

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155692	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/20/2016
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NAME OF PROVIDER OR SUPPLIER HERITAGE OF HUNTINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1180 W 500 N HUNTINGTON, IN 46750
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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>Survey dates: June 14, 15, 16, 17, and 20, 2016.</p> <p>Facility number: 002910 Provider number: 155692 AIM number: 200345390</p> <p>Census bed type: SNF/NF: 56 SNF: 15 Residential: 50 Total: 121</p> <p>Census payor type: Medicare: 9 Medicaid: 24 Other: 88 Total: 121</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 11474 on June 21, 2016.</p>	F 0000		
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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 0282 SS=D Bldg. 00	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to follow careplan interventions to maintain a resident's bowel and bladder continence for 1 of 35 residents reviewed for careplans (Resident #65).</p> <p>Findings include:</p> <p>During an interview, on 6/15/16 at 9:19 a.m., Resident #65's son indicated she had voiced a concern to him that she was told by staff to relieve herself in her brief instead of being toileted. He indicated she had voiced this concern on more than one occasion.</p> <p>On 6/16/16 at 1:38 p.m., Resident #65 was in her bed. There was no bed pan observed in her bathroom; an open bag of incontinence briefs was sitting on the plastic chest of drawers.</p> <p>Review of Resident #65's clinical record</p>	F 0282	<p>1- A bedpan was put in Resident #65's room. CNAs were informed of the assignment sheet requirement to offer a bedpan This was completed on all shifts from 6/17/16 through 6/24/16. An Abuse Inservice was presented to all Nursing Department staff beginning 6/21/16. The information will be reviewed at the POC Nursing Department Inservices. Dates are attached.</p> <p>2- The Care plans, assignment sheets and ipods (CNA charting device) were reviewed for accuracy for our incontinent residents. Updates were completed as needed .</p> <p>3- Daily rounds five days a week will be completed by the ADON and 2nd Shift Supervisor or designee for one month to ensure needed equipment and supplies are available in all residents rooms. If 100% compliance is not achieved in one month, the checks will continue until 100% accuracy is achieved.</p> <p>4- Random (each shift) weekly</p>	07/20/2016			

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	<p>began on 6/14/16 at 2:00 p.m. Diagnoses included, but were not limited to, dementia, hemiplegia and hemiparesis, urinary incontinence, and muscle weakness.</p> <p>Resident #65 had a quarterly Minimum Data Set assessment, dated 4/13/16, which indicated she was severely cognitively impaired. The assessment further indicated Resident #65 was frequently incontinent of bowel and bladder and required extensive assistance for toileting.</p> <p>Resident #65 had a current careplan problem of urinary habit training with a goal of voiding in a bedpan at least once daily. Interventions included, but were not limited to, "offering the bedpan upon waking, before and after meals, every two hours at night, and as needed and keeping the call light within reach."</p> <p>A bowel and bladder program screener document, dated 4/19/16, indicated Resident #65 had occasions of urinary and bowel incontinence and was sometimes aware of her need to toilet.</p> <p>During an interview on 6/16/16 at 2:16 p.m., CNA #3 indicated Resident #56 was usually continent of bowel if offered a bedpan.</p>		<p>checks will be preformed by the DON or designee to ensure needed supplies are available in resident's rooms. Random (shifts) weekly questioning of CNAs will be conducted by the DON or designee to ensure CNAs are aware of care that needs to be performed with residents and how to follow the resident's plan of care provided on the ipods and assignment sheets This process will occur for three months, unless 100% compliance is not achieved then will remain in effect until there is total awareness. The form is attached.</p>		

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F 0329 SS=D Bldg. 00	<p>During an interview, on 6/17/16 at 10:07 a.m., CNA #5 indicated Resident #56 required total assistance with ADLs and was incontinent of both bowel and bladder. She further indicated Resident #65 used only incontinence briefs for her toileting needs.</p> <p>During an interview, on 6/17/16 at 10:20 a.m., CNA #7 indicated Resident #65 as incontinent of both bowel and bladder. She further indicated Resident #65 used only incontinence briefs for her toileting needs. She indicated each resident's care needs were listed for the CNAs in their iPods and on a paper inside the residents' closets.</p> <p>Review of the note posted inside Resident #65's closet, on 6/17/16 at 10:22 a.m., indicated instruction on how to assist the resident with transfers and to offer a bed pan every 2 hours and before and after meals. The note was dated 4/26/16.</p> <p>3.1-35(g)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free</p>						

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	<p>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 observation, interview, and record review, the facility failed to identify and monitor targeted behaviors for 2 of 5 residents reviewed for unnecessary medications (Residents #30 and #71). Furthermore, the facility failed to ensure psychoactive medications were not increased or started without indication (Residents #30 and #71).</p> <p>Findings include:</p> <p>1. On 6/16/16 at 9:31 a.m., Resident #30 was in her room in her wheelchair, chin to chest, a lidded drinking cup in her hand.</p>	F 0329	1-A list was compiled of all residents receiving psychoactive medications with start dates and dose reduction dates. A list of residents on Behavior Management Program with targeted behaviors was compiled. Care Plans were reviewed to ensure targeted behaviors were a part of the Plan of Care Updates were made as necessary. 2-Behavior charting will be documented in the CNA documentation. Psychotropic drug monitoring will be completed monthly for every resident receiving a psychotropic drug by the staff nurses. The assessments are attached. A flow sheet was created for each	07/20/2016

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	<p>On 6/16/16 at 10:48 a.m., Resident #30 remained in her room in her wheelchair, chin to chest, the lidded drinking cup in her hand.</p> <p>Review of Resident #30's clinical record began on 6/15/16 at 11:45 a.m. Diagnoses included, but were not limited to, muscle weakness, obsessive-compulsive disorder (OCD), psychotic disorder with delusions, and anxiety.</p> <p>Resident #30 had current physician's orders for medications including, but not limited to, Seroquel 12.5 mg (anti-psychotic medication) once daily for dementia with delusional features and Zoloft 50 mg (an anti-depressant medication) once daily for OCD.</p> <p>A physician's order, dated 11/9/15, indicated to increase Resident #30's Zoloft to 50 mg. There was no indication of why the medication had been increased.</p> <p>Resident #30 had a significant change Minimum Data Set (MDS) assessment, dated 4/5/16, which indicated she was severely cognitively impaired, but had no delusions, hallucinations, or behavioral symptoms. The assessment further</p>		<p>resident receiving a psychotropic drug. The flow sheet includes name of drug, dose, start date, adjustment date, and targeted behavior for the drug in a comments section. The flow sheet is intended to ensure accuracy. The assessments will be reviewed and flow sheet updates weekly during behavior meetings with IDT, and with the pharmacist monthly at the Gradual Dose Reduction Meetings. 3-The facility Behavior Management Program will be over seen by the Social Service Director. The Social Service Director (SSD) has initiated a Flow Sheet to monitor targeted behaviors. The SSD or her designee will review nursing and CNA documentation five days per week. The SSD will document findings on the Flow Sheet. The SSD will bring the information to the weekly behavior meetings for discussion. For new or worsening behaviors, the SSD or designee will monitor by the flow sheet for two weeks then bring to the behavior meeting unless the behavior warrants immediate attention . The IDT will then decide if the behavior warrants a Behavior Management Program. 4-Monitoring will be completed by the QA process. The form is attached. Monitoring will begin for six residents weekly through September 2016. Then added to the monthly QA through</p>	

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	<p>indicated she required extensive assistance with ADLs.</p> <p>Resident #30 had a current careplan problem of dementia with delusions and OCD. The careplan indicated to "monitor for lashing out, refusing ADLs, calling out at night, repetitive verbalizations and actions, repetitive/compulsive behaviors, and unrealistic fear of situations."</p> <p>Resident #30 had a current careplan problem of behavior problem with yelling a yodeling sound during care, being physically and verbally aggressive with staff and at times yelling out for no reason. The careplan further indicated she was "picky" with how she wanted things done.</p> <p>Review of a "HOH Behavior document", dated 10/14/15 at 8:31 p.m., indicated Resident #30 had exhibited a behavior of crying out once and requesting two washcloths so she could wash her face since "they didn't let me do it". The document further indicated she wanted her glasses in the right place on her table and to have her wheelchair face in the other direction. The document also indicated the resident appeared satisfied with the writer's actions.</p>		December 2016 If 100% accuracy is not achieved, the process will remain on the QA as long as needed.				

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	<p>Review of a "HOH Behavior document", dated 11/20/15 at 7:40 p.m., indicated Resident #30 was pinching, biting, and kicking others and scratching/pinching herself and yelling/screaming. The document indicated the resident had the listed behaviors during bedtime care and had stopped when care was completed.</p> <p>There was no other behavior documentation in the clinical record between 10/14/15 and 11/20/15 to explain the increase in medication on 11/15/15.</p> <p>Review of a Social Service note, dated 10/6/15, indicated some resistance to care behavior noted during the assessment period, but the resident had not exhibited any delirium or psychosis.</p> <p>Review of a Social Service note, dated 12/22/15, indicated the resident had not had any behaviors, delirium or psychosis.</p> <p>There was no Social Services documentation for the month of November, 2015.</p> <p>Review of a Social Service note, dated 1/15/16, indicated Resident #30 was lethargic and had "dozed off". It further indicated the resident had one episode of resisting taking medications, but had later</p>			

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	<p>taken them. There were no other concerns documented on the assessment.</p> <p>Review of Social Service notes, dated 2/2/16, 3/29/16, and 4/5/16 indicated Resident #30 had not exhibited behaviors and no concerns were noted.</p> <p>Review of a pharmacy document, dated 6/1/16-6/4/16, indicated Resident #30's Zoloft had been increased from 25 mg due to an increase in OCD behavior and indicated the Seroquel had not been decreased until 5/6/16 due to aggressive behaviors.</p> <p>During an interview, on 6/17/16 beginning at 10:45 a.m., the DON and Social Services Director (SSD) indicated Resident #30's OCD symptom was the need to be specific with her care. The SSD further indicated staff was to observe for lashing out, refusing ADL care, calling out at night during care, and unrealistic fears. The SSD indicated she monitored behaviors through staff documenting in either a "HOH Behavior document" or a "Behavior document" in the clinical record. She further indicated she did not review the CNA documentation of behaviors. The DON indicated the nurses reviewed CNA documentation and if they felt it needed to be charted in a behavior document, it</p>			

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	<p>was done so at their discretion. The DON indicated Resident #30 had not seen the psychiatric provider since an exam on 4/21/15.</p> <p>During an interview, on 6/16/16 at 2:16 p.m., CNA #9 indicated Resident #30 would yell at times both during care and for no reason, but was easily redirected or accepted care when reapproached.</p> <p>During an interview, on 6/17/16 at 10:18 a.m., CNA #11 indicated Resident #30's behavior depended on whether she was having a good day or not. She further indicated Resident #30 would scream during care, but usually accepted care if staff talked her through it.</p> <p>The DON indicated on 6/20/16 at 8:36 a.m., there was no further information available to indicate why Resident #30's Zolofit had been increased on 11/9/15.</p> <p>2. The clinical record for Resident #71 was reviewed on 6/14/2016 at 3:08 p.m. Resident #71's current diagnoses included, but were not limited to, weakness, dementia without behavioral disturbance, and anxiety. Resident #71 had a current physician's order for Zyprexa (antipsychotic) 2.5 mg.</p> <p>Resident #71 had a current, 4/27/2016, quarterly Minimum Data Set (MDS)</p>				

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	<p>assessment that indicated she was moderately cognitively impaired. The assessment indicated Resident #71 had no hallucinations, delusions, verbal or physical behaviors during the assessment period and was receiving an antipsychotic medication.</p> <p>CNA's #21 and #22 were interviewed on 6/16/2016 at 1:42 p.m. CNA #21 indicated she regularly worked on the hall where Resident #71 resided and was familiar with her daily routines. She indicated Resident #71 did not have any behaviors. She further indicated that Resident #71 was generally quiet and spent a lot of time in her room. CNA #22 indicated that he was new to the facility, but was familiar with Resident #71 and indicated the resident did not have any behaviors.</p> <p>LPNs #23 and #24 were interviewed on 6/17/2016 at 10:08 a.m. LPN #23 indicated Resident #71 did not have any behaviors. LPN #24 indicated Resident #71 repeated herself a lot when she first came to live at the facility. LPN #24 then indicated Resident #71 was not having behaviors at this time.</p> <p>During an interview with the SSD, on 6/17/2016 at 10:45 a.m., she indicated Resident #71 was one of 17 residents she</p>			

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	<p>was following on her behavior management program. SSD indicated Resident #71 was taking Zyprexa for dementia with delusions. She indicated she did not know what delusions Resident #71 had. SSD further indicated the last documented behavior for Resident #71 was in June 2015.</p> <p>During an interview, with the Director of Nursing (DON) on 6/17/2016 11:03 a.m., she indicated on 6/19/15 Resident #71 had thrown herself on the floor. The nursing staff then requested that Zyprexa be restarted at half the dose. The DON indicated the staff did not try any non-pharmacological interventions prior to requesting the medication to be restarted. She later indicated Resident #71's delusions were throwing herself on the floor and asking for meals when they were right in front of her.</p> <p>Resident #71 had a current care plan focus of "....diagnoses: ...dementia with delusions takes Zyprexa...Observe for...Zyprexa: screaming out, throwing self on floor, putting on call light and not knowing why...Goal: resident will remain mentally stable." Interventions included but were not limited to "1:1 with SSD (social service director) as requested, consider psych eval and validate resident feelings."</p>			

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	<p>A progress note for Resident #71, dated 5/12/2015, and provided by the DON on 6/17/2016 at 3:09 p.m., indicated the following: "Communication- with Physician...NEW ORDER RECEIVED FROM [PHYSICIAN NAME] [NAME OF PHARMACY] TO D/C (discontinue) ZYPREXA AND NOT ATIVAN. LEFT MESSAGE FOR POA [NAME OF POA]."</p> <p>A "HOH Behavior Document" for Resident #71 was provided for June, 2015 by the DON on 6/17/2016 at 3:09 p.m., and indicated the following:</p> <p>On 6/1/2015, "resident had call light on. Staff enter room to answer call light. Resident states 'I dropped my call light' Staff give the call light to resident and remind res [resident] to use. resident pushed call light and then dropped it on the floor while staff was in the room. Res then call son stating [name of son] stating she dropped her call light. [Name of Son] call HOH and ask staff to 'check on my mom because she dropped her call light.' res had call light in reach. Res pushed it on then dropped it on the floor several times. No s/s [signs / symptoms] pain or discomfort noted, Fluids and food offered. All other needs are met."</p>			

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	<p>On 6/5/2015, "resident asked repeatedly for the nurse. When the writer explained she is the nurse, resident stated ok then asked for the nurse. The resident asked for a 'reversal of medication' Writer asked what medication she wanted to DC and resident stated 'the one that makes me repeat'"</p> <p>On 6/10/2015, "res.[resident] using call light excessively. C/O [complain of] roommate, asked writer 'Well what does she need you for? What is she saying? why are you talking to her?' Then as soon as writer left rm resident turned light back on. C/O room too hot, set thermostat on 72, was on 74. Writer left room et resident. turned light back on a few minutes later et resident chanting 'I'm hot, I'm hot, I'm hot' Then roommate began to complain that it was too cold. When staff is with roommate this res calls out to staff 'I need you, come here'"</p> <p>On 6/14/2015, "CNA staff reported that resident put her call light on repeatedly to use the bathroom with no results. Resident was toileted 16 times and had 1 BM [bowel movement] and voided 5 or 6 times. Many times resident would tell staff she forgot what she needed or state 'I need you.'"</p> <p>A facsimile addressed to the physician of</p>						

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	<p>Resident #71, dated 6/19/2015, and provided by the DON on 6/17/2016 at 3:09 p.m., indicated "Res [resident] found in bathroom sitting on floor- tried transferring self- no injuries V/S [vital signs] stable denies hitting head- Also may we resume 1. Zyprexa 2.5 mg Q.D. [everyday] - increased behaviors...."</p> <p>A progress note for Resident #71, dated 6/19/2015, and provided by the DON on 6/17/2016 at 3:09 p.m., indicated "...NO NEW ORDER RECEIVED FROM [Physician Name] R/T [related to] FOUND IN BATHROOM FLOOR. NEW ORDER RECEIVED FROM [Physician Name] to start Zyprexa 2.5 MG P.O. [by mouth] DAILY D/T [due to] INCREASED BEHAVIORS. NEURO CONSULT R/T STROKE AND RES [resident] REPEATS HERSELF SEVERAL TIMES THROUGHOUT THE...."</p> <p>A pharmacy review, dated 11/8/2015, for Resident #71 and provided by the DON on 6/17/2016 at 3:09 p.m., indicated the following: "[Resident name] is on Zyprexa 2.5 mg QD for delusional behaviors. She failed the last reduction attempt had documented behaviors within a couple weeks including yelling and throwing self on the floor...please consider a contraindication to dose</p>			

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F 0502 SS=D Bldg. 00	<p>reduction at this time." The physician responded in agreement on 11/9/2015. There was a hand written note at the bottom of the page that said "DO NOT REDUCE MEDS." There was no assessment of the resident included by the physician.</p> <p>A current "BEHAVIOR MANAGEMENT POLICY" dated 10/2013, and provided by the DON on 6/17/2016 at 3:09 p.m. It indicated "...A Behavior Record will be developed. The record will describe the behaviors that the resident is exhibiting and appropriate interventions will be initiated by the Behavior Management Team..."</p> <p>On 6/17/2016 at 2:28 p.m., letters of contraindication for the past 12 months were requested. No further documentation was provided prior to exiting on 6/20/16.</p> <p>3.1-48(a)(6) 3.1-48(b)(2)</p> <p>483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p>			

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	<p>Based on record review and interview, the facility failed to ensure labs were completed for 1 of 5 residents reviewed for unnecessary medications. (Resident #38)</p> <p>Findings include:</p> <p>The clinical record for Resident #38 was reviewed on 6/15/16 at 2:30 p.m. Diagnoses for the resident included, but were not limited to, diabetes mellitus, chronic obstructive pulmonary disease, hypertension, chronic kidney disease and fibromyalgia.</p> <p>Physician's orders, signed 6/3/16, indicated the resident had orders that included a Hgb (hemoglobin) A1C (a standard tool to determine blood sugar control for patients with diabetes) original order dated 9/7/15. The lab was to be drawn every 3 months: September, December, March and June.</p> <p>A review of the labs completed for Resident #38 indicated no Hgb A1C was completed March, 2016 as ordered.</p> <p>During an interview with the D.O.N. on 6/16/16 at 1:17 p.m., indicated she was unable to find any labs completed March 2015 for HgbA1C.</p>	F 0502	<p>1-The lab was completed and the physician notified on 6/16/16. No new orders were received. 2- It was found the lab order was not input into the computer correctly. All lab orders for every resident in the facility were reviewed by 6/24/16 for accuracy. No other orders were found incorrect. Night shift reviewed all routine lab draws to ensure the draws were completed as ordered. This too, was in order. 3- Nurses will be in serviced on the input of orders into the computer system. The posted dates of these inservices is attached. 4- A Daily Report of all new orders can be obtained through our computer system. This report will be ran five days per week and reviewed by the DON or designee. On Mondays, the report will be ran for 3 days to ensure the weekend orders are also correct. This action will continue indefinitely. Monthly monitoring will be completed by the QA process for six months. The QA will continue if 100% accuracy is not accomplished in the six month time frame. QA form is attached.</p>	07/20/2016

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R 0000 Bldg. 00	<p>Review of the current, undated, facility policy, titled "LABORATORY ORDERS ", provided by the D.O.N. on 6/7/16 at 11:07 a.m., included, but was not limited to, the following:</p> <p>"PURPOSE: To obtain lab orders as ordered by the physician.</p> <p>POLICY: Lab orders will be obtained as ordered.</p> <p>PROCEDURE: The physician...into the computer system...blood will be drawn...laboratory for processing."</p> <p>3.1-49(a)</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Residential Census: 50</p> <p>Sample: 7</p> <p>Heritage of Huntington was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.</p>	R 0000		

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	QR completed by 11474 on June 21, 2016.				