

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155586	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/12/2015
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NAME OF PROVIDER OR SUPPLIER LUTHERAN LIFE VILLAGES	STREET ADDRESS, CITY, STATE, ZIP CODE 6701 S ANTHONY BLVD FORT WAYNE, IN 46816
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included a state Residential Licensure survey.</p> <p>This visit included the Investigation of Complaint IN00162545.</p> <p>Complaint IN00162545: Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey Dates: February 3, 4, 5, 6, 9, 10, 11, and 12, 2015</p> <p>Facility number: 000283 Provider number: 155586 AIM number: 100275020</p> <p>Survey Team: Virginia Terveer, RN, TC (2/3, 2/4, 2/5, 2/6, 2/10, 2/11, 2/12, 2015) Sue Brooker, RN Julie Call, RN (2/3, 2/4, 2/5, 2015) Martha Saull, RN Angela Strass, RN (2/3, 2/4, 2/5, 2/6, 2015)</p> <p>Census bed type: SNF: 3 SNF/NF: 112</p>	F000000	<p>Please accept this as our credible allegation of compliance to our recent ISDH annual survey. Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or the corrections set forth on the statement of deficiencies.</p> <p>This Plan of Correction is prepared and submitted because of requirements under State & Federal Law. We are also scanning in several attachments as supportive documentation. We respectfully request the opportunity to have POC reviewed / accepted / approved with paper compliance if possible</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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F000282 SS=D	<p>Residential: 51 Total: 166</p> <p>Census payor type: Medicare: 16 Medicaid: 70 Other: 29 Total: 115</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on February 16, 2015 by Randy Fry RN.</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. Based on observation, interview and record review, the facility failed to ensure a back brace, which was ordered by a physician, was worn as ordered for 1 of 1 resident reviewed for back braces. (Resident # 24)</p> <p>Findings include: On 2/5/15 at 2 p.m. the clinical record of</p>	F000282	Please accept this as our credible allegation of compliance to our recent ISDH annual survey. Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or the corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of	03/14/2015

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	<p>Resident #24 was reviewed. Diagnoses included, but were not limited to, the following: osteoarthritis, late effect of stroke, major depressive disorder, hemiplegia affecting non dominant side and low back pain syndrome. The MDS (minimum data set assessment) dated 9/25/14 indicated the following: cognition indicated was moderately impaired; transfer required extensive assistance for self performance and 2 plus person physical assistance for support; height was 5 feet 6 inches and weight was 274 lbs. (pounds); was on scheduled pain medication regimen; yes to presence of pain; frequently had pain; pain limited her day to day activities; and pain was very severe. The MDS dated 12/25/14 indicated the following: cognition was moderately impaired; transfer required extensive assistance for self performance and 1 person physical assist for support; weight was 270 lbs; was on a scheduled pain medication regimen; no pain present.</p> <p>A physician order dated 12/19/14 indicated: "Wear back brace when up only. Dx (diagnosis) back pain."</p> <p>A plan of care, which addressed the problem of "Having back pain" was dated 12/22/14. Approaches included, but were not limited to, the following: "To wear</p>		<p>requirements under State & Federal Law. We are also scanning in several attachments as supportive documentation. F282 Corrective Actions to be accomplished for those residents affected: The facility contacted SRT(Superior Rehabilitation Techniques), the company to repair or replace this back brace, on 2-11-2015. On 2-13-2015, facility contacted SRT again to explain the situation; and the representative shared that the back brace is useable through the weekend and that another representative will be out on Monday, 2-16-2015, to thoroughly evaluate the condition of the backbrace. The representative came out to the facility on 2-16-2015; it was determined the back brace needed replaced and SRT replaced the back brace for resident #24 on 2-16-2015, see attached F282-A. Resident #24 is a 2-person transfer; her CNA assignment sheet has been updated along with her careplan to reflect such changes, (see attachment F282-B.) Other residents having the potential to be affected and the corrective actions: The facility has updated their policy and procedure for the use of adaptive equipment, see attachment F282-C. The facility has audited the other residents who have adaptive equipment (6 residents) to ensure the equipment is functioning properly, applied</p>				

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	<p>back brace as ordered."</p> <p>An "OT Evaluation and Plan of Treatment" dated 1/29/15 included but was not limited to, the following: "Diagnoses:...Lumbago (low back pain) syndrome...Short term goals: patient will sit upright in chair with use of adaptive equipment to facilitate correct anatomical alignment for 2 hours w/o sliding or complaints of pain..." Background Assessment: Precautions:...back brace should be on when sitting and standing..." Assessment summary: Impressions: "Clinical Impressions: Patient currently complains of low back pain due to abnormal sitting posture..."</p> <p>On the following dates and times, the resident was observed: On 2/6/15 at 9:06 a.m. the resident was in her room in her wc, no brace was observed on the resident at this time. The black back brace was observed on a stool across the room from the resident On 2/6/15 at 10:21 a.m. the resident was observed in her recliner, with the black, back brace observed on the stool in her room. On 2/6/15 at 1 p.m. the resident was not in her room but the large, black brace type device was observed on the footstool in the resident's room. On 2/6/15 at 2:22 p.m. the resident was</p>		<p>correctly, applied appropriately, etc. See attachment F282-D. The facility reviewed/audited all other residents who utilize adaptable equipment, and found them to be in compliance. Residents utilizing adaptive equipment will continue to be reviewed for appropriateness (including proper functioning and timely application of the equipment) at our weekly facility resident review meetings (held every Thursday @ 1pm) which include all IDT members.</p> <p>What Measures were put into place to ensure this does not happen again: The facility has updated their policy and procedure for the use of adaptive equipment, see attachment F282-C. The facility presented an in-service (see attached XX) on this updated policy to the nurses on 2-16-2015 and another in-service (see attached YY) was presented to the CNA's on 2-26-2015. All residents with adaptive equipment will be reviewed/audited on a daily basis for the next 30 days and weekly thereafter for the next 60 days; monthly thereafter. See attached audit form – F282-D. How the corrective actions will be monitored: The results from the adaptive equipment audit will be reviewed at our weekly resident review meetings and our monthly QA meeting for compliance. Nursing Unit Managers to monitor for compliance and Director of</p>	

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	<p>observed in her room in her recliner with both feet elevated. At the time, the large black brace was observed beside the resident on the table.</p> <p>On 2/9/15 at 11:40 a.m. the resident was not observed in her room and her wc was gone. The black brace device was observed on a stool in the resident's room.</p> <p>On 2/9/15 at 11:50 a.m., the resident was observed in her wc to be coming from the dining room.</p> <p>On 2/10/15 at 11:35 a.m. the OT #1 (Occupational therapist) was interviewed. He indicated the resident had been referred to the Occupational Therapy department for back pain.</p> <p>On 2/10/15 at 11:40 a.m. the OT #1 was interviewed. He indicated he had seen the resident the week before 1/29/15 and the resident's back brace was broken at that time. OT #1 indicated he does not document on the wearing of the brace.</p> <p>On 2/10/15 at 11:45 a.m. CNA #7 was interviewed. She indicated she was caring for Resident #24 today. She indicated the resident has a back brace but refused to wear it the past few days. She indicated one string on the brace was broken. She indicated when the brace is in place it goes over the residents'</p>		<p>Nursing will monitor for ongoing compliance. Please find the following attachments: F282-A Documentation regarding the replaced back brace. F282-B Resident#24 updated CNA assignment sheet and updated careplan documentation. F282-C Policy and procedure for Adaptive Equipment F282-D Adaptive equipment audit form XX Nurse In-service YY CNA In-service</p>	

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	<p>clothing and is visible. She indicated when in place on the resident, the brace is positioned underneath the resident ' s breasts, down the abdomen and was similar to a back support. The CNA indicated the resident wore the brace last Friday, 2/6/15. CNA #7 indicated she does not document if the resident wears the brace or not but that the nurses do. At the time, LPN #8 was interviewed. She indicated nurses document in the progress notes if the resident wears the brace or not. LPN #8 and CNA #7 indicated the order "back brace on when up " indicated when the resident was out of bed, for example in the recliner and/or the wheelchair, she was to have the back brace on "to give her more support."</p> <p>On 2/10/15 at 1:30 p.m. the nurse ' s progress notes were reviewed. The most current documentation of the back brace, was dated 1/17/15 and included but was not limited to, the following: "...Resident complaint with back brace..." Documentation was lacking in the nurses notes of the brace being broken and/or the resident refusing to wear the back brace.</p> <p>On 2/11/15 at 3 20 p.m. the DON (Director of Nursing) was interviewed. She indicated it was the nurse ' s responsibility to ensure the</p>			
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F000323 SS=D	<p>documentation of the resident's brace and that the resident's brace was on.</p> <p>3.1-35(g)(2)</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.</p> <p>A. Based on observation, interview and record review, the facility failed to ensure adequate supervision and assistance was provided to prevent falls for 1 of 3 residents reviewed for falls. (Resident # 24)</p> <p>B. Based on observation, interview and record review, the facility failed to ensure water temperatures in resident care areas were maintained at a safe temperature after adjustments were performed on the facility mixing valve for on 2 of 4 resident occupied halls observed in the facility.</p> <p>Findings include:</p> <p>A. On 2/5/15 at 2 p.m. the clinical record of Resident #24 was reviewed.</p>	F000323	Please accept this as our credible allegation of compliance to our recent ISDH annual survey. Submission of this Plan of Correction doesnot constitute an admission or agreement by the provider of the truth of facts alleged or the corrections set forth on the statement of deficiencies. This Plan of Correction isprepared and submitted because of requirements under State & FederalLaw. We are also scanning in severalattachments as supportive documentation. F323 Corrective Actions to beaccomplished for those residents affected: A, The nurse staff were presented with an in-service (see attached XX) on 2-16-2015 regarding the updated Gait Belt policy/procedure and the importance/safety of utilizing gait belts when transferring residents.	03/14/2015

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	<p>Diagnoses included, but were not limited to, the following: osteoarthritis, late effect of stroke, hemiplegia affecting non dominant side and low back pain syndrome. The MDS (minimum data set assessment) dated 9/25/14 indicated the following: cognition indicated was moderately impaired; transfer required extensive assistance for self performance and 2 plus person physical assistance for support; height was 5 feet 6 inches and weight was 274 lbs. (pounds); number of falls since admission or prior assessment: 2 or more; the MDS dated 12/25/14 indicated the following: cognition was moderately impaired; transfer required extensive assistance for self performance and 1 person physical assist for support; weight was 270 lbs; number of falls since admission or prior assessment: 2 or more.</p> <p>A physician order, dated 9/23/14 indicated the following: " to use chair alarm (alarm used to sound to alert staff that resident is getting up) in recliner and wheelchair (WC)."</p> <p>Nurses notes dated 2/2/15 at 2:02 p.m. included, but were not limited to, the following: "did find resident in room trying to transfer herself."</p> <p>On 2/9/15 at 10 a.m. the DON (Director</p>		<p>The CNA's were presented with an in-service (see attached YY) on 2-26-2015 regarding the updated Gait Beltpolicy/procedure and the importance/safety of utilizing gait belts when transferring residents. Please find an updated Gait Beltpolicy/procedure in attachment F323-BC. Resident #24 is a 2-person transfer; her CNA assignment sheet has been updated along with her careplan to reflect such changes, see attachment F323-AA. B, The Maintenance Department had been working on adjusting some water temperatures in the facility on Monday, 2-2-2015, that were around 110 F degrees (they were within normal limits of the regulation); however, the facility works to keep them around the 115 F degree mark. The facility had slightly adjusted the mixing valve on Monday evening and were scheduled to check the water temperatures on Tuesday morning. The Maintenance Department was actively working on this issue. The facility had contacted their plumbing vendor, who was present in the facility on 2-3-2015 through 2-5-2015, to assure the water temperatures were accurate and the mixing valves were working correctly, etc. The water temperatures in question were resolved on Tuesday, 2-4-2015; as the Maintenance department readjusted the mixing valve. The</p>		

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	<p>of Nursing) provided the "Fall Tracker" records for the resident's falls from November 2014 to present. They included, but were not limited to, the following: 11/15 /14 at 11:15 a.m.: "...CNA (certified nursing assistant) transferring res (resident) off toilet into her w/c (wheelchair). Res asked if she could sit down, CNA stated "not yet." Res. sat down anyways and fell...Intervention to prevent further falls: use gait belt with transfers..."</p> <p>1/1/15 at 5:50 p.m.: "...observed on floor, resident reported she was trying transfer herself from w/c to recliner...Intervention to prevent further falls: alarm in place to w/c...Resident is non compliant with waiting for staff to transfer..."</p> <p>1/21/15 at 12:45 p.m.: "...transferring to bathroom with CNA and res reported she was "going to fall" CNA lowered res to the floor, gait belt in place. Intervention to prevent further falls...currently receiving PT (physical therapy) 5 x week...Resident has multiple behaviors. Attention seeking, sees psych (psychiatric) NP (nurse practitioner) for med (medication) adjustments..."</p> <p>1/22/15 at 3:25 p.m.: "CNA assisting resident to her recliner. Resident reported her legs "buckled." Res lowered to the floor: Intervention to prevent</p>		<p>ISDH surveyors In conjunction with the LLV Maintenance Staff took temperatures together as indicated on the 2567 report. The Maintenance Department continued to adjust the water mixing valve until the water temperatures were constant,consistent and within the accepted threshold of 101F degrees to 120Fdegrees. The water temperature on 2-4-2015 in room 406 @ 12:36pm was 114.1 F degrees; and for room 306 was 108.1 F degrees @ 1:29pm. See attachments F323-E, F323-H. Other residents having thepotential to be affected and the corrective actions: A, To assure the staff is following the Gait Belt policy/procedure, the nursing staff are being monitoredfor compliance regarding the use of gait belts during transfers, observationthat the CNA has a gait belt with them at all times and that the gait belt isfunctioning appropriately. The facility is doing this through a review/audit – see attached F323-CC. The Nurse management team will audit at least 5 CNA's daily for 1 month (2-23-2-15 through March 31, 2015); and then 5 CNA's weekly for 1 month (April 1, 2015 through April 30, 2015); followed by a monthly audits thereafter – continuing to audit at least 5 CNA's each month. The results will be reviewed/discussed in our monthly QA meetings. B, The</p>				

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	<p>further falls: Review meds with pharmacist 1/23..."</p> <p>1/27/15 at 8:10 p.m.: "...CNA left bathroom to get gait belt and resident attempted to get herself off toilet...Intervention to prevent further falls: Re-educated CNA to have gait belt on her at all times...Res noncompliant with waiting for staff to assist..."</p> <p>2/6/15 at 1:05 p.m.: "Resident lowered to floor during transfer, res stated her legs were giving out. Gait belt was in place during transfer...Intervention to prevent further falls: 2 person transfer now, OT (occupational therapy) orders rec'd...PT (physical therapy) consult for strengthening...Resident has multiple behaviors, Resident c/o back pain..."</p> <p>On 2/9/15 at 4 p.m. the DON (Director of Nursing) was interviewed. She indicated the resident had "a lot of behaviors" which included some "attention seeking behaviors." The DON indicated that with some of the falls the resident indicated "my legs gave out." The DON indicated it was a consideration of the resident stating "my legs gave out" could possibly be an attention seeking behavior. The DON indicated with the 1/27/15 fall, the resident should not have been left alone in the bathroom and the CNA should have had her gait belt with her at all</p>		<p>Maintenance Department took the water temperatures in every resident room, shower rooms and nursing stations; along with the time the temperature was taken to develop a benchmark of current water temperatures on 2-5-2015. The water temperatures were also taken in accordance with our new policy. See attachments F323-B, F323-D, F323-F What Measures were put into place to ensure this does not happen again: A, To assure the staff are following the Gait Belt policy/procedure, the nursing staff are being monitored for compliance regarding the use of gait belts during transfers, observation that the CNA has a gait belt with them at all times and that the gait belt is functioning appropriately. The facility is doing this through a review/audit – see attached F323-CC. The Nurse management team will audit at least 5 CNA's daily for 1 month (2-23-2-15 through March 31, 2015); and then 5 CNA's weekly for 1 month (April 1, 2015 through April 30, 2015); followed by a monthly audits thereafter – continuing to audit at least 5 CNA's each month. The results will be reviewed/discussed in our monthly QA meetings B, The policy for taking water temperatures in the facility was adapted to reflect additional water temperatures getting tested twice month per our new policy. See attachments F323-B, F323-D.</p>				

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	<p>times. The DON indicated they had considered the resident being a 2 person assist but after the fall on 2/6/15, the resident was changed to a 2 person assist with transfers. The DON indicated at this time, a resident with a fall prevention alarm in place, should not have been left alone in the bathroom and also that the CNA should have had the gait belt with her at all times.</p> <p>On 2/11/15 at 1:20 p.m. the DON provided a copy of the facility policy and procedure for "Fall Program", with a revision date of 10/2014. The policy and procedure included, but was not limited to, the following: "A fall risk assessment will be completed on all residents upon admission, quarterly...and with each fall...each resident that experiences a fall will have an evaluation of their current plan of care within 24 hours. This information will be discussed during the weekly resident review meeting and monthly Quality Assurance meeting...Fall risk scores and risk levels area as follows:...scores of 10 or greater places the resident at high risk for falls..."</p> <p>On 2/11/15 at 1:20 p.m. the DON also provided copies of the resident's fall risk assessments from 1/2/15 - 2/9/15. These assessments all had a risk assessment score which ranged from 14 - 22, which</p>		<p>How the corrective actions will be monitored: A, The results from the gait belt audits will be reviewed at our monthly QA meetings for compliance. The Nurse Managers to monitor for compliance. Director of Nursing will monitor for ongoing compliance. B, The results from our bi-monthly water tests will be reviewed at our monthly QA meetings for compliance. The Maintenance Director and the Administrator will monitor for ongoing compliance. See attachment F323-G; for the initial recordings that will be reported in QA. Please find the following attachments: F323-A Old TELSpolicy on how to take the water temperature with a thermometer. F323-B NewTELS policy on how to accurately take the water temperatures as discussed by Administrator with ISDH Surveyor utilizing a plastic cup. F323-C Old TELS policy on how often we took the water temperatures; 1x a month. F323-D New TELS policy on how often (2x a month), and documenting each location of the water temperatures (6x on each wing) along with the time the temperatures were recorded. F323-E The report from our plumbing vendor, Allied Mechanical dated from 2-3-2015 to 2-5-2015 F323-F The benchmark audit where the facility took water temperatures in every resident</p>				

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	<p>indicated the resident was at high risk for falls.</p> <p>On 2/12/15 at 10:30 a.m. the Unit Manager was interviewed. She indicated the following: with the 11/15/14 fall, the CNA should have already been using a gait belt to transfer the resident. The Unit manager was interviewed at this time as to why the resident was a 2 person assist to transfer for the 9/25/14 MDS assessment and changed to a 1 person assist to transfer for the 12/25/14 MDS assessment. The Unit manager indicated the resident's ability to transfer did change at times, despite her hemiplegia. According the 9/25/14 MDS, the resident was to be a 2 person assist for transfers but the "fall tracker", dated 11/15/14, indicated "CNA transferring res off toilet into her w/c..." Documentation was unclear if two CNAs were assisting the resident or one CNA. At the time, the Unit Manager was also interviewed regarding the 1/27/15 fall. The description of events indicated "...CNA left bathroom to get gait belt and resident attempted to get herself off toilet..." The Unit Manager indicated the CNA should have used a gait belt to transfer the resident from the wc to the toilet and should have already had a gait belt in place when she was placed on the toilet.</p>		<p>room on 2-5-2015.</p> <p>F323-G The water temperature report(reflecting our new policy F323-D), that were taken the week of 2-16-2015; recording the water temps, location and time.</p> <p>F323-H The water temperatures taken in rooms 306 & 406 on 2-4-2015.</p> <p>F323- AA Resident#24 updated careplan</p> <p>F323 – BB Policy / procedure for use of gait belts</p> <p>F323 – CC Gait Belt audit form</p> <p>XX Nurse in-service</p> <p>YY CNA in-service</p>		

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	<p>B. On 2/4/15 at 9:10 a.m. the water temperature in room 408 was tested with an ISDH (Indiana State Department of Health) thermometer with a result of 123 F (Fahrenheit).</p> <p>On 2/4/15 at 9:20 a.m. the water temperature in room 406 was tested with an ISDH (Indiana State Department of Health) thermometer with a result of 137.8 F (Fahrenheit). At this time, the resident in room 406 was observed in her wheelchair in her room sleeping.</p> <p>On 2/4/15 at 9:40 a.m. the Maintenance Supervisor (MS) went to room 406 to test the water temperature in the resident sink with his thermometer. The MS was interviewed at this time and indicated that he normally did not test the water temperatures but his assistant did. At this time, the MS held his thermometer in the stream of water from the faucet and read the temperature at 118.7 F. The MS supervisor was observed to not be holding the tip of the thermometer directly underneath the direct stream of water at the time the temperature was read at 118.7 F. When the MS was made aware of this, he then placed the tip of his thermometer directly underneath the stream of water and the temperature was then read at 120.4 F. The MS was</p>			
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	<p>interviewed and indicated "this room is right off the water heater, this room is usually a little higher." The MS indicated he wanted the water temperature to be 120 F or below. He indicated the 400 hall or D wing and the 300 hall or C wing would have the highest temperatures because they were closest to the water heater. He indicated the water temperatures would be lower the farther away from the hub end of the hall the room was located. Room, 406 was the first resident room closest to the hub area.</p> <p>On 2/4/15 at 9:46 a.m. the water temperature was rechecked in room 406, this time with a drinking cup placed in the base of the sink underneath the stream of water. The temperature was read by the MM with his thermometer at 133.7 F. He indicated he had the maintenance man check the temps yesterday and they were all ok. He indicated he would turn the water temperature down right away as he had never seen the water temperatures that high before. At 9:50 a.m. the water temperature in room 306 in the C hall was also checked. This room is the closest resident room to the water heater in this hall. The water temperature was checked by putting the thermometer in a cup of water underneath the stream of water and the MS read the temperature at</p>			

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	<p>127.2 F. This room however, was unoccupied at the time.</p> <p>On 2/4/15 at 10 a.m. the MS went to turn down the mixing valve in an attempt to lower the water temperatures to an acceptable level.</p> <p>On 2/4/15 at 10:05 a.m. the MA (Maintenance Assistant) was interviewed. He indicated he had checked the water temperatures on 2/3/15 and found them to be low at 105.7 F. He indicated they had never had water temperatures that low so since the plumbers were already in the facility, they had the plumbers look at the mixing valves. The MA indicated the plumbers had completed their work on the mixing valves at approximately 2 p.m. on 2/3/15. The MA indicated it takes awhile for the warmer water to circulate, depending on usage, etc. so he had planned to check the water temperatures the morning of 2/4/15 when he came to work. He indicated that when he arrived at work on 2/4/15, he was assisting a resident with a problem so he didn't get to check the water temperatures as he had planned. He indicated he was unaware of the high water temperatures until it was brought to his attention by the MS. He indicated he was going to check the water temperatures but "you beat me to it." He</p>			

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	<p>indicated the water temperatures are lower the further down the hall they get away from the mixing valve at the hub of the hall C and D wing. The MA also indicated at this time, he is only required to check the water temperatures once a month but he does it twice a month. He indicated they had 2 recirculating pumps down yesterday and this would have affected the water temperatures. He indicated the work on the pumps was completed approximately 2 p.m. - 2:45 p.m. yesterday and the pumps would have been restated at that time.</p> <p>On 2/4/15 at 10:20 a.m. the MS provided copies of the facility water temperature logs 2/2014 to 2/3/2015. They included but were not limited to the following: On 2/3/15 the water temperatures ranged from 105.7 F -109 F on the B wing and had a temperature range of 117.5 F - 110 F on the C wing. On the D wing had a range documented of 115.9 F - 116.4 F.</p> <p>On 2/4/15 at 10:20 a.m. the water temperature logs were reviewed. The most recent log dated 2/3/15 documented a range of numbers for each of the A, B, C and D wings of the facility. Documentation was lacking as to the location of the room the temperatures were taken and or the time of day the temperatures had been taken. The log</p>			

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	<p>dated from 6/23/14 to 1/9/15 listed only one temperature for each of the A, B, C and D wings for the entire month with the exception of October 2014. This month had 3 different temperatures logged but documentation was lacking as to where the temperatures were obtained on each of the wings.</p> <p>On 2/4/15 at 11:15 a.m. the Maintenance Assistant (MA) was interviewed. He indicated he checks the water temperatures in the facility once a month. He demonstrated when he checks the water temperatures, he holds the thermometer vertically, directly in the flow of water to obtain the water temperature. He indicated he does not document the room number he checks monthly on each hall but that he checks the rooms at both far ends of the each hall, then each month after that, he checks one room further into the hall and also alternates the sides of the halls he checks. He indicated he checks at least two room per hall each month. He indicated even though he doesn't document which rooms he checks water temperatures on, he remembers which rooms he did the month prior so he is aware where to begin temperature checks for the next month.</p> <p>On 2/4/15 at 3:28 p.m. the MS was</p>			

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	<p>interviewed. He indicated all the water temperatures checked today have been within normal limits so far since he has started checking them after turning the water temperature down.</p> <p>On 2/6/15 at 1:50 p.m. the Administrator (Adm) was interviewed. He indicated they try to keep the water temps at 115 F and they "were in the process of making it better by turning the mixing valve up a little bit." He indicated they "tweaked the mixing valve just a little bit" and "we do that from time to time." The ADM indicated after the mixing valve was "tweaked" it takes some time for the temperature to change depending on the usage of the water. He indicated that the facility should have checked the water temperatures in the afternoon after adjusting the mixing valve. He indicated monthly, they check the nursing station, 1 room at each end of the hall, 1 on the right and 1 on the left, so this would be three temps in each wing. He said they will now do 4 rooms plus the nursing station (which is in the middle of the hall) and the nursing shower.</p> <p>On 2/9/15 at 1:50 p.m. the Administrator provided a copy of the facility policy and procedure for testing water temperatures. This policy was undated and included, but was not limited to, the following:</p>				

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F000329 SS=D	<p>"Let the water run for at least three minutes before taking your reading...ensure patient room water temperatures are between 105 F and 115 F...check rooms at the end of each wing on a rotating basis...retest as necessary..."</p> <p>3.1-45(a)(2)</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 interview and record review the facility failed to attempt a gradual dose</p>	F000329	Please accept this as our credible allegation of compliance to our recent ISDH annual survey. Submission of this Plan of	03/14/2015			

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	<p>reduction for a psychotropic medication for 1 resident (Resident #106) and anti-anxiety medications for 1 resident (Resident #114) of 5 residents reviewed for unnecessary medication.</p> <p>Findings include:</p> <p>1. Review of the clinical record for Resident #106 on 2/5/15 at 10:38 a.m., indicated the following: diagnoses included, but were not limited to, cognitive deficits and senile dementia with delusional features.</p> <p>A Mood, Behavior and Psychotropic Medication Review Sheet for Resident #106, dated 1/31/13, indicated he received Cymbalta 60 mg (milligrams) BID (twice a day) for dementia with delusions, Risperidone 1 mg BID for dementia with delusions and Risperdal Consta 25 mg/2 ml (milliliters) IM (injection) every 2 weeks for dementia with delusions. The review recommended to decrease the Risperidone to 0.5 mg BID x (times) 30 days.</p> <p>An EMAR (Electronic Medication Administration) record for Resident #106, dated for the month of February 2013, indicated the Risperidone 0.5 mg BID was discontinued on 2/28/13.</p>		<p>Correction doesnot constitute an admission or agreement by the provider of the truth of facts alleged or the corrections set forth on the statement of deficiencies. This Plan of Correction isprepared and submitted because of requirements under State & Federal Law. We are also scanning in several attachments as supportive documentation. F329 Corrective Actions to beaccomplished for those residents affected: Resident #106 medicationswere reviewed again per policy (see attachment F329-A) on 2-5-2015. Facility came to the conclusion that the supportive documentation was lacking to validate the use of the antipsychotic medication in question. On 2-6-2015, Social Services and Nurse Manager contacted the family of resident#106 to set up a careplan meeting to discuss the use of medications. Per the family request, the meeting was held on 2-18-2015 @ 2pm with the family,Nursing, Social Services and Mental Health Professional all present. The family was in agreement to discontinue the antipsychotic medication inquestion; the order was written on 2-18-2015. See attachment f329-B. Resident #114, medicationswere reviewed per policy (see attachment F329-A) on 1-28-2015, with recommendations from the</p>		

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	<p>A Consultation Report for Resident #106, dated 7/31/13 and written by the Consultant Pharmacist, indicated he was receiving Risperdal-Consta for behavioral or psychological symptoms of dementia. The report also requested his Psychiatrist evaluate for a gradual dose reduction (GDR) in the Risperdal Consta. The Psychiatrist declined the recommendation indicating a GDR was clinically contraindicated, "Pt (patient) is high risk of relapse."</p> <p>A Medication Management Progress Note for Resident #106, dated 2/11/14 and written by the Psychiatrist, indicated the continuation of his current medication of Risperdal Consta 25 mg IM q (every) 2 weeks was for relapse prevention.</p> <p>A Mood, Behavior and Psychotropic Medication Review Sheet for Resident #106, dated 2/11/14, indicated there were 2 behaviors since the last date of review on 12/3/13. The review did not indicate he had experienced any delusional symptoms. The review also indicated he received Cymbalta 60 mg BID for dementia and Risperdal Consta 25 mg every 14 days for dementia.</p> <p>A Consultation Report for Resident #106, dated 2/26/14 and written by the</p>		<p>Mental Health Professional to decrease the dosage from BID (0.25mg) to HS (0.25mg) regarding the medication in question. Nursing contacted the family with the new medication order and family strongly rejected the recommendation. On 2-9-2015, Social Services contacted the family to get additional information/examples on the anxiety the family was observing. The family shared a few recent examples. The daughter was still not agreeable to the medication reduction. On 2-20-2015, Social Services set up a careplan meeting with the family to discuss the use of medications and provide additional education on anxiolytic medications per the telephone. During the telephone communication the daughter did not realize that her mother was on two anxiolytic medications and then agreed to decrease the xanax per Mental Health Professional's recommendation from BID 0.25mg to HS 0.25mg. The daughter and Social Services agreeable to monitor any signs or changes in anxiety, mood or inappropriate behaviors for resident #114. Social Services and daughter have established a careplan meeting time/date per the daughter's schedule @ 3-2-2015 @ 10am. The order to reduce the xanax was received on 2-25-2015. See attachment F329C. Other residents</p>		

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	<p>Consultant Pharmacist, indicated he was receiving Risperdal Consta 25 mg q 14 days for behavioral or psychological symptoms of dementia. The report also requested the Psychiatrist evaluate the need for the continued use of Risperdal Consta, perhaps considering a gradual dosage reduction. The Psychiatrist declined the recommendation indicating a GDR was clinically contraindicated, "likely to relapse."</p> <p>A Mood, Behavior and Psychotropic Medication Review Sheet for Resident #106, dated 3/4/14, indicated there were no behaviors since the last date of review on 2/11/14. The review also indicated he received Cymbalta 60 mg BID for dementia and Risperdal Consta 25 mg every 14 days for dementia.</p> <p>Social Service Progress Notes for Resident #106, dated 3/19/14 and 4/30/14, indicated his diagnoses included dementia with delusions. The notes also indicated his medications included Risperdal Consta and Cymbalta. The notes further indicated he was followed by the Psychiatrist regularly and as needed. The notes also indicated the need for Risperdal remained appropriate as his behaviors had been at a minimum and he was at ease around others.</p>		<p>having the potential to be affected and the corrective actions: All residents that receive antipsychotic and anxiolytic medications will be reviewed prior to March 14,2015 for supportive diagnosis and/or supportive documentation. The facility has 26 residents receiving antipsychotic medications and 21 residents receiving anxiolytic medications. All residents receiving either of these medications will be reviewed by March 14, 2015. (see attachment F329-A). What Measures were put into place to ensure this does not happen again: The facility Pharmacy Consultant reviews all residents on a monthly basis and provides recommendations to the facility for residents to be considered for a gradual dose reduction (GDR). Psychotropic medications will continue to be reviewed for appropriateness (including diagnosis and supportive documentation) at our weekly facility resident review meetings (held every Thursday @ 1pm) which includes all IDT members. Facility also conducts a monthly resident behavior meeting (this includes a review of all psychotropic medications) with team members present to include Social Services, Nursing, Mental Health Professional and Pharmacy Consultant. All residents are reviewed at least quarterly – (see attached</p>				

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	<p>A Consultation Report for Resident #106, dated 6/27/14 and written by the Consultant Pharmacist, indicated he had received Risperdal Consta 25 mg q 2 weeks for behavioral or psychological symptoms of dementia since January 2013. The report also requested his Physician evaluate the need for the continued use of Risperdal Consta, perhaps considering a gradual dosage reduction. The Physician declined the recommendation indicating a GDR was clinically contraindicated, "Pt is high risk of relapse."</p> <p>A Social Service Progress Note for Resident #106, dated 8/1/14, indicated he had a diagnosis of dementia with delusional features and was being treated with Risperdal Consta 2.5 mg/2 ml every two weeks. The note also indicated he had a history of becoming angry and exit seeking. The note further indicated he had been without moods/behaviors in the MDS (Minimum Data Set) review period.</p> <p>A Consultation Report for Resident #106, dated 8/14/14 and written by the Consultant Pharmacist, recommended a decrease in Cymbalta from 60 mg BID to 30 mg AM and 60 mg PM, and a decrease in Risperdal Consta 25 mg q 2 weeks. The recommendation was</p>		<p>schedule, F329-D). An all staff in-service will be presented on 2-25-2015 regarding inappropriate/appropriate behaviors connected to anxiety, delusions, hallucinations, paranoia and other signs /symptoms of depression etc. (See attachment ZZ). Additionally, nursing staff and social services staff will be presented with an in-service regarding the corrective actions of F329 on 3-10-2015 and 3-11-2015, (seeattached 329-F). How the corrective actions will be monitored: Social Services will report on resident behaviors, psychotropic medications, etc., comparing our medication usage to state, regional and national averages in our monthly QA. The Pharmacy consultant also reports the facility psychotropic medication usage @quarterly QA Meetings; also comparing to state, regional and national statistics. Social Services Director and Administrator will monitor for ongoing compliance. Please find the following attachments: F329-A Policy and procedure for psychotropic medication review F329-B Notes and Physician order for medication change for resident # 106 F329-C Notes and Physician order for medication change for resident # 114 F329-D Facility schedule for</p>		

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	<p>approved by the Psychiatrist for the decrease in the Cymbalta, but not for the decrease in the Risperdal Consta.</p> <p>A Social Service Progress Note for Resident #106, dated 8/20/14, indicated the Psychiatrist reviewed the pharmacy recommendation on 8/12/14 but did not reduce the Risperdal Consta as the resident's behaviors worsened after the most recent GDR. The note did not indicate the date of the last GDR.</p> <p>A Mood, Behavior and Psychotropic Medication Review Sheet for Resident #106, dated 9/8/14, indicated there was 1 behavior since the last date of review on 8/12/14. The review did not indicate he had experienced any delusional symptoms. The review also indicated he received Cymbalta 60 mg BID for dementia with delusions and Risperdal Consta 25 mg every 14 days for dementia with delusions. The review further indicated his Cymbalta had been decreased on 8/12/14 as a GDR.</p> <p>A Medication Management Progress Note for Resident #106, dated 9/9/14 and written by the Psychiatrist, indicated he was manageable at this time. The note also indicated his Cymbalta was decreased from 60 mg BID to Cymbalta 30 mg AM and 60 mg HS (hour of sleep).</p>		<p>monthly psychotropic medicationreview meetings for 2015</p> <p>F329-E Psychotropic medication review sheet</p> <p>F329-F Additional inservicing for nursing staff and social services staff</p> <p>ZZ Facility in-service</p>		

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	<p>The note further indicated the continuation of his current medication of Risperdal Consta 25 mg q 2 weeks was for relapse prevention</p> <p>A Social Service Progress Note for Resident #106, dated 9/10/14, indicated he was seen by the Psychiatrist on 9/9/14 for a routine follow-up. The note also indicated he had been receiving Cymbalta 60 mg BID and Risperdal Consta 25 mg every 2 weeks. New orders were clarified for Cymbalta 30 mg AM and 60 mg HS for depression. The note further indicated he had 1 documented behavior since 8/12/14.</p> <p>A Mood, Behavior and Psychotropic Medication Review Sheet for Resident #106, dated 9/11/14, indicated there was 1 behavior since the date of the last review on 8/12/14. The review also indicated he received Cymbalta 60 mg BID for dementia with delusions and Risperdal Consta 25 mg q 2 weeks for senile dementia with delusions.</p> <p>Review of Physician orders for Resident #106 indicated the order to decrease Cymbalta to 30 mg. a.m. and 60 mg. p.m. was not written until 9/9/14, and was not actually implemented until 9/23/14.</p> <p>A Social Service Progress Note for</p>			

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	<p>Resident #106, dated 10/29/14, noted 1 documented behavior since 9/10/14. The note also indicated the Behavior Management Team and the Psych (Psychiatric) NP (Nurse Practitioner) had reviewed the resident's behaviors and medications.</p> <p>A Mood, Behavior and Psychotropic Medication Review Sheet for Resident #106, dated 10/29/14, indicated he received Cymbalta 30 mg AM and 60 mg HS for depression, and Risperdal Consta 25 mg every 2 weeks for senile dementia with delusions. The review also indicated he had 1 behavior since 8/12/14 and no changes were made at that time. The review further indicated the Psych NP would evaluate during the next rounding session.</p> <p>A Social Service Progress Note for Resident #106, dated 10/31/14, indicated during a care plan meeting his responsible party questioned the use of Risperdal and if the medication had been lowered. The note also indicated a new psych service reviewed his medications (pharmacy recommendations) but had made no changes until the resident was evaluated.</p> <p>A Social Service Progress Note for Resident #106, dated 11/3/14, indicated</p>				

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	<p>he had no moods/behaviors since the last MDS review of 9/22/14. The note also indicated he was followed by the facility psych services and a recent GDR of Risperdal Consta was declined.</p> <p>A Nurse Practitioner Note for Resident #106, dated 12/17/14, indicated he denied feeling sad, lonely or depressed. The note also indicated he denied hearing voices, paranoia, or delusions during his session with the Psych NP.</p> <p>A Social Service Progress Note for Resident #106, dated 12/17/14, indicated he had no behaviors since 9/10/14. The note also indicated he was seen by the Psych NP and no changes were made in his medication.</p> <p>A Mood, Behavior and Psychotropic Medication Review Sheet for Resident #106, dated 1/21/15, indicated he received Cymbalta 30 mg AM and 60 mg HS for depression and Risperdal Consta 2 ml every 2 weeks for senile dementia with delusions. The review also indicated no changes in medication were recommended.</p> <p>A Nurse Practitioner note for Resident #106, dated 1/23/15, indicated there were no aggression or delusions related to dementia. The note also indicated there</p>			

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	<p>were no signs or symptoms of anxiety or depression. The note further indicated he received Cymbalta 90 mg daily and Risperdal Consta 2 ml q 2 weeks.</p> <p>A Social Service Progress Note for Resident #106, dated 1/27/15, indicated he was seen by the Psych NP on 1/21/15. The note also indicated there were no documented behaviors in the review period. The note further indicated the Psych NP noted no signs of anxiety or depression, but the delusions the resident was claiming to have were related to his dementia. The note did not describe the type of delusions or frequency.</p> <p>A Mood, Behavior and Psychotropic Medication Review Sheet for Resident #106, dated 1/28/15, indicated he received Cymbalta 30 mg AM and 60 mg HS for depression and Risperdal Consta 2 ml every 2 weeks for senile dementia with delusions. The review also indicated no changes in medications were recommended.</p> <p>A facility care plan for Resident #106, with a review date of 12/18/14, indicated the problem area of potential for alteration in mood and behavior related to diagnosis of dementia with delusions. Approaches to the problem included, but were not limited to, if reporting</p>			

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	<p>delusions, hallucination, paranoid thoughts do not argue with him, simply listed and give emotional support then document statements, Psychiatrist to follow, keep MD (physician) and Psychiatrist updated, and monitor effects of meds (medication).</p> <p>A facility care plan for Resident #106, with a review date of 12/18/14, indicated the problem area of mood state. Approaches to the problem included, but were not limited to, administer medication per MD orders for diagnosis of depression, allow him to share thoughts/feelings, and psych services PRN (as needed).</p> <p>The Social Service Director was interviewed on 2/9/15 at 3:05 p.m.. During the interview she indicated Resident #106 had a history of delusions. She further indicated she could not find any documentation of delusions during the past year in his clinical record.</p> <p>The Social Service Director was interviewed on 2/10/15 at 9:30 a.m. During the interview she indicated Resident #106 had in the past received both liquid Risperdal and the Risperdal Consta. She also indicated the liquid Risperdal was discontinued in February 2013. She further indicated the Risperdal</p>			

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	<p>Consta had remained the same.</p> <p>2. Review of the clinical record for Resident #114 on 2/5/14 at 1:49 p.m., indicated the following: diagnoses included but were not limited to, senile dementia with delusional features, depressive disorder, and anxiety state.</p> <p>A Medication Management Progress Note for Resident #114, dated 3/18/14 and written by the Psychiatrist, indicated she was paranoid and delusional, but was manageable from input by nursing and social work staff. The note also indicated she received Zoloft (anti-depressant) 100 mg daily and Xanax 0.25 mg (anti-anxiety) BID and PRN (as necessary). No changes in medication were recommended.</p> <p>A Mood, Behavior and Psychotropic Medication Review Sheet for Resident #114, dated 4/8/14, indicated the diagnoses of dementia with delusions, depressive disorder, and anxiety. The review also indicated she received Zoloft 100 mg daily for depressive disorder and Xanax 0.25 mg BID and PRN for anxiety. The review further indicated she displayed the behaviors of resisting care, but her mood was calm.</p> <p>A Subsequent Nursing Facility Care Note</p>			

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	<p>for Resident #114, dated 4/29/14 and written by the Psychiatrist, indicated she was still wandering a lot and the POA (power of attorney) wanted to increase the Xanax. The note also indicated she was receiving Zoloft 100 mg daily and Xanax 0.25 mg BID and PRN. The note recommended the addition of Buspar 5 mg (anti-anxiety) TID (three times a day).</p> <p>A Medication Management Progress Note for Resident #114, dated 6/10/14 and written by the Psychiatrist, indicated she was manageable overall. The note also indicated she received Zoloft 100 mg daily, Xanax 0.25 mg BID PRN, and Buspar 5 mg TID. The note further indicated the reason for the continuation of current medications was relapse prevention.</p> <p>A Social Service Progress Note for Resident #114, dated 6/10/14, indicated she was seen by the Psychiatrist and no changes in her medication were made. The note also indicated she had no noted behaviors since the last evaluation.</p> <p>A Mood, Behavior and Psychotropic Medication Review Sheet for Resident #114, dated 6/12/14, indicated she had not displayed any behaviors since the date of her last review on 2/11/14.</p>						

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	<p>A Medication Management Progress Note for Resident #114, dated 7/22/14 and written by the Psychiatrist, indicated she was manageable overall. The note also indicated the reason for the continuation of current medications was relapse prevention.</p> <p>A Social Service Progress Note for Resident #114, dated 9/9/14, indicated the Psychiatrist reviewed her medications related to the recommendation to decrease the Xanax to 0.25 mg daily and to increase the Buspar as needed. The note also indicated the Psychiatrist declined the recommendation.</p> <p>A Social Service Progress Note for Resident #114, dated 10/29/14, indicated she had been without any moods or behaviors during the review period.</p> <p>A Social Service Progress Note for Resident #114, dated 11/10/14, indicated no periods of anxiousness/restlessness were witnessed. The note also indicated she displayed no moods or behaviors</p> <p>A Nurse Practitioner Note for Resident #114, dated 12/17/14, indicated she was receiving Xanax 0.25 mg BID, Zolof 100 mg daily, and Buspar 0.5 mg TID. The note also indicated her mood was</p>			
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	<p>anxious with no active hallucinations, paranoia, or delusions.</p> <p>A Consultation Report for Resident #114, dated 11/28/14 and written by the Consultant Pharmacist, indicated she was taking 2 or more anxiolytic medications of Xanax and Buspar and was also on Zoloft. The report recommended reducing the Xanax to 0.25 mg daily and increasing the Buspar as needed.</p> <p>A Social Service Progress Note for Resident #114, dated 12/17/14, indicated she was seen by the Psych NP. The note also indicated she continued to receive Zoloft 100 mg daily, Xanax 0.25 mg BID, and Buspar 5 mg TID. The note further indicated there were no documented behaviors during the last date of review on 9/9/14. The note indicated the recommendation was made to re-evaluate the use of the combination of Xanax and Buspar, reducing the Xanax and increasing the Buspar. The note also indicated the Psych NP declined, "medication is combined are adequately (sic) addressed for anxious symptoms; no change at this time."</p> <p>A Mood, Behavior and Psychotropic Medication Review Sheet for Resident #114, dated 12/17/14, indicated she received Zoloft 100 mg daily for</p>			

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	<p>depression, and Xanax 0.25 mg BID and Buspar 5 mg TID for anxiety. The review also indicated there were no behaviors documented since the date of the last review on 9/9/14. No changes in medications were recommended.</p> <p>A Social Service Progress Note for Resident #114, dated 1/27/15, indicated she was seen by the Psych NP on 1/21/15 for a routine visit. The note also indicated the resident had no documented behaviors during the review period. The note further indicated the Psych NP made no changes in her medication after meeting with the resident.</p> <p>A Mood, Behavior and Psychotropic Medication Review Sheet for Resident #114, dated 1/28/15, indicated she received Xanax 0.25 mg BID for anxiety, Zoloft 100 mg daily for depression, and Buspar 5 mg TID for anxiety. The review also indicated she had not displayed any behaviors. The recommendation was made to change Xanax to 0.25 mg HS.</p> <p>A Social Service Progress Note for Resident #114, dated 1/29/15, indicated the resident had no documented behaviors in the last 3 months. The note also indicated the Psych NP reduced the Xanax from 0.25 mg BID to Xanax 0.25</p>			

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	<p>mg HS, after reviewing the resident.</p> <p>A physician's order for Resident #114, dated 1/28/15, indicated to decrease Xanax to 0.25 mg HS for anxiety.</p> <p>A physician's order for Resident #114, dated 1/28/15, indicated to discontinue Xanax 0.25 mg HS and to resume Xanax 0.25 mg BID per family mandates.</p> <p>A facility care plan for Resident #114, with a review date of 1/29/15, indicated the problem area of diagnoses of depression, anxiety, and senile dementia. At risk for alteration in mood. Approaches to the problem included, but were not limited to, inform nurse of changes in mood, schedule routine and as needed psychiatrist visits, and treat diagnosis with prescribed medication.</p> <p>A facility care plan for Resident #114, with a review date of 1/29/15, indicated the problem area of antianxiety, antidepressant, and antipsychotic medication received daily. Approaches to the problem included, but were not limited to, give medication as ordered, monitor behaviors daily, and monitor resident's mood and response to medication.</p> <p>The Social Service Director was</p>				

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	<p>interviewed on 2/9/15 at 3:04 p.m. During the interview she indicated she could not find any documentation of anxiety for Resident #114.</p> <p>The Social Service Director was interviewed on 2/10/14 at 10:43 a.m. During the interview she indicated the facility held meetings monthly to discuss residents who received psychotropic medications. She also indicated each resident who received psychotropic medications was required to be reviewed quarterly or more frequently as the need arose. She further indicated the meetings consisted of the Consultant Pharmacist, the Psych Nurse Practitioner, and the core facility team. Each resident's medications and behaviors were discussed and recommendations were made to the resident's physician.</p> <p>A current facility policy "Behavior/Psychotropic Medication Review", dated 10/29/14 and provided by the Administrator on 2/9/15 at 1:50 p.m., indicated "...It is the policy of this facility to review all residents receiving a psychotropic medication at least quarterly...Medical orders to be obtained from physician, nurse practitioners or mental health specialist as recommended by IDT or documentation as to why recommendations declined...Pharmacy</p>			

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F000332 SS=D	<p>report/consultant will provide information on GDR's for residents reviewed...Residents...to be monitored for changes in mood/behaviors by nursing staff and social service staff with appropriate documentation...."</p> <p>3.1-48(a)(2)</p> <p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, interview and record review, the facility failed to ensure the medication administration error rate did not exceed 5%, as 7 of 34 medication administration opportunities observed were errors for one resident, which resulted in an error rate of 20.58%. (Resident #35)</p> <p>Findings include:</p> <p>An observation of the medication pass with LPN #6 for Resident #35 on 2-10-2015 from 10:20 a.m. to 10:45 a.m., indicated the following:</p> <p>LPN #6 was observed to prepare the medications by placing a Furosemide (a water pill) 20 mg (milligram) tablet, a</p>	F000332	<p>Please accept this as our credible allegation of compliance to our recent ISDH annual survey. Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or the corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State & Federal Law. We are also scanning in several attachments as supportive documentation. F332 Corrective Actions to be accomplished for those residents affected: There was no harm to resident#35; regarding the alleged medicine pass. The nursing staff were represented with an in-service (see attached XX) on 2-16-2015 regarding the</p>	03/14/2015

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NAME OF PROVIDER OR SUPPLIER LUTHERAN LIFE VILLAGES			STREET ADDRESS, CITY, STATE, ZIP CODE 6701 S ANTHONY BLVD FORT WAYNE, IN 46816		
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	<p>Spironolactone (a potassium sparing water pill) 12.5 mg tablet, a chlorthalidone (blood pressure medication) 25 mg tablet, an amlodipine besylate (a heart pill) 5 mg tablet and 2 potassium chloride 10 mEq (milliequivalents) ER (extended release) capsules in a plastic medication cup. LPN #6 was observed to remove the 2 potassium chloride capsules and opened each capsule and emptied the contents into another plastic medication cup. LPN #6 was observed to crush the 4 tablets in a plastic pouch and put the crushed contents in a plastic drinking cup. Nurse #6 was observed to add the potassium capsule contents to the other crushed medications in the plastic drinking cup.</p> <p>LPN #6 was observed to place citalopram solution, an antidepressant, (10 mg/ 5 ml) of 5 ml (milliliters) in a separate plastic medication cup and a solution of valproic acid, an anticonvulsant and mood stabilizing drug, (250 mg/5 ml) 2.5 ml in another plastic medication cup.</p> <p>During the administration of the medications by LPN #6 via Resident #35's g-tube (gastrostomy tube, a feeding tube in the stomach), the following was observed:</p>		<p>updated policy and procedure on G-tube Medicine Administration (see attached F332 A). Nurse #6 was provided education on this policy/procedure and was counseled in writing (see attached F332 B). Other nurses interviewed on the proper administration of meds per the G tube policy were correct in their responses. This appeared to be an isolated incident. Other residents having the potential to be affected and the corrective actions: The facility will identify other residents having the potential to be affected by this issue through Medpass observations occurring on a daily basis. The facility has 6 total residents that require meds to be administered via the G-tube. To assure the nursing staff are following the updated G-Tube Med. Administration Policy/Procedure (F332 A) and that no other residents are affected or will be affected, the nursing staff are being monitored for compliance with daily Med passes audits / observations (see attached F 332 C) on the 6 total residents with a G-tube. Additionally, Nursing Management will conduct daily audits regarding this policy, observing residents every day, for 1 month (from now until March 31, 2015). For the month of April, 2015, the facility will conduct weekly audit to assure the policy and procedure for proper Med</p>		

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	<p>LPN #6 stopped the feeding, attached a 50 ml syringe to the g-tube, auscultated the g-tube placement and checked for any residual. The g-tube was flushed with 50 ml of water. LPN #6 was observed to add water to the crushed medication mixture, stir the mixture and instilled the mixture into the g-tube, with additional water being added to the crushed medication residue in the bottom of the cup and given through the g-tube. Without flushing the g-tube with any plain water, LPN #6 was observed to give the valproic acid liquid followed by the citalopram liquid, without flushing with plain water in between. Plain water was not observed to be given after all medications were instilled in the g-tube.</p> <p>A review of the physician's current order sheet printed on 2-10-2015 for Resident #35 and provided by the DON (Director of Nursing) on 2-11-215 at 8:45 a.m., indicated the following, "...flush gtube [sic] (gastrostomy tube) with 50cc (cubic centimeters) H2O(water) before and after med pass...3 times per day...."</p> <p>An interview with LPN #5 on 2-10-2015 at 2:40 p.m., indicated for medications given via the g -tube, each medication is to be crushed and diluted with 30 ml of water and administered separately with 30 ml of water given in between</p>		<p>Administration per the G-Tube. On May 1, 2015 the facility will conduct monthly audits regarding compliance to our g-Tube policy and procedure. What Measures were put into place to ensure this does not happen again: To assure the nursing staff are following the updated G-Tube Med. Administration Policy/Procedure (F332 A) and that no other residents are affected or will be affected, the nursing staff are being monitored for compliance with daily Med passes audits / observations (see attached F 332 C) on the 6 total residents with a G-tube. Additionally, Nursing Management will conduct daily audits regarding this policy, observing residents every day, for 1 month (from now until March 31, 2015). For the month of April, 2015, the facility will conduct weekly audit to assure the policy and procedure for proper Med Administration per the G-Tube. On May 1, 2015 the facility will conduct monthly audits regarding compliance to our g-Tube policy and procedure. How the corrective actions will be monitored: The results from our G – Tube Medicine Administration audit will be reviewed at our monthly QA meeting for compliance. Nursing Unit Manager will monitor for compliance and Director of Nursing will monitor for ongoing compliance. Please find the</p>				

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	<p>medications. LPN #5 indicated each liquid medication is to be diluted with 30 ml of water, given per the g-tube and flushed with 30 ml of water after each medication.</p> <p>A policy "Gastric/Jejunal Tube-Administration of Medication" dated 08-14 and provided by the DON on 2-10-2015 at 1:45 p.m., indicated the following: "...4. Medication(s) will be prepared as follows: A. Measure exact amount of liquid into a calibrated cup. B. Crush tablet into fine powder, pour the powder from each tablet into a separate cup, and dilute with 30 cc water to enable easy pouring... C. Open each capsule and empty contents into a separate cup and dilute with 30 cc water to enable easy pouring...</p> <p>13. ...Administer the liquid medications, one cup at a time flushing with 30 cc of warm tap water between each cup. Flush tubing again with 30 cc of warm tap water after all medications have been administered. NOTE: The water flush volumes may vary dependent upon specific physician orders...."</p> <p>3.1-25(b)(9)</p>		<p>following attachments: F332 – A G-tube Medication administration policy/procedure F 332 – B Education/counseling for corrective action for nurse #6 F332 – C G-tube audit form XX Nurse in-service on 2-16-2015</p>		

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F000411 SS=D	<p>483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care.</p> <p>A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.</p> <p>Based on interview and record review the facility failed to obtain dental services to meet the needs of 1 resident with a broken tooth in her denture (Resident #140) of 2 residents who met the criteria for dental status and services.</p> <p>Findings include:</p> <p>Review of the clinical record for Resident #140 on 2/5/15 at 2:36 p.m., indicated the following: diagnoses included, but were not limited to, vascular dementia with delirium, depressive disorder, anxiety state, anemia, diabetes mellitus, cerebrovascular disease, and hypertension.</p>	F000411	Please accept this as our credible allegation of compliance to our recent ISDH annual survey. Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or the corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State & Federal Law. We are also scanning in several attachments as supportive documentation. F411 Corrective Actions to be accomplished for those residents affected: Facility requested resident #140 to be seen by a dentist on 12-15-2014, and resident was seen on that date. Recommendations were made to family to enroll in	03/14/2015

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	<p>A family member of Resident #140 was interviewed on 2/4/15 at 9:05 a.m. During the interview she indicated her loved one had a missing tooth and a chipped tooth in her dentures. She also indicated she was the POA (Power of Attorney) for Resident #140.</p> <p>An application for limited benefit in-facility dental policy for Resident #140, dated 1/8/14, was completed.</p> <p>A Social Service Progress Note for Resident #140, dated 1/8/14, indicated her POA had signed consent forms for Dental services.</p> <p>A Consultant Dental Note for Resident #140, dated 4/8/14, indicated her denture showed evident areas of past repairs/relines. The note also indicated there was heavy plaque and calculus on the dentures which would need to be removed during the next visit. The note further indicated maintaining her dentures and cleaning the calculus from her dentures was pending enrollment in the program.</p> <p>A Consultant Dental Note for Resident #140, dated 12/15/14, indicated she was seen at the request of the facility. The note also indicated staff stated the resident had a broken tooth. The note</p>		<p>Resident MedicaidDental Program so appropriate repairs could be made to her broken denture. Prior to this visit, the representative from the Resident Dental Medicaid Program had communicated to the family on 11-3-2014, 11-19-2014, 12-2-2014 and 12-4-2014 on the benefits of enrolling in this program, with no enrollment activity from the daughter except for the last communication on 12-2-2014 where the daughter agreed to the free annual assessment, only. The facility is unable to enroll resident # 140 into this program as the daughter is payee for her income. On 2-8-2015, Social Services contacted the daughter again to explain the benefits of the Resident Medicaid Dental Program along with following up on the broken denture. On 2-9-2015, the daughter called facility on how she wanted to proceed with the denture repairs. Daughter finally agreed to take the denture into get repaired on 2-10-2015. The facility agreed to help out the daughter this time, since she had not enrolled her mother in the Resident Medicaid Dental Program. The facility paid for the denture repairs @ \$105. (See attached receipt, facility notes, F411-A). Other residents having the potential to be affected and the corrective actions: The facility has revised their policy on</p>				

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	<p>further indicated the resident's records indicated she had dentures, but staff were unaware she was wearing dentures. The note also indicated the resident had a maxillary anterior tooth broken on her denture. The note further indicated the resident was not currently enrolled in the dental program and the dentist was not able to complete the repair. The note indicated the repair was pending enrollment in the program.</p> <p>Review of the progress notes for Resident #140, dated 12/12/14 through 2/5/15, did not indicate the facility had addressed the problem of the broken denture with the resident's POA.</p> <p>A Social Service Progress Note for Resident #140, dated 2/6/15, indicated the writer was made aware of the resident's broken dentures by the surveyor. The note also indicated the writer called the resident's POA who stated there was a tooth missing and a tooth broken in the dentures.</p> <p>Certified Nursing Assistant #1 was interviewed on 2/6/15 at 1:20 p.m. During the interview she indicated Resident #140 still had a broken tooth on her denture.</p> <p>Activity Director #2 was interviewed on</p>		<p>ancillary services (vision, hearing, dental and podiatry), (see attached F411-B). Our contracted service – Resident Medicaid Dental offers ongoing dental care for our residents and provides a monthly summary of dental findings and recommendations. Nursing staff will also do a weekly audit (see attached – D). All residents will also be reviewed for their dental assessment for their quarterly MDS. An In-service will be provided to nursing staff prior to 3-14-2015, (see attached F411 – C). What Measures were put into place to ensure this does not happen again: The facility has revised their policy on ancillary services (vision, hearing, dental and podiatry), see attached F411-B. Our contracted service – Resident Dental Program offers ongoing dental care for our residents and provides a monthly summary of dental findings and recommendations. Nursing staff will also do a weekly audit (see attached – D). All residents will also be reviewed for their dental assessment for their quarterly MDS. These findings/recommendations will be reviewed by Nursing and Social Services @ our weekly resident review held one every Thursday. How the corrective actions will be monitored: Nursing staff will do a weekly audit (see attached – D). Compliance to our revised facility policy will be reviewed at</p>				

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	<p>2/6/15 at 1:22 p.m. During the interview she indicated the time period when the dental appointments to repair the broken tooth in her denture were to have been scheduled may have been during the time when the social service staff changed.</p> <p>Neighborhood Coordinator #3 and the Social Service Director were interviewed on 2/6/15 at 2:26 p.m. During the interview they could not identify why the dental needs of Resident #140 were missed. They indicated there had been a change in social service staff around that time.</p> <p>The Social Service Director was interviewed on 2/9/15 at 10:00 a.m. During the interview she indicated the POA for Resident #140 signed a consent form for her loved one to receive dental services, but had not paid the premium (since the POA was the payee) for her loved one to be enrolled in the dental program. She also indicated the dentist could not repair her broken tooth since Resident #140 had not been enrolled in the program. She further indicated she did not know how long the tooth in her dentures had been broken or if the facility had contacted the POA about the problem with her dentures since that was at the time there was a change in social service staff for the memory unit.</p>		<p>our monthly QA meeting for compliance. Social Services and Director of Nursing to monitor for compliance. Administrator will monitor for ongoing compliance.</p> <p>Please find the following attachments: F411– A, Dental receipt, nursing notes and social service notes F411– B, Adapted policy & procedure for ancillary services F411-C, Staff in-service on adapted policy from F411 – B F411 – D Dental audit form</p>		

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F000431 SS=E	<p>The Administrator was interviewed on 2/9/15 at 2:23 p.m. During the interview he indicated the facility was short on social service hours from before Thanksgiving in 2014 until sometime in January in 2015. He also indicated the facility did not communicate the need for Resident #140's dentures to be repaired.</p> <p>3.1-24(a)(2) 3.1-24(a)(3)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 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</p>			

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	<p>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 the medication carts were maintained in a clean manner, medications were properly labeled, and the unit medication room was maintained in a secure manner for 5 of 10 medication carts (100 hall-cart 1 and cart 2, 300 hall (Peerage-cart 1), 400 hall and Magnolia, the memory care unit) and for 1 of 4 medication rooms (medication room for the 100, 200, 300, and 400 halls)</p> <p>Findings include:</p> <p>1. On initial tour of the facility on 2/3/15 at 9:20 a.m. the main entryway was observed. A large circular area in the center was partitioned off to direct traffic to the edges of the area as construction was in progress in the center of the area. The resident halls originated from this circular area and fanned out as compared to the spokes of a wheel. There are 4</p>	F000431	<p>Please accept this as our credible allegation of compliance to our recent ISDH annual survey. Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of fact salleged or the corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State & Federal Law. We are also scanning in several attachments as supportive documentation. F 431 Corrective Actions to beaccomplished for those residents affected: The facility promotes safe practices/protocols when storing all medications. A large STOP sign (seeattached F431 A) was posted on 2-9-2015 at the Med Room in question(Additionally, all Med Rooms have this sign now posted). Med cart #1 andMed cart #2 were both cleaned on 2-9-2015 and the labeling of the Meds werealso corrected on</p>	03/14/2015

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	<p>resident halls which originated from this circular area as well as the entrance for the main dining room. A door with the label of "med (medication) room" was observed along one of the edges of the main circular area.</p> <p>On 2/4/15 at 11:53 a.m. the med room was observed with the door opened. No nurse was observed inside this room and/or in the hall outside the room but there were two maintenance men (MM) inside the room. One of the MM told the other man he would look at the cables. At this time, MM #14 left the room, leaving MM #13 in the medication room alone.</p> <p>On 2/4/15 at 11:55 a.m. MM #13 was observed on a ladder in the med room with the door opened. The man's head was up in the ceiling as he was working on cables in the ceiling. The door to the medication room remained opened, again with no nurse in the room and/or hall outside the opened door. Observed in this room on the counter was a portable, tiered box, similar to a tackle box. A tote was observed on the floor with zip ties closing it being used as a prop to hold the door open. MM#13 was observed to be up and down on the ladder in several locations in the med room. The door remained open during this time, again</p>		<p>2-9-2015. An educational in-service (see attachedXX) was presented to the nursing staff on 2-16-2015 regarding policies / procedures for the cleaning of Med Carts and storage of meds; authorized personnel in theMed Rooms and the proper labeling of meds. Nursing staff were also in-serviced on the policy / procedure for proper Med Administration (seeattached F431 E). Other residents having thepotential to be affected and the corrective actions: The facility will identify other residents having the potential to be affected by these issues through observations/audits (Med room/authorized personnel only; cleaning of the medcare/proper med storage, proper labeling of meds and proper med administration)occurring on a daily basis. To assure the nursing staff are following the Med Administration Policy/Procedure (See attached 432E); the locking of medroom doors/authorized personnel only policy/procedure (see attached F431 B),proper labeling of meds policy/procedure (see attached F 431D) and assuring theMed carts are clean/proper med storage policy/procedure (see attached F431 C) the nursing staff are being monitored for compliance with daily Med administration audits / observations (see attached F431 F). What Measures were putinto place to</p>	

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	<p>with no nurse present in the room. At this time, staff, visitors, and residents were observed to be passing by the opened medication room door.</p> <p>On 2/4/15 at 12:01 p.m. the man who had been on the ladder, was observed to exit the opened door med room. As he was leaving the room, RN #12 was entering the med and she stated "I'll stay here." The man stated "OK" and left the room.</p> <p>On 2/4/15 at 12:03 p.m., MM #13 returned to the medication room and RN #12 left the room. On 2/4/15 at 12:05 p.m. the man, who was in the medication room, exited the room, leaving the door open and no one at all in the medication room. He walked around the corner and was out of complete sight of the opened med room door for at least 5 seconds. He returned to the room, removed the ladder as he left the room. He then closed the med room door.</p> <p>On 2/4/15 at 1:25 p.m. MM #13 was interviewed. He indicated he had been in the medication room at time with another MM. He indicated the nurse on the 100 hall is the one who had the keys to this med room and she let him in the room.</p> <p>On 2/4/15 at 1:42 p.m. LPN #9 was interviewed,. She indicated she had let</p>		<p>ensure this does not happen again: To assure the nursing staffare following the Med Administration Policy/Procedure (See attached 432E); the locking of med room doors/authorized personnel only policy/procedure (seeattached F431 B), proper labeling of meds policy/procedure (see attached F431D) and assuring the Med carts are clean/proper med storage policy/procedure(see attached F431 C) the nursing staff are being monitored for compliance with daily Med administration audits / observations (see attached F431 F and G). Additionally, Nursing Management will conduct daily audits regarding all ofthese policies, observing nurses every day, for 1 month (from now untilMarch 31, 2015). For the month of April, 2015, the facility will conduct weekly observations / audits on all of these policies to check forcompliance. On May 1, 2015 the facility will start to conduct monthly observations /audits regarding compliance for all of these policies. How the corrective actionswill be monitored: The results from these audits (Locking of med room doors/authorized personnel only; appropriate cleaning of med carts/storage of meds; proper labeling of meds and proper med administration) will be reviewed at our monthly QA meeting for compliance. Nursing Unit</p>		

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	<p>the MM in the med room earlier. She indicated it depended how long the MM would be in the medication room if she stayed with them or not. She indicated if the MM was in the med room a short time, she would stay with them at that time, but "sometimes they take awhile..." She indicated all the narcotics were locked in the med room. At the time, the medication room was toured with LPN #9. The EDK (Emergency Drug Kit) was observed on the counter. This was the multi tiered tackle box type container, which was observed to have zip ties on it. This EDK box had a handle on the top of it and was not secured to the counter but was able to be freely moved with the push of a hand.</p> <p>2. On 2/6/15 at 10:30 a.m. the 100 hall medication carts were observed with LPN # 9. Cart 1 was observed to have a bottle of over the counter (OTC) Calcium 600 mg tablets, was dated as opened on 1/17/15, but documentation was lacking on the bottle of a resident or physician name. LPN #9 was interviewed at the time as to how she knew which resident this medication belonged to. She indicated she knew which resident it belong to as "I just know it's hers, I've given it to her for a long time."</p> <p>In the second drawer, was an opened,</p>		<p>Managers will monitor for compliance and Director of Nursing will monitor for ongoing compliance. Please find the following attachments: F431-A Stop sign posted on Med Room doors F431 – B Med room policy / procedure F431 – C Med cart policy / procedure F431 – D Medication labeling policy / procedure F431 – E Medication Administration policy /procedure F431 – F Medication pass audit form F431 – G Med room audit form</p>	

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	<p>tube of Aspercreme, which had 1/4 of the tube contents remaining, was observed to have no resident name, no physician name, and no date opened.</p> <p>The third drawer down was observed to have various dried spills in the base of the drawer. The right back corner was observed to have what appeared to be bacon fragments, no more than 1/2 inch in size.</p> <p>The 100 hall cart 2 was also observed with LPN #9. Dried spills were observed in the base of the drawers. A bottle of liquid Colace was observed to be opened but had no documentation of the date it was opened. Also observed in the cart drawers were pill residue accumulated in the corners and edges of the interior of the cart base.</p> <p>3. On 2/6/15 at 11 a.m. the 400 hall carts were observed with LPN #8. The following was observed: the bases of the drawers had dried spills and also pill residue accumulated along the edges and corners of the drawer base; a box of over the counter brand Mucus Relief had no physician's name;</p> <p>On 2/6/15 at 11:40 a.m. the 200 hall medication cart was observed with LPN #10.</p>						

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	<p>A bottle of over the counter Arthritis Pain Relief 650 mg tablets was observed to be lacking the physician name; another bottle of over the counter regular strength pain reliever tylenol 325 mg also lacked the physician name on the bottle. Cart 2 was also observed to have an opened bottle of over the counter ASA 81 mg with no physician name on the bottle. Also observed were dried spills and accumulation of pill residue along the edges of the interior cart drawers and corners.</p> <p>On 2/9/15 at 2 p.m. the 100 hall medication cart was observed. The substance which resembled bacon, remained in the medication cart as observed on 2/6/15 at 10:30 a.m. Also observed were the scattered spills and the pill residue accumulated in the corners and along the edges of the drawer base.</p> <p>4. An observation of the 300 unit (Peerage) medication cart #1 with LPN #6 on 2-6-2015 at 10:45 a.m., indicated several pills in an unidentified medication cup were stored in the top drawer.</p> <p>An interview with LPN #6 on 2-6-2015 at 10:46 a.m., indicated she had prepared the pills but the resident had left to go to the beauty shop and LPN #6 indicated</p>			

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	<p>she placed the container of pills in the medication cart until the resident returned.</p> <p>5. An observation of the Magnolia unit medication cart with LPN #9 on 2-6-2015 at 1:30 p.m., indicated two 1/2 pills were loose in the bottom of the 2nd drawer and two more partial pills were loose in the bottom of the 3rd drawer.</p> <p>An observation in the Magnolia medication cart indicated a container of persersion eye drops for a resident did not have a date opened, physician name or the resident 's complete name on the container.</p> <p>An interview with LPN #9 on 2-6-2015 at 1:35 p.m., indicated the resident's name, date opened and dose should have been labeled on the container.</p> <p>On 2/9/15 at 2:10 p.m. the DON (Director of Nursing) was interviewed. She was made aware of the unsupervised medication room. The DON indicated the medication room should not have been left unsupervised by nursing staff. She indicated the maintenance man should not be in the medication room unsupervised. At the time, the DON provided a list of the contents of the 4 level EDK, which was sitting on the</p>			

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	<p>counter in the med room. The list indicated there were 128 different types of medication in the EDK, which ranged from a supply, to tablets, Intravenous/intramuscular medication and patches. It included, but was not limited to, the following: 11 tablets of Seroquel (antipsychotic); 6 tablets of Risperdal (Antipsychotic); Zyprexa (antipsychotic); 2 ampules of Epinephrine injectable (Adrenalin); 10 tablets and 2 ampules of injectable Haldol (antipsychotic) and 4 ampules of Heparin injectable (blood thinner).</p> <p>On 2/9/15 at 2:10 p.m. the DON also provided a copy of the facility policy and procedure for "Storage and Expiration Dating of Medications..." This policy was dated 8/9/11 and included, but was not limited to, the following: "Facility should ensure that all medications and biologicals...are securely stored in a locked cabinet...or locked medication room that is inaccessible by residents and visitors...once any medication...is opened...facility staff should record the date opened on the medication container..."</p> <p>On 2/9/15 at 2:10 p.m. the DON provided a copy of the policy and procedure for "Medication Room" dated 12/2014. This policy included but was not limited to,</p>			

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	<p>the following: "...No staff member without licensure of LPN (licensed practical nurse), RN (registered nurse) or QMA (qualified medical assistant) shall be permitted to enter medication room without the nurse present..."</p> <p>On 2/9/15 at 2:27 p.m. LPN #11 was interviewed. She indicated nursing staff cleaned the medication carts on the 3rd shift on Wednesdays and Saturdays. She indicated they go through the carts, look for expired medications and also clean the carts by wiping them down inside and out.</p> <p>On 2/10/15 at 9:51 a.m. the DON (Director of Nursing) was interviewed. She indicated the Over the counter medications should always have the resident's name and physician name on the bottle.</p> <p>On 2/10/15 at 10 a.m. the DON provided the following copy of the "Medication room/medication cart/treatment cart audit. Audit form to be completed weekly on Wednesday and Saturday on the night shift." A copy of this completed form for the 100 hall (A hall) was dated 2/5/15 and 2/8/15 and indicated the "drawers clean and organized/bottles wiped clean...all over the counter medications properly</p>			

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R000000	<p>labeled..."</p> <p>3.1-25(j) 3.1-25(l)(1)(2)</p> <p>Lutheran Life Villages Assisted Living was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.</p>	R000000	<p>Please accept this as our credible allegation of compliance to our recent ISDH annual survey. Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or the corrections set forth on the statement of deficiencies.</p> <p>This Plan of Correction is prepared and submitted because of requirements under State & Federal Law. We are also scanning in several attachments as supportive documentation. We respectfully request the opportunity to have POC reviewed / accepted / approved with paper compliance if possible</p>		