 mg in the afternoon and to decrease in Seroquel (anti-psychotic) from 25 mg, twice a day and 75 mg at bedtime, to Seroquel 75 mg at bedtime.</p> <p>A Physician's Order, dated 06/12/15, indicated Lorazepam 2 mg, give in the afternoon (changed from three times daily to daily) and to give Seroquel 75 mg at bedtime.</p> <p>Nurses' Progress Notes, dated 06/12/15 at 4:02 a.m., 1:33 p.m., and 10:54 p.m. indicated there were no concerns with the resident's mood or behavior.</p>			

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	<p>A Nurses' Progress Note, dated 06/13/15 at 5:47 p.m. indicated there were no concerns with the resident's mood or behavior.</p> <p>Nurses' Progress Notes, dated 06/14/15 at 3:21 a.m., indicated there were no concerns with the resident's mood or behavior and the resident had behavior at times. At 6:07 p.m., indicated there were no concerns with the resident's mood and behavior.</p> <p>Nurses' Progress Notes, dated 06/15/15 at 8:35 a.m., 06/16/15 at 1:07 a.m., 9:41 a.m., 06/16/15 at 6:06 p.m., 06/17/15 at 1:05 a.m. and 8:55 a.m., indicated there were no concerns with the resident's mood and behavior.</p> <p>A Nurses' Progress Note, dated 06/16/15 at 11:35 a.m., indicated the Nurse Practitioner was notified due to the resident being lethargic and a new order for Lorazepam 1 mg three times daily had been received.</p> <p>A Physician's Order, dated 06/16/15, indicated Lorazepam 1 mg three times a day for anxiety.</p> <p>Nurses' Progress Notes, dated 06/18/15 at 6:35 a.m. indicated there were no concerns with the resident's mood or</p>			

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	<p>behavior and the resident had behaviors at times and at 11:55 a.m. there was no concerns with the resident's mood or behavior.</p> <p>The Behavior Symptoms Report, dated 06/05/15 through 06/18/15 indicated the resident had no behaviors.</p> <p>The Progress Notes dated 06/01/15 through 06/18/15, lacked documentation of Social Service interventions for behaviors and psychotropic medication use.</p> <p>During an interview on 07/07/15 at 12:21 p.m., Social Service #1 indicated the resident did not have a care plan for behaviors. Social Service #1 indicated the resident acted out, "every now and then". Social Service #1 and #2 indicated they were not aware of the medication changes and were not informed of the resident behaviors.</p> <p>A facility policy, dated 06/12, titled, "Behavior Management", received from the Assistant Director of Nursing (ADoN) as current on 07/07/15 at 1:58 p.m., indicated, "...The nurse or social service will complete behavior documentation upon being notified of or witnessing a behavior. 3. Social Services will complete follow-up documentation</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155580	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  07/07/2015
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F 0279 SS=D Bldg. 00	<p>of behaviors under progress notes...If a behavior management program is needed Social Service will develop the Behavior Management Program and enter it into the EMR (electronic medical record) under care plans..."</p> <p>A facility policy, dated 06/13, titled, "Psychoactive Medications/Gradual Dose Reduction Policy", received from the ADoN as current on 07/06/15 at 5:17 p.m., indicated, "...Residents receiving psychoactive medications will have a care plan initiated that contains interventions regarding the target behaviors..."</p> <p>This Federal Tag relates to Complaint IN00176573.</p> <p>3.1-34(a)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p>			

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	<p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to develop a care plan for a resident, related to behaviors for 1 of 7 residents reviewed for care plans in a total sample of 7. (Resident #B)</p> <p>Finding includes:</p> <p>Resident #B's record was reviewed on 07/07/15 at 9:26 a.m. The resident's diagnoses included, but were not limited to, dementia and congestive heart failure.</p> <p>A Physician's Order, dated 03/10/15, indicated Lorazepam (Ativan) (anti-anxiety) by mouth. 1 mg (milligram) every six hours as needed for anxiety.</p>	F 0279	<p><b>F 279 The facility requests paper compliance for this citation.</b> <i>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: Resident # B has been discharged from facility. 2) How the facility identified other residents: All resident care plans will be reviewed to ensure that appropriate care plans are in</i></p>	07/22/2015

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	<p>A Physician's Order, dated 03/11/15, indicated an order for Quetiapine (Seroquel) (anti-psychotic) 25 mg, twice a day at 8 a.m. and 8 p.m. for dementia with behavioral disturbance.</p> <p>A Physician's Order, dated 03/12/15, indicated Lorazepam, intramuscularly (IM), 2 mg every six hours as needed for anxiety.</p> <p>A Physician's Order, dated 03/13/15, indicated an order for Seroquel 75 mg at bedtime for dementia with behavioral disturbance.</p> <p>A Nurses' Progress Note, dated 06/01/15 at 1:42 p.m., indicated the resident was in the dining room, cursing, yelling, and threatening staff. The staff attempted redirections, snacks and the family was called and all interventions were unsuccessful. The note indicated Lorazepam 2 mg IM had been given.</p> <p>A Nurses' Progress Note, dated 06/05/15 at 7:26 p.m., indicated the resident was uncooperative, resisted care and had socially inappropriate behavior.</p> <p>A Physician's Progress Note, dated 06/08/15, indicated medications were reviewed and the resident had aggressive behavior, required medication changes</p>		<p>place. This will include all residents who receive psychotropic medications and/or have behaviors to ensure that they had a mood/ behavior care plan in place and that the interventions are appropriate.</p> <p><b>3) Measures put into place/ System changes:</b> The Director of Nursing or designee will review at least 5 resident care plans per week to ensure appropriate care plans are in place. <b>4) How the corrective actions will be monitored:</b> The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. <b>5) Date of compliance: 7/22/15</b></p>		

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	<p>and behavior modifying.</p> <p>Physician's Orders, dated 06/08/15, indicated Ativan (anti-anxiety) 1 mg (milligram), take one tablet, three times daily.</p> <p>A Physician's Order, dated 06/10/15, indicated Lorazepam (Ativan), give 2 mg, three times a day for anxiety.</p> <p>A Physician's Order, dated 06/12/15, indicated Lorazepam 2 mg, give in the afternoon (changed from three times daily to daily) and to give Seroquel 75 mg at bedtime.</p> <p>Nurses' Progress Note, dated 06/14/15 at 3:21 a.m., indicated there were no concerns with the resident's mood or behavior and the resident had behavior at times.</p> <p>A Physician's Order, dated 06/16/15, indicated Lorazepam 1 mg three times a day for anxiety.</p> <p>Nurses' Progress Note, dated 06/18/15 at 6:35 a.m. indicated there were no concerns with the resident's mood or behavior and the resident had behaviors at times</p> <p>During an interview on 07/07/15 at 12:21</p>			

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	<p>p.m., Social Service #1 indicated the resident did not have a care plan for behaviors. Social Service #1 indicated the resident acted out, "every now and then".</p> <p>A facility policy, dated 06/12, titled, "Behavior Management", received from the Assistant Director of Nursing (ADoN) as current on 07/07/15 at 1:58 p.m., indicated, "...The nurse or social service will complete behavior documentation upon being notified of or witnessing a behavior. 3. Social Services will complete follow-up documentation of behaviors under progress notes...If a behavior management program is needed Social Service will develop the Behavior Management Program and enter it into the EMR (electronic medical record) under care plans..."</p> <p>A facility policy, dated 06/13, titled, "Psychoactive Medications/Gradual Dose Reduction Policy", received from the ADoN as current on 07/06/15 at 5:17 p.m., indicated, "...Residents receiving psychoactive medications will have a care plan initiated that contains interventions regarding the target behaviors..."</p> <p>This Federal Tag relates to Complaint IN00176573.</p>			

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F 0329 SS=D Bldg. 00	<p>3.1-35(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 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</p>			

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	<p>these drugs.</p> <p>Based on record review and interview, the facility failed to ensure a resident was free of unnecessary medications, related to an increase of hypnotic (Ambien and Lorazepam) and Lorazepam (Ativan) (Anti-anxiety) dosages without indications for the increased dosage, for 1 of 3 residents reviewed for psychoactive medications in a total sample of 7. (Resident #B)</p> <p>Finding includes:</p> <p>Resident #B's record was reviewed on 07/07/15 at 9:26 a.m. The resident's diagnoses included, but were not limited to, dementia and congestive heart failure.</p> <p>A Care plan, dated 08/01/14, indicated the resident had a diagnosis of insomnia. The interventions were to administer medications as ordered, encourage the resident to go to bed at the same time daily, evaluate the resident's room for noise, darkness, temperature, and comfort.</p> <p>There were no care plans to indicate the resident had behaviors.</p> <p>A Physician's Order, dated 03/10/15, indicated Lorazepam (Ativan) (anti-anxiety) by mouth. 1 mg</p>	F 0329	<p><b>F 329</b></p> <p><b>The facility requests paper compliance for this citation.</b></p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p><b>1) Immediate actions taken for those residents identified:</b></p> <p>Resident # B has been discharged from facility.</p> <p><b>2) How the facility identified other residents:</b></p>	07/22/2015

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	<p>(milligram) every six hours as needed for anxiety.</p> <p>A Physician's Order, dated 03/10/15, indicated Lorazepam (hypnotic) 15 mg, one capsule as needed for insomnia.</p> <p>A Physician's Order, dated 03/10/15, indicated Ambien (hypnotic) 5 mg, as needed for insomnia.</p> <p>A Physician's Order, dated 03/12/15, indicated Lorazepam, intramuscularly (IM), 2 mg every six hours as needed for anxiety.</p> <p>A Nurses' Progress Note, dated 06/01/15 at 1:42 p.m., indicated the resident was in the dining room, cursing, yelling, and threatening staff. The staff attempted redirections, snacks and the family was called and all interventions were unsuccessful. The note indicated Lorazepam 2 mg IM had been given.</p> <p>The Medication Administration Record (MAR), dated 06/15, indicated 2 mg of Lorazepam IM was given at 3:11 p.m. on 06/01/15, and was effective.</p> <p>The Mar, dated 06/15/15, indicated on 06/03/15 at 8:06 p.m., the Lorazepam was given for insomnia and was effective.</p>		<p>All psychotropic medication orders received since 7/1/15 will be reviewed to ensure medication changes were clinically indicated and appropriate.</p> <p><b>3) Measures put into place/ System changes:</b></p> <p>Social Services Director and/or Director of Nursing/ designee will review all new psychotropic medication order changes and behaviors at least 3x/week to ensure changes are indicated and appropriate.</p> <p><b>4) How the corrective actions will be monitored:</b></p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3</p> <p>Months, then quarterly x1 for a total of 6 months.</p>		

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	<p>A Nurses' Progress Note, dated 06/04/15 at 2:39 p.m. indicated there were no concerns with the resident's mood or behaviors.</p> <p>A Nurses' Progress Note, dated 06/05/15 at 7:26 p.m., indicated the resident was uncooperative, resisted care and had socially inappropriate behavior.</p> <p>The MAR, dated 06/15, indicated on 06/05/15 at 7:45 p.m. Ambien 5 mg for insomnia had been administered and was effective.</p> <p>The MAR, dated 06/15, indicated on 06/05/15 at 7:46 p.m., Lorazepam (Ativan) (anti-anxiety) 1 mg (milligram) was given and was effective.</p> <p>The Mar, dated 06/15, indicated on 06/07/15 at 7:03 p.m., Lorazepam 15 mg had been administered to the resident for insomnia and was effective.</p> <p>A Pharmacy recommendation, dated 05/27/15 and responded to by the Nurse Practitioner on 06/08/15, indicated, "The resident has orders for both PRN (as needed) Ambien 5 mg and Lorazepam 15 mg at bedtime. This may be viewed as duplicate therapy. Recommend discontinuing Lorazepam 15 mg and</p>		5) Date of compliance: 7/22/15		

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	<p>continuing Ambien 5 mg PRN HS (bedtime). The Physician/Prescriber Response indicated by a check the Nurse Practitioner disagreed and wrote, "continue c/ (with) Lorazepam 15 mg hs".</p> <p>A Physician's Progress Note, dated 06/08/15, indicated medications were reviewed and the resident had aggressive behavior, required medication changes and behavior modifying.</p> <p>Physician's Orders, dated 06/08/15, indicated Ativan (anti-anxiety) 1 mg (milligram), take one tablet, three times daily, which was increased from the as needed dosage and Lorazepam (hypnotic) 15 mg, take one tablet at bedtime, which was increased from the as needed dosage, and to discontinue the Ambien.</p> <p>There were no indications in the resident's electronic record to indicate the resident had been exhibiting insomnia nightly. The MAR, dated 06/15 indicated a hypnotic had been given on June 3, 5, and 7, 2015. and was effective. The MAR, dated 06/15, indicated the as needed doses of Lorazepam were effective for the resident's behavior on June 1, 5, and 7, 2015.</p> <p>A Physician's Order, dated 06/10/15,</p>			

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	<p>indicated Lorazepam (Ativan), give 2 mg, three times a day for anxiety, which was increased from 1 mg three times a day. There was no indicated in the resident's electronic record to indicate the reason for the increase in the Lorazepam dosage.</p> <p>A Nurses' Progress Note, dated 06/10/15 at 2:11 p.m., indicated the Nurse attempted to notify the resident's Physician due to the resident's alertness, and there was no answer from the Physician.</p> <p>A Nurses' Progress Note, dated 06/10/15 at 4:21 p.m., indicated the 4 p.m. dose of Lorazepam 2 mg had been held due to lethargy.</p> <p>The MAR, dated 06/15, indicated the Lorazepam 15 mg had been held</p> <p>A Nurses' Progress Note, dated 06/10/15 at 4:47 p.m., indicated there were no concerns with the resident's mood or behavior.</p> <p>A Nurses' Progress Note, dated 06/10/15 at 6:08 p.m., indicated the Nurse had spoke with the Nurse Practitioner in regards to the Lorazepam dose and received an order to hold the third dose of Ativan until the resident exhibited signs of agitation.</p>			

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	<p>The MAR, dated 06/15, indicated the Lorazepam 15 mg had been held at 8 p.m. on 06/10/15 due to the resident was sleeping.</p> <p>Nurses' Progress Notes, dated 06/11/15 at 1:29 a.m. and 1:57 P.M., indicated there were no concerns with the resident's mood or behavior.</p> <p>A Nurses' Progress Note, dated 06/11/15 at 10:35 p.m., indicated the Physician had been notified of the families concern in regards to the higher dose of Lorazepam, and changes in the resident's activities of daily living functions, and sleepiness and a new order for Lorazepam 2 mg in the afternoon.</p> <p>A Physician's Order, dated 06/12/15, indicated Lorazepam 2 mg, give in the afternoon (changed from three times daily to daily). There were no changes in the Lorazepam orders and the Lorazepam 15 mg was continued to be given nightly at 8 p.m. except on 06/10/15.</p> <p>Nurses' Progress Notes, dated 06/12/15 at 4:02 a.m., 1:33 p.m., and 10:54 p.m. indicated there were no concerns with the resident's mood or behavior.</p> <p>A Nurses' Progress Note, dated 06/13/15</p>			

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	<p>at 5:47 p.m. indicated there were no concerns with the resident's mood or behavior.</p> <p>Nurses' Progress Notes, dated 06/14/15 at 3:21 a.m., indicated there were no concerns with the resident's mood or behavior and the resident had behavior at times. At 6:07 p.m., indicated there were no concerns with the resident's mood and behavior.</p> <p>Nurses' Progress Notes, dated 06/15/15 at 8:35 a.m., 06/16/15 at 1:07 a.m., 9:41 a.m., 06/16/15 at 6:06 p.m., 06/17/15 at 1:05 a.m. and 8:55 a.m., indicated there were no concerns with the resident's mood and behavior.</p> <p>A Nurses' Progress Note, dated 06/16/15 at 11:35 a.m., indicated the Nurse Practitioner was notified due to the resident being lethargic and a new order for Lorazepam 1 mg three times daily had been received.</p> <p>A Physician's Order, dated 06/16/15, indicated Lorazepam 1 mg three times a day for anxiety, which was increased from Lorazepam 2 mg in the afternoon to 3 mg a day. There were no changes to the Lorazepam orders.</p> <p>The MAR, dated 06/15, indicated the</p>			

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NAME OF PROVIDER OR SUPPLIER  APERION CARE TOLLESTON PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2350 TAFT ST GARY, IN 46404
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	<p>resident received the Lorazepam 15 mg as ordered on 06/16/15 at 8 p.m.</p> <p>Nurses' Progress Notes, dated 06/18/15 at 6:35 a.m. indicated there were no concerns with the resident's mood or behavior and the resident had behaviors at times and at 11:55 a.m. there was no concerns with the resident's mood or behavior.</p> <p>The Behavior Symptoms Report, dated 06/05/15 through 06/18/15 indicated the resident had no behaviors.</p> <p>During an interview on 07/07/15 at 11:39 a.m., the ADoN (Assistant Director of Nursing), indicated she could not find why the Lorazepam had been ordered routinely every night. She indicated the Nurse Practitioner comes in and decides what medications to order. She indicated she could not find why the changes in the Lorazepam and why the Lorazepam was increased to 2 mg three times a day on 06/10/15. She indicated the facility "failed" to document any behaviors for the resident.</p> <p>During an interview on 07/07/15 at 12:21 p.m., Social Service #1 indicated the resident acted out, "every now and then". Social Service #1 and #2 indicated they were not aware of the medication</p>			

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	<p>changes and were not informed of the resident behaviors.</p> <p>A facility policy, dated 06/12, titled, "Behavior Management", received from the Assistant Director of Nursing (ADoN) as current on 07/07/15 at 1:58 p.m., indicated, "...The CNA's will document behaviors in the Electronic Medical Record when behaviors occur. The CNA will notify the nurse of the behavior. 2. The nurse or social service will complete behavior documentation upon being notified of or witnessing a behavior. 3. Social Services will complete follow-up documentation of behaviors under progress notes...If a behavior management program is needed Social Service will develop the Behavior Management Program and enter it into the EMR (electronic medical record) under care plans..."</p> <p>A facility policy, dated 06/13, titled, "Psychoactive Medications/Gradual Dose Reduction Policy", received from the ADoN as current on 07/06/15 at 5:17 p.m., indicated, "It is the policy of this facility that a resident will receive psychoactive medications only when it is necessary to improve the resident's overall psychosocial health status. To ensure the resident is receiving the necessary medication at the lowest</p>			

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	<p>effective dose with an appropriate diagnosis..."</p> <p>This Federal Tag relates to Complaint IN00176573.</p> <p>3.1-48(a)(4)</p>				