

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155758	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/19/2015
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NAME OF PROVIDER OR SUPPLIER ASBURY TOWERS HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 102 W POPLAR ST GREENCASTLE, IN 46135
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F 000 Bldg. 00	<p>This visit was for a recertification and state licensure survey.</p> <p>This visit included a State Residential Licensure Survey.</p> <p>Survey dates: March 12-13, 2015 and March 16-19, 2015.</p> <p>Facility Number: 001120 Provider Number: 155758 AIM Number: 200525120</p> <p>Survey Team: Vickie Nearhoof, RN, TC Laura Brashear, RN Mary Weyls, RN Geoff Harris, RN Jennifer McElwee, RN</p> <p>Census bed type: SNF/NF: 37 Residential: 61 Total: 98</p> <p>Census payor type: Medicare: 3 Medicaid: 39 Other: 56 Total: 98</p>	F 000		
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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 164 SS=D Bldg. 00	<p>Residential sample: 5</p> <p>These deficiencies reflect state findings cited in accordance with 10 IAC 16.2-3.1.</p> <p>Quality review completed on 3/23/15 by Brenda Marshall, RN</p> <p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p>				

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	<p>Based on observation, interview, and record review, the facility failed to ensure privacy was afforded for 3 of 3 random observations of a treatment and/or injections being given. (Residents #2, #8 and #32)</p> <p>Findings include:</p> <p>1. On 3/18/15 at 10:15 a.m., LPN #1 and the Assistant Director of Nursing (ADON) were observed to provide a dressing treatment to Resident #2's coccyx. The resident was in the first bed of the room. After the resident was positioned on her side, the back and buttocks were exposed. The old dressing was removed, treatment performed, and new dressing applied. During the treatment at 11:13 a.m., the ADON exited the room and returned with additional supplies. The resident's back side remained exposed and a curtain was not pulled around the bed to maintain privacy.</p> <p>On 3/18/15 at 3:00 p.m., the ADON was interviewed. The ADON indicated there was not a privacy curtain on the resident's side of the room.</p> <p>2. On 3/19/15 at 11:26 a.m., RN #2 administered an insulin injection to</p>	F 164	<p>Based on observation, interview, and record review, the facility failed to ensure privacy was afforded for 3 of 3 random observations of a treatment and/or injections being given. No residents were harmed by the failure to ensure these residents privacy (1) An inspection of all the rooms was completed to ensure all semi-private rooms have privacy curtains. Privacy curtains were ordered (4-8-15) for all rooms lacking privacy curtains and will be installed by the maintenance department when they arrive.</p> <p>(2 & 3) Nursing staff will be in-serviced on the Procedures for the Implementation of Resident Rights on 4-23-15 to ensure a privacy curtain is used when performing treatment on a resident. Nursing staff will be observed for maintaining privacy policy/procedure during morning rounds by the DON or designee on an ongoing basis. Monitoring the condition and replacement of curtains, when needed, will be ongoing by the maintenance department. The privacy curtains will be inspected monthly during the bed rail inspections by the maintenance department for any deficiencies. If deficiencies are found the curtain will be replaced.</p> <p>Completion date 04/23/15</p>	04/23/2015	

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	<p>Resident #8. The door to the resident's room was left open, while the resident lifted his shirt to expose his abdomen to receive the injection.</p> <p>During review of Resident #8's clinical record on 3/19/15 at 3:30 p.m., a quarterly assessment, dated 1/21/15, identified the resident without cognitive impairment.</p> <p>3. On 3/19/15 at 11:52 a.m., LPN #1 administered an insulin injection to Resident #32. During the injection the resident's door to the hallway was left open.</p> <p>During review of Resident #32's clinical record on 3/19/15 at 3:45 p.m., a quarterly assessment, dated 1/21/15, identified the resident without cognitive impairment.</p> <p>A facility policy provided by the Assistant Director of Nursing (ADON) on 3/19/15 at 8:30 a.m., titled, "Procedures For Implementation of Resident Rights," (no date,) included but was not limited to: "...17. Protection of a resident's right to be treated as individuals with consideration and respect for personal privacy shall be fully explained to all facility staff upon employment and included in periodic</p>			

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F 241 SS=D Bldg. 00	<p>inservices. Privacy considerations shall also be specifically addressed in administrative and departmental policies and procedures. Privacy in personal care and accommodations shall be facilitated by use of privacy curtains which provide full visual privacy around the bed and closing of resident room and bathroom doors. Privacy during treatment and examination shall be assured by staff and other health care disciplines including physicians, therapists, etc. to conduct treatments in office areas or residents rooms providing closed door when necessary to protect body privacy..."</p> <p>3.1-3(o)(4)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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 observation, record review and interview, the facility failed to ensure dignity by administering medication to 2 residents during a meal with peers in the dining room (Resident #22 and #18).</p> <p>Findings include:</p>	F 241	F 0241 SS=D Based on observation, record review and interview, the facility failed to ensure dignity by administering medication to 2 residents during a meal with peers in the dining room. No Residents were harmed by administering medications during meals. In-service certified and licensed	05/01/2015

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	<p>1. During the breakfast meal on 3/19/15 at 7:49 a.m., Resident # 22 was observed in the dining room eating. QMA (qualified medication aide) #3 interrupted the resident during the meal and administered oral medication, which included Miralax (laxative) 17 grams mixed in 8 ounces of water. The resident swallowed the pills and slowly drank the water mixture through a straw by taking small sips. After the resident finished the Miralax, she left the dining room and did not return to finish meal.</p> <p>During review of Resident #22's clinical record on 3/19/15 at 2:45 p.m., a significant change assessment dated 1/29/15, indicated the resident had severe cognitive impairment.</p> <p>2. During the breakfast meal on 3/19/15 at 8 a.m., Resident #18 was observed eating breakfast in the dining room. QMA #3 interrupted the resident's meal and administered oral medications, which included Arginaid powder mixed with 8 ounces of water. The resident after taking a pill, had to take several drinks to clear her throat. The resident took several minutes to drink the Arginaid solution. The resident was observed after the medication administration, to sit at the dining table with her head in her hand.</p>		<p>nursing staff on 04/23/15, that medication will not be administered in the dining rooms unless the resident prefers this. If they prefer to receive their medication in the dining room, a physician's order will be obtained noting the resident's preference and will be on the MAR. a. Medication times of supplements and any medication that needs to be mixed with eight ounces of water or more will be changed to in between meal times by 05/01/15.</p> <p>b. Monthly monitoring by DON or designee of dining rooms will be done to observe for medication administration at meal time. (see Exhibit C)</p> <p>c. Preferences will be added to the nursing admission check list (Exhibit D) to ask if the resident prefers to receive their medication during a meal. This will be done initially for every resident (Exhibit G) by 05/01/15 and upon admission for any new resident. If a resident is cognitively impaired, the POA will be asked for the resident's preference. Once monthly on an ongoing basis the DON/designee will monitor the nursing staff to ensure medications are not given in the dining room to a resident who has not given permission to receive their medications in the dining room. Monitoring will be logged and reported quarterly to the CQI committee.</p>	

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F 242 SS=D Bldg. 00	<p>The resident was heard to state, "I don't want to throw up."</p> <p>During review of Resident #18's clinical record on 3/19/15 at 3 p.m., a quarterly assessment, dated 1/28/15, indicated the resident with moderately cognitive impairment.</p> <p>During interview of the Administrator on 3/19/15 at 2:15 p.m., the Administrator indicated medications were not administered during meal time.</p> <p>During interview of the DON (director of nursing) on 3/19/15 at 4:30 p.m., the DON indicated staff were encouraged to avoid administering medications during the meal service.</p> <p>3.1-3(t)</p> <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>	F 242	F 0242 SS=D Based on interview	04/23/2015

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	<p>Based on interview and record review the facility failed to ensure the resident's preferences were obtained and/or followed pertaining to morning wake up times and showers for 3 of 3 residents reviewed for choices. (Residents #32, #39 and #2)</p> <p>Findings include:</p> <p>1. On 3/13/15 at 10:37 a.m., during the stage 1 interview, Resident #32 indicated the staff get her up at 7:00 a.m.. On 3/18/15 at 10:22 a.m., the resident indicated she was never asked what time she wanted to get up in the morning when she was admitted to the Health Center.</p> <p>Resident #32's record was reviewed on 3/18/15 at 9:57 a.m. The Minimum Data Set (MDS) assessment, dated 1/21/15, indicated Resident #32 was cognitively intact.</p> <p>A care plan, dated 9/12/14, indicated the resident preferred a dressing/grooming routine of medication, dressing, then breakfast.</p> <p>On 3/18/15 at 1:30 p.m., during an interview, the Director of Nursing (DON) indicated the facility did not have a form that documented residents' preferences.</p>		<p>and record review the facility failed to ensure the resident's preferences were obtained and/or followed pertaining to morning wake up times and showers for 3 of 3 residents reviewed for choices. No residents were harmed by failure to obtain preferences. The updated preference form (Exhibit E) will be implemented initially for every current resident by 05/01/15. Residents #32, #39 and #2 will be interviewed first. Thereafter, the preference form will be completed via interview for all new admissions. All residents will then be re-assessed annually via the MDS schedule by the Activities Director. The Activities Director will copy the preferences form to Medical Records and implement preferences within seven days. This will be monitored by the care plan team at the quarterly and annual care plan meetings from 05/01/15 and thereafter.</p>	

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	<p>On 3/19/15 at 9:36 a.m., during an interview, the Assistant Director of Nursing (ADON) indicated the facility used a form titled "CNA Admission Checklist." The ADON indicated the form had not been completed for the resident because she had been in the Health Center prior to implementation of the form.</p> <p>2. Resident #39 was interviewed on 3/13/15 at 10:02 a.m. The resident indicated she had been put on the shower schedule for Mondays and Thursdays, but had told the staff she preferred to be bathed every evening at 8:00 p.m.</p> <p>On 3/18/15 at 11:50 a.m., the Assistant Director of Nursing (ADON) indicated Resident #39 was assigned shower days according to her room number on Mondays and Thursdays.</p> <p>Resident #39's clinical record was reviewed on 3/16/15 at 2:04 p.m. An admission assessment, dated 9/5/14, indicated the resident had severe cognitive impairment and required extensive assist of one to two staff for personal hygiene care.</p> <p>A form titled, "CNA Assignment 1st Floor" was received from RN #10 on 3/18/15 at 10:10 a.m. The form indicated</p>				

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	<p>Resident #39 received two showers a week on the evening shift.</p> <p>A form titled, "C.N.A. Admission Checklist," dated 9/6/14, received from the ADON #8 on, 3/18/15 at 11:50 a.m., indicated Resident #39's preference for time and frequency of showers was "every evening 8 p.m."</p> <p>3. On 3/13/15 at 11:33 a.m. Resident #2 was interviewed. The resident indicated she had not been asked how many baths or showers she preferred weekly.</p> <p>The Director of Nursing (DON) was interviewed on 3/17/15 at 12:04 p.m. The DON indicated the Certified Nursing Assistants (CNAs) filled out a form on admission regarding resident choices.</p> <p>On 3/17/15 at 1:50 p.m. the DON provided a form, identified as a tool to assess residents' choices. The DON indicated the assessment for Resident #2 had not been done until 3/17/15. The assessment tool included, but was not limited to, "2. What are their shower days Tues/(Tuesday)/Fri (Friday) Do they prefer a different day/time evening." Documentation at the bottom of the form indicated "Please use this tool with every new admission/readmission. After this is complete, give to your nurse."</p>			

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F 250 SS=D	<p>The CNA assignment sheet, provided by the Assistant Director of Nursing (ADON) on 3/17/15 at 3:30 p.m., indicated the resident received evening showers on Tuesday and Friday.</p> <p>The admission Minimum Data Set (MDS), dated 1/16/15, indicated it was somewhat important to the resident to choose what type of bath she preferred and required physical help of one for bathing.</p> <p>The facility policy titled, "Procedures for Implementation of Resident Rights," (no date) provided by the ADON on 3/19/15 at 8:30 a.m., included but was not limited to "...27. Residents will be encouraged to choose activities, schedules and health care consistent with their own interest and needs whenever possible. Residents will be afforded flexibility in bathing schedules, wake up times, meal service, table assignments, and other activities of daily living to the extent possible as long as the scheduling does not affect care being given to other residents or interfere with meal preparation..."</p> <p>3.1-3(p)(2)</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED</p>			

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Bldg. 00	<p>SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on interview and record review, the facility failed to identify and implement interventions through assessment and care planning to reduce behaviors of verbal disputes/threats for 3 of 3 residents reviewed for psychosocial needs (Resident #6, #43 and #48).</p> <p>Findings include:</p> <p>1. On 3/13/15 at 2:21 p.m., Resident # 6 was interviewed. He indicated Resident #48 called him dirty names and cursed at him daily in the hallway and dining room. Resident #6 indicated Resident #48 initiated the verbal conflict and indicated he was "going to finish it."</p> <p>On 3/13/15 at 3:08 p.m., LPN #1 indicated there had been times when Resident #6 and Resident #48 did not get along. LPN #1 stated, "They don't like each other."</p> <p>On 3/13/15 at 3:12 p.m., Director of Nursing (DON) indicated Resident #6 often initiated conflicts between himself and Resident #48.</p> <p>On 3/17/15 at 9:55 a.m., Restorative Aide</p>	F 250	<p>Based on interview and record review, the facility failed to identify and implement interventions through assessment and care planning to reduce behaviors of verbal disputes/threats for 3 of 3 residents reviewed for psychosocial needs. No residents were physically harmed the verbal disputes. Resident's 6, 43, and 48 were interviewed on 03/13/15 for potential verbal abuse. Resident 48 was moved to another room on a different hallway (state reportable, Exhibit H). Nursing staff will be In-serviced on 04/23/15 to record behaviors on 24 Hour report sheet for review by the DON/designee Monday - Friday on an ongoing basis. Included in the in-service for nursing staff held on 04/23/15 will be a review of the Abuse Policy and Behavior Documenting. Also, the on call nurse will be notified by the charge nurse daily of any verbal disputes or threats made by residents and the on call nurse will notify the social services director immediately should one of those actions have occurred. DON/designee will report any behaviors to the Social Service Director Monday through Friday on an ongoing basis along with the review of behavior tracking</p>	04/23/2015
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	<p>(RA) #9 indicated Resident #6 got upset when he saw Resident #48 walk the hallway and pace. RA #9 indicated sometimes the two residents bickered back and forth.</p> <p>On 03/18/2015 at 10:41 a.m., during an interview with Resident #6's wife, the wife indicated Resident #6 and Resident #48 had a verbal altercation 2-3 weeks ago. She indicated Resident #6 said some words to Resident #48 and she responded back by calling him a name. Resident #6's wife indicated they both instigated the verbal altercations.</p> <p>Resident #6's record was reviewed on 03/13/2015 at 2:21 p.m. A Minimum Data Set (MDS) assessment dated, 02/05/2015, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating moderate cognitive impairment. The assessment indicated the resident did not have physical, verbal or other behavioral symptoms.</p> <p>2. On 3/13/15 at 10:34 a.m., Resident #43 was interviewed. She indicated she did not get along with her roommate, Resident #48. She indicated Resident #48 was "mean and nasty" and stated, "If she doesn't stop, I am going to bop her."</p>		<p>monthly and as behaviors are reported at the weekly risk meetings. Behaviors will be reviewed by the Social Service Director weekly at the risk meeting. The primary care physician will be notified of behaviors monthly naseeded and provided a list of the resident's psychotropic medication. (See Exhibit F) Monitoring will be ongoing by the care plan team.</p>	

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NAME OF PROVIDER OR SUPPLIER ASBURY TOWERS HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 102 W POPLAR ST GREENCASTLE, IN 46135
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	<p>On 3/13/15 at 3:21 p.m., in an interview, Resident #43 indicated facility staff had not addressed to her satisfaction the concern with her roommate because they still shared a room.</p> <p>During an interview on 03/13/15 at 3:08 p.m. , LPN #1 indicated Resident #43 did not always get along with her roommate, Resident #48.</p> <p>On 3/17/15 at 9:51 a.m., during an interview with CNA (Certified Nurse Aide) #11, the CNA indicated Resident #43 and Resident #48 got upset with each other a lot. The CNA indicated Resident #43 hummed in the dining room and it upset Resident #48.</p> <p>On 3/18/15 at 9:55 a.m., CNA #12 indicated Resident #43 and Resident #48 did not always get along in the dining room.</p> <p>Resident #43's record was reviewed on 3/12/15 at 2:35 p.m. A Minimum Data Set (MDS) assessment dated, 2/18/15, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 3 out of 15, indicating severe cognitive impairment. The assessment indicated the resident did not have physical, verbal or other behavioral symptoms.</p>			

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	<p>3. On 3/13/15 at 3:08 p.m., LPN #1 indicated there had been times when Resident #48 and Resident #6 did not get along. LPN #1 stated, "They don't like each other."</p> <p>On 3/17/15 at 9:51 a.m., during an interview with CNA (Certified Nurse Aide) #11, the CNA indicated Resident #48 and Resident #43 got upset with each other a lot. CNA #11 indicated Resident #48 became upset when Resident #43 hummed in the dining room.</p> <p>On 3/18/15 at 9:48 a.m., during an interview with QMA (Qualified Medication Aide) #6, the QMA indicated Resident #48 called out a lot for attention. QMA #6 indicated Resident #48 cursed at her roommate and had disputes in the dining room with the roommate. QMA #6 indicated the behaviors increased in the beginning of February 2015.</p> <p>On 3/18/15 at 9:55 a.m., CNA #12 indicated Resident #48 and Resident #43 did not always get along in the dining room.</p> <p>On 3/18/15 at 10:30 a.m., during an interview with SSD (social service designee), the SSD indicated behaviors were documented on the behavior</p>			

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	<p>monitoring record by staff observing the behavior. The SSD indicated staff needed to be in-serviced in regard to documenting behaviors.</p> <p>On 3/19/15 at 2:10 p.m., during an interview with CNA #7, the CNA indicated Resident #48 had frequent mood changes and got angry. CNA #7 indicated symptoms were worse after she returned from the hospital.</p> <p>The clinical record for Resident #48 was reviewed on, 3/16/15 at 1:51 p.m. A diagnosis included, but was not limited to, Depression.</p> <p>A care plan, initiated 9/15/14, indicated a Problem, "The Resident has a behavior problem cursing at staff, resisting care, hitting staff r/t [related to] Dementia."</p> <p>A psychology progress note, dated 10/2/14, indicated Resident #48 reported periodic depressive mood. A recommendation was made to increase Lexapro (antidepressant) to 20 mg daily. The record indicated the dose was increased on 10/19/15. The record indicated Resident #48 was hospitalized in January 2015 and returned to the facility on 1/16/15.</p> <p>A readmission order, dated 1/16/15</p>			

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	<p>indicated the resident returned to the facility from the hospital with Lexapro 10 mg daily instead of the pre-hospitalization dose of 20 mg daily.</p> <p>A Minimum Data Set (MDS) assessment, dated, 2/11/15, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 7 out of 15, indicating severe cognitive impairment. The assessment indicated the resident did not have physical, verbal or other behavioral symptoms.</p> <p>The behavior monitoring record for Resident #48, indicated the following behaviors on 2/14/15: screamed at others, cursed at others, yelling help me, and not wanting to do for self.</p> <p>A Nurses' Note, dated 3/18/15 at 12:00 p.m., indicated Resident #48 responded "good" when another resident indicated she felt unwanted. The note indicated Resident #48 stated "I would like to kill her."</p> <p>During an interview on 3/18/15 at 10:30 a.m., the SSD (social service designee), the SSD indicated behaviors were documented on the behavior monitoring record by staff observing the behavior. The SSD indicated there was not a facility policy for behavior monitoring</p>			

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F 329 SS=D Bldg. 00	<p>and indicated staff needed to be in-serviced in regard to documenting behaviors.</p> <p>3.1-44(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 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 a system for monitoring, documenting, and reporting behavioral symptoms after a dose reduction of an antidepressant for 1 of 5 residents reviewed for unnecessary</p>	F 329	F 0329 SS=D Based on interview and record review the facility failed to ensure a system for monitoring, documenting, and reporting behavioral symptoms after a dose reduction of an antidepressant for 1 of % residents reviewed for	04/23/2015

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	<p>medication use. (Resident #48).</p> <p>Findings include:</p> <p>On 3/13/15 at 3:08 p.m., LPN #1 indicated there had been times when Resident #48 and Resident #6 did not get along. LPN #1 stated, "They don't like each other."</p> <p>On 3/17/15 at 9:51 a.m., during an interview with CNA (Certified Nurse Aide) #11, the CNA indicated Resident #48 and Resident #43 got upset with each other a lot. CNA #11 indicated Resident #48 became upset when Resident #43 hummed in the dining room.</p> <p>On 3/18/15 at 9:48 a.m., during an interview with QMA (Qualified Medication Aide) #6, the QMA indicated Resident #48 called out a lot for attention. QMA #6 indicated Resident #48 cursed at her roommate and had disputes in the dining room with the roommate. QMA #6 indicated the behaviors increased at the beginning of February 2015.</p> <p>On 3/18/15 at 9:55 a.m., CNA #12 indicated Resident #48 and Resident #43 did not always get along in the dining room.</p>		<p>unnecessary medication use. No residents were harmed by the lack of reporting behavioral symptoms. An in-service for nursing staff will be held on 04/23/15 on Abuse Policy and Behavior Documenting. Resident #48's behaviors were monitored daily by staff members. Resident was transferred to Generations, a geriatric behavior center on 04/09/15. Behaviors will be monitored daily on an ongoing basis by all staff and reviewed by the Interdisciplinary team weekly at the risk meeting. (Exhibit F, Behavior Monitoring Sheet) The behaviors will be reviewed by the Social Service Director weekly(Exhibit F,) and reviewed weekly at risk meeting. Social Service Director will review plan of care on residents with behaviors with staff on unit and family quarterly, or more often if needed. The primary care physician will be notified of behaviors monthly, or more often if needed and provided a list of the resident's psychotropic medication. (See Exhibit F & I) Licensed nursing staff will notify Social Service Director upon admission if a resident is on a psychotropic medication. (See Exhibit D) Monitoring will be ongoing by the Care Plan Team.</p>	

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	<p>On 3/18/15 at 10:30 a.m., during an interview with SSD (social service designee), the SSD indicated behaviors were documented on the behavior monitoring record by staff observing the behavior. The SSD indicated the facility did not have a policy for monitoring behaviors and indicated staff needed to be in-serviced in regard to documenting behaviors.</p> <p>On 3/19/15 at 2:10 p.m., during an interview with CNA #7, the CNA indicated Resident #48 had frequent mood changes and got angry. CNA #7 indicated symptoms were worse after she returned from the hospital.</p> <p>The clinical record for Resident #48 was reviewed on, 3/16/15 at 1:51 p.m. A diagnosis included, but was not limited to, Depression.</p> <p>The care plan, initiated 9/15/14, indicated a Problem, "The Resident has a behavior problem cursing at staff, resisting care, hitting staff r/t [related to] Dementia", Intervention included, but was not limited to, administer medications as ordered and monitor/document side effects and effectiveness of the medication.</p> <p>A psychology progress note, dated 10/2/14, indicated Resident #48 reported</p>			

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F 371 SS=F Bldg. 00	<p>periodic depressive mood. A recommendation was made to increase Lexapro to 20 milligrams (mg) daily. The record indicated the dose was increased to 20 mg daily on 10/19/14.</p> <p>The clinical record indicated Resident #48 was hospitalized in January, 2015 and returned to the facility on 1/16/15. Re-admission orders indicated the resident was to receive Lexapro 10 mg daily.</p> <p>The behavior monitoring record for Resident #48, indicated the following behaviors on 2/14/15: screamed at others, cursed at others, yelling help me, and not wanting to do for self. The behavior monitoring record did not indicate behaviors occurred from September 2014 until February 2015.</p> <p>3.1-48</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based upon observation, interview and</p>	F 371	F 0371 SS=F Based upon	04/23/2015

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	<p>record review the facility failed to ensure staff with facial hair wore a beard restraint during meal preparation and when handling clean dishes for 2 of 3 kitchen observations. This deficient practice had the potential to affect 37 of 37 residents receiving food served from the kitchen.</p> <p>Findings include:</p> <p>On 3/17/15 at 10:00 a.m., during observation of pureed food preparation Cook #4 was observed with short facial hair on his chin and a short mustache. The employee was not wearing a beard restraint.</p> <p>During an observation on 3/18/14 at 10:47 a.m., Cook #4 was observed preparing food without a restraint over his facial hair. Dietary Aide #5 was putting clean dishes away without a restraint over his facial hair. The Dietary Manager (DM) did not have a beard restraint over his facial hair and indicated in an interview no cover was required for facial hair 1/8 inch or shorter.</p> <p>On 3/18/15 at 11:45 a.m., the DM provided a copy of the undated policy and procedure titled "Hair Restraints." The policy indicated "...Team members shall wear hair restraints such as</p>		<p>observation, interview and record review the facility failed to ensure staff with facial hair wore a beard restraint during meal preparation and when handling clean dishes for 2 of 3 kitchen observations. No residents were harmed by failure to wear beard restraints. The hair restraint policy was changed to accurately reflect Title 410 IAC 7-24, Section 139(b). Action completed 04/02/15. (See Exhibit H) Dietary employees must have a clean shaven face or wear a beard restraint to prevent contamination of food or equipment. An in-service will be held on 04/13 & 04/14 addressing the policy change and receipt of the policy will be signed by the dietary staff member and placed in employee file. The dietary manager will follow up to make sure all staff have been educated and sign policy by 04/18/15 or removed from schedule until action is completed. Beard restraints were ordered via US FOODS 04/02/15. Shift supervisors will monitor daily on an ongoing basis to make sure staff members comply with policy change</p>	

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R 000 Bldg. 00	<p>hats...beard restraints, and clothing that covers body hair, in excess of 1/8 of an inch in length, and worn to effectively keep their hair from contacting exposed food; clean equipment..."</p> <p>The Retail Food Establishment Sanitation Requirements, Title 410 IAC 7-24, effective November 13, 2004, indicated, "...Section 138(b) food employees shall wear hair restraints, such as hats...beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting (1) exposed food; (2) clean equipment..."</p> <p>3.1-21(i)(2)</p> <p>Asbury Towers Health Care Center was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Survey.</p>	R 000		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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