STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155295		03/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON HOUSE HEALTH AND REHAB CENTER	809 W FREEMAN ST FRANKFORT, IN 46041

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit was in conjunction with the Investigation of Complaint IN00194779. This visit resulted in an Extended Survey-Immediate Jeopardy Survey dates: March 7, 8, 9, 10, & 11, 2016 Extended survey dates: March 8, 9, 10, &11, 2016 Facility number: 000192 Provider number: 155295 AIM number: 100291120 Census bed type: SNF/NF: 67 Total: 67 Census payor type: Medicare: 10 Medicaid: 53 Other: 4 Total: 67 These deficiencies reflect state findings cited in accordance with 410 IAC	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	16.2-3.1. Quality Review was completed by 21662 on March 16, 2016.			
F 0155 SS=J Bldg. 00	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES 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. 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. Based on interview and record review the facility failed to ensure a resident's right in self determination regarding implementation of the formulated advanced directive which resulted in death, in that when a resident made the determination for CPR (cardio-pulmonary resuscitation) in the event of unresponsiveness or cardiac	F 0155	· Resident # 2957 expired on 2/29/2016. Nurse was suspended pending investigation. Nurse's employment was terminated on 3/7/2016 and reported to the Indiana Professional Licensing Bureau for not initiating CPR on a full code resident. · Residents who currently, or in the future, have the potential to be affected. · Licensed staff have been	04/01/2016

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	arrest, the Licensed Practical Nurse (LPN#4) failed to follow the resident's advanced directive and initiate CPR when he was found unresponsive. (Resident "B"). This deficient practice had the potential to affect all residents in the facility. This deficient practice resulted in Immediate Jeopardy. The Immediate Jeopardy began on 2-29-16 when the nursing staff failed to provide medical intervention (CPR) to restore circulatory and respiratory function that had ceased. The Administrator and Regional Director of Clinical Operations were notified of the Immediate Jeopardy at 4:05 p.m., on 3-7-16. Findings include: The record for Resident "B" was reviewed on 3-7-16. Diagnoses included, but were not limited to, Atrial Fibrillation, Hypertension, Heart Failure, Chronic Obstructive Pulmonary Disease. The Resident was found in his recliner pulseless with no respirations on 2-29-16. On admission to the facility on 6-1-15, the Resident's representative signed a form titled "Indiana Physician Orders for Scope of Treatment," indicating they requested attempted resuscitation in the		re-educated on the CPR process and their responsibilities of code status. Licensed and non-licensed staff have been re-educated on their roles and responsibilities during the CPR process. Staff was not allowed to work until they had been through CPR in-service. An audit was completed to validate current nurses with CPR certification. All new hires will be CPR certified or recertified within 6 weeks of employment. Mock Code blues will be conducted by the Director of Staff Development 1 time on each shift monthly for 3 months, then quarterly thereafter. · Non compliance will be addressed through re-education and progressive disciplinary actions as indicated. Results of audits will be reviewed in QAPI meeting monthly for 6 months.	

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	event the resident had no pulse and is not breathing. During a review of the progress notes dated 2-29-16, it was noted the physician of record ordered a 2-view chest x-ray in response to telephone interaction with nurse. Resident had complained of shortness of breath. During an interview with spouse of Resident "B" on 3-7-16 at 11:30 a.m., she indicated she was present when LPN#4 entered room and listened to her husband's chest. She indicated "no one pushed on his chest." On 3-7-16, a written statement and signed statement was received from the x-ray technician. The statement indicated, the technician entered the room and spoke with spouse of the resident. The technician noticed no response from the resident with his mouth open and gray coloring of the skin. The technician left the room to get assistance from the nurse. The certified nurse aide (CNA#1) entered the room. The nurse entered the room with the technician. She checked for a pulse and checked for a heartbeat with stethoscope. The technician indicated no CPR was performed on the resident. The technician and LPN#4 both left the room. CNA#1 stayed in the room with the			

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	spouse. During an interview with CNA#1 on 3-7-16 at 1:45 p.m., he indicated he entered the room after the x-ray technician left to get the nurse. He stated he observed the nurse check for pulse and heartbeat. He stated no CPR was started at that time. He stated he stayed in the room to comfort spouse until he left to retrieve a bed to place Resident "B" and assist with post mortem care. During an interview with RN#2 on 3-7-16 at 2:10 p.m., she indicated she was working on east hall when she was requested by the LPN#4 on the west hall for assistance. She was asked to confirm a resident had passed away. She entered the room and visually assessed the resident as having sallow complexion, no chest movement, she listened to chest and took vital signs in both wrists. Resident's recliner was in the upright position. She indicated LPN#4 and myself left the room. RN#3 was certified in CPR. During an interview with CNA#4 on 3-7-16 at 2:30 p.m., she indicated she followed both nurses into the room of Resident "B". She indicated she witnessed RN#3 checking resident for pulses. She noticed the recliner was in the upright position. She stayed to assist with			

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	post mortem care. During an interview with CNA#5 on 3-7-16 at 2:40 p.m., she indicated she was called into the room to assist other CNAs with hoyer lift to move Resident "B" from the recliner, which was in the upright position. The recliner had to be changed to the reclining position to place a hoyer pad under the resident to transfer him to a bed to perform post mortem care. During an interview with the Health Facility Administrator on 3-7-16 at 2:55 p.m., he indicated he was notified of the death of Resident "B" at 7 p.m., on 2-29-16. He indicated he knew they did not follow policy. He and the Director of Nursing (DON) asked LPN#4 to finish charting and suspended her. He indicated the Staff Development came into the facility and started re-education on CPR policy on 2-29-16. He started an investigation of the incident and reported to the Indiana State Department of Health on 3-1-16. During a telephone interview with LPN#4 on 3-7-16 at 3:20 p.m., she indicated the x-ray technician came out of room and stated she needed the nurse in the room. She stated she checked for pulses and started compressions while the			

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	resident was in the recliner and the spouse yelled at her to stop, she spoke to the spouse to make sure she was talking about CPR. She indicated she stopped compressions because he was in a bad position for CPR and she had no help. He was flaccid with no expression, in the recliner. She left the room to call the doctor and the night shift supervisor. She also called the DON. LPN#4 was certified in CPR. A review of the Procedure 235A on 3-7-16, titled Cardiopulmonary Resuscitation (CPR), dated August 2014. The procedure stated "... Basic Responsibility... Licensed Nurse, Other Purpose: to ventilate and establish circulation for a resident with absence of respirations and pulse. Assessment Guidelines: May include but are not limited to: -Pulse rate or absence of pulse -Pulse rhythm -Pulse quality - Cyanosis -Respiratory distress -Respiratory rate or absence of respirations - Respiratory rhythm -Respiratory quality -Level of consciousness -Vital signs -Allergies to assess if cardiac arrest is due			

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	to allergic reaction Equipment Cardiac arrest board or hard surface Sphygmomanometer and stethoscope Airway Suction machine Disposable CPR mask, use per manufacturer's instructions Face mask with hand held portable pressure device use per manufacturer's instruction Procedure 1. CPR that is done properly or on a resident improperly or whose heart is still beating can cause serious injury. Do not perform CPR unless: a. The resident has stopped breathing or is breathing abnormally b. The resident is unresponsive and does not have signs of circulation and respirations c. No one with more training in CPR is present 2. Determine unresponsiveness by tapping or gently shaking resident and shouting ,"Are you okay?" If you suspect head or neck injury, do not shake. 3. If the resident does not respond, call out for help.			

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	4. Delegate a specific individual to check resident's advance directives, orders and care plan for CPR, or no CPR (DNR) order; have specific individual call paramedics, attending physician and administrative personnel per facility procedure and report back to you as soon as possible. 5. Do not start CPR if resident is breathing normally and has a pulse, Start emergency oxygen, delegate a specific individual to stay with the resident and monitor vital signs. Notify the attending physician of the resident's condition and request further orders for care, 6. Position the resident on a cardiac arrest board or hard surface by back as a unit, supporting head and neck. Circulation: 1. Determine pulselessness. Palpate the carotid artery gently to void compression the artery. Check circulation for no more than 10 seconds. 2. If the resident is unconscious with no normal breathing and no pulse,begin compressions. 3. Perform external chest compressions by placing heel of dominate hand on the center of the chest between nipples. The			

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	second hand should be placed directly on top of the first hand. 4. Depress sternum 2 inches. Give 30 chest compressions at a rate of at least 100 compressions per minute. Keep hands of sternum during upstroke. Airway: 1. Open airway using head tilt chin lift (by tilting the head back with one hand while lifting up the resident's chin with your other hand.) 2. Maintain an open airway. Look in the mouth to make sure the airway is clear. 3. If a foreign object is present, sweep it out right away. Breathing: 1. If the resident is breathless or has abnormal breathing, perform rescue breathing by gently placing the face mask over the resident's nose and mouth to create an airtight seal. 2. Deliver two breaths, each lasting one second. Pause between breaths. 3. Observe for chest rise and fall. The volume of each rescue breath should be sufficient to produce visible chest rise. a. Avoid delivering more breaths that			

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	recommended or breaths that are too large or too forceful. b. If the resident's chest does not rise when first breath delivered, perform the head tilt/chin lift again before giving second breath. 4. Allow chest deflation between breaths. 5. If there are signs of circulation, but no signs of breathing continue to give rescue breaths at the rate of one breath very five seconds or twelve breaths per minute. Repeat cycle of 30 compressions to 2 breaths. Continue uninterrupted until you are relieved by another knowledgeable about CPR, emergency life support arrives; a physician pronounces the resident expired or you are unable to continue. CPR Quick Reference Guide- Adults 1. Check the resident for responsiveness and normal breathing. 2. Call for help. If the resident is unresponsive delegate someone to call 911 emergency services. 3. Check pulse in the carotid artery of the neck 4. If the patient is unconscious with normal breathing and no pulse, begin chest compressions. 5. Locate the compression landmark:			

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	center of chest between nipples 6. Do chest compressions with two hands stacked; heel of one hand on sternum. Give 30 chest compressions 7. Open the airway. IF the resident is not breathing normally, begin rescue breathing: Give two full breaths at one second per breath. 8. Continue cycle ration of 30 compressions to 2 breaths. Total rate of 100 compressions per minute with compression depth of 2 inches. Documentation Guidelines: Documentation many include: Completion of CPR Change of Condition Form Notification of physician Notification of resident family or responsible party...." The Immediate Jeopardy that began on 2-29-16 was removed on 3-8-16, but the noncompliance remained at the lower scope and severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy because of the need for ongoing staff training. The surveyor confirmed the following by observation, interview and record review: 1. The facility ensured the Advanced Directive forms were completed appropriately, and Physician ordered			

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	obtained and reflective of the resident's decision for end of life care. Resident care plans were reviewed and reflective of resident's end of life care. 2. The facility completed an inservice for all licensed and unlicensed staff on code response currently available in the facility was completed on 3-8-16. Remaining staff would be required to be re-inserviced prior to next scheduled shift. 3. The facility performed Mock Code Drill to ensure staff's understanding of responsibilities during a code. This was completed on all three shifts on 3-2-16 and 3-3-16. 4. A review of staff involved in Resuscitative efforts were CPR certified. CPR certification reviewed and verified by ISDH surveyors on 3-8-16. 5. Through observation, record review, staff were interviewed to ensure they were aware of the facility policy and procedure and their responsibility in regard to code status. This Federal Tag relates to the Complaint IN00194779.			

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	3.1-3(a) 3.1-3(u)(3)			
F 0279 SS=D Bldg. 00	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. 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. 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, the facility failed to ensure the accuracy of the plan of care as it relates to safety for 1 of 2 residents reviewed for accidents. (Resident #99). Findings include:	F 0279	· Resident # 99 has been discharged. · Residents who are at risk for elopement have the potential to be effected by this alleged	04/01/2016

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	A review of the record for Resident #99 was completed on 3/9/16 at 9:00 a.m. Diagnoses included, but were not limited to, psychotic disorder with delusions, Alzheimer's Disease, anxiety disorder, abnormalities of gait, unsteadiness on feet, and cognitive communications deficit. A review of the plan of care, dated 12/30/15, indicated the resident had exit seeking behavior and had wanderguard in place. The plan of care included instructions for nursing staff to check wanderguard for placement each shift. An elopement risk assessment was completed on admission and identified Resident #99 as having exit seeking behavior. A review of the Treatment Administration Record (TAR) dated 12/13/15 through 1/21/16, indicated no checks for the wanderguard were completed. A review of the physician orders on admission did not indicate a wanderguard was ordered. During an interview on 3/9/16 at 10:20 a.m., with the Director of Resident		deficient practice. · Elopement assessments were validated for residents who triggered for elopement. Interventions and Care plans were put in place and updated. Elopement binders have been updated for current residents with wander guards. All new residents will be assessed upon admission and interventions and care plans will be put in place. Quarterly IDT/change of condition will be reviewed for proper interventions and care planning. RAI Director will audit all new charts, Change of condition, 7 day, 14 day and 30 day assessment and quarterly thereafter for up dated or revised care plans. Nursing staff will be	

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	Assessment, she indicated the resident was on the Memory Care Unit. There were no checks of the wanderguard because no wanderguard was ordered. The plan of care was never changed. A review of the Procedure #236, dated 8/2014, titled "Care Plan, Comprehensive," indicated "... Basic Responsibility IDT... Policy: It is the policy of this facility to develop, in conjunction with the resident and/or representative, the Comprehensive Resident Care Plan. The care plan is directed toward achieving and maintaining optimal status of health, functional ability, and quality of life. It is completed no later than seven days (7) after the completion of the RAI. It is reviewed and revised by the Interdisciplinary Team quarterly, following the completion of the MDS assessment, and following assessment for significant change....6. The individualized Care Plan is accessible to all caregivers to assure resident specific care information is exchanged and the consistent delivery of care services and approaches...." 3.1-35(a)		in-serviced on assessments and creating, revising, or updating care plans. Director of Nursing or designee will audit medical record with each new admission or change in condition to ensure assessments have been completed and care plans put in place, revised and or updated. · Non compliance will be addressed through re-education and progressive disciplinary actions as indicated. Results of audits will be reviewed in QAPI meeting monthly for 6 months.	

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	155295		03/11/2016

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F 0280 SS=D Bldg. 00	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on record review and interview the facility failed to update the treatment plan to include the psychotropic medication for 1 out of 5 residents reviewed for unnecessary medications. (Resident #39). Findings include: The record for Resident #39 was reviewed on 3/9/16 at 3:33 p.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance, Alzheimer's disease, delusional disorder,	F 0280	· Resident # 39 has been assessed and has no adverse effects from the antipsychotic medication. · Residents who receive antipsychotic medications have the potential to be effected by this alleged deficient practice. · Residents who	04/01/2016

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	hypertension, insomnia, generalized muscle weakness, mood disorder, atherosclerotic heart disease, hypelipidemia, osteoarthritis, pain. The use of an antipsychotic medication was not in the care plan dated 2/3/16. Physician order dated 2/25/16 indicated Risperidone (antipsychotic medication) 0.25 mg one tablet by mouth one time a day. During an interview on 3/10/16 at 10:42 a.m., with the Social Services Designee she indicated she was responsible for the care plan for psychotropic medication and would also add to watch for side effects. She indicated she had 7 days to get the care plan updated and she did not update the care plan for Resident #39 for the psychotropic medication. A policy titled "Psychopharmacological Agents, Clinical Use of" dated December 2012 was provided by the Director of Resident Assessments on 3/10/16 at 11:44 a.m.. The policy indicated: "...Care Plan Documentation Guidelines. Problem: Include functional impairment prompting the need for psychopharmacological agent. Goal: Maintain highest practicable mental, physical, and psychological well-being(define). Approaches:		receive antipsychotic medications have been audited for monitoring tool in the electronic medical for effectiveness and follow up. Care plans have been updated or revised to include use of antipsychotic medications. Social Service will be in-serviced on including antipsychotic medications on the care plan upon admission and quarterly. Nursing staff will be in-serviced on using the monitoring tool in the electronic medical record and how to complete follow up after each antipsychotic medication given. Residents who have an antipsychotic medication will have an AMIS completed upon admission and quarterly thereafter. Social Service	

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	Include(primary) non-pharmacological and (secondary) pharmacological interventions to alleviate behavior and limit identified triggers(antecedents) as practical." 3.1-35(c)(2)(B)		will audit each care plan of those residents who have an antipsychotic medication monthly and present to the Director of Nursing. Director of Nursing will audit each new resident for antipsychotic medications to ensure proper monitoring and care planning 5 days a week. · Non compliance will be addressed through re-education and progressive disciplinary actions as indicated. Results of audits will be reviewed in QAPI meeting monthly for 6 months.	
F 0323 SS=D Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to update the care plan to prevent the possibility of further falls	F 0323	· Resident #93 has been assessed with no	04/01/2016

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	for 1 of 2 residents reviewed for accidents. (Residents #93). Findings include: The clinical record of Resident #93 was reviewed on 3/9/16 at 1:16 p.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, dysphagia, muscle weakness, cognitive communication deficit, difficulty in walking, hypertension, hypothyroidism, hyperlipidemia, congestive heart failure, chronic kidney disease, and atherosclerotic heart disease. Nursing notes indicated Resident #93 had a fall on 11/11/15, 11/14/15, 12/9/15, and 1/7/16. A review of the care plan for Resident #93, dated 11/5/15, identified the resident was at risk for falls related to gait/balance problem. Goals were documented as the resident will be free of minor injury. Interventions included anticipate and meet needs, be sure call light is in reach, ensure appropriate footwear and nonskid socks when ambulating or mobilizing in wheelchair. Physical Therapy evaluate and treat as ordered or as needed, review information on past falls and attempt to determine cause of falls and alter or remove any potential causes if possible, and provide a safe environment. All interventions were initiated on 11/5/15. During an interview on 3/10/16 at 9:00		adverse reactions noted from alleged deficient practice. · Residents who are risk for falls have the potential to be effected by this alleged deficient practice. · Nursing staff will be re-educated on falls and fall procedures along with updating care plans and adding interventions with each fall. Director of Nursing or designee will audit EMR and care plan on the following business day for interventions and care planning after each fall. · Non compliance will be addressed through re-education and progressive disciplinary actions as indicated. Results of audits will be reviewed in QAPI meeting monthly for 6 months.	

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	a.m., with the Director of Resident Assessments, she indicated care plans were updated when warranted by a change in condition and Resident #93's care plan should have been revised or updated due to additional falls. A review of the facility policy, titled "Care Plan, Comprehensive" dated 8/14, indicated "...Procedure...4. Resident progress is regularly evaluated in each category with approach revisions and updates as appropriate...." 3.1-45(a)(2)			
F 0329 SS=D Bldg. 00	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. 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			

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	receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on record review and interview the facility failed to ensure side effect monitoring for psychotropic medication was completed for 1 out of 5 residents reviewed for unnecessary medications. (Resident #39). Findings include: The record for Resident # 39 was reviewed on 3/9/16 at 3:33 p.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance, Alzheimer's disease, delusional disorder, insomnia, and mood disorder. Physician order dated 2/25/16 indicated Risperidone (antipsychotic medication) 0.25 mg one tablet by mouth one time a day. The record did not have side effect monitoring for the antipsychotic medication. 2014 Nursing Drug Handbook indicated a black box warning of Fatal CV(cardiovascular) or infectious adverse events may occur in elderly patients with dementia and monitor patient for tardive dyskinesia (causes repetitive and	F 0329	· Resident #39 has been assessed and has no adverse effects noted from this alleged deficient practice. · Residents who receive antipsychotic drugs have the potential to be effected by this alleged deficient practice. · Residents who receive antipsychotic medications have been audited and the appropriate monitoring tools have been put in place in the EMR. Residents who receive an antipsychotic medication have been audited and all AIMS are in place. Social Service will be in-serviced on including antipsychotic medications on the care plan upon admission and	04/01/2016

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	involuntary movements such as grimacing and eye blinking). During an interview on 3/10/16 at 10:19 a.m., LPN #3 indicated there was no specific form to complete on routine basis for side effect monitoring for psychotropic medications. During an interview on 3/10/16 at 11:44 a.m., with the Director of Resident Assessments she indicated there is an every shift clinical monitoring for side effects on the MAR(Medication Administration Record) to be completed by nurses for residents receiving psychotropic medication. The Director of Resident Assessments indicated this form was not implemented for Resident #39. She also indicated this form should be initiated at admission or when psychotropic medication started. She indicated the AIMS(abnormal involuntary movement scale) should be completed upon start of psychotropic medication and quarterly. The Director of Resident Assessments indicated the AIMS was not completed for Resident #39. A policy titled "Psychopharmacological Agents, Clinical Use of" dated December 2012 was provided by the Director of Resident Assessments on 3/10/16 at		quarterly. Nursing staff will be in-serviced on using the monitoring tool in the electronic medical record and how to complete follow up after each antipsychotic medication given. · Non compliance will be addressed through re-education and progressive disciplinary actions as indicated. Results of audits will be reviewed in QAPI meeting monthly for 6 months.	

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	11:44 a.m. The policy indicated; "...5. Document medication effectiveness, side effects, and response to drug and non-drug approaches. 6. An AIMS assessment should be completed for medications with extrpyramidal (symptom) risks upon admission or initiation of therapy, with dosing increase, and every 6 months following use...." 3.1-48(a)(3)			
F 0371 SS=F Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review the facility failed to ensure expired foods were discarded and foods were dated when opened in 1 of 1 kitchens. This deficient practice had the potential to affect 66 of 66 residents who received food from the kitchen. Findings include:	F 0371	· No residents were affected by this alleged deficient practice. · Residents who reside at this facility have the potential to be affected by this alleged	04/01/2016

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	During the tour of the kitchen on 3/7/16 at 9:07 a.m., the following observations were made: 1. The dry storage area was observed to have one opened bag of tostitos not dated when opened and manufacturer expiration date of December, 2015. 2. The walk in cooler was observed to have one ten pound roll of hamburger thawing on tray with thaw date as 3/2/16 and use by 3/4/16. During an interview on 3/7/16 at 9:07 a.m., the Dietary Supervisor indicated all opened foods should be dated. A policy titled "Food Safety In Receiving and Storage" dated 2/09 received from the Dietary Supervisor on 3/7/16 at 2:27 p.m., indicated "...2. Expiration dates and use-by dates will be checked to assure the dates are within acceptable parameters...." 3.1-21(i)(3)		deficient practice. · Food service staff will be in serviced on food storage, temps, dating, and caring for foods by the Registered Dietician. Certified Dietary Manager will audit food storage, open foods and dates on a daily basis 5 times a week for 3 months, 3 times a week for 3 months and randomly thereafter. · Non compliance will be addressed through re-education and progressive disciplinary actions as indicated. Results of audits will be reviewed in QAPI meeting monthly for 6 months.	
F 0431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS			

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Bldg. 00	& 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. 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. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. 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.			
	Based on observation, interview and record review the facility failed to monitor the medication refrigerator temperatures daily for 1 of 2 medication storage rooms. This practice had the potential to affect 5 out of 5 residents	F 0431	· Residents # 91, 106, 81, 48, and 67 had the potential to be affected by this alleged deficient practice. No resident s was given medication from the refrigerator on East hall during the time period identified. The medication	04/01/2016

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	receiving medications from the east hall refrigerator (Residents #91,106, 81, 48, and 67). Findings include: During an observation on 3/8/2016 at 3:10 p.m., of the medical storage room on the east floor, the thermometer in the medication storage refrigerator, registered a temperature reading of 50 degrees Fahrenheit. The thermometer was repositioned in the refrigerator and a second reading was conducted on 3/8/2016 at 4:45 p.m. and the thermometer registered 50 degrees Fahrenheit. During an interview on 3/8/2016 at 3:15 p.m., with RN#1, she indicated the night shift nurse checked the refrigerator temperature in the medication storage room nightly and indicated the temperature reading on the refrigerator temperature log. During an interview on 3/8/2016 at 3:35 p.m., with LPN# 2, she indicated the nursing night shift checked the temperatures of the medication storage refrigerators nightly. On 3/8/3016 at 3:20 p.m., an observation of the refrigerator temperature log for the		in the refrigerator was disposed of and new medications ordered from pharmacy. Refrigerator was taken out of service until a new one could be obtained. Medications were taken to the West hall and secured. · Residents who have medications requiring being refrigerated have the potential to be affected by this alleged deficient practice. · All refrigerators have been checked for proper temperatures. Refrigerators logs have been updated to contain the correct range for temps. · Nursing staff will be in-serviced on checking temps logs of all refrigerators nightly and the process if temps are not with in stated parameters. · Director of nursing or designee will check temp logs 3 times a week for correct temps and monitoring for 8 weeks, 2 times a week for 4 weeks, once a week for 3 months to ensure compliance. · Non compliance will be addressed through re-education and progressive disciplinary actions as indicated. Results of audits will be reviewed in QAPI meeting monthly for 6 months.	

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	east hall medical storage room refrigerator indicated no temperature readings were registered for 3/1/2016, 3/5/2016, and 3/7/2016. During an interview on 3/9/2016 at 3:00 p.m., with the Director of Resident Assessments, she indicated the refrigerator was not functioning properly and the medications for 5 residents were transferred to the west hall refrigerator which was working. She indicated no resident had an adverse reaction on 3/7/2016 to medications given. A policy for "DELIVERY AND STORAGE OF MEDICATIONS AND SUPPLIES", dated 8/15/2008, received from the Administrator on 3/9/2016 at 8:25 a.m., indicated "...5.2 The refrigerator temperature should be set between 36 and 46 degrees Fahrenheit to maintain stability...." 3.1-25(m)			
F 0465 SS=E Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for			

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	residents, staff and the public. Based on observation, record review and interview, the facility failed to ensure a clean, sanitary, and home like environment related to 5 of 26 resident rooms, east and west hallways, and facility furniture (Room's # 510, 514, 515, 518, and 519). Findings include; 1. During the initial tour on 3/7/2016 at 9:15 a.m., the following was observed: a.) The overhead ceiling vent in the east hallway, outside room #210 was observed to contain dust, dirt and debris. b.) The water fountain in the main hallway, located outside the lunch room was chipped and rust was exposed along the sides of the fountain, dust and debris was found along the sides and underneath the fountain. c.) The overhead ceiling vent in the east hallway, outside the utility service and storage was observed to contain dust, dirt and debris. d.) The wood panel in the hallway on the wall outside rooms #418 and #508 was gouged, splintered and cracked.	F 0465	· All areas identified were corrected by the maintenance supervisor/housekeeping supervisor in order to meet the regulation of maintaining residents' rooms and common areas in clean and orderly state of repair. · Residents who live in the facility have the potential to be affected by this alleged deficient practice. · The Executive Director and the Maintenance Director or designee, will complete an audit of resident care areas and common areas to identify any areas that are not in good repair and those areas will be repaired. The Maintenance Director or designee will develop a monthly schedule of painting door frames and a part time painter will be employed. The painter will paint door frames twice a month and stain doors as needed. The Housekeeping Supervisor or designee will complete and audit weekly all rooms and identify any areas of concern. Rounds will be made by the Housekeeping Supervisor or designee, 5 times weekly for 2 months, then 3 times a week for 2 months, and 1 time a week for 2 months to identify areas of concern. These audits will be reviewed at the end of each business day. Housekeeping and Maintenance audits will be reviewed weekly for 2 months in QAPI and monthly thereafter. · Non compliance will be	04/02/2016

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	2. During resident room observations on 3/7/2016, the following was observed: a.) Room #510 on 3/7/2016, at 12:20 p.m., the toilet seat handle was broken, bathroom and bedroom doors were marred, chipped and peeling, the dresser and closet combination furniture was chipped, gouged and marred, the bathroom floors were stained and the corners of the bathroom floors were imbedded with dirt. b.) Room #514 on 3/7/2016, at 12:10 p.m., the bathroom sink was separating from the wall and the bathroom door and walls were chipped, gouged and marred. wall. c.) Room #515 on 3/7/2016 at 12:25 p.m., the bedroom walls were marred, the bathroom floor was stained and the corners of the bathroom floor were imbedded with dirt. d.) Room #518 on 3/7/2016 at 3:30 p.m., the bathroom sink was separating from the wall, the toilet attachment parts were rusted, the bathroom door was marred, chipped, and gouged, and the bathroom floor was stained and the corners of the bathroom floor were imbedded with dirt. e.) Room #519 on 3/7/2016 at 2:48 p.m.,		addressed through re-education and progressive disciplinary actions as indicated.	

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NAME OF PROVIDER OR SUPPLIER CLINTON HOUSE HEALTH AND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 809 W FREEMAN ST FRANKFORT, IN 46041	

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	the bathroom sink and toilet were separating from the wall, the toilet attachment parts were rusted, the bathroom door was splintered, marred, gouged and chipped, and the bathroom floor was stained. During the environmental tour with the Maintenance Supervisor and the Housekeeping and Laundry Supervisor on 3/10/2016 at 10:10 a.m., the following was observed: a.) The entry arches to the main dining area were marred, gouged, cracked and chipped and the floor corners were imbedded with dirt and debris. b.) The corner wallboard attached to the wall across from the east hall nursing station was splintered,gouged, chipped and peeling. During an interview on 3/10/2016 at 10:30 a.m., with the Housekeeping and Laundry Supervisor indicated she was not aware of the maintenance and housekeeping issues revealed during the environmental tour. During an interview on 3/10/2016 at 11:00 a.m., with the Administrator, he indicated the facility had a reporting system for all staff to notify the			

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	Maintenance Supervisor and himself of facility needed repairs and housekeeping issues. During an interview on 3/10/2016 at 10:45 p.m., with the Maintenance Supervisor, he indicated he was not aware of the facility needing these repairs or that areas were in need of cleaning by housekeeping. The policy titled "Maintenance Repair Requisition Protocol", dated 2/9/2015, received on 3/10/2016 at 1:30 p.m., from the Administrator indicated "...EMPLOYEE'S RESPONSIBILITY 1. All employees will utilize the repair requisition form that is located outside the MDS Directors Office in a plastic wall attachment. a. The form in which is attached to this policy is to be filed out co mpletely including a legible signature. The details of the location and what is not functioning correctly or not to our facility standard. b. The completed form will be placed in the plastic wall attachment in the file folder labeled [Completed Repair Requisitions],,,," 3.1-19(f)			

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