

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155379	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/07/2015
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF ROCHESTER	STREET ADDRESS, CITY, STATE, ZIP CODE 827 W 13TH ST ROCHESTER, IN 46975
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F 000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint #IN00169306.</p> <p>This visit was in conjunction with the Investigation of Complaint #IN00170818.</p> <p>Complaint #IN00169306 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: March 30, 31, April 1, 2, 6 and 7, 2015</p> <p>Facility number: 000325 Provider number: 155379 AIM number: 100274300</p> <p>Census bed type: SNF/NF: 75 Total: 75</p> <p>Census payor type: Medicare: 12 Medicaid: 50 Other: 13 Total: 75</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC</p>	F 000		
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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 157 SS=D Bldg. 00	<p>16.2-3.1.</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</p>			

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	<p>the resident's legal representative or interested family member.</p> <p>Based on record review and interviews, the facility failed to ensure an injury was reported to the family timely for 1 of 3 residents reviewed. (Resident C)</p> <p>Finding includes:</p> <p>The clinical record for Resident C was reviewed on 04/06/15 at 11:00 A.M. Resident C was originally admitted to the facility on 07/02/13, and most recently readmitted to the facility on 04/02/15, with diagnosis, including but not limited to edema, right below the knee amputation, diabetes mellitus, osteomyelitis, morbid obesity and recent amputation of the left third toe.</p> <p>A podiatrist exam note, dated 12/15/14, indicated the podiatrist had drained an abscess located on the distal tip of the resident's third toe on her left foot. The podiatrist ordered betadine ointment [antiseptic ointment] and bandaid to the area until it was healed.</p> <p>The facility non pressure wound documentation, from 12/15/14 to 01/19/15, indicated the resident's third toe area was assessed and treated until the area resolved on 01/19/15.</p>	F 157	<p>F Tag 157 Notification of Family <i>What Corrective action will be accomplished for those residents found to be affected by the deficient practice?</i> Facility will follow it's policy to ensure any changes of condition for resident C will be reported to the family timely .</p> <p><i>How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</i> Full facility audit of incidents and significant changes for the past 30 days was conducted to ensure timely reporting of incidents and significant changes to families/responsible parties.</p> <p><i>What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</i> Staff Development Coordinator will educate new staff upon hire on the importance of notification and review policy and procedure. Director of Nursing will re-educate nursing staff on notifying POA/Family of any change of condition or incidents. Director of Nursing will institute audit tool</p> <p><i>How will the corrective action be monitored to ensure the deficient practice will not recur?</i> Director of Nursing or designee to audit 10 random charts 3x a week for 2 weeks;</p>	05/07/2015			

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	<p>A nursing progress note, dated 03/19/15 at 11:25 P.M., indicated the following: "Res [Resident] left foot third toe old area re-opened. res foot/toe was laying up against the foot of bed. [physician's name] notified for tx [treatment], staff given instructions to raise foot of bed and boost res up so toe does not lay against footboard cont [continue] to monitor."</p> <p>Nursing progress notes, from 03/19/15 through 03/23/15 at 12:44 P.M., indicated although the physician and the nursing unit manager were contacted regarding the resident's toe injury and the continued deteriorating condition of the resident's toe, there was no documentation the resident's family was notified of the toe injury.</p> <p>A nursing progress note, dated 03/23/15 at 1:13 P.M., indicated the resident's responsible party, her son was telephoned regarding the issue with the resident's toe and the conversation with her physician, and the physician's order to send the resident to the acute care facility for treatment.</p> <p>The face sheet for Resident C and admission documentation indicated although the name and phone number of her spouse were listed as "Next of kin," the resident's son's name and phone</p>		then 2x a week for 2 weeks; then 1x a week for 2 months; then 1x a month for 6 months. Audit results and system components will be reviewed during monthly PII/QA committee meeting with subsequent plans of correction developed and implemented as deemed necessary		

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F 246 SS=D Bldg. 00	<p>number was listed as "Call 1st" and the durable Power of Attorney forms, located on the chart, indicated the resident's son as her power of attorney.</p> <p>During an interview on 04/07/2015 at 3:56 P.M., the Director of Nursing indicated the nurse involved had been contacted and said she left a message for the son but he did not call back and she did not chart the notification.</p> <p>3.1-5(a)(1)</p> <p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on observation, record review and interviews, the facility failed to ensure the bathing preference for 1 of 3 residents reviewed for choices was honored. (Resident #28)</p> <p>Finding includes:</p>	F 246	<p>F-Tag 246 Reasonable Accommodation of needs of Preferences</p> <p>What Corrective action will be accomplished for those residents found to be affected by the deficient practice? Resident #28 was immediately interviewed for her bathing preference. Care plan and care guide</p>	05/07/2015

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	<p>During an interview on 03/31/2015 at 2:19 P.M., Resident #28 indicated she preferred a tub bath and all the sudden she had been told she could not have a tub bath anymore. She indicated staff claimed the tub was broken.</p> <p>The clinical record for Resident #28 was completed on 04/01/15 at 9:10 A.M. The most recent MDS assessment, completed on 04/01/15, indicated it was very important for the resident to choose between a tub bath, shower, or bed bath.</p> <p>A care plan related to hygiene needs for Resident #28, initiated on 12/26/14, indicated the following: " Poor hygiene: Resident refuses to bath, shower or allow staff to clean up. Resident prefers a bed bath which she does on her own per choice."</p> <p>The bathing records for past 3 months for Resident #28 only documented bathing was done on Tuesday and Saturday evenings but did not indicate what type of bathing was done.</p> <p>During an interview on 04/02/2015 at 10:43 A.M., Resident #28 indicated before she was moved from the North unit to the Central unit she received tub baths but since she had moved to the Central unit she was told she was "not</p>		<p>was adjusted to reflect the resident's preference. Tubs were repaired to allow for residents preference.</p> <p>How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</p> <p>Full facility audit of bathing preferences completed by Unit Managers (or designee) amendments made to the care plan, care guide and bathing schedules</p> <p>What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <p>Activity Director (or designee) will be responsible for instituting new preference sheet upon admission. Preferences will be communicated during morning meeting and immediately implemented into care guide by the Unit Managers (or designee)</p> <p>Social Service Director (or designee) will review resident preferences at their next scheduled MDS assessment and changes will be added to care guide and care plans. Social Service Director (or designee) will re-educate staff related to preferences/residents rights. C.N.A will obtain signature of charge nurse on shower sheet upon resident refusal. Unit Manager and</p>	

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	<p>allowed" to take a bath "due to a medical issue" and she had been informed the tub was broken.</p> <p>During an observation of the Central Shower room, on 04/02/15 at 10:00 A.M., there was a sign on the whirlpool tub which indicated, " Lock out does not work." The sign was dated 09/26/13.</p> <p>During an interview on 04/02/2015 at 10:03 A.M., LPN #20 indicated she was not aware of the status of the central tub but indicated there was a shower room with just a shower on the south/skilled unit and on north there was a shower room with a whirlpool and a shower.</p> <p>An interview was conducted on 04/02/15 at 10:10 A.M., while in the South unit shower room, with the Maintenance Supervisor, Employee #21 and South/skilled unit manager, LPN #22. Both employees indicated the tub, located in the shower room, did work. LPN #22 indicated they did not use the tub in the south shower room because everyone on the south and skilled units preferred showers. She did indicate residents from other units could receive a bath on the south shower room. She reaffirmed the tub was not utilized.</p> <p>An observation of the North unit shower</p>		<p>wound care nurse will audit shower sheets to ensure showers are done and ensure completeness Maintenance to assess tub for mechanical issues and repairs made timely. Maintenance will add tub audits to monthly preventive maintenance program.</p> <p>How will the corrective action be monitored to ensure the deficient practice will not reoccur?</p> <p>The Unit Managers or designee will audit the shower sheets 3x week x 4 weeks, then 2x week x 4 weeks, then 1 x weekly x 4 weeks and once weekly for 3 months and prn thereafter. Audit results and system components will be reviewed during monthly PI/QA committee meeting with subsequent plans of correction developed and implemented as deemed necessary</p>				

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	<p>room was conducted on 04/02/15 at 10:12 A.M., with the Maintenance supervisor, Employee #21. The North unit now housed staff offices; however, there was a shower stall and a tub. The whirlpool tub had a little bit of standing water in the bottom of the tub. During an interview at this time, the Maintenance supervisor, Employee #21, indicated some staff did not like to go on the North unit because they thought there were "ghosts." He indicated the facility was waiting to start a total remodel/gut job of all three shower rooms.</p> <p>During an interview on 04/07/15 at 2:36 P.M., CNA #23 indicated she assisted Resident #28 with her showers. She indicated the resident would prefer a whirlpool but since she had been working (January 2015) all three whirlpools/bath tubs were broken. She indicated she had not offered a whirlpool to Resident #28 She indicated the resident was capable of bathing herself and just needed supervision and set up.</p> <p>The current CNA assignment sheet for March 2015, provided by the Unit Manager, RN #24 indicated Resident #28 preferred a whirlpool bath with the assistance of 1 staff.</p> <p>3.1-3(v)(1)</p>						

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F 247 SS=B Bldg. 00	<p>483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE</p> <p>A resident has the right to receive notice before the resident's room or roommate in the facility is changed.</p> <p>Based on interview and record review, the facility failed to properly notify a residents legal representative of a room change. This affected 1 of 1 residents reviewed for admission, discharge and transfer information. (Resident #70)</p> <p>Finding includes:</p> <p>On 4/6/15 at 2:41 P.M., Resident #70's clinical record was reviewed. The diagnoses included, but were not limited to, Alzheimer's disease, hypothyroidism, acute pain, insomnia, edema and depressive disorder.</p> <p>The annual MDS (Minimum Data Set) assessment, completed on 12/17/14, indicated the resident is moderately cognitively impaired in making daily decisions.</p> <p>During an interview on 3/31/15 at 2:23</p>	F 247	<p>F Tag 247 Notification of Room Change</p> <p>What corrective action will be accomplished for those residents found to be affected by the deficient practice? Facility will properly notify Resident #70 legal representative of any room changes</p> <p>How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</p> <p>All residents with future room changes have a potential to be affected by the deficient practice. A full facility audit of residents having room changes for the past 30 days has been completed to ensure notification of responsible party/legal representative</p> <p>What measure will be put into place or what systemic changes</p>	05/07/2015

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	<p>P.M., the daughter-in-law of Resident #70 indicated sometime around the holidays the family came into to visit her and she was in a different room. She further indicated neither her or her husband received any notification of the room change.</p> <p>A form titled "Room Change Notification," dated 10/22/14, indicated "...Room change dated, 10/24/14 3:00 P.M., from room 202-1 to 323-1...Reason for room change: Per DON (Director of Nursing) resident needs a different roommate, more compatible...Resident representative notified? NO...tried to call several times...I voluntarily agree to the move to room 323-1, the box next to this was marked Yes..." The signature line for the resident/resident representative located at the bottom of the form indicated, "...Resident can't sign..."</p> <p>A form titled "Room Change Notification," dated 1/7/15, indicated "...Room change dated, 1/7/15 no time, from room 323-2 to room 218-2...Reason for room change: Residents room will be painted as requested...I voluntarily agree to the move to room 218-2, the box next to this was marked Yes...Resident gave verbal consent..." The signature line for the resident/resident representative was blank.</p>		<p>will be made to ensure that the deficient practice does not recur?</p> <p>Interdisciplinary team review of policy and procedure for room moves. Social Services Director (or designee) will in-service staff on policy and procedure. New audit tool instituted for 6 months to ensure compliance. Social Services will send out a letter related to room changes when she/he is not able to make contact via phone with family and will document in the medical chart when the letter was mailed.</p> <p>How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <p>Social Service Director (or designee) will monitor room changes and perform an audit of the notification to roommate, resident, family/POA 4x a week for 2 weeks; then 2x a week for 1 month; then 1x a month for six months. Audit results and system components will be reviewed during monthly PI/QA committee meeting with subsequent plans of correction developed and implemented as deemed necessary.</p>	

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F 280 SS=E Bldg. 00	<p>During an interview on 4/6/15 at 3:34 P.M., the Social Service Assistant indicated when the resident had a room change in October 2014 and January 2015 a letter should have been sent to the residents representative when she couldn't contact them by phone and a letter was not sent.</p> <p>On 4/7/15 at 9:16 A.M., review of the current policy titled, "Resident Room Relocation," received from the Social Service Assistant, indicated "...The Social Services staff develop a plan to ensure that needs and concerns related to the resident's ability to cope and adjust to the relocation are addressed by taking the following steps. 1. Providing the resident, legal guardian, and interested family member with a verbal notice and documenting this in the medical record...."</p> <p>3.1-3(v)(2)</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</p>				

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	<p>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>A. Based on observation, record review and interview, the facility failed to update the care plan for 1 of 3 reviewed for nutritional status. (Resident #89)</p> <p>B. The facility failed to update the care plan's related to psychotropic medications and behaviors for 2 of 5 residents reviewed for unnecessary medications. (Resident #3 and Resident #81)</p> <p>C. Based on record review and interview, the facility failed to update the care plan related to the use of Remeron for 1 of 5 residents reviewed for unnecessary medications. (Resident #79)</p> <p>Findings include:</p> <p>A.1. On 4/6/15 at 8:40 A.M., a review of</p>	F 280	<p><u>F 280 Related to Care plan</u></p> <p>-</p> <p>What Corrective action will be accomplished for those residents found to be affected by the deficient practice?</p> <p>Resident #89 preferences were immediately taken and immediately added to the care plan</p> <p>Resident #3 care plan was immediately adjusted to reflect new interventions. Behavior monitoring immediately changed to monitor behaviors to include side effects.</p> <p>Resident #81 was discharged the same day of survey (d/c on 4/1/15)</p> <p>Resident #79 care plan was updated to include diagnosis of insomnia and the use of remeron for an appetite stimulate. Social Service Director completed new</p>	05/07/2015

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	<p>the clinical record for Resident #89 was conducted. The record indicated the resident was admitted on 12/2/14. The resident's diagnoses included, but were not limited to: congestive heart failure, renal failure, diabetes, atrial fibrillation, iron deficiency anemia and hypertension.</p> <p>A Care plan, dated 12/2/14, for a problem of nutritional risk as evidenced by weight gain in past 30 days related to noncompliance with fluid restriction, a required therapeutic diet due to diabetes and iron deficiency anemia. The goal: resident will sustain no significant weight change through next review on 5/25/15. The interventions included but were not limited to: observe/report significant weight change, observe lab results and report to physician, provide diet as ordered, provide/observe intake of diet/fluids and honor food preferences.</p> <p>A Nutritional Data Collection/Assessment, dated 12/3/14, completed by the Dietary Manager and the Registered Dietician, indicated the resident was allergic to milk and eggs and was admitted with diet orders for an 1800 calorie diet with a 1500 milliliters (ml) fluid restriction. The resident's weight was 116 with a BMI (Body Mass Index) of 18.41. The resident was eating in her room and consuming 50 % of breakfast,</p>		<p>assessment to ensure resident's psychosocial needs are met and adjusted care plan and behavior monitoring.</p> <p>How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</p> <p>Full house audits for nutritional care plans: Dietary Manager and Director of Nursing (or designee) will audit all significant weight changes in the past 30 days. They will audit and review all the nutritional care plans for residents admitted within the last 30 days. Dietary Manager (or designee) will do a full house audit of resident preferences, adjust care plans, and adjust tray cards for consistency with preferences. The Dietary Manager or designee will audit the Registered Dietitian's recommendations and cross reference to the nutritional care plan and nutritional observation. Dietary Manager will educate all staff on following nutritional care plans. Executive Director will educate Dietary Manager on following Registered Dietitian recommendations, care plans and tray cards. The Social Services Director (or designee) will audit discharge instructions for all patients who have had a psychiatric admission and returned within the last 3 months. Discharge</p>	

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	<p>75% of lunch, 100% of dinner and HS (before bedtime) snack. The resident's Energy Needs were: 1431 Calories, Protein Needs were: 70 Grams/day and Fluid Needs were: 1500 milliliters (ml) per order. The assessment indicated the percent of the resident's intake (1125 calories) did not meet estimated calorie needs. The nutritional intervention indicated the resident's diet should be changed from 1800 Calorie ADA (American Diabetic Association) diet to a regular diet with a fluid restriction of 1500 ml, offer 1/2 sandwich at bedtime, and large protein entree at dinner.</p> <p>A Dietary Progress Note made by the RD, dated 2-18-15, indicated the resident had a significant weight gain of 15 pounds/12.5%. The resident received a regular diet with a fluid restriction of 1500 ml. The resident received a large portion entree, due to dislike of milk, to replace the protein. Meal intakes were 69% (approximately 1450 calories). The estimated calorie needs were 1534 calories (25 calories per kilogram). The resident's weight gain was due to noncompliance with the fluid restriction. The estimated protein needs were 74 grams (1.2 Grams per kilogram). The estimated protein intake was 60 GM. The RD added cottage cheese to dinner to increase protein and calcium, as well as</p>		<p>recommendations will be evaluated and implemented to address the suggested therapeutic interventions. Social Services department (or designee) will immediately update the care plan and behavior monitoring flow sheets. Social Services Director (or designee) will conduct a full house audit for consistency in care planning related to psychiatric diagnosis and psychiatric medications. They will audit the behavior monitoring sheets to ensure there is consistency with what is being observed to include side effects and ensure it is related to the psychiatric diagnosis. Social Services Director or designee will conduct staff education on the behavioral monitoring system to include behavior management flow record and ensure proper utilization.</p> <p>What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Director of Nursing or designee will in-service interdisciplinary team and staff on care plan process and utilization of psych meds and their appropriateness. New audit tool will be instituted. The Social Services Director will implement a new systematic process for the behavior</p>	

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	<p>continuing the 1/2 sandwich at HS.</p> <p>During an interview, on 4/6/15 at 11:30 A.M., the Registered Dietician (RD) indicated when she assessed the resident her BMI was low and she did not want to start any liquid protein supplements at the time. She had ordered a regular diet, 1/2 sandwich at bedtime and large protein entree at lunch. She further indicated the dietary manager would assess the resident quarterly, update the care plan, review the labs and report to the RD if there were any changes or concerns.</p> <p>On 4-6-15 at 12:40 P.M., Resident #89 was observed in the dining room eating her lunch. The resident had eaten 95% of her meat portion but only bites of her vegetables. She was eating her cottage cheese portion. The meal ticket indicated the resident was to receive a large protein portion at noon meal but there was no indication the resident was to receive cottage cheese.</p> <p>On 4-6-15 at 12:42 P.M., the Dietary Manager indicated the larger portion protein was served at the noon meal and the resident had always asked for cottage cheese at the noon and dinner meals and she had no note of cottage cheese probably because of resident's preference to ask for it anyhow. The Dietary</p>		<p>management meeting.</p> <p>How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <p>The Social Service Director (or designee) will audit new orders, 24 hr report sheets for new psych meds, new psych dx and inpatient stays cross referencing to the care plans and behavior monitoring flow record. The social worker will utilize the new audit tool. 3x a week for 4 weeks; then 2x a week for 2 weeks; then 1x a week for 2 weeks and 1x a month for 6 months. Results will be reviewed by the administrator weekly and brought to Performance Improvement meeting /QA for 6 months or until 100% compliance is achieved on the audit tool. Subsequent plans of correction will be developed and implemented as deemed necessary.</p> <p>The Dietary Manager will monitor the Registered Dietitian's recommendations and cross reference to the nutritional care plan and nutritional observation of the patients 3x a week for 4 weeks; then 2x a week for 2 weeks; then 1x a week for 2 weeks and 1x a month for 6 months. Results will be reviewed by the Director of Nursing and presented in the Performance Improvement meeting /QA for 6 months or until 100% compliance is achieved on the audit tool.</p>	

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	<p>Manager further indicated she had not updated the care plan to reflect the resident's current diet, 1/2 sandwich at bedtime, an increased protein entree and cottage cheese due to not being in the facility at the time of the changes.</p> <p>On 4/6/15 at 3:45 P.M., an interview was conducted with the Director of Nursing (DON) and Administrator. The Administrator indicated the care plan for nutrition at risk should have the current approach/interventions to increase protein entree at noon meal, cottage cheese and 1/2 sandwich at bedtime. The DON indicated the care plan did not reflect the resident's current diet and her dislike of milk. The administrator further indicated the current care plan had not been updated to reflect the resident's current plan of care.</p> <p>B.1. On 4/7/15 at 2:33 P.M., a review of the clinical record for Resident #3 was conducted. The record indicated the resident was admitted, on 2/17/15 and readmitted on 3/24/15, after an admission to a local psychiatric hospital. The resident's diagnoses included, but were not limited to: dementia, depression, anxiety and fatigue.</p> <p>The admission orders, dated 2/19/15, indicated the resident's medication</p>		<p>Subsequent plans of correction will be developed and implemented as deemed necessary.</p> <p><u>F 280 Related to Care plan</u></p> <p><i>What Corrective action will be accomplished for those residents found to be affected by the deficient practice?</i></p> <p>Resident #89 preferences were immediately taken and immediately added to the care plan Resident #3 care plan was immediately adjusted to reflect new interventions. Behavior monitoring immediately changed to monitor behaviors to include side effects. Resident #81 was discharged the same day of survey (d/c on 4/1/15) Resident #79 care plan was updated to include diagnosis of insomnia and the use of remeron for an appetite stimulate. Social Service Director completed new assessment to ensure resident's psychosocial needs are met and adjusted care plan and behavior monitoring.</p> <p><i>How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</i></p> <p>Full house audits for nutritional care plans: Dietary Manager and Director of Nursing (or designee) will audit all</p>	

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	<p>included but was not limited to: Chlordiazepoxide (Librium) 25 milligrams (mg) twice a day (BID) for depression with anxiety. The readmission orders, dated 3/24/15, indicated the resident's medication included but was not limited to: Buspar 10 mg three times a day (TID) for anxiety, Remeron 7.5 mg at bedtime for depression and Zyprexa 2.5 mg at bedtime for delusions.</p> <p>An order request/notification form, dated 2/20/15, indicated the physician was contacted regarding the resident's increased agitation, physical aggression with staff, scratching and hitting staff, and increased confusion. A new order was received for Buspar 7.5 mg BID. On 3/9/15, an order indicated the resident was transferred to a local psychiatric hospital.</p> <p>A discharge summary, from a local psychiatric hospital, indicated the resident was admitted on 3/9/15 and discharged on 3/24/15. The summary indicated the resident would be discharged back to facility with recommendations to follow up with outpatient psychiatric care. Also, during the adjustment phase back to the facility, the information indicated the patient may become slightly more confused, which</p>		<p>significant weight changes in the past 30 days. They will audit and review all the nutritional care plans for residents admitted within the last 30 days. Dietary Manager (or designee) will do a full house audit of resident preferences, adjust care plans, and adjust tray cards for consistency with preferences. The Dietary Manager or designee will audit the Registered Dietitian's recommendations and cross reference to the nutritional care plan and nutritional observation. Dietary Manager will educate all staff on following nutritional care plans. Executive Director will educate Dietary Manager on following Registered Dietitian recommendations, care plans and tray cards. The Social Services Director (or designee) will audit discharge instructions for all patients who have had a psychiatric admission and returned within the last 3 months. Discharge recommendations will be evaluated and implemented to address the suggested therapeutic interventions. Social Services department (or designee) will immediately update the care plan and behavior monitoring flow sheets. Social Services Director (or designee) will conduct a full house audit for consistency in care planning related to psychiatric diagnosis and psychiatric medications. They will</p>	

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	<p>may lead to some anxiety and agitation. If this occurred, it was recommended that the staff remove the patient to a quiet area to reduce stimuli, and offer food, fluids, and toileting. It was also recommended the resident not have a gradual dose reduction of any of her antipsychotic for the next 6 months.</p> <p>The Behavior/Intervention Monthly Flow Record for February 2015 indicated the facility was monitoring for the behavior-wandering with interventions to redirect, validate and encourage activities. There was no documentation of monitoring the side effects nor behaviors associated with the use of the anti-anxiety medications librium or buspar. Behavior/Intervention Monthly Flow Record for March of 2015 indicated resident was monitored for a behavior of restlessness and side effects with the use of Buspar an anti-anxiety medication. In addition, the resident was monitored for a behavior of wandering and side effects with the use of Librium. The Behavior/Intervention Monthly Flow Record for April indicated the facility was monitoring behaviors of "paranoid delusions" and side effects with the use of Zyprexa for depression. A behavior of "wandering" related to anxiety for the use of Buspar and a behavior of "isolation" related to depression and the use of</p>		<p>audit the behavior monitoring sheets to ensure there is consistency with what is being observed to include side effects and ensure it is related to the psychiatric diagnosis. Social Services Director or designee will conduct staff education on the behavioral monitoring system to include behavior management flow record and ensure proper utilization.</p> <p>What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Director of Nursing or designee will in-service interdisciplinary team and staff on care plan process and utilization of psych meds and their appropriateness. New audit tool will be instituted. The Social Services Director will implement a new systematic process for the behavior management meeting.</p> <p>How will the corrective action be monitored to ensure the deficient practice will not recur? The Social Service Director (or designee) will audit new orders, 24 hr report sheets for new psych meds, new psych dx and inpatient stays cross referencing to the care plans and behavior monitoring flow record. The social worker will utilize the new audit tool. 3x a week for 4 weeks; then 2x a week for 2 weeks; then 1x a week for 2 weeks and 1x a month for 6 months. Results will be reviewed by the administrator</p>	

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	<p>Zoloft. All three behaviors had the same interventions: encourage activities, validate, and identify triggers. Wandering had an additional intervention of redirect.</p> <p>A Care plan, dated 2/18/15, for "Behavior" indicated the resident had a behavior problem related to physically abusive, wandering and resists care. On 3/9/15, an additional problem of intrusive wandering was added to the care plan. There was no plan of care for the use of an antipsychotic, anti-anxiety or antidepressant medication. There was no specific care plan for the targeted behaviors of delusions, agitation and anxiety with no clear interventions to address the resident's agitation nor anxiety issues, as directed by the summary from the psychiatric hospital.</p> <p>During an interview, on 4-7-15 at 4:32 P.M., the DON (Director of Nursing) indicated the nurses do not add/or start the Behavior/Intervention Monthly Flow Records, the Social Service Director would be responsible to add it. The nurses would be responsible to document on each shift any behaviors, interventions, and side effects noted with the use of antipsychotic medications.</p> <p>During an interview on 4/7/15 at 4:46</p>		<p>weekly and brought to Performance Improvement meeting /QA for 6 months or until 100% compliance is achieved on the audit tool. Subsequent plans of correction will be developed and implemented as deemed necessary.</p> <p>The Dietary Manager will monitor the Registered Dietitian's recommendations and cross reference to the nutritional care plan and nutritional observation of the patients 3x a week for 4 weeks; then 2x a week for 2 weeks; then 1x a week for 2 weeks and 1x a month for 6 months. Results will be reviewed by the Director of Nursing and presented in the Performance Improvement meeting /QA for 6 months or until 100% compliance is achieved on the audit tool. Subsequent plans of correction will be developed and implemented as deemed necessary.</p>	

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	<p>P.M., the Social Service Assistant #1 indicated the Psychiatric Hospital recommendations were not on the care plan or Behavior/Intervention Record. She further indicated the she was responsible for starting the Behavior/Intervention Monthly Flow Records, and care plans for anti-anxiety, anti-depressants and anti-psychotic medication for Resident #3.</p> <p>B.2. On 4-2-15 at 3:28 P.M., a review of the clinical record for Resident #81 was conducted. The record indicated the resident was admitted, on 7-8-14 and readmitted on 12-30-14, after an admission to a local psychiatric hospital. The resident's diagnoses included, but were not limited to: senile dementia with behaviors and delusions.</p> <p>The current Medication Administration Record indicated the resident was being administered the following medications: *Klonopin 0.25 milligrams (mg) at HS (bed time) for dementia behavioral disorder *Seroquel 12.5 mg at 8 A.M. and 2 P.M., Give 25 mg at HS for aggression/delusion.</p> <p>A care plan, dated 9/30/15, indicated the resident was at risk for adverse effects related to psychotropic drug use. The</p>				

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	<p>interventions were: administer drugs as ordered and AIMS (Abnormal Involuntary Movement Scale) assessment per facility policy, quarterly and as needed.</p> <p>The January 2015 Behavior/Intervention Monthly Flow Record indicated the nurse documented the resident had no behaviors nor side effects for the months of January, February and March 2015. In February. Delusions was added to the Behavior/Intervention Monthly Flow Record and the resident had no record of any delusions in the month of February and had only one delusional episode, documented on 3/15/15 on the day shift , and redirection was effective. There were no other notations in the nursing notes or flow sheet regarding the type of delusions. The Behavior Monthly Flow Records for January, February and March did not contain documentation for the monitoring of behaviors or side effects for the resident's use of the Klonopin.</p> <p>On 4/6/15 at 4:02 P.M., the DON provided a policy titled "Interdisciplinary Care Plan," dated 6/17/2008, and indicated "...The Social Services staff communicate identified and psychosocial problems, needs, and concern to the ICP [Interdisciplinary Care Plan] team for inclusion in the care plan...The Social</p>			

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	<p>Services staff contribute specific approaches inclusive of social services methods and techniques to address problems, needs, and concerns identified by the ICP team. The approaches incorporate resident strengths and are developed to enable residents to meet specific goals."</p> <p>On 4/7/15 at 10:15 A.M., an interview was conducted with the and the Social Service Assistant #1 (SSA) . The SSA #1 indicated the resident had not been observed nor monitored for the use of the antipsychotic medication seroquel during the month of January. The SSA #1 further indicated during a Behavior Management Meeting in January it was discovered the resident did not have a Behavioral/Intervention Monthly Flow Record for the use of seroquel and it was added in February. The SSA #1 indicated the klonopin did not have a Behavioral/Intervention Monthly Flow Record during the course of the medications use in January, February and March of 2015.</p> <p>On 4-7-15 at 11:56 A.M., the DON provided a policy titled "Resident Care Plan," dated 12/2008, and indicated the policy was the one currently use by the facility. The policy indicted "...Resident Care Plan Definition: A brief written</p>			

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	<p>portrait of the resident and an individualized guide of the nursing care needed...4. Methods, approaches, or plan: description of what is actually going to be done for, to or with the resident in order to achieve the goals. 6. Review & evaluation a. This may state progress made and goals continued. b. May show no progress and change of approach. c. May show accomplishment of short term goal and new goal and approach...7. Care plan identifies the patient/resident problem, where you are with a resident, where you are going (goals), and how you are going to get there (plan/approach)...."</p> <p>C.1. On 4/2/15 at 10:19 A.M., Resident #79's clinical record was reviewed. Resident #79 was admitted to the facility on 9/30/14 with the diagnoses, including but not limited to, left hip fracture and repair, atrial fibrillation, congestive heart failure, peripheral vascular disease, dementia, history of stomach cancer resection and coronary bypass graft.</p> <p>A physician order, dated 9/30/14, indicated "...mirtazapine [Remeron] 7.5 mg (milligram) 1 tab daily for appetite stimulant...."</p> <p>A physician order, dated 11/24/14, indicated "...Increase Remeron to 15 mg</p>			

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	<p>change time to HS [hours sleep]."</p> <p>The quarterly MDS (Minimum Data Set) assessment, completed on 12/30/14, indicated Resident#79 had these active diagnoses: anemia, hypertension, PVD (peripheral vascular disease), hip fracture, dementia, anxiety and depression. The assessment further indicated the resident was currently taking anti-anxiety, antidepressant and anticoagulant medications.</p> <p>A nursing home worksheet, dated 2/26/15, indicated assessment and plan: insomnia continue Remeron. There was no mention of insomnia in the diagnosis list and no care plan for insomnia.</p> <p>The electronic care plans for nutrition documented the use of vitamin supplements and Med pass tid (three times daily). There was no documentation about the use of Remeron as an appetite stimulant.</p> <p>During an interview on 4/6/15 at 11:38 A.M., the Dietician indicated Resident #79 was admitted in September on Remeron as an appetite stimulant. She further indicated the resident did not have a care plan to address the use of Remeron as an appetite stimulant.</p>			

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F 323 SS=D Bldg. 00	<p>On 4/7/15 at 9:27 A.M., review of the current policy titled, "Interdisciplinary Care Plan," received from the Director of Nursing, indicated "...The ICP was reviewed at least quarterly to evaluate effectiveness and was revised/updated as necessary to address resident needs in accordance with the most current assessment...."</p> <p>3.1-35(d)(2)(B)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review the facility failed to ensure the resident environment was free of hazardous chemicals and hygiene items on 1 of 5 nursing units.</p> <p>Finding includes:</p> <p>On 4/1/15 at 8:55 A.M., Resident #28's room was observed to have Efferent tablets and multiple hygiene times stored in a bin and sitting out on a low top dresser in her room.</p> <p>On 4/7/15 from 9:05 A.M. to 11:30</p>	F 323	<p><u>F- Tag 323 Related to Hazardous Material</u></p> <p><i>What Corrective action will be accomplished for those residents found to be affected by the deficient practice?</i></p> <p>The Social Service Director immediately met with resident #28 and #27 and explained the safety concerns related to hazardous items. Residents gave permission to remove the Hazardous items. Resident #28 and roommate #27 were kept safe. Families were notified as both residents have periods of confusion. Immediately a letter was send out to inform</p>	05/07/2015

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	<p>A.M., an environmental tour was conducted of the facility with the Maintenance Director, the Assistant Maintenance Director and the Administrator, during which the following was observed:</p> <p>At 11:00 A.M., an observation of Resident # 28's room indicated the following personal care items located in a bin that was stored on a low dresser none of the personal care items were labeled. The bin contained 2 boxes of Efferent Antibacterial Denture Cleanser tablets. The warning label on the boxes indicated " Caution: Keep out of reach of children. Do not put tablets or solution directly in mouth." In addition there was a can of Aussie instant freeze hair spray. The warning label indicated "Flammable do not use near flame or while smoking use near ventilated areas avoid spraying in eyes." There was also Aveeno daily moisturizing lotion. The warning label indicated "For external use only." There were 2 bottles of Aloe Vesta level 2 Skin Conditioner and Skin Protectant. The warning label indicated "For external use only." In addition, there was Equate Moisturizing after sun lotion. The warning label indicated "For external use only. Keep out of reach of children. Avoid contact with eyes and eyelids."</p>		<p>families and residents of the importance of proper storage related to hazardous chemicals and hygiene products.</p> <p>How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</p> <p>Full house audit of hazardous chemical and hygiene products. An educational letter was sent to families and residents. Angel care staff will provide residents the option of storage bags, containers, or baskets to keep items in safe area and will assist with organization of items.</p> <p>What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <p>Nursing education done by Director of Nursing or designee. The educational letter to families and residents will be placed in the new admission packet. An angel care audit will be implemented.</p> <p>How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <p><u>Interdisciplinary team/ angels</u> to monitor 3x a week for two weeks, then 2x a week for 1 month then 1x a week for 6 months. Audits and system components will be reviewed</p>	

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	<p>At 11:30 A.M., an observation of Resident #28's bedside night stand, indicated the following items stored on the stand unlabeled on a bedside night stand:</p> <p>*Modesa Fresh Antibacterial Hand sanitizer. The warning label indicated "For external use only. Flammable keep away from children."</p> <p>*Aloe Vesta level 1 cleanser body wash and shampoo. The warning label indicated "For external use only."</p> <p>During an interview conducted with the Administrator, at this time, the Administrator indicated that the personal care items should be marked/labeled and placed in a baggy and then stored in a drawer.</p> <p>On 4/7/15 at 3:10 P.M., review of the current policy titled, "Keeping a Resident's room in order," received from the Marketing Director, indicated "...15. All personal items, e.g. razors, hairbrushes, combs, and toothpaste MUST be marked with the resident's name...."</p> <p>Observation of Resident #28's roommate Resident #27, on 03/31/15, indicated Resident #27 was confused, did not remember what she had eaten in the past day, could not recall where she was from, and did not recall where she now lived.</p>		<p>in the Performance Improvement meeting /QA for 6 months or until 100% compliance is achieved. Subsequent plans of correction will be developed and implemented as deemed necessary.</p>	

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F 329 SS=D Bldg. 00	<p>She was noted to be able to get herself out of her bed.</p> <p>3.1-45 (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 contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, record review and interview the facility failed to ensure there were adequate indications to support the use of antipsychotic medications for 2 of 5 residents reviewed for unnecessary medication use. (Resident #3 and Resident #81)</p>	F 329	<p>F- Tag 329 Related to Psych Meds</p> <p>What Corrective action will be accomplished for those residents found to be affected by the deficient practice? The psychiatric notes for resident #3 were immediately reviewed and</p>	05/07/2015

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	<p>Findings include:</p> <p>1. On 4/7/15 at 2:33 P.M., a review of the clinical record for Resident #3 was conducted. The record indicated the resident was admitted, on 2/17/15 and readmitted on 3/24/15, after an admission to a local psychiatric hospital.. The resident's diagnoses included, but were not limited to: dementia, depression, anxiety and fatigue.</p> <p>The admission orders, dated 2/19/15, indicated the resident's medication included but was not limited to: Chlordiazepoxide (Librium) 25 milligrams (mg) twice a day (BID) for depression with anxiety. The readmission orders, dated 3/24/15, indicated the resident's medication included but was not limited to: Buspar 10 mg three times a day (TID) for anxiety, Remeron 7.5 mg at bedtime for depression and Zyprexa (antipsychotic) 2.5 mg at bedtime for delusions.</p> <p>A order request/notification form, dated 2/20/15, indicated the resident was increasingly agitated, becoming physically aggressive with staff-scratching and hitting staff, with increased confusion. A new order was obtained for Buspar 7.5 mg BID. On</p>		<p>implemented into her care plan and behavior monitoring.</p> <p>#81 no longer resides in the facility and discharged the date of survey (d/c 4/1/15)</p> <p>How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</p> <p>Social Services Director (or designee) will complete a full house audit to ensure all psychiatric medications have a proper diagnosis and are being monitored for the associated behaviors and side effects.</p> <p>What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <p>Social Services Director will implement new audit tool. A full house audit will be done to ensure consistency with psychiatric diagnosis, psychiatric medication, care plans, and monitoring. The Social Services Director will receive training on how to identify targeted behaviors, implement an individualized care plan, and implement an individualized behavior monitoring system by the consultant or designee. The Director of Nursing and Social Services Director or designee will develop a systematic agenda for the behavior management meeting. The Social</p>	

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	<p>3/9/15, an order was obtained to transfer the resident to a local psychiatric hospital.</p> <p>A Psychiatric Progress Notes, dated 3/2/15, indicated resident strongly engaged in exit seeking behaviors, displayed as great amount of confusion, and had been engaging in frequent combative behaviors. The physically aggressive/combative behaviors reportedly occurred mostly in the evenings. Resident was a candidate for psychotherapy and behavior management.</p> <p>A discharge summary indicated the resident had a stay at a local psychiatric hospital from 3/9/15 thru 3/24/15. Upon admission the summary indicated the resident was agitated, confused, exit seeking, wanting to work in the yard, and aggressive with other patients. The summary indicated the resident would be discharged back to facility with recommendations to follow up with outpatient psychiatric care. During the adjustment phase, the return to the facility, the patient may become slightly more confused, which may lead to some anxiety and agitation. If this does occur, it is recommended that the staff remove the patient to a quiet area to reduce stimuli, and offer food, fluids, and</p>		<p>Services Director or designee will conduct staff education on behaviors/ dementia/ behavior monitoring.</p> <p>How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <p>The Social Service Director (or designee) will audit orders, 24 hr report sheets for new psych meds, new psych dx and inpatient stays cross referencing to the care plans and behavior monitoring flow record 3x a week for 4 weeks; then 2x a week for 2 weeks; then 1x a week for 2 weeks and 1x a month for 6 months. Audits and system components will be reviewed in the Performance Improvement meeting /QA for 6 months or until 100% compliance is achieved. Subsequent plans of correction will be developed and implemented as deemed necessary.</p>	

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	<p>toileting. It was also recommended the resident does not have a gradual dose reduction of any of her antipsychotic for the next 6 months.</p> <p>The Behavior/Intervention Monthly Flow Record for February 2015 indicated the facility was monitoring for the behavior-wandering with interventions to redirect, validate and encourage activities. There was no documentation of monitoring the side effects nor behaviors associated with the use of the anti-anxiety medications Librium or Buspar. There was no monitoring or interventions for the aggression/combative behaviors the resident was experiencing per the psychiatric note above.</p> <p>Behavior/Intervention Monthly Flow Record for March of 2015 indicated resident was monitored for a behavior of restlessness and side effects with the use of Buspar an anti-anxiety medication. In addition, the resident was monitored for a behavior of wondering and side effects with the use of librium. The Behavior/Intervention Monthly Flow Record for April indicated the facility was monitoring behaviors of "paranoid delusions" and side effects with the use of zyprexa for depression. A behavior of "wandering" related to anxiety for the use of buspar and a behavior of "isolation" related to depression and the use of</p>			

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	<p>zoloft. All three behaviors had the same interventions: encourage activities, validate, and identify triggers. Wandering had an additional intervention of redirect.</p> <p>A care plan, dated 2/18/15, for "Behavior" indicated the resident had a behavior problem related to physically abusive, wandering and resists care. On 3/9/15, an additional problem of intrusive wandering was added to the care plan. The interventions included but were not limited to: address wandering by walking with resident, redirect from inappropriate areas, engage in diversion activity, provide safe wandering, wander guard, approach in calm manner, divert attention and remove from situation. There was no plan of care for the use of an antipsychotic, anti-anxiety or antidepressant medication. There was no specific care plan for the targeted behaviors of delusions, agitation and anxiety with no clear interventions to address the resident's agitation nor anxiety issues, as directed by the summary from the psychiatric hospital.</p> <p>On 4-7-15 at 4:24 P.M., the resident was observed to have a wanderguard placed on her left ankle.</p> <p>During an interview, on 4-7-15 at 4:32</p>			

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	<p>P.M., the DON (Director of Nursing) indicated the nurses do not add/or start the Behavior/Intervention Monthly Flow Records, the Social Service Director would be responsible to add it. The nurses would be responsible to document on each shift any behaviors, interventions, and side effects noted with the use of antipsychotic medications.</p> <p>During an interview, on 4/7/15 at 4:46 P.M., the Social Service Assistant #1 indicated the Psychiatric Hospital recommendations were not on the care plan or Behavior/Intervention Record. She further indicated she was responsible for starting the Behavior/Intervention Monthly Flow Records, and care plans for anti-anxiety, anti-depressants and anti-psychotic medication for Resident #3.</p> <p>2. On 4-2-15 at 3:28 P.M., a review of the clinical record for Resident #81 was conducted. The record indicated the resident was admitted, on 7-8-14 and readmitted on 12-30-14, after an admission to a local psychiatric hospital. The resident's diagnoses included, but were not limited to: senile dementia with behaviors, hypertension, depressive disorder and delusions.</p> <p>The current Medication Administration</p>						

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	<p>Record indicated the resident was being administered the following medications:</p> <ul style="list-style-type: none"> *Klonopin 0.25 milligrams (mg) at HS (bed time) for dementia behavioral disorder. *Paxil 20 mg daily for depression. *Seroquel 12.5 mg at 8 A.M. and 2 P.M., Give 25 mg at HS for aggression/delusion. <p>A care plan for problem of sexual inappropriate behavior and resident isolated self in his room, revised on 10/27/14, was reviewed. The interventions included but were not limited to: intervene as needed to protect the rights and safety of others, approach in a calm manner, divert attention, investigate/observe need for psychiatric support, provide services, invite/support activity programs, provide opportunities for positive interaction and monitor behaviors/moods. Another care plan dated 9/30/14 indicated the resident was at risk for adverse effects related to psychotropic drug use. The interventions were: administer drugs as ordered and AIMS (Abnormal Involuntary Movement Scale) assessment per facility policy, quarterly and as needed. A care plan for diagnosis of depression, dated 11/28/14, was reviewed. The interventions included: encourage and allow open expression of feelings and encourage</p>			

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	<p>frequent contact with family and friends, if desired.</p> <p>A review of a local neuropsychiatric hospital indicated the resident was admitted on 12/15/14 from the facility. The admitting diagnosis was organic psychosis w/behavioral disturbances physical and verbal. Resident was discharged back to the facility on 12/30/14.</p> <p>The January 2015 Behavior Monthly Flow Record indicated the resident was being monitored daily, each shift for isolation, attention seeking and sexually inappropriate behaviors. The form indicated the nurse documented the resident had no behaviors nor side effects for the month of January, February and March for 2015 related to the behaviors and use of an antidepressant medication called paxil. In February, delusions were added to the Behavior Monthly Flow Record and the resident had no record of delusions in the month of February. The resident had one delusion on 3/15/15 during the day shift and redirection was effective. There were no other notations in the nursing notes or flow sheet regarding the delusion. The Behavior Monthly Flow Records for January, February and March did not contain documentation for the monitoring of</p>			

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	<p>behaviors or side effects for the resident's use of the Klonopin.</p> <p>The Quarterly Minimum Data Set (MDS) Assessment, dated 2/24/15, indicated the resident had a Brief Interview Mental Status (BIMS) score of 12 (cognition moderately impaired). The MDS assessment further indicated the resident had the following active diagnoses: psychiatric mood/disorder, anxiety, and depression and received an antipsychotic, anti-anxiety and antidepressant medications. The psychosis section indicated the resident had no delusions nor behaviors.</p> <p>On 4/7/15 at 10:15 A.M., an interview was conducted with the Director of Nursing (DON) and the Social Service Assistant #1 (SSA). The SSA #1 indicated the resident had not been observed nor monitored for the use of the antipsychotic medication Seroquel, during the month of January. The SSA #1 further indicated during a Behavior Management Meeting in January it was discovered the resident did not have a Behavioral Monthly Flow Record for the use of seroquel and one was added in February. The SSA #1 indicated Klonopin did not have a Behavioral Monthly Flow Record during the course of the medication's use. The DON</p>			

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	<p>indicated there was no GDR (Gradual Dose Reduction) completed to date on the antipsychotic medications started on the resident after his readmission to the facility on 12/30/15. She further indicated there were no GDR recommendations from the pharmacist to date and the resident was no longer residing at the facility.</p> <p>On 4/7/15 at 10:25 A.M., the DON provided two policies one titled "Antipsychotic Drug Protocol", dated 6/26/2006, and "Anti-anxiety Drug Protocol", dated 6/28/2006. The DON indicated the policies were the ones currently used by the facility. Both policies indicated "...8. Dose reduction will be considered as soon as behavior problems appear under control, with the goal of eventual discontinuation of the drug...."</p> <p>During an interview, on 4/7/15 at 2:25 P.M., the MDS Coordinator #2 indicated she had no documentation or diagnosis for the anti-anxiety medication Klonopin. She may have included anxiety disorder in the MDS quarterly assessment, on 2/24/15, due to resident receiving an anti-anxiety medication. She did not explore further to see if the resident had a care plan for the use of an anti-anxiety medication.</p>						

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F 428 SS=D Bldg. 00	<p>3.1-48(b)(2)</p> <p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on record review and interviews, the facility failed to ensure the physician responded timely to a pharmacist recommendations for 1 of 5 residents reviewed for unnecessary medications. (Resident #8)</p> <p>Finding includes:</p> <p>The clinical record for Resident #8 was reviewed on 04/02/2015 at 2:10 P.M. Resident #8 was admitted to the facility on 02/08/10 and readmitted on 10/23/13 with diagnoses, including but not limited to, diabetes mellitus.</p> <p>The current physician's orders for medication for Resident #8 included Novulin R insulin to be given on a sliding scale.</p>	F 428	<p><u>F-Tag 428 Related to Drug Regimen</u></p> <p><i>What Corrective action will be accomplished for those residents found to be affected by the deficient practice?</i> MD was contacted and pharmacy recommendation completed.</p> <p><i>How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</i> Audit of Pharmacy recommendations for past 90 days to ensure recommendations were followed. All residents with pharmacy recommendations have the potential to be affected.</p> <p><i>What measure will be put into</i></p>	05/07/2015

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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF ROCHESTER			STREET ADDRESS, CITY, STATE, ZIP CODE 827 W 13TH ST ROCHESTER, IN 46975		
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F 431 Bldg. 00	<p>The most recent pharmacy review was completed on 02/19/15. The pharmacist had made a recommendation to consider changing the Novulin R sliding scale insulin to a Novolog insulin due to its shorter duration of action and the reduced risk of hypoglycemia 2 - 5 hours after administration. The bottom of the form for the physician response was noted to be blank. The Director of Nursing indicated she would have to resend the form to the physician.</p> <p>During an interview on 04/07/15 at 3:05 P.M., the Director of Nursing indicated the facility had no policy and/or procedure regarding the physician response to pharmacy recommendations. The Director of Nursing indicated she would consider a response obtained within two weeks as a timely response. She indicated the pharmacy she had queried indicated they would consider a response within 30 days as timely.</p> <p>3.1-25(j)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p>		<p>place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <p>Director of Nursing/designee will audit pharmacy recommendations monthly to ensure physicians complete recommendations</p> <p>How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <p>Director of Nursing or designee will review pharmacy recommendations monthly for completion and will review during QA. Audits and system components will be reviewed in the Performance Improvement meeting /QA for 6 months or until 100% compliance is achieved. Subsequent plans of correction will be developed and implemented as deemed necessary.</p>		

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	<p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview and record review, the facility failed to ensure expired vials of insulin were removed from the medication cart and disposed of according to facility policy. This one of five medication carts observed for</p>	F 431	<p><u>F- Tag 431 Drug Records and Label</u></p> <p>What Corrective action will be accomplished for those residents found to be affected by the deficient practice?</p>	05/07/2015

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	<p>medication storage. (West Hall Medication Cart)</p> <p>Finding includes:</p> <p>On 3/31/15 at 1:55 P.M., the West Hall Medication Cart was observed for Medication Storage accompanied by RN #25. The following medication were noted to be stored in the medication cart ready for use:</p> <p>*For Resident #89: Levemir (antidiabetic medication) 100 units/ml (milliter) vial, with an open date of 2/12/15. A label on the medication indicated do not use after 3/26/15.</p> <p>*For Resident #50: Lantus insulin (antidiabetic medication) 100 units/ml, with an open date of 2/24/15. A label on the medication indicated do not use after 3/24/15.</p> <p>During an interview at this time, RN #25 indicated these medications should not be in the medication cart.</p> <p>On 4/2/15 at 10:00 A.M., the Director of Nursing provided the policy for Medication Administration, revised date 06/06, and indicated the policy was the one currently being used by the facility. The policy indicated, "Outdated, contaminated, or deteriorated medication</p>		<p>All carts were audited for expired or mislabeled medications.</p> <p>How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</p> <p>All other residents on insulin have the potential to be affected. A full house audit of the carts was completed.</p> <p>What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <p>Director of Nursing or designee will train nursing staff on proper insulin labeling, storage and expiration dates.</p> <p>How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <p>Med carts to be audited 3x week for 4 weeks, 1x weekly x4 weeks, biweekly x 4 weeks, and monthly thereafter. The pharmacist will review monthly. Audits and system components will be reviewed in the Performance Improvement meeting /QA for 6 months or until 100%</p>	

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	and those in containers that are cracked, soiled, or without secure closures are immediately removed form stock, locked in the medication room in a segregated area, and disposed of according to procedure for medication destruction...." 3.1-25(o)		compliance is achieved. Subsequent plans of correction will be developed and implemented as deemed necessary.		