

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155762	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/05/2016
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NAME OF PROVIDER OR SUPPLIER FOREST PARK HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2401 S L ST RICHMOND, IN 47374
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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.</p> <p>Dates of survey: March 28, 29, 30, 31, April 1, 4 and 5, 2016</p> <p>Facility number: 011387 Provider number: 155762 AIM number: 200853180</p> <p>Census bed type: SNF: 24 SNF/NF: 43 Residential: 22 Total: 89</p> <p>Census payor type: Medicare: 27 Medicaid: 27 Other: 13 Total: 67</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 30576 on April 11, 2016.</p>	F 0000		

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 0242 SS=D Bldg. 00	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on observation, interview and record review, the facility failed to provide a resident with showers according to her preference and plan of care for 1 resident reviewed for choices of 1 who met the criteria for choices. (Resident #34)</p> <p>Findings include:</p> <p>Resident #34's record was reviewed on 3/31/16 at 3:53 p.m. Her diagnoses documented on her Diagnoses Report for March 2016 included but were not limited to, multiple sclerosis and abnormal involuntary movements.</p> <p>Resident #34's quarterly Minimum Data</p>	F 0242	<p>F 242</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #34's personal preference was updated on 4/1/16 to ensure preferences were current, preference for showers on 3rd shift on Wednesday and Saturday.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: Audit completed of resident bathing preference and no deficient practice found.</p> <p>Measures put in place and</p>	05/05/2016

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	<p>Set (MDS) assessment dated 1/16/16, indicated she was understood and had the ability to understand others. She was moderately impaired in her cognitive daily decision making skills. She required extensive assistance of 2 persons for bed mobility, dressing, toileting, and personal hygiene. She had limited range of motion in both of her upper and lower extremities.</p> <p>A plan of care for Resident #34 indicated she required extensive assistance with her activity's of daily living (ADL). She preferred to be showered 2 times a week on night shift and bathed on all other days.</p> <p>Resident #34's bathing documentation indicated she received 5 showers in January 2016, 1 shower in February 2016, and no showers in March 2016.</p> <p>The facility was unable to provide documentation Resident #34 had received 2 showers a week or that she had refused to be showered.</p> <p>An interview with Resident #34's daughter on 3/30/16 at 9:20 a.m., indicated sometimes she felt like her mothers hair and skin looked greasy. She indicated her mother was not reliable to tell her about her hygiene.</p>		<p>systemic changes made to ensure the alleged deficient practice does not recur: Staff will be re- educated on the facilities guidelines of personal preference of care by the DHS and/or designee</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: Point of Care bathing documentation will be monitored daily at the clinical care meeting for 5 residents, 3 x's a week for 4 weeks, then weekly for 4 weeks, then monthly for 4 months by the DHS and/or designee.</p> <p>Completion date: 5/5/2016</p> <p><i>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</i></p>		

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	<p>On 3/30/16 at 2:29 p.m., Resident #34 was observed lying in bed. Her face had a shiny appearance.</p> <p>On 3/31/16 at 11:16 a.m., Resident #34 was observed lying in bed. Her face had a shiny appearance.</p> <p>On 3/31/16 at 2:15 p.m., Resident #34 was observed lying in bed. Her face had a moist/oily appearance.</p> <p>On 4/1/16 at 4:04 p.m., the Assistant Director of Health Services (ADHS) indicated Resident #34 was listed on the Certified Resident Care Assistant (CRCA) Assignment Sheet to receive showers Wednesday and Saturday on night shift.</p> <p>On 4/5/16 at 10:20 a.m., the Director of Health Services (DHS) indicated the facility tried to follow residents preferences. To ensure residents were bathed and shampooed routinely the staff made rounds and interviewed residents. If a resident refused care a Refusal of Care would be filled out and staff would follow up.</p> <p>A Guidelines For Resident Personal Preferences And Profile procedure provided by the DHS on 4/5/16 at 1:18</p>			

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F 0309 SS=D Bldg. 00	<p>p.m., indicated the following: "Purpose: To provide guidelines obtaining resident personal preferences and including them in the care planning process. Procedure: 1. The Nursing Staff shall discuss the resident's preference for sleep/wake times and bathing as part of the admission assessment process... 5. The resident preferences and other care plan interventions shall be entered into the Resident Profile in the Care tracker system by a member of the nursing leadership team for communication to nursing assistants... 8. The preferences shall be included in the resident's plan of care to ensure it is reflective of their interest and choices."</p> <p>3.1-3(u)(1) 3.1-3(u)(3)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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 assess bruising for 1 of 3 residents who met the criteria for non pressure related skin</p>	F 0309	<p>F 309</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient</p>	05/05/2016			

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	<p>conditions. (Resident #32)</p> <p>Findings include:</p> <p>On 3/29/2016 at 11:23 a.m., Resident #32 was observed to have a half dollar sized bruise on her left lower arm, near her wrist, and a bruise on her left arm, by the inside of the elbow. The resident indicated these bruises were from blood draws.</p> <p>Resident #32's record was reviewed on 3/30/16 at 3:00 p.m. Diagnoses from the continuity of care documentation, in the electronic record, included but was not limited to; pneumonia, chronic obstructive pulmonary disease, high blood pressure, gastro-esophageal reflux disease, anxiety, muscle wasting, difficulty in walking, and shortness of breath.</p> <p>An Admission minimum data set assessment, dated 2/24/16, indicated Resident #32 was cognitively intact.</p> <p>A re-admission assessment, dated 3/21/16, indicated Resident #32 was readmitted on 3/21/16. The "Skin Impairment" section indicated the resident had skin impairment, with "yes (Complete appropriate Wound Circumstance for further assessment)"</p>		<p>practice: Resident # 32 was assessed by the wound nurse on 4/1/16 and a 3.0cm x 2.5 cm bruise noted on left anticubital and a 3.0 cm x 2.0 cm bruise noted on left forearm , a bruise event was initiated.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: Audit completed of new admissions/readmissions nursing assessment to ensure the Skin impairment section was completed accurately, with no deficient practice noted.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS and /or designee will re-educate Licensed nursing staff on completing the Skin Integrity section of the nursing admission/readmission assessment</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: DHS and/or designee will audit new admissions/readmissions nursing assessments during the daily clinical care meeting 5 days a week for 4 weeks, then weekly for 8 weeks and monthly for 3 months</p>		

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	<p>checked. The "Wound Circumstance" section addressed rash/lesions on the resident's buttocks that she was admitted with, but did not assess the two areas of bruising on her left arm.</p> <p>On 3/31/2016 at 11:11 a.m., the bruised areas on her left arm were observed to be red/purplish at the inner elbow, and dark purple with faint yellow edges on her left wrist.</p> <p>During an interview, on 4/01/2016, at 3:26 p.m., LPN #1 indicated when Resident #32 came back from the hospital, the nurse who filled out the readmission form checked that she had a skin condition but didn't elaborate what the problem was. LPN #1 indicated she filled out an event today on the two bruises.</p> <p>A "Bruise Event" dated 4/1/16, at 11:49 a.m., indicated a bruise on the left anticubital (inner elbow) area that measured 3.0 by 2.5 centimeters and was light purple in color. A bruise on the left forearm measured 3.0 by 2.0, was fading and was yellowish purple in color. The resident denied pain and said she had gotten the bruise at the hospital. The new skin interventions included, but were not limited to; apply moisturizer to skin to keep it supple, and encourage the resident</p>		<p>Completion date: 5/5/16</p> <p><i>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</i></p>	

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	<p>to drink fluids.</p> <p>Progress notes, dated 4/1/16, at 11:58 a.m., indicated: "Resident has bruise on left anticubital (inner elbow) that is reddish purple in color, no pain and denies any discomfort. States she got bruises at [Local hospital]. Resident also has a greenish yellow bruise on left forearm that is fading and healing. Family present in room."</p> <p>Progress notes dated 4/1/16 at 9:42 p.m. indicated; "Bruises remain and continue to heal. Treatment continues to buttocks which is pink in color."</p> <p>A policy and procedure for "Bruise, Rash, Lesion, Skin Tear, Laceration Assessment Guidelines", with a revised date of 2/25/16, was provided by the Director of Health Services on 4/4/16 at 9:16 a.m. The Policy indicated, but was not limited to; "Purpose: Utilized to describe and monitor Bruises, Rashes, Lesions, Skin Tears, and Lacerations. Procedure: Bruise: 1. May complete Bruise Event in EHR (electronic health record) by an RN/LPN if the bruise warrants documentation due to the extent and/or location...2. Complete one event for up to five bruises...."</p> <p>3.1-37(a)</p>			

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F 0312 SS=D Bldg. 00	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, interview and record review, the facility failed to provide a resident with adequate oral hygiene for 1 resident reviewed for activity's of daily living (ADL) of 1 who met the criteria for ADL and failed to provide a resident with clean hands and fingernails for 1 of 3 residents reviewed for dental status of 3 who met the criteria for dental status. (Resident #34 and #39)</p> <p>Findings include:</p> <p>1. Resident #34's record was reviewed on 3/31/16 at 3:53 p.m. Her diagnoses documented on her Diagnoses Report for March 2016 included but were not limited to, multiple sclerosis and abnormal involuntary movements.</p> <p>Resident #34's quarterly Minimum Data Set (MDS) assessment dated 1/16/16, indicated she was understood and had the ability to understand others. She was moderately impaired in her cognitive daily decision making skills. She required extensive assistance of 2 persons</p>	F 0312	<p>F 312</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #39's hand and fingernails was immediately cleaned. Resident # 34 was provided oral care.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: Facility determined that dependant residents are potentially at risk.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS and/or designee will re-educate nursing staff on cleaning residents hands after meals and ensurinbg nails are clean and performing oral care per resident preference</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does</p>	05/05/2016

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	<p>for bed mobility, dressing, toileting, and personal hygiene. She had limited range of motion in both of her upper and lower extremities.</p> <p>A plan of care for Resident #34 indicated she required extensive assistance with ADL. She would be provided assistance brushing her teeth. The plan of care did not indicate how often Resident #34 would receive assistance with oral hygiene or Resident #34's response to oral hygiene.</p> <p>Resident #34's most recent dental exam dated 11/5/15, indicated her oral hygiene was poor. Her gingival tissue was inflamed Her supragingival (pertaining to the tooth surface above the gum line) calculus level was heavy.</p> <p>An interview with Resident #34's daughter on 3/30/16 at 9:20 a.m., indicated she believed her mothers teeth were not being brushed properly and plaque was building up on her teeth. She indicated her mother was not reliable to tell about her hygiene.</p> <p>No documentation was available related to Resident #34's response to oral hygiene or if she refused to allow staff to provide oral hygiene.</p>		<p>not recur: DHS or designee will conduct random observation of 5 residents who are dependant on staff for oral hygiene and hand/fingernail care 3 times a week for 8 weeks , then weekly times 4 weeks then monthly for 4 months Completion date: 5/5/16</p> <p><i>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</i></p>	

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	<p>On 3/30/16 at 2:29 p.m., Resident #34 was observed with whitish colored debris visible in the crevices of her lower teeth near the gum line.</p> <p>On 3/30/16 at 3:58 p.m., Certified Resident Care Assistant (CRCA) #3 indicated she worked evening shift and she tried to brush Resident #34's teeth after meals and at bedtime. She indicated Resident #34 was totally dependent on staff for oral care and would often not allow staff to brush her teeth.</p> <p>On 3/31/16 at 11:16 a.m., Resident #34 was observed with whitish colored debris visible in the crevices of her upper and lower teeth near the gum line.</p> <p>On 3/31/16 at 11:31 a.m., CRCA #4 indicated night shift staff brushed Resident #34's teeth when they got her dressed in the mornings and then Resident #34's teeth was brushed at bedtime.</p> <p>On 3/31/16 at 2:15 p.m., Resident #34 was observed with whitish colored debris visible in the crevices of her upper and lower teeth near the gum line.</p> <p>On 4/1/16 at 9:38 a.m., Resident #34 was observed with whitish colored debris visible in the crevices of her lower teeth</p>			

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	<p>near the gum line.</p> <p>On 4/1/16 at 3:28 a.m., Resident #34 was observed with whitish colored debris visible in the crevices of her lower and upper teeth near the gum line.</p> <p>On 4/4/16 at 8:33 a.m., Resident #34 was observed with whitish colored debris visible in the crevices of her upper and lower teeth near the gum line.</p> <p>On 4/4/16 at 10:59 a.m., CRCA #5 indicated she had completed Resident #34's morning care which consisted of changing Resident #34's brief, dressing her lower body, and getting her up for breakfast. CRCA #5 indicated night shift staff had bathed Resident #34 and dressed her upper body prior to her beginning work. CRCA #5 assumed if Resident #34 had been bathed by night shift staff, Resident #34's oral care had been completed. CRCA #5 had not asked Resident #34 if she needed her teeth brushed or offered to brush her teeth.</p> <p>During a telephone interview on 4/4/16 at 11:25 a.m., CRCA #6 indicated she worked night shift on weekends. CRCA #6 indicated personal and oral hygiene was part of Resident #34's morning care for night shift staff. CRCA #6 indicated</p>			

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	<p>Resident #34 received oral hygiene on the weekends CRCA #6 worked with her. CRCA #6 indicated Resident #34 had allowed CRCA #6 to brush her teeth when she had provided her care.</p> <p>2. Resident #39's record was reviewed on 4/1/16 at 10:26 a.m. His diagnoses documented on his Diagnoses Report for March 2016 included but were not limited to, Alzheimer's disease and generalized muscle weakness.</p> <p>Resident #39's quarterly MDS assessment dated 2/18/16, indicated he was understood and had the ability to understand others. He was moderately impaired in his cognitive daily decision making skills. He required extensive assistance of 2 persons for bed mobility, transfer, toileting, and personal hygiene. He required extensive assistance of 1 person to dress.</p> <p>A plan of care for Resident #39 indicated he had problems providing his own care related to dementia and weakness. He would be provided set up assistance for grooming and hygiene needs. He would be encouraged/allowed to participate at his highest possible level while provided cues and supervision. He would be assisted as needed to complete each task.</p>			

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	<p>On 3/29/16 at 10:40 a.m., Resident #39 was observed with a dark substance underneath his fingernails and around his outer fingernails.</p> <p>On 3/30/16 at 2:48 p.m., Resident #39 was observed with a dark substance underneath his fingernails.</p> <p>On 4/1/16 at 11:17 a.m., Resident #39 was observed with a dark substance underneath his fingernails and yellowish discoloration on top of some of his fingernails and fingers.</p> <p>On 4/1/16 at 3:32 p.m., Resident #39 was observed with a dark substance underneath his fingernails and yellowish discoloration on top of some of his fingernails and fingers. Resident #39 indicated he cleaned his fingernails himself with a brush.</p> <p>On 4/1/16 at 3:59 p.m., CRCA #7 indicated Resident #39's spouse usually liked to clean Resident #39's fingernails. CRCA #7 indicated Resident #39's spouse would inform staff she wanted to provide Resident #7 nail care and staff would provide her with the supplies.</p> <p>On 4/4/16 at 8:25 a.m., Resident #39 was observed with a dark substance underneath his fingernails and yellowish</p>			

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NAME OF PROVIDER OR SUPPLIER FOREST PARK HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2401 S L ST RICHMOND, IN 47374
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F 0329 SS=D Bldg. 00	<p>discoloration around his fingernails and skin surrounding his fingernails. His hands had an unpleasant odor.</p> <p>On 4/4/16 at 9:18 a.m., CRCA #8 indicated she had given Resident #39 a partial bath that morning. CRCA #8 indicated CRCA's were responsible for residents nail care or any staff who observed a resident needed nail care. CRCA #8 indicated Resident #39's fingernails looked dirty underneath his fingernails and he had a yellowish and orange substance on some of his fingernails.</p> <p>3.1-38(a)(3)(C)(E)</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</p>			

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	<p>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 have documented clinical rationale for the use of an antipsychotic medication for 1 of 5 residents who met the criteria for unnecessary medication use (Resident #20).</p> <p>Finding include:</p> <p>Interview with Resident #20 on 4/4/16 at 11:20 a.m., indicated she had experienced anxiety and received ativan (antianxiety medication) for this and the medication helped. The resident indicated she was not aware that she was on haldol (antipsychotic medication) or what haldol was used for. Resident #20 indicated the facility had not talked to her about the medication haldol.</p> <p>Review of the record of Resident #20 on 4/4/16 at 12:30 p.m., indicated the resident's diagnoses included, but were not limited to, Alzheimer's disease, chronic pain, muscle wasting, osteoporosis, history of falling, hyperlipidemia, dementia, depression, anxiety, osteoarthritis and hypertension.</p>	F 0329	<p>F 329</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #20's MD was notified on 4/5/16 and a Gradual dose reduction was initiated for her order of haldol 1mg to be reduced to 0.5mgs.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: Audit was conducted of residents who are receiving antipsychotic medication to ensure there is documentation of clinical rationale for useage.</p> <p>Measures put in place and systemic changes made to</p>	05/05/2016

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	<p>The record indicated Resident #20 was admitted to the facility from the local hospital on 7/2/15 with an physician order for haldol 2 milligrams sublingual twice a day.</p> <p>The physician order for Resident #20, dated 7/21/15, indicated discontinue haldol 2 mg and start haldol 1 mg every day.</p> <p>The physician order for Resident #20, dated 8/23/15, indicated discontinue haldol.</p> <p>The Admission Minimum Data Set (MDS) assessment for Resident #20, dated 7/9/15, indicated the resident had no behaviors, hallucinations or delusions.</p> <p>The Quarterly MDS assessment for Resident #20, dated 10/1/15, indicated the resident had no behaviors, hallucinations or delusions.</p> <p>The Quarterly MDS assessment for Resident #20, dated 12/30/15, indicated the had the ability to understand others and make herself understood. The resident had no behaviors, hallucinations or delusions.</p> <p>The physician progress note for Resident</p>		<p>ensure the alleged deficient practice does not recur: Nursing staff will be re-educated on the need to document the clinical indications for useage of antipsychotic medications by DHS and/or designee.</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not reoccur: DHS and /or designee will monitor residents who are receiving antipsychotic medications for documentation of clinical rational weekly at the clinical care meeting times 8 weeks then monthly times 4 months.</p> <p>Completion date:5/5/16</p> <p><i>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for</i></p>	

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	<p>#20, dated 9/2/14, indicated the resident had a history of dementia with hallucinations, "currently stable."</p> <p>The physician progress note for Resident #20, dated 10/7/15, indicated the resident was stable for depression and hallucination.</p> <p>The physician progress note for Resident #20, dated 11/4/15, indicated the resident currently stable with depression, hallucinations and Alzheimer's dementia.</p> <p>The nurses note for Resident #20, dated 11/6/15 at 12:00 p.m., indicated the resident voiced concerns about increased anxiety and increased anxiety attacks and bad dreams. The resident indicated she woke up during the night crying and shaking after having dreams about deceased family members. The resident worried about things constantly.</p> <p>The nurses note for Resident #20, dated 11/17/15 indicated the resident woke up crying and stated someone was in her room. The light was turned on in her room and she calmed down. The resident indicated she had a nightmare.</p> <p>The local hospital Psychiatrist note for Resident #20, dated 11/19/15, indicated the "subjective" was "depression,</p>		further recommendation.		

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	<p>memory problem, anxiety, hallucinations." The "pertinent findings on mental status examination" indicated the resident was an 83 year old that looked her stated age. The resident was "alert, oriented to place, person, partially to situation." The resident was calm and pleasant and reports she was doing well at the facility. The recommendations included, but were not limited to, haldol 1 mg at night for hallucinations.</p> <p>The physician order for Resident #20, dated 11/19/15, indicated the resident was ordered haldol 1 mg at bedtime for hallucinations.</p> <p>The physician order for Resident #20, dated 11/20/15, indicated the resident was ordered nitrofurantoin (antibiotic medication) 100 mg two times a day for a urinary tract infection.</p> <p>Interview with LPN #1 on 4/4/16 at 3:45 p.m., indicated Resident #20 had not had any behaviors since her admission to the facility.</p> <p>Interview with Resident #20's family member/Power Of Attorney (POA) on 4/4/16 at 3:50 p.m., indicated the resident had "high anxiety" and received ativan for anxiety. When queried if the family member was aware the resident was</p>			

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	<p>receiving haldol, the family member indicated she was not aware and asked if haldol was used to treat dementia. The family member indicated she talked to the resident frequently on the telephone and the resident had not reported to her of "seeing people" or hallucinating. The family member indicated the resident had no psychiatric diagnosis that she was aware of except anxiety.</p> <p>Interview with Resident #20 on 4/4/16 at 4:45 p.m., indicated she had seen a psychiatrist for anxiety. The resident indicated she had not had hallucinations that she was aware of. The resident indicated she was not aware of any psychiatric diagnosis except anxiety and she had experienced anxiety since she was in her 30's. The resident indicated she had not reported having hallucinations to the psychiatrist. The resident indicated one time she did have "black out" due to an "bladder infection".</p> <p>Interview LPN #1 on 4/4/16 at 5:20 p.m., indicated the Psychiatrist treating Resident #20 was unavailable for an interview.</p> <p>Interview with the Director Of Health Services (DHS) on 4/5/16 at 9:00 a.m., indicated the facility had not been able to find documentation that Resident #20 had</p>			

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	<p>hallucinations. The DHS indicated she was not aware, where the Psychiatrist treating Resident #20 received the information the resident was having hallucinations. The DHS indicated she was not aware if anyone from the facility had contacted and inquired with the Psychiatrist about the haldol order or where the information was obtained that Resident #20 was experiencing hallucinations.</p> <p>Interview with the DHS on 4/5/16 at 9:40 a.m., indicated the facility Doctor had started a gradual dose reduction on Resident #20's haldol to 0.5 mg starting 4/5/16.</p> <p>The physician order for Resident #20, dated 4/5/16, indicated the resident was ordered haldol 0.5 milligrams.</p> <p>The "Psychotropic medication usage and gradual dose reductions" policy provided by LPN #1 on 4/4/16 at 3:30 p.m., indicated the purpose was to ensure every effort was made for residents receiving psychoactive medications obtain the maximum benefit with minimal unwanted side effects through appropriate use, evaluation and monitoring by the interdisciplinary team. "The resident shall receive psychotropic medications by the prescriber, with</p>			

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R 0000 Bldg. 00	<p>appropriate diagnosis or documentation to support its usage." "The medical necessity will be documented in the resident's medical record".</p> <p>The "Nursing 2014 drug handbook" by "Lippincott Williams & Wilkins" indicated "black box warning" "Elderly patients with dementia-related psychosis treated with atypical or conventional antipsychotic's are at increased risk for death." "Antipsychotic's aren't approved for the treatment of dementia-related psychosis."</p> <p>3.1-48(a)(4)</p> <p>Forest Park Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Survey.</p>	R 0000		