

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155803	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/31/2016
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NAME OF PROVIDER OR SUPPLIER HAMILTON POINTE HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 3800 ELI PLACE NEWBURGH, IN 47630
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00196216.</p> <p>Complaint IN00196216- Substantiated. Federal/State deficiencies cited at F157, F279, and F329.</p> <p>Survey dates: March 30 & 31, 2016</p> <p>Facility number: 012966 Provider number: 155803 AIM number: 201110390</p> <p>Census bed type: SNF: 38 SNF/NF: 53 Residential: 54 Total: 145</p> <p>Census payor type: Medicare: 21 Medicaid: 44 Other: 26 Total: 91</p> <p>Sample: 4</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by #02748 on April 4,</p>	F 0000	<p>The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. <i>Preparation and/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 in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></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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F 0157 SS=D Bldg. 00	<p>2016.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to ensure a physician</p>	F 0157	F157 Resident C is no longer a resident at facility All licensed nurses will be educated on	04/30/2016			

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	<p>was notified of low blood sugars and medications not being given for 1 of 4 residents reviewed. (Resident C)</p> <p>Findings include:</p> <p>On 3/30/16 at 1:00 p.m., Resident C's clinical record was reviewed. Resident C's diagnoses included, but were not limited to, diabetes mellitus.</p> <p>The most recent signed physician's recapitulation orders, signed 3/17/16, included, but were not limited to: Novolin R solution (Insulin Regular Human) Inject 3 units subcutaneously every 6 hours, ordered 2/24/16. Novolin R solution, inject as per sliding scale, every 6 hours: 141-190=1 unit 191-230=2 units 231-270=3 units 271-310=4 units 311-350=5 units if greater than 350 call physician</p> <p>The Progress Notes included, but not limited to: 12/16/15 at 11:48 a.m., Novolin R held related to a blood glucose level of 44. 12/19/15 at 6:12 a.m., Novolin R held related to a blood glucose level of 30. 2/24/16 at 2:17 p.m., Novolin R sliding scale insulin coverage held. The note</p>		<p>notification procedures related to all circumstances requiring notification of either family and/or physician. Education will be completed by 4/30/2016. All residents' records will be audited for medications which have been held/change in condition or other required needs for notification of MD or family. Any resident who has medications that have been held or have another required need for notification of MD/ family will be audited for the notifications. If there is a lack of notification, notification will occur immediately. The audit will be completed by nursing administration/designee. Audit will be completed by April 30, 2016. Records will be audited daily for held medications/other needs for notification per regulation daily x 2 weeks. Then 3 times per week for 2 weeks. Then weekly for 4 weeks for 1 month. Then bi-monthly for 2 months. Then once monthly for 2 months. The audit will be completed by the DON/designee. Audits will be monitored for trends and patterns, findings will be brought to QAPI monthly.</p>				

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	<p>further indicated the resident's blood glucose level was 277.</p> <p>2/27/16 at 7:23 p.m., scheduled Novolin R held related to a blood glucose level of 78.</p> <p>2/28/16 at 6:25 p.m., scheduled Novolin R held related to a blood glucose level of 96.</p> <p>2/29/16 at 12:09 a.m., scheduled Novolin R held related to a blood glucose level of 81.</p> <p>3/1/16 at 10:51 p.m., scheduled Novolin R held related to blood glucose level of 149. The note further indicated the resident would not receive a bolus feeding until 3:00 a.m.</p> <p>3/3/16 at 10:51 p.m., scheduled Novolin R held related to resident had eaten two hours ago and would not be eating again until a bolus feeding at 3:00 a.m.</p> <p>3/5/16 at 5:46 p.m., scheduled Novolin R was held related to blood glucose level of 93.</p> <p>3/7/16 at 12:06 a.m., scheduled Novolin R was held related to blood glucose level of 142. The note further indicated the resident would not be eating again until a bolus feedings at 3:00 a.m.</p> <p>3/7/16 at 8:01 p.m., scheduled Novolin R was held related to a blood glucose level of 128.</p> <p>3/8/16 at 11:06 p.m., scheduled and sliding scale Novolin R was held related to a blood glucose level of 147. The note</p>			

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	<p>further indicated the resident would not be eating again until a bolus feeding at 3:00 a.m.</p> <p>3/10/16 at 9:32 p.m., scheduled Novolin R was held related to a blood glucose level of 132, after the resident's meal at 3:00 p.m.</p> <p>3/13/16 at 10:22 p.m., scheduled Novolin R was held related to a blood glucose level of 134.</p> <p>3/14/16 at 5:38 a.m., scheduled Novolin R was held related to a blood glucose level of 114.</p> <p>3/15/16 at 10:58 p.m., scheduled Novolin R was held related to a blood glucose level of 99.</p> <p>3/16/16 at 6:24 p.m., scheduled Novolin R was held related to a blood glucose level of 104.</p> <p>3/17/16 at 12:08 a.m., scheduled Novolin R was held related to a blood glucose level of 100.</p> <p>3/17/16 at 2:34 p.m., scheduled and sliding scale Novolin R was held related to a blood glucose level of 192.</p> <p>3/17/16 at 7:59 p.m., scheduled and sliding scale Novolin R was held related to a blood glucose level of 152.</p> <p>3/17/16 at 11:02 p.m., scheduled and sliding scale Novolin R was held related to a blood glucose level of 199.</p> <p>3/18/16 at 11:59 p.m., scheduled Novolin R was held related to a blood glucose level of 117.</p>			

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	<p>The clinical record lacked notification of the physician regarding low blood glucose levels and/or notification of the physician insulin was being held.</p> <p>On 3/31/16 at 1:43 p.m., Staff #2 indicated staff should notify the physician if a blood glucose level is less than 60. Staff #2 further indicated nursing staff should not be holding medications ordered by a physician.</p> <p>On 3/31/16 at 3:58 p.m., Staff #2 provided the "Physician/Family/Responsible Party Notification for Change in Condition" policy, dated 8/2013. The policy included, but was not limited to: Physician and family/responsible party notification is to include, but is not limited to: blood glucose reading below 60....., change in condition that may warrant a change in current treatment.</p> <p>This Federal tag relates to Complaint IN00196216.</p> <p>3.1-5(a)(2) 3.1-5(a)(3)</p>			

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F 0279 SS=D Bldg. 00	<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 provide a comprehensive care plan, in that, a care plan was not developed for the use of an antipsychotic medication, for 1 of 4 residents reviewed. (Resident D)</p> <p>Findings include:</p>	F 0279	F279 Resident D's careplan was modified to add monitoring for side effects related to anti-psychotic medication on 3/31/2016. All licensed staff will be educated on need to careplan for monitoring for side effects or complications of all psychoactive medications. Education will be completed by 4/30/2016. All residents on psychoactive	04/30/2016

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F 0329 SS=D Bldg. 00	<p>On 3/30/16 at 10:45 a.m., a review of Resident D's clinical record indicated that there was not a care plan for an antipsychotic medications. Resident D had an order for Risperdal (an antipsychotic medication) 0.25 milligrams daily.</p> <p>On 3/31/16 at 3:18 p.m., Staff #2 indicated that there was not a care plan for antipsychotic medications in Resident D's clinical record.</p> <p>On 3/31/16 at 4:00 p.m., Staff #2 provided a policy on care plan protocol, which indicated that the care plan should be revised on an on-going basis to reflect changes in the resident and the care the resident was receiving.</p> <p>This Federal tag relates to Complaint IN00196216.</p> <p>3.1-35(a)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate</p>		<p>medications will have careplan audited for interventions related to the monitoring for side effects. Audit will be completed by 4/30/2016. Careplans will be monitored on all residents with psychoactive medications to check for monitoring of side effects/complications daily for 2 weeks. Then 3 times per week for 2 weeks. Then weekly for 4 weeks for 1 month. Then bi-monthly for 2 months. Then once monthly for 2 months. The audits will be completed by nursing administration/designee. Audits will be monitored for trends and patterns, findings will be brought to QAPI monthly.</p>				

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	<p>monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to ensure a medication was reviewed in the presence of adverse consequences for 1 of 4 residents reviewed for unnecessary medications. (Resident C)</p> <p>Findings include:</p> <p>On 3/30/16 at 1:00 p.m., Resident C's clinical record was reviewed. Resident C's diagnoses included, but were not limited to, Bipolar Disorder.</p> <p>The Progress Notes included, but were not limited to: 12/18/16 at 6:12 a.m., Resident noted to be becoming more non compliant with care from nursing staff and therapy.</p>	F 0329	F329 Resident C is no longer a resident at facility All licensed staff will be educated the addition of the nursing measure to the EMAR for all residents on medications of psychoactive class to monitor for side effects or complications of all psychoactive medications. Education will be completed by 4/30/2016. All residents' records will be audited for anti-psychotic, hypnotic, anti-anxiety, or anti-depressant medications. All resident with those classes of medications will be reviewed for evidence of adverse change in mood/behavior and/or side effects. Those with issues will have their prescribing physician and family notified immediately. These reviews will be conducted by the DON/designee. Reviews will be	04/30/2016

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	<p>Resident will cuss at staff and has started saying "Just leave me the hell alone, I want to die, let me die". The note further indicated the nurse had spoken with the residents son. The note indicated the son had asked for a psychiatric consult. 12/23/16 at 1:17 p.m., a social work progress note indicated the psychiatrist had been contacted and would be in the facility on 1/5/16 to see the resident. 1/5/16 at 9:11 a.m., a social service behavior note indicated on 1/4/16 the resident had repetitive verbalizations and was cursing. 1/5/16 at 5:51 p.m., a nursing note indicated the psychiatrist had been there that day to assess the resident. The note further indicated there were new orders for Seroquel (an antipsychotic medication), 25 mg (milligrams), orally twice a day of bipolar/depressive disorder. 1/6/16 at 4:51 p.m., a nursing note indicated the Seroquel was to be in the facility from the pharmacy that night. 1/10/16 at 12:38 a.m., a fall progress note indicated the resident had fallen onto the floor beside the bed. 1/10/16 at 7:10 a.m., a nursing note indicated the resident continued to yell out. 1/12/16 at 12:37 a.m., a fall progress note indicated the resident rolled out of bed on to the mat.</p>		<p>completed by 04/30/2016. All residents with medications of these classes will have a nursing measure added to the EMAR to monitor for changes in mood/behavior and/or side effects. Any resident with ill effects will have the MD notified immediately by nursing staff. Audits will be conducted daily for 2 weeks. Then 3 times per week for 2 weeks. Then weekly for 4 weeks. Then bi-monthly for 2 months. Then monthly for 2 months. Audits will be monitored for trends and patterns, findings will be brought to QAPI monthly.</p>				

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	<p>1/13/16 at 7:00 a.m., a fall progress note indicated the resident fell out of the wheelchair in the dining room.</p> <p>1/13/16 at 9:53 a.m., a nursing note indicated the resident was visibly upset that morning yelling aloud stating "You just wait, I'll throw myself back in the floor again".</p> <p>1/16/16 at 4:50 a.m., a fall progress note indicated the resident's alarm was sounding and the resident had slid out of the bed onto the floor.</p> <p>1/18/16 at 8:17 a.m., a Fall IDT (Interdisciplinary) note regarding the resident's fall on 1/16/16, indicated the resident stated "I threw myself out of bed and if you put me back in bed I will do it again".</p> <p>1/18/16 at 4:15 p.m., a nursing note indicated the resident's alarm was sounding and the resident was found sitting on the floor next to her bed.</p> <p>1/21/16 at 3:57 p.m., a fall progress note indicated the resident was found face down on the floor in the hallway.</p> <p>1/21/16 at 7:04 p.m., a nursing note indicated the resident had thrown herself out of the wheelchair five times since 3:00 p.m., a new order was received to give an additional Seroquel 25 mg orally now and to increase the Seroquel to 50 mg orally twice a day, the next day.</p> <p>1/23/16 at 1142 p.m., a nursing note indicated the resident was noted to be</p>						

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	<p>trying to expel herself from the wheelchair. The note further indicated the resident stated, "I'm going to keep throwing myself out, I want to go home".</p> <p>1/26/16 at 1:15 p.m., a nursing note indicated the resident was sitting in the dining room and a staff member noticed the resident was removing herself from her wheelchair and landed on her right side.</p> <p>1/26/16 at 4:33 p.m., a nursing note indicated the resident was found on her buttocks in front of her wheelchair.</p> <p>1/27/16 at 12:25 p.m., a nursing note indicated the resident was found laying on the floor in the living room area.</p> <p>1/29/16 at 2:16 p.m., a social service behavior note indicated the resident had behaviors on 1/28/16 that included resistive to care, repeated verbalizations, crying and tearful, cursing, yelling and screaming at staff stating, "I want the hell out of here, I want to go home. If you don't let me go home I'm going to keep throwing myself on the floor."</p> <p>The clinical record lacked indication the new medication had been discussed with a physician regarding adverse consequences.</p> <p>On 3/31/16 at 3:18 p.m., Staff #2 indicated therapy had indicated during a care conference the resident was going</p>			

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	<p>through traumatic brain injury phases, specifically challenging authority.</p> <p>On 3/31/16 at 4:06 p.m., Staff #2 provided the "Psychoactive Medications/Gradual Dose Reduction" policy, dated 6/2013. The policy included, but was not limited to: nursing will observe for adverse side effects of psychoactive medications every shift....</p> <p>This Federal tag relates to Complaint IN00196216.</p> <p>3.1-48(a)(5)</p>			