

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155785	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/04/2014
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NAME OF PROVIDER OR SUPPLIER WEST RIVER HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 714 S EICKHOFF RD EVANSVILLE, IN 47712
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F000000	<p>This visit was for the a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: May 27, 28, 29 June 2, 3, 4, 2014</p> <p>Facility number: 012448 Provider number: 155785 AIM number: 201639500</p> <p>Survey team: Anna Villain, RN TC Barbara Fowler, RN Diane Hancock, RN 5/27,5/28, 6/2, 6/3, 6/4/14 Diana Perry, RN 5/27, 5/28, 5/29/14 Denise Schwandner, RN 5/28, 5/29, 6/2, 6/3/14</p> <p>Census bed type: SNF: 47 SNF/NF: 14 Residential: 69 Total: 130</p> <p>Census payor type: Medicare: 18 Medicaid: 9 Other: 103 Total: 130</p>	F000000	<p>Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged, or conclusions set forth on the statement of deficiencies.</p> <p>This plan of correction is prepared and executed solely because it is required by Federal and State law.</p> <p>This plan of correction is submitted in order to respond to the allegations of noncompliance cited during a recertification/licensure survey review concluding on June 4, 2014</p> <p>Please accept this plan of correction as the provider's credible aggregation of compliance effective on or before June 24, 2014.</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=D	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on June 10, 2014 by Jodi Meyer, RN</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>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 interview and record review, the facility failed to ensure a care plan was initiated for the use of a psychoactive medication for 1 of 5 residents reviewed for unnecessary medications in a sample of 5 who met the criteria. (Resident #34)</p> <p>Findings include:</p>	F000279	Resident #34 suffered no ill effects from the alleged deficiency. Resident #34s Plan of Care has been updated to reflect the residents' needs. All residents have the potential to be affected and therefore through alteration in provision of care and staff in-servicing, the Executive Director will assure the	06/24/2014

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	<p>On 5/28/14 at 8:24 a.m., Resident #34's clinical record was reviewed.</p> <p>Resident #34's diagnoses included, but were not limited to, dementia with behavioral disturbances and depression.</p> <p>The physician's recapitulation orders dated 5/1/14 through 5/31/14, included, but were not limited to, Risperdal (a psychoactive medication) 0.5 mg (milligrams) by mouth, every evening, for a diagnosis of dementia, initiated on 4/3/14.</p> <p>Resident #34's clinical record lacked a care plan pertaining to the use of Risperdal and/or the related diagnosis.</p> <p>The "Resident Conference Notes", dated 4/10/14, indicated resident behaviors were controlled by Lexapro (an anti-depressant medication), Aricept (an anti-dementia medication), and Risperdal. The note further indicated care plans were reviewed and updated.</p> <p>On 5/29/14 at 10:02 a.m., the DHS (Director of Health Services) indicated all care plans were located in the resident's charts.</p> <p>On 6/2/14 at 9:19 a.m., RN #1 indicated a</p>		<p>interdisciplinary team utilizes the results of the assessment(s) to develop, review and revise the resident's comprehensive plan of care. The campus has reviewed all resident plans of care to assure resident care plans are implemented as appropriate. An in-service has been completed with interdisciplinary team member concerning developing comprehensive care plans. Systemic change is all new physician orders and admission orders will be reviewed in daily CCM. Social Services will initiate care plan or revisions/update at that time as appropriate. DHS or designee will audit 3 random resident care plans to ensure comprehensive care plans have been developed and have been implemented 5 times a week for one month, then 3 times weekly for one month, then weekly thereafter with results forwarded to QA committee for 6 months and quarterly thereafter for review and further suggestions/comments.</p>	

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F000318 SS=D	<p>care plan was initiated after a new psychoactive medication is ordered for a resident. RN #1 further indicated a care plan was written for both the psychoactive medication and the diagnosis warranting the use of the medication.</p> <p>On 6/4/14 at 9:40 a.m., the "Interdisciplinary Team Care Plan Guideline" policy, provided by the ED (Executive Director), at that time, was reviewed. The policy indicated, "New problem areas should be printed and added to the existing care plans".</p> <p>3.1-35(b)(1)</p> <p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>Based on observation, interview, and record review, the facility failed to ensure 1 of 2 residents reviewed for positioning received ROM (range of motion) exercises according to their plan of care. (Resident #27)</p>	F000318	Resident #27 suffered no ill effects from the alleged deficiency. Resident #27 has been screened by therapy to assure restorative program is meeting resident needs. Nursing staff have been in-serviced on resident #27 restorative nursing program. All residents have the	06/24/2014

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	<p>Findings include:</p> <p>During an observation on 5/28/14 at 10:47 a.m., Resident #27 was observed to be sitting in a wheelchair in the lobby. Resident #27's head and upper body were leaning to the right. Resident #27 had a splint on the left hand and arm which was resting on a large armboard attached to the wheelchair. During an interview, Resident #27 indicated the staff applied the splint to her left arm/hand in the morning and removed it at night.</p> <p>During an observation on 5/29/14 at 10:05 a.m., Resident #27 was observed to be dozing in the lobby on the unit in a wheelchair. Resident #27's head and upper body were observed to be leaning to the right side. The splint was in place to the left arm/hand and positioned on the armboard attached to the wheelchair. Resident #27's right arm would fall off of the right armboard while the resident was dozing.</p> <p>Resident #27's clinical record was reviewed on 5/29/14 at 8:37 a.m. Resident #27 had diagnoses including, but not limited to, cerebral vascular disease, chronic obstructive pulmonary disease, hypertension, anxiety, dysphagia, congestive heart failure, and</p>		<p>potential to be affected by the alleged deficient practice and therefore through corrective actions and in-servicing the Executive Director will ensure a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion. Program Director will review residents to assure residents are receiving restorative services if needed. All nursing staff have been in-serviced on current restorative programs. Systemic change is a master list has been completed of all residents receiving restorative services will be maintained in the CRCA book and alert charting binder. DHS or designee will monitor 3 random residents to assure restorative program completed per plan of care 5 times per week for one month, then 3 times per week for one month, then weekly thereafter with results forwarded to the QA committee for 6 months and quarterly thereafter for further review and suggestions/recommendations.</p>				

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	<p>gastroesophageal reflux disorder. A MDS (Minimum Data Set) assessment, dated 3/20/14, indicated the resident had a BIMS (Brief Interview for Mental Status) score of 9 out of 15, indicating moderate cognitive impairment. The MDS further indicated Resident #27 had functional ROM impairment to the bilateral upper and lower extremities. The MDS indicated Resident #27 received ROM.</p> <p>A care plan, dated 3/20/14, indicated Resident #27 received a restorative program. The care plan further indicated Resident #27 was to receive PROM (passive range of motion) to the arms and legs, 6 (six) to 7 (seven) days per week. The care plan further indicated Resident #27 was to receive 2 repetitions of 10 (ten) flexion and extension exercises.</p> <p>The CNA (certified nursing assistant) assignment sheet, dated 5/28/14, indicated Resident #27 received ROM, No location for the ROM exercises were identified.</p> <p>The "Restorative Nursing Care Report" dated 4/19/14 - 5/30/14 and obtained from the DSS (Director of Social Services) on 6/2/14 at 10:40 a.m., indicated Resident #27 did not receive ROM exercises on the following dates:</p>			

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	<p>4/20/14, 4/25/14, 5/3/14, 5/4/14, 5/10/14, 5/26/14, 5/28/14, and 5/20/14.</p> <p>During an interview on 5/28/14 at 10:47 a.m., Resident #27 indicated she did not receive exercises to the right side. Resident #27 indicated the staff applied the splint to her left arm/hand and placed it on a pillow on the armboard of her wheelchair. Resident #27 indicated she had leaned to the right side since having a stroke but indicated she felt it was becoming worse.</p> <p>During an interview on 5/29/14 at 10:27 a.m., CNA #2 indicated it was difficult to keep Resident #27 propped straight while in a wheelchair. CNA #2 indicated Resident #27 appeared to be leaning more to the right recently. CNA #2 indicated documentation for restorative programs were located in the dining room. Upon further query, CNA #2 indicated she would need to ask someone where the restorative documentation was located.</p> <p>During an interview on 5/29/14 at 11:00 a.m., CNA #1 indicated she did not know where the restorative program was documented for the dining room. Upon query, CNA #1 indicated the ROM was documented by the CNAs in the computer.</p>			

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	<p>During an interview on 6/3/14 at 8:50 a.m., CNA #1 indicated the CNAs ambulated the residents and did the ROM. CNA #1 indicated LPN #1 was in charge of the program.</p> <p>During an interview on 6/3/14 at 9:00 a.m., CNA #4 indicated Resident #27 received ROM to the left side but did not receive ROM to the right side.</p> <p>During an interview on 6/3/14 at 9:05 a.m., CNA #5 indicated ROM was completed prior to the resident getting out of bed in the morning and after lunch. CNA #5 indicated she would flex both arms and legs when she did ROM exercises with Resident #27.</p> <p>During an interview on 6/3/14 at 9:40 a.m., the DHS (Director of Health Services) indicated the MDS Coordinator oversaw the Restorative program.</p> <p>The "Program Guidelines for Restorative/Functional Maintenance Plan and Summary," dated October, 2007, and obtained from the DHS on 6/3/14 at 9:50 a.m., indicated the purpose was to evaluate progress towards program goals and interventions and modify as indicated.</p>			

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F000322 SS=D	<p>3.1-42(a)(2)</p> <p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that --</p> <p>(1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and</p> <p>(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>Based on observation, interview, and record review, the facility failed to ensure placement of a gastrostomy tube was checked prior to administration of water and medication through the tube, for 1 of 1 resident with a gastrostomy tube observed during medication administration. (Resident #69)</p> <p>Finding includes:</p>	F000322	Resident #69 suffered no ill effects from the alleged deficiency. All residents with gastostomy tubes have the potential to be affected by the alleged deficient practice and therefore through corrective actions and in-servicing the Executive Director will ensure placement of a gastrostomy tube is checked prior to administration of water and medication through the tube. All licensed nursing staff have been in-serviced on	06/24/2014

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	<p>On 6/2/14 at 9:12 a.m., RN #1 was preparing to administer medications to Resident #69. She prepared lorazepam 0.5 milligrams (mg) 1/2 tablet by crushing the tablet and placing the powder in a medication cup. She obtained water to use to flush the tube. She entered the room, positioned the resident and found the gastrostomy tube. She proceeded to uncap the tube and place a syringe tube into the opening. She poured water into the tube and it flowed into the resident by gravity. She then sprinkled the medication powder into the syringe and followed it with water. She did not check placement of the tube prior to administration of the water and medication.</p> <p>RN #2 was interviewed immediately after the medication administration. She indicated it was normal practice to inject air into the abdomen through the tube and listen to the abdomen with a stethoscope to check for proper placement of the tube. She indicated she had forgotten to do that at that time. She indicated she had checked placement at 6:30 that morning with morning medications.</p> <p>The policy and procedure for Enteral Tube Medication Administration, dated 9/17/2012, was provided by the Director</p>		<p>administering medications per gastrostomy tube and checking placement. Systemic change is all licensed nurses will complete a competency on gastrostomy tubes now and annually thereafter. DHS and/or designee will monitor 1 resident to assure gastrostomy use per procedure 5 times per week for one month, 3 times per week for one month, then weekly thereafter with results forwarded to the QA committee for 6 months and quarterly thereafter for further review and suggestions/recommendations.</p>	

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F000323 SS=G	<p>of Nurses on 6/3/14 at 9:50 a.m. The policy and procedure included, but was not limited to, the following instructions: "Verify tube placement. Unclamp tube and use either of the following procedures: Insert a small amount of air into the tube with the syringe and listen to stomach with stethoscope for gurgling sounds; or Aspirate stomach contents with syringe..." "Crush tablets and dissolve in 10-15 ml [milliliters] of water or other appropriate liquid..." "Flush the tube with 30 ml of water prior to medication administration..." "Allow medication to flow down tube via gravity." "Flush the tube with 30 ml of water..."</p> <p>3.1-44(a)(1)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to ensure planned interventions were implemented, in that, a sit to stand mechanical lift was not used</p>	F000323	Resident #64s transfer needs have been reviewed. The resident is now transferring utilizing a Hoyer lift.All other residents are at risk to be	06/24/2014

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	<p>to transfer a resident, resulting in a fracture for 1 of 3 residents reviewed for accidents in a sample of 4 who met the criteria. (Resident #64)</p> <p>Findings include:</p> <p>The DHS (Director of Health Services) was interviewed on 6/2/14 at 11:22 a.m., regarding the investigation into a lower leg fracture on Resident #64. The DHS indicated, on 5/25/14 CNA #5 and CNA #6 had used the stand and pivot method to transfer Resident #64 for toileting. The DHS further indicated the resident showed no signs of pain. After the evening meal, on 5/25/14 CNA #5 and CNA #6 discovered an apple sized light blue area on the residents left knee and notified the nurse. The DHS indicated LPN #2 did not think anything was wrong with the resident's legs due to constant discoloration related to poor perfusion. The DHS indicated on 5/26/14 when the staff attempted to transfer Resident #64, the resident began complaining of pain and a large bruise was discovered.</p> <p>On 6/2/14 at 11:30 a.m., Resident # 64's clinical record was reviewed.</p> <p>Resident #64's diagnoses included, but were not limited to, osteoporosis,</p>		<p>affected by the alleged deficient practice. Through alterations in processes and in-servicing, the Executive Director will ensure the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistive devices to prevent accidents. All residents have been assessed for proper transfer assistance. Systemic change is lift assessments are to be completed on all residents upon admission, quarterly and with significant change in their condition. Transfer assistance will be placed on the CRCA assignment sheet. Nursing staff have been in-serviced on lift assessments and following CRCA assignment sheets. DHS or designee will monitor 3 random residents at risk for falls to assure safety interventions are in place per resident plan of care, and adequate supervision is being utilized to prevent accidents 5 times per week for one month, then 3 times per for one month, then weekly with results forwarded to QA committee monthly for 6 months and quarterly thereafter for review and further suggestions/comments.</p>		

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	<p>osteoarthritis, tibia/fibula fracture, and dementia.</p> <p>The "Resident Lift Assessment Profile", dated 7/3/13, indicated Resident #64 required a sit to stand lift device for transfers.</p> <p>The "Monthly Nursing Assessment and Data Collection" tool, dated 5/19/14, indicated Resident #64 required a wheelchair and a sit to stand lift for mobility and transfers. The tool further indicated Resident #64 was non-weight bearing.</p> <p>The "Nurse's Notes" indicated:</p> <p>a. On 5/26/14 at 10:30 a.m., a large bruise was discovered to the left lower leg, just below the knee, measuring 16.0 by 10.0 cm (centimeters). A new order was obtained for an x-ray of the left lower leg.</p> <p>b. On 5/26/14 at 11:50 a.m., the x-ray results were received and reported to physician, DHS, and hospice. A new order was received for therapy to evaluate for possible splinting/immobilization.</p> <p>c. On 5/27/14 during the 6:00 a.m. to 2:00 p.m. shift, Resident #64's family requested resident to be seen by an</p>			

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	<p>orthopedic physician.</p> <p>d. On 5/27/14 at 5:20 p.m., resident sent to emergency room. The facility physician discussed with the nurse on duty that an oblique fracture, in that location, in an individual with osteoporosis, can be caused by simply bearing weight, pivot transfer, or use of sit to stand lift.</p> <p>The "Radiology Report", dated 5/26/14, indicated oblique fractures of the proximal tibia and fibula.</p> <p>The "Care Plan", dated 4/14/14, indicated " I am at risk for falls and use a sit to stand lift for transfers with staff assist to prevent any injury or fall."</p> <p>The "Care Plan", dated 4/18/14, indicated "I have osteoporosis and am at high risk for fractures. Please use caution when you are assisting me to turn and reposition, transfer, dress, ect. Observe me for any complaints of new onset of pain. Also observed (sic) for any unexplained swelling, tenderness, and guarding of my joints or extremities. Notify my Doctor of any significant findings. My goal is to remain free of fractures."</p> <p>The CNA assignment sheet, dated</p>			

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F000329 SS=E	<p>5/19/14, indicated resident required a sit to stand lift for assistance with transfers.</p> <p>On 6/4/14 at 9:42 a.m., the "Guidelines for Resident Transfers" policy was reviewed. The policy indicated its purpose was to ensure the safety of residents and staff when performing mobility/transfer tasks. The policy further indicated, "...shall determine the type of transfer device, amount of assistance required to assist with safe mobility...."</p> <p>3.1-45(a)(2)</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</p>						

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	<p>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 observation, interview, and record review, the facility failed to ensure 4 of 5 residents reviewed for unnecessary medications were adequately monitored and had adequate indications for the use of the medications, in that diagnoses were lacking, behavior monitoring was lacking, and appropriate side effects were not being monitored. (Residents #104, #57, #70, #34)</p> <p>1. Resident #104's clinical record was reviewed on 5/28/14 at 3:04 p.m. The resident was admitted to the facility on 4/23/14 with diagnoses including, but not limited to, senile dementia, anxiety state, depressive disorder, essential hypertension, atrial fibrillation, and chronic pain.</p> <p>Signed physician's orders 5/1/14 through 5/31/14 indicated the resident's medications included, but were not limited to, the following: Lexapro (antidepressant) 10 milligrams (mg) twice a day (4/23/14) Seroquel (antipsychotic) 25 mg every</p>	F000329	Residents #104, #57, #70 and #34 suffered no ill effects from the alleged deficient practice. Residents #104, #57, #70 and #34 medications have been reviewed by their attending physician. All residents have the potential to be affected by the alleged deficient practice therefore through systemic changes stated below the Executive Director will ensure medications are administered as indicated with adequate indications for use. All residents with psychotropic medications have been reviewed. An in-service was provided to licensed nursing staff concerning unnecessary drugs and proper diagnosis for medications and monitoring of side effects. Systemic change is the implementation of antipsychotic fax form for appropriate diagnosis. A monthly psychotropic meeting will be held to review medications for appropriateness. DHS or designee will perform audits of 3 random residents medications to assure resident is free from unnecessary drugs 5 times per week for one month, then 3 times per week for one month, then weekly with	06/24/2014			

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	<p>bedtime (4/23/14)</p> <p>The resident's initial Minimum Data Set (MDS) assessment, dated 4/30/14, indicated the presence of inattention and psychomotor retardation, but no behaviors. The MDS indicated the resident was receiving antipsychotic and antidepressant medications. The resident had a care plan, date 5/12/14, regarding having a diagnosis of depression and receiving an antidepressant and antipsychotic daily. Interventions included, but were not limited to, the following: "I need you to administer my medication as ordered and observe for signs and symptoms of effectiveness and adverse side effects. Notify my MD of any adverse side effects...My goal is to have no adverse side effects of my psychotropic medication..."</p> <p>The Behavior Detail Report for 5/1/14 through 5/31/14 was reviewed on 6/2/14 at 1:23 p.m. Only one occurrence was recorded, dated 5/22/14 at 7:05 p.m. "Verbally Abusive" and indicated this occurred on 5/22/14 at 6:30 p.m. There was no indication of any interventions used to address the incident and/or effectiveness of the interventions. The Medication Administration Record (MAR) for 5/1/14 through 5/31/14 was reviewed at the same time. The record</p>		<p>results forwarded to the QA committee monthly for 6 months and quarterly thereafter for review and further suggestions/comments.</p>	

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	<p>had a pre-printed sticker indicating the following: "Anti-Depressant MEDICATION Lexapro Observe the patient closely for significant side effects and report to the Physician. SIDE EFFECTS: Common - Sedation, drowsiness, dry mouth, blurred vision... SPECIAL ATTENTION FOR: Heart disease, glaucoma, chronic constipation..."</p> <p>Handwritten on the sticker was "Seroquel," indicating they were monitoring for side effects of the Seroquel as well. The staff would then initial each shift that they were monitoring for the side effects. There was no indication, or documentation, they were monitoring the side effects of the anti-psychotic medication, as these were not indicated on the record.</p> <p>The resident was observed on 5/28/14 at 3:26 p.m. in her room, seated in a recliner chair, with a visitor at her side. She was smiling and appeared comfortable. The resident was observed on 6/2/14 at 9:30 a.m. to be up in a wheelchair in the unit lounge area, facing the television. Her eyes were closed; she appeared comfortable.</p> <p>CNA #8 was interviewed on 6/2/14 at 9:35 a.m. She indicated the resident</p>			

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	<p>would occasionally grab at things when they were attempting to move her, and scream. Other than that, she indicated the resident had no behaviors.</p> <p>The Director of Nurses was interviewed on 6/3/14 at 4:30 p.m. She indicated the MAR should have indicated they were monitoring for side effects of an antipsychotic medication.</p> <p>2. Resident #57's clinical record was reviewed on 5/28/14 at 3:30 p.m. The resident was admitted to the facility on 4/23/14 with diagnoses including, but not limited to, senile dementia, anxiety state, essential hypertension, esophageal reflux, constipation, and unspecified hypothyroidism.</p> <p>The record contained physician's orders, signed 5/21/14, included, but were not limited to, the following medications: Citalopram (antidepressant) 40 milligrams (mg) one daily Risperdal (antipsychotic) 0.25 mg one tablet twice a day since 4/23/14</p> <p>The resident's initial Minimum Data Set (MDS) assessment, dated 4/30/14, indicated the resident had inattention and disorganized thinking. The MDS indicated the resident had no behaviors, and was receiving antipsychotic and</p>			

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	<p>antidepressant medications.</p> <p>The resident had care plans in place for being at risk for depression and having diagnoses of anxiety and dementia with behaviors, all dated 5/11/14. Interventions included, but were not limited to, providing diversional activity, liking to sort jewelry, assessing for pain, discomfort, need to toilet, continue to administer medications as they are ordered and monitor their effectiveness and any side effects... A care plan was also in place for having dementia with behaviors, depression, and anxiety and receiving antipsychotic and antidepressant medications daily, dated 5/11/14. Interventions included, but were not limited to, the need to administer medication as ordered and observe for signs and symptoms of effectiveness and adverse side effects.</p> <p>A physician's progress note, dated 5/21/14, indicated the resident was having no issues and was calm and cooperative.</p> <p>The only nurse's note regarding the resident was dated 4/23/14. There were no circumstance forms for any behaviors. The Medical Records Nurse, interviewed on 5/28/14 at 4:00 p.m., indicated psychoactive medications and behaviors</p>			

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	<p>were monitored on the Medication Administration Record (MAR).</p> <p>The MAR for 5/1/14 through 5/31/14 was reviewed on 6/2/14 at 2:00 p.m. The MAR included a pre-printed sticker as follows: "Anti-anxiety MEDICATION Risperidal Observe the patient closely for significant side effects and report to the Physician. SIDE EFFECTS: Sedation, Drowsiness, Ataxia (drunk walk), Dizziness, Nausea, Vomiting, Confusion, Headache, Blurred Vision, Skin Rash. NURSING ALERT: If given with other sedatives or hypnotics, and alcohol. Monitor behavior on medication sheet."</p> <p>There was no indication the facility was monitoring the resident for side effects of the antipsychotic medication, as they were identifying the Risperidal as an anti-anxiety medication.</p> <p>A Behavior Detail Report for May, 2014 was reviewed on 6/2/14 at 1:23 p.m. The record indicated the following incidents of behavior: 5/17/14 8:15 p.m. physically abusive, provided 1 to 1 care and it was effective. 5/17/14 8:15 p.m. socially inappropriate behavior, provided redirection and it was effective</p>			

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	<p>5/21/14 8:30 p.m. physically abusive, no indication of interventions or effectiveness.</p> <p>5/28/14 6:00 p.m. verbally abusive, no indication of interventions or effectiveness.</p> <p>CNA #9 was interviewed on 5/28/14 at 4:06 p.m. She indicated Resident #57 resisted care when she was first admitted, but not anymore.</p> <p>The resident was observed in her room in a wheelchair asleep on 6/2/14 at 9:09 a.m.; her breakfast tray was on the overbed table in front of her and she had eaten. The resident was observed to be in bed asleep with her lunch tray untouched on 6/2/14 at 1:45 p.m.</p> <p>RN #2 was interviewed on 6/2/14 at 1:53 p.m. She indicated, "When she doesn't want to be bothered, she doesn't want to be bothered." She indicated the resident had wanted to lay back down after her shower. The RN had asked her about getting up for lunch and the resident had told the nurse to "go the he-- away."</p> <p>3. During an observation on 5/27/14 at 2:45 p.m., Resident #70 was observed to be sitting in a high-backed wheelchair the lobby next to the nurse's station. Resident #70 had periods of confusion</p>						

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	<p>but redirected easily.</p> <p>During an observation on 5/28/14 at 11:05 a.m. and again at 3:10 p.m., Resident #70 was observed to be in the lobby in a high-backed wheelchair. Resident #70 had periods of confusion but redirected easily.</p> <p>During an observation on 6/2/14 at 10:15 a.m., Resident #70 was observed to be sitting in a high-backed wheelchair in the lobby. Resident #70 would attempt to get out of the wheelchair but was redirected easily by the staff.</p> <p>The clinical record of Resident #70 was reviewed on 5/28/14 at 2:48 p.m. Resident #70 had diagnoses including, but not limited to, hypothyroidism, hypertension, dementia, hyperglycemia, prostate cancer, anemia, hyperlipidemia, and gastroesophageal reflux disorder. The most recent quarterly MDS (Minimum Data Set) assessment, dated 2/20/14, indicated Resident #70 had severe cognitive impairment.</p> <p>A physician's order, dated 5/25/14, indicated Resident #70 was to receive Ativan 1 mg IM (intramuscularly) x (times) 1 now and Risperdal (an antipsychotic medication) 0.25 mg 1 tablet po q HS (hour of sleep.) No</p>			

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	<p>diagnosis or indication was documented for the medications.</p> <p>A care plan, dated 5/28/14, indicated Resident #70 received antipsychotic medication. The care plan indicated the following interventions:</p> <ol style="list-style-type: none"> Medications were to be administered as ordered. Staff was to observe the resident for signs/symptoms of extrapyramidal symptoms. Staff was to observe the resident for effectiveness and adverse side effects of the medications, and notify the physician if necessary. Monitor labs - all routine labs were discontinued due to hospice, dated 3/31/14. Monitor behaviors and nonverbal signs of anxiety, dated 5/25/14. <p>During an interview on 6/2/14 at 10:07 a.m., the DSS (Director of Social Services) indicated she had attempted to obtain a diagnosis an indication for the use of the Risperdal. The DSS further indicated the facility just recently began tracking the resident's behavior in the computer. The DSS indicated tracking was done on the unit on a behavioral tracking form and was tracked for 72 hours after the behavior occurred.</p>						

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	<p>During an interview on 6/2/14 at 3:45 p.m., the ED (Executive Director) indicated the facility staff had not completed the documentation for behaviors. The ED indicated she was aware the facility did not have a diagnosis for the Risperdal.</p> <p>During an interview on 6/3/14 at 9:20 a.m., the DHS (Director of Health Services) indicated the facility did not have a diagnosis for the Risperdal and the facility staff had not documented Resident #70's behaviors properly.</p> <p>4. On 5/28/14 at 8:24 a.m., Resident #34's clinical record was reviewed.</p> <p>Resident #34's diagnoses included, but were not limited to, dementia with behavioral disturbances and depression.</p> <p>The physician's recapitulation orders dated 5/1/14 through 5/31/14, included but were not limited to, Risperdal (a psychoactive medication) 0.5 mg (milligrams) by mouth, every evening, for a diagnosis of dementia, initiated on 4/3/14.</p> <p>The Social Service Note, dated 4/4/14, indicated the supporting diagnosis for the use of Risperdal was dementia with behavioral disturbances.</p>			

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	<p>The "Resident Conference Notes" dated 4/10/14 indicated resident behaviors controlled by Lexapro (an anti-depressant medication), Aricept (an anti-dementia medication), and Risperdal.</p> <p>The Annual MDS (Minimum Data Set) Assessment, dated 3/26/14 indicated Resident #34 exhibited no behaviors.</p> <p>The Physician's Clinical Encounter Summaries dated 4/2/14 indicated Resident #34's depressive disorder was to be treated with Risperdal. The Summary further indicated Resident #34's diagnosis of dementia was without behavioral disturbances.</p> <p>The Monthly Nursing Assessment and Data Collection dated 5/5/14 indicated Resident #34 exhibited no behavior issues.</p> <p>The Assessment Review and Considerations dated 4/1/14 indicated under section "Behavior Risk", the resident's diagnosis of dementia with behavioral disturbances. The assessment further indicated, "although risk factors have been identified the resident is not exhibiting behavior symptoms at this time".</p> <p>The Group Behavior Chart for 4/1/14</p>			

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	<p>through 5/31/14 lacked any documented behaviors.</p> <p>The CNA assignment sheet last updated on 5/29/14 lacked documentation indicating resident exhibits behaviors.</p> <p>On 5/29/14 at 1:49 p.m. Resident #34 was observed sleeping in his room.</p> <p>On 6/2/14 at 9:00 a.m., Resident #34 indicated he was doing well this morning.</p> <p>On 6/2/14 at 2:22 p.m., DSS (Director of Social Services) indicated Resident #34 has had no behaviors since 4/1/14. The DSS further indicated on 3/26/14 Resident #34 had some irritability with his roommate.</p> <p>On 6/3/14 at 3:10 p.m., the DSS indicated Resident #34's irritability with his roommate was discussed prior to the doctor's appointment on 4/2/14. The DSS further indicated when the resident returned for the appointment the resident has a new order for Risperdal. The DSS indicated the MD indicated the Risperdal was for the treatment of depression.</p> <p>A policy titled, "Psychoactive Drug Monitoring," revised 9/17/12 and obtained from the DHS on 6/3/14 at 9:50 a.m., indicated the resident's physician</p>			

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F000363 SS=E	<p>should provide a justification for the continued use of the antipsychotic and dosage as clinically appropriate and this justification appears in the chart. The policy further indicated antipsychotics are given only if the resident has been diagnoses with one of the following indications: schizophrenia, schizo-affective disorder, delusional disorder, psychotic mood disorders, acute psychotic episodes, brief reactive episodes, schizophreniform disorder, atypical psychosis, or organic mental syndromes.</p> <p>The policy also indicated, "Nonpharmacological interventions such as behavior modification or social services and their effects are documented as a part of the care planning process, and are utilized by the prescriber in assessing the continued need for psychoactive medication".</p> <p>3.1-48(a)(3) 3.1-48(a)(4)</p> <p>483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of</p>			

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	<p>Sciences; be prepared in advance; and be followed.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the recipe was followed for puree diets, for 1 of 1 observation of puree food preparation, in that the amount of food pureed was smaller than required by the recipe. (Noon meal, 5/28/14)</p> <p>Finding includes:</p> <p>On 5/28/14 at 11:00 a.m. Cook #1 was observed pureeing peas with pearl onions. She indicated she was pureeing five servings. She measured out five two-ounce scoops of the vegetables. She pureed the vegetables and placed them in a steam table pan. The recipe, dated 7/11/13, was reviewed at that time. The recipe for five servings indicated five four-ounce scoops were to be measured out and pureed. According to the recipe, and the menu, the resident would then be served a two-ounce portion of the pureed vegetables. Cook #1 and the Dietary Manager were informed of the error. The Dietary Manager indicated they would need to puree and add two more ounces of vegetables to make the required amount.</p> <p>3.1-20(a)</p>	F000363	<p>There were no residents affected by the alleged deficient practice. All residents receiving a puree diet have the potential to be affected by the deficient practice and through alterations and in-services the Executive Director will ensure puree diet recipes are followed. An in-service was provided to our Food Service staff on following puree recipes properly. Systemic change is DFS to monitor production of puree menu items. DFS or her designee will monitor preparation of puree menu items for one meal 5 times per week for one month, then 3 times per week for one month, then weekly with results forwarded to QA committee monthly for 6 months and quarterly thereafter for review and further suggestions/comments.</p>	06/24/2014	

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F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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</p>			
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	<p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the infection control program was maintained to prevent potential infections for 1 of 2 residents observed receiving care, in that glove changes and handwashing procedures were not completed as necessary. (Resident #27)</p> <p>Findings include:</p> <p>During an observation on 5/29/14 at 10:05 a.m., CNA (certified nursing assistant) #1 and CNA #2 were observed to take Resident #27 to the room. CNA #1 and CNA #2 were observed to apply gloves prior to placing Resident #27 in the sit to stand lift. No handwashing was done. CNA #1 and CNA #2 were observed removing Resident #27's pants and brief. CNA #1 was observed to position Resident #27 on the commode. The sit to stand lift was then removed and the CNAs left the resident's room.</p> <p>On 5/29/14 at 10:36 a.m., CNA #2 and CNA #3 reentered Resident #27's room. The CNA's applied gloves but no handwashing was performed. Resident #27 was lifted with the sit to stand lift.</p>	F000441	Resident #27 suffered no ill effects from the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice and through alterations in processes and in-servicing will ensure corrective actions to prevent the spread of infection are being followed. Staff will be in-serviced on infection control while toileting. Systemic change is all nursing staff will complete a competency on Infection Control with toileting. DHS or designee will monitor 3 random residents for proper infection control measures daily 5 days per week for 2 weeks, 3 times per week for 2 weeks and weekly with results forwarded to QA committee monthly for 6 months and quarterly thereafter for review and further suggestions/comments.	06/24/2014

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	<p>CNA #3 used a disposable wipe and cleaned the periarea. Both CNAs pulled Resident #27's brief and pants up. Resident #27 was then placed into her wheelchair. CNA #2 removed the lift sling and placed the sling on the bathroom door. CNA #2 repositioned Resident #27 in the wheelchair and placed a folded blanket to the back of the resident. CNA #2 and CNA #3 removed their gloves and washed their hands after completing the task.</p> <p>During an interview on 6/2/14 at 10:52 a.m., CNA #2 indicated hands should be washed prior to gloves being applied, when going from dirty to clean, and after gloves are removed.</p> <p>The "Guidelines for Handwashing," dated 10/2004, and obtained from the DHS (Director of Health Services) on 6/3/14 at 9:37 a.m., indicated health care workers should wash hands before/after having direct physical contact with residents and after removing gloves worn per Standard Precautions for direct contact with excretions, resident equipment, et cetera. The guidelines further indicated residents shall be offered the opportunity to wash their hands after toileting.</p> <p>3.1-18(b)(1) 3.1-18(l)</p>			

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R000000	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-5.	R000000	<p>Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged, or conclusions set forth on the statement of deficiencies.</p> <p>This plan of correction is prepared and executed solely because it is required by Federal and State law.</p> <p>This plan of correction is submitted in order to respond to the allegations of noncompliance cited during a recertification/licensure survey review concluding on June 4, 2014</p> <p>Please accept this plan of correction as the provider's credible aggregation of compliance effective on or before June 24, 2014.</p>	

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R000414	<p>410 IAC 16.2-5-12(k) Infection Control - Deficiency (k) 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>Based on observation, interview, and record review, the facility failed to ensure the infection control program was maintained to prevent potential infections for 1 resident observed receiving care, in that handwashing procedures were not completed as necessary. (Resident #160)</p> <p>Findings include:</p> <p>During an observation on 6/3/14 at 11:31 a.m., CNA (certified nursing assistant) # 7 was observed to assist Resident #160 to the bathroom. CNA #7 applied gloves with no handwashing observed. CNA #7 assisted Resident #160 to a standing position and lowered Resident #160's pants and briefs. CNA #7 then lowered Resident #160 to the commode. CNA #7 removed her gloves and obtained a gait belt. CNA #7 applied the gait belt. CNA #7 applied clean gloves, completed pericare, and pulled Resident #160's brief and pants up. Resident #160 was assisted to the wheelchair. CNA #7 removed the</p>	R000414	<p>Resident #160 suffered no ill effects from the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice and through alterations in processes and in-servicing the Executive Director will ensure corrective actions to prevent the spread of infection are followed. Staff will be in-serviced on infection control while toileting a resident. Systemic change is all nursing staff will complete a competency test on infection control while toileting a resident. DHS or designee will monitor 3 random residents for proper infection control practices 5 times per week for 2 weeks, 3 times per week for 2 weeks, then weekly with results of compliance being forwarded to QA committee monthly for 6 months and quarterly thereafter for review and further suggestions/comments.</p>	06/24/2014

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	<p>gloves and proceeded to wheel Resident #160 into the lobby. CNA #7 washed her hands after placing Resident #160 in the dining room. CNA #7 also did not offer to allow Resident #160 to wash her hands after toileting.</p> <p>During an interview with the ED (Executive Director) on 5/29/14 at 4:00 p.m., the ED indicated staff should wash their hands after giving direct patient care and after removing their gloves.</p> <p>During an interview on 6/2/14 at 10:52 a.m., CNA #2 indicated hands should be washed prior to gloves being applied, when going from dirty to clean, and after gloves are removed.</p> <p>The "Guidelines for Handwashing," dated 10/2004, and obtained from the DHS (Director of Health Services) on 6/3/14 at 9:37 a.m., indicated health care workers should wash hands before/after having direct physical contact with residents and after removing gloves worn per Standard Precautions for direct contact with excretions, resident equipment, et cetera. The guidelines further indicated residents shall be offered the opportunity to wash their hands after toileting.</p>			

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