

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155821	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/15/2016
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NAME OF PROVIDER OR SUPPLIER  ASPEN TRACE HEALTH AND LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 S SR 135 GREENWOOD, IN 46143
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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>This visit was in conjunction with the Investigation of Complaints IN00197084 and IN00197971.</p> <p>Survey dates: April 6, 7, 8, 11, 12, 13, 14, and 15, 2016.</p> <p>Facility number: 013185 Provider number: 155821 AIM number: 201221460</p> <p>Census bed type: SNF: 49 SNF/NF: 51 Residential: 37 Total: 137</p> <p>Census payor type: Medicare: 25 Medicaid: 40 Other: 35 Total: 100</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p>This plan of correction is to serve as Aspen Trace Health and Living Community credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Aspen Trace or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. We would like to respectfully request paper compliance for Aspen Trace Health and Living Community's annual 2016 survey.</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 0279 SS=D Bldg. 00	<p>Q.R. completed by 14466 on April 20, 2016.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS 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 record review and interview, the facility failed to ensure a careplan was developed for a resident who experienced a significant weight loss, for 1 of 1 resident reviewed for significant weight loss. (Resident #82)</p>	F 0279	Corrective action for the resident affected by the deficient practice Resident # 82 was immediately re-assessed and plan of care and interventions was revised and updated to reflect resident's current status. The facility will identify other residents that may potentially be affected by the	05/05/2016

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	<p>Findings include:</p> <p>The clinical record of Resident #82 was reviewed on 4/12/16 at 10:00 a.m. Diagnoses for the resident included, but were not limited to, anxiety, depressive disorder, and dysphagia (difficulty swallowing).</p> <p>Review of the resident's weight record indicated:</p> <p>11/1/15 weight was 102.8.</p> <p>2/11/16 weight was 92. (a significant weight loss of 10% from 11/1/15)</p> <p>A nutrition note, dated 2/19/16, indicated the resident had experienced significant weight loss and the Registered Dietician (RD) recommended the resident receive a nutritional supplement of a house shake daily. The note indicated Resident #82 had agreed to receiving this supplement. No order was found in the resident's record for this nutritional supplement nor any documentation the resident received the house shake.</p> <p>3/1/16 weight was 87. (a significant weight loss of 5% from 2/11/16 and a significant weight loss of 15% from 11/1/15)</p>		<p>deficient practice. Any resident who resides at this facility, and has a weight loss has the potential to be affected by the alleged deficient practice. The facility will put into place the following systematic changes correct the alleged deficient practice It is the practice of this provider to identify, develop, and initiate resident's plan of care and ensure the residents maintain acceptable parameters of nutritional status unless the resident's clinical condition demonstrates that this is not possible. All residents who have a significant weight change have been identified. C/P have been reviewed to verify that they are complete with appropriate interventions. The IDT and facility staff, covering all shifts, will be re-educated on the facility weight management policy and procedure on 5/5/16. The IDT team will review the weights of new admissions/readmissions in the clinical stand up meeting and will initiate weight loss C/Ps as necessary during this meeting to include appropriate interventions to stabilize weight. IDT to review M-F, and the clinical weekend manager will review on weekends ongoing. The IDT team will review all new significant weight changes during the weekly IDT meeting. A C/P will be put into place at that time and will include all appropriate interventions to stabilize resident's weight. IDT</p>		

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	<p>A care plan for the Resident #82 was created on 3/14/16, for being nutritionally at risk after the resident had a documented weight loss 2/11/16, 2/19/16, and 3/1/16.</p> <p>On 3/17/16, an RD note indicated Resident #82 had agreed to receive the house shake supplement 2 times per day, and a physician order was written.</p> <p>On 4/3/16, the resident's weight was 88.6, a 1.6 pound gain from the previous month.</p> <p>A care plan for Resident #82 was created on 4/17/16 for the identification of a significant weight loss between 11/1/15 and 2/11/16.</p> <p>On 4/13/16 at 11:15 a.m., the Administrator provided an undated policy, titled, "Weight Management Policy," and indicated it was the policy currently used by the facility. The policy indicated the Interdisciplinary Team (IDT) would meet, "weekly on residents with significant weight changes to evaluate current interventions and make changes as necessary to stabilize the resident and attain the care plan goal...Review any assessment information provided by other disciplines outside of nursing such</p>		<p>team meets weekly and will be an ongoing practice. The facility will monitor the corrective action by implementing the following measures. The DON or designee will utilize DEVELOP COMPREHENSIVE CAREPLANS Audit Tool (Attachment A) to verify Care Plan is complete and accurate with appropriate interventions to stabilize weight. This tool will be completed daily for 2 weeks, weekly x 4 weeks, monthly x 3, and then quarterly thereafter. Any finding will be discussed, logged, and tracked at the monthly facility Quality Assurance Committee meeting. Administrator is responsible for ensuring compliance.</p>	

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F 0280 SS=D Bldg. 00	<p>as...Dietary...Implement additional interventions..."</p> <p>3.1-35(a)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interview, the facility failed to ensure a care plan was updated for a resident who developed pressure ulcers for 1 of 3 residents who met the criteria for review of updated pressure ulcer care plans. (Resident #77)</p>	F 0280	Corrective action for the resident affected by the deficient practice Resident # 77 no longer resides at the facility. The facility will identify other residents that may potentially be affected by the deficient practice. Any resident with a skin condition may be potentially affected. The facility	05/05/2016

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	<p>Findings include:</p> <p>The clinical record of Resident #77 was reviewed on 4/12/16 at 3:07 p.m. Diagnoses for the resident included, but were not limited to, hip fracture and muscle weakness.</p> <p>An admission Minimum Data Set assessment, dated 2/10/16, indicated the resident did not have a pressure ulcer, needed extensive assistance for bed mobility, and was at risk for developing a pressure ulcer.</p> <p>A care plan, initiated 2/8/16, and current through 5/19/16, indicated the resident was at risk for skin breakdown related to decreased mobility. Interventions, including offloading of heels while in bed, were put in place and documented as done.</p> <p>The record indicated on 2/19/16, the resident developed unstageable pressure ulcers on her left and right heels, suspected due to deep tissue injury.</p> <p>An updated care plan for the resident having actual skin breakdown was not found in the resident's record.</p> <p>On 4/15/16 at 11:30 a.m., Licensed</p>		<p>will put into place the following systematic changes correct the alleged deficient practice Residents are reviewed upon admission, quarterly, and with significant change. Any resident with a Skin condition has been reviewed to ensure plan of care is up to date. The IDT and facility staff will be re-educated on care planning process on 5/5/16. The facility will monitor the corrective action by implementing the following measures. The DON or designee will utilize RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP Audit Tool (Attachment B) weekly x 4 weeks, monthly x 3, and then quarterly thereafter. Any finding will be discussed, logged, and tracked at the monthly facility Quality Assurance Committee meeting. Administrator is responsible for ensuring compliance.</p>	

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F 0282 SS=D Bldg. 00	<p>Practical Nurse (LPN) #1 indicated the resident's care plan had not been updated for for developing pressure ulcers on her heels bilaterally.</p> <p>On 4/14/16 at 3:00 p.m., LPN #1 provided an undated policy, titled, "Wound Management," and indicated it was the policy currently used by the facility. The policy indicated, "...Each wound will be visualized by the wound team to provide oversight of the care plan interventions...Skin conditioned worsened...Review of care plan...Any changes made to care plan..."</p> <p>3.1-35(d)(2)(B)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN 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 record review and interview, the facility failed to ensure a Registered Dietitian's plan of care was followed for a resident who experienced a significant weight loss, for 1 of 1 resident reviewed for significant weight loss. (Resident #82)</p>	F 0282	Corrective action for the resident affected by the deficient practice Resident # 82 was immediately re-assessed and plan of care and interventions was revised and updated to reflect resident's current status. The facility will identify other residents that may potentially be affected by the deficient practice. Any resident	05/05/2016

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	<p>Findings include:</p> <p>The clinical record of Resident #82 was reviewed on 4/12/16 at 10:00 a.m. Diagnoses for the resident included, but were not limited to, anxiety, depressive disorder, and dysphagia (difficulty swallowing).</p> <p>Review of the resident's weight record indicated:</p> <p>11/1/15 weight was 102.8.</p> <p>2/11/16 weight was 92. (a significant weight loss of 10% from 11/1/15)</p> <p>A nutrition note, dated 2/19/16, indicated the resident had experienced significant weight loss and the Registered Dietician (RD) recommended the resident receive a nutritional supplement of a house shake daily. The note indicated Resident #82 had agreed to receiving this supplement. No order was found in the resident's record for this nutritional supplement nor any documentation the resident received the house shake.</p> <p>3/1/16 weight was 87. (a significant weight loss of 5% from 2/11/16 and a significant weight loss of 15% from 11/1/15)</p>		<p>who resides at this facility, and has a weight loss has the potential to be affected by the alleged deficient practice. The facility will put into place the following systematic changes correct the alleged deficient practice It is the practice of this provider to follow Registered Dietitian plan of care and to ensure the residents maintain acceptable parameters of nutritional status unless the resident's clinical condition demonstrates that this is not possible. The IDT and facility staff, covering all shifts, will be re-educated on the facility weight management policy and procedure on 5/5/16. The IDT team will review the weights of new admissions/readmissions in the clinical stand up meeting and will initiate weight loss C/Ps as necessary during this meeting to include appropriate interventions to stabilize weight. IDT to review M-F, and the clinical weekend manager will review on weekends ongoing. The IDT team will review all new significant weight changes during the weekly IDT meeting. A C/P will be put into place at that time and will include all appropriate interventions to stabilize resident's weight. IDT team meets weekly and will be an ongoing practice. The facility will monitor the corrective action by implementing the following measures. The DON or designee will utilize DEVELOP</p>		

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	<p>On 3/17/16, an RD note indicated Resident #82 had agreed to receive the house shake supplement 2 times per day and a physician order was written.</p> <p>On 4/3/16, the resident's weight was 88.6, a 1.6 pound gain from the previous month.</p> <p>on 4/12/16 at 2:00 p.m., Licensed Practical Nurse #3) indicated she did not find any documentation Resident #82 received her nutritional supplement house shakes between 2/19/16 and 3/17/16.</p> <p>On 4/13/16 at 11:15 a.m., the Administrator provided an undated policy, titled, "Weight Management Policy," and indicated it was the policy currently used by the facility. The policy indicated the Interdisciplinary Team (IDT) would meet, "weekly on residents with significant weight changes to evaluate current interventions and make changes as necessary to stabilize the resident and attain the care plan goal...Worsening...Review of the care plan...Review any assessment information provided by other disciplines outside of nursing such as...Dietary...Implement additional interventions..."</p> <p>3.1-35(g)(2)</p>		<p>COMPREHENSIVE CAREPLANS Audit Tool (Attachment A) to verify Care Plan is complete and accurate with appropriate interventions to stabilize weight. This tool will be completed daily for 2 weeks, weekly x 4 weeks, monthly x 3, and then quarterly thereafter. Any finding will be discussed, logged, and tracked at the monthly facility Quality Assurance Committee meeting. Administrator is responsible for ensuring compliance.</p>	

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F 0325 SS=D Bldg. 00	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on record review and interview, the facility failed to ensure a resident who experienced a significant weight loss received nutritional supplements as recommended by the Registered Dietician, had a plan of care implemented to prevent further weight loss, and was reviewed by the Interdisciplinary Team (IDT), which resulted in a significant loss of 15%, for 1 of 1 resident reviewed for significant weight loss. (Resident #82)</p> <p>Findings include:</p> <p>The clinical record of Resident #82 was reviewed on 4/12/16 at 10:00 a.m. Diagnoses for the resident included, but were not limited to, anxiety, depressive disorder, and dysphagia (difficulty swallowing).</p>	F 0325	Corrective action for the resident affected by the deficient practice Resident # 82 was immediately re-assessed and plan of care and interventions was revised and updated to reflect resident's current status. The facility will identify other residents that may potentially be affected by the deficient practice. Any resident who resides at this facility, and has a weight loss has the potential to be affected by the alleged deficient practice. The facility will put into place the following systematic changes correct the alleged deficient practice It is the practice of this provider to ensure the residents maintain acceptable parameters of nutritional status unless the resident's clinical condition demonstrates that this is not possible. The IDT and facility staff will be re-educated on the facility weight management policy	05/05/2016

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	<p>Review of the resident's weight record indicated:</p> <p>11/1/15 weight was 102.8.</p> <p>2/11/16 weight was 92 (a significant weight loss of 10% from 11/1/15).</p> <p>A nutrition note, dated 2/19/16, indicated the resident had experienced significant weight loss and the Registered Dietician (RD) recommended the resident receive a nutritional supplement of a house shake daily. The note indicated Resident #82 had agreed to receiving this supplement. No order was found in the resident's record for this nutritional supplement nor any documentation the resident received the house shake.</p> <p>3/1/16 weight was 87. (a significant weight loss of 5% from 2/11/16 and a significant weight loss of 15% from 11/1/15)</p> <p>A care plan for the Resident #82 was created on 3/14/16, for being nutritionally at risk after the resident had a documented weight loss 2/11/16, 2/19/16, and 3/1/16.</p> <p>On 3/17/16, an RD note indicated Resident #82 had agreed to receive the</p>		<p>and procedure on 5/5/16. Any resident who has experienced a weight loss has been reviewed by IDT, RD and will be followed routinely until weight is stable or deemed to be unavoidable. The facility will monitor the corrective action by implementing the following measures. The DON or designee will utilize MAINTAIN NUTRITION STATUS Audit Tool (Attachment D) weekly x 4 weeks, monthly x 3, and then quarterly thereafter. Any finding will be discussed, logged, and tracked at the monthly facility Quality Assurance Committee meeting. Administrator is responsible for ensuring compliance.</p>	

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	<p>house shake supplement 2 times per day, and a physician order was written.</p> <p>The record indicated the IDT team reviewed Resident #82's significant weight loss on 3/25/16. IDT note from 3/25/16, indicated resident would be weighed weekly, had received Lasix recently, and family ok with her current weight because she can breathe better.</p> <p>On 4/3/16, the resident's weight was 88.6, a 1.6 pound gain from the previous month.</p> <p>A care plan for Resident #82 was created on 4/17/16 for the identification of a significant weight loss between 11/1/15 and 2/11/16.</p> <p>on 4/12/16 at 2:00 p.m., Licensed Practical Nurse #3 indicated she did not find any documentation Resident #82 received her nutritional supplement house shakes between 2/19/16 and 3/17/16.</p> <p>On 4/13/16 at 11:15 a.m., the Administrator provided an undated policy, titled, "Weight Management Policy," and indicated it was the policy currently used by the facility. The policy indicated the Interdisciplinary Team (IDT) would meet, "weekly on residents with significant weight changes to</p>			

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F 0329 SS=D Bldg. 00	<p>evaluate current interventions and make changes as necessary to stabilize the resident and attain the care plan goal...Review any assessment information provided by other disciplines outside of nursing such as...Dietary...Implement additional interventions..."</p> <p>3.1-46(a)(1)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically</p>			

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NAME OF PROVIDER OR SUPPLIER  ASPEN TRACE HEALTH AND LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 S SR 135 GREENWOOD, IN 46143
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	<p>contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure a pharmacy recommendation was reviewed by the resident's physician and a gradual dose reduction (GDR) of a medication was attempted for 1 of 5 residents reviewed for use of an unnecessary medication. (Resident #128)</p> <p>Findings include:</p> <p>The clinical record review for Resident #128 was completed on 4/11/16 at 3:01 p.m. Diagnoses included, but were not limited to, psychotic disorder and depressive disorder.</p> <p>a. A review of a physician order dated 1/6/15 and current through 4/11/16, indicated Resident #128 was to receive Seroquel (a medication used to treat psychotic disorders) 25 milligrams daily.</p> <p>A review of a pharmacy recommendation dated 1/11/16, indicated Resident #128 was due for a gradual dose reduction for Seroquel. The recommendation lacked documentation indicating a physician reviewed the recommendation.</p> <p>During an interview on 4/15/16 at 4:08</p>	F 0329	<p><b>Corrective action for the resident affected by the deficient practice Resident # 128 antipsychotic medication was reviewed and a GDR was completed 4/29/2016. Residents dose was changed from 25mg to 12.5 mg QHS. The resident is currently being monitored. The facility will identify other residents that may potentially be affected by the deficient practice. Residents currently receiving antipsychotic medications could be affected The facility will put into place the following systematic changes correct the alleged deficient practice The IDT and facility staff will be re-educated on behavior management program will be conducted on 5/5/16. All residents receiving antipsychotic medications have been reviewed by the physician for a potential GDR. The social service director and or designee will maintain a GDR Log (Attachment F) of all antipsychotics medications being used within the facility with order date, diagnosis for use and gradual dose reduction history. The log will be updated and discussed monthly at facility behavior management meeting. In order to monitoring ongoing compliance The social service</b></p>	05/05/2016

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	<p>p.m., the Director of Nursing (DON) indicated there was no documentation found in Resident #128's clinical record indicating the physician was notified of the pharmacy recommendation dated 1/11/16. The DON indicated pharmacy recommendations are dispersed to unit managers and the unit managers give them to the physician's to review, if no physician response then a second attempt is made. The DON indicated, "The physician did not get the pharmacy recommendation for the gradual dose reduction that we can see in the chart."</p> <p>b. A review of a physician order dated 1/6/15 and current through 4/11/16, indicated Resident #128 was to receive Seroquel (a medication used to treat psychotic disorders) 25 milligrams daily.</p> <p>A pharmacy recommendation dated 7/24/15, indicated "A GDR may impair the resident's function or cause psychiatric instability by exacerbating an underlying psychiatric disorder." No documentation was found indicating a GDR was clinically contraindicated.</p> <p>A review of Resident #128's clinical record lacked documentation indicating a 2nd attempt at a GDR for Seroquel was made.</p>		<p><b>director or designee with complete UNNECESSARY DRUGS Audit Tool (Attachment E) on residents receiving antipsychotic medication weekly x 4 weeks, monthly x 3, and then quarterly thereafter. Any finding will be discussed, logged, and tracked at the monthly facility Quality Assurance Committee meeting. Administrator is responsible for ensuring compliance.</b></p>	

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R 0000  Bldg. 00	<p>During an interview on 4/15/16 at 3:00 p.m., LPN #1 indicated no 2nd attempt at a GDR for Seroquel had been made after 7/4/15 and physician documentation was not found in Resident #128's clinical record indicating a GDR was clinically contraindicated.</p> <p>On 4/15/16 at 3:02 p.m., LPN #1 provided a policy titled, Behavior Management Program, and indicated it was the current policy used by the facility. The policy indicated, "...<u>Reduction</u>... Residents who are on an antipsychotic medication will have a dose reduction attempt documented by the attending physician and clinical team two (2) separate times within the first 12 months from the admission date. The two (2) separate attempts should be at least one (1) month apart from each attempt unless this is clinically contraindicated and documented by the physician. If a dose reduction is clinically contraindicated the physician will document the clinical rationale why...."</p> <p>3.1-48(b)(2)</p>			
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	<p>disposition of a discharged resident's medications were documented in the clinical record for 1 of 2 discharged residents reviewed for disposition of medications. (Resident #56)</p> <p>Findings include:</p> <p>The closed clinical record for Resident #56 was reviewed on 4/14/16 at 9:30 a.m. Diagnoses included, but were not limited to, heart failure and edema. Resident #56 discharged from the facility on 2/29/16.</p> <p>The following medications were current through discharge from the facility on 2/29/16: eliquis (prevents blood clots) with an original date of 1/16/16; diltiazem (treats high blood pressure) with an original date of 7/7/15; ferrous sulfate (provides iron) with an original date of 7/7/15, miralax (for constipation) with an original date of 7/7/15; synthroid (synthetic thyroid hormone) with an original date of 7/7/15; and Lasix (treats excess fluid) with an original date of 12/18/15. No documentation of disposition for these medications was found in the clinical record.</p> <p>During an interview on 4/15/16 at 4:10 p.m., the Director of Nursing (DON) indicated no disposition of medications was found in Resident #56's clinical</p>		<p><b>deficient practice Resident # 56 no longer resides in facility. The facility will identify other residents that may potentially be affected by the deficient practice. All residents who discharge have the potential to be effected by the alleged deficient practice The facility will put into place the following systematic changes correct the alleged deficient practice The nursing staff educated on drug disposition forms on or before 5/5/16. The facility will monitor the corrective action by implementing the following measures. DON or designee will complete Drug Disposition Audit Tool (Attachment G) of discharge records weekly x 4 weeks, monthly x 3, and then quarterly thereafter. Any finding will be discussed, logged, and tracked at the monthly facility Quality Assurance Committee meeting. Administrator is responsible for ensuring compliance. Compliance date: 5/5/2015</b></p>		

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R 0410 Bldg. 00	<p>record. The DON indicated information regarding the disposition of Resident #56's medications should have been documented in the resident's progress notes.</p> <p>On 4/15/16 at 4:10 p.m., the Executive Director (ED) provided a policy titled Clinical - Resident Discharge and Transfer Policy, and indicated it was the current policy used by the facility. The policy lacked information regarding disposition of resident medications.</p> <p>410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p>			

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	<p>Based on record review and interview, the facility failed to ensure an annual tuberculin skin test was administered to 1 of 7 residents reviewed for receiving tuberculin skin tests. (Residents #54)</p> <p>Findings include:</p> <p>The clinical record of Resident #54 was reviewed on 4/15/16 at 9:00 a.m.</p> <p>The resident was admitted to the facility on 9/26/14, at which time she received the two-step tuberculin skin test. The results were negative.</p> <p>No documentation was found in the resident's record which indicated an annual tuberculin skin test had been performed since the annual test dated 9/26/2014.</p> <p>On 4/15/16 at 4:15 p.m., the Director of Nursing indicated a tuberculin skin test had not been given to Resident #54 since the annual test dated 9/26/14 . She indicated it is the facility policy to perform annual tuberculin skin tests on residents as part of their infection control program.</p>	R 0410	<p><b>Corrective action for the resident affected by the deficient practice Resident # 54 received tuberculin skin test immediately on 4/15/2016. The facility will identify other residents that may potentially be affected by the deficient practice. All residents who reside in this facility have the potential to be effected by the alleged deficient practice. The facility will put into place the following systematic changes correct the alleged deficient practice The nursing staff will be re-education on tuberculin skin test policy on 5/5/16. All resident who records on residential have been reviewed any resident who did not receive an annual tuberculin skin test have been ordered and administered on or before 5/5/2016. The facility will monitor the corrective action by implementing the following measures. DON or designee will complete TB Skin Test Audit Tool (Attachment H) residents due for of an annual tuberculin skin test weekly x 4 weeks, monthly x 3, and then quarterly thereafter. Any finding will be discussed, logged, and tracked at the monthly facility Quality Assurance Committee meeting. Administrator is responsible for ensuring</b></p>	05/05/2016			

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			<b>compliance.</b>		