

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/29/2015
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NAME OF PROVIDER OR SUPPLIER LYND PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 2410 E MCGALLIARD RD MUNCIE, IN 47303
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R 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00185177.</p> <p>Complaint IN00185177-Substantiated. State deficiency related to the allegation is cited at R0036.</p> <p>Survey date: October 29, 2015</p> <p>Residential Census: 53</p> <p>Sample: 3</p> <p>This deficiency reflects a state finding cited in accordance with 410 IAC 16.2-5.</p> <p>QR completed by 11474 on October 30, 2015.</p>	R 0000		
R 0036 Bldg. 00	<p>410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>consequences or to commence a new form of treatment.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to notify the resident's physician when a resident voiced self-harm that could result in the need to alter medication or treatment related to care for 1 of 4 residents reviewed for physician's notification. (Resident B)</p> <p>Findings Include:</p> <p>Review of Resident B's clinical record began on 10/29/15 at 10:00 a.m. Diagnoses included, but were not limited to, hypertension, depression and anxiety.</p> <p>Resident B's current medications included, but were not limited to, mirtazapine (antidepressant) 30 mg daily, Seroquel (antipsychotic) 25 mg three times daily, escitalopram (antidepressant) 10 mg daily, Trazadone (antidepressant) 150 mg at night and Clonazepam (to treat panic disorder or seizure disorder) 0.5 mg twice daily.</p> <p>A medication self-administration assessment was last completed on 7/22/15. Resident B was deemed able to self medicate.</p>	R 0036	Resident B's Physician was notified on 9/9/015 by B. Holland, LPN of the occurrence The physician recommended Resident B see the Psychiatric Physician in the next 1 to 2 weeks Current residents have the potential to be affected by the alleged deficient practice The nursing staff received in-service training on 11/5/2015 by D Anderson, executive director, regarding reporting significant occurrences to family and physician The CSM is responsible for sustained compliance The ED and/or CSM will review clinical records upon notification of an occurrence Review and monitoring will be on going Completion Date 11/27/2015	11/27/2015

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	<p>Review of the clinical record, indicated Resident B received psychiatric services on 9/1/15. The chief complaint was major depressive disorder, recurrent, severe, without psychotic features and anxiety.</p> <p>A nursing note, dated 9/8/15, indicated Resident B was overheard talking to another resident about suicide and how to accomplish it. The family was notified and indicated "he does this all the time and he's not getting anymore pills". The note indicated the resident remained in his apartment all evening and was checked on several times.</p> <p>There was no documentation in the clinical record regarding the physician having been notified of the conversation.</p> <p>During an interview on 10/29/15/15 at 12:26 p.m., the Director of Nursing (DON) indicated she overheard the two resident's talking. She indicated she first thought they were talking about intercourse. She indicated she called the resident's daughter-in-law, but did not notify the physician. She indicated there was no documented monitoring of the resident following the statement of suicide.</p>			

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	<p>Review of a current facility policy, dated 12/10/2011, provided by the Executive Director on 10/29/15 at 10:30 a.m., titled "INDIANA STATE DEPARTMENT OF HEALTH-RESIDENT RIGHTS" indicated the following:</p> <p>"...10. The facility must immediately consult the resident's physician...when the facility has noticed: (a) A significant decline...mental, or psychosocial status; or (b) A need to alter treatment...."</p> <p>This State tag relates to Complaint IN00185177.</p>			