

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155744	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/23/2016
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NAME OF PROVIDER OR SUPPLIER  LUTHERAN LIFE VILLAGES	STREET ADDRESS, CITY, STATE, ZIP CODE 351 N ALLEN CHAPEL RD KENDALLVILLE, IN 46755
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: February 17, 18, 19, 22, 23, 2016.</p> <p>Facility number: 000570 Provider number: 155744 AIM number: 100275010</p> <p>Census bed type: SNF: 8 SNF/NF: 72 Total: 80</p> <p>Census Payor type: Medicare: 7 Medicaid: 52 Other: 21 Total: 80</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed on February 24, 2016 by 17934.</p>	F 0000	<p>This plan of correction is being submitted as our allegation of compliance. It is noted that the survey dates should read: February 17, 18, 19, 22, 23, 2016. It is further noted that there is no Resident #34 listed on the "Stage 2 Sample Resident List" for F0329. The response submitted is in reference to Resident #43 for F0329. Please consider this Plan of Correction for "paper compliance."</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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F 0224 SS=D Bldg. 00	<p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATION</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to ensure staff did not misappropriate the property of 2 of 3 residents reviewed for abuse (Resident #37 and Resident #39).</p> <p>Findings include:</p> <p>The facility Administrator and the Director of Nursing (DON) were both interviewed on 2/23/2016 at 1:30 P.M.</p> <p>During the interview, the DON indicated she had arrived at the facility on 2/11/2016 at approximately 6:40 A.M. and was informed by the charge nurse that on 2/10/2016 at approximately 10:20 P.M., LPN #2 had administered Phenergan (medication used to treat nausea and vomiting) by intramuscular injection to CNA #3 because the CNA had been feeling ill during the shift. After the injection, CNA #3 had become dizzy and fell to the floor. LPN #2 had a QMA (Qualified Medication Aide) call 911. CNA #3 was then transported to a local hospital emergency room via</p>	F 0224	<p>1 On 2/24/16, the medication misappropriated from the 2 residents identified was credited to the resident's pharmacy bill; the facility was billed for the two medications by the pharmacy 2 On 2/24/16, reviewed monthly pharmacy medication audits; no other medication discrepancies were identified for the remaining residents in the facility 3 On 2/24/16, reviewed the current Abuse Policy regarding Misappropriation of Resident Property, and no changes required at this time 4 On 2/24/16, the Abuse Policy was distributed to all staff members to review, specifically, regarding Misappropriation of Resident Property 5 By 3/4/16, all departments will review the Abuse Policy with each staff member regarding Misappropriation of Resident Property in terms of medications 6 On-going resident medication audits will occur via pharmacy consultant's monthly review; results will be shared during the monthly QAA Committee meeting 7 The annual employee abuse training coordinated by Human</p>	03/04/2016			

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	<p>ambulance by Emergency Medical Services (EMS). The DON further indicated she informed the facility Administrator of the incident on 2/11/2016 at 8:00 A.M.</p> <p>During the interview, the facility Administrator indicated she instructed the DON to investigate the incident. The Administrator indicated she also reported the incident to the State Department of Health at 8:30 A.M. on 2/11/2016.</p> <p>During the interview, the DON indicated the subsequent investigation indicated LPN #2 had removed the Phenergan from Resident #37's medication supply and had administered the Phenergan to CNA #3.</p> <p>The DON further indicated that during the investigation of the incident, it was discovered CNA #3 had also complained to QMA #4 of not feeling well earlier on 2/10/2016 at 6:30 P.M. and QMA #4 had removed a dose of Zofran (medication used to treat nausea and vomiting) from Resident #39's medication supply and administered the medication to CNA #3.</p> <p>During the interview, the facility Administrator indicated taking medication from a resident's supply of medication to administer to another</p>		Resources will continue as a part of our QAA Program for employee training UPLOAD: Abuse Policy In-Service Posting		

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F 0329 SS=D Bldg. 00	<p>person was considered misappropriation of the resident's property. The Administrator further indicated LPN #2, CNA #3, and QMA #4 were terminated from employment for misappropriation of resident property.</p> <p>A facility policy entitled "Abuse Prohibition", with a revision date on 10/12/2015, was provided by the facility Administrator on 2/23/2016 at 1:45 P.M. The policy indicated misappropriation of resident funds or property as the "deliberate misplacement, exploitation, , or wrongful, temporary or permanent use of a resident's property or money without the resident's consent." The policy further indicated property included "any medication dispensed in the name of the resident."</p> <p>3.1-28(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</p>			

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	<p>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 record review and interview, the facility failed to ensure non-pharmacological interventions were attempted before administering as needed (PRN) psychotropic medications for 1 of 5 residents (#43) reviewed for unnecessary medications.</p> <p>Findings include:</p> <p>Resident #43's clinical record was reviewed on 2/17/16 at 2:06 P.M.. Resident #43's physician's orders for medications indicated Ambien (a sedative medication) 5 milligrams (mg) was ordered 3/29/15 and was to be given by mouth PRN 1 time per day for insomnia. Resident #43 also had a physician's order for Xanax (an anti-anxiety medication)</p>	F 0329	<p>NOTE: There is no Resident #34 on the "Stage 2 Sample Resident List" during prior discussions with the surveyor, it is noted this should be Resident #43 1 On 2/24/16 reviewed PRN anxiety and/or hypnotic resident medications during the monthly Behavior Management/Pharmacy Meeting 2 On 2/25/16 a list of residents taking a PRN hypnotic and/or anxiety medication was reviewed to identify other residents for non-pharmacological interventions 3 On 2/29/16 the physician reviewed Resident #43 medication orders for the hypnotic and anxiety medications; no changes were made to these PRN medications 4 By 3/11/16 the "other" identified residents' care plans will be reviewed/revised regarding</p>	03/18/2016

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	<p>9.5 mg was ordered on 11/4/15, and was to be given by mouth PRN 3 times per day for anxiety disorder.</p> <p>Review of Resident #43's Medication Administration Record (MAR), provided by the Director of Nursing (DoN) on 2/22/16 at 2:15 P.M., from 1/1/16 through 2/22/16, indicated PRN Ambien 5 mg was administered on 14 occasions for insomnia. On 12 of the 14 Ambien 5 mg, PRN administrations for insomnia, no non-pharmacological interventions were documented as being attempted before administration of the medication.</p> <p>Review of Resident #43's Medication Administration Record (MAR), provided by the DoN on 2/22/16 at 2:15 P.M., from 1/1/16 through 2/22/16, indicated PRN Xanax 0.5 mg was administered on 15 occasions for anxiety. On 1 occasion of PRN Xanax 0.5 mg administration, non-pharmacological interventions were documented as attempted, but unsuccessful, before administration of the medication. On 7 of the 16 occasions of PRN Xanax 0.5 administration, the resident requested the medication and it was administered. On 8 of the 16 occasions of PRN Xanax 0.5 mg administration, no request for the medication or non-pharmacological interventions attempted, were</p>		<p>non-pharmacological interventions 5 On 2/29/16 the Monitoring of Sedatives Policy and the Monitoring of Hypnotics Policy was reviewed. It was decided to combine the two policies into one and revise the language to include non-pharmacological intervention documentation prior to administering a PRN hypnotic and/or anxiety medication. 6 On 2/26/16 DON created non-pharmacological intervention documentation MAR forms for hypnotic and anxiety PRN medications 7 By 3/11/16 a licensed nurse in-service will be conducted to review the revised policy regarding non-pharmacological interventions documentation prior to administering a PRN hypnotic and/or anxiety medication 8 Clinical documentation for non-pharmacological interventions for PRN hypnotic and/or anxiety medications will be audited by the DON/designee on a monthly basis by auditing 10% of the MARs per unit; the results will be reported to QAA Committee monthly meeting UPLOAD: Documentation for Use of Anxiolytics/Sedative-Hypnotics In-Service Posting; Revised Monitoring of Anxiolytics and Sedative-Hypnotics Policy; PRN Anxiolytic MAR; and PRN Sedative-Hypnotic MAR</p>	

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	<p>documented before administration of the medication.</p> <p>Resident #43 had a care plan started on 3/29/15 for complaints of sleeplessness. The goal was to have 6-8 hours uninterrupted sleep. Interventions included, but were not limited to: encourage the resident to develop a nighttime routine that is conducive to sleep, time of bed, soft music, low lights, reading, etc.; offer hot chocolate, sleepytime tea, decaf coffee, warm milk; try non-medical interventions if the resident allows (support pillows, back rub, offer food/drink)</p> <p>Resident #43 had a care plan started on 9/26/15 for a bi-polar disorder and anxiety. The goal was the resident's signs and symptoms of bi-polar and anxiety will be managed through interventions and medication. The interventions included, but were not limited to: allow resident to calm down before continuing care; encourage resident to participate in out of room social, activity programs; talk with resident about topics of interests (dogs, reading, shopping); allow resident to express feelings openly; encourage resident to leave common areas and to go to another area of the building if other residents make her feel uncomfortable.</p>			

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	<p>An interview with the DoN on 2/22/16, at 2:00 P.M. indicated no further documentation of non-pharmacological interventions before administration of PRN Ambien and Xanax could be located for resident #43. The DoN indicated nursing staff should attempt non-pharmacological interventions before administration of PRN medications.</p> <p>Review of a current facility policy/procedure "Monitoring of Sedatives", revision date 5/22/08, provided by the DoN on 2/22/16 at 2:15 P.M., indicated Xanax was a short acting sedative. Under Procedure, #2: "Non-Pharmacological behavior modification activities and their effects, as well as the effect of the Pharmacological behavior modifiers are addressed in the progress notes (nurse's notes) of the resident's medical record. Under Procedure, #4: "Sedative medications ordered on PRN basis are administered only at the request of the resident or, if nursing judgment indicates it is warranted in the case of a non communicative resident or other situation where sedation is in the resident's best interest."</p> <p>Review of a facility policy/procedure "Monitoring of Hypnotics", revision date 5/23/08, provided by the DoN on 2/22/16</p>			

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	<p>at 2:15 P.M., indicated Ambien was a hypnotic medication. Under Procedure, #2: "Non-Pharmacological behavior modification activities and their effects, as well as the effect of Pharmacological behavioral modifiers are addressed in the nursing notes in the resident's chart." .</p> <p>Under Procedure, #4: "Hypnotic medications ordered on PRN basis are administered only at the request of the resident or, if nursing judgment indicates it is warranted in the case of a non communicative resident or other situation where sedation is in the resident's best interest."</p> <p>3.1-48(b)(1)</p>			