

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155290	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/09/2013
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NAME OF PROVIDER OR SUPPLIER ST ELIZABETH HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 ARMORY RD DELPHI, IN 46923
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F000000	<p>This visit was for Recertification and State Licensure survey.</p> <p>Survey dates: September 3, 4, 5, 6, and 9, 2013</p> <p>Facility number: 000187 Provider number: 155290 AIM number: 100267300</p> <p>Survey team: Bobette Messman RN, TC Rita Mullen RN Michelle Carter RN (September 4, 5, 6, and 9, 2013)</p> <p>Census bed type: SNF: 20 SNF/NF: 40 Total: 60</p> <p>Census payor type: Medicare: 13 Medicaid: 31 Other: 16 Total: 60</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review was completed by</p>	F000000	<p>St. Elizabeth Healthcare Center (the Provider) submits this Plan of Correction (POC) in accordance with specific regulatory requirements. The submission of this POC does not indicate an admission by St. Elizabeth Healthcare Center that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of St. Elizabeth Healthcare Center. This POC shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests a desk review of the deficiencies noted.</p>	
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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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	Tammy Alley RN on September 11, 2013.			

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F000246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on interview and record review, the facility failed to meet a residents sleep preferences in order to administer a breathing treatment for 1 of 3 residents reviewed for choices. (Resident #102)</p> <p>Findings include:</p> <p>The record for Resident #102 was reviewed on 9/5/13 at 1:15 p.m.</p> <p>Diagnoses for Resident #102 included, but were not limited to, chronic airway obstruction, atrial fibrillation, high blood pressure, dyspepsia, anxiety disorder, depression, and chronic anemia.</p> <p>During an interview with Resident #102 on 9/4/13 at 2:35 p.m., the resident indicated she did not get to choose when to get up in the morning. She indicated the nurse brought the breathing treatment to her at 5:30 a.m. When she (Resident #102) told the nurse she wanted to</p>	F000246	<p>1) Resident #102 is no longer in facility.2) All residents have the potential to be affected by this practice. Resident preferences were reviewed and any changes updated. No adverse effects noted. Preferences are reviewed upon admission and on an as needed basis.3) Licensed nursing staff will be re-inserviced by September 25, 2013, concerning resident preferences. The Director of Nursing (DON) or designee will interview five residents per week for three months to ensure that preferences are being followed. DON or designee will report findings monthly to QAA.4) QAA will monitor findings for any trends and make recommendations to the plan of correction as needed. QAA will monitor for three months or until 100% compliance is achieved.</p>	09/30/2013	

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	<p>sleep and didn't want the breathing treatment that early, the nurse told her the medication treatment would be marked "refused". Resident #102 explained difficulty going back to sleep after receiving the breathing treatment. Resident #102 did not recall the name of the nurse.</p> <p>The Medication Administration Record (MAR) for September 2013, dated 8/25/13, indicated the following: Pulmicort 0.5 mg. (milligrams)/2 ml. (milliliters) Resp (respiratory): give one UD (unit dose) per nebulizer treatment every 12 hours, at 6 a.m., and 6 p.m.</p> <p>The MAR for September 2013 indicated the Pulmicort breathing treatment was not administered on the morning of 9/3/13. During an interview with the Director of Nursing (DoN), on 9/5/13, at 1:55 p.m., she indicated documentation to indicate the medication treatment was or was not given was not completed. She indicated the nurse on duty was RN #1, and was expected to mark her initials, after administering the medication treatment or mark her initials with a circle around the initials, if the medication treatment was not administered and document the reason why it wasn't administered on</p>						

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	<p>the back of the sheet.</p> <p>The MAR September 2013 indicated the Pulmicort breathing treatment was refused on the mornings of 9/4 and 9/5/13. The refusal reasons were documented as follows: "9/4/13 0530, res [resident] declined neb tx [treatment], wants to sleep." "9/5/13 0530, res declined neb tx. "</p> <p>During an interview with the DoN, on 9/5/13, at 1:55 p.m., she indicated RN #1 should have asked Resident #102 if she (the resident) would like the treatment at a later time, instead of not giving it at all. The DoN indicated the administration times should be changed to accommodate the resident's preferences.</p> <p>3.1-3(v)(1)</p>				

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F000282 SS=E	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <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 record review, observation, and interview, the facility failed to ensure physicians orders, care plans, and the facility policies for medication administration and gradual dose reduction were followed for 2 of 8 medication administration observation and 3 of 6 residents reviewed for gradual dose reduction and 1 of 1 reviewed for following physicians orders. (Residents #102, #58, #103, #9, #24, and #7)</p> <p>Findings include:</p> <p>1. The record for Resident #102 was reviewed on 9/5/13 at 1:15 p.m.</p> <p>Diagnoses for Resident #102 included, but were not limited to, chronic airway obstruction, atrial fibrillation, high blood pressure, dyspepsia, anxiety disorder, depression, and chronic anemia.</p> <p>The Medication Administration Record (MAR) for September 2013, dated 8/25/13, indicated the following: Pulmicort 0.5 mg. (milligrams)/2 ml.</p>	F000282	<p>1) Resident #7 had gradual dose reduction (GDR) initiated. The effect of the GDR will be reported to the nurse practitioner or MD. Dosage will be adjusted per the nurse practitioner or MD. Resident plan of care will be revised as indicated based on the effects of the GDR. Resident #24 had physician order updated to reflect diagnosis for medication. Resident #58 was assessed for medication time and no adverse effects noted. Resident is now receiving medications based on preferences. Resident #102 is no longer in facility. Resident #103 is no longer in facility.2) All residents have the potential to be affected by this practice. Residents' preferences regarding medication pass times were assessed and updated as needed, unless specifically otherwise directed by attending physician. Any resident receiving psychotropic medication was assessed by DON or designee for appropriate reduction.3) Licensed staff re-inserviced by September 25, 2013, on proper techniques of medication administration and revised gradual dose reduction policy. DON or designee will review residents on psychotropic</p>	09/30/2013			

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	<p>(milliliters) Resp (respiratory): give one UD (unit dose) per nebulizer treatment every 12 hours, at 6 a.m., and 6 p.m.</p> <p>The MAR for September 2013 indicated the Pulmicort breathing treatment was not administered on the morning of 9/3/13. During an interview with the Director of Nursing (DON), on 9/5/13, at 1:55 p.m., she indicated there was not any indication the medication treatment was or was not given was not completed. She indicated the nurse on duty was RN #1, and was expected to mark her initials, after administering the medication treatment or mark her initials with a circle around the initials, if the medication treatment was not administered and document the reason why it wasn't administered on the back of the sheet.</p> <p>The MAR September 2013 indicated the Pulmicort breathing treatment was refused on the mornings of 9/4 and 9/5/13. The refusal reasons were documented as follows: "9/4/13 0530, res [resident] declined neb TX [treatment], wants to sleep." "9/5/13 0530, res declined neb TX. "</p> <p>During an interview with the DON, on 9/5/13, at 1:55 p.m., she confirmed</p>		<p>medications monthly and follow up with attending physicians on recommendations for GDR as needed. DON or designee will observe medication administration three times per week to include all three shifts for three months.4) QAA will monitor findings for any trends and make recommendations to the plan of correction as needed. QAA will monitor monthly for three months or until 100% compliance is achieved.</p>				

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	<p>RN #1 did not administer the breathing treatments, for Resident #102, on 9/3, 4, & 5, 2013, as ordered by the physician.</p> <p>2. The record for Resident #103 was reviewed on 9/6/13 at 3:00 p.m.</p> <p>Diagnoses for Resident #103 included, but were not limited to, benign prostatic hyperplasia (BPH), gastroesophageal reflux (GERD), and high blood pressure.</p> <p>The September 2013 MAR, dated 8/25/13, indicated the following orders for Resident #103: Flomax (for BPH) 0.4 mg 1 capsule with breakfast daily. Florastor (a probiotic) 200 mg 1 capsule, BID (twice per day), upon rising and HS (bedtime).</p> <p>During a medication administration observation with QMA #2, on 9/6/13, at 11:20 a.m., QMA #2 administered, to Resident #103, 1 Flomax capsule and 1 Florastor capsule.</p> <p>During an interview with QMA #2, on 9/6/13 at 11:27 a.m., he indicated the reason for the late morning medication pass was due to having double duties. He was the CNA and the QMA, that shift. He indicated he</p>						

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	<p>got the residents up in the morning, completed morning care and took residents to breakfast, then when the residents returned from breakfast, he began the medication pass.</p> <p>During an interview with the DoN, on 9/6/13 at 2:10 p.m., she indicated QMA #2 had time to administer medications in the time specified in the physicians orders because the residents, on the unit he was working, required minimal assistance due to a combined low accuity level.</p> <p>3. The record for Resident #58 was reviewed on 9/6/13 at 3:10 p.m.</p> <p>Diagnoses for Resident #58 included, but were not limited to, high blood pressure, chronic obstructive pulmonary disease, and depressive disorder.</p> <p>The September 2013 MAR, dated 8/25/13, indicated the following orders, for Resident #58: Lasix 80 mg 1 tablet PO (orally) BID, at 8:00 a.m. and 2:00 p.m. Isosorbide 30 mg 1 tablet PO BID, upon rising & HS.</p> <p>During a medication administration observation with QMA #2, on 9/6/13, at 11:09 a.m., QMA #2 administered,</p>				

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	<p>to Resident #58, 1 Lasix tablet and 1 Isosorbide tablet.</p> <p>During an interview with QMA #2, on 9/6/13 at 11:27 a.m., he indicated the reason for the late morning medication pass was due to having double duties, the CNA and the QMA, that shift. He indicated he got the residents up in the morning, completed morning care and took residents to breakfast, then when the residents returned from breakfast, he began the medication pass.</p> <p>During an interview with the DoN, on 9/6/13 at 2:10 p.m., she indicated QMA #2 had time to administer medications in the time specified in the physicians orders because the residents, on the unit he was working, required minimal assistance due to a combined low acuity level.</p> <p>4. The clinical record of Resident #24 was reviewed on 9/6/13 at 9:34 a.m. The Resident was admitted to the facility on 8/8/12.</p> <p>Diagnoses included, but were not limited to, dementia, depression, anxiety, congestive heart failure and chronic obstructive pulmonary disease.</p> <p>A Physician order dated 12/1/12,</p>			

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	<p>indicated lorazepam (ativan an anti anxiety medication) 0.5 mg (milligrams) three time a day PRN (as needed).</p> <p>A Physician order dated 12/1/12, indicated celexa (an antidepressant) 20 mg every morning.</p> <p>A Physician order dated 12/1/12, indicated wellbutrin (an antidepressant) 100 mg every morning.</p> <p>A Care Plan dated 8/21/12 and updated quarterly, for "Use of psychotropic drugs" indicated interventions to include, but not limited to, monitor for effectiveness of psychotropic drugs and work with physician/pharmacy to provide lowest therapeutic dosage.</p> <p>A "Note to Attending Physician/Prescriber" dated 2/20/13, indicated "Patient has been on Celexa [an antidepressant] 20 mg [milligrams] qd [every day] depression since 8/20/12. Please evaluate continued benefit vs risk and assess if at lowest effective dose. Consider a trial dose reduction per NH [nursing home] regulations if appropriate. If a dose reduction is not indicated, please document the reason below</p>			

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	<p>for surveyors benefit."</p> <p>The Nurse Practitioner on 2/22/13, checked the "disagree" box and indicated a trial dose reduction is contraindicated secondary to risk of exacerbation of: depression and to continue current therapy.</p> <p>A review of PRN (as needed) medication tracking for Resident #24 for the months of January 2013 to March 2013 and the month of July 2013, indicated the resident received Ativan (an anti anxiety medication) on 1/29/13, 1/20/13 and on 7/25/13 x 2, 7/26/13, and 7/27/13 x 2 for anxiety.</p> <p>A review of behavior tracking for the months of January 2013 to March 2013, indicated the Resident did not have behaviors and a review of the behavior tracking for the month of July 2013 indicated the Resident did not have behaviors.</p> <p>During an interview with the Director of Social Service on 9/9/13 at 10:50 a.m., she indicated she looked at the behaviors entered into the computer behavior tracking program and informs nursing of any resident patterns of behaviors at the weekly Clinically at Risk (CAR) meeting.</p>						

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	<p>During an interview with the Director of Nursing, on 9/9/13 at 12:00 p.m., she indicated Resident #24 did not have behaviors, the resident had symptoms related to her shortness of breath that caused anxiety.</p> <p>5.) Resident #7's record was reviewed on 9/5/2013 at 1:30 p.m.</p> <p>Resident #7's current diagnosis included, but were not limited to, cardiomyopathy, cerebrovascular disease with left sided weakness, senile dementia, atrial fibrillation, severe kidney disease stage IV, rectocele, cystocele, hypopotassemia, malaise and fatigue, hyperlipidemia, anxiety, constipation, insomnia, atherosclerotic heart disease.</p> <p>Resident #7 had a physician's order dated 2/18/13, for Ambien 5 mg (a hypnotic medication) 1 tablet every day at hour of sleep.</p> <p>On 8/22/2013 a Gradual Dose Reduction was suggested by the consultant pharmacist to reduce Resident #7's Ambien medication. The nurse practitioner disagreed and wrote, "cont [continue], current regimen".</p> <p>During an interview with the nurse</p>			

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	<p>practitioner, on 9/6/13 at 10:10 a.m., he indicated he was not aware he had to document the clinical rationale for why any additional attempted dose reduction would likely impair the resident's function, increase distressed behavior, or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder.</p> <p>On 9/9/2013 at 10:00 a.m., a review of the facility policy "medication monitoring and management" on hypnotics, gradual dose reduction, indicated the physician will document the clinical rationale for why any additional attempted dose reduction would likely impair the resident's function, increase distressed behavior, or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder.</p> <p>3.1-35(g)(2)</p>			

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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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. Based on observation and interview, the facility failed to ensure a hazard free environment was maintained, during 1 of 8 medication administration observations.</p> <p>Findings include:</p> <p>During a medication administration observation, on 9/6/13 at 10:56 a.m., QMA #2 left 4 medications, including 2 ferrous sulfate, 1 Lasix tablet, and 1 Isosorbide tablet, in a souffle cup, on top of the medication cart, as he went to take a blood pressure for Resident # 58. The medications were left unattended and unsecured.</p> <p>QMA #2 returned to the medication cart and added appropriate medications to the souffle cup. At 11:09 a.m., he left the medication cart, again, to administer medications to Resident #58. QMA #2 left a pre-packaged medication blister card, that contained 3 Lisinopril (high blood pressure medication) tablets, on top</p>	F000323	<p>1) No specific residents listed. QMA #2 had one-on-one re-inservice concerning medication administration with DON.2) All residents have the potential to be affected by this practice. No adverse effects noted.3) Licensed staff will be re-inserviced by September 25, 2013, on proper techniques of medication administration. DON or designee will observe medication administration three times per week to include all three shifts for three months.4) QAA will monitor findings for any trends and make recommendations to the plan of correction as needed. QAA will monitor monthly for three months or until 100% compliance is achieved.</p>	09/30/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155290	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/09/2013
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	<p>of the medication cart, unattended and unsecured.</p> <p>During an interview with QMA #2, on 9/6/13 at 11:27 a.m., he indicated when he leaves the med (medication) cart, the cart should be locked and there should be no medicine left on the cart, unattended.</p> <p>On 9/6/13 at 2:10 p.m., during an interview with the DoN, she confirmed medications were not to be left unsecured and unattended.</p> <p>3.1-45(a)(1)</p>			

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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</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 interview, the facility failed to attempt Gradual Dose Reductions (GDR) as recommend by the Pharmacy Consultant and explain the physician's refusal to follow the Pharmacy Consultant's recommendations for 3 of 6 residents reviewed for unnecessary medications (Resident #7, 9, and 24).</p> <p>Findings include:</p>	F000329	<p>1) Resident #9 was assessed for gradual dose reduction. Resident #24 had GDR initiated and physician will be notified of any effects. Resident #7 had GDR initiated and physician will be notified of any effects.2) All residents have the potential to be affected by this practice. Any resident receiving psychotropic medication was assessed by DON or designee for appropriate reduction.3) Licensed staff and attending physicians will be re-inserviced by September 25, 2013, on revised gradual dose</p>	09/30/2013			

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	<p>1. The clinical record of Resident #24 was reviewed on 9/6/13 at 9:34 a.m. The Resident was admitted to the facility on 8/8/12.</p> <p>Diagnoses included, but were not limited to, dementia, depression, anxiety, congestive heart failure and chronic obstructive pulmonary disease.</p> <p>A Physician order dated 12/1/12, indicated lorazepam (ativan an anti anxiety medication) 0.5 mg (milligrams) three time a day PRN (as needed)</p> <p>A Physician order dated 12/1/12, indicated celexa (an antidepressant) 20 mg every morning.</p> <p>A Physician order dated 12/1/12, indicated wellbutrin (an antidepressant) 100 mg every morning.</p> <p>A Care Plan dated 8/21/12 and updated quarterly, for "Use of psychotropic drugs," indicated the goal was, "Resident will receive minimal dosage of the prescribed psychotropic drug (s) to ensure maximum functional ability both mentally and physically." Interventions included, but were not</p>		<p>reduction policy. DON or designee will review residents on psychotropic medications monthly and follow up with attending physicians on recommendations for gradual dose reduction as needed.4) QAA will monitor findings for any trends and make recommendations to the plan of correction as needed. QAA will monitor monthly for three months or until 100% compliance is achieved.</p>		

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	<p>limited to," monitor for effectiveness of psychotropic drug (s) and work with physician/pharmacy to provide lowest therapeutic dosage."</p> <p>A "Note to Attending Physician/Prescriber" dated 2/20/13, indicated "Patient has been on Celexa [an antidepressant] 20 mg [milligrams] qd [every day] depression since 8/20/13. Please evaluate continued benefit vs risk and assess if at lowest effective dose. Consider a trial dose reduction per NH [nursing home] regulations if appropriate. If a dose reduction is not indicated, please document the reason below for surveyors benefit."</p> <p>The Nurse Practitioner on 2/22/13, checked the "disagree" box and indicated a trial dose reduction was contraindicated secondary to risk of exacerbation of: depression and to continue current therapy.</p> <p>A review of PRN (as needed) medication tracking for Resident #24 for the months of January 2013 to March 2013, indicated the resident received Ativan (an anti anxiety medication) on 1/29/13 at 2:15 a.m. and 1/20/13 at 9:00 a.m.</p> <p>A review of behavior tracking for the</p>						

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	<p>months of January 2013 to March 2013, indicated the Resident did not have behaviors.</p> <p>During an interview with the Director of Social Services on 9/9/13 at 10:50 a.m., she indicated she looks at the behaviors entered into the computer behavior tracking program and informs nursing of any resident patterns of behaviors at the weekly Clinically at Risk (CAR) meeting.</p> <p>During an interview with the Director of Nursing, on 9/9/13 at 12:00 p.m., she indicated Resident #24 did not have behaviors, the resident had symptoms related to her shortness of breath that caused anxiety.</p> <p>2. The record for Resident #9 was reviewed on 9/6/13 at 9:47 a.m.</p> <p>Diagnoses for Resident #9 included, but were not limited to, depressive disorder, severe spinal stenosis, osteoarthritis, hypokalemia, high blood pressure, chronic renal insufficiency, chronic kidney disease-stage 3, stress incontinence, vaginitis, restless leg syndrome, macular degeneration to both eyes, generalized anxiety disorder, peripheral vascular disease, and anemia.</p>			

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	<p>A GDR (gradual dose reduction) note, dated 7/25/13, from the facility pharmacist to the attending physician/prescriber, indicated the following:</p> <p>"Patient has been on Paxil 10 mg qd [daily] for depression since 7/2012. Please evaluate continued benefit vs. risk and assess if at lowest effective dose. Consider a trial dose reduction per NH [nursing home] regulations, if appropriate. If a dose reduction is not indicated, please document the reason below for surveyors benefit."</p> <p>The physician checked the box on the GDR note that indicated:</p> <p>"A trial dose reduction is contraindicated secondary to risk of exacerbation of depression. Resident does not tolerate change and is very obsessive with changes and worries a lot. Continue current regimen."</p> <p>The behavior tracking graph received from the DoN on 9/6/13 at 11:50 a.m., indicated Resident #9 did not display any behaviors and no behaviors were observed at the facility.</p> <p>During an interview with the Assistant Director of Nursing (ADON), on 9/6/13 at 2:00 p.m., she indicated the need</p>				

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	<p>to review guidelines with the practitioner(s).</p> <p>During an interview with the Nurse Practitioner (NP), on 9/5/13 at 10:10 a.m., he indicated he did not know about documenting specific behavior and information related to GDR's.</p> <p>3.) Resident #7's record was reviewed on 9/5/2013 at 1:30 p.m.</p> <p>Resident #7's current diagnosis included, but were not limited to, cardiomyopathy, cerebrovascular disease with left sided weakness, senile dementia, atrial fibrillation, severe kidney disease stage IV, rectocele, cystocele, hypopotassemia, malaise and fatigue, hyperlipidemia, anxiety, constipation, insomnia, atherosclerotic heart disease.</p> <p>Resident #7 had a physician's order dated 2/18/13 for Ambien 5 mg (a hypnotic medication) 1 tablet every day at hour of sleep.</p> <p>Resident #7's record for 4/30/13 to 9/5/13 lacked any documented indicators for the use of a hypnotic medication.</p> <p>On 8/22/2013 a Gradual Dose Reduction was suggested by the</p>				

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	<p>consultant pharmacist to reduce Resident #7's Ambien medication. The nurse practitioner disagreed and wrote, "cont [continue], current regimen".</p> <p>During an interview with the nurse practitioner, on 9/6/13 at 10:10 a.m. he indicated he was not aware he had to document the clinical rationale for why any additional attempted dose reduction would likely impair the resident's function, increase distressed behavior, or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder.</p> <p>During an interview with the Director of Nursing on 9/5/2013 at 3:04 p.m. she indicated she was unable to find any information regarding documentation of sleeping behaviors for Resident #7 in nursing notes, social services psychosocial assessments or resident behavior graph dated 6/8/2013 to 9/5/2013 for the period 4/30/13 to 9/5/2013.</p> <p>On 9/9/2013 at 10:00 a.m., a review of the facility policy "medication monitoring and management" on hypnotics, gradual dose reduction, indicated the physician will document the clinical rationale for why any</p>				

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NAME OF PROVIDER OR SUPPLIER ST ELIZABETH HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 ARMORY RD DELPHI, IN 46923
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	<p>additional attempted dose reduction would likely impair the resident's function, increase distressed behavior, or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder.</p> <p>3.1-48(b)(2)</p>			

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F000371 SS=C	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to ensure the cleanliness of the equipment and flooring, for 1 of 1 kitchen observed for cleanliness. This deficient practice had the potential to effect 60 of 60 residents residing in the facility.</p> <p>Findings include:</p> <p>During the initial tour of the kitchen with the Director of Food Services on 9/3/13 at 10:15 a.m., the following items were noted.</p> <ol style="list-style-type: none"> The mixer had dried batter adhering to the housing surface. The flooring between the convection oven, stove, deep fat fryer, and grill had grease and debris. <p>During an interview with the Director of Food Services, on 9/3/13 at 10:35 a.m., he indicated the floor and mixer needed to be cleaned.</p>	F000371	<p>1) No specific residents listed.2) All residents have the potential to be affected by this practice. Dietary staff are expected to store, prepare, distribute and serve food under sanitary conditions. No adverse effects noted.3) Director of Food Services will re-inservice dietary staff by September 25, 2013, on kitchen sanitation generally and specifically to mixer housing and flooring between convection oven, stove, deep fat fryer and grill. Director of Food Services or designee will observe sanitation rounds twice a week for three months.4) QAA will monitor findings for any trends and make recommendations to the plan of correction as needed. QAA will monitor monthly for three months or until 100% compliance is achieved.</p>	09/30/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155290	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/09/2013
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	3.1-21(i)(2)				