

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155535	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  02/22/2011
NAME OF PROVIDER OR SUPPLIER  WILLOW CROSSING HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 CENTRAL AVE COLUMBUS, IN47203		
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F0000	<p>This visit was for the investigation of Complaint Number IN00085952.</p> <p>Complaint Number IN00085952-Substantiated, federal/state deficiencies related to the allegations are cited at F312</p> <p>Unrelated deficiencies cited.</p> <p>Survey Date: February 22, 2011</p> <p>Facility Number: 000572 Provider Number: 155535 AIM Number: 100267710</p> <p>Survey Team: Marla Potts, RN, TC Melinda Lewis, RN Amy Wininger, RN</p> <p>Census Bed Type: SNF: 7 SNF/NF: 51 Total: 58</p> <p>Census Payor Type: Medicare: 4 Medicaid: 47 Other: 7 Total: 58</p> <p>Sample: 7</p>	F0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance.		

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/18/2011

FORM APPROVED

OMB NO. 0938-0391

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	<p>These deficiencies also reflect State findings in accordance with 410 IAC 16.2.</p> <p>Quality review completed 2-24-11 Cathy Emswiller RN</p>				

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F0312 SS=D	<p>Based on observation, interview and record review, the facility failed to ensure that residents requiring assistance with pericare [Resident I and Resident E] received the necessary assistance to maintain good personal hygiene, in that staff did not cleanse the front of the peri-area for 2 of 3 residents observed for peri-care in a sample of 7.</p> <p>Findings include:</p> <p>Care was observed for Resident I on 02/22/11 at 10:00 A.M. Resident I was observed to be incontinent of urine. CNA #1 was observed to cleanse the buttocks and was not observed to cleanse the front of the peri-area where the soiled incontinence product had been.</p> <p>Care was observed for Resident E on 02/22/11 at 10:20 A.M. Resident E was observed to be continent of bowel and bladder. CNA #1 was observed to cleanse the buttocks and was not observed to cleanse the front of the peri-area.</p> <p>In an interview with CNA #2 on 02/22/11 at 10:15 A.M. CNA #2 she indicated that the front and back of the peri-area was to be cleaned when providing pericare to an incontinent resident.</p>	F0312	<p><b>F312 requires that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</b></p> <p>The facility will ensure this requirement is met through the following corrective measures: Residents I and E were not harmed. Once brought to the facility's attention, proper peri-care was provided immediately. Neither show signs or symptoms of urinary tract infection. CNA #1 was re-educated on performance of peri-care and observations of her while providing care were initiated (see attachment 1). All residents requiring assistance with peri-care are at risk. See below for corrective measures. The policy and procedure for PeriCare was reviewed and no changes were indicated (see attachment 2). Nursing staff were re-educated on the PeriCare policy and procedure (see attachment 1 and 2). The DON or her designee will randomly observe three (3) weekly for six (6) weeks, the five (5) staff per month for three (3) months, then five (5) per quarter thereafter to ensure continued compliance (see attachment 3). The findings of these audits will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action</p>	03/07/2011	

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	<p>The Policy and Procedure for Perinea Care provided by the DoN [Director of Nursing] on 02/22/11 at 12:15 P.M. indicated, "10. Wipe from front to back and from center of perineum to thighs."</p> <p>This federal tags relates to Complaint IN00085952.</p> <p>3.1-38(a)(3)(A)</p>		<p>adjusted accordingly. The above corrective measures will be completed on or before March 7, 2011.</p>		

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F0329 SS=D	<p>Based on interview and record review, the facility failed to ensure drugs used to control behaviors were only utilized as needed or increased, when non drug interventions were attempted and failed, for 2 of 3 resident reviewed with medications used for behaviors, in the sample of 7.</p> <p>Resident H and M</p> <p>Findings include:</p> <p>1. The clinical record for Resident H was reviewed on 2/22/11 at 10:00 A.M. The record indicated Resident H had diagnoses that included but were not limited to anxiety and depression. The MDS [minimum data set] assessment, dated 1/4/11, indicated Resident H had moderately impaired cognition. Resident H required assistance with mobility. Resident H was verbally abusive behavior 1-3 days in the 7 days assessment.</p> <p>A Physician order, dated 11/23/10, indicated "Clonazepam 0.5 mg give 1 tablet orally every 12 hours as needed for anxiety."</p> <p>A Social Services Progress Notes, dated 1/5/11 (no time), indicated "...Currently being treated for depression and anxiety."</p>	F0329	<p><b>F329</b> requires that 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 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>The facility will ensure this requirement is met through the following corrective measures: Residents H and M were not harmed. Resident H's Clonazepam was changed to prn (as needed). Her behaviors are being monitored closely and documented. Resident M's Lorazepam was changed to prn (as needed). Her behaviors are being monitored closely and documented as well (see attachment 4).</p> <p>All residents taking anti-anxiety medications or benzodiazepines used to treat anxiety have the potential to be affected. These medical records were reviewed to ensure the least amount of medication and the most appropriate drug is being used, that indications for use are present and reductions are attempted as indicated.</p> <p>The Anti-Anxiety Drug Use policy was reviewed and no changes are indicated at this time (see attachment 5). Licensed nursing staff were</p>	03/07/2011	

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	<p>A Care plan, dated 1/18/11 and updated on 2/4/11, indicated a problem of "Psychotropic drug: Anti-anxiety. The resident requires the use of an anti-anxiety Clonazepam due to anxiety and is at risk for adverse reactions." The interventions were "Monitor for adverse side effects such as: drowsiness, light-headedness, depression, dry mouth, diarrhea, constipation. Administer medications as ordered. Observe for changes in mood or behavior. Notify the charge nurse of noted problems for further evaluation and possible physician and responsible party notification. Refer for psychological evaluation as indicated. Attempt dosage reductions per policy. Complete psychotropic medication reviews per policy."</p> <p>The February 2011 PRN [as needed] Medication Flow Sheet indicated on "Date- 2/2/11. Time- 9:30 p. Reason- nervous. Attempted Interventions- B, C. (The form indicated "Interventions attempted: A. Position change, B. Behavioral, C. Dietary, D. Activity, E. Other, F. Refused").</p> <p>Date- 2/6. Time- 8. Reason- anxiety. (No interventions attempted).</p> <p>Date-2/15. Time- 1:20 P. Reason- anxiety. (No interventions attempted).</p>		<p>re-educated on the Anti-Anxiety Drug Use policy (see attachment 6). The DON or her designee will utilize the Anti-Anxiety Drug Log, reviewing weekly to ensure reductions are attempted in a timely manner (see attachment 7). The DON or her designee will also monitor 24-Hour Condition Report Sheets, Nurse's Notes, new physician's orders and MAR's daily on scheduled work days for four (4) weeks, then twice weekly for four (4) weeks, then weekly for four (4)weeks, then monthly to ensure continued compliance (see attachment 8).</p> <p>These audits will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly.</p> <p>The above corrective measures will be completed on or before March 7, 2011.</p>		

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	<p>Date- 2/16. Time- 10 P. Reason- anxiety. (No interventions attempted).</p> <p>Date- 2/17. Time- 8:30 P. Reason-anxiety. (No interventions attempted).</p> <p>Date- 2/19. Time- 8 P. Reason- increased anxiety. (No interventions attempted)."</p> <p>The Nurses Notes, dated 2/21/11 at 12:35 P.M., indicated "Order rec'd [received] to have Clonazepam routinely BID [two times daily] and keep prn [as needed] order."</p> <p>A Physician order, dated 2/21/11, indicated "Clonazepam 0.5 mg po [by mouth] BID [two times daily] anxiety/nervousness. Continue Clonazepam 0.5 mg po BID prn [as needed] order."</p> <p>In an interview with the Director of Nursing, on 2/22/11 at 11:30 A.M., she indicated she was not aware the medication had been started routinely.</p> <p>In an interview with the Assistant Director of Nursing, on 2/22/11 at 11:45 A.M., she indicated the physician had been notified of Resident H having increased anxiety yesterday. She did not know why the nurse had not just given Resident H a dose of prn Clonazepam instead of asking the physician for an</p>				

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	order to give routinely and as needed.				

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F0329 SS=D	<p>2. The clinical record for Resident #M was reviewed on 02/22/11 at 10:40 A.M.</p> <p>Resident M was observed on 02/22/11 at 9:00 A.M. lying in bed with eyes closed.</p> <p>The most current MDS [Minimum Data Set Assessment] dated 02/03/11 indicated Resident M was severely cognitively impaired. The MDS further indicated an identified behavior of delusions that had not been exhibited.</p> <p>The Social Service Progress Notes dated 02/14/11 indicated, "...on 2/3/11 resident complained that she sleeps too much ...Resident continues to see [name of psychiatric care] for behavioral issues that has stableized [sic] "</p> <p>The Physician Recap order for February indicated Resident M had a current order for "Lorazepam 0.5 mg [milligram] 1/2 tab every 4 hours as needed for anxiety."</p> <p>The MAR [Medication Administration Record] for January 2011 indicated Lorazepam had been given once on January 5, 2011 at 1:00 A.M.</p> <p>The MAR for December 2010 indicated Lorazepam had been given once on December 18, 2010.</p> <p>A Physician Order dated 02/16/11 indicated</p>	F0329	<p><b>F329</b> requires that 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 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>The facility will ensure this requirement is met through the following corrective measures: Residents H and M were not harmed. Resident H's Clonazepam was changed to prn (as needed). Her behaviors are being monitored closely and documented. Resident M's Lorazepam was changed to prn (as needed). Her behaviors are being monitored closely and documented as well (see attachment 4).</p> <p>All residents taking anti-anxiety medications or benzodiazepines used to treat anxiety have the potential to be affected. These medical records were reviewed to ensure the least amount of medication and the most appropriate drug is being used, that indications for use are present and reductions are attempted as indicated.</p> <p>The Anti-Anxiety Drug Use policy was reviewed and no changes are indicated at this time (see attachment 5). Licensed nursing staff were</p>	03/07/2011	

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	<p>an order was received for "Lorazepam 0.25 mg bid [twice daily] 8:00 A.M. and 4:00 P.M. routinely."</p> <p>The Nurse's Notes dated 02/16/11 at 10:00 A.M. indicated, "New Order received per M.D. [physician] for Lorazepam 0.25 mg by mouth b.i.d. [twice daily] for anxiety."</p> <p>The Nurse's Notes lacked any documentation for 01/05/11.</p> <p>The Nurse's Notes lacked any documentation for 12/18/10.</p> <p>The Behavior Monthly Flow Record for November 2010, December 2010, January 2011 and February 2011 indicated a target behavior of "Restless, taking off seatbelt." The flow records further indicated the resident had no episodes of exhibiting this behavior.</p> <p>The [name of Psychological Services] Progress Report dated 12/22/10 indicated no medication changes were indicated.</p> <p>In an interview with the DoN [Director of Nursing] on 02/22/11 at 11:45 A.M. she indicated the resident was started on routine Lorazepam on 02/16/11 because she was having difficulty breathing.</p> <p>The Policy and Procedure for Anti-Anxiety Drug Use Policy provide by the DoN on 0/22/11 at 12:15 P.M.</p>		<p>re-educated on the Anti-Anxiety Drug Use policy (see attachment 6). The DON or her designee will utilize the Anti-Anxiety Drug Log, reviewing weekly to ensure reductions are attempted in a timely manner (see attachment 7). The DON or her designee will also monitor 24-Hour Condition Report Sheets, Nurse's Notes, new physician's orders and MAR's daily on scheduled work days for four (4) weeks, then twice weekly for four (4) weeks, then weekly for four (4)weeks, then monthly to ensure continued compliance (see attachment 8).</p> <p>These audits will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly.</p> <p>The above corrective measures will be completed on or before March 7, 2011.</p>		

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	<p>indicated, "7. ...Dementia and other cognitive disorders associated behaviors that: are quantitatively and objectively documented; are persistent; are not due to preventable or correctable reasons; and constitute clinically significant distress or dysfunction to the resident or represent a dager to the resident or others...evidence exists that other possible reasons for the individual's distress have been considered."</p> <p>3.1-48(a) 3.1-48(a)(1) 3.1-48(a)(2)</p>				