

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155665	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/19/2011
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NAME OF PROVIDER OR SUPPLIER  JENNINGS HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN47265
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F0000	<p>This visit was for the Investigation of Complaint IN00098449 and IN00098090.</p> <p>Complaint IN00098449- Substantiated, Federal/State deficiencies related to the allegations are cited at F 221, F279, F 315 and F 323</p> <p>Complaint IN00098090-Substantiated, Federal/State deficiencies related to the allegations are cited at F 282.</p> <p>Unrelated deficiencies cited.</p> <p>Survey date: October 18 and 19, 2011</p> <p>Facility number: 010996 Provider number: 155665 AIM number: 200232210</p> <p>Survey team: Marla Potts, RN, TC Melinda Lewis, RN</p> <p>Census bed type: 108 SNF/NF 108 Total</p> <p>Census payor type: 10 Medicare 90 Medicaid 8 Other</p>	F0000	Preparation and or execution of this plan of correction in general, or this correction action in particular, does not constitute an admission or an agreement by Jennings Healthcare Center of the facts alleged 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 regulations.	

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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F0221 SS=D	<p>108 Total</p> <p>Sample: 7</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 10/23/11 Cathy Emswiller RN</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Based on observation, interview and record review, the facility failed to ensure a resident was free of physical restraints, in that facility staff utilized a harness restraint for safety rather than other interventions that would have required more staff assistance, Resident A and Resident B for 2 of 3 residents utilizing restraints, in the sample of 7.</p> <p>Findings include:</p> <p>1. Resident A was observed on the locked</p>	F0221	<p><b>221 SS: D Free to be free from physical restraints</b></p> <p>It is the policy of Jennings Healthcare to comply with regulatory requirement right to be free from physical restraints.</p> <p>1.a. Resident A had shoulder harness discontinued 10/19/2011 after physician notification. Order for alarming lap belt clarified. Care plan reviewed and revised by the interdisciplinary team (IDT).</p> <p>b. Resident B had an order written on 10/25/1011 to</p>	11/18/2011	

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	<p>unit, on 10/18/11 at 10:45 A.M. sitting in the wheelchair in the dining room. The resident was observed to have a splint on both of her wrists. The resident was observed to have an alarming lap belt and a harness restraint (a vest type restraint that holds her shoulders back and then has straps that cross behind her back and then ties in the back of the chair.) The charge nurse, LPN #1, indicated at this same time, Resident A was in the harness for positioning and could release if told how to do so but did not attempt to on her own. She further indicated the resident had recent falls in the facility.</p> <p>Resident A's clinical record was reviewed on 10/18/11 at 11:00 A.M. Resident A's MDS assessment (minimum data set), dated 8/11/11, indicated the resident was severely cognitively impaired, with memory loss, required supervision with transfers, one person limited assist with ambulation, had fallen since admission, was continent of bladder, and no restraints were utilized at that time.</p> <p>The current care plan with problems dated 5/9/11 through 5/20/11, did not include any plan for the use of the shoulder harness restraint, or a plan to decrease the use of the restraint.</p> <p>A progress note dated 9/7/11 120 p.m.</p>		<p>discontinue the alarming seat belt.</p> <p>c. Care plan reviewed and revised by IDT.</p> <p>1.a. Clinical records of residents utilizing physical restraints were reviewed by the IDT for utilization of the decision tree: Restraint/Enabler evaluation, the Restraint Data Collection and Evaluation, and Restraint Information and Consent.</p> <p>b. Physicians orders were reviewed by the IDT to ensure the following included in the order, medical symptoms being treated, the type of restraint to be utilized, when restraint is to be utilized, length of time the restraint is to be utilized and a plan for reduction and or elimination. Orders clarified as indicated.</p> <p>c. Care plans were reviewed and revised by the IDT to reflect the least restrictive device.</p> <p>1.a. Licensed and non-licensed staff re-educated by DON on 10/28/2011 on facility policy and procedure related to restraints and restraint management.</p> <p>b. The IDT will complete an evaluation of the resident prior to applying a physical restraint/enable based on the medical symptom being treated and functional status of resident. Restraints will be reviewed monthly and as needed by the IDT.</p>		

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	<p>indicated "OT (occupational therapy) providing chest harness to remind her not to get up without assist..."A Rehabilitation Screening Form Nursing Referral Form, dated 9/7/11 indicated a shoulder harness was added for safety.</p> <p>A Restraint Information and Consent form, dated 9/8/11 indicated: "Medical symptom being treated: "frequent falls with lack of safety awareness, type of device shoulder harness, estimated duration-up to 3 months."</p> <p>A physician order, dated 9/6/11 indicated "May have shoulder harness while in wheelchair to prevent falls."</p> <p>During interview with the Director of Nursing on 10/18/11 at 2:00 P.M. he indicated he was not aware the resident was using a harness restraint and could not locate a restraint assessment for the device.</p> <p>The policy and procedure for Restraint Management, obtained from Unit Manger #1 on 10/18/11 at 12:00 P.M. indicated "The facility recognizes that a physical restraint may be indicated when: Resident has medical symptoms that may benefit from the short term use of a physical restraint and/or enabler, Resident is experiencing behaviors that threatened</p>		<p>c. DON or designee will QI monitor residents response to restraint daily times one month then 5x weekly times one month, weekly times one month then monthly. Negative findings will ne addressed immediately.</p> <p>1.DON or designee will present findings of the QI monitoring to the Risk Management Quality Improvement (RMQI) meeting for development of an action plan to ensure residents are free of restraints or in the least restrictive device.</p> <p>5. 11/18/2011</p>		

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	<p>their safety or the safety of others, Alternative measures have been determined to be ineffective." "A restraint management program consist of the following components: evaluation of alternative measures to physical restraint use, evaluation of medical symptoms that may benefit from the use of the physical restraint and or enable, Education of resident/patient and or family responsible party of risks and benefits of restraint/enabler use, Selection and application of the least restrictive restraint to treat the medial symptom, Plan for restraint reduction and or elimination," "Select and apply the least restrictive restraint for the least amount of time, develop the plan of care with the interdisciplinary team and input form the resident/patient and or family...Educate staff on the type of restrain/enabler in use, how to apply, and length of time to be used...review care plan for restraint reduction and or during the Care management Meeting. Modify goals and interventions as indicated."</p> <p>The Administrator provided the product sheet, on 10/19/11 at 10:00 A.M., for Wheelchair Posture Support. The information sheet, no date, indicated"...The Wheelchair Posture Support is intended to provide posture control for wheelchair residents who lean or fall forward...Caution This devise has a</p>				

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	<p>Velcro closure that can be opened and removed easily by most resident. Do not use this product with resident who require physical restraints. The determination as to the appropriateness of the Wheelchair Posture Support for a specific resident is the responsibility of the facility and its professional and medical staff..."</p> <p>2. The clinical record for Resident B was reviewed on 10/18/11 at 11:15 A.M. The record indicated Resident B had diagnoses that included but were not limited to dementia Alzheimer's type with depression and agitation. The MDS [minimum data set] assessment, dated 8/17/11, indicated Resident B was cognitively impaired, had no falls and did not utilize restraints.</p> <p>A Restraint/Enabler Data Collection and Evaluation form, dated 10/7/11, indicated "Data Collection. 1. Condition/Circumstances for Restraint/Enabler Consideration: to reduce fall risk, Other: recent hospitalization and illness. Family request. 2. Current Interventions: visual/verbal cues for call lights, chair/bed alarm, routine eating schedule, encourage family/caregiver support. Evaluation 3. Check the following, as indicated, to assist with completing the evaluation: (nothing checked). 4. Based on</p>				

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	<p>Evaluation: initiate least restrictive restraint. 5. The interdisciplinary team has determined that the following device is necessary: Medical symptom: leans forward when walking. Type of device: Posey belt. When to use: when up in w/c. Release Q [every] 2 hours and PRN [as needed] ADLs [activities of daily living]. Plan for reduction: re-evaluate in 7-10 d [days]." The form lacked any documentation of re-evaluation.</p> <p>The plan of care, with problems dated 3/3/11 through 9/11, lacked any documentation of Resident B's need to utilize a restraint or a plan for reduction of the restraint.</p> <p>A Progress Note, dated 10/9/11 at 6:30 A.M., indicated "Called to this hall per CNA stating res [resident] on floor in hall on face. Upon inspection of res noted laceration on bridge of nose V-shaped 1.2 cm x [by] 1 cm, skin tear L [left] forearm 2.5 cm x 1.2 cm, skin tear L eyebrow, 0.2 cm abrasion L cheek 2.5 cm round raised area L forehead and 1.2 cm raised area L cheek...Staff sts [states] res was found on floor in this position..."</p> <p>The Progress Notes, dated 10/9/11 at 2:00 P.M., indicated "Res has been awake and very alert all day. Talking, answering questions. Easy to engage in</p>				

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	<p>conversation. Wanting to be up and active. Placed in w/c with seatbelt at breakfast to avoid any further falls today as res is so active but unsteady. Wife updated on res at about 10 AM and notified of seatbelt. Ambulates with 1 assist. Is easily distracted, unaware of safety hazards and pre-occupied with the floor...Wife concerned about safety once res placed in bed tonight. Will put a pressure sensitive alarm on bed until res regains strength and is able to safely get up and move about on own..."</p> <p>The Care Track Narrative Note, dated 10/15/11 at 3:00 P.M., indicated "Family in to visit...Family encouraged him to eat lunch. Inappropriate comments were made to (Resident B) about why do they make you sit down, do you try to take your lap belt off. Do they make you just sit here all day, don't you get exercise, and when CNAs were passing lunch trays they commented on why don't they feed instead of passing trays, so talked to social services and I redirected family and told them all they had said I corrected them on."</p> <p>In an interview with the Director of Nursing, on 10/19/11 at 9:00 A.M., he indicated the resident did not have the seatbelt on at time of fall on 10/9/11. He stated the CNA working was not even</p>				

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	<p>aware Resident B was suppose to utilize a seat belt. He was unable to provide a physician's order for the restraint.</p> <p>This federal tag relates to Compliant IN00098449.</p> <p>3.1-26(o)</p>				

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F0250 SS=D	<p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on interview, observation and record reviewed, the facility failed to ensure residents received social services in order assist staff with behaviors associated with dementia, for 2 of 4 residents reviewed with behaviors, in the sample of 7. Resident B and H</p> <p>Findings include:</p> <p>1. Resident B was observed in the activity area of the locked dementia unit on 10/19/11 at 9:00 A.M. He was observed to start to stand up from the table with LPN #1 instructing from across the room "(Resident B's name) sit down." The resident was not observed to have been offered any other intervention to maintain his attention or provide an activity he would enjoy.</p>	F0250	<p><b>F 250 SS: D Provision of Medically related Social Services</b></p> <p>It is the policy of Jennings Healthcare Center to comply with regulatory requirement provision of medically related social services.</p> <p>1. a. Resident B has had medication regimen reviewed, utilization of restraint usage reviewed, activity data collection reviewed and interventions prior to PRN medication administration reviewed. Care plan reviewed and revised. b. Following re-admission to facility on 10/7/2011 resident H, the care plan was implemented to address behaviors with specific interventions.</p> <p>2. a. Clinical records of</p>	11/18/2011

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	<p>The clinical record for Resident B was reviewed on 10/18/11 at 11:15 A.M. The record indicated Resident B had diagnoses that included but were not limited to dementia Alzheimer's type with depression and agitation. The MDS [minimum data set] assessment, dated 8/17/11, indicated Resident B was cognitively impaired and had wandering daily and other behavior 1 to 3 days in the 7 days assessment period.</p> <p>A plan of care: Behavior Management, dated 3/11 and updated on 6/11 and 7/11, indicated a behavior of agitation and aggression. The interventions were "Separate from stressful situation, person, or place. Reduce environmental stressors ( ex. noise, crowding, caffeine, TV). Other (describe): 7/8/11 Depakote started. Alternated rest/activity; do not over stimulate. Distract with food, activity, or conversation. Use gentle touch, respond calmly and slowly."</p> <p>A plan of care: Behavior Management, dated 3/11 and updated on 6/11 and 7/11, indicated a behavior of wandering/crawling on floor. The interventions were "Mark room with familiar objects, pictures, labels. Assist to bathroom if necessary. Maintain routine. Prompt to stand and sit appropriately in</p>		<p>residents with identified behavior associated with</p> <p>Dementia were reviewed by the IDT to determine need for additional social service interventions and documentation.</p> <p>b. Care plans of residents with identified behaviors associated with dementia were reviewed and revised to reflect specific interventions by the IDT.</p> <p>c. Residents with PRN orders of chemical restraints have been reviewed by the IDT to determine need for continued use.</p> <p>3. a. Licensed and non-licensed staff reeducated on policy and procedure related to behavior management by the DON on 10/28/2011.</p> <p>b. Social Services Director re-educated by the Regional Clinical Consultant on documentation and the provision of medically related services of residents with identified behaviors.</p> <p>c. Behaviors with specific interventions reviewed monthly by the IDT in care management to determine effectiveness of specific interventions.</p> <p>d. Each hallway will be assigned a specific week of the month for review.</p> <p>e. Social Services/designee to QI monitor resident's behaviors and response to specific interventions monthly.</p>	

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	<p>chair. Engage in meaningful activities. Have comfortable furniture available (ex recliner). Ask the person to assist you with a task."</p> <p>A plan of care: Behavior Management, dated 3/11 and updated on 6/11 and 7/11, indicated a behavior of Inappropriate urination. The interventions were "Prompt/assist to urinate in urinal./BR [bathroom] routinely. Promptly redirect to cover self/ go to appropriate area."</p> <p>The Social Service Progress Notes, dated 8/17/11, no time, indicated "Met with (Resident B) for assessment. 2 days of irritability, 1 day little interest, 1 day sleep concern, 1 x [time] pee inappr [inappropriate] area and 2 times of wandering reported yet still doing better overall behaviorally with improved mood since recent med [medication] ghgs [changes]. Depakote, Trazadone, prn [as needed] Zyprexa and psych- beh [behavior] team review ongoing for Axis/ dx [diagnosis]. Repeated 1 of 3 words after SSD [Social Services Director] first try (bed, sock, blue) but did not recall within 5 min. "25" was answer given to all date questions. Care planning memory, decision making, agitation, inappr elimination, and depression. Code status unchanged. LT [long term] placement with no plans to discharge. Wanders daily</p>		<p>4. Social Services/designee to present findings to RMQI monthly for review and development of action plan to ensure medically related social services are provided.</p> <p>5. 11/18/2011</p>				

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	<p>about the b hall unit per wife, staff verbal report and SSD observation."</p> <p>The Social Service Progress Notes, dated 9/7/11, no time, indicated "Appetite stimulant, Remeron , started at 7.5 mg hs [bedtime]. Depakote reduced recently d/t [due to] possible ASE [adverse side effects]. Improved."</p> <p>A physician order, dated 9/9/11, indicated "Zyprexa Zydis 5 mg po [by mouth] Q [every] 8 hours prn [as needed] agitation and restlessness."</p> <p>The September 2011 Medication Administration Record indicated Resident B had received Zyprexa Zydis on 9/10/11 at 9:00 A.M., 9/10/11 at 8:00 P.M., 9/11/11 at 9:00 A.M., 9/12/11 at 9:00 A.M., 9/14/11 at 9:00 A.M., 9/17/11 at 9:00 A.M., 9/18/11 at 9:00 A.M., 9/21/11 at 5:00 A.M., 9/22/11 at 9:00 A.M., and 9/24/11 at 9:00 A.M. The 9/24/11 9:00 A.M. dose indicated it was given for restlessness. The other entries lacked the reason the medication was given.</p> <p>The September 2011 Behavior Monitoring Log indicated a behavior of Agitation, inappropriate urination and crawling on floor. The form indicated Resident B had 2 episodes of agitation on 9/24/11 during the evening shift. The staff</p>				

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	<p>provided redirection and 1 on 1 with positive results. Resident B had no behaviors of inappropriate urination during September. Resident B had 3 episodes of crawling on floor during the night shift on 9/11/11 and 2 episodes on 9/12/11. Staff attempted redirection, one on one, return to room and toilet with no change in behavior. Resident B had 6 episodes of crawling on the floor during the day shift on 9/19/11, 2 episodes on 9/20/11 and 5 episodes on 9/21/11. Staff attempted redirection with no change in behavior. Resident B had 5 episodes of crawling on floor during the night shift on 9/21/11 and 2 episodes on 9/22/11. Staff attempted redirection, one on one, return to room and encourage to rest with no change in behavior. Resident B had 4 episodes of crawling on floor during the day shift on 9/24/11. Staff attempted redirection with no change in behavior. Resident B had 1 episode of crawling on floor during the night shift on 9/25/11. Staff attempted redirection, one on one, return to room and encourage to rest with positive results.</p> <p>The Progress Notes, dated 9/10/11 at 2:45 P.M., indicated "Nite shift reported res up all night. Res very active and busy today. (Moving furniture, intruding on others, etc) Becomes agitated with redirection at x's [times]. Gave prn Zyprexa with food</p>				

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	<p>results x 4 hours. At lunch time res unable to sit still, moving furniture, climbing on furniture, trying to turn tables over while others are sitting at them would not eat lunch..." There were no other documentation of behaviors in the progress notes.</p> <p>The clinical record lacked any documentation of these behaviors by Social Services or the updating of the behavior management plans to address the behaviors with new interventions prior to giving medications to control behaviors.</p> <p>2. Resident H was observed on 10/18/11 at 1:00 P.M. in the dining area of the locked dementia unit. She was sitting in a gown in a reclining gerichair, crying periodically.</p> <p>The clinical record for Resident H was reviewed on 10/18/11 at 2:30 P.M. The record indicated Resident H had diagnoses that included but were not limited to Alzheimer's disease. The MDS [minimum data set assessment, dated 9/25/11, indicated Resident H had impaired cognition and had physically abusive behavior and resisting care that occurred 1 to 3 days during the 7 day assessment period.</p> <p>The Progress Notes, dated 8/31/11 at 6:00</p>				

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	<p>P.M., indicated "Res [resident] arrived via private auto with her 2 sons. Res assisted via ii [two] staff into w/c et [and] transport to room (number)..."</p> <p>The Admission/Re-Admission Data Collection and Initial Plan of Care, dated 8/31/11, indicated "...Functional Status: Bed Mobility- supervision assist of one...Transfer- supervision assist of one...Walk in room supervision assist of one...Walk in hallway supervision assist of one...Dressing supervision assist of one...Eating- supervision assist of one...Toileting able to use toilet/commode, bedpan- supervision assist of one...Personal hygiene- supervision assist of one..."</p> <p>The Progress Notes, dated 8/31/11 at 10:20 P.M., indicated "Res found on floor beside bed R [right] side on her bottom. Charge nurse notified to assess. No apparent injuries noted at present..."</p> <p>The Progress Notes, dated 9/1/11 at 7:00 A.M., indicated "CNA reported resident is combative when trying to redirect or give personal care. It can take 3-4 staff members to provide hygiene after incontinence episodes. Resident kicks, slaps, punches and pulls away from staff. Resident straps off clothing and then sits on the floor. Refuses fluids. Orientation is</p>				

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	<p>only to name."</p> <p>The Progress Notes, dated 9/1/11 at 4:30 P.M., indicated "(Name) ambulance here to transport res to (name) behavior center..."</p> <p>The Social Services Notes lacked any documentation of Resident H behaviors from 8/31 to 9/1/11.</p> <p>In an interview with the Social Services Director, on 10/19/11 at 9:30 A.M., she indicated Resident H was having issues with behaviors on admission. She indicated the record lacked documentation of the behaviors and interventions attempted by the staff. The Social Services Director did provide the behavior log from the care tracker which indicated Resident H had one episode of physical and one episode of verbal abuse on 9/1/11.</p> <p>The Behavior Unit Discharge Summary, dated 9/1/11- 9/21/11, indicated "...Presenting Problems: mood swings, yelling out, refusing care, combative and aggressive behavior..."</p> <p>3. The policy and procedure for Behavior Management, dated 8/10, was provided by the Administrator on 10/19/11 at 9:30 A.M. The policy indicated "...The facility</p>				

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	<p>does not use chemical restraints which are defined...as drugs used for discipline or convenience and are not required to treat medical symptoms...Implement and document individualized goals and interventions to treat underlying causes of behaviors and reduce/eliminate triggers...Communicate triggers and interventions to the care giving team. Monitor and document resident/patient response to interventions. Evaluate effectiveness of interventions and progress toward treatment goals at the care management meeting. review medication regimen at least monthly with the pharmacist. Notify physician of recommendation and document response. Modify and document goals and interventions as indicated with input from the interdisciplinary team and the resident/patient and family/responsible party..."</p> <p>3.1-34(a)</p>				

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

PRINTED: 11/22/2011

FORM APPROVED

OMB NO. 0938-0391

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F0279 SS=D	<p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on observation, interview and record review the facility failed to ensure a care plan was developed to address a residents toileting needs and the use of a should harness restraint, Resident A for 1 of 7 residents reviewed for care plans in the sample of 7.</p> <p>Findings include:</p> <p>1. Resident A was observed on the locked unit, on 10/18/11 at 10:45 A.M. sitting in the wheelchair in the dining room. The resident was observed to have a splint on both of her wrists. The resident was observed to have an alarming lap belt and</p>	F0279	<p><b>F 279 SS: D Develop Comprehensive Care Plans</b> It is the policy of Jennings Healthcare Center to comply with regulatory requirement development of comprehensive care plan.</p> <p>1. a. Resident A had shoulder harness discontinued 10/19/2011 after physician notification. Order for alarming lap belt clarified. b. Resident A reassessed by IDT to determine /clarify status of bowel / bladder function. c. Care plan reviewed and revised by IDT with specific interventions to manage incontinence. 2. a. Clinical records of residents</p>	11/18/2011			

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	<p>a harness restraint (a vest type restraint that holds her shoulders back and then has straps that cross behind her back and then ties in the back of the chair.) The charge nurse, LPN #1, indicated at this same time, Resident A was in the harness for positioning and could release it told how to do so but did not attempt to on her own. She further indicated the resident had recent falls in the facility.</p> <p>Resident A's clinical record was reviewed on 10/18/11 at 11:00 A.M. Resident A's MDS assessment (minimum data set), dated 8/11/11, indicated the resident was severely cognitively impaired, was continent of bladder, and no restraints were utilized at that time.</p> <p>A physician order, dated 9/6/11 indicated "May have shoulder harness while in wheelchair to prevent falls."</p> <p>The current care plan with problems dated 5/9/11 through 5/20/11, did not include any plan for the use of the shoulder harness restraint. A bladder incontinence evaluation, dated 9/8/11, indicated the resident was incontinent of urine, irreversible, and was not consistently able to communicate need to eliminate, yes to history of incontinence and question mark as to how long incontinent. The current care plan with</p>		<p>coded as continent on admission and are now incontinent will be reviewed by the IDT to determine status of bowel /bladder function.</p> <p>b. Care plans reviewed and revised by the IDT for specific interventions to manage incontinence.</p> <p>3. a. Nursing staff re-educated by DON on 10/28/2011 on care plans- to include assessment for toileting needs and interventions specific to resident toileting needs.</p> <p>b. DON or designee will QI monitor monthly x 6 incontinent residents to ensure toileting needs are met through specific interventions.</p> <p>4. DON to present findings to RMQI monthly for review and development of action plan to ensure toileting with specific interventions are met.</p> <p>5. 11/18/2011</p>		

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	<p>problems, dated 5/9/11 through 5/20/11, did not include any plan for urinary incontinent or a toileting plan to address toileting needs. This was confirmed by LPN #1, the charge nurses for the dementia unit on 10/18/11. LPN #1 indicated the plan for care for the resident would be in the kiosk system where elimination was documented.</p> <p>The policy and procedure for Restraint Management, obtained from Unit Manger #1 on 10/18/11 at 12:00 P.M. indicated".Educate staff on the type of restrain/enabler in use, how to apply, and length of time to be used...review care plan for restraint reduction and or during the Care management Meeting. Modify goals and interventions as indicated."</p> <p>A bladder incontinence evaluation, dated 9/8/11, indicated the resident was incontinent of urine, irreversible, and was not consistently able to communicate need to eliminate, yes to history of incontinence and question mark as to how long incontinent.</p> <p>The current care plan with problems, dated 5/9/11 through 5/20/11, did not include any plan for urinary incontinent or a toileting plan to address toileting needs. This was confirmed by LPN #1, the charge nurses for the dementia unit on</p>				

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	<p>10/18/11. LPN #1 indicated the plan for care for the resident would be in the kiosk system where elimination was documented.</p> <p>The resident was documented to have fallen on the way to the bathroom on 6/24/11, in the bathroom on 8/5/11, 8/16/11 and 9/16/11.</p> <p>The MDS Coordinator, on 10/18/11 at 2:45 P.M. demonstrated the kiosk system and what the care plan was for this resident. The care cues for this resident for toileting was "please check bed and resident often." The resident was documented to have been incontinent of urine 50 % of the time from 10/1/11 through 10/17/11.</p> <p>During interview with CNA #3 on 10/18/11 at 2:00 P.M. she indicated Resident A was toileted on and off, wears a brief.</p> <p>The facility lacks evidence of having developed interventions to maintain the residents urinary continence.</p> <p>This federal tag relates to Compliant IN00098449.</p> <p>3.1-35 (a)</p>				

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F0282 SS=D	<p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review the facility failed to follow the physician orders for administration of routine pain medications for 2 of 5 residents reviewed for the administration of pain medications, in the sample of 7. Resident F, and G</p> <p>Findings include:</p> <p>1. Resident F's clinical record was reviewed on 10/19/11 at 10:30 A.M. The resident had a physician's order dated 8/8/11 and repeated 10/7/11 for "oxycontin" (narcotic pain medicine) 200 mg every 8 hours, administer (2) 80 mg tablets and( 1) 40 mg tablet, send 60 tablets ( 15 days). The October medication administering record indicated both the 2- 80 mg tablets and the 40 mg tablet were administer daily at 6 a.m., 2 p.m. and 10 p.m. The narcotic controlled substance record, indicated the 40 mg was signed out as having been administered on</p>	F0282	<p><b>F 282 SS: D Services by qualified persons per care plan.</b> It is the policy of Jennings Healthcare to comply with regulatory requirement services by qualified persons per care plan.</p> <p>1. a. Resident F primary physician notified of missed medication administration. b. Resident F interviewed by social services to ensure pain management, needs are being met. c. Resident G primary physician notified of medication dispensing error by pharmacy. d. Resident G interviewed by social services to ensure pain management, needs are being met.</p> <p>2. a. Clinical records of residents receiving narcotic analgesic reviewed by the IDT to ensure routine medication is administered as ordered. b. Care plans were reviewed to ensure routine narcotic analgesics are provided</p>	11/18/2011

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	<p>10/6/ 11 and 10/7/11 at 6 a.m., 1 p.m., and 9 p.m. The narcotic sign out log for the 2 -80 mg tablets indicated the 10/5/11 9 p.m. dose was given and the next dose of 80 mg oxycontin was administered at 9 p.m. on 10/7/11. Documentation was lacking of the 2- 80 mg tabs having been give on 10/6/11 at 6 a.m., 2 p.m., or 10 p.m., or on 10/7/11 at 6 a.m. or 2 p.m. The 40 mg sigh out logs did not indicate extra 40 mg tablets had been given to equal the 80 mg dose.</p> <p>2. Resident G's clinical record was reviewed on 10/19/11 at 11:00 A.M. A hand written physician's prescription indicated 10/3/11 "Morphine Sulfate 30 one TID (3 times daily) written in above was SA by the Morphine sulfate. Another hand written prescription dated 10/5/11 indicated "Morphine Sulfate SA 30 mg one po (orally) TID routinely. The Medication administration record indicated the Morphine Sulfate had been initialed as given each day in October. The narcotic sign out sheet indicated Morphine sulfate SA was given last 10/3/11 at 2 P.m. and again on 10/5/11 at 9 P.M. The sign out forms for 10/3 at 9 p.m., 10/4/11 at 6 a.m., 2 p.m. and 10 p.m., and 10/5/11 at 6 a.m. and 2 p.m. were not observed.</p>		<p>per the care plan.</p> <p>3. a. Licensed staff re-education by the DON on 10/28/2011 on providing pain medication per physician orders, documentation of medications errors in the clinical record and management of narcotic scripts. b. DON or designee will QI monitor monthly times x6 clinical records of resident receiving routine ordered narcotic analgesics.</p> <p>4. DON will present findings to the RMQI for review and development of action plan to ensure physician orders for administering of routine pain medications.</p> <p>5. 11/18/2011</p>		

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	<p>During interview with the Director of Nursing on 10/19/11 at 11:00 A.M., he indicated the doses had all been given but a pharmacy error had been made. He indicated the pharmacy had sent Morphine Sulfate IR on 10/3/11, rather than the ordered Morphine SA. He indicated the pharmacy discovered their error, called the facility picked up the Morphine IR, took the narcotic sign out sheet and delivered the Morphine SA 30 mg on 10/5/11 in the evening. He indicated this was on the medication error form and not in the clinical record. He indicated the nurses should have checked the label and not administered the wrong type of morphine. He indicated this was the reason for the clarification order on 10/5/11 as the Nurse Practitioner had left the SA off the first order on 10/3, tried to add it and refax but the pharmacy would not accept and had her rewrite the order on 10/5/11.</p> <p>During interview the Nurse Practitioner on 10/19/11 at 11:15 A.M. she indicated she was aware of the resident having received the Morphine IR at the time of the error and that it was a quicker acting drug and would not keep his pain control as steady as the SA but would not have been harmful to him.</p> <p>This federal tag is related to Complaint</p>				

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F0315 SS=G	<p>IN00098090.</p> <p>3.1-35(g)(2)</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview and record review the facility failed to ensure a residents who admitted continent of urine, continence did not decline while in the facility for 1 of 7 residents reviewed for incontinent in the sample of 7.</p> <p>Resident A</p> <p>Findings include:</p> <p>1. Resident A was observed on the locked unit, on 10/18/11 at 10:45 A.M. sitting in the wheelchair in the dining room. The resident was observed to have an alarming lap belt and a harness restraint (a vest type restraint that holds her shoulders back and then has straps that cross behind her back and then ties in the back of the chair.)</p>	F0315	<p><b>F315 SS: G No catheter, prevent UTI- Restore Bladder</b></p> <p>It is the policy of Jennings Healthcare to comply with regulatory requirement no catheter, prevent UTI –restore bladder.</p> <p>1. a. Resident A had shoulder harness discontinued on 10/19/2011 following physician notification. Order for alarming seat belt clarified.</p> <p>b. Resident A re-assessed by IDT to determine/clarify status of bowel / bladder function.</p> <p>c. Care plan reviewed and revised by IDT with specific intervention to manage incontinence.</p> <p>2.a. Clinical records of residents coded, as continent on admission</p>	11/18/2011	

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	<p>Resident A's clinical record was reviewed on 10/18/11 at 11:00 A.M. Resident A's MDS assessment (minimum data set) dated 8/11/11, indicated the resident was severely cognitively impaired, with memory loss, required supervision with transfers, one person limited assist with ambulation, limited assist of one staff with toileting and was continent of bladder, and had no toileting plan. The admission MDS dated 5/26/11, indicated the resident was continent of urine. A bladder incontinence evaluation, dated 9/8/11, indicated the resident was incontinent of urine, irreversible, and was not consistently able to communicate need to eliminate, yes to history of incontinence and question mark as to how long incontinent.</p> <p>The current care plan with problems, dated 5/9/11 through 5/20/11, did not include any plan for urinary incontinent or a toileting plan to address toileting needs. This was confirmed by LPN #1, the charge nurses for the dementia unit on 10/18/11. LPN #1 indicated the plan for care for the resident would be in the kiosk system where elimination was documented.</p> <p>The resident was documented to have fallen on the way to the bathroom on</p>		<p>and are now incontinent will be reviewed by the IDT to determine status of bowel and bladder function.</p> <p>b. Residents referred to restorative program as indicated.</p> <p>c. Care Plans reviewed and revised by the IDT for specific interventions to manage incontinence.</p> <p>3.a Nursing staff re-educated by DON on 10/28/2011 on care plans to include assessment for toileting needs with interventions specific to residents toileting needs and restorative program for toileting.</p> <p>b. DON or designee to QI monitor monthly times 6 incontinent residents to ensure toileting needs are met through specific interventions and restorative program if indicated.</p> <p>4. Don to present findings to RMQI meeting monthly x 6 months for review and development of action plan if indicated to ensure residents who are on admission continent do not experience an avoidable decline.</p> <p>5. 11/18/2011</p>		

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	<p>6/24/11, in the bathroom on 8/5/11, 8/16/11 and 9/16/11.</p> <p>The MDS Coordinator, on 10/18/11 at 2:45 P.M. demonstrated the kiosk system. The care cues for this resident for toileting was "please check bed and resident often." The resident was documented to have been incontinent of urine 50 % of the time from 10/1/11 through 10/17/11.</p> <p>During interview with CNA #3 on 10/18/11 at 2:00 P.M. she indicated Resident A was toileted on and off, wears a brief.</p> <p>The facility lacks evidence of having implemented interventions to maintain the residents urinary continence.</p> <p>The policy and procedure for Bowel and Bladder Continence Management, policy and procedure, 8/10, was provided by the health facility administrator, on 10/19/11 at 9:30 A.M., indicated staff strives to assist residents in restoring and maintaining bladder incontinence to the extent possible...verify risk factors/underlying cause have been evaluated...determine interventions appropriate for resident/patient. Bladder retraining...Prompted /scheduled voiding require staff assistance as opposed to resident function...document care plan</p>				

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F0323 SS=G	<p>goals and interventions...communicate individualized interventions to the care giving team...modify interventions and goals as needed. document changes...evaluate effectiveness of interventions and document progress towards goal weekly..."</p> <p>This federal tag relates to Compliant IN00098449</p> <p>3.1-41(a)(2)</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, interview and record review the facility failed to ensure a resident at risk of falls was provided with interventions and supervision to prevent falls resulting in 8 falls in the facility, with fractures of both wrists, in a 5 month period, in that staff did not assure resident had assistance while ambulating, nor a plan to address her toileting needs, and was unable to respond to alarms in time to prevent falls, for 1 of 5 residents reviewed for falls in the sample of 7.</p> <p>Resident A</p> <p>Findings include:</p>	F0323	<p><b>F323 SS: G Free of Accident Hazard/Supervision</b> It is the policy of Jennings Healthcare to comply with regulatory requirement free of accident / hazard /supervision.1. a. Resident A had shoulder harness discontinued on 10/19/2011 following physician notification. Order for alarming lap belt clarified. Care plan reviewed and revised by the IDT.b. Resident B had an order written on 10/25/2011 to discontinue the alarming seat belt.c. Resident A reassessed by the IDT to determine, clarify status of bowel and bladder functiond. Resident A</p>	11/18/2011

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	<p>1. Resident A was observed on the locked unit, on 10/18/11 at 10:45 A.M. sitting in the wheelchair in the dining room. The resident was observed to have a splint on both of her wrists. The resident was observed to have an alarming lap belt and a harness restraint (a vest type restraint that holds her shoulders back and then has straps that cross behind her back and then ties in the back of the chair.) The charge nurse, LPN #1, indicated at this same time, Resident A was in the harness for positioning and could release it told how to do so but did not attempt to on her own. She further indicated the resident had recent falls in the facility.</p> <p>Resident A's clinical record was reviewed on 10/18/11 at 11:00 A.M. The MDS assessment, (minimum data set), dated 8/11/11, indicated the resident was severely cognitively impaired, with memory loss, required supervision with transfer, one person limited assist with ambulation, limited assist of one staff with toileting, had fallen since admission, was continent of bladder, and no restraints were utilized at that time.</p> <p>A care plan problem, dated 5/9/11, for "Potential for falls injuries related to history of falls and weakness and</p>		<p>re-assessed to determine fall risk factors with specific interventions to manage fall risk.e. Care plan reviewed and revised with specific intervention to manage incontinence and fall risk. 2. a. Clinical records of residents utilizing physical restraints were reviewed by the IDT for utilization of the decision tree: Restraint enabler evaluation, the restraint data collection, evaluation, restraint information, and consent.b. Physician orders were reviewed by the IDT to ensure the following is included in the order: medical systems being treated, type of restraint, when restraint is to be utilized, length of time restraint is to be utilized and plan for restraint reduction and/ or elimination. Orders clarified as indicated.c. Care plans reviewed and revised by the IDT.d. The clinical records of residents with multiple falls in past 60 days were reviewed to determine fall risk.e. Care plans reviewed and revised by the IDT.f. Clinical records of residents coded as continent on admission and are now incontinent will be reviewed by the IDT to determine status of bowel / bladder function. Resident referred to restorative program as indicated.g. Care plans reviewed and revised by the IDT for specific interventions to manage incontinence. 3. a Nursing staff re-education by the DON on 10/28/2011 on restraints, management of bowel and</p>		

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	<p>unsteady gait." Interventions included "clip ppa at all times-dced (discontinued) 6/9/11," "therapy as ordered, 1 assist transfers [cga][contact guard assist]" "walker for transfers/ambulation, wheelchair for distance," "6/24/11 keep personal items in reach," "8/6/11 remind to call for help," "8/12/11 refer to therapy; ambulating-no restraint or alarm indicated," "8/26/11 alarming seat belt on wheelchair." A bladder incontinence evaluation, dated 9/8/11, indicated the resident was incontinence. The current care plan with problems dated 5/9/11 through 5/20/11, did not include any plan for urinary incontinent or a tilting plan to address toileting needs.</p> <p>Progress notes, dated 5/4/11 indicated the resident was admitted to the facility with "resident instructed on how to use call light (may not be cooperative due to dementia when assist needed with call light). At 415 p.m. progress notes indicated "resident was evaluated by physical therapist and determined to be a fall risk. Had actually tripped and or almost fell times 3 whole with PT..placed a clip alarm on resident...."</p> <p>Progress notes indicated "6/24/11 2:20 p.m. Res was up walking to bathroom another male res was in her room and</p>		<p>bladder function, continence, incontinence accidents and safety and documentation.b. DON or designee will QI monitor incontinence residents response to restraints daily x one month then 5x week times one month then weekly times one month then monthly. c. Don or designee will QI monitor residents with falls monthly to ensure interventions are specific to the resident. 4. DON will present findings to RMQI monthly meeting for review and development of action plan to residents are free of accidents/hazards, to ensure toileting with specific interventions are met, free of physical restraints or least restrictive. 5. 11/18/2011ADDENDUM IN RESPONSE TO LETTER FROM ISDH REQUESTING ADDITIONAL INFORMATION FOR DEFICIENCY F323 SUPERVISION TO PREVENT ACCIDENT:A. A root cause analysis is conducted by the interdisciplinary team (Falls Action Team) following each resident fall. The interdisiplinary team is comprised of the Director of Nursing, Assistant Director of Nursing, Dietary Manager, Social</p>		

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	<p>when res was attempting to get male res out of room, she tripped and fell over walker. Res was assisted up with 2 staff...res stated she fell on her buttocks..."</p> <p>"6/24/11 3:50 p.m. ...res stated that she was having a lot of back pain related to fall stated that her back hurt with her not moving, just lying in bed but it hurt even more when she was moving..." During interview on 10/18/11 at 4:00 P.M. with the Director of Nursing [DON] he indicated the resident who wandered into her room was Resident B. A Rehabilitation Screening Form Nursing Referral Form, dated 6/27/11, indicated "walking to bathroom with walker...clip alarm had been discontinued 2nd to no falls. staff feel isolated incident...wanderstrips to be placed across pt's doorway to deter wandering residents."</p> <p>Progress notes indicated "8/5/11 at approximately 315 p.m. CNA called writer to res room. Res found on floor in bathroom states slipped off toilet denies pain or discomfort no injury noted. res denies hitting head states landed on my butt and 'nothing hurts but my pride'..encouraged resident to use call light for assistance... non skid footwear was in place..." A Rehabilitation Screening Form Nursing Referral Form,</p>		<p>Services Director, Activity Director, MDS Coordinator and Director of Rehabilitation Services. The root cause of each fall is identified by the Fall Action Team during a fall review during which time issues such as underlying illnesses, medication, functioal status, visual ability, psychological status and environmental factors are reviewed. Fall reviews are done conducted within 24-48 hours post incident. Root cause analysis guide the action team's response in the development of specific interventions including care plan updating and therapy referrals. B. The clinical record of resident #A was reviewed by the IDT team initially on 10/24/2011 and again on 11/01/2011 and 11/09/2011. Care plan revision took place with appropriate interventions to address fall prevention including:-alarming seat belt while up in wheelchair due to decreased safety awareness-therapy</p>		

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	<p>dated 8/8/11 indicated "res has poor safety awareness secondary to poor short term memory."</p> <p>Progress notes dated 8/16/11 "745 p.m. called to res room by CNA Roommate turned on light to report res fell in bathroom. Res sitting on floor with back to cabinet, facing toilet. able to move all extremities without pain or difficulty...assisted to stand observed res back...reminded to call for assist..."</p> <p>A progress note dated 8/26/11 at 2:30 p.m. indicated "res up in wheelchair today, to the den for nail care...following lunch about 1 p.m. checked res still sitting up in wheelchair, by 115 p.m. housekeeper came to report res up walking in room by the time it took nurse to walk down hall, res sitting on buttocks on floor hanging to side of wheelchair and the bedside table...reported to (family members name) wants seat belt on wheelchair and should not be in room when up in wheelchair...4 p.m. alarming seat belt applied to wheelchair." "8/26/11 8 p.m. up in wheelchair with seat belt has tried to get out of chair several times set off the alarm-doesn't listen..."</p> <p>A progress note dated 9/3/11 at 8:40 a.m. res found on floor in B hall dining room lying on back complains aches</p>		<p>evaluation for proper positioning in the wheelchair and treatment if necessary.-resident not to be alone in room while up in the wheelchair.-release alarming seat belt at meal times and every 2 hours to provide range of motion to all extremities-release seat belt for al ADLs and toiletingsubmitted by Stephanie Toomey, R.N., Director of Nursing Services11/10/11</p>	

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	<p>generalized able to move all extremities...alarm belt was sounding at time...9:45 a.m. noted swelling right wrist medial lateral aspect..pea sized bruise over ulna...complains tenderness with palpitation...2:50 p.m. received x ray report right wrist fracture. Notes indicate the resident was sent out to a local hospital for treatment.</p> <p>A progress note dated 9/6/11 indicated 3-11 "fingers warm to touch remain discolored...new order for shoulder harness when up in chair for safety..." A note dated 9/7/11 120 p.m. "OT (occupational therapy) providing chest harness to remind her not to get up without assist..." 9/9/11 5 p.m. returned from Dr apt now has cast on right lower arm fingers warm..." A Rehabilitation Screening Form Nursing Referral Form, dated 9/6/11 indicated clip alarm added for resident safety. A form dated 9/7/11 indicated a shoulder harness was added for safety.</p> <p>A progress note dated 9/16/11 at 9:30 P.M. indicated "CNA's entered room last bed check and noted res OOB (out of bed) opened bathroom door and found res sitting in floor/. Res stated I knew you girls would come writer entered bathroom and assessed res head to toe...assessed</p>				

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	<p>PPA and noted clip string attached to res gown, alarm box found in front of roommates bed not sounding, noted battery ajar resulting in faulty alarm res assisted to and from toilet to bed. alarm replaced... family noticed and informed they were aware on 9/15/11 alarm was faulty..."</p> <p>A care review progress note, dated 9/19/11 indicated "met to discuss treatment options regarding falls resident fall again after removing PSA and walking to the bathroom on 9/16/11. Family member very upset at time..decided upon a low bed with mat at bedside and one side of bed against wall..."</p> <p>A progress note dated 10/12/11, "720 p.m. alarm sounded from res room CNA entered res found on floor sitting position...complaints in pain in left wrist and left knee, swelling noted sl [slight] bluish discoloration of knee swelling noted...8 p.m. x rays taken of left wrist and left knee..10 p.m. radiology report received...left wrist demonstrates an acute impacted distal radial metaphysical fracture, soft tissue swelling present...sent to hospital..." The resident wrist was too swollen to place in a cast and follow up appointment made with orthopedic physician.</p>			

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	<p>A progress note dated 10/15/11 indicated 420 a.m."splint in place to left wrist, cast in place to right wrist forearm..."</p> <p>The unit manager, LPN #2, during interview on 10/18/11 at 2 P.M., indicated she could find no added interventions following the falls in bathroom on 8/5 and 8/16/11 nor on 10/12/11. She indicated staff just monitored.</p> <p>This federal tag relates to Compliant IN00098449.</p> <p>3.1-45(a)(2)</p>				

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F0329 SS=D	<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 interview and record review the facility failed to ensure a drug to control behaviors, zyprexa (antipsychotic) ordered as needed, was only administered when alternate non drug interventions were attempted prior, for 1 of 3 reviewed for use of as needed medications ordered to control behaviors, in the sample of 7. Resident B</p> <p>Findings include:</p> <p>1. The clinical record for Resident B was reviewed on 10/18/11 at 11:15 A.M. The record indicated Resident B had diagnoses that included but were not limited to</p>	F0329	<p><b>F329 SS:D Drug Regimen is free from unnecessary drugs.</b> It is the policy of Jennings Healthcare to comply with regulatory requirement drug regimen is free from unnecessary drugs.</p> <p>1.a. Resident B had a clinical record review to determine if drug regimen is free if unnecessary drugs. Physician notified as indicated.</p> <p>b. Care Plan reviewed and revised as indicated.</p> <p>2. Medical regimens of those residents with identified behaviors associated with dementia Alzheimer's type to include</p>	11/18/2011

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	<p>dementia Alzheimer's type with depression and agitation. The MDS [minimum data set] assessment, dated 8/17/11, indicated Resident B was cognitively impaired and had wandering daily and other behavior 1 to 3 days in the 7 days assessment period.</p> <p>A physician order, dated 9/9/11, indicated "Zyprexa Zydis 5 mg po [by mouth] Q [every] 8 hours prn [as needed] agitation and restlessness."</p> <p>The September 2011 Medication Administration Record indicated Resident B had received Zyprexa Zydis on 9/10/11 at 9:00 A.M., 9/10/11 at 8:00 P.M., 9/11/11 at 9:00 A.M., 9/12/11 at 9:00 A.M., 9/14/11 at 9:00 A.M., 9/17/11 at 9:00 A.M., 9/18/11 at 9:00 A.M., 9/21/11 at 5:00 A.M., 9/22/11 at 9:00 A.M., and 9/24/11 at 9:00 A.M. The 9/24/11 9:00 A.M. dose indicated it was given for restlessness. The other entries lacked the reason the medication was given.</p> <p>The September 2011 Behavior Monitoring Log indicated a behavior of Agitation, inappropriate urination and crawling on floor. The form indicated Resident B had 2 episodes of agitation on 9/24/11 during the evening shift. The staff provided redirection and 1 on 1 with positive results. Resident B had no</p>		<p>depression and agitation reviewed to determine unnecessary drugs completed.</p> <p>3.a. Nursing staff re-educated on medication regimens and unnecessary drugs by the DON on Oct 28, 2011. b. DON or designee will QI monitor residents identified behaviors at daily clinical meeting and monthly at care review meeting to ensure medication regimens are necessary.</p> <p>4. DON will present findings to the RMQI committee monthly for review and development of action plans to ensure residents are free from unnecessary drugs.</p> <p>5. 11/18/2011</p>		

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	<p>behaviors of inappropriate urination during September. Resident B had 3 episodes of crawling on floor during the night shift on 9/11/11 and 2 episodes on 9/12/11. Staff attempted redirection, one on one, return to room and toilet with no change in behavior. Resident B had 6 episodes of crawling on the floor during the day shift on 9/19/11, 2 episodes on 9/20/11 and 5 episodes on 9/21/11. Staff attempted redirection with no change in behavior. Resident B had 5 episodes of crawling on floor during the night shift on 9/21/11 and 2 episodes on 9/22/11. Staff attempted redirection, one on one, return to room and encourage to rest with no change in behavior. Resident B had 4 episodes of crawling on floor during the day shift on 9/24/11. Staff attempted redirection with no change in behavior. Resident B had 1 episode of crawling on floor during the night shift on 9/25/11. Staff attempted redirection, one on one, return to room and encourage to rest with positive results.</p> <p>The Progress Notes, dated 9/10/11 at 2:45 P.M., indicated "Nite shift reported res up all night. Res very active and busy today. (Moving furniture, intruding on others, etc) Becomes agitated with redirection at x's [times]. Gave prn Zyprexa with food results x 4 hours. At lunch time res unable to sit still, moving furniture, climbing on</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155665	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/19/2011
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	<p>furniture, trying to turn tables over while others are sitting at them would not eat lunch..." There were no other documentation of behaviors in the progress notes.</p> <p>2. The policy and procedure for Behavior Management, dated 8/10, was provided by the Administrator on 10/19/11 at 9:30 A.M. The policy indicated "...The facility does not use chemical restraints which are defined...as drugs used for discipline or convenience and are not required to treat medical symptoms...Implement and document individualized goals and interventions to treat underlying causes of behaviors and reduce/eliminate triggers...Communicate triggers and interventions to the caregiving team. Monitor and document resident/patient response to interventions. Evaluate effectiveness of interventions and progress toward treatment goals at the care management meeting. review medication regimen at least monthly with the pharmacist. Notify physician of recommendation and document response. Modify and document goals and interventions as indicated with input from the interdisciplinary team and the resident/patient and family/responsible party..."</p> <p>3.1-48(a)(4)</p>				

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

PRINTED: 11/22/2011

FORM APPROVED

OMB NO. 0938-0391

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