

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155754	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/27/2016
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NAME OF PROVIDER OR SUPPLIER HUBBARD HILL ESTATES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 28070 CR 24 ELKHART, IN 46517
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit also included the Investigation of Complaint IN00197131.</p> <p>Complaint IN00197131 - Substantiated. Federal/State deficiencies related to the allegations are cited at F223 and F241.</p> <p>Dates: April 18, 19, 20, 21, 22, 25, 26 & 27, 2016.</p> <p>Facility number: 001131 Provider number: 155754 AIM number: 200823940</p> <p>Census bed type: SNF: 37 SNF/NF: 9 Residential: 103 Total: 149</p> <p>Census payor type: Medicare: 15 Medicaid: 5 Other: 26 Total: 46</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC</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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F 0223 SS=D Bldg. 00	<p>16.2-3.1.</p> <p>Quality Review completed by 14454 on May 2, 2016.</p> <p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on record review and interviews, the facility failed to ensure 2 of 3 residents reviewed for abuse was free from abuse. (Resident D and Resident G)</p> <p>Findings include:</p> <p>During a confidential interview on 04/19/16 at 10:33 A.M., alert and oriented Resident E indicated the same</p>	F 0223	<p>Resident D's meal consumption is unchanged over the past 3months, averaging 50-75%. OT evaluationfor feeding techniques completed 5-12-16. Resident's E's meal consumption is unchanged since admission, rangingfrom 75-100%. Residents residing in Healthcare and Rehab have beeninterviewed regarding Abuse. No concernsbrought forward.</p> <p>1.All departments inserved</p>	05/20/2016

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	<p>gal who had disrespected him/her by being rude and bossy, had hit another resident on the mouth with a spoon during an evening meal. He/she indicated they did not recall the staff members name but knew they were from an "outside source." Resident E indicated "outside source" meant a staffing agency.</p> <p>During a confidential interview on 04/21/16 at 2:44 P.M., Resident E indicated he/she had personally witnessed the staff member use a spoon to hit a female resident who was sitting at the round table in the healthcare dining room. He/she indicated the round table was positioned next to the dining table where Resident E was seated. He/she indicated Resident D was the resident who had been hit in the mouth with the spoon. Resident E indicated he/she did not report the abuse to staff because there were several staff in the dining room who had witnessed the abuse. He/she indicated they were uncertain to whom they had reported the disrespectful and bossy care given to themselves. Resident E indicated no staff member had asked him a bout the dining room incident after it had occurred. Resident E also indicated Resident D could not speak much anymore and when she did not want to eat, she would just not open her mouth and the nursing staff member had</p>		<p>regarding HubbardHill Abuse and Neglect Policy effective 5/13/16.</p> <p>2.All departments inserviced on Resident's Rights includingthe right to refuse meals and the right to eat where resident chooses effective5/13/16.</p> <p>3.Nursing Unit Managers, on scheduled days ofwork, will audit meal service to ensure residents are assisted properly, areable to eat their meal where they choose and can refuse the meal if theychoose. These audits will occur atrandom meal times daily X 2 weeks, then 3 times per week X 2 weeks, then weeklyX 4 weeks, then monthly.</p> <p>Results of the audits will bereviewed bi-weekly at the Clinical Management Meeting with the Director ofNursing/VP of Quality Management, and quarterly at the QA meeting x 2. At that time will review for continued needfor auditing.</p>				

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	<p>been upset when Resident D would not open her mouth and that is when she (staff) hit the resident in the mouth.</p> <p>During an interview on 04/20/16 at 6:25 P.M., CNA (Certified Nursing Assistant) #11 indicated a dietary staff member had notified her she had observed an agency staff member, Employee #10, hit Resident D in the mouth with a spoon. CNA #11 indicated she herself had not witnessed the abuse but she took the dietary staff member to the nurse and told the staff member she should report to the nurse her observations.</p> <p>During an interview on 04/20/16 at 5:58 P.M., the evening nursing House Supervisor, RN (Registered Nurse) #12 indicated she had heard about an incident of abuse that had occurred about a month ago involving an agency staff member who was feeding Resident D and when the resident would not open her mouth the agency staff had reportedly "popped" the resident on the mouth with the spoon. RN #12 indicated she was not working that particular weekend but she knew the agency staff member, Employee #10 had been sent home immediately.</p> <p>Review of the investigation into the incident with Resident D and agency staff member CNA #10 was reviewed on</p>			

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	<p>04/21/2016 at 2:30 P.M. The form, titled "Proof of Internal Investigation Report" indicated an alleged incident occurred on 04/02/16 in the healthcare dining room. The allegation was reported to the State Department of Health on 04/03/16 at 2:00 P.M. The allegation was also reported to the Ombudsmen. The form indicated nurse, RN #16 had notified the Director of Nursing of the allegation. The form indicated on 04/02/16 at 6:30 P.M., CNA #11 had been notified of the allegation by dietary server, Employee #13. The form indicated agency CNA, Employee #10 was feeding Resident D. Resident D would not open her mouth so CNA #10 tried "pushing" the spoon in anyway. The investigation also indicated Employee #10 would not allow Resident G to eat his dessert in the dining room and forced him to leave the dining room.</p> <p>A staff interview summary form, completed on 04/03/16 at 10:00 A.M., by the Director of Nursing in her handwriting, indicated a phone interview had been completed for dietary server, Employee #13. The summary section indicated in the dining room CNA, Employee #10 was feeding Resident D, and when the resident did not open her mouth, Employee #10 shoved the spoon into her mouth. CNA #10 then "tapped" her (Resident D) on the mouth with the</p>				

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	<p>back of the spoon and Resident D still would not open her mouth. CNA #10 was "visibly frustrated" and was overheard commenting "I'm sick of this s- -- - these residents not wanting to eat." She quit trying (to feed Resident D) and walked away. The form also indicated CNA #10 would not let Resident G eat his dessert at the dining room table and she pulled the resident away from the dining room table even though he both verbalized and tried to pull himself up to the table.</p> <p>A staff interview summary form, completed on 04/03/16 no time given, in the Director of Nursing's handwriting, for dietary server, Employee #14 indicated CNA #10 was observed by Employee #14 "bullying" Resident G in the dining room and not letting him do what he wanted to do. The summary also indicated CNA #10 was feeding Resident D and was trying to "push" the spoon into her mouth. Resident D would not open her mouth so CNA #10 "tapped" Resident D on the lip with the spoon to get her to open her mouth.</p> <p>The Incident report and 5 day follow up form, submitted by the facility to the Indiana State Department of Health indicated the following: "04/03/16 Agency CNA (Agency Name) , (CNA</p>			

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	<p>#10's name) was feeding (Resident #D's name and age) with dementia. (Resident D's name) closed her mouth, per her usual, when she didn't want anymore to eat. (CNA #10's name) continued pushing the spoon to (Resident D's) mouth to get her to eat. Agency CNA (Agency Name) (Resident #10's name) approached (Resident G's name) to take him back to his room He stated he wanted to eat dessert. (CNA #10's name) told him he could eat in his room. He stated he wanted to eat it in the dining room. She told him sharply "No, we are going back to your room." (CNA #10's name) pulled his chair back from the table and helped him stand and walked him away from the dining room towards the nurses station...Follow up added 04/07/16 As a result of the investigation, we have the alleged incident with CNA (Employee #10's name) and residents (Resident D and G's names) unsubstantiated. After discussion with (CNA #10's name) and other staff on duty, it was noted that there was no willful harm towards residents. Due to concerns brought forward, (CNA #10's name) will not be returning to Hubbard Hill at this time as she does not meet the professional standards of care."</p> <p>During an interview on 04/22/2016 at 11:46 A.M., RN (Registered Nurse) #15,</p>			

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	<p>the Vice President of Quality, indicated the accused aide sounded "hurried" not "willful" regarding abuse. She indicated there was documentation of "tapping" but not "hitting" Resident D on the mouth.</p> <p>During an interview on 04/22/2016 at 11:58 A.M., the Administrator indicated Resident G was taken care of ultimately by another CNA and the witnesses were young, high school girls and their observations were "subjective" when it came to abuse.</p> <p>Both the Administrator and RN #15 indicated the Director of Nursing (DON) had completed the investigation. The DON was not in the building on 04/22/16 to be interviewed regarding the incident.</p> <p>During a telephone interview on 04/26/16 at 8:57 P.M., dietary server, Employee #14, indicated she had witnessed a staff member who was not a usual staff member (nursing agency staff) "hit another resident in the mouth with the back of the spoon." When asked if the employee had "tapped" the spoon against Resident D's mouth, Employee #14 indicated "No, she hit her because she wouldn't open her mouth. It was not gentle and it made a noise when she hit her." Employee #14 indicated she and another staff member, Employee #13 had</p>			

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	<p>both witnessed the abuse and Employee #13 had reported the abuse. She indicated the staff member "in charge of the nursing department" had directed Employee #13 to provide a written statement. Employee #13 indicated both she and Employee #14 had written down their statements. Employee #13 confirmed she had written the word, "hit" and not "tapped." She also indicated the same employee had tried to "hurry" and "force feed" Resident G also.</p> <p>During an interview on 04/27/2016 9:20 A.M., the DON indicated the staff involved in the CNA #10 abuse investigation did submit written statements but she also spoke to them on the telephone and read back their statements to them so she did not keep the written statements. She indicated she knew she should have kept copies of written statements for an abuse investigation.</p> <p>This Federal tag related to Complaint #IN00197131.</p> <p>3.1-27(a)(1)</p>			

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F 0241 SS=E Bldg. 00	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observations, record review and interviews, the facility failed to ensure call lights were answered timely for 2 residents. (Residents B and C). In addition, the facility failed to ensure meals were served in a dignified manner to 2 dependent residents in 1 of 2 dining rooms observed. (Resident #13 and #65)</p> <p>Findings include:</p> <p>1. During the dining observation in the Healthcare dining room, conducted on 04/20/16 at 5:05 P.M., Resident #65 was seated in the dining room at a circle shaped table with no food while all other residents at the same table were being fed. Resident #65 did not receive her food until 5:25 P.M., 20 minutes later.</p> <p>Resident #13 was observed on 04/20/16 from 5:05 P.M. - 5:23 P.M., seated at a circle shaped table with her food in front of her. Resident #13 was not being assisted to eat, but was awake staring at her food. A staff member was seated next to Resident #13 and was feeding</p>	F 0241	<p>Resident B has been interviewed and states call lightresponse has been timely. Resident C has discharged home from rehab on 5-13-16. Resident #65 discharged home from rehab on 4-6-16. Resident #13's meal consumption has been consistent over the past 3 months. Resident 13's weight has been stable for past year. Residents residing in Healthcare and Rehab have been interviewed regarding Call light response. No significant concerns brought forward. The residents requiring assistance with meals all have the potential to be affected during meal service related to waiting for assistance. Residents requiring assistance will be escorted to their table once their meal is ready and assistance is available.</p> <p>1. All departments inserviced regarding Hubbard Hill Call Light Policy effective 5/13/16.</p> <p>2. Nursing Staff inserviced regarding Dining Assistance in Dining Room Policy effective 5/13/16.</p> <p>3. Dietary Staff inserviced on Dining Assistance in Dining Room Policy effective 5/13/16.</p>	05/20/2016

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	<p>another resident but made no attempt to assist Resident #13 with her food.</p> <p>On 04/21/16 at 8:31 A.M., Resident #65 was observed in the healthcare dining room at a circle shaped table. Resident #65 was awake and did not have her breakfast food even though there were other residents and three staff members seated at the table. The residents on both sides of her were being fed their breakfast by staff members. Resident #65 did not receive her breakfast food or any beverages until 8:44 A.M. Once Resident #65 was served her meal, she began feeding herself toast and gave herself a drink from her cup.</p> <p>During an interview on 04/27/16 at 11:30 A.M., the Director of Nursing indicated dependent residents were not fed until staff were available to feed them. She indicated they were also not fed until they arrived at the table. She indicated she would have to "look into it" regarding concerns with how long a dependent resident should sit while others at the same table are being assisted.</p> <p>The current, undated, facility policy titled "Unidine," regarding dining was provided by the Director of Nursing on 04/26/16 at 1:35 P.M. The policy indicated "...Open Dining Description:...Residents are</p>		<p>4. Staff Development Coordinator, on scheduled days of work, will audit meal service for residents requiring assistance in the healthcare dining room to assure residents are not at the table without food while others at their table are eating and/or are assisted timely once their food arrives. These audits will occur daily X 2 weeks, biweekly X 2 weeks, weekly X 4 weeks, and then monthly.</p> <p>5. Social Services, on scheduled days of work, will audit call light response time during meal service for breakfast and lunch daily X 1 week, three times per week X 3 weeks, weekly X 4 weeks, then monthly.</p> <p>6. Evening House Supervisor, on scheduled days of work, will audit call light response time during meal service for dinner daily X 1 week, three times per week X 3 weeks, weekly X 4 weeks, then monthly.</p> <p>Results of the audits will be reviewed bi-weekly at the Clinical Management Meeting with the Director of Nursing/VP of Quality Management, and quarterly at the QA meeting x 2. At that time will review for continued need for auditing.</p>		

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	<p>waited on at their tables as they arrive to ensure them customized timely service. The exception to this is: Residents who need assistance to eat or to be cued or for any other designated safety concern, will be provided their meal once the caregiver arrives."</p> <p>2. During an observation of the evening care and staffing, completed on 04/20/16 from 5:05 P.M. - 7:00 P.M., the following was noted:</p> <p>Resident #B's call light was first observed activated at 5:15 P.M. Resident #B was propelling his wheelchair around the Blue healthcare hallway. There were 6 nursing staff members in the health care dining room, and two staff members in the Rehab 2 dining room. There were no staff members noted on the Blue hallway or at the Healthcare nursing station. Resident B's call light was not answered until 5:29 P.M. Alert and oriented Resident B indicated he was very frustrated and his light had been on for 45 minutes. He indicated he needed to go to the bathroom.</p> <p>Resident #C's call light was first observed activated at 6:00 P.M. Resident #C was in her room and she had a visitor in the room with her. There were no nursing staff observed in close proximity</p>			

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	<p>to her room, CNA (Certified Nursing Assistant) #17 was serving meal trays and room meal trays in the Rehab 1 dining room and other sections of the rehab unit unit. There were no nursing staff members at the Rehab nurse's station. The was a non- nursing staff member seated in a chair in the lounge area just outside Resident C's room talking and visiting with visitors. At 6:17 P.M., Resident C's family member verbalized loudly she was "p----." She indicated Resident C needed to go to the bathroom and she had waited 37 minutes for assistance. She indicated this was unusual and she had noted CNA #17 in the hallway holding a meal tray "for a long time." Resident C's family member finally spoke to the non-nursing staff member, who had stood from his seated position, explained her frustration and he was overheard explaining to Resident C's family member that she would need to wait for help as staff were still delivering meal trays. At 6:21 A.M., CNA #18 was noted to answer Resident C's call light and assist her to the bathroom.</p> <p>During an interview with CNA #17 on 04/20/16 at 7:00 P.M. she indicated she was offended by the attitude of Resident C's family member because she (CNA #17) had to pass meal trays and could not answer the call light.</p>			

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F 0323 SS=D Bldg. 00	<p>The current facility policy and procedure titled "Answering the Call Light," dated April 2013, was provided by LPN (licensed Practical Nurse) #19 on 04/27/16 at 11:30 A.M. The policy and procedure included the following: "...8. Answer the resident's call as soon as possible."</p> <p>This Federal tag related to Complaint #IN00197131.</p> <p>3.1-3(t)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure chemicals were stored properly. This deficient practice had the ability to affect 1 of 7 residents reviewed for chemicals in their rooms. (Residents #67)</p>	F 0323	<p>Resident #67's personal supplies have all been placed in a drawer in her room.</p> <p>Residents residing in Healthcare and Rehab have had all of their personal supplies placed in a drawer in their rooms.</p> <p>1. Nursing Staff inserviced on</p>	05/20/2016

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NAME OF PROVIDER OR SUPPLIER HUBBARD HILL ESTATES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 28070 CR 24 ELKHART, IN 46517		
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	<p>Finding includes:</p> <p>On 4/19/16 at 9:42 A.M., a box of denture tablets and a bottle of air freshener was observed to be sitting on the sink in Resident #67's room.</p> <p>During an environment tour on 4/26/2016 at 10:27 A.M., the following was observed:</p> <p>A box of denture tablets and a bottle of mouth wash was observed to be sitting on the sink in Resident #67's room.</p> <p>A bottle of air freshener was observed sitting on a dresser in Resident #67's room.</p> <p>During an interview conducted on 4/26/16 at 10:27 A.M., the maintenance director and the director of housekeeping indicated they also observed the chemicals in Resident #67's room.</p> <p>A BIMS (Brief Interview for Mental Status) examination was performed on 2/11/2016 and indicted Resident #67s score was 4. A BIMS score of 4 indicated the resident was severely cognitively impaired.</p> <p>A policy for the proper storage of chemicals in the facility was requested on</p>		<p>Personal Care Items Policyeffective 5-13-16. 2.Nursing Managers will audit resident rooms onscheduled days of work, to ensure all personal care items are storedappropriately. Audits will occur daily X2 weeks, biweekly X 2 weeks, weekly X 4 weeks, then monthly. Results of the audits will bereviewed bi-weekly at the Clinical Management Meeting with the Director ofNursing/VP of Quality Management, and quarterly at the QA meeting x 2. At that time will review for continued needfor auditing.</p>		

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F 0329 SS=D Bldg. 00	<p>4/26/16 at 11:00 A.M., and the facility indicated they did not have a policy for chemical storage.</p> <p>3.1-45(a)(1)</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 these drugs.</p> <p>Based on interview and record review, the facility failed to ensure proper documentation to support the use of antipsychotic medication for 2 of 3</p>	F 0329	Resident #54 and resident #98 have had Behavior Monitoring Flowsheets updated to reflect target behaviors. Resident #54 has a longstanding diagnosis of psychosis	05/20/2016	

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	<p>residents reviewed for unnecessary medications. (Residents #54 and #98)</p> <p>Findings include:</p> <p>1. A clinical record review was conducted on 4/21/2016 at 10:28 A.M., for Resident #54 and indicated she was admitted on 7/29/2015. Diagnoses included but were not limited to: osteoarthritis, obstructive sleep apnea, cognitive deficits secondary to cardiovascular disease, depression and psychosis.</p> <p>A physician order, dated 3/8/16, indicated Resident #54 was to have Risperadol 0.25 mg (an antipsychotic medication) (milligrams) twice a day due to psychosis.</p> <p>The nurses notes for resident #54 indicated no supporting documentation for the use of an antipsychotic medication before the Risperadol order dated 3/8/16.</p> <p>The monthly behavior monitoring flowsheets for the months of February and March 2016 indicated only one episode of hallucinations on 2/22/16 and indicated the hallucination was ended with re-direction. No other supporting documentation was available to support the use of an antipsychotic medication</p>		<p>and was started on an antipsychotic in March 2016. Her Gradual Dose Reduction review will occur in September 2016. Resident #98 has had a Gradual Dose Reduction of his antipsychotic on 3/10/16.</p> <p>Resident #54 and resident #98 are the only two residents on antipsychotic medications.</p> <p>1. Nursing staff inserviced regarding Behavior Assessment and Monitoring Policy, effective 5/13/16.</p> <p>2. Pharmacist educated Psychiatric Nurse Practitioner regarding regulations, behavior monitoring, and specific behaviors that warrant antipsychotic use in the elderly on 5/6/16.</p> <p>3. Pharmacist and Psychiatric Nurse Practitioner inserviced key nursing staff regarding antipsychotic use, behavior tracking and assessment on 5/6/16.</p> <p>4. Residents exhibiting new behaviors will have a nursing assessment completed, primary physician notified, Nursing Unit Manager notified and behaviors tracked x 1 week, prior to involving psychiatric services and/or initiating antipsychotic medications.</p> <p>5. Nursing Unit Managers will audit resident behavior monitoring flow sheets on scheduled days of work, to ensure new behaviors are tracked. Audits will occur daily X 2 weeks, biweekly X 2 weeks,</p>	

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	<p>initiation.</p> <p>During an interview on 4/25/2016 at 10:05 A.M., the social service director indicated they had looked through Resident #54's chart and were not able to find enough documentation to support the use of an antipsychotic medication.</p> <p>2. A clinical record review was conducted on 4/21/2016 at 2:38 P.M., for Resident #98 and indicated he was admitted on 7/30/2016. Diagnoses included but were not limited to: symptomatic bradycardia, rheumatoid arthritis, colon cancer, prostate cancer, memory loss, and sundowning/behaviors and end stage Alzheimer's.</p> <p>A physician order, dated 10/28/2015, indicated Resident #98 was to have Seroquel 25 mg (an antipsychotic medication). The order showed no indication for the medication.</p> <p>A physician clarification order, dated 4/25/2016, indicted the 10/28/2015 was ordered for dementia with behavioral disturbance.</p> <p>The monthly behavior monitoring flowsheet for October 2015 indicated the facility was monitoring "calling out" and "resisting care." The flowsheet showed</p>		<p>weekly X 4 weeks, then monthly.</p> <p>Results of the Unit Manager audits will be reviewed weeklyat the Clinical Management Meeting with the Director of Nursing/VP of QualityManagement, and quarterly at the QA meeting x 2. At that time will review for continued needfor auditing.</p>				

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	<p>multiple occasions where Resident #98 was "calling out." The flowsheet did not show any behaviors that would support the use of an antipsychotic medication.</p> <p>The nurses notes for October 2015 did not indicate supporting documentation for the use of an antipsychotic medication.</p> <p>During an interview on 4/26/2016 at 9:50 A.M., the Vice President of Quality, RN (Registered Nurse) #15, indicated there was no further documentation to support the use of an antipsychotic medication available.</p> <p>The Vice President of Quality, RN #15, provided a procedure form on 4/26/2016 at 9:54 A.M., titled "SPECIFIC MEDICATION ADMINISTRATION PROCEDURES," dated 6/1/2015 and indicated this was the procedure form currently followed by the facility. The procedure form indicated "...Unnecessary Medications (F329) [Federal citation number] as: "any medication used for managing behavior, stabilizing mood, or treating psychiatric disorders."...."</p> <p>A policy was requested on 4/25/2016 at 10:05 A.M., the Vice President of Quality, RN #15, indicated the facility had no other policy regarding the specific</p>			

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R 0000 Bldg. 00	<p>topic.</p> <p>3.1-48(a)(4)</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Residential Census: 103</p> <p>Sample: 7</p> <p>Hubbard Hill Estates was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.</p>	R 0000		