

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/12/2013
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NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: June 5, 6, 7, 10, 11, and 12, 2013</p> <p>Facility Number: 000057 Provider Number: 155132 AIM Number: 100266570</p> <p>Survey Team: Lora Brettnacher, RN - TC Heather Lay, RN</p> <p>Census Bed Type: SNF: 23 SNF/NF: 65 Total: 88</p> <p>Census Payor Type: Medicare: 22 Medicaid: 54 Other: 12 Total: 88</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on 06/18/2013 by Brenda Nunan, RN.</p>	F000000	<p><i>"This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report."</i> Danville Regional Rehabilitation Center respectfully requests a desk review for paper compliance on the Licensure Recertification Annual Survey. Not only will you find the Plan of Correction, but also additional and supplemental actions we have taken to ensure we as care givers are ensuring the residents are able to meet the highest practicable physical, mental, and psychosocial well being. Should you need any additional information for the compliance review, please feel free to contact the facility at 317-745-5451. Thank You for your consideration.</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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F000279 SS=E	<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> <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 an individualized care plan for 3 of 10 residents reviewed for unnecessary medications [Residents #114, #217, and #219] and failed to develop a coordinated hospice care plan for 1 of 1 resident reviewed for hospice services [Resident #7].</p> <p>Findings include:</p> <p>1. On 6/10/13 at 10:34 A.M., Resident #114's record was reviewed. Diagnoses included, but were not</p>	F000279	Resident # 114 has been re-assessed by the IDT with care plan updates completed as deemed appropriate. Resident #217 has been re-assessed by the IDT with care plan updates completed as deemed appropriate. Resident # 219 has been re-assessed by the IDT with care plan updates completed as deemed appropriate. Resident # 7 has been re-assessed by the IDT with care plan updates completed as deemed appropriate. A one time audit has been completed for current resident population to ensure residents with as needed anti-anxiety meds have	07/12/2013	

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	<p>limited to, diabetes mellitus, hypertension, and dementia.</p> <p>A medication administration record [MAR], dated 5/1/13 through 5/31/13 indicated, "...Lorazepam [Ativan] [anti-anxiety medication] 0.5 milligrams [mg] give 1 tablet bid as needed.... [marked as given on]: 5/1/13, 5/2, 5/4 thru 5/6, 5/10, 5/14 thru 5/17, 5/21 thru 5/26/13.</p> <p>A medication administration record [MAR], dated 6/1/13 through 6/30/13 indicated, "...Lorazepam [Ativan] [anti-anxiety medication] 0.5 mg give 1 tablet bid as needed.... [marked as given on]: 6/3/13, 6/6, 6/7, 6/8, and 6/9/13.</p> <p>There was no documentation in Resident #114's clinical record of non-pharmacological interventions used prior to the administration of the as needed anti-anxiety medication.</p> <p>A "Mood and Behavior Symptom Assessment/Plan of Care," dated 9/28/12, indicated, "...Psychotropic drug use: Ativan: Diagnosis: Anxiety... Behavioral symptoms drug is intended to treat: panic, nervousness... Goal: No negative outcomes resulting from use of psychotropic medication...</p>		<p>non-pharmacological interventions listed, residents with Coumadin have anti-coagulant care plans in place which addresses associated risks, and residents receiving Hospice have a coordinating care plan process. Supervisory Nursing staff have been re-educated on providing non-pharmacological interventions and completing documentation of said interventions in the clinical record. The interdisciplinary team has been re-educated on completing required care plans within the appropriate RAI instruction, as well coordinating care with Hospice. It is the responsibility of the Licensed Nurse to offer non-pharmacological interventions to a resident prior to administering an as needed medication. It is the responsibility of the IDT to complete necessary care plans and include associated risk factors and to coordinate care with Hospice. The DON/designee will be responsible to review compliance with non-pharmacological interventions and documentation prior to administering an as needed medication, completion of required care plans, and hospice coordination daily for 14 days, weekly for 12 weeks, monthly for 4 months, and then quarterly for two quarters. Any identified concerns will be immediately addressed and 1:1</p>	

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	<p>Interventions: 12/28/12: Monitor for side effects, Monitor for drug-related Cognitive/Behavioral impairment, Monitor for drug related discomfort...."</p> <p>The care plan did not address the non-pharmacological interventions used prior to administration of the as needed anti-anxiety medication.</p> <p>On 6/10/13 at 11:32 A.M., in an interview, Licensed Practical Nurse [LPN] #2 indicated prior to administering an as needed anti-anxiety medication, non-pharmacological interventions were required and and should have been documented in the clinical record.</p> <p>On 6/11/13 at 12:50 P.M., in an interview, the Administrator indicated the facility did not develop a care plan for Resident #114 that included non-pharmacological interventions used prior to administration of the as needed anti-anxiety medication.</p> <p>2. On 6/11/13 at 2:24 P.M., Resident #217's record was reviewed. Diagnoses included, but were not limited to, atrial flutter, general muscle weakness, hyperpotassemia, and closed kidney injury.</p>		<p>re-education will be completed. Continued non-compliance will result in disciplinary action up, to and including termination as per policy. The Administrator/designee will review results of the auditing and forward to the Quality Performance Improvement monthly. Any further action necessary will be as determined by the QPI committee.</p>				

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	<p>A physician's orders, dated 5/24/13, indicated, "...Coumadin [anti-coagulant] 10 milligrams daily...."</p> <p>A "Cardiovascular/Circulatory Care Plan," dated, 5/24/13, indicated, "... Potential for alteration in circulation related to: atrial flutter and right sided chronic heart failure... Will be free from signs/symptoms of increased shortness of breath, dyspnea, chest pain, or other signs/symptoms of cardiac distress daily... Interventions: Medications/treatments as ordered, Update physician/family as needed, Vital signs per protocol...."</p> <p>The care plan did not address risks associated with Coumadin use.</p> <p>On 6/12/13 at 9:10 A.M., the Administrator indicated the facility failed to develop a care plan related to Coumadin use and the associated risks of use for Resident #217.</p> <p>3. On 6/11/13 at 1:54 P.M., Resident #219's record was reviewed. Diagnoses included, but were not limited to, renal failure, malignant neoplasm of the vulva, status post mechanical valve placement, and chronic kidney disease.</p> <p>A physician's orders, dated 5/31/13,</p>			

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	<p>indicated, "...Warfarin [Coumadin] 2.5 mg by mouth on Monday and Tuesday for mechanical valve... Warfarin 5 mg on Wednesday, Thursday, Friday, Saturday, and Sunday...."</p> <p>A "Cardiovascular/Circulatory Care Plan," dated, 6/1/13, indicated, "... Will be free from signs/symptoms of increased shortness of breath, dyspnea, chest pain, or other signs/symptoms of cardiac distress daily... Interventions: Medications/Treatments as ordered, Update physician/family as needed, Vital signs per protocol...."</p> <p>The care plan did not address risks associated with Coumadin use.</p> <p>On 6/12/13 at 9:10 A.M., the Administrator indicated the facility failed to develop a care plan related to Coumadin use and the associated risks of use for Resident #219.</p> <p>4. Resident #7's record was reviewed on 6/10/2013 at 11:18 A.M. Resident #7 had diagnoses which included, but were not limited to, depression, dementia, hypertension, and anxiety.</p>				

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	<p>On 2/7/2013, Resident #7 was placed on hospice for a diagnoses of adult failure to thrive.</p> <p>Resident #7's record lacked documentation of a comprehensive, coordinated care plan which indicated the disciplines responsible for assisting in achieving goals set for her.</p> <p>During an interview on 6/10/2013 at 1:00 P.M., Registered Nurse (RN) #1 indicated hospice had a separate binder in which they documented their plan of care and interventions. The facility's documentation was separate. She indicated the facility and hospice did not have a coordinated care plan..</p> <p>During an interview on 6/10/2013 at 1:20 P.M., the Director of Nursing (DON) and RN #2 both indicated hospice and the facility did not have a coordinated plan of care for Resident #7.</p> <p>3.1-35(a) 3.1-35(d)(2)(A)</p>				

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident's medication was given as ordered. This deficient practice affected 1 of 3 residents observed during medication pass [Resident #32].</p> <p>Findings include:</p> <p>On 6/12/13 at 10:05 A.M., Licensed Practical Nurse [LPN] #1 was observed administering medications to Resident #32. At that time, Resident #32 received Paxil [anti-depressant] 30 milligrams/15 milliliters [ml] via her gastrostomy tube [g-tube].</p> <p>A physician's orders, dated 6-1-13 through 6-30-13, indicated, "...Paroxetine HCL [Paxil] 20 mg tablet, give 1 tablet via g-tube once a day [order date 1/31/13]...."</p> <p>On 6/12/13 at 10:15 A.M., in an interview LPN #1 indicated she administered 30 mg/15 ml.</p>	F000282	<p>Resident # 32 has been re-assessed by the IDT with care plan updates completed as deemed appropriate. A one time medication cart review has been completed to ensure medication orders are correct. Licensed staff nurses have been re-educated on the six rights of medication pass, and confirming medication orders prior to giving a medication should there be a discrepancy. It is the responsibility of the Licensed Nurses to administer medications as per physician's order. The DON/designee will conduct medication pass observations 5 times a week for 4 weeks, 3 weekly for 4 weeks, 2 monthly for 4 months, and then five medication pass observations per quarter for 2 quarters. Any identified concerns will be immediately addressed and 1:1 re-education will be completed. Continued non-compliance will result in disciplinary action, up to and including termination as per policy. The Administrator/designee will review results of the auditing and forward to the Quality Performance Improvement monthly. Any further action necessary will be as determined by the QPI committee.</p>	07/12/2013			

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	<p>On 6/12/13 at 11:25 A.M., in an interview, the Administrator indicated Resident #32 was given the wrong dose of medication and had notified her family and physician of the error.</p> <p>3.1-35(g)(2)</p>				

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F000309 SS=G	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to evaluate the effectiveness of pain management interventions which resulted in uncontrolled pain that interfered with daily care and prevented participation in previously enjoyed activities. This deficient practice affected 1 of 35 residents reviewed for pain management (Resident #7).</p> <p>Findings include:</p> <p>Resident #7's record was reviewed on 6/10/2013 at 11:18 A.M. Resident #7 had diagnoses which included, but were not limited to, depression, dementia, hypertension, anxiety, and adult failure to thrive.</p> <p>An un-timed, physician's note, dated 1/18/2013, indicated Resident #7 had been combative during care. The physician indicated in this note the behavior was most likely due to pain. The physician changed Resident #7's</p>	F000309	Resident # 7 has been re-assessed by the IDT with care plan updates completed as deemed appropriate. One time audits have been completed of current resident population for the following areas: cognitively impaired resident pain assessments to ensure pain management appropriate, and activity needs to include 1:1 needs or small or large group needs to ensure resident needs have been identified. A one time interview process of staff providing care for the past 30 days has been completed to ensure resident needs have been identified to provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well being. Staff have been re-educated on conducting and completing pain assessments, communication of resident changes to Licensed Supervisory Nursing staff and/or Nursing Management, and encouraging and assisting residents to their activities of choice as per plan of care. In	07/12/2013	

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	<p>pain medication from as needed to scheduled.</p> <p>During an interview on 6/11/2013 at 10:44 A.M., Resident #7 stated, "I don't hurt when I am in bed. Just when I get up, I hurt all over."</p> <p>During an observation on 6/11/2013 at 11:02 A.M., CNA's #11 and #12 were observed transferring Resident #7 from her bed to her chair for lunch. Prior to being transferred to the chair, Resident #7 did not exhibit verbal or non-verbal expressions of pain. CNA #11 and #12 put Resident #7's shoes on her feet and began to transfer her. At this time Resident #7 stated, "They hurt my feet. Oh, Oh, Oh, please don't do that. Please don't do that. Please don't do that. Oh, Oh that's awful. I can't do it. I'm sorry. No, I can't. I'm sorry. Make them leave me alone, please. Don't. It hurts. I'm trying to. Oh, Oh, my goodness gracious." Once Resident #7 was up and in the chair she no longer complained of pain. During an interview at this time, CNA #11 and #12 indicated they had told nursing about her pain during care. They further indicated they felt pain very much affected Resident #7's quality of life.</p>		<p>addition, the Interdisciplinary Team had been re-educated on coordinating care with residents receiving Hospice services. It is the responsibility of the Licensed Supervisory Nurses to provide pain control as per physician order, and to assess changes in resident pain levels. The DON/designee will audit for any pain control changes daily for 14 days, weekly for 12 weeks, monthly for 4 months, and then quarterly for two quarters. The Life Enrichment Director will audit for changes in activity participation daily for 14 days, weekly for 12 weeks, monthly for 4 months, and then quarterly for two quarters to ensure residents are able to participate at their highest level of well being. The IDT will be responsible to ensure communication is completed with Hospice, and changes in the plan of care are coordinated with Hospices services weekly for 12 weeks, monthly for 3 months, and then quarterly for 2 quarters. Any identified concerns will be immediately addressed and 1:1 re-education will be completed. Continued non-compliance will result in disciplinary action, up to and including termination as per policy. The Administrator/designee will review results of the auditing and forward to the Quality Performance Improvement monthly. Any further action necessary will be as determined by the QPI committee.</p>		

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	<p>A care plan, dated 4/25/2013, indicated Resident #7 had acute pain. A goal listed for Resident #7 was "Amelioration" of immediate pain. Interventions listed to meet this goal included administer pain medication as ordered, monitor and record effectiveness of medication, assess for verbal and not-verbal signs and symptoms of distress or pain unrelieved by ordered treatments/medication, and report to provider signs and symptoms of distress or pain unrelieved by ordered treatments/medications.</p> <p>A care plan, dated 5/17/2013, indicated Resident #7 had cognitive impairment, her orientation had severe impairment, she was oriented to person and place, and had long term and short term memory problems. An intervention listed included staff were to anticipate her needs.</p> <p>A care plan, dated 6/3/2013, indicated Resident #7 yelled obscenities during oral care related to pain and was physically abusive during ADL (activity of daily living) care with staff. Goals listed for Resident #7 included: Resident #7 would not harm herself or others, she would accept care, and the frequency of her behaviors would</p>				

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	<p>decrease. Interventions to meet these goals included assess for pain.</p> <p>The May 2013 and June 2013, Medication Administration Records (MAR) indicated, nurses were to provide a rating if Resident #7's pain program was not effective. The MARs lacked documentation of a pain rating.</p> <p>An un-timed quarterly nursing data collection and assessment note, dated 5/24/2013, indicated Resident #7 currently had pain, the pain had been present in the past several months, and she effectively used a Pain Rating Scale. This form further indicated Resident #7 was totally dependent on staff for bed mobility, transfers, locomotion, dressing, toilet use, personal hygiene, and bathing.</p> <p>An un-timed pain data collection and assessment document, dated 5/24/2013, indicated Resident #7 vocalized crying/whining and stated "ouch" during care and transfers. Resident #7 was unable to rate her pain on a zero to ten scale so the Wong-Baker Face pain Scale Number was utilized. Staff rated Resident #7's pain as a 4 (hurts little more) on the pain scale. Documentation was lacking of an</p>				

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	<p>assessment of the effectiveness of the current pain interventions provided to Resident #7.</p> <p>An un-timed pain data collection and assessment note, dated 6/7/2013, indicated Resident #7 cried and whined and was agitated. A score of 4 (hurts little more) was documented as staff's rating of her pain. The record lacked documentation of an assessment of the effectiveness of the current pain medication/interventions.</p> <p>An un-timed nursing assessment update note, dated 6/10/2013, indicated Resident #7 was awake, alert to person, combative with care, demeanor was peaceful other than became anxious and agitated with care. This assessment contained a nursing narrative which indicated, "...Patient gets extremely upset, cursing, hitting and anxious with any type of care...." This narrative lacked documentation of an assessment of the effectiveness of current pain control interventions.</p> <p>A care plan, dated 5/17/2013, indicated it was very important or somewhat important for Resident #7 to choose between a bath or shower and she preferred a shower.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/12/2013	
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	<p>During an interview on 6/10/2013 at 1:00 P.M., the DON (Director of Nursing) and RN (Registered Nurse) #2 both indicated Resident #7 got very agitated during showers. They indicated she did not get as agitated for bed baths. The DON indicated the family wanted Resident #7 to have showers. At this time, the DON was queried about interventions addressing Resident #7's pain prior to showers. She indicated she was not for sure. Documentation of all pain management interventions, assessments, and evaluations of the effectiveness of her current pain management regimen was requested.</p> <p>A 6/10/2013-4:00 P.M., verbal/telephone order, indicated, "DC (discontinue) showers, change to bed baths due to patient's anxious behaviors in showers." The record lacked documentation of a pain assessment to determine if current pain interventions were effective prior to having Resident #7's preferred form of bathing discontinued.</p> <p>A care plan, dated 5/17/2013, indicated Resident #7 enjoyed all kinds of music and doing things with groups of people. Goals for Resident #7 included going to morning groups,</p>						

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	<p>music, showers, A.M. groups, and attending special events 2-5 times a week. Interventions to meet these goals included to provide her with her preferred choices of group activities and to provide transportation to group activities.</p> <p>On 6/10/2013 at 10:00 A.M., an activity called "Chronicle Review" was provided for the residents. Resident #7 had been assessed to enjoy this activity. During this activity, Resident #7 was observed sitting in her room with her eyes open. At 10:30 A.M., an activity called "Fit and Fun" was provided for the residents. Resident #7 had been assessed to enjoy this activity. During this activity, Resident #7 was observed sitting in her room with her eyes open.</p> <p>On 6/10/2013 at 10:00 A.M., an activity called "Chronicle Review" was provided for the residents. Resident #7 had been assessed to enjoy this activity. During this activity, Resident #7 was observed in her bed with her eyes open. At 10:30 A.M., an activity called "Fit and Fun" was provided for the residents. Resident #7 had been assessed to enjoy this activity. During this activity, Resident #7 was observed in her bed with her eyes open.</p>				

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NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122
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	<p>During an interview on 6/11/2013 at 2:25 P.M., the Activity Director indicated she brought Resident #7 to activities when she was up. She included her in group activities but she usually had to leave because she hurt. She wasn't able to tell staff where she hurt. Her mood fluctuated a lot because of her pain. The Activity Director further indicated Resident #7 would apologize for having to leave because she hurt. The Activity Director clarified the activity listed as "Mix and Mingle" occurs at lunch when she goes around and talks to the residents at lunch. The Activity Director indicated she did not provide 1:1 activities to Resident #7. At this time documentation of Resident #7's activity attendance for May and June 2013, was requested.</p> <p>Resident #7's activity attendance for May 1-31, 2013, indicated activities that met her assessed preferences were available thrifty-one of the thrifty-one days in May. Other than the activity called "Mix and Mingle" provided during lunch, Resident #7 was not taken to activities twenty-six out of the thirty-one days in May.</p> <p>Resident #7's activity attendance for</p>			

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	<p>June 1-11, 2013, indicated activities that met her assessed preferences were available on eleven of the eleven days. Other than the activity called "Mix and Mingle" provided during lunch, Resident #7 was not taken to activities on nine of the eleven days reviewed.</p> <p>During an interview on 6/12/2013 at 9:24 A.M., the Administrator indicated he felt the facility had identified Resident #7's pain but because of the lack of coordination between staff they had not put the pieces together to evaluate the effectiveness of the current pain control interventions. He further indicated even though the nurses were documenting on the MAR the pain interventions were effective; documentation in other places indicated it was not effective.</p> <p>3.1-37(a)</p>			

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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>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 attempt a gradual dose reduction [GDR] of an anti-psychotic medication [Geodon] and failed to ensure non-pharmacological interventions were attempted before an as needed psychoactive medication [Ativan] was administered. This deficient practice affected 2 of 10 residents reviewed for unnecessary medication use [Resident #14 and #114].</p>	F000329	Resident # 14 has been re-assessed by the IDT with care plan updates completed as deemed appropriate. Resident # 114 has been re-assessed by the IDT with care plan updates completed as deemed appropriate. A one time audit has been completed for current resident population to ensure residents with as needed anti-anxiety meds have non-pharmacological interventions listed, and gradual dose reductions are current. Supervisory Nursing staff have	07/12/2013

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	<p>Findings include:</p> <p>1. On 6/10/13 at 2:13 P.M., Resident #14's record was reviewed. Diagnoses included, but were not limited to, renal insufficiency, depression, dementia with agitation, and explosive disorder with history of paranoia.</p> <p>A physician's orders, dated 6/1/13 through 6/30/13, indicated, "...Geodon [anti-psychotic] 60 milligrams [mg] daily... [started on 10/17/09]...."</p> <p>A "Mood and Behaviors Care Plan," dated 3/4/13, indicated, "...Geodon for explosive disorder, paranoia... Abusive behaviors, Paranoia...."</p> <p>An un-timed "Social Service Progress Notes," dated 2/23/13, indicated, "...Reported to writer patient [Resident #14] was verbally aggressive during [care] towards staff... Care planned accordingly to explain to patient care about to be received...."</p> <p>There was no additional documentation of aggressive behavior in Resident #14's clinical record.</p>		<p>been re-educated on providing non-pharmacological interventions and completing documentation of said interventions in the clinical record. The IDT has been re-educated on requesting GDRs timely. It is the responsibility of the Licensed Nurse to offer non-pharmacological interventions to a resident prior to administering an as needed medication. It is the responsibility of the IDT to monitor timely gradual dose reductions. The DON/designee will be responsible to review compliance with non-pharmacological interventions and documentation prior to administering an as needed medication, and reviewing current resident population for GDRs weekly for 12 weeks, monthly for 4 months, and then quarterly for two quarters. Any identified concerns will be immediately addressed and 1:1 re-education will be completed. Continued non-compliance will result in disciplinary action, up to and including termination as per policy. The Administrator/designee will review results of the auditing and forward to the Quality Performance Improvement monthly. Any further action necessary will be as determined by the QPI committee.</p>		

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	<p>On 6/11/13 at 1:00 P.M., the Administrator provided Resident #14's behavior summary, dated 2/1/13 through 6/11/13 and GDR documentation for Geodon. The behavior summary indicated Resident #14 had 2 episodes of verbal abuse and 3 episodes of resisting care over a 4 month timeframe. The "Gradual Dose Reduction Tracking Report," dated 5/18/12 indicated a GDR attempt should have been attempted on 10/1/12. However, at that time, in an interview, the Administrator indicated Resident #14's physician refused a GDR and the facility did not have documentation of an attempted GDR and the facility did not have additional behavioral documentation to support the contraindication of a GDR attempt.</p> <p>2. On 6/10/13 at 10:34 A.M., Resident #114's record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus, hypertension, and dementia.</p> <p>A medication administration record [MAR], dated 5/1/13 through 5/31/13 indicated, "...Lorazepam [Ativan] [anti-anxiety medication] 0.5 mg give 1 tablet bid as needed.... [marked as given on]: 5/1/13, 5/2, 5/4 thru 5/6, 5/10, 5/14 thru 5/17, 5/21 thru</p>						

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	<p>5/26/13.</p> <p>A medication administration record [MAR], dated 6/1/13 through 6/30/13 indicated, "...Lorazepam [Ativan] [anti-anxiety medication] 0.5 milligrams [mg] give 1 tablet bid as needed.... [marked as given on]: 6/3/13, 6/6, 6/7, 6/8, and 6/9/13.</p> <p>There was no documentation in Resident #114's clinical record of non-pharmacological interventions used prior to the administration of the as needed anti-anxiety medication.</p> <p>A "Mood and Behavior Symptom Assessment/Plan of Care," dated 9/28/12, indicated, "...Psychotropic drug use: Ativan: Diagnosis: Anxiety... Behavioral symptoms drug is intended to treat: panic, nervousness... Goal: No negative outcomes resulting from use of psychotropic medication... Interventions: 12/28/12: Monitor for side effects, Monitor for drug-related Cognitive/Behavioral impairment, Monitor for drug related discomfort...."</p> <p>The care plan did not address the non-pharmacological interventions used prior to administration of the as needed anti-anxiety medication.</p>			

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	<p>On 6/10/13 at 11:32 A.M., in an interview, Licensed Practical Nurse [LPN] #2 indicated prior to administering an as needed anti-anxiety medication, non-pharmacological interventions were required and should have been documented in the clinical record.</p> <p>On 6/12/13 at 1:00 P.M., in an interview, the Administrator indicated the facility did not have documentation of non-pharmacological interventions for Resident #114 related to the Ativan use.</p> <p>3.1-48(b)(2) 3.1-48(a)(4)</p>			

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F000441 SS=D	<p>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.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and policy review, the facility failed to</p>	F000441	Licensed Nurses have been re-educated on hand washing	07/12/2013			

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	<p>ensure staff washed and/or sanitized their hands between resident contact during 2 of 3 medication administration observations.</p> <p>Findings include:</p> <p>During a medication administration observation on 6/12/2013 at 10:02 A.M., Licensed Practical Nurse (LPN) #3 was observed to prepare medication for Resident #119, enter her room, administer the medication, and leave the room. LPN #3 did not wash and/or sanitize her hands after administering medication to Resident #119. At 10:08 A.M., LPN #3 obtained Resident #34's vitals, prepared, and administered her medications. LPN #3 did not wash and/or sanitize her hands after having contact with Resident #119 and before preparing and administering medications to Resident #34.</p> <p>During an interview on 6/12/2013 at 10:16 A.M., LPN #3 indicated she forgot to wash her hands between residents.</p> <p>On 6/12/2013 at 11:38 A.M., the Administrator provided the facility's current infection control policy dated November 2011. This policy indicated, "...Hand hygiene is the</p>		<p>techniques during medication administration. It is the responsibility of the Licensed Nurse to conduct hand washing at the appropriate times. The Education and Training Director/designee will conduct hand washing competencies for Licensed Nurses during medication administration 5 times weekly for 2 weeks, 3 times a week across shift for 2 weeks, and then 3 times a month across shifts for 5 months, and then 3 times a quarter across shifts for two quarters. Any identified concerns will be immediately addressed and 1:1 re-education will be completed. Continued non-compliance will result in disciplinary action, up to and including termination as per policy. The Administrator/designee will review results of the auditing and forward to the Quality Performance Improvement monthly. Any further action necessary will be as determined by the QPI committee.</p>				

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	<p>most important procedure for preventing Healthcare Associated Infections.... A plain soap and water hand wash or an alcohol hand rub may also be used... before having direct contact with residents... after contact with a resident's skin (e.g., when taking a pulse or blood pressure...) after contact with inanimate objects (including medical equipment) in the immediate vicinity of the resident...."</p> <p>3.1-18(a)</p>			