

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155561	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/11/2013
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NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN HOME & REHABILITATIVE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 231 N JACKSON ST OAKLAND CITY, IN 47660
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: December 2, 3, 4, 5, 10, 11, 2013</p> <p>Facility number: 000327 Provider number: 155561 AIM number: 100273920</p> <p>Survey team: Denise Schwandner, RN TC Diane Hancock, RN Amy Winingner, RN (December 2, 3, 4, 5, 10, 2013) Barb Fowler, RN (December 10, 11, 2013)</p> <p>Census bed type: SNF/NF: 79 Total: 79</p> <p>Census payor type: Medicare: 6 Medicaid: 55 Other: 18 Total: 79</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on</p>	F000000	The creation and submission of this plan of correction does not constitute by the provider of any conclusion set forth in the statement of deficiencies, or of any violation or regulation. The provider respectfully request that the 2567 Plan of Correction be considered by the letter of credible allegation and request a post certification desk review in lieu of a post survey re-visit on or after January 10, 2014.	

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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	December 18, 2013, by Jodi Meyer, RN			

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F000159 SS=D	<p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that</p>			

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	<p>receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>Based on record review and interview, the facility failed to notify a resident's representative when a resident's account was within \$200 of the resource limit, for 1 of 1 resident who exceeded the resource limit and had not been notified. (Resident #36)</p> <p>Finding includes:</p> <p>The personal funds account for the facility was reviewed on 12/10/13 at 12:10 p.m. The personal fund account for Resident #36 indicated the resident had a balance of \$2246.68, which exceeded the \$1500.00 resource limit for Medicaid residents.</p> <p>During an interview on 12/11/13 at 9:40 a.m., the Payroll Coordinator indicated she just noticed Resident #36's account was over what it needed to be and that she had contacted the corporate person regarding the amount yesterday. The Payroll Coordinator indicated the</p>	F000159		01/10/2014

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	<p>corporate person was to send a letter to Resident #36's legal representative regarding the balance. The Payroll Coordinator indicated the BOM (Business Office Manager) would usually send the letters to the representative but the BOM is new to the facility and still in training.</p>			

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			F 159 It is the intent of this community to notify resident's responsibility party when a residents account is within \$200	

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			of the resource limit. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? All residents have the potential to be affected. The Business Office Manager contacted the responsible party for resident #36 regarding the balance of funds that were not in compliance with SSI limits. The responsible party immediately came into the building to meet requirements within the SSI limits	

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			How will you identify other residents having the potential to be affected by the same deficient practice and what corrective	

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			action will be taken?The Business Office Manager along with the Executive Director will be reviewing residents funds weekly to ensure that all residents remain within the SSI guidelines. Responsible parties will be notified upon any findings that may result in the \$200 of the resource limit.	

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			<p>What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur? A mandatory in-service will provide for all management team members regarding SSI requirements regarding personal funds. Completion Date January 10. 2014How the corrective action will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place..CQI Audit toolTo ensure compliance, the ED/Designee is responsible for the completion of the Personal Fund CQI tool weekly times 4 weeks, monthly times 4 and then quarterly for at least 6 months. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p>	

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F000160 SS=D	<p>483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. Based on record review and interview, the facility failed to convey, within 30 days of a resident's death, the resident's funds in 1 of 2 residents who met the criteria for fund deposition upon death. (Resident #102)</p> <p>Finding includes</p> <p>The personal funds account for the facility was reviewed on 12/11/13 at 12:05 p.m. The form indicated Resident #102 had a balance of \$900.26.</p> <p>During an interview on 12/11/13 at 9:07 a.m., the Payroll Coordinator indicated Resident #102 had expired on 7/14/13. The Payroll Coordinator indicated she did not know what was happening with the account of Resident #102. The Payroll Coordinator indicated she had contacted the corporate office yesterday and a letter was to be mailed to Resident #102's legal</p>	F000160	F 160It is the intent of this community to convey within 30 days the resident's funds upon death.What corrective action will be accomplished for those residents found to have been affected by deficient practice?The Business Office Manager contacted Home Office regarding resident # 102 regarding a balance of funds. The funds were returned to appropriate agency immediately. The Business Office Manager and the Executive Director will review accounting records weekly to ensure that all residents funds are returned to the appropriate agency upon death. This corrective action will ensure that the Conveyance of personal funds upon death will remain in compliance guidelines.	01/10/2014			

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	<p>representative regarding the account money. The Payroll Coordinator indicated the BOM (Business Office Manager) does the monthly accounts and sends out the letters but the BOM is new to the facility and is being trained.</p> <p>3.1-6(h)</p>		<p>What measurements will be put into place for what systemic changes will be made to ensure that the deficient practice does not recur? A mandatory in-service will be conducted for all management team members regarding the Conveyance Of Personal Funds Upon Death. This corrective action will ensure that accounting records remain in compliance. Completion date January 10, 2014 How the corrective action will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place. CQI Audit tool To ensure compliance, the ED/Designee is responsible for the completion of the Personal Fund CQI tool weekly times 4 weeks, monthly times 4 and then quarterly for at least 6 months. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved and action plan will be developed to ensure compliance.</p>		

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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a medication was clinically indicated for 2 of 5 residents reviewed for unnecessary medications, in the sample of 5 residents who met the criteria for review of unnecessary medications. (Resident #12, Resident #10)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #12</p>	F000329	F 329What corrective action will be accomplished for those residents found to be affected by the deficient practice?Res #12 had a medication review per MD on 12/10/2013 and found that medication was clinically indicated and contraindicated to reduceRes#10 had a medication/chart review per MD on 12/12/2013 and diagnosis of Dementia with Delusions was added. Medication was clinically indicated and contraindicated to reduceHow will you identify other residents having the potential to	01/10/2014			

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	<p>was reviewed on 12/04/13 at 12:07 p.m. The record indicated the diagnoses of Resident #12 included, but were not limited to, Dementia, w(with)/bhvr (behavior) dsturb (disturbance), Anxiety disorder, generalized, and Dsord (disorder) persistent mental.</p> <p>The most recent quarterly MDS (Minimum Data Set Assessment) dated 09/25/13 indicated Resident #12 experienced moderate cognitive impairment and no behaviors during the assessment period. The MDS further indicated Resident #12 required the extensive assist of two staff members for transfers and the extensive assist of one staff member for locomotion on unit.</p> <p>The most recent Physician's Order Recap dated 11/30/13 included, but was not limited to, an order for Ativan (an anti-anxiety medication) 0.25 mg [milligrams] daily at bedtime.</p> <p>A Physician's Telephone order dated 12/03/13 "...stat [immediately] Ativan 0.5 mg po [by mouth] q [every] hs [hour of sleep] for rest...". The telephone order further included a Care Plan for "...poor sleep pattern" and included interventions of "...medication as ordered, monitor</p>		<p>be affected by deficient practice and what corrective action will be taken? All residents receiving antipsychotic medications have the potential to be affected. The IDT team will review and discuss daily in AM meeting as well as do a review monthly with primary physician. All residents that meet requirement for an attempted GDR per consultant pharmacy or that have exhibited behavioral symptoms which warrant a psychotropic medication reduction will have a reduction attempted per MD order with documentation supportive of the attempt or rationale not to proceed with reduction by IDT committee and determined by physician. What measures will be put into place or systemic changes will you make to ensure deficient practice does not recur? A mandatory in-service for nursing team members and social services will be conducted by Social Services Consultant regarding the protocol for GDR and completion of behavioral summaries as well as documentation as it relates to contraindicated reductions. DNS/Designee will be notified prior to administration of PRN psychotropic medications to ensure that non pharmaceutical interventions were attempted prior to administration of medication.</p>				

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	<p>results of meds [medication], notify physician prn [as needed]..."</p> <p>A Care Plan dated 10/15/13 for Behavior Symptoms: confusion with anxious [sic], included, but was not limited to, interventions of "...monitor oxygen, change tank as needed, one on one conversation/attention, with reassuring words, encourage resident to participate in activities..., if all interventions fail, administer PRN med [medicine] as ordered by PCP [Primary Care Physician]..."</p> <p>A Care Plan dated 10/15/13 for Behavior Symptoms: delusion behaviors, included, but was not limited to, interventions of "...respond to expressions of fears with validation, assist [sic] resident to feel safe in environment, check environment for objects that may be misconstrued and remove them..."</p> <p>A Care Plan dated 10/15/13 for Behavior Symptoms: cursing others, included, but was not limited to, "...pain management...offer to lay down for rest, one on one conversation about nephew..."</p> <p>A Pharmacy Recommendation to the Physician dated 11/11/13 included, but was not limited to, a</p>		<p>How will the corrective action be monitored to ensure deficient practice will not recur and what quality assurance programs will be put into place.?To ensure compliance, the DNS/Designee is responsible for completion of psychotropic management CQI tool weekly x 4 weeks, bi-monthly x 2 months, monthly x 4 and quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by Executive Director. If threshold of 95% compliance is achieved an action plan will be developed to ensure compliance.</p>	

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	<p>recommendation for Resident #12 to be evaluated for a gradual dose reduction of Lorazepam (Ativan) 0.25 mg q HS (hour of sleep).</p> <p>The Behavior Flowsheets for November 2013 indicated Resident #12 experienced 11 episodes of confusion with anxiety that were effectively resolved using interventions of, "...monitor oxygen, change tank as needed, one on one conversation/attention with reassuring words, and encourage resident to participate in activities...". The Flowsheets further indicated Resident #12 experienced 1 episode of delusional behavior that was effectively resolved using interventions of, "...assist resident to stabilize emotions, respond to expressions of fears with validation, assist [sic] resident to feel safe in environment, and check environment for objects that may be misconstrued and remove them." The November 2013 Behavior Flowsheets indicated Resident #12 experienced no episodes of cursing others.</p> <p>The Behavior Flowsheets for December 2013 indicated Resident #12 experienced 3 (three) episodes of confusion with anxiety that were effectively resolved using</p>			

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	<p>interventions of, "...monitor oxygen, change tank as needed, one on one conversation/attention with reassuring words, and encourage resident to participate in activities..." from 12/01/13 through 12/03/13. The Behavior Flowsheets further indicated Resident #12 experience no episodes of delusional behavior or cursing others from 12/01/13 through 12/03/13.</p> <p>The Nursing Notes from 11/01/13 through 12/03/13 were reviewed and indicated Resident #12 experienced no episodes of confusion with anxiety, delusional behavior, or cursing others from 11/01/13 through 11/13/13.</p> <p>A Nursing Note dated 11/14/13 at 3:44 a.m. indicated, "...Resident was up et [and] down setting off alarm, when asked resident what she needed she started her legs hurt et she wanted her bed straightend [sic]. Bed was straightend [sic] and PRN pain medication given after non-pharmacological [sic] intervention (offered fluid, food, turning et reposition) not effective. The subsequent nursing notes through 11/25/13 indicated Resident #12 experienced no behavior disturbance through 11/25/13.</p>				

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	<p>A Nursing Note dated 12/01/13 at 3:11 a.m. indicated, "Resident woke up and screamed out "somebody stoled [sic] my baby" was redirected and talked to about nobody being here that would want to take her baby-she settled down and went back to sleep" .</p> <p>A Nursing Note dated 12/03/13 at 2:21 a.m. indicated "...Resident has been up several times this shift crying out that a man with a hat is in her room and he won't believe that 'she is not here'. Pain medication given due to resident stated that she was hurting. Continues to cry out et has been up et down all shift. Resident refuses to lay down et refuses to sit up in w/c [wheelchair]. Resident is sitting up in bed. "</p> <p>The Social Service Progress Notes dated 11/01/13 through 12/03/13 lacked any documentation related to the monitoring of psychotropic medication and behaviors for Resident #12.</p> <p>Resident #12 was observed on 12/05/13 at 10:00 a.m. sitting in a wheelchair, leaning to the left, with closed eyes during an exercise activity. Resident #12 was observed, at that time, to not be participating in</p>			

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	<p>the activity.</p> <p>During an interview of 12/04/13 at 3:25 p.m., RN #5 indicated Resident #12 had been experiencing nightmares related to the use of another medication. RN #5 further indicated, she was not aware of any specific event which would have led to the increase of the Ativan.</p> <p>During an interview on 12/04/13 at 3:30 p.m., LPN #5 stated "...she [Resident #12] usually has anxiety, wants someone to be with her all the time..."</p> <p>During an interview on 12/05/13 at 8:40 a.m. the SSD (Social Service Designee) indicated if the behavior plan interventions are effective then the medications should not be increased. The SSD further indicated, at that time, the medications should only be increased as a last resort.</p> <p>During an interview on 12/05/13 at 10:20 a.m., the SSD indicated she could not identify a clinical reason for the Ativan dose increase.</p> <p>During an interview on 12/05/13 at 10:25 a.m., the DoN (Director of Nursing) indicated documentation</p>			

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	<p>could not be located to support the increase of Ativan for Resident #12.</p> <p>The Policy and Procedure for Behavior Management Policy and Procedure provided by the SSD on 12/05/13 at 10:00 a.m. indicated, "...It is the policy of American Senior Communities to provide behavior interventions and monitoring for residents with problematic or distressing behaviors. Interventions provided are both individualized and non-pharmacological and part of a supportive physical and psychosocial environment that is directed toward preventing, relieving, and/or accommodating a resident's distressed behavior..."</p> <p>2. The clinical record of Resident #10 was reviewed on 12/04/13 at 11:24 a.m. The record indicated the diagnoses of Resident #10 included, but was not limited to, Dementia, unspec (unspecified) w (with)/o(out) bhav (behavior) disturb (disturbance), depressive disorder, and dsord (disorder) persistent mental.</p> <p>The most recent annual MDS (Minimum Data Set Assessment) indicated Resident #10 experienced moderate cognitive impairment, exhibited no behaviors during the</p>			

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	<p>assessment period, was independent when walking in room, and required limited assist of one staff member for transfers. The assessment further indicated Resident #10 received no anti-psychotic medications during the assessment period.</p> <p>A Physician's Telephone Order dated 11/14/13 at 1445 (2:45 p.m.) indicated a new order was received for "...Geodon [an anti-psychotic medication] 25 mg [milligram] p.o. [by mouth] @ [at] 1700 [5:00 p.m.]...". The telephone order included a care plan update that indicated, "Increase falls/confusion..." with interventions that included, but were not limited to, "increase in medication..."</p> <p>A Care Plan for Use of Psychotropic Medication dated 10/23/13 included, but was not limited to, interventions of, "...administer meds as ordered, observe for effectiveness, document side effects as observed and notify MD [Medical doctor], IDT [Interdisciplinary Team] to review routinely to attempt gradual dose reductions, unless contraindicated by MD, observe for side effects: non-anti-psychotic meds: ...insomnia, ...confusion ... pharmacist to review meds routinely..."</p>			

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	<p>A Care Plan for Behaviors dated 10/27/13 included, but was not limited to, interventions of, "... #1 reassure resident that family knows were [sic] she is, #2 one on one conversation with resident to reassure resident that she is safe, #3 offer to call daughter, #4 show resident her room and her belongings to reassure resident that she lives here, #5 redirect [sic] resident to activities [sic] such as bingo, looking at books/magazines, special parties..."</p> <p>The November 2013 behavior flowsheets indicated Resident #10 experienced 5 (five) episodes of identified behaviors from 11/01/13 through 11/12/12 that were effectively managed with the identified interventions. The flowsheets further indicated Resident #10 experienced 4 (four) episodes of identified behaviors during the day shift on 11/13/13 that were not effectively managed with the identified interventions and "redirect resident to activities [sic]..."</p> <p>A nursing note dated 11/01/13 at 11:07 p.m., indicated Resident #10 experienced a fall while walking in her room. The nursing notes through 11/14/13 lacked any documentation Resident #10 experienced further falls.</p>			

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	<p>An IDT note dated 11/04/13 at 9:40 a.m. indicated Resident #10 experienced a witnessed fall on 11/01/13. The note further indicated, "...had been sitting in hall, got up to go to bathroom and fell after she came out on the way to her bed. Staff states resident had caught her foot on the leg of the overbed table..." The IDT notes through 11/14/13 lacked any documentation Resident #10 experienced further falls.</p> <p>A late entry nursing note dated 11/03/13 at 9:22 p.m. for 11/02/13 at 10:00 p.m. indicated, "When staff was leaving at shift change res [resident] stood et [and] walked quickly to follow stated that she was leaving now too et wanted a ride from staff, ..."</p> <p>A nursing note dated 11/03/13 at 3:16 a.m. indicated, "...Pleasant et cooperative with care..."</p> <p>A nursing note dated 11/03/13 at 9:22 p.m. indicated, "...attempted unsafe transfers during shift...frequently asked where she is et why..."</p> <p>A nursing note dated 11/04/13 at 2:17 a.m. indicated, "...Pleasant et cooperative with care..."</p>			

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	<p>A nursing note dated 11/05/13 at 7:11 p.m. indicated, "...alert and oriented to person and family only and talking about leaving more frequently...non-compliant with safety instructions and disease process does not allow her to comprehend the consequences..."</p> <p>A nursing note dated 11/05/13 at 9:25 p.m. indicated, "...alert et oriented to self only. Resident is unclear why she is here when all of her babies are at home with no one to care for them. States her husband is going to be worried about her and call the police. has asked several times how to get out of facility. Resident easily redirected at this time.</p> <p>A nursing note dated 11/06/13 at 3:29 a.m. indicated, "...has had no exit seeking behavior this shift."</p> <p>A nursing note dated 11/06/13 at 2:51 p.m. indicated, "...has been pleasant and cooperative..."</p> <p>A nursing note dated 11/07/13 at 2:36 a.m. indicated, "slept well during night..."</p> <p>A nursing note dated 11/09/13 at 3:15 a.m. indicated, "no exit seeking behavior noted"</p>			

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	<p>A nursing note dated 11/09/13 at 10:27 a.m. indicated, "...pleasant et cooperative with care..."</p> <p>A nursing note dated 11/10/13 at 12:24 a.m. indicated, "no exit seeking behavior noted..."</p> <p>A nursing note dated 11/12/13 at 9:52 p.m. indicated, "alert with confusion. Refuses to go to bed. States it wouldn't do any good. I can't sleep. Cont [continue] to sit in hall..."</p> <p>A nursing note dated 11/13/13 at 10:56 a.m. indicated, "Resident pleasantly confused this morning..."</p> <p>The nursing notes for 11/13/13 during the day shift lacked any documentation related to Resident #10 experiencing anxiety when wanting to leave and unable to determine where she is.</p> <p>The nursing notes were reviewed from 11/01/13 through 11/15/13 and indicated Resident #10 experienced 1 (one) fall on 11/01/13, two episodes of verbalizing the wish to exit facility, 1 episode of attempting unsafe transfers, and 4 (four) episodes of confusion. The nursing notes lacked any documentation of insomnia or</p>			

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	<p>being argumentative with staff.</p> <p>The social service progress notes from 11/01/13 through 11/14/13 lacked any documentation related to monitoring of medications, behaviors, and/or effectiveness of interventions.</p> <p>The social services notes reviewed 10/21/13 through most recent lacked any documentation related to monitoring behaviors and effectiveness of plan</p> <p>A social service progress note dated 11/15/13 at 11:01 a.m. indicated, "Per physician order...start Geodon 25 mg every 1700 [5:00 p.m.] . Resident has increased confusion, not sleeping at night, being argumentative with staff..."</p> <p>A Physician's Progress Note dated 11/14/13 at 1445 (2:45 p.m.) indicated, "...Behaviors have increased. Fax yesterday reports up most of night, wanting to call daughter, 'go home' etc...A/A/O X2 [alert and oriented times two], Pleasant, interactive..."</p> <p>On 12/05/13 from 10:30 a.m. through 10:55 a.m., Resident #10 was observed leaning over the left side of a stationary chair across from the</p>			
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	<p>nursing station asleep.</p> <p>During an interview on 12/04/13 at 2:40 p.m. the DoN (Director of Nursing) stated the Geodon was started because "it would keep her from exit seeking...she requires constant 1:1..."</p> <p>During an interview on 12/05/13 at 10:20 a.m., the SSD [Social Service Designee) indicated she could not provide a clinical indication for the use of Geodon for Resident #10. The SSD further indicated, at that time, the use of Geodon had not been reviewed since it had been started because anti-psychotic medications were only reviewed monthly and the medication had been used less than one month.</p> <p>During an interview on 12/05/13 at 12:52 p.m. the Attending Physician of Resident #10 indicated it was her impression the behaviors had been occurring for a long time and were getting progressively worse. The attending physician further stated, at that time, "they [the facility staff] do not tell me if the behaviors are resolved via non-pharmacological methods...sitting and sleeping throughout the day is definitely not her [Resident #10] normal behavior..."</p>			

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NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN HOME & REHABILITATIVE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 231 N JACKSON ST OAKLAND CITY, IN 47660
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	<p>The Policy and Procedure for Psychotropic Medication Management program provided by the DoN on 12/10/13 at 12:30 p.m. indicated, "...Procedure 1. Each resident receiving psychotropic medication will have a supporting diagnosis for use..."</p> <p>3.1-48(a)(4)</p>			

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F000441 SS=E	<p><b>483.65</b> <b>INFECTION CONTROL, PREVENT SPREAD, LINENS</b> The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on record review and interview, the facility failed to maintain</p>	F000441	F441What corrective action will be accomplished for those found	01/10/2014			

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	<p>an Infection Control Program, in that 9 of 10 employees whose files were reviewed for Mantoux skin tests for TB (tuberculosis) failed to have second step Mantoux skin tests, and 7 of 10 employees who did not have second step Mantoux skin tests failed to have risk assessments completed. (Business Office Manager, RN #1, Housekeeping Aide #1, LPN #1, Laundry Aide #1, Dietary Aide #1, Activity Assistant #1, Restorative Aide #1, CNA (Certified Nursing Assistant) #1, Cook #1)</p> <p>Findings include:</p> <p>The employee files of 10 new employees were reviewed on 12/11/13 at 10:45 a.m. During the review, 9 of 10 employees hired in the past year failed to have second step Mantoux skin tests. (Business Office Manager, Restorative Aide #1, RN #1, CNA #1, LPN #1, Laundry Aide #1, Dietary Aide #1, Cook #1, Activity Assistant #1).</p> <p>During an interview on 12/11/13 at 11:08 a.m., the CEC (Clinical Education Coordinator) indicated the facility had experienced a shortage of medication for the Mantoux skin test, but she did not know why the new employees did not receive their 2nd</p>		<p>to be affected by deficient practice?An audit of employee files has been completed.All employees have completed a TB risk assessment including Business Office Manager, Restorative Aide #1, RN#1, CNA#1, LPN#1, Laundry Aide #1, Cook#1 and Activity Assistant #1How will you identify others having the potential to be affected by deficient practice and what corrective action will be taken? All staff have the potential to be affected.DNS/Designee have conducted an audit of employee records to ensure that all employees have completed 2 step PPD or TB risk assessment. What measures will be put into place or systemic changes will you make to ensure that deficient practice does not recur?DNS will track employee PPD utilizing personnel/employee check list. Progress will be discussed with CQI committee and tracked monthly until 100% compliance is achieved. ED will in-service CEC/DNS regarding 2 step PPD by January 10, 2013How will the corrective action be monitored to ensure deficient practice will not recur and what quality programs will be in place?To ensure compliance, the DNS/Designee is responsible for the completion of employee file CQI tool weekly x 4 weeks, bi-monthly x 2 months, monthly x 4 and then quarterly until continued compliance is maintained for 2 consecutive</p>				

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	<p>step; she had only been employed five weeks. The CEC indicated she is having the new employees fill out a TB risk assessment when the TB solution is unavailable.</p> <p>Seven of the ten employees failed to have TB risk assessments completed when their second step Mantoux skin test was not given. (Business Office Manager, RN #1, Housekeeping Aide #1, LPN #1, Laundry Aide #1, Dietary Aide #1, Activity Assistant #1)</p> <p>During an interview on 12/11/13 at 12:42 p.m., the CEC indicated she was unable to locate any other of the TB risk assessments for the new employees who had not received the 2nd step.</p> <p>3.1-14(t)(1) 3.1-18(b)(1)</p>		<p>quarters. The results will be reviewed by the CQI committee overseen by Executive Director. If threshold of 95% is not achieved an action plan will be developed to ensure compliance</p>		