

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155448	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/08/2013
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NAME OF PROVIDER OR SUPPLIER  LOWELL HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 710 MICHIGAN ST LOWELL, IN 46356
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F000000	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Survey Dates: March 4, 5, 6 , 7, &amp; 8, 2013</p> <p>Facility Number: 000361 Provider Number: 155448 AIM Number: 100266340</p> <p>Survey Team: Heather Tuttle, R.N. TC Lara Richards, R.N. Kathleen Vargas, R.N. Regina Sanders, R.N. 3/5-3/8/13</p> <p>Census Bed Type SNF/NF: 80 Total: 80</p> <p>Census Payor Type Medicare: 17 Medicaid: 47 Other: 16 Total: 80</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on March 12, 2013, by Janelyn Kulik, RN.</p>	F000000	<p><b>The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</b></p> <p><b>Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit on or after April 7, 2013.</b></p>	

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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F000223 SS=A	<p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on record review and interviews, the facility failed to ensure all residents were free from abuse related to an allegation of verbal abuse for 1 of 2 residents reviewed for abuse of the 2 residents who met the criteria for abuse. (Resident #16)</p> <p>Findings include:</p> <p>Interview with Resident #16 on 3/04/13 at 11:48 a.m., indicated CNA #1 and a Student Nursing Assistant were providing care for her. She indicated the CNA was "snotty" and took off her gloves and left the room. The resident indicated "she was rude to me right from the start." The resident indicated she had reported it to the nurse who then informed other staff. The resident also indicated that CNA #1 no longer worked there.</p> <p>The record for Resident #16 was reviewed on 3/6/13 at 8:34 a.m. The resident's diagnoses included, but</p>	F000223	<p><b>F223 – Free from Abuse/Involuntary Seclusion</b></p> <p>It is the practice of this provider that each resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p><b><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</i></b></p> <p><i>Resident #16</i> – physician and family have been updated regarding this resident's current status. This resident experienced no negative psychosocial reaction or outcome related to this finding and is being treated with respect and dignity during ADL care.</p> <p><b><i>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</i></b></p> <p>All residents are at risk to be affected by this finding. Resident and family interviews were conducted per CQI Abuse Questionnaire devised by CMS</p>	04/07/2013	

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	<p>were not limited to, depression, malaise and fatigue, and insomnia.</p> <p>Review of the annual Minimum Data Set (MDS) assessment dated 2/6/13 indicated the resident was alert and oriented with a brief interview for mental status (BIMS) score of 15. The resident needed extensive assist with two person physical assist for bed mobility, transfers, dressing, toilet use, and bathing.</p> <p>Review of the summary of the allegation of abuse from the Incident Form dated 3/2/13, indicated "it was reported that CNA #1 told Resident #16 that nobody wants to f#@%ing deal with you." The Administrator, family and Physician were notified. The resident was assessed for injury, and the CNA was suspended pending investigation. The resident indicated she could not remember the details but she knows the aide started to get a really bad attitude. The CNA said something to the resident took off her gloves and left the bathroom. The resident indicated that CNA #1 should not be in healthcare because she doesn't take the time needed to care for her and she has a terrible attitude. Further review of the summary of the allegation indicated that based on witness statements, it was believed</p>		<p>with no findings. The ED, DNS/designee will be responsible for conducting facility interviews with staff (including after hours and on weekends) regarding Abuse Prohibition, Reporting and Investigation. The ED, DNS/designee will conduct an all staff in-service on or before 4/7/13. This in-service will include review of the facility policy related to Abuse Prohibition, Reporting and Investigation and review of the Elder Justice Act.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b> All staff in-services will be conducted on or before 4/7/13. This in-service will include review of the facility policy related to Abuse Prohibition, Reporting and Investigation and review of the Elder Justice Act. All staff will be re-educated regarding the various types of abuse including emotional abuse and rude and disrespectful conduct when interacting with residents. The procedure for responding to and timely reporting of any alleged or actual abuse situation will also be reviewed. Any allegation or statement regarding resident abuse or mistreatment will be reported immediately to the ED and/or DNS. The facility will immediately initiate a full investigation as well as ensure notification to the MD, family,</p>		

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	<p>that CNA #1 did say that to Resident #16. The CNA was terminated effective 3/2/13.</p> <p>Review of the witness statement by the Student Nursing Assistant (no date) indicated "I answered call light (Resident Name) room. On toilet with CNA #1 while assisting (Resident name) off toilet she said brief is not up at all the way and other CNA said ok. (Resident Name) said you are not listening, its not on. Other CNA shouted I'm doing, wait. (Resident Name) said you are not listening. Other CNA said that's why no one wants to f##@ing deal with you and walked out."(sic)</p> <p>Review of CNA #1's statement (no date) indicated "When I was toileting (Resident Name) I was getting her off the toilet, she was standing up so I could clean her up and put her cream on her butt. As I was putting the cream on her butt she started to loose (sic) stability so I finished putting the cream on her butt and started to pull the brief up and she started yelling and so I sat her back down on the toilet and she was yelling the brief wasn't up in the front. I told her, I couldn't see the front because I was behind you. She yelled, 'you need to shut up you don't listen shut up.' I</p>		<p>ISDH and other agencies as outlined in the facility policy. The ED, DNS/designee will be responsible for conducting this in-service. The ED, DNS/designee will be responsible for conducting facility interviews with staff (including after hours and on weekends) regarding Abuse Prohibition, Reporting and Investigation.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</b> The ED, DNS/designee will be responsible for completion of the CQI Audit tool titled, "Abuse Prohibition, Reporting and Investigation" weekly for 4 weeks then monthly for 6 months to monitor for ongoing compliance of this corrective action. If threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up.</p> <p><b>By what date the systemic changes will be completed:</b> Compliance Date: 4/7/13.</p>				

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	<p>told (Resident Name) then she was being rude and that she didn't have to yell. There was another aid in the bathroom so I left out and the other aid continued to assist her."</p> <p>Interview with the Administrator on 3/6/13 at 3:19 p.m., indicated when he interviewed CNA #1 she insisted that she did not swear at the resident. He indicated the CNA said she should have finished taking care of the resident and getting her off the toilet and then left the room and vented to someone about the resident. He further indicated CNA #1 was terminated after the incident.</p> <p>3.1-27(b)</p>			

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F000329 SS=D	<p><b>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</b></p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interviews, the facility failed to ensure each resident was free from unnecessary medications related to the lack of an indication for the use of an antipsychotic medication for 1 of 10 residents reviewed for unnecessary medications. (Resident #86)</p> <p>Findings include:</p> <p>The record for Resident #86 was</p>	F000329	<p><b>F329 – Drug Regimen Is Free From Unnecessary Drugs</b></p> <p>It is the intent of this provider that each resident's drug regimen be free from unnecessary drugs.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b></p> <p><i>Resident #86</i> – the mental health specialist and the physician have been informed and updated related to this resident's current status and mental health issues. Clarification orders have been</p>	04/07/2013	

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	<p>reviewed on 3/6/13, at 10:27 a.m. The resident was admitted to the facility on 12/1/11. The resident's diagnoses included, but were not limited to, depression, insomnia, alcohol abuse, adjustment disorder, anxiety, agitation, and dementia.</p> <p>Review of Physician Orders on the current 3/13 recap, indicated Risperidone (an antipsychotic medication) .5 milligrams (mg) twice a day for adjustment disorder. The Risperidone medication had been increased from .25 mg three times a day to .5 mg twice a day on 5/25/12.</p> <p>Review of the quarterly 2/20/13 Minimum Data Set (MDS) assessment indicated the resident was not alert and oriented. The resident had no mood or behavior problems. The resident was receiving an antipsychotic medication seven days a week.</p> <p>Review of the behavior log for 12/12, 1/13, and 2/13 indicated the resident had no behaviors exhibited in the last three months.</p> <p>Interview with the Social Serviced Director on 3/6/13 at 11:47 a.m., indicated the only diagnosis for the Risperidone was "adjustment</p>		<p>obtained regarding diagnosis and medication reduction.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b></p> <p>Any resident who receives a psychotropic medication has the potential to be affected by this finding. The Nurse Management Team, SSD and/or designee will be responsible for conducting a facility audit reviewing psychotropic medication usage. This audit will ensure that any resident currently receiving a psychotropic medication has proper indication for use including appropriate diagnosis as well as continued need for use of the medication based on review of behavior logs, mood indicators, etc. In addition, the Nurse Management Team and SSD will monitor all new orders for psychotropic medications to ensure thorough and complete documentation is present in the clinical record supporting the need for psychotropic medication use. They will also work closely with the facility mental health provider to ensure that any resident receiving a psychotropic medication has appropriate indication for use, is closely monitored for effectiveness of the medications, is receiving the lowest effective dose and that reduction and/or elimination of psychotropic medications are</p>				

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	<p>disorder." She further indicated the resident was being seen by the Psychiatrist who controls the psychotropic medications. The Social Service Director indicated the resident has not had any behaviors for the months 11/12, 12/12, 1/13, and 2/13.</p> <p>3.1-48(a)(4)</p>		<p>attempted when indicated. Orders will be corrected and clarified as needed. A mandatory nursing/SS in-service will be conducted by the DNS/designee on or before 4/7/13. This in-service will include review of the facility policy titled "Psychoactive Medication Management Program". Nursing staff will be re-educated regarding clinical justification for use of any psychoactive medication as well as required and appropriate supportive documentation and close monitoring.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b> A mandatory nursing/SS in-service will be conducted by the DNS/designee on or before 4/7/13. This in-service will include review of the facility policy titled "Psychoactive Medication Management Program". Nursing staff will be re-educated regarding clinical justification for use of any psychoactive medication as well as required and appropriate supportive documentation and close monitoring. The Nurse Management Team and SSD will monitor all current orders for psychotropic medications to ensure thorough and complete documentation is present in the clinical record supporting the ongoing need for psychotropic</p>		

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			<p>medication use. They will also work closely with the facility mental health provider to ensure that any resident receiving a psychotropic medication has appropriate indication for use, is closely monitored for effectiveness of the medications, is receiving the lowest effective dose and that reduction and/or elimination of psychotropic medications are attempted when indicated. In addition, the Nurse Management Team will monitor all new orders for psychotropic medications to ensure thorough and complete documentation is present as well as an appropriate diagnosis to justify the need for the medication and referrals to mental health services when indicated.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</b> To ensure ongoing compliance with this corrective action, the DNS/designee will monitor all new orders for psychotropic medications to ensure thorough and complete documentation is present as well as an appropriate diagnosis to justify the need for the medication. The DNS/designee will also be responsible for completion of the CQI Audit tool titled, "Unnecessary Medications" weekly for 4 weeks, then monthly for 6 months. If threshold of 90%</p>		

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			is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. <b>By what date the systemic changes will be completed:</b> Compliance date = 4/7/13.		

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F000431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to ensure multi-dose vials of insulin were destroyed 28 days after the vials were</p>	F000431	<p><b>F431 – Drug Records, Label/Store Drugs &amp; Biologicals</b> It is the practice of this facility that all drugs and biologicals used in the facility be</p>	04/07/2013			

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	<p>opened for 3 of 10 insulin dependent diabetics on the First Floor Unit (Residents #28, #34 and #39) and failed to store medications securely, related to a propped opened Medication Room door for 1 of 3 Medication Rooms (Third Floor Unit), which had the potential to affect 34 of 34 residents who reside on the Third Floor Unit.</p> <p>Findings include:</p> <p>1. During an observation on 03/5/13 at 7:19 a.m., with LPN #1 present, there was an opened vial of Novolog regular insulin, dated 01/20/13, for Resident #39, an opened vial of Novolog regular insulin, dated 01/31/13, for Resident #34, and an opened vial of Novolog regular insulin, dated 02/01/13 for resident #28.</p> <p>During an interview at the time of the observation, LPN #1 indicated everyone was responsible to ensure there were no expired medications. She indicated there was a log they write in to mark when the bottle of insulin was opened.</p> <p>A form received from the Director of Nursing, titled, "Medications Requiring Special Storage", dated 04/11,</p>		<p>labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. It is also the practice of this facility to store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys. <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #28, #34, #39</b> - physicians and family has been updated regarding each resident's current status. The opened vial of Novolog Regular Insulin was discarded. None of the residents experienced a negative outcome related to this finding. All medication rooms are equipped with an automatic door closure to ensure they are properly closed and secure. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b> All residents who receive insulin have the potential to be affected by this finding. The DNS/designee will complete an inspection of all medication rooms, medication room refrigerators and medication carts to ensure that any opened multi</p>		

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	<p>indicated, "...Novolog...Expires 28 fays after removing from the refrigerator opened or un-opened..."</p> <p>2. During an observation on 03/05/13 at 7:27 a.m., the Third Floor Unit Medication Room door was propped open and not visual to the nurses' working the floor. LPN #2 was in the Dining Room and LPN #3 was sitting at the Nurses' Station, around the corner from the door.</p> <p>During an interview on 03/13/13 at 7:30 a.m., LPN #2 indicated the door should not have been propped open.</p> <p>3.1-25(k)(6)</p>		<p>dose vials of medications have appropriate date opened stickers in place and are within the drug expiration date per manufacturer's recommendations. Any expired medications will be destroyed and/or discarded immediately. In addition, the DNS/Unit Manager/designee will be responsible for facility wide weekly medication cart/room/refrigerator inspections. This will ensure that all medications are within the drug expiration date per manufacturer's recommendations. The DNS/Unit Manger/designee will perform daily rounds and environmental inspections on all shifts to ensure that all medication room doors are properly closed and secured per regulation. A mandatory nursing in-service will be conducted by the DNS/designee on or before 4/7/13. This in-service will include review of the facility policy related to medication storage, expiration dates and locked medication rooms. Nursing staff will be re-educated regarding applying a date opened sticker on all multi-dose vials of medications and the importance of checking expiration dates prior to administration of any medication. They will also be re-educated regarding keeping medication room doors locked and secured.</p> <p><b>What measures will be put into</b></p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155448	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/08/2013
NAME OF PROVIDER OR SUPPLIER  LOWELL HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 710 MICHIGAN ST LOWELL, IN 46356		
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			<p><b>place or what systemic changes will be made to ensure that the deficient practice does not recur:</b> A mandatory nursing in-service will be conducted by the DNS/designee on or before 4/7/13. This in-service will include review of the facility policy related to medication storage, expiration dates and locked medication rooms. They will also be re-educated regarding keeping medication room doors locked and secured. Nursing staff will be re-educated regarding applying a date opened sticker on all multi-dose vials of medications and the importance of checking expiration dates prior to administration of any medication. In addition, the DNS/Unit Manager/designee will be responsible for facility wide weekly medication cart/room/refrigerator inspections. This will ensure that all medications are within the drug expiration date per manufacturer's recommendations. Any expired medications will be destroyed by DNS/designee. The DNS/Unit Manger/designee will perform daily rounds and environmental inspections on all shifts to ensure that all medication room doors are properly closed and secured per regulation. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur,</b></p>		

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			<p><b>i.e., what quality assurance program will be put into place:</b> To ensure ongoing compliance with this corrective action, the DNS/SSD/designee will be responsible for completion of the CQI Audit Tool, "Medication Storage Review" daily for 3 weeks, weekly for 6 months. Daily rounds and environmental inspections will also ensure that all medication room doors are properly closed and secured per regulation. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. <b>By what date the systemic changes will be completed:</b> Compliance date = 4/7/13</p>		