

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155546	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/21/2014
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NAME OF PROVIDER OR SUPPLIER BETHEL POINTE HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 3400 W COMMUNITY DR MUNCIE, IN 47304
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: November 17, 18, 19, 20, 21, 2014</p> <p>Facility number: 000565 Provider number: 155546 AIM number: 100267630</p> <p>Survey team: Ginger McNamee, RN-TC Karen Lewis, RN Tina Smith-Staats, RN Toni Maley, BSW</p> <p>Census bed type: SNF/NF: 88 Total: 88</p> <p>Census payor type: Medicare: 23 Medicaid: 51 Other: 14 Total: 88</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by Debora Barth, RN.</p>	F000000	The following Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. Submission of this Plan of Correction is not an admission that the deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by State and Federal law. This facility respectfully requests paper compliance for the deficiencies cited.	

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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F000155 SS=D	<p>483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES</p> <p>The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>Based on interview and record review, the facility failed to allow a resident to refuse treatment for 1 of 7 residents reviewed for behavior monitoring. (Resident #17)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #17 was reviewed on 11/19/14 at 8:16 a.m. Diagnoses included, but were not limited to, mood disorder, depression, and dementia with behavioral disturbances.</p>	F000155	<p>1. This event happened in the past, therefore, the facility is unable to correct it. 2. All residents reviewed for behavior monitoring have the potential to be affected. 3. DON/Designee will review and audit behavior sheets during morning meeting to ensure resident rights are being honored. Staff were inserviced on residents' rights to refuse on 12/9/14. 4. Results of the audits will be forwarded to QA monthly for review times three months, then quarterly for a total of six months.</p>	12/21/2014

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	<p>A "Behavior Sheet", dated 11/14/14, indicated Resident #17 "was insisting on having a Pepsi and staff told him he was only allowed clear liquids and he became very angry. Resident began yelling and cursing at staff." The staff offered water and Sprite to Resident #17. Resident #17 stated "If you don't give me my Pepsi I'm going to f---- you up!" Resident #17 asked for another CNA to come into his room and when the CNA entered the room Resident #17 threw the water at the CNA. Resident #17 was reapproached several times and continued "to swear and yell at staff members." Resident #17 was never offered a Pepsi.</p> <p>During an interview with the Director of Nursing and the Nurse Consultant on 11/21/14 at 7:45 a.m., they both indicated a resident has the right to refuse treatment. They further indicated Resident #17 should have been able to have a Pepsi after the staff had explained the reason the physician had ordered the clear liquids.</p> <p>During an interview with LPN #3 on 11/21/14 at 7:40 a.m., she indicated residents have the right to refuse treatment. She further indicated Resident #17 had the right to refuse clear liquids and have a Pepsi on 11/14/14.</p>						

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F000250 SS=D	<p>Review of the current undated policy, titled "RESIDENT RIGHTS", provided by the Nurse Consultant on 11/21/14 at 9:45 a.m. included, but was not limited to,</p> <p>"The Resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident, including each of the following rights... ...B. Notice of rights and services... ...4. The resident has the right to refuse treatment..."</p> <p>3.1-4(a)(4)(A)(ii)</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, interview and record review, the facility failed to ensure staff were knowledgeable regarding resident specific approaches to behaviors and were attempted prior to the</p>	F000250	1. The facility is unable to correct the past occurrences of Resident 69 receiving as needed anti-anxiety medication without following behavior plan interventions. A physician's order was obtained to discontinue the	12/21/2014

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	<p>administration of as needed medication for anxiety for 1 of 5 residents reviewed for behavior monitoring and management associated with psychoactive medication use (Resident #69). In addition, the facility failed to act upon psychiatric services recommendations regarding depression and weight loss for 1 of 4 residents reviewed for services to promote nutritional health (Resident #176).</p> <p>Findings include:</p> <p>1. Resident #69's clinical record was reviewed on 11/19/2014 at 9:12 a.m. Resident #69's current diagnoses included, but were not limited to, Alzheimer's disease, psychogenic paranoid psychosis, senile dementia with depressive features and adjustment disorder with depressed mood. Resident #69 was admitted to hospice on 11/11/14.</p> <p>Resident #69 had a current, November 2014, physician's order for the following medications for mood and behavior:</p> <p>a. Lorazepam 0.5 mg (an anti-anxiety medication) as needed every four hours for agitation. This order originated 11/11/14.</p> <p>b. Lorazepam Solution 2 mg/ml- inject</p>		<p>as needed anti-anxiety medication and reduce the dosage of the anti-psychotic medication. Social Service and Activity one to one visits were initiated for Resident 176 and this resident's care plan was updated as indicated. 2. All residents receiving anti-psychotic medications and as needed anti-anxiety medications have the potential to be affected. An audit was completed on residents receiving as needed anti-anxiety medications to ensure non-chemical interventions were utilized prior to use over the past thirty days. An audit was completed for residents receiving anti-psychotic medications to ensure gradual dose reductions occurred unless clinically contraindicated within the last quarter. All residents receiving mental health services have the potential to be affected. All mental health notes completed in the last thirty days were reviewed with recommendations addressed as appropriate. 3. Staff were inserviced on the Behavior Management program and resident-specific behavioral interventions on 12/9/14. Social Service Department and Nursing Management were inserviced over Behavior Management Psychoactive Medication/Gradual Dose Reduction Policies and Procedures on 12/5/14. Social Services Department were inserviced on 12/5/14 over the</p>				

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	<p>0.5 mg intramuscularly (IM) every 12 hours as needed for anxiety and increased behaviors. This order originated 2/8/14.</p> <p>c. Zyprexa 5 mg (an anti-psychotic medication) give 1 tablet (5 mg) daily at bed time related to psychogenic paranoid psychosis. This order originated 11/3/14.</p> <p>d. Depakote sprinkles capsules 125 mg (a mood stabilizer) - give 2 tablets (250 mg) two times daily related to adjustment disorder with mixed anxiety and depressed mood. This order originated 4/16/14.</p> <p>e Trazadone 50 mg (an anti-depressant) take three 1/2 tablets to total 75 mg daily at bed time. This order originated 6/25/14.</p> <p>Resident #69 had a current, 10/27/14, care plan problem/need regarding behaviors associated with dementia and mood disorders. Approaches to this problem, included but were not limited to, "If I don't want to keep my shirt on, help me to my bed where I can cool off without having to wear my shirt and Resident enjoys spending time on the Dementia unit where it is quieter, for their evening activities. Staff to offer to take back there if behaviors start. and Offer items in Busy Box to distract</p>		<p>appropriate follow up for mental health recommendations. Upon receipt of mental health notes, Social Services will review all recommendations with the Interdisciplinary Team and the appropriate department will follow up on the recommendation and a progress note will be entered. DON/Designee will review/audit the administration of as needed anti-anxiety medication during morning meeting to ensure non-chemical interventions were utilized prior to its use. DON/Designee will review/audit anti-psychotics to assess the need for Gradual Dose Reductions monthly during Interdisciplinary Psychopharmacological Review meeting. Social Services Director/Designee will review three residents weekly for eight weeks, then twice monthly for two months, then monthly for two months to ensure mental health recommendations were addressed and interview three staff weekly for eight weeks, then twice monthly for two months, then monthly for two months to ensure staff are aware of resident-specific interventions for behaviors. 4. Results of the audits will be forwarded to QA monthly for review times three months, then quarterly for a total of six months.</p>	

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	<p>resident when she seems agitated...."</p> <p>Resident #69 had a current, 9/23/14, annual, MDS (Minimum Data Set) assessment which indicated the resident was severely cognitively impaired and rarely or never made independent choices and displayed behaviors not toward others (such as disrobing) 1 to 3 days of the assessment period.</p> <p>Resident #69 had an 11/13/14, 4:39 p.m., "Behavior Sheet" which indicated she was shaking and making repetitive verbalizations and removed her shirt in public. Interventions were documented as attempted. The option of allowing her to remain in her room in bed without a top was not offered. IM Lorazepam was documented as given.</p> <p>Resident #69 had an 11/12/14, 4:37 p.m., "Behavior Sheet" which indicated she was in the hall yelled help and removed her shirt. She was moved to a quieter area and calmed for 15 minutes. After 15 minutes, she removed her shirt and refused to wear anything. Interventions where documented as attempted. The option of allowing her to remain in her room in bed without a top was not offered. IM Lorazepam was documented as given.</p>				

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	<p>Resident #69 had a 10/31/14, 10:59 p.m., "Behavior Sheet", which indicated she was resistant during care and continued to undress. Interventions were documented as attempted. The option of allowing her to remain in her room in bed without a top was not offered. IM Lorazepam was documented as given.</p> <p>Resident #69 had a 10/15/14, 12:35 p.m., "Behavior Sheet", which indicated she was removing her top in a public area. Interventions were offered. She continues to undress. The option of allowing her to remain in her room in bed without a top was not offered. IM Lorazepam was documented as given.</p> <p>Resident #69 had a 10/9/14, 9:41 p.m., "Behavior Sheet", which indicated she was removing her top in a public area. Resident #69 was taken to her room, changed her clothes and helped to bed. Her behavior discontinued. No chemical intervention was needed.</p> <p>Resident #69 had a 10/7/14, 6:56 a.m., "Behavior Sheet", which indicated she was removing her top in a public area. Resident #69 was taken to her room, changed her clothes and helped to bed. Her behavior discontinued. No chemical intervention was needed.</p>			

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	<p>Review of the CNA "Behavior" tracking records from 9/17/14 to 11/19/14 indicated no maladaptive behaviors had been displayed during this period.</p> <p>Resident #69 was observed during the following dates and times:</p> <p>On 11/17/2014 at 10:09 a.m., Resident #69 was calmly watching an activity.</p> <p>On 11/17/14 at 1:30 p.m., Resident #69 was in bed asleep.</p> <p>On 11/17/2014 at 2:22 p.m., Resident #69 was in bed asleep.</p> <p>On 11/18/2014 at 9:19 a.m., Resident #69 was calmly sitting in the lounge.</p> <p>On 11/19/2014 at 8:49 a.m., Resident #69 was calmly eating her meal with staff assistance.</p> <p>On 11/19/2014 at 9:51 a.m., Resident #69 was in bed asleep.</p> <p>On 11/19/2014 at 12:26 p.m., Resident #69 was in bed asleep</p> <p>On 11/19/2014 at 1:43 p.m., Resident #69 was in bed asleep</p> <p>On 11/19/2014 at 2:36 p.m., Resident #69 was in bed asleep</p> <p>On 11/20/2014 at 8:06 a.m., Resident #69 was in her wheelchair in the dining room calmly awaiting the meal.</p> <p>During an 11/19/14, 1:25 p.m., interview, CNA #4 indicated she had worked in the facility for over 1 year. She indicated she</p>			

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	<p>was unaware of any place in the facility where resident specific approaches to behaviors were available. She indicated she used the general approaches on the computerized monitoring program. Lastly she indicated Resident #69 pulled her top over her head at times and said "oh" when in pain during care.</p> <p>During an 11/19/14, 1:30 p.m., interview, CNA #5 indicated she was unaware of any location in the facility where resident specific approaches to behaviors were located. She indicated Resident #69 called for help at times.</p> <p>During an 11/19/14, 1:35 p.m., interview, CNA #6 indicated she was unaware of any resident specific approaches to behavior management. She was also unaware of any place in the facility where resident specific approaches to behaviors were located.</p> <p>During an 11/19/14, 1:39 p.m., interview, CNA #7 indicated she was unaware of any resident specific approaches to behaviors. She indicated she was also unaware of any place in the facility where resident specific approaches to behaviors were located.</p> <p>During an 11/19/14, 2:10 p.m., interview the RN Consultant indicated CNA #4 had</p>			

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	<p>informed her of her lack of knowledge of a resident specific approach to behavior and/or the location of said information. The RN Consultant indicated the facility was currently educating direct care staff regarding resident specific approaches to behavior management. The RN Consultant indicated the facility had a book regarding resident specific approaches to behavior management which was maintained behind the nursing stations close to the copiers.</p> <p>During an 11/20/14, 11:16 a.m., interview, the Director of Nursing indicated staff should remove Resident #69 to her room and allow her to change clothes or be in bed without her shirt when she disrobed. The DON indicated the facility had not considered allowing the resident to be in her room without a shirt on, in her wheelchair with the privacy current pulled. She additionally indicated staff members should document all attempted approaches prior to the use of as needed psychoactive medications.</p> <p>During an 11/21/14, 8:26 a.m. interview, the DON indicated the facility did not have any documentation of Resident #69 being permitted to be unclothed in private prior to the administration of as needed Lorazepam in September, October and November 2014. She additionally</p>			

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	<p>indicated the facility did not have documentation of behaviors that significantly negatively impacted Resident #69's quality of life or quality of care other than disrobing prior to the failure of the gradual dose reduction of Zyprexa. Lastly she indicated that in response to this information, the facility was discontinuing the Lorazepam and making another attempt to reduce the Zyprexa.</p> <p>2. Resident #176's clinical record was reviewed on 11/19/14 at 7:56 a.m. The resident's diagnoses included, but were not limited to, cognitive deficits due to cerebrovascular disease and depression.</p> <p>The resident had an order for Remeron [an anti-depressant being used as an appetite stimulant] 15 mg one tablet by mouth at bedtime.</p> <p>A 10/24/14, 3:14 p.m., late entry Social Service note indicated the Director of Social Services [DSS] spoke with the resident's wife about the resident's recent refusals of care and therapy. The wife indicated she had noticed the changes as well and did not know where the behaviors were coming from. The wife indicated it would be a good idea for the resident to receive psychiatric services. The wife indicated she understood the resident would not be covered by</p>			

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	<p>insurance for his stay if he did not work with the staff and therapists.</p> <p>The 10/28/14, 4:34 p.m., late entry Social Service note indicated the psychiatric visits would continue and one to one Social Service visits as needed.</p> <p>An 11/17/14, 5:14 p.m., late entry Social Service note indicated "Upon further review of resident's behaviors, IDT [Interdisciplinary Team] determined that resident should remain on behavior management at this time."</p> <p>Resident #176 had a 11/3/14, Psychologist note with a recommendation for daily room visits by staff for purposes other than providing care or treatments, as well as continuing to encourage time spent out of his room. Resident #176 had a gospel music CD he enjoyed, and care staff might try putting it on during care to provide distraction from discomfort.</p> <p>Review of the resident's clinical record lacked an indication of the 11/3/14, psychologist recommendations followed up on.</p> <p>During an interview with LPN #10 on 11/20/2014 at 12:45 p.m., she indicated the psychologist notes go to Social Services and the nurses did not see them.</p>			

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	<p>During an interview with the DSS on 11/20/14 at 3:49 p.m., she indicated the psychologist sent their report via fax to the facility after their visits. She indicated the report went to the DSS and they review the recommendations. She indicated they would act on the recommendations if they agreed with them or make alterations if needed. She indicated typically she developed the care plan for these problems. She indicated the resident did not receive one to one services but she could see where he might benefit from this.</p> <p>During an interview with the Activity Director on 11/21/14 at 10:00 a.m., he indicated the resident had not been on one to one activity visits. 3. Review of the current facility policy, revised 6/2012, titled "Behavior Management", provided by the QAPI Nurse on 11/20/14 at 3:15 p.m., included, but was not limited to, the following: "...10. If a behavior management program is needed Social Service will develop the Behavior Management Program and enter it into the EMR [electronic medical records] under care plans. A copy of the Behavior Management Program will be kept at the Nurses's Station to allow access to all staff....14. Copies of the behavior management plan will be kept at nurse's</p>			

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	<p>station to allow access to all staff to the interventions for the residents on the behavior management plans...."</p> <p>4. Review of the current facility policy, revised 6/2013, titled "PSYCHOACTIVE MEDICATIONS/GRADUAL DOSE REDUCTION POLICY", provided by the QAPI Nurse on 11/20/14 at 3:15 p.m., included, but was not limited to, the following: "Policy: It is the policy of this facility that a resident will receive psychoactive medications only when it is necessary to improve the resident's overall psychosocial health status....To ensure gradual dose reduction attempts are made unless contraindicated....2. Residents receiving psychoactive medications will have a care plan initiated that contains interventions regarding the target behaviors and possible adverse side effects of the medication(s)....11. Prior to the administration of a prn psychoactive medication, the nurse will attempt non-pharmacological interventions document the interventions attempted and outcomes of the interventions....Considerations Specific to Psychopharmacological Medications Other than Antipsychotics and Hypnotics/Sedatives....The resident's target symptoms returned or worsened after the most recent attempt at tapering</p>			

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F000279 SS=D	<p>the dose within the facility and the physician has documented the clinical rational for why additional attempted dose reduction at that time would be likely to impair the resident's function or cause psychiatric instability by exacerbating underlying medical or psychiatric disorder...."</p> <p>3.1-52(b)(2)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review and interview,</p>	F000279	1. A care plan for malnutrition was placed for Resident 176. 2.	12/21/2014	

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	<p>the facility failed to develop a care plan for a resident assessed for malnutrition for 1 of 16 residents reviewed for the development of care plans. (Resident #176)</p> <p>Findings include:</p> <p>Resident #176's clinical record was reviewed on 11/19/14 at 7:56 a.m. The resident's diagnoses included, but were not limited to, cognitive deficits due to cerebrovascular disease, depression, acute respiratory failure, kidney replaced by transplant, gout, retention of urine, renal failure, and hypertension.</p> <p>The resident had a current physician's order for daily weight and to notify the physician for an increase of two pounds in one day or five pounds in seven days. The resident had an order for a reduced sodium diet with mechanical soft texture. His diet was to have diet desserts with egg substitute, 2000 ml fluid restriction, no bread, no bacon, no toast, and no green leafy vegetables or broccoli.</p> <p>The resident had a 10/10/14, Admission Minimum Data Set assessment. The assessment indicated the resident had no cognitive impairment. The assessment indicated the resident's weight was 216 pounds.</p>		<p>An audit was completed by the RD of all care plans for those residents with a mini nutrition assessment scoring malnourished to ensure a nutritional care plan was initiated. 3. The RD/Designee will create a care plan following a nutrition assessment that indicates malnutrition and the care plan will be reviewed quarterly in planned care meetings. The RD/Designee will audit those residents with scored assessment of malnutrition weekly and three of these residents' care plans will be checked for completion. 4. Results of these audits will be forwarded to QA monthly for review times three months, then quarterly for a total for six months.</p>		

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	<p>The resident had a 10/10/14, protein level of 5.3. The normal laboratory value was 6.0 - 8.5. The albumin level at that time was 3.3 with the normal being 3.6 - 4.8.</p> <p>Review of the October, 2014, Meal Consumption logs for Resident #176 indicated the resident was offered 84 meals. The resident refused 5 meals and/or alternates offered, consumed 0 to 25% for 13 of the meals, ate 26 to 50% of 35 of the meals, consumed 51 to 75% of the meals 27 times, ate 76 to 100 % 3 times, and was unavailable for 1 meal.</p> <p>There were 53 meals reviewed on Resident #176's Meal Consumption logs for November, 2014. The resident refused 1 meal, ate 0 to 25% for 5 meals, 25 to 50% for 8 meals, 51 to 75% for 27 meals, and 75 to 100% for 12 meals.</p> <p>The resident had a, 10/15/14, Dietary-nutritional risk assessment completed by the Corporate Dietician. The assessment indicated the resident was at risk for malnutrition.</p> <p>The resident's care plan did not identify malnutrition as a problem requiring interventions.</p> <p>During an interview with the Registered</p>				

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F000282 SS=D	<p>Dietary Consultant on 11/21/14 at 9:50 a.m., she indicated she had reviewed the resident's record and did not think the resident had a problem with weight loss or malnutrition.</p> <p>3.1-35(a)</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 record review and interview, the facility failed to follow the care plan related to bowel protocol for 1 of 5 residents reviewed for bowel movement monitoring related to medication use. (Resident #38)</p> <p>Findings include:</p> <p>The clinical record for Resident #38 was reviewed on 11/19/14 at 8:17 a.m. Diagnoses for Resident #38 included, but were not limited to, diabetes, hypertension, dementia, constipation, chronic kidney disease and venous embolism.</p> <p>A health care plan problem, dated</p>	F000282	<p>1. The objective of the bowel protocol was met for Resident 38, due to this resident experiencing bowel evacuation every three days. Resident did not experience fecal impaction or obstruction. 2. All residents have the potential to be affected. 3. DON/Designee will review/audit the Bowel Movement Report during morning meeting to ensure appropriate initiation of bowel protocol. Licensed nursing staff inservice was held on 12/9/14 on the Bowel Elimination Protocol. 4. Results of the audit will be forwarded to QA monthly for review times three months, then quarterly for a total of six months.</p>	12/21/2014

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	<p>11/18/13, indicated Resident #38 was at risk for constipation due to: "history of constipation, decreased mobility, change in environment and analgesic use." Approaches for this problem included, but were not limited to, "Administer prn [as needed] laxative as ordered; Initiate facility bowel protocol after 2 days without BM; Notify MD as needed."</p> <p>The BM (bowel movement) Report, from 9/17/14 through 11/19/14, indicated Resident #38 had no documented bowel movements for 2 consecutive days on the following dates: 9/27/14 to 9/28/14, 10/9/14 to 10/10/14, 10/19/14 to 10/20/14, 11/11/14 to 11/12/14 and 11/15/14 to 11/16/14. The Medication Administration Record (MAR) for September, October and November 2014, indicated the resident did not receive the laxative intervention as ordered by the physician, per facility protocol or resident care plan on these dates.</p> <p>Review of the Nursing Notes, dated 9/25/14 through 11/12/14, lacked documentation of constipation or interventions for constipation for the dates indicated.</p> <p>During an interview with the Director of Nursing on 11/21/14 at 11:10 a.m., she indicated Resident #38 should have</p>			

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F000314 SS=D	<p>received interventions for constipation per the facility protocol if the resident did not have a bowel movement for two days.</p> <p>A policy, dated 2/2012, titled "Bowel Elimination Protocol", provided by the Administrator on 11/21/14 at 11:17 a.m., indicated: "Purpose: 1. To avoid constipation and fecal impaction in the resident. ... General Protocol:.. 3. Each nurse will complie [sic] a daily laxative list on all residents who have not had a bowel movement for two days (six shifts) at the beginning of the shift. 4. The nurse that is notified of no bowel movement in 48 hours will give the first line of intervention for those residents who have not had a bowel movement for two days (six shifts), as ordered by physician.... b. Give laxative as ordered...."</p> <p>3.1-35 (g)(2)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure</p>			

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	<p>sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview, and record review, the facility failed to provide services to promote wound healing related to nutrition for 1 of 3 residents reviewed out of 5 who met the criteria for pressure ulcers. (Resident #176)</p> <p>Findings include:</p> <p>Resident #176's clinical record was reviewed on 11/19/14 at 7:56 a.m. The resident's diagnoses included, but were not limited to, cognitive deficits due to cerebrovascular disease, depression, acute respiratory failure, kidney replaced by transplant, gout, retention of urine, renal failure, and hypertension.</p> <p>The resident had a 10/10/14, Admission Minimum Data Set assessment. The assessment indicated the resident had no cognitive impairment. The assessment indicated the resident had an unstageable pressure ulcer.</p> <p>Review of a 10/3/14, admission nursing assessment indicated the resident had a 3 cm by 4.5 cm suspected deep tissue injury to his left heel.</p>	F000314	<p>1. A physician's order was obtained and a Pre-Albumin level was drawn on 11/25/14 for Resident 176. High protein supplements were also ordered for this resident. 2. All residents with malnourished mini nutrition assessments were checked for appropriate interventions. All residents receiving extra protein supplements are documented in their medical record. 3. The RD/Designee will complete an audit weekly, in Nutrition-At-Risk meetings, for those residents with malnourished mini nutrition assessments to ensure interventions are updated as needed. The RD/Designee will complete an audit weekly for residents on the pressure ulcer list to ensure that nutrition interventions are documented when initiated or changed. 4. Results of the audits will be forwarded to QA monthly for review times three months, then quarterly for a total of six months.</p>	12/21/2014			

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	<p>An observation of Resident #176's left heel was made. LPN #11 removed the resident's dark blue footie and applied skin prep to the left heel. There were no open areas observed. The heel was covered with fuzzy residue from the sock. The skin prep was applied over the fuzzy residue. The resident refused further observations to be made of the area.</p> <p>The resident had a 11/12/14 "Pressure Progress Report" indicating the area was 3.5 cm by 4 cm suspected deep tissue injury to his left heel.</p> <p>The resident had a 10/10/14, protein level of 5.3. The normal laboratory value was 6.0 - 8.5. The albumin level at that time was 3.3 with the normal being 3.6 - 4.8.</p> <p>The resident had a, 10/15/14, Dietary-nutritional risk assessment completed by the Corporate Dietician. The assessment indicated the resident was at risk for malnutrition. The recommendation was "Review weights and food intake. SLP [Speech Language Pathologist] is treating and will follow her recommendations. Needs more protein intake...will determine sources he accepts."</p> <p>Resident's Braden scale assessment, on 10/24/14, was scored at 12 and</p>			

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	<p>considered a high risk for skin breakdown.</p> <p>Review of a 11/20/14, 11:38 a.m., Registered Dietician note, indicated "food consistency increased 10/21 to Mech [mechanical] Soft with Reduced Sodium, diet desserts and egg sub. [substitute] 2000 ml fluid restriction continues. Per SLP recommendations-omit bread, bacon, toast, green leafy vegetables and broccoli. Meals consumed 51-75% except refused the last two days supper. Nurses note constipation and received MOM [milk of magnesia.]"</p> <p>The clinical record lacked an indication of the recommendation for extra protein being followed.</p> <p>During an interview with the Dietary Manager on 11/22/14 at 8:40 a.m., she indicated the Speech Therapist was responsible for completing the resident's food preferences and notifying dietary of their likes and dislikes.</p> <p>During an interview with the Speech Therapist on 11/22/14 at 8:45 a.m., she indicated speech therapy recommends the food consistency and will tell dietary if residents mention they would like a specific food. She indicated they did not</p>			

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	<p>record the food preferences for residents. She further indicated she had never been made aware of Resident #176 needing an increase in protein or of his having a weight loss.</p> <p>The resident was observed eating lunch on 11/20/2014 at 12:34 p.m. The resident had a bowl of mixed vegetables [corn, green beans, and lima beans] set off of the side of the tray.</p> <p>During an interview on 11/20/2014 at 12:43 p.m., CNA # 8 and CNA #9 both indicated the resident cannot have any kind of green vegetables. They indicated they could not offer the resident the alternate because it was also on the list of things the resident could not have.</p> <p>The Director of Nursing and RN Consultant were interviewed on 11/20/2014 at 3:10 p.m. They indicated the Respiratory Therapist was responsible for reviewing the weights and notifying nursing of weight changes. They indicated the weights were probably not accurate.</p> <p>The Respiratory Therapist was interviewed on 11/20/14 at 3:12 p.m., she indicated she reviewed the weights for weight gains related to congestive heart failure or increased edema.</p>			

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F000325 SS=D	<p>During an interview with the Registered Dietary Consultant on 11/21/14 at 9:50 a.m., she indicated she had reviewed the resident's record and did not think he had a problem with weight loss or protein to promote wound healing of the pressure area.</p> <p>3.1-40(a)(2)</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on record review and interview, the facility failed to maintain the nutritional status for 1 of 4 residents reviewed out of 9 residents who met the criteria for nutritional risk. (Resident #176)</p> <p>Findings include:</p>	F000325	<p>1. Resident 176 was reevaluated by the RD for current protein needs and high protein supplements were ordered. The facility is unable to correct inaccurate weights for Resident 176. 2. All residents at risk for nutrition have the potential to be affected. An audit was completed on those residents at risk for nutrition to ensure interventions were in place to maintain their</p>	12/21/2014

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	<p>1. Resident #176's clinical record was reviewed on 11/19/14 at 7:56 a.m. The resident's diagnoses included, but were not limited to, cognitive deficits due to cerebrovascular disease, depression, acute respiratory failure, kidney replaced by transplant, gout, retention of urine, renal failure, and hypertension.</p> <p>The resident had a current physician's order for daily weight and to notify the physician for an increase of two pounds in one day or five pounds in seven days. The resident had an order for a reduced sodium diet with mechanical soft texture. His diet was to have diet desserts with egg substitute, 2000 ml fluid restriction, no bread, no bacon, no toast, and no green leafy vegetables or broccoli.</p> <p>The resident had a 10/10/14, Admission Minimum Data Set assessment. The assessment indicated the resident had no cognitive impairment. The assessment indicated the resident's weight was 216 pounds.</p> <p>Review of Resident #176's weight sheets indicated the resident was admitted on 10/3/14 and lacked a weight for the day of admission. The resident had a weight of 228 pounds recorded on 10/5/14. The residents October, 2014, weights were as follows:</p>		<p>nutritional status. 3. The RD will leave the report of her recommendations upon completion of her visit the original copy being given to the Adminstrator and copies given to the CDM and DON. The RD/Designee will compile a list of recommendations and completion dates weekly. The RD/Designee will audit the previous week's recommendations weekly to ensure completion. The DON will provided an insservice to the nursing staff on the Weights protocol on 12/9/14. The DON/Designee will audit daily weights during morning meeting and will assign re-weights to be obtained as necessary. 4. Results of the audits will be forwarded to QA for review monthly for six months.</p>				

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	<p>10/10 - 215.6 lbs [pounds] 10/11 - 216.1 lbs 10/12 - 228.6 lbs 10/13 - 228.6 lbs 10/14 - 226.6 lbs 10/15 - 230.8 lbs 10/16 - 222 lbs 10/17-10/24 - refused 10/25 - 222 lbs 10/26 - 10/27 - refused 10/28 - 223.6 lbs 10/29 - refused 10/30 - 212.8 lbs 10/31 - refused</p> <p>The resident's November, 2014, weight sheets indicated the following: 11/1 - refused 11/2 - 209.2 lbs 11/3 - 11/5 - refused 11/6 - 213.2 lbs 11/7 - 213.1 lbs 11/8 - 212.4 lbs 11.9 - refused 11/10 - 205 lbs 11/11 - 210.6 lbs 11/12 - refused 11/13 - 211 lbs 11/14 - refused 11/15 - 211 lbs 11/16 - 212.4 lbs 11/17 - 11/19 - refused</p> <p>Review of the October, 2014, Meal</p>			

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	<p>Consumption logs for Resident #176 indicated the resident was offered 84 meals. The resident refused 5 meals and/or alternates offered, consumed 0 to 25% for 13 of the meals, ate 26 to 50% of 35 of the meals, consumed 51 to 75% of the meals 27 times, ate 76 to 100 % 3 times, and was unavailable for 1 meal.</p> <p>There were 53 meals reviewed on Resident #176's Meal Consumption logs for November, 2014. The resident refused 1 meal, ate 0 to 25% for 5 meals, 25 to 50% for 8 meals, 51 to 75% for 27 meals, and 75 to 100% for 12 meals.</p> <p>The resident had a 10/10/14, low protein level of 5.3. The normal laboratory value was 6.0 - 8.5. The albumin level at that time was 3.3 with the normal being 3.6 - 4.8.</p> <p>The resident had a 10/15/14, Dietary-nutritional risk assessment completed by the Corporate Dietician. The assessment indicated the resident was at risk for malnutrition. The recommendation was "Review weights and food intake. SLP [Speech Language Pathologist] is treating and will follow her recommendations. Needs more protein intake...will determine sources he accepts."</p>			

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	<p>Review of a 11/20/14, 11:38 a.m., Registered dietician note, indicated "food consistency increased 10/21 to Mech [mechanical] Soft with Reduced Sodium, diet desserts and egg sub. [substitute] 2000 ml fluid restriction continues. Per SLP recommendations- omit bread, bacon, toast, green leafy vegetables and broccoli. Meals consumed 51-75% except refused the last two days supper. Nurses note constipation and received MOM [milk of magnesia.]"</p> <p>The clinical record lacked an indication of the recommendation for extra protein being followed.</p> <p>During an interview with the Dietary Manager on 11/22/14 at 8:40 a.m., she indicated the Speech Therapist was responsible for completing the resident's food preferences and notifying dietary of their likes and dislikes.</p> <p>During an interview with the Speech Therapist on 11/22/14 at 8:45 a.m., she indicated speech therapy recommended the food consistency and would tell dietary if residents mention they would like a specific food. She indicated they do not record the food preferences for residents. She further indicated she had never been made aware of Resident #176 needing an increase in protein or of</p>			

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	<p>having a weight loss.</p> <p>The resident was observed eating lunch on 11/20/2014 at 12:34 p.m. The resident had a bowl of mixed vegetables [corn, green beans, and lima beans] set off to the side of the tray.</p> <p>During an interview on 11/20/2014 at 12:43 p.m., CNA # 8 and CNA #9 both indicated the resident cannot have any kind of green vegetables. They indicated they could not offer the resident the alternate because it was also on the list of things the resident could not have.</p> <p>The Director of Nursing and RN Consultant were interviewed on 11/20/2014 at 3:10 p.m. They indicated the Respiratory Therapist was responsible for reviewing the weights and notifying nursing of weight changes. They indicated the weights were probably not accurate.</p> <p>The Respiratory Therapist was interviewed on 11/20/14 at 3:12 p.m., she indicated she reviewed the weights for weight gains related to congestive heart failure or increased edema. She indicated she was not monitoring for nutritional risk.</p> <p>During an interview with the Registered</p>						

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	<p>Dietary Consultant on 11/21/14 at 9:50 a.m., she indicated she had reviewed the resident's record and did not think he had a problem with weight loss.</p> <p>2. Review of the current facility policy, revised 3/2012, titled "WEIGHTS", provided by the QAPI Nurse on 11/20/14 at 3:12 p.m., included, but was not limited to, the following: "Purpose: 1. To determine a baseline weight on the resident. 2. To provide an ongoing record of the resident's body weight as an indicator of the nutritional status and medical condition of the resident. Performed By: Nursing Policy: In order to ensure effectiveness of interventions and evaluate changes if necessary, residents will be weighed monthly and/or weekly, unless the residents' clinical condition demonstrates that this is not possible....3. Residents with a significant weight change in one week (gain/loss of 5 pounds or more) in one week will result in a reweight. Reweights should be completed within 24-48 hours. 4. Residents with a significant weight change of 5% in one month or 10% in 6 months will receive a reweight within 24-48 hours.... 9. Dietary recommendations will be acted upon in a timely manner."</p> <p>3.1-46(a)(1)</p>			

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F000329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview and record review, the facility failed to ensure the resident specific non-chemical intervention of allowing a resident to be unclothed in private was attempted prior to the use of as needed anti-anxiety medication and/or the facility identified a failed gradual dose reduction of a anti-psychotic medication for 1 of 5 residents reviewed for unnecessary</p>	F000329	<p>1. Resident 69's as needed anti-anxiety medication and anti-psychotic medication was reviewed by the interdisciplinary team. A physician's order was obtained to discontinue the as needed anti-anxiety medication and reduce the dosage of the anti-psychotic medication. 2. All residents receiving anti-psychotic medications and as needed anti-anxiety medications have the potential to be affected. An audit</p>	12/21/2014

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	<p>medication (Resident #69)</p> <p>Findings include:</p> <p>1. Resident #69 was observed either asleep or interacting in a calm manner during the following dates and times:</p> <p>On 11/17/2014 at 10:09 a.m., Resident #69 was calmly watching an activity. On 11/17/14 at 1:30 p.m., Resident #69 was in bed asleep. On 11/17/2014 at 2:22 p.m., Resident #69 was in bed asleep. On 11/18/2014 at 9:19 a.m., Resident #69 was calmly sitting in the lounge. On 11/19/2014 at 8:49 a.m. Resident #69 was calmly eating her meal with staff assistance. On 11/19/2014 at 9:51 a.m., Resident #69 was in bed asleep. On 11/19/2014 at 12:26 p.m., Resident #69 was in bed asleep On 11/19/2014 at 1:43 p.m., Resident #69 was in bed asleep On 11/19/2014 at 2:36 p.m., Resident #69 was in bed asleep On 11/20/2014 at 8:06 a.m., Resident #69 was in her wheelchair in the dining room calmly awaiting the meal.</p> <p>Resident #69's clinical record was reviewed on 11/19/2014 at 9:12 a.m. Resident #69's current diagnoses</p>		<p>was completed on residents receiving as needed anti-anxiety medications to ensure non-chemical interventions were utilized prior to the use over the past thirty days. An audit was completed for residents receiving anti-psychotic medications to ensure gradual dose reductions occurred, unless clinically contraindicated within the last ninety days. 3. Social Services and Nurse Management were inserviced on Behavior Management and Psychoactive Gradual Dose Reduction Policies on 12/5. DON/Designee will review/audit the administration of as needed anti-anxiety medications during morning meeting to ensure non-chemical interventions were utilized prior to its use. DON/Designee will review/audit anti-psychotics to assess the need for Gradual Dose Reductions monthly during Interdisciplinary Psychopharmacological Review meeting. Licensed nursing staff inserviced on 12/9/14 on the Policies for Behavior Management and Psychoactive Medications/Gradual Dose Reductions. 4. Results of the audits will be forwarded to QA for review times three months, then quarterly for a total of six months.</p>				

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	<p>included, but were not limited to, Alzheimer's disease, psychogenic paranoid psychosis, senile dementia with depressive features and adjust disorder with depressed mood. Resident #69 was admitted to hospice on 11/11/14.</p> <p>Resident #69 had a current, November 20114, physician's order for the following medications for mood and behavior:</p> <p>a. Lorazepam 0.5 mg (an anti-anxiety medication) as needed every for hours for agitation. This order originated 11/11/14.</p> <p>b. Lorazepam Solution 2 mg/ml- inject 0.5 mg intramuscularly every 12 hours as needed for anxiety and increased behaviors. This order originated 2/8/14.</p> <p>c. Zyprexa 5 mg (an anti-psychotic medication) give 1 tablet (5 mg) daily at bed time related to psychogenic paranoid psychosis. This order originated 11/3/14. Prior to 11/3/14, Resident #69 had a,10/18/14, order for Zyprexa 2.5 mg - take 1 tablet (2.5 mg) two times daily. Preceding the Zyprexa 2.5 mg two time daily order, Resident #69 had a,10/1/14, order for Zyprexa 2.5 mg -take 1 tablet (2.5 mg) one time daily at bedtime. Before the 2.5 mg daily at bedtime order, Resident #69 had a,12/19/13, order for</p>			

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	<p>Zyprexa 5 mg, take one tablet daily at bed time.</p> <p>d. Depakote sprinkles capsules 125 mg (a mood stabilizer) - give 2 tablets (250 mg) two times daily related to adjustment disorder with mixed anxiety and depressed mood. This order originated 4/16/14.</p> <p>e Trazadone 50 mg (an anti-depressant) take three 1/2 tablets to total 75 mg daily at bed time. This order originated 6/25/14.</p> <p>Resident #69 had a current, 10/27/14, care plan problem/need regarding behaviors associated with dementia and mood disorders. Approaches to this problem, included but were not limited to, "If I don't want to keep my shirt on, help me to my bed where I can cool off without having to wear my shirt and Resident enjoys spending time on the Dementia unit where it is quieter, for their evening activities. Staff to offer to take back there if behaviors start. and Offer items in Busy Box to distract resident when she seems agitated..."</p> <p>Resident #69 had a current, 9/23/14, annual, MDS (Minimum Data Set)</p>			

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	<p>assessment which indicated the resident was severely cognitively impaired and rarely or never made independent choices and displayed behaviors not toward others (such as disrobing) 1 to 3 days of the assessment period.</p> <p>Resident #69 had an 11/13/14, 4:39 p.m., "Behavior Sheet" which indicated she was shaking and making repetitive verbalizations and removed her shirt in public. Interventions were documented as attempted. The option of allowing her to remain in her room in bed without a top was not offered. IM Lorazepam was documented as given.</p> <p>Resident #69 had an 11/12/14, 4:37 p.m., "Behavior Sheet" which indicated she was in the hall, yelled help, and removed her shirt. She was moved to a quieter area and calmed for 15 minutes. After 15 minutes, she removed her shirt and refused to wear anything. Interventions were documented as attempted. The option of allowing her to remain in her room in bed without a top was not offered. IM Lorazepam was documented as given.</p> <p>Resident #69 had a 10/31/14, 10:59 p.m., "Behavior Sheet", which indicated she was resistant during care and continued to undress. Interventions were</p>			

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	<p>documented as attempted. The option of allowing her to remain in her room in bed without a top was not offered. IM Lorazepam was documented as given.</p> <p>Resident #69 had a 10/15/14, 12:35 p.m., "Behavior Sheet", which indicated she was removing her top in a public area. Interventions were offered. She continued to undress. The option of allowing her to remain in her room in bed without a top was not offered. IM Lorazepam was documented as given.</p> <p>Resident #69 had a 10/9/14, 9:41 p.m., "Behavior Sheet", which indicated she was removing her top in a public area. Resident #69 was taken to her room, changed her clothes and helped to bed. Her behavior discontinued. No chemical intervention was needed.</p> <p>Resident #69 had a 10/7/14, 6:56 a.m., "Behavior Sheet", which indicated she was removing her top in a public area. Resident #69 was taken to her room, changed her clothes and helped to bed. Her behavior discontinued. No chemical intervention was needed.</p> <p>Review of the CNA "Behavior" tracking records for 9/17/14 to 11/19/14 indicated no maladaptive behaviors had been displayed during this period.</p>			

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	<p>Resident #69 had no documented behaviors that negatively impacted the resident's quality of life and quality of care other than anxiety and clothing removal prior to the failed dose reduction of the anti-psychotic medication Zyprexa in November 2014.</p> <p>During an 11/19/14, 1:25 p.m., interview, CNA #4 indicated she had worked in the facility for over 1 year. She indicated she was unaware of any place in the facility where resident specific approaches to behaviors were available. She indicated she used the general approaches on the computerized monitoring program. Lastly she indicated Resident #69 pulled her top over her head at times and said "oh, oh, oh," when in pain during care.</p> <p>During an 11/19/14, 1:30 p.m., interview, CNA #5 indicated she was unaware of any location in the facility where resident specific approaches to behaviors were located. She indicated Resident #69 called for help at times.</p> <p>During an 11/19/14, 1:35 p.m., interview, CNA #6 indicated she was unaware of any resident specific approaches to behavior management. She was also unaware of any place in the facility where resident specific approaches to behaviors</p>			

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	<p>were located.</p> <p>During an 11/19/14, 1:39 p.m., interview, CNA #7 indicated she was unaware of any resident specific approaches to behaviors. She indicated she was also unaware of any place in the facility where resident specific approaches to behaviors were located.</p> <p>During an 11/19/14, 2:10 p.m., interview the RN Consultant indicated CNA #4 had informed her of her lack of knowledge of a resident specific approached to behavior and/or the location of said information. The RN Consultant indicated the facility was currently educating direct care staff regarding resident specific approached to behavior management. The RN Consultant indicated the facility had a book regarding resident specific approaches to behavior management which was maintained behind the nursing stations close to the copiers.</p> <p>During an 11/20/14, 11:16 a.m., interview the Director of Nursing indicated staff should remove Resident #69 to her room and allow her to change clothes or be in bed without her shirt when she disrobed. The DON indicated the facility had not considered allowing the resident to be in her room without a</p>			

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	<p>shirt on, in her wheelchair with the privacy current pulled. She additionally indicated staff members should document all attempted approaches prior to the use of as needed psychoactive medications. She indicated she would review the records for Resident #69's behaviors during the last 3 months and determine if the resident had been allowed to be unclothed prior to the administration of as needed Lorazepam. She indicated she would also review the record to see if any behaviors other than anxiety and removing clothing had been present when Resident #69's gradual dose reduction of Zyprexa had been considered a failure and the dose increased.</p> <p>During an 11/21/14, 8:26 a.m. interview, the DON indicated the facility did not have any documentation of Resident #69 being permitted to be unclothed in private prior to the administration of as needed Lorazepam in September, October and November 2014. She additionally indicated the facility did not have documentation of behaviors that significantly negatively impacted Resident #69's quality of life or quality of care other than disrobing prior to the failure of the gradual dose reduction of Zyprexa. Lastly she indicated that in response to this information, the facility was discontinuing the Lorazepam and</p>				

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	<p>making another attempt to reduce the Zyprexa.</p> <p>Review of the current facility policy, revised 6/2012, titled "Behavior Management", provided by the QAPI Nurse on 11/20/14 at 3:15 p.m., included, but was not limited to, the following: "...10. If a behavior management program is needed Social Service will develop the Behavior Management Program and enter it into the EMR under care plans. A copy of the Behavior Management Program will be kept at the Nurses's Station to allow access to all staff....14. Copies of the behavior management plan will be kept at nurse's station to allow access to all staff to the interventions for the residents on the behavior management plans...."</p> <p>Review of the current facility policy, revised 6/2013, titled "PSYCHOACTIVE MEDICATIONS/GRADUAL DOSE REDUCTION POLICY", provided by the QAPI Nurse on 11/20/14 at 3:15 p.m., included, but was not limited to, the following: "Policy: It is the policy of this facility that a resident will receive psychoactive medications only when it is necessary to improve the resident's overall psychosocial health status....To ensure gradual dose reduction attempts are made unless contraindicated....2. Residents receiving psychoactive</p>			

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F000334 SS=C	<p>medications will have a care plan initiated that contains interventions regarding the target behaviors and possible adverse side effects of the medication(s)...11. Prior to the administration of a prn psychoactive medication, the nurse will attempt non-pharmacological interventions document the interventions attempted and outcomes of the interventions...Considerations Specific to Psychopharmacological Medications Other than Antipsychotics and Hypnotics/Sedatives....The resident's target symptoms returned or worsened after the most recent attempt at tapering the dose within the facility and the physician has documented the clinical rational for why additional attempted dose reduction at that time would be likely to impair the resident's function or cause psychiatric instability by exacerbating underlying medical or psychiatric disorder...."</p> <p>3.1-37(a)</p> <p>3.1-37(a)</p> <p>483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza</p>			

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	<p>immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p>			

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	<p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>Based on interview and record review, the facility failed to provide influenza vaccine education for 88 of 88 residents who live in the facility and failed to provide the opportunity to decline the influenza vaccine for 1 of 5 residents reviewed. (Resident #84)</p> <p>Findings include:</p> <p>The clinical record for Resident #84 was reviewed on 11/20/14 at 2:30 p.m. The record indicated the most current "Immunization Consent or Refusal" form was dated 8/8/13. Resident #84 refused the influenza vaccine due to having the flu vaccine in the Fall of 2012.</p> <p>The clinical record for Resident #84 indicated the resident was given the</p>	F000334	<p>1. This event happened in the past, therefore the facility is unable to correct it. Resident 84's daughter consented to the annual Influenza Vaccine on 11/21/14. 2. All residents have the potential to be affected. An audit was completed of all influenza consent forms to ensure the residents were provided the opportunity to decline the vaccine. 3. DON/Designee will review/audit Influenza consent forms on all new admissions during morning meeting to ensure the opportunity to decline the vaccine and educational information were provided. Licensed nursing staff were inserviced on 12/9/14 on the Policy for Influenza Vaccine. The Influenza Policy was reviewed during the Corporate Policy and Procedure meeting on 12/5/14. An inservice was provided to the Infection</p>	12/21/2014			

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	<p>influenza vaccine on 10/9/14.</p> <p>During an interview on 11/21/14 at 8:15 a.m., with the Assistant Director of Nursing, she indicated Resident #84 had refused the influenza vaccine on 8/8/13. The facility did not obtain a consent for vaccination prior to giving the vaccine on 10/9/14.</p> <p>During an interview on 11/20/14 at 3:15 p.m., the Assistant Director of Nursing indicated the Business Office Manager (BOM) mailed residents and/or their legal representatives the CDC 2014-2015 Influenza information document and a notification letter related to the flu vaccine.</p> <p>During an interview on 11/21/14 at 8:30 a.m., the Human Resources Director indicated she received a list of resident legal representatives from the BOM. She indicated she had mailed the education letter using this list. She did not have the mailing list nor did she have a date for the mailing. She indicated the BOM did not have the list either.</p> <p>During an interview on 11/21/14 at 8:15 a.m., the Assistant Director of Nursing indicated she did not have a list of residents or legal representatives who were mailed/given the information</p>		Control Nurse and Human Resources Coordinator on maintaining a log of the educational mailings sent to legal representatives annually. The educational mailing will include the cover letter and the current Vaccine Information Statement. An inservice was provided to the Infection Control Nurse over checking consent forms prior to administration of the Influenza vaccine. 4. Results of the audits will be forwarded to QA monthly for review times three months, then quarterly for a total of six months.		

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F000363 SS=E	<p>related to the flu vaccine. She also indicated she did not have a date for the mailing. The facility lacked any evidence of education given prior to administering the flu vaccine.</p> <p>3.1-18(b)(5)</p> <p>483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.</p> <p>Based on observation, interview and record review, the facility failed to ensure menus were followed for 5 of 5 residents with pureed diet orders (Residents #4, #121, #90, #182 and #2).</p> <p>Findings include:</p> <p>1. During an 11/19/14, 10:47 a.m., observation of the pureeing process, Cook #8 indicated she would be pureeing veal for 5 residents. Cook #8 did not follow the recipe for pureed veal. She added beef base to the hot liquid using a serving spoon to measure as opposed to a measuring spoon. When interviewed, at this time, she indicated she did not know</p>	F000363	<p>1. CDM immediately inserviced the AM Cook on proper preparation of puree-cooked meats and by dinner time, the puree foods were the correct consistency and tasted appropriately. 2. The Corporate Dietician revised the recipe for breaded meat. A puree recipe for each menu item will be placed in a binder in the kitchen for the cooks to use. 3. An inservice was held on 12/4/14 to the dietary employees on pureeing foods. The cook will audit puree foods served for thirty days and recipes with undesirable outcomes will be modified to be acceptable. CDM will continue to audit twice a week for random meals, thereafter. 4. Results of the audits will be</p>	12/21/2014			

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	<p>there was a difference between a measure spoon and a spoon for serving and table service. Cook #8 made 4 cups of beef base. The recipe indicated 1 1/2 cups of broth should be added. Cook #8 added all 4 cups of the beef broth to the pureed veal. She did not add any bread to the pureed meat. The recipe called for 6 slices of bread and the menu indicated bread and butter was to be served. Cook #8 added only 4 pats of margarine when the recipe called for 6. When the meat was finished it was thin and dripped from a serving spoon. When informed she had not followed the recipe, Cook #8 acknowledged her error and indicated she intended to serve the meat that had not been pureed to recipe. A tasting of the pureed veal on 11/19/14 at 10:58 a.m., found the product to be thin and too salty.</p> <p>During an 11/19/14, 10:58 a.m. interview, the Dietary Manager indicated she was unclear how to interpret the recipe because the veal was a pre-breaded product. She indicated she had not contacted the Registered Dietitian for clarification. She did indicate the regular diet menu did list bread and margarine as part of the menu.</p> <p>A list provided by the Dietary Manager on 11/19/14 at 12:20 p.m., indicated Residents #4, #121, #90, #182 and #2 all</p>		forwarded to QA monthly for review monthly for six months.		

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F000441 SS=E	<p>received pureed diets and would have received the veal that had not been prepared following the menu. Review of the current menu and recipe for pureed foods provided by the Dietary Manger on 11/19/14 at 12:22 p.m., included, but was not limited to, the following: "Lunch menu Regular: Veal parmesan, Butter noodles, sauteed summer squash, bread/margarine, mixed fruit cup, and cold beverage. Pureed: #6 pureed veal parmesan, #8 pureed Butter noodles, #8 pureed summer squash, #8 pureed fruit cup, and cold beverage." "The recipe for purred foods/cooked lean meat Number of portions desired - 5 Cooked lean meat - 14 oz Hot liquid - 1 1/2 cup Bread - 6 Margarine (pats) - 6 Reheat after blending" 3.1-20(i)(4)</p>			
	483.65 INFECTION CONTROL, PREVENT			

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	<p>SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation and interview, the facility failed to ensure the disinfecting wipes for cleaning the glucometers were</p>	F000441	1. Expired disinfecting wipes were immediately replaced. 2. All residents who receive blood sugar monitoring have the	12/21/2014			

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	<p>not expired on 1 of 4 medication carts for 1 of 1 observation of blood sugar monitoring. (LPN #3, Resident #37) This deficient practice had the potential to effect 17 of 17 residents with orders for blood sugar monitoring.</p> <p>Findings include:</p> <p>1. During an observation on 11/20/14 at 12:03 p.m., LPN #3 returned to the East hall medication cart and indicated she was going to disinfect the glucometer. LPN #3 unlocked the medication cart and retrieved a container of "Microdot bleach wipes" from the bottom drawer of the cart. LPN #3 removed a bleach wipe and began disinfecting the glucometer. The bleach wipe container had an expiration date of 6/2014. LPN #3 indicated she had been given the bleach wipes that morning and had used them throughout the morning.</p> <p>The Director of Nursing was informed of the expired bleach wipes on 11/20/14 at 12:10 p.m. She indicated she did not know when the bleach wipes were received. She also indicated there were 17 residents in the facility who had their blood tested for glucose monitoring. She provided a list of the residents potentially affected.</p>		<p>potential to be affected. 3. DON/Designee will audit weekly to ensure disinfecting wipes for cleaning the glucometers are not expired. Licensed staff were inserviced on 12/9/14 on the Policy for Glucometer Cleaning. 4. Results of the audits will be forwarded to QA monthly for review times three months, then quarterly for a total of six months.</p>				

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	<p>The bleach wipes on the Center hall medication cart were reviewed on 11/20/14 at 12:14 p.m. The expiration date for the bleach wipes was 2/2015.</p> <p>The bleach wipes on the locked unit medication cart were reviewed on 11/20/14 at 12:23 p.m. The expiration date for the bleach wipes was 2/2015.</p> <p>The bleach wipes on the Rehabilitation hall were reviewed on 11/20/14 at 12:27 p.m. The expiration date for the bleach wipes was 2/1015.</p> <p>The bleach wipes in the supply storage room were observed on 11/20/14 at 12:30 p.m., with the DON. The expiration date for the bleach wipes was 2/2015. The DON indicated the only expired bleach wipes found in the facility were the bleach wipes that had been on East hall medication cart.</p> <p>Review of the current facility policy, dated 9/2014, titled "GLUCOMETER CLEANING POLICY", provided by the DON on 11/20/14 at 12:57 p.m., included, but was not limited to, the following:</p> <p>"Purpose: To prevent cross contamination when using a glucometer between residents....</p>						

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F000520 SS=C	<p>...3. Clean/disinfect glucometer by wiping the outside of the glucometer with disinfectant bleach wipe. Using a clean bleach disinfectant wipe wrap the glucometer in the wipe and place in clean plastic baggie and let sit for at least 3 minutes. After each use...."</p> <p>3.1-18(a)</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will</p>						

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	<p>not be used as a basis for sanctions.</p> <p>Based on record review and interview, the QA Committee failed to identify the failure to provide influenza education and an opportunity to decline the vaccination if desired for 88 of 88 residents residing in the facility.</p> <p>Findings include:</p> <p>1. During an interview with the Administrator and the Director of Nursing on 11/21/14 at 2:00 p.m., they indicated the QA Committee had not reviewed the letters for education for annual flu vaccines and ensured residents/families were informed and were given and received confirmed consents or an opportunity to decline the vaccine.</p> <p>2. The clinical record for Resident #84 was reviewed on 11/20/14 at 2:30 p.m. The record indicated the most current "Immunization Consent or Refusal" form was dated 8/8/13. Resident #84 refused the influenza vaccine due to having the flu vaccine in the Fall of 2012.</p> <p>The clinical record for Resident #84 indicated the resident was given the influenza vaccine on 10/9/14.</p> <p>During an interview on 11/21/14 at 8:15</p>	F000520	<p>1. The concern with the failure to identify the failure to provide influenza education and the opportunity to decline the vaccination if desired will be reviewed by the QA Committee at the next monthly meeting for review and action plan. 2. All residents have the potential to be affected. 3. Staff were inserviced on the role of the QA Committee on 12/9/14. 4. The QA Committee will meet monthly to identify issues, develop, and implement appropriate plans of actions to correct the identified issues. The QA Committee will review the status of action plans monthly. The Administrator will maintain minutes of the meetings.</p>	12/21/2014	

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	<p>a.m., with the Assistant Director of Nursing, she indicated Resident #84 had refused the influenza vaccine on 8/8/13 and the facility did not obtain a consent for vaccination prior to giving the vaccine on 10/9/14.</p> <p>During an interview on 11/20/14 at 3:15 p.m., the Assistant Director of Nursing indicated the Business Office Manager (BOM) mailed residents and/or their legal representatives the CDC 2014-2015 Influenza information document and a notification letter related to the flu vaccine.</p> <p>During an interview on 11/21/14 at 8:30 a.m., the Human Resources Director indicated she received a list of resident legal representatives from the BOM. She indicated she had mailed the education letter using this list. She did not have the mailing list nor did she have a date for the mailing. She indicated the BOM did not have the list either.</p> <p>During an interview on 11/21/14 at 8:15 a.m., the Assistant Director of Nursing indicated she did not have a list of residents or legal representatives who were mailed/given the information related to the flu vaccine. She also indicated she did not have a date for the mailing. The facility lacked any evidence</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155546	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2014
NAME OF PROVIDER OR SUPPLIER BETHEL POINTE HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 3400 W COMMUNITY DR MUNCIE, IN 47304		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	of education given prior to administering the flu vaccine. 3.1-52(b)(2)				