

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155681	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/10/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER AUTUMN WOODS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2911 GREEN VALLEY RD NEW ALBANY, IN 47150
--	---

(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
F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: July 07, 08, 09, and 10, 2015</p> <p>Facility number: 002657 Provider number: 155681 AIM number: 200308930</p> <p>Census bed type: SNF: 41 SNF/NF: 47 Total: 88</p> <p>Census payor type: Medicare: 23 Medicaid: 34 Other: 31 Total: 88</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000		
F 0155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE			

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: 155681	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/10/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AUTUMN WOODS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2911 GREEN VALLEY RD NEW ALBANY, IN 47150
--	---

(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
Bldg. 00	<p>ADVANCE DIRECTIVES</p> <p>The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. Based on interview and record review, the facility failed to ensure a resident's right to refuse medication (Resident #10) was honored for 1 of 1 residents reviewed for choices.</p> <p>Findings include:</p> <p>The clinical record for Resident #10 was reviewed on 7/9/15 at 9:15 a.m. Diagnoses included, but were not limited to, depression, dementia with behavior disturbance and anxiety. The clinical record also indicated Resident #10 had a Power of Attorney.</p> <p>A physician's order for Resident #10, dated 10/7/2014 at 12:15 p.m., included,</p>	F 0155	<p>1. Resident #10's as needed antipsychotic medication was not obtained on the physician admission orders dated 7/1/2015. The Medication Administration Record was updated by the licensed nurse on 7/1/15 to reflect no order for as needed antipsychotic medication.</p> <p>2. All remaining residents medications were reviewed and no other as needed antipsychotic medications were identified by the Director of Health Services (DHS) on July 9, 2015. All residents receiving psychotropic medications were reviewed in the behavior management meeting with the Pharmacist, Nurse Practitioner, Assistant Director of Health Services (ADHS), Legacy Lane Director (LLD) and Social</p>	07/31/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155681		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/10/2015	
NAME OF PROVIDER OR SUPPLIER AUTUMN WOODS HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 2911 GREEN VALLEY RD NEW ALBANY, IN 47150			
(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>but was not limited to, the following: "Olanzapine [Zyprexa] [antipsychotic medication] 2.5 mg [milligrams] IM [intramuscularly] [q with a line over the top of it] [every] 12 hrs [hours] PRN [as needed] when res [resident] refuses PO [by mouth] meds [medications] [dash] do not d/c [discontinue]...."</p> <p>A nurse's note for Resident #10, dated 6/20/15 at 12:00 p.m., included, but was not limited to, the following: "Res [resident] refused PO [by mouth] meds [medications] [the letter x] [times] 2 this morning. PRN [as needed] Zyprexa IM [intramuscularly] given. Mood unchanged. Would tell all staff 'you should be ashamed of yourself treating me like this'. [sic]...."</p> <p>The clinical record for Resident #10 lacked documentation regarding resident education on the risks versus the benefits of medication refusal.</p> <p>During an interview with the DHS (Director of Health Services) on 7/9/15 at 2:20 p.m., she indicated she was unaware of Resident #10 having that order. She also indicated if Resident #10 refuses medication, Resident #10's behaviors worsen and she has to be sent out to the hospital.</p>		<p>Services Director (SSD) on July 13, 2015. No as needed antipsychotics were identified during the review. All remaining interviewable residents will be interviewed by the SSD to verify their rights have been honored in regard to accepting or refusing medications by July 31, 2015.</p> <p>3. All nursing staff were re-educated by the DHS on resident's rights with emphasis on a residents right to refuse medication on 7/22/2015. Education will be provided to residents on admission, resident council and as needed regarding resident rights. 4. The DHS/ADHS will conduct an audit to review residents for medication refusal and documented education provided on MAR. Ten residents / week for four weeks then five residents / week for eight weeks will be audited. The DHS/ADHS will conduct random staff interviews for five staff / week for twelve weeks to verify understanding of the resident right to refuse medication. The ED/SSD will interview alert and oriented residents to verify they feel their rights are being honored in regard to receiving and refusing medications. Five residents /week for twelve weeks will be audited.</p> <p>The SSD will meet with all residents upon admission to review resident's rights. The Life Enrichment Director will review resident's rights monthly at the resident council. Weekly</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155681	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/10/2015
NAME OF PROVIDER OR SUPPLIER AUTUMN WOODS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 2911 GREEN VALLEY RD NEW ALBANY, IN 47150		
(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	
F 0329 SS=D Bldg. 00	<p>3.1-4(d)</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, interview and record review, the facility failed to follow</p>	F 0329	<p>monitoring of as needed anti psychotics, behavioral monitoring and non pharmacological interventions will be reviewed at the Clinically at Risk meeting by the DHS/ADHS/SSD/LLD and the Medical Records Coordinator.</p> <p>Results of these audits will be presented by the DHS to the QA committee for further recommedations until substantial compliance has been achieved.</p> <p><u>F 329 Drug Regimen is free from unnecessary drugs</u> 1. Resident #10's pharmacy</p>	07/31/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155681		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/10/2015	
NAME OF PROVIDER OR SUPPLIER AUTUMN WOODS HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 2911 GREEN VALLEY RD NEW ALBANY, IN 47150			
(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>pharmacy recommendations regarding the need for routine medication review and failed to attempt non-pharmacological interventions before administering an as needed antipsychotic medication for 1 of 5 residents reviewed for unnecessary medications. (Resident #10)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #10 was reviewed on 7/9/15 at 9:15 a.m. Diagnoses included, but were not limited to, depression, dementia with behavior disturbance, psychosis and anxiety. The quarterly Minimum Data Set assessment, dated 5/16/2015, indicated Resident #10 had no mood or behavior issues.</p> <p>During an observation on 7/8/15 at 1:45 p.m., Resident #10 became tearful and stated, "I feel like I'm going crazy."</p> <p>Resident #10's pharmacy recommendation, dated 3/2/15, included, but was not limited to, the following: "... [Physician name], Last psych [psychiatric] note is from October. Resident is on multiple psychoactive medications. Is she still being followed? Her meds [medications] need routine evaluation...[Consultant Pharmacist</p>		<p>recommendations were reviewed and addressed by the nurse practioner on 7/9/2015. The as needed antipsychotic medication was not obtained on the physicaian admission orders dated 7/1/2015. The Medication Administration Record was updated by the licensed nurse on 7/1/15 to reflect no order for as needed antipsychotic medication. 2. All remaining residents medications were reviewed and no other as needed antipsychotic medications were identified by the DHS on July 9, 2015. All residents receiving psychotropic medications were reviewed in the behavior management meeting with the Pharmacist, Nurse Practioner, Assistant Director of Health Services (ADHS), Legacy Lane Director (LLD) and Social Services Director (SSD) on July 13, 2015. No as needed antipsychotics were identified during the review. The July pharmacy recommendations were reviewed by the ADHS on July 20, 2015 to validate appropriate and timely follow through. 3. All nursing staff were re-educated by the Director of Health Services (DHS) on Residents Rights with emphasis on a residents right to refuse medication on 7/22/2015. In addition educations was provided to all nursing staff on ensuring that medications are administered in accordance with its specific indications for use and</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155681	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/10/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER AUTUMN WOODS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2911 GREEN VALLEY RD NEW ALBANY, IN 47150
--	---

(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>name]...Physician/Prescriber Response...." The physician response was blank and unsigned.</p> <p>Resident #10's pharmacy recommendation, dated 6/1/15, included, but was not limited to, the following: "... [Physician name], [resident name] is on multiple psychoactive medications for dementia with sever disturbance of behavior and mood. She was followed by [physician name] in the past (psychiatry), but no note is on the chart since last October. Her med [medications] need routinely evaluated. Please document review of psychoactive meds [medications] and whether a trial dose reduction of any of her meds may be indicated at this time, as none have been reduced in a long time...[Consultant Pharmacist name]...Physician/Prescriber Response...[resident name] out at [name of hospital] today...[name of nurse practitioner]...6/30/15...."</p> <p>A pharmacist progress note for Resident #10, dated 3/2/15, included, but was not limited to, the following: "...Behaviors documented in nursing notes...P [arrow pointing to the right] Last note Oct [October]? Need visit...."</p> <p>The clinical record for Resident #10 indicated the last psychiatric note/visit</p>		<p>proper documentation of the identified need for its use is reflected in the residents medical record on 7/22/2015. In addition, all Nursing staff, SSD and LLD were re- educated on the policy and procedure for Pharmacy Recommendations on 7/22/2015.</p> <p>4. The DHS/ADHS will audit as needed medication records to verify non pharmacoloical attempts are being made prior to administration of as needed psychotropic medication. Ten residents / week for four weeks then five residents / week for eight weeks will be audited by ADHS/DHS. ADHS/SSD and LLD will review all pharmacy recommendations monthly and ensure timely completion. DHS will audit the ADHS, SSD and LLD for monthly pharmacy recommendation completion for 12 weeks. The DHS/ADHS will review each order daily for any changes in as needed medications in the am meeting. Weekly monitoring of as needed anti psychotics, behavioral monitoring and non pharmacological interventions will be reviewed at the Clinically at Risk meeting by the DHS/ADHS/SSD/LLD and the Medical Records Coordinator. The behavior management team (Pharmacist, Nurse Practioner, ADHS, LLD and SSD) will continue to meet monthly to review antipsychotics to monitor compliance. Results of these audits will be presented by the DHS to</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155681		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/10/2015	
NAME OF PROVIDER OR SUPPLIER AUTUMN WOODS HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 2911 GREEN VALLEY RD NEW ALBANY, IN 47150			
(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>was on 10/19/2014.</p> <p>During an interview with the Social Services Director on 7/9/15 at 9:35 a.m., she indicated she was unaware of the pharmacy recommendation dated 3/2/15. She indicated the psychiatric physician had not been in the facility for some time and Resident #10's family refused to let the psychiatric nurse practitioner follow Resident #10.</p> <p>The document titled, "Psychotropic Medication Usage and Gradual dose Reductions", was provided by the Administrator on 7/9/15 at 12:47 p.m. and indicated as current. It included, but was not limited to, the following: "PURPOSE: To ensure every effort is made for residents receiving psychoactive medications obtain the maximum benefit with minimal unwanted side effects through appropriate use, evaluation and monitoring by the interdisciplinary team...2. Regular review for continued need, appropriate dosage, side effects, risks and/or benefits will be conducted, to ensure the use of psychopharmacologic medications are therapeutic and remain beneficial to resident. 3. Efforts to reduce dosage or discontinue psychotropic medications will be ongoing as appropriate. 4. A gradual dose reduction (GDR) will be attempted for two (2)</p>		the QA committee for further recommendations and continue until substantial compliance has been achieved.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155681	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/10/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AUTUMN WOODS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2911 GREEN VALLEY RD NEW ALBANY, IN 47150
--	---

(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>separate quarters...8. Orders for PRN psychotropic medications will be time limited and designate circumstances for use. a. Administered PRN medications will be documented on the PRN Medication Administration Form. 9. Non-pharmacological interventions (such as behavioral interventions) are to be considered and used when indicated, instead of or in addition to, medications. a. Attempted non=pharmacological intervention will be documented on the PRN Medication Administration Form."</p> <p>2. The clinical record for Resident #10 was reviewed on 7/9/15 at 9:15 a.m. Diagnoses included, but were not limited to, depression, dementia with behavior disturbance, psychosis and anxiety. The quarterly Minimum Data Set assessment, dated 5/16/2015, indicated Resident #10 had no mood or behavior issues.</p> <p>The physician order, dated 10/7/14 at 12:15 p.m., indicated to administer Olanzapine (antipsychotic medication) 2.5 milligrams, intramuscularly, every 12 hours as needed if resident refuses by mouth medications.</p> <p>The nurses note, dated 6/20/15 at 12:00 p.m., included the following: "Res [resident] refused PO [by mouth] meds [medications] [the letter x] [times] 2 this</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155681	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/10/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AUTUMN WOODS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2911 GREEN VALLEY RD NEW ALBANY, IN 47150
--	---

(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>morning. PRN [as needed] Zyprexa [generic for Olanzapine] IM [intramuscularly] given...."</p> <p>The June 2015 Medication Administration Record (MAR) and nurses notes lacked documentation of non-pharmacological interventions attempted prior to administering the Zyprexa. The MAR also lacked the nurses signature and/or initials for administration of the medication.</p> <p>The document titled, "Individual Plan Report", was provided by the Medical Records Director on 7/9/15 at 9:27 a.m. It included, but was not limited to, the following: "MOOD AND BEHAVIORS...I will refuse my meds also. Give me reassurance [sic], time, 1:1 and validate my feelings to change my behaviors...."</p> <p>During an interview with the Director of Health Services on 7/10/15 at 9:00 a.m., she indicated education on attempting non-pharmacological interventions prior to administering antipsychotic medication for behaviors was provided to the staff.</p> <p>3.1-48(a)(6) 3.1-48(b)(2)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155681	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/10/2015
---	--	--	--

NAME OF PROVIDER OR SUPPLIER AUTUMN WOODS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2911 GREEN VALLEY RD NEW ALBANY, IN 47150
--	---

(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