

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/20/2012
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NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122
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F0000	<p>This visit was for Investigation of Complaint IN00109086.</p> <p>Complaint IN00109086: Substantiated, Federal/State deficiencies related to the allegations are cited at F224, F309, F329 and F333</p> <p>Dates of survey: June 14, 15, 18, 19, 20, 2012</p> <p>Facility number: 000057 Provider number: 155132 AIM number: 100266570</p> <p>Survey team: Vanda Phelps, RN</p> <p>Census bed type: 102 SNF/NF 102 Total</p> <p>Census payor type: 20 Medicare 69 Medicaid 13 Other 102 Total</p> <p>Sample: 4</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F0000	The submission of this Plan of Correction does not constitute an admission by the Provider of any fact or conclusion set forth in the statement of deficiencies. The Plan of Correction is submitted because it is required by law.	

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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	Quality review completed on June 28, 2012 by Bev Faulkner, RN			

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F0224 SS=G	<p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRI ATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on observation, record review and interview, the facility failed to follow their policies and procedures to ensure the prevention of neglect in treatment and services related to basic bowel care and assessment and monitoring of opioid pain medication for 1 of 4 residents reviewed for neglect of care and services. The resident required medical intervention at the emergency room twice in two weeks. (Resident Y)</p> <p>Findings include:</p> <p>1. Resident Y's clinical record was reviewed on 6/15/12 at 10:55 a.m. It indicated he was admitted 8/15/2011 for surgical wound care. His diagnoses included, but were not limited to, severe autistic disorder and MRDD, which had been present since infancy.</p> <p>The 9/9/2011 admission MDS (Minimum Data Set) assessment and the 6/1/2012 readmission MDS assessment both indicated he was nonverbal and totally</p>	F0224	<p>Resident Y has been re-evaluated for bowel function needs. The care plan has been updated to reflect the current status of the resident. A one time audit has been completed of residents who exhibit cognitive impairment, with a Breif Interview for Mental status (BIMS) score of 8 or less, for their needs in maintaining bowel function. Licensed Nurses have been re-educated on the bowel regimen, daily review of residents who have not had a bowel movement , or small bowel movement, in the last 9 shifts, and the bowel regimen that is to be initiated immediately should they meet the criteria of no bowel movement, or small bowel movement, in the last 72 hours.It is the responsibility of the licensed nurses to pull the "No BM in the last 9 shifts, or small bowel movement" report daily for review and provide/initiate the bowel regimen should it be necessary. The Unit Managers/designee will be responsible to review the reports pulled by the Licensed Nurses 5 days/week x 30 days,</p>	07/18/2012	

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	<p>dependent on staff for all aspects of his care. The MDS assessment indicated Resident Y was not able to take himself to the bathroom independently or to verbally express feelings of discomfort and/or pain.</p> <p>A careplan entry, dated 10/25/2011, indicated Resident Y had a history of constipation and the interventions included that the Care Tracker BM Reports should be reviewed.</p> <p>Review of the computerized bowel care sheets indicated Resident Y had no recorded bowel movements from May 15 through May 22, 2012, i.e. seven days. Further, he'd had a small BM on May 12th, none on the 13th, and two small BMs on May 14th. This indicated he had not had an adequate bowel evacuation since May 11th.</p> <p>On May 22, 2012, Resident Y's family alerted staff that the resident was "not acting right." The note of 5/22/2012 at 2:20 p.m., indicated "approached by mother, requested to eval resident. Mom states something is not right with (resident)...eyes open, pupils reactive yet sluggish. resident is still, not moving limbs or body...very still, reactive to tactile stimuli..." The physician was notified and authorized transfer to the</p>		<p>then 3x/week x 60 days, to ensure proper follow up has been completed. In addition, resident bowel elimination records pulled by the Licensed Nurse will be reviewed by the Unit Manager/designee 3x/week ongoing to identify those residents with small or no BM for the last 9 shifts, or small bowel movement, to ensure follow up has been completed as per expectation. If there are no BM's noted for a resident, the physician ordered bowel program will be initiated. Any identified concerns will be immediately addressed and corrected, up to and including 1:1 re-education and disciplinary action as needed. The DON/designee will review the audits completed weekly for 12 weeks to ensure the bowel regimen has been initiated as necessary. Results of the audits will be forwarded to the Quality Assurance Committee monthly for three months, and then quarterly for three quarters. Any further action will be as determined by the QA committee. Completion Date: July 18, 2012</p>				

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	<p>emergency room per the family's request.</p> <p>The "Emergency Department Discharge Instructions" form, dated 5/22/12, was reviewed on 6/15/12 at 10:55 a.m. At the emergency room (E.R.) on 5/22/12, Resident Y was diagnosed with "fecal impaction," which emergency room staff explained to the family as "locked bowels." An abdominal CT (computed tomography) taken at that time indicated "There is a large amount of formed stool noted throughout the colon...Impression: 1. large stool burden." The E.R. nursing note indicated the resident returned to the facility 5/23/12 at 12:15 a.m.</p> <p>Family interview on 6/19/12 at 12:48 p.m., indicated she had not changed a BM brief during her visits in the facility nor when she took Resident Y out of the facility. She stated she'd seen "scratch marks on his abdomen and behind his legs" which she believed Resident Y had self inflicted pulling and tearing at his abdomen and legs due to abdominal discomfort. She indicated that as soon as the bowel impaction was manually removed in the emergency room, Resident Y had visibly relaxed.</p> <p>Observations on 6/14/12 at 12 noon, 1:00 p.m., 2:22 p.m. and 4:10 p.m.; 6/15/12 at 11:05 am, 1:35 p.m., 2:55 p.m.;</p>			

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	<p>6/18/12 at 10:35 a.m., 12:52 p.m., 2:10 p.m. and 4:15 p.m., indicated Resident Y spent most of his time in bed and was up only for meals. The privacy curtain was kept closed enough to be unable to visualize the resident without going into the room past the curtain. Staff were noted in the room only when direct care was necessary.</p> <p>The facility protocol for bowel care indicated their "standard bowel care to relieve constipation with a provider order may include the following: Milk of Magnesia 30 cc (cubic centimeters) PO (orally) every third day without BM Bisacodyl Suppository rectally if no results from Milk of Magnesia Fleets Enema rectally if no results from Bisacodyl Suppository"</p> <p>Review of the nursing notes from May 11 through May 22, 2012 indicated there was no documentation related to bowel care/management or constipation. There was no indication the bowel sheets had been reviewed. There was no indication assessment or treatment had been provided.</p> <p>Review of the physician orders for May 2012 and review of the May 2012 MAR (Medication Administration Record)</p>						

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	<p>indicated Resident Y had a 11/7/2011 physician order for Milk of Magnesia to be given daily as needed for constipation. In addition, the resident had a physician order, dated 11/7/2011, to use Bisacodyl suppositories every three days as necessary for constipation. Milk of Magnesia was documented as having been given once, 5/10/2012, during the month of May 2012. No doses of Bisacodyl were documented as given.</p> <p>This issue was discussed during an interview with the Administrator and Director of Nursing Services (DNS) at 5 p.m. on 6/18/2012. The DNS shook her head negatively and insisted this could not have occurred. She indicated the family had taken the resident out of the facility and failed to report a BM had occurred during the outing.</p> <p>Family interview on 6/19/12 at 12:48 p.m., indicated the only time she had taken Resident Y out of the facility in May 2012 was to the dentist on 5/16/12. She indicated she had not changed a BM brief during her visits in the facility nor when she took Resident Y out of the facility. She added, "He's much too big for that now. There are no places we could do that. I'd have to bring him back to the facility and let them do it."</p>						

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	<p>2. Continued record review for Resident Y indicated he had a 1/19/2012 physician's order for an opioid pain medication, Oxycodone 5 mg (milligrams) every four hours as needed for pain. This was used sparingly until 5/16/2012 when he had two teeth extracted. Until that time, Oxycodone was documented on the May 2012 MAR (medication administration record) as having been given once on May 4, May 7 and May 13, 2012.</p> <p>Review of the May 2012 MAR and the Oxycodone sign out sheets indicated Resident Y then received Oxycodone more often: On May 15th (the day before the extraction) he received 5 doses, none on the 16th or 17th, 5 doses on the 18th, 5 doses on the 19th, 5 doses on the 20th, 3 doses on the 21st, 1 dose on the 22nd, 2 doses on the 23rd. On the 24th he received 4 doses, 5 doses on the 25th, 3 doses on the 26th, and 4 doses on the 27th. A nursing note entry of 5/27/12 at 3:22 p.m., indicated "spent all day sleeping et was unable to be aroused by staff or family to eat lunch. He had 2 doses on the 28th. This was now twelve days after the teeth extractions.</p> <p>The indications documented in the nursing notes for giving the Oxycodone</p>				

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	<p>were usually related to increased agitation, head banging and thrashing around in bed. However, not all doses of Oxycodone were recorded in the nursing notes. Examples not inclusive of all were: 5 doses of Oxycodone were documented on the Oxycodone tracking sheet as given to Resident Y on 5/19/12, but there were no nursing notes for that date. On 5/20/12, he received 5 doses of Oxycodone: 4 am, 8 am, 12 noon, 4 pm and 8 pm. The nursing notes for that day were as follows: "2:20 am, lab results called to physician. no new orders.; 3 am, rested quietly, some moaning & yelling out early in the shift. 0 bleeding noted to his gums around his mouth r/t (related to) teeth being pulled. Pt inc (incontinent) of bladder, staff provides peri care & repositioning...."</p> <p>The system the facility used for tracking controlled drugs was to maintain a booklet for each month with a different page for each drug order. Each page had spaces to be completed by staff each time a new order of controlled medication was received. These spaces were listed as "resident's name, Rx #, date, medication, strength, nurse receiving medication, directions, physician, transferred from page number (if applicable), and quantity." There was no space on this designated tracking page to</p>			

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	<p>indicate what indicators were to be followed.</p> <p>The behaviors of head banging, throwing his body to and fro and becoming agitated were common to his diagnoses.</p> <p>Family interviewed on 6/19/12 at 12:45 p.m., indicated these behaviors had been displayed since Resident Y's infancy and seemed to come in "spurts." They indicated Resident Y's usual indicators of pain were biting his clothes and a certain pitched squeal.</p> <p>There were no comprehensive assessments documented regarding whether or not the head banging and throwing his body to and fro were his ways of expressing pain or frustration or behaviors related to his severe autism and retardation.</p> <p>On 5/28/2012, the 1:55 p.m. nursing note indicated, "T-95.6, O2 (oxygen) 96%, BP 68/42, P 56, R 18. Writer notified by family that approx (approximately) 12 p res stopped breathing. Upon assessment noted res (resident) pale, cool et (and) clammy. Lung fields cl (clear). resp shallow at 18. BP 68/42, O2 sats 96% RA (room air). MD notified and received order to send res out. At 12:15 res resp (respirations) decreased to 14,</p>						

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	<p>bradycardia noted on auscultation. Res moved to floor c (with) stimulation res open eyes briefly. Crash cart obtained at 12:25 p. 911 arrived at 12:30 p et res transferred out to HRH (hospital). Family followed ambulance out."</p> <p>Review of the hospital discharge summary of 5/29/2012 indicated Resident Y's primary diagnosis was "over sedation with opiates, resolved" The second diagnosis was aspiration pneumonia likely secondary to over sedation with opiates. With the third diagnosis listed as hypotension secondary to medications, resolved. He was discharged back to the facility on 5/29/2012 with a change in his pain medication from scheduled Oxycodone to Lortab Elixer on an as needed basis "to avoid over sedation."</p> <p>To be noted, the Oxycodone order had also been on an as needed basis.</p> <p>The Administrator and Director of Nursing Services indicated during an interview on 6/18/2012 at 5 p.m., that the behaviors of head banging and throwing his body to and fro were indicators of pain and could not be further evaluated due to his mute autism and mental retardation. They did not offer an explanation for the lack of assessment of his lethargy.</p>			

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	<p>Review of the facility Abuse/Neglect protocol on 6/18/2012 at 11:35 a.m. indicated the facility defined neglect as "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. This presumes that instances of abuse/neglect of all residents, even those in a coma, cause physical harm, pain or mental anguish." The most recent abuse/neglect all staff inservice was dated 8/18/2011.</p> <p>This federal tag relates to complaint IN00109086.</p> <p>3.1-28.(a)</p>				

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F0309 SS=G	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interviews, the facility failed to provide adequate bowel care for a mute resident receiving opiate pain medication over an extended period of time by failure to monitor the BM sheets, failure to utilize the existent physician orders for management of constipation and failure to assess resident behavior relative to extreme constipation. This affected 1 of 4 residents reviewed for bowel care and resulted in transfer to the emergency room with diagnosis of a fecal impaction with a decline in his level of consciousness. (Resident Y)</p> <p>Findings include:</p> <p>1. Resident Y's clinical record was reviewed on 6/15/12 at 10:55 a.m. It indicated he was admitted 8/15/2011 for surgical wound care. His diagnoses included, but were not limited to, severe autistic disorder and MRDD, which had been present since infancy.</p> <p>The 9/9/2011 admission MDS (Minimum</p>	F0309	Resident Y has been re-evaluated for bowel function needs. The care plan has been updated to reflect the current status of the resident. A one time audit has been completed of residents who exhibit cognitive impairment, with a Breif Interview for Mental status (BIMS) score of 8 or less, for their needs in maintaining bowel function. Licensd Nurses have been re-educated on the bowel regimen, daily review of residents who have not had a bowel movement , or small bowel movement, in the last 9 shifts, and the bowel regimen that is to be initiated immediately should they meet the criteria of no bowel movement, or small bowel movement, in the last 72 hours.It is the responsibility of the licensed nurses to pull the "No BM in the last 9 shifts, or small bowel movement" report daily for review and provide/initiate the bowel regimen should it be necessary. The Unit Managers/designee will be responsible to review the reports pulled by the Licensed Nurses 5	07/18/2012			

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	<p>Data Set) assessment and the 6/1/2012 readmission MDS assessment both indicated he was nonverbal and totally dependent on staff for all aspects of his care. The MDS assessment indicated Resident Y was not able to take himself to the bathroom independently or to verbally express feelings of discomfort and/or pain.</p> <p>A careplan entry, dated 10/25/2011, indicated Resident Y had a history of constipation and the interventions included that the Care Tracker BM Reports should be reviewed.</p> <p>Interviews of LPN #3 and #4 and the Director of Nursing Services about facility bowel protocol indicated the following:</p> <p>A. LPN #3 6/18/12 at 4 p.m.: There is a bowel sheet printed out for the nurses every day. We are to monitor it. If a resident goes 3 days without a BM, give PRN dose of Milk of Mag. Repeat it if necessary.</p> <p>B. LPN #4, 6/18/12 at 4:40 p.m.: Day shift monitors and gives PRN Milk of Mag if over 3 days without BM or if they only have small BMs. They tell the 2nd shift nurse and if no</p>		<p>days/week x 30 days, then 3x/week x 60 days, to ensure proper follow up has been completed. In addition, resident bowel elimination records pulled by the Licensed Nurse will be reviewed by the Unit Manager/designee 3x/week ongoing to identify those residents with small or no BM for the last 9 shifts, or small bowel movement, to ensure follow up has been completed as per expectation. If there are no BM's noted for a resident, the physician ordered bowel program will be initiated. Any identified concerns will be immediately addressed and corrected, up to and including 1:1 re-education and disciplinary action as needed. The DON/designee will review the audits completed weekly for 12 weeks to ensure the bowel regimen has been initiated as necessary. Results of the audits will be forwarded to the Quality Assurance Committee monthly for three months, and then quarterly for three quarters. Any further action will be as determined by the QA committee. Completion Date: July 18, 2012</p>		

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	<p>results, give another dose Milk of Mag. Said would tell day shift if no results and they would call MD.</p> <p>C. Director of Nursing Services 6/18/12 at 5 p.m.: Daily print outs of CNA computerized bowel care sheets. Nurse is to monitor. Give Milk of Mag if 3 days without BM. Follow up with Bisacodyl if no results from Milk of Mag.</p> <p>Review of Resident Y's physician orders noted an order, dated 1/19/12 for Oxycodone 5 mg (milligrams) to be given orally every 4 hours as needed for pain. Review of Oxycodone in the 2010 Nursing Spectrum Drug Handbook indicated it is classified as an opioid narcotic to be used for moderate or severe pain when continuous around-the-clock analgesia is needed. Potential adverse reactions included constipation and pruritis (extreme itching).</p> <p>The May 2012 MAR (Medication Administration Record) indicated Oxycodone was given once on 5/4/12, 5/7/12 and 5//13/12. On the 15th of May it was given 5 times for suspected oral pain. Two teeth were extracted 5/16/12. He received no doses on the 16th or 17th, 5 doses on the 18th, 5 doses on the 19th, 5</p>			

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	<p>doses on the 20th, 3 doses on the 21st, 1 dose on the 22nd, 2 doses on the 23rd. On the 24th he received 4 doses, 5 doses on the 25th, 3 doses on the 26th, and 4 doses on the 27th. A nursing note entry of 5/27/12 at 3:22 p.m. indicated "spent all day sleeping et was unable to be aroused by staff or family to eat lunch. He had 2 doses on the 28th. It was by then twelve days after the teeth extractions.</p> <p>Review of the computerized bowel care sheets mentioned above indicated Resident Y had no recorded bowel movements from May 15 through May 22, 2012, i.e. seven days. Further, he'd had a small BM on May 12th, none on the 13th, and two small BMs on May 14th. This indicated he had not had an adequate bowel evacuation since May 11th.</p> <p>On May 22, 2012, Resident Y's family alerted staff that the resident was "not acting right." The note of 5/22/2012 at 2:20 p.m., indicated "approached by mother, requested to eval resident. Mom states something is not right with (resident)...eyes open, pupils reactive yet sluggish. resident is still, not moving limbs or body...very still, reactive to tactile stimuli..." The physician was notified and authorized transfer to the</p>						

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	<p>emergency room per the family's request.</p> <p>The "Emergency Department Discharge Instructions" form, dated 5/22/12, was reviewed on 6/15/12 at 10:55 a.m. At the emergency room (E.R.) on 5/22/12, Resident Y was diagnosed with "fecal impaction," which emergency room staff explained to the family as "locked bowels." An abdominal CT (computed tomography) taken at that time indicated "There is a large amount of formed stool noted throughout the colon...Impression: 1. large stool burden." The E.R. discharge document indicated the impaction was removed and the resident returned to the facility 5/23/12 at 12:15 a.m.</p> <p>Review of the nursing notes from May 11 through May 22, 2012 indicated there was no documentation related to bowel care/management or constipation. There was no indication the bowel sheets had been reviewed. There was no indication assessment or treatment had been provided.</p> <p>Review of the physician orders for May 2012 and review of the May 2012 MAR (medication administration record) indicated Resident Y had a 11/7/2011 physician order for Milk of Magnesia to be given daily as needed for constipation.</p>			

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	<p>In addition, the resident had a physician order, dated 11/7/2011, to use Bisacodyl suppositories every three days as necessary for constipation. Milk of Magnesia was documented as having been given once, 5/10/2012, during the month of May 2012. No doses of Bisacodyl were documented as given.</p> <p>Family interview on 6/19/12 at 12:48 p.m., indicated she had not changed a BM brief during her visits. She stated she'd seen "scratch marks on his abdomen and behind his legs," which she believed Resident Y had self inflicted by pulling and tearing at his abdomen and legs due to abdominal discomfort. She indicated that as soon as the bowel impaction was removed in the emergency room, Resident Y had visibly relaxed.</p> <p>The facility protocol for bowel care was reviewed on 6/18/12 at 4:50 p.m. and indicated their "standard bowel care to relieve constipation with a provider order may include the following: Milk of Magnesia 30 cc (cubic centimeters) PO (orally) every third day without BM Bisacodyl Suppository rectally if no results from Milk of Magnesia Fleets Enema rectally if no results from Bisacodyl Suppository"</p>						

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	<p>Review of the nursing notes from May 11 through May 22, 2012 was notable in that nothing was mentioned about bowel care, constipation, etc.</p> <p>Further review of the computerized bowel care sheets for May through June 16, 2012 indicated there was no documented bowel movement from June 1 through June 8, 2012. This was 8 days without a documented bowel movement. Review of the MAR indicated there was no documentation that Milk of Magnesia or Bisacodyl were administered. A small bowel movement was documented for June 9, 2012 and two extra large bowel movements were documented on 6/10/12.</p> <p>This issue was discussed during an interview with the Administrator and Director of Nursing Services (DNS) at 5 p.m. on 6/18/2012. The DNS shook her head negatively and insisted this could not have occurred. She indicated the family had taken the resident out of the facility and failed to report a BM had occurred during the outing.</p> <p>Family interview on 6/19/12 at 12:48 p.m., indicated the only time she had taken Resident Y out of the facility in May 2012 was to the dentist on 5/16/12. She indicated she had not changed a BM brief during her visits in the facility nor</p>			

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	<p>when she took Resident Y out of the facility. She added, "He's much too big for that now. There are no places we could do that. I'd have to bring him back to the facility and let them do it."</p> <p>The 10/25/2012 care plan addressing "alteration in bowel elimination plan of care" indicated Resident Y had a history of constipation. The interventions included "Review Care Tracker BM Reports."</p> <p>This federal tag relates to complaint IN00109086.</p> <p>3.1-37(a)</p>			

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F0329 SS=G	<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, record review and interviews, the facility failed to ensure 1 of 4 residents sampled for medication review did not receive unnecessary medication. This was due to the facility's failure to perform thorough assessments of the resident's condition to determine need for these medications and/or to monitor for adverse reactions. This resulted in the resident being transferred to the emergency room with a resultant diagnosis of over sedation with opiates. (Resident Y)</p>	F0329	Resident Y has been re-assessed by the attending physician for pain management as well as behavior management needs. The care plan has been updated to reflect the current status of the resident. A one time audit has been completed for current resident population reviewing narcotic medication and anti-anxiety medications Licensed Nurses have been re-educated on documentation of antipsychotic drug orders and the appropriate resident assessments for causative factors related to	07/18/2012

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	<p>Findings include:</p> <p>During the orientation tour of 6/14/2012 at 11:15 a.m., Resident Y was observed lying on a mattress on the floor of his room. He was observed to be unable to get out of bed independently unless he rolled out. RN #5 indicated at the time that Resident Y was severely autistic and had behaviors of yelling, thrashing when in a wheelchair, rolling into furniture, biting self and staff and wore a helmet at all times to prevent injuries during these behaviors.</p> <p>Resident Y's clinical record was reviewed on 6/15/12 at 10:55 a.m. It indicated he was admitted 8/15/2011 for surgical wound care. His diagnoses included, but were not limited to, severe autistic disorder and MRDD (mental retardation/developmental disability), which had been present since infancy. The 9/9/2011 admission MDS (Minimum Data Set) assessment and the 6/1/2012 readmission MDS assessment both indicated he was nonverbal and totally dependent on staff for all aspects of his care. The MDS assessment indicated Resident Y was not able to take himself to the bathroom independently or to verbally express feelings of discomfort and/or pain.</p>		<p>pain and behaviors. It is the responsibility of the Licensed Nurses to administer medications as per MD order, and to perform a thorough assessment of the residents prior to administering antipsychotic drug orders and narcotic analgesics. The Unit Manager/designee will be responsible to review the administration of as needed narcotic analgesics and anti-anxiety medications daily for 30 days, weekly for 8 weeks, and then monthly thereafter, to ensure as needed medications are being given appropriately. Any identified issues will be immediately addressed and corrected, up to and including 1:1 re-education and disciplinary action as necessary. The DON/designee will review the audits completed weekly for 12 weeks to ensure medications are given as per expectation. Results of the audits will be forwarded to the Quality Assurance Committee monthly for three months, and then quarterly for three quarters. Any further action will be as determined by the QA committee. Completion Date: July 18, 2012</p>				

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	<p>Interview with LPN #6 on 6/18/12 at 2:20 p.m., indicated Resident Y had been calm and quiet when admitted last year, but as his physical condition improved, he became more and more active and now was uncontrollable at times, requiring staff to stay with him 1:1 just to keep him safe from his potentially self-injurious behaviors.</p> <p>Nursing notes and physician orders indicated the resident required the extraction of two teeth on 5/16/12. Because the resident began chewing on his clothing and trying to put things in his mouth at that time, the family suggested he was in pain. Staff began utilizing a PRN (as needed) physician order of 1/19/2012 for Oxycodone 5 mg (milligrams) every 4 hours as needed for pain. Oxycodone is classified as an opioid narcotic. On May 15th, the controlled substance register for the Oxycodone indicated 5 doses were administered to Resident Y for oral pain. The teeth were extracted on 5/16/12 and he received 3 doses on the 16th and none on the 17th of May. He received 5 doses on the 18th, 5 doses on the 19th, 5 doses on the 20th, 3 doses on the 21st, 1 dose on the 22nd, 2 doses on the 23rd. On the 24th he received 4 doses, 5 doses on the 25th, 3 doses on the 26th, and 4 doses on</p>						

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	<p>the 27th. A nursing note entry of 5/27/12 at 3:22 p.m. indicated "spent all day sleeping et was unable to be aroused by staff or family to eat lunch. He had 2 doses on the 28th. It was by then twelve days after the teeth extractions.</p> <p>Review of the physician orders also noted a 5/4/2012 order for Xanax 0.5 mg. twice daily if needed for anxiety. Xanax is in the benzodiazepine classification of drugs. Review of Xanax in the 2010 Nursing Spectrum Drug Handbook indicated the interaction between Xanax and opioids (Oxycodone) included depression of the CNS (central nervous system) which is the control center for breathing, blood pressure, and heart rate, amongst other functions. It advised "watch for excessive CNS depression, i.e. low blood pressure, slow heart rate and respirations."</p> <p>Comparison of the nursing notes and controlled substance registers indicated Resident Y was given both of these medications, sometimes at the very same time. Evidence of staff attempts to determine whether the resident needed a pain pill or an anxiety pill, if any, were lacking. Examples, not inclusive of all:</p> <p>a. 5/18/12: Nursing note, no time stated: "alert, rested quietly in bed most of night.</p>						

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	<p>Oxycodone 5 mg tab PO (orally) @ 12 am and 4 am per order, crushed in applesauce c thickened water...0 bleeding noted form extraction sites to mouth..."</p> <p>There was no indication Resident Y needed these two doses of an opioid. A nursing note at 2 p.m. indicated, "Res agitated @ breakfast this morning. Res was banging head on back of w/c (wheelchair) et yelling loudly. PRN Xanax given as ordered by MD. Res laid down p (after) breakfast. Continued to roll around mat et make loud noises. Res fell asleep approximately 10 a.m....remains in bed asleep @ this time. 0 further behaviors noted since breakfast."</p> <p>The controlled substance register indicated he received Oxycodone every 4 hours (12 a.m., 4 a.m., 8 a.m., 4 p.m., and 8 pm) and Xanax 0.5 mg at 8 a.m. and 8 p.m. Both were to be given only if needed.</p> <p>b. 5/19/12: There were no nursing notes for the entire day. Resident Y received 5 doses of Oxycodone and 0.5 mg of Xanax at 7 a.m. and 1.0 mg at 7:40 p.m.</p> <p>c. 5/23/12: Nursing note at 7:30 p.m.: "Has remained quiet most of shift. Resting soundly. 0 symp (symptoms) of agitation, medication x 1 for pain. Oral care provided..." Resident Y received</p>						

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	<p>Oxycodone at 6 p.m. and 10 p.m. and Xanax at 2 a.m. and 9 p.m.</p> <p>There were no comprehensive assessments documented regarding whether or not the head banging and throwing his body to and fro were his ways of expressing pain or frustration or behaviors related to his severe autism and retardation.</p> <p>On 5/28/2012, the 1:55 p.m. nursing note indicated, "T-95.6, O2 (oxygen) 96%, BP 68/42, P 56 R 18. Writer notified by family that approx (approximately) 12 p res stopped breathing. Upon assessment noted res (resident) pale, cool et (and) clammy. Lung fields cl (clear). resp shallow at 18. BP 68/42, O2 sats 96% RA (room air). MD notified and received order to send res out. At 12:15 res resp (respirations) decreased to 14, bradycardia noted on auscultation. Res moved to floor c (with) stimulation res open eyes briefly. Crash cart obtained at 12:25 p. 911 arrived at 12:30 p et res transferred out to HRH (hospital). Family followed ambulance out."</p> <p>Review of the emergency room discharge summary of 5/29/2012 indicated Resident Y's primary diagnosis was "over sedation with opiates, resolved" The second diagnosis was aspiration pneumonia</p>						

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	<p>likely secondary to over sedation with opiates. The third diagnosis was hypotension secondary to medications, resolved. He was discharged back to the facility on 5/29/2012 with a change in his pain medication from scheduled Oxycodone to Lortab Elixer on an as needed basis "to avoid over sedation."</p> <p>During interview with the Administrator and the Director of Nursing on 6/18/12 at 5 p.m., they indicated staff were giving the Oxycodone for behaviors of head banging, throwing his body to and fro/especially while in a wheelchair, and biting. The Director of Nursing indicated it was hard for them to tell what was bothering him because he is mute and mentally disabled. They indicated the reason the medication was given was to be documented in the nursing notes.</p> <p>This federal tag relates to complaint IN00109086.</p> <p>3.1-48(a)(3) 3.1-48(a)(4) 3.1-48(a)(5) 3.1-48(a)(6)</p>			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/20/2012	
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122			
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F0333 SS=E	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>Based on record review and interviews, the facility failed to assure error free benzodiazapine administration for 1 of 4 residents reviewed for medication errors. The resident received a double dose of as needed Xanax multiple times during May and early June of 2012 . (Resident Y)</p> <p>Findings include:</p> <p>Resident Y's clinical record was reviewed on 6/15/12 at 10:55 a.m. It indicated his diagnoses included, but were not limited to, severe autistic disorder and MRDD (mental retardation/developmental disability), which had been present since infancy. The 6/1/2012 readmission MDS (Minimum Data Set) assessment indicated he was nonverbal and totally dependent on staff for all aspects of his care.</p> <p>Review of his medication orders indicated a physician order, dated 5/4/2012, for antianxiety medication, Xanax (generic name Alprazolam) 0.5 mg (milligram) one tablet, twice daily as needed. This was a new medication for Resident Y. Review of the controlled substance register for May and June of 2012</p>	F0333	<p>Resident Y's benzodiazapine medication orders have been reviewed, with new orders obtained. Care plans have been updated to reflect the current resident status. 1:1 re-education has been provided for the nursing staff. A one time audit of benzodiazapine medication orders has been completed for current resident population. Licensed Nurses have been re-educated on the administration of benzodiazepine medications and giving the medications as per physician order, and the correct use of the controlled substance record book. It is the responsibility of the Licensed Nurses to administer medications as per physician order. The Unit Managers/designee will complete an audit of benzodiazepine medications administration daily x 30 days, weekly x 8 weeks, and then monthly for 6 months. In the event that a medication error is found, a medication error report will be completed, with physician, resident, and or family notification. Any identified concern will be immediately brought to the attention of the DON, as well as identified non-compliance addressed with 1:1 re-education, and/or including</p>	07/18/2012			

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	<p>indicated the resident had been given two 0.5 mg tablets at a time on the following dates and times:</p> <ol style="list-style-type: none"> 1. 5/5/12 at 2 A.M. 2. 5/9/12 at 3 A.M. 3. 5/9/12 at 6 A.M. 4. 5/14/12 at 12 A.M. 5. 5/18/12 at 8 A.M. 6. 5/18/12 at 8 P.M. 7. 5/19/12 at 7 A.M. 8. 5/23/12 at 2 A.M. 9. 5/23/12 at 9 P.M. 10. 5/24/12 at 11 A.M. 11. 5/25/12 at 9 A.M. 12. 5/25/12 at 10 P.M. 13. 5/26/12 at 7 ? 14. 5/27/12 at 12 A.M. 15. 5/27/12 at 11:30 ? 16. 6/1/12 at 4:45 ? 17. 6/2/12 at 8:15 P.M. 18. 6/3/12 at 1:45 A.M. 19. 6/12/12 at 6:10 A.M. 20. 6/12/12 at 12 A.M. <p>The signatures on these double dosed medication administrations represented eight different nurses, but the signatures were difficult to read and it could not be ascertained if they were LPNs or RNs. Nurse employees #1, 2, 5, 6, 7, 8, 9, and 10 had signed out the double dose.</p> <p>Review of Xanax in the 2010 Nursing Spectrum Drug Handbook indicated the</p>		<p>disciplinary action as appropriate. The DON/designee will review the audits completed weekly for 12 weeks to ensure medications are given as per expectation, and the controlled substance record books are used as per expectations. Results of the audits will be forwarded to the Quality Assurance Committee monthly for three months, and then quarterly for three quarters. Any further action will be as determined by the QA committee. Completion Date: July 18, 2012</p>		

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	<p>interaction between Xanax and opioids (Oxycodone) included depression of the CNS (central nervous system) which is the control center for breathing blood pressure and heart rate, amongst other functions. It advised "watch for excessive CNS depression, i.e. low blood pressure, slow heart rate and respirations."</p> <p>It was noted Resident Y received Xanax on 5/27/12 at 11:30 (am/pm not designated). A nursing note on 5/27/12 at 3:22 p.m. indicated, "...Res has been quiet today. 0 s/s (signs and symptoms) of pain. Res spent all day sleeping et was unable to be aroused by staff or family to eat lunch. Res currently in bed, helmet intact...." Review of the controlled substance register indicated Resident Y received four doses of Oxycodone on 5/27/12 and one Xanax 0.5 mg at 12 a.m., two tablets at 11:30 and one tablet at 10:30 p.m. There was no indication the facility staff were aware of this potential drug interaction.</p> <p>The Administrator and Director of Nursing Services did not offer an explanation when this issue was mentioned during the interview on 6/18/2012 at 5 p.m. They indicated the resident's behaviors were being agitated and anxious, specifically head banging and throwing his body to and fro, kicking</p>			

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	<p>and biting. These were the same behaviors they had stated were the signs of pain for which they had given Oxycodone and were currently giving Lortab Elixer.</p> <p>This federal tag relates to complaint IN00109086.</p> <p>3.1-48(c)(2)</p>			