

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/27/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321
--	---

(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
--------------------	--	---------------	---	----------------------

F000000	<p>This visit was for the Investigation of Complaint IN00143414.</p> <p>This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaints IN00142011 and IN00142361 completed on 1/17/14.</p> <p>Complaint IN00143414 - Substantiated. Federal/State deficiency related to the allegations is cited at F329.</p> <p>Survey date: Febuary 27, 2014</p> <p>Facility number: 010758 Provider number: 155662 Aim number: 200229550</p> <p>Survey team: Yolanda Love, RN-TC Lara Richards, RN Heather Tuttle, RN</p> <p>Census bed type: SNF: 86 SNF/NF: 16 Total: 102</p> <p>Census payor type: Medicare: 30 Medicaid: 11</p>	F000000	Preparation and/or execution of the plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement of Nursing Care at Hartsfield Village of the facts alledged or conclusion set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal laws.It is the intention of this facility that this plan of correction serves as the facility's credible allegation of compliance with all regulatory guidelines.	
---------	---	---------	---	--

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/27/2014	
NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321			
(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			
F000329 SS=D	<p>Other: 61 Total: 102</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on March 5, 2014, by Janelyn Kulik, RN.</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, record review and interview, the facility failed to ensure each resident's medication</p>	F000329	F329: 1. Corrections for previous timeframes cannot be made. Resident #B remains a	03/20/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/27/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321
--	---

(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
	<p>regime was free from unnecessary medications related to the lack of an appropriate indication for the use of Seroquel (an antipsychotic) medication for 1 of 3 residents reviewed for unnecessary medications. (Resident #B)</p> <p>Findings include:</p> <p>On 2/27/14 at 11:30 a.m., Resident #B was observed in her wheelchair. She was in her room visiting with family. Interview with the resident's daughter at the time indicated the resident was 91 years of age with a diagnosis of dementia and she was pleasantly confused.</p> <p>The record for Resident #B was reviewed on 2/27/14 at 11:00 a.m. The resident's diagnoses included, but were not limited to, dementia, anxiety, and hypertension.</p> <p>Review of the 60-day Scheduled Assessment Minimum Data Set (MDS) Assessment dated 12/17/13, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 4, indicating she had severe cognitive impairment. Further review of the MDS indicated the resident had no potential indicators for psychosis. She also had no</p>		<p>resident in the facility and was awaiting a bed on our secured unit since meeting with the family on 1-20-14 . A bed became available on the secured unit on 2-27-14, and the resident was moved without incident. Resident's physician was made aware of the move to Special Care bed and an order to reduce the Seroquel was received on 2-28-14 with a goal for discontinuation . 2. All residents could have been affected by this alleged deficient practice. A 100% review of residents drug regimen was complete on 2-19-14. An additional request was made to the Consultant Pharmacist for a focus review of antipsychotic medications and the review was completed on 3-13-14. The recommendations were received and sent to the Physicians for their review on 3-14-14 The Behavior management team also met on 3-14-14 to review resident records for those receiving antipsychotic medications. The team reviewed the behavior documentation and determined a need for action in regard to collecting behavior data and making further recommendations for GDR(Gradual Dose Reductions). Consultant Pharmacist began additional Drug Regimen Reviews on 3-18-14. 3. The policy entitled "Psychotropic Medications Policy" was reviewed and the Behavior Team also</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/27/2014	
NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321			
(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			
	<p>physical or verbal behavioral symptoms toward others. However, the resident wandered, which occurred 1 to 3 days during the review period.</p> <p>Review of the Resident Progress Notes dated 12/1/13 through 2/27/14, indicated:</p> <p>The resident was monitored hourly for safety, she had a personal alarm and padded mats on the floor at her bedside.</p> <p>On 12/4/13 at 11:15 a.m., the resident asked the nursing staff if she could go home indicating she lived two blocks away. Her voice began to quiver as though she was ready to cry. Staff reoriented the resident, explained to her that her son would be in for a visit on that date, she then began to calm down and calmly waited near the nursing station.</p> <p>On 12/6/13 around 5:45 p.m., the resident was noted near the elevator. When redirected by staff the resident became upset and began cursing at staff. At the time the resident's daughter arrived for a visit. The behavior was noted by the resident's daughter and she</p>		<p>reviewed F329 to see where systematic changes in our program could be implemented. All Staff in-service training was held on 3-5-14 and 3-6-14 on topic of Dementia and Behavior Management. Additionally, nurse training 3-14-14 and going regarding Psychotropic Medications Policy. There was further training 3-19-14 and on-going for nurses and department managers for behavior monitoring. A new system was developed and instituted to document resident behaviors exhibited on the Care Plan, with precipitating events, and non-pharmalogical interventions that helped reduce or eliminate the behavior. The form entitled "New Behavior Communication Form"(attached#1) will be available at the nurses station in Behavior Binder, as well as in all department work areas for all staff to utilize when they witness resident behaviors or signs of escalation. Additionally in the Behavior Binder, each resident who has a care plan for behaviors will have a tracking log entitled, "Resident Behaviors" (attached#2). The nurses will use this form to track resident behaviors, triggers and non-pharmalogical interventions. Social Services will review the behavior book daily, 5 times per week, and add any new behaviors and/or interventions to the plan of</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/27/2014
NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321		
(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	
	<p>requested the staff order an Urine Analysis (U/A test for Urinary Tract Infections). The Physician was notified and an U/A was ordered.</p> <p>On 12/8/13 at 4:30 p.m., the resident attempted to wander twice during the 2nd shift. She was easily redirected. No combative behaviors noted.</p> <p>On 12/9/13 at 4:28 p.m., the resident was found on the floor in her room. The Physician was notified, new orders were received to send the resident to the Emergency Room (ER) for evaluation and treatment.</p> <p>On 12/9/13 at 8:45 p.m., the resident returned to the facility with a diagnosis of an Urinary Tract Infection (UTI). The first dose of antibiotics were received in the ER.</p> <p>On 12/21/13 at 7:40 p.m., the resident was noted wandering, confused, and agitated. When redirected by staff the resident became angry with staff, she also refused to eat dinner. At 8:40 p.m., the resident spoke with her daughter over the telephone. It was noted the resident verbalized feeling better knowing her family was safe.</p>		<p>care. The Behavior management team will meet monthly, but will now be gathering the data from the Resident Behaviors binders to aid in Behavior tracking. If no behaviors are present for the month, the team will go to the physician to request a GDR. They will collect all effective interventions and assure that they are present in the care plans. If resident behaviors continue, causing any risk to harm self or others, a referral will be made for Psychiatric/Behavioral Consultation. The Consultant Pharmacist will continue to conduct a Drug Regimen Review Monthly to ensure that residents are not receiving unnecessary medications or duplicate therapy. DON/ADON/Designee will be contacted when physicians try to initiate antipsychotic medications without and attempting other interventions or alternative medications. Contact with the ordering physician will take place to explain regulation and request of other measures. Medical Director will be contacted with the name of any physician who is non-compliant for follow-up.4. DON/ADON/designee will review all physician orders daily 5 times per week, to ensure that each medication has an appropriate indication for use. The Physician orders will be reviewed daily 5 times per week ongoing. The tool entitled, "Antipsychotic Drug-Quality</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/27/2014
NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321		
(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	
	<p>On 12/29/13 at 8:00 a.m., the resident was found on the floor mat next to her bed. The resident was waiting for the CNA to get her up for breakfast and indicated she had to use the bathroom. The Physician and the resident's daughter were both notified. No new orders were received.</p> <p>On 12/29/13 at 2:41 p.m., the resident was noted wandering to the elevator, when redirected by staff the resident became combative and stomped her feet on the floor, she then pushed her wheelchair back, bumping the staff member with her wheelchair. At the time she stated, "Mind your own business and leave me alone, I'll do what I want!" The resident's daughter was called and indicated she would be in soon.</p> <p>On 12/31/13 at 6:19 p.m., the resident refused to go to the dining room for dinner, stating she was not hungry. When asked if she just wanted to socialize the resident indicated she likes being alone because she won't fight herself.</p> <p>On 1/1/14 at 4:30 p.m., the resident was noted at the nursing station seated in her wheelchair. She stood</p>		<p>Review Data Collection Form" (attached #3) will be used to audit all residents charts receiving an antipsychotic medications and the indications for use. New orders regarding antipsychotic medication will be noted on this audit as an ongoing way to monitor compliance. This audit along with the behavior management meeting minutes will be brought to the Quality Assurance Nurse Monthly for tracking, trending and follow up education needs and to the QAPI committee quarterly for review and recommendations. 5. DON responsible for compliance</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/27/2014
NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321		
(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	
	<p>from her wheelchair and her personal alarm sounded. When staff asked the resident to be seated she became verbally abusive and attempted to punch and kick the staff member. No further interventions were noted.</p> <p>On 1/14/14 at 2:14 a.m., the resident was found on the floor undressed. She indicated to staff she was trying to get dressed. The resident was assessed, dressed, and assisted to bed. The Physician and the resident's daughter were both notified. No new orders were received.</p> <p>On 1/14/14 at 12:05 p.m., the resident was found sitting on the floor in the bathroom with her personal alarm in hand sounding. At the time the resident indicated she was looking for her sister. The resident was assessed, no injuries noted. The Physician and the resident's daughter were both notified of the resident's wandering and restlessness. New orders were received for an U/A and auto-lock brakes to be applied to the resident's wheelchair.</p> <p>On 1/14/14 at 4:00 p.m., the resident was noted exiting the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/27/2014	
NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321			
(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			
	<p>stairwell, the exit alarm was sounding. When the resident was redirected she became combative and requested to talk with her daughter. At the time the resident's daughter was called and she indicated to staff she would be in to see the resident. The resident also spoke with her daughter at the time and calmed down.</p> <p>On 1/14/14 at 5:15 p.m., the resident attempted to exit the stairwell again. When staff tried to redirect her she became combative, punching and scratching. The resident was moved to the dining room where she waited for her daughter's arrival. At 5:30 p.m., the resident's daughter arrived. When the nurse came to give the resident her medication she became agitated and combative. The resident's daughter was able to convince her to take her medication.</p> <p>On 1/14/14 at 7:45 p.m., the was resident was noted attempting to get onto the elevator. When staff tried to redirect her the resident became combative, swinging and telling the staff to mind their business. The resident was then asked if she would like to speak with her daughter. She became agitated</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/27/2014
NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321		
(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	
	<p>and began yelling at staff telling them they can't do their jobs if they have to call her daughter and bother her with their problems. The staff then tried to explain to the resident that hitting and kicking staff was not nice and speaking with the resident's daughter was a part of their job, the resident then stated, "Then you are fired, get the hell away from me". The resident was then left safely at the end of the hallway because redirection was not an option at the time.</p> <p>On 1/14/14 at 8:00 p.m., the resident was changed into her nightgown, however, when staff attempted to assist her to bed the resident became combative, therefore, the staff member left the resident in her wheel chair in her room. Shortly after, the resident was noted propelling herself down the hallway to the nursing station. At the time she was noted mumbling and talking to other resident's stating how staff did not mind their own business and how they are always trying to tell her what to do. The resident then stated, "They just need to leave me the hell alone".</p> <p>On 1/14/14 at 11:52 a.m., the resident's U/A results were received,</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/27/2014	
NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321			
(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			
	<p>which indicated the resident had a UTI. The Physician was paged for notification.</p> <p>On 1/15/14 at 2:18 a.m., the resident was noted sitting in front of the nursing station watching television refusing to go to bed. It was also noted, at times the resident thinks staff is talking about her and she gets agitated.</p> <p>On 1/16/14 at 11:08 a.m., new orders for antibiotics were received for the treatment of the resident's UTI.</p> <p>On 1/16/14 the resident displayed periods of wandering behavior. She was also verbally abusive to her roommate, staff, and her daughter.</p> <p>On 1/17/14 the resident was assessed by the Psychiatric Nurse Practitioner related to staff reporting increased behaviors. The resident was ordered Seroquel 12.5 mg at bedtime (to begin when the resident completed her antibiotics to treat her UTI), and Lorazepam 0.25 mg twice a day.</p> <p>On 1/18/14 at 2:30 p.m., the resident was found on the floor in her room between her wheelchair</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/27/2014	
NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321			
(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			
	<p>and the closet, her personal alarm was sounding. The resident indicated she was trying to retrieve something from her closet. The resident was assessed, no injuries noted. There was no evidence of documentation of any other interventions.</p> <p>On 1/19/14 at 3:10 a.m., the resident was found sitting on the floor mat next to her bed, her personal alarm was still attached. The resident indicated she did not fall, she was attempting to turn off the light in the bathroom, which was already turned off. The resident was assessed and bruising was noted at the time.</p> <p>On 1/19/14 at 6:50 a.m., the resident was found sitting on the floor mat next to her bed, her personal alarm was in hand not sounding. The resident indicated she was going to the bathroom at the time of her fall. The resident was assessed, no injuries noted.</p> <p>On 1/19/14 at 6:00 p.m., the resident was noted wandering into other resident's rooms. She was also noted attempting to get onto the elevator. When the resident was redirected to the dining room she</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/27/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321
--	---

(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
	<p>stated, "I don't trust you, you will probably try to poison me, I'm going to kick you in the --- with my bad leg".</p> <p>On 1/19/14 at 7:30 p.m., the Physician and the resident's daughter were notified of the resident's two falls. A 24-hour companion was suggested.</p> <p>On 1/20/14 at 1:43 p.m., the resident was noted being verbally abrasive and wandering the halls.</p> <p>On 1/20/14 at 4:08 p.m., new orders were received by the Psychiatric Nurse Practitioner, indicating she spoke with the resident's daughter who recently spoke with the resident's primary Physician, and he indicated it was okay for the resident to start the Seroquel before the completion of the antibiotic. An order was placed for Seroquel 12.5 mg before bed.</p> <p>On 2/3/14 at 8:45 p.m., the resident was found sitting on the floor next to her wheelchair facing hallway C. She indicated she slid out of the chair, stating "I know how to fall I do this all the time". The resident was assessed, no injuries were noted and the Physician was paged.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/27/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321
--	---

(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
	<p>On 2/4/14 at 6:25 p.m., the resident was observed on the floor close to her bathroom, her wheelchair was noted by the window. The resident indicated she did not remember where she was going. The resident was assessed, no injuries were noted. The Physician and daughter were both notified.</p> <p>On 2/15/14 at 8:35 p.m., the Resident was heard yelling, "You need to call my sister, I've been waiting here for someone to pick me up!" When staff turned to see who was yelling the resident was observed standing holding the molding of the window near the nursing station. The resident was asked to sit back down in her wheelchair, when trying to sit she missed the wheelchair and fell to the floor. A small skin tear was noted and first aide was rendered. The Physician was notified.</p> <p>Further review of Resident Progress Notes also indicated the resident was exit seeking and wandered off her unit on the 2nd floor and was found on the 1st floor on the following dates:</p> <p>On 1/21/14 at 2:26 p.m.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/27/2014
NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321		
(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	
	<p>On 2/4/14 at 9:34 a.m. On 2/10/14 at 3:40 p.m. On 2/12/14 at 11:15 p.m. On 2/20/14 at 2:00 p.m. On 2/22/14 at 2:29 p.m.</p> <p>A personal caregiver was provided for the resident, on 1/26/14 the resident attempted to slap her caregiver when she told her not to go to the elevator. It was noted that the resident often wonders looking for her deceased sister and becomes agitated when redirected.</p> <p>Review of the Physician's Orders dated 2/2014, indicated an order dated 10/17/13 for Donepezil 10 milligrams (mg) at bedtime for the diagnosis of dementia, Seroquel (an anti-psychotic medication) 25 mg at bedtime order dated 1/21/14, and Ativan (an anti-anxiety medication) 0.5 mg daily order dated 1/19/14, there was no evidence of documentation indicating the diagnosis.</p> <p>Review of the Psychoactive Medication Monthly Flow Record (PMMFR) dated 12/2013, indicated the resident was being monitored daily for exit seeking and repetitive requests to go home. There was no evidence of documentation</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/27/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321
--	---

(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
	<p>indicating the resident had any behaviors. The PMMFR dated 1/2014, indicated the resident had 9 exit seeking behaviors on 1/14/14, 3 exit seeking behaviors on 1/22/14, and was found wandering on the first floor on 1/26/14. The PMMFR dated 1/20/14 indicated the resident was being monitored for Seroquel 12.5 mg for the diagnosis of dementia with behavior disturbances. The behaviors included hitting, kicking, pinching, and scratching, which are not described as indications for the use of Seroquel. There was no evidence of documentation indicating the resident had any psychotic behaviors. The PMMFR dated 2/2014, also indicated no evidence of documentation indicating the resident had any psychotic behaviors.</p> <p>Review of the Michiana Multi-Specialty Medical Group progress notes dated 12/20/13 indicated the resident was calm and cooperative. Further review also indicated no Gradual Dose Reduction (GDR) or medication adjustment was clinically indicated at the time. There was a follow-up visit dated 1/17/14 related to staff reporting increased behaviors. The</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/27/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321
--	---

(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
	<p>resident was ordered Seroquel 12.5 mg at bedtime (to begin when the resident completed her antibiotics to treat her UTI), and Lorazepam 0.25 mg twice a day.</p> <p>Review of the Psychotropic Medication policy indicated, "(Name of facility) shall ensure that residents do not receive psychotropic drugs unless such therapy is necessary to treat a specific condition as diagnosed by the attending physician or psychiatric consultant.....Chemical restraints shall not be used to discipline a resident or for staff convince, but only in accordance with physician's orders when other interventions have proven unsuccessful, as documented in the medical record."</p> <p>Interview with the Director of Nursing (DoN) on 1/27/14 at 3:00 p.m., indicated the Seroquel was prescribed due to the resident exhibiting behaviors such as punching, hitting, scratching, pinching, and delusional thoughts, which she at the time indicated were psychotic behaviors.</p> <p>Review of Drugs.com indicated, "Seroquel is used to treat nervous,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/27/2014
NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321		
(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	
	<p>emotional, and mental conditions (e.g., schizophrenia). It may be used alone or together with other medicines (e.g., lithium or divalproex) to treat symptoms of bipolar disorder (manic-depressive illness) or mania that is part of bipolar disorder. This medicine should not be used to treat behavioral problems in older adult patients who have dementia or Alzheimer's disease."</p> <p>3.1-48(a)(6)</p>				