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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155217 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 03/04/2014 |
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| NAME OF PROVIDER OR SUPPLIER WATERS OF HUNTINGBURG THE | STREET ADDRESS, CITY, STATE, ZIP CODE 1712 LELAND DR HUNTINGBURG, IN 47542 |
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| F000000 | <p>This visit was for the Investigation of Complaint IN00143979 and Complaint IN00144563.</p> <p>Complaint IN00143979 - Substantiated, Federal/State deficiencies related to the allegations are cited at F514.</p> <p>Complaint IN00144563 - Substantiated, Federal/State deficiencies related to the allegations are cited at F371.</p> <p>Unrelated deficiency is cited.</p> <p>Survey dates: February 27 and 28, 2014 March 4, 2014</p> <p>Facility number: 000122 Provider number: 155217 AIM number: 100290560</p> <p>Survey Team: Anne Marie Crays, RN</p> <p>Census bed type: SNF/NF: 65 Total: 65</p> <p>Census payor type:</p> | F000000 | | |

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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| | <p>Medicare: 10 Medicaid: 35 Other: 20 Total: 65</p> <p>Sample: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on March 5, 2014, by Jodi Meyer, RN</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 observation, interview, and record review, the facility failed to ensure a resident who was receiving Risperdal, then had it increased, was adequately monitored while on the medication, for 1 of 1 residents reviewed who were receiving psychotropic medications, in a sample of 7.</p> <p>Resident B</p> <p>Findings include:</p> | F000329 | <p>Preparation and/or execution of the plan of correction in general, or this corrective action in particular does not constitute an admission agreement by the facility of facts alleged or conclusions 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 laws.</p> <p>F329-SSD</p> <p>Drug Regimen is Free form Unnecessary Drugs</p> <p>It is the intent of this facility to</p> | 03/17/2014 |

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| | <p>1. On 2/27/14 at 11:10 A.M., the clinical record of Resident B was reviewed. The resident was admitted to the facility on 12/23/13 with diagnoses including, but not limited to, dementia and general muscle weakness.</p> <p>The resident was admitted from the hospital with a physician's order for Risperdal 0.25 mg (an anti-psychotic) once daily.</p> <p>Progress Notes included the following notations:</p> <p>1/2/14 at 1:29 P.M.: "...D/C [discharge] plan uncertain. Family is hopeful to return home [sic] but depends on progress...Working with therapies at this time...."</p> <p>1/7/14 at 4:41 A.M.: "Noted red/bumpy rash to bil. [bilateral] breasts...Res. [resident] states it itches. [Name of physician] notified."</p> <p>1/7/14 at 2:59 P.M.: "New orders received to increase risperdal, treatment to breast rash, and diet change. [Family] notified of changes."</p> <p>A physician's order, dated 1/7/14, indicated, "Risperdal [increase] to</p> | | <p>ensure that all resident's drug regiment is free from unnecessary drugs.</p> <p>1. Actions Taken: A) Resident B's monitoring for Risperdal was put in place appropriately.</p> <p>2. How other residents have the potential to be affected: A) All residents receiving psychoactive medications would have the potential to be affected.</p> <p>3. Measures Taken: A) A 100% audit was taken to determine all residents who are currently on psychotropic medication and plan of care were updated as needed to reflect resident's current status. B) Nursing staff was in-serviced concerning Behavior monitoring protocol.</p> <p>4. How Monitored: A) Social Service Director will review all Antipsychotic order/Behavior monitor report in daily Clinical Quality Indicator (CQI) meeting to assure each order is accurate, complete and proper monitoring is placed. B) Social and IDT members will complete the weekly behavior meeting per policy and procedure for completeness and monitoring. Any inconsistent results will be immediately clarified and corrected appropriately. Results would be monitored and reviewed at the monthly and quarterly QA Meeting for determination of ongoing</p> | | | | |

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| | <p>0.25 mg po [by mouth] bid [twice daily]. Dx [diagnosis] confusion, hallucinations due to dementia [and] brain atrophy."</p> <p>Documentation regarding the resident hallucinating or having delusions was not found in the clinical record.</p> <p>On 2/27/14 at 11:35 A.M., Resident B was observed lying in bed. Resident B was pleasant, and appeared to be tired. She indicated she was "fighting a cold."</p> <p>On 2/27/14 at 11:55 A.M., during interview with LPN # 1, she indicated she usually worked on Resident B's unit. LPN # 1 indicated she did not know why the resident's Risperdal was increased.</p> <p>On 2/27/14 at 3:10 P.M., the Social Services Director (SSD) was interviewed. The SSD indicated her and the Director of Nursing (DON) monitor the residents' psychotropic medication. The SSD indicated she was unsure why Resident B's Risperdal was increased. The SSD indicated there should have been some notes explaining why it was increased. The SSD indicated she was "kind of surprised we missed</p> | | monitoring. | |

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| | <p>that. We review orders every morning." The SSD indicated she was unsure why the Risperdal times were changed.</p> <p>On 2/28/14 at 10:25 A.M., the DON provided a physician fax form, dated 1/10/14. The form indicated: "Concern: Recently increased Risperdal 0.25 mg from daily to BID. Since then, resident has been very drowsy in the morning. Difficulty w/hand/eye coordination et [and] staying awake. Could we change Risperdal back to daily? No hallucinations or delusions noted." The physician responded, "She did have hallucinations on Risperdal 0.25 mg q [every] day, and now doesn't on bid. So [change] to 0.25 mg q 1600 [4:00 P.M.] et 2000 hr [8:00 P.M.]."</p> <p>On 2/28/14 at 10:50 A.M., Resident B was observed lying abed, asleep.</p> <p>On 2/28/14 at 12:00 P.M., Resident B's clinical record was again reviewed. The DON indicated at that time that the January behavior monitoring form would be in the clinical record, and the February behavior monitoring form would be in the Medication Administration Record (MAR). Documentation of a</p> | | | |

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| | <p>monitoring form for January or February for the Risperdal was not found in the resident's MAR.</p> <p>On 3/4/14 at 11:30 A.M., during interview with the resident's physician, she indicated she thought the facility had sent her a fax regarding the resident's delusions. The physician indicated she herself had spoken to the resident, and the resident had delusions regarding going home. The physician indicated she thought the resident "saw someone in her closet."</p> <p>On 3/4/14 at 11:40 A.M., the Assistant Director of Nursing looked through the "fax book," and could not find a fax regarding delusions or hallucinations which had been sent to the physician.</p> <p>2. On 2/28/14 at 11:40 A.M., the DON provided the current facility policy on "Behavior Management Psychotropic Medication Protocol," dated 7/20/12. The policy included: "Residents who receive antipsychotic...medications are to be maintained at the safest, lowest dosage necessary to manage the resident's condition. Residents will be reviewed routinely for effectiveness and monitored for side</p> | | | | | | |

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| F000371 SS=E | <p>effects of these medications...When a resident is prescribed an antipsychotic the specific clinical diagnosis for which the drug is being given must be documented in the resident's record along with documentation of how interventions alone have not been successful enough to manage the condition...."</p> <p>3.1-48(a)(3)</p> <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</p> | | | |

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| | <p>Based on observation and interview, the facility failed to ensure the kitchen was in clean and sanitary condition, in that walls, floors, and shelving were dusty, dirty, and food splattered, for 1 of 2 kitchen observations.</p> <p>Findings include:</p> <p>On 2/27/14 at 9:45 A.M., during the initial tour of the kitchen, the following was observed:</p> <ol style="list-style-type: none"> 1. Dead bugs were observed on all levels of the shelving units in the dry food pantry area. The shelves were observed to be dusty. 2. Floors were dirty, especially near the edges. Dead bugs were observed on the floor. The floor in front of the refrigerator and freezer was soiled with deep grey ground in dirt. 3. Walls were food-splattered behind the toaster area. The toaster was soiled with a grease-like dirt. <p>During interview with the Dietary Manager at that time, she indicated dietary staff mops the kitchen twice daily, and Maintenance staff strip</p> | F000371 | <p>Preparation and/or execution of the plan of correction in general, or this corrective action in particular does not constitute an admission or agreement by the facility of facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific correction actions are prepared and/or executed in compliance with state and federal laws.</p> <p>F371-SSE Food procure store/prepare/serve-sanitary It is the intent of this facility to store, prepare, distribute and serve food under sanitary conditions as approved by Federal, State or local authorities. 1. Actions Taken: A) The Dietary Service Manager and her staff cleaned areas identified. B) The floor tech stripped and waxed kitchen floor. 2. How other residents have the potential to be affected: A) All residents would have potential to be affected. 3. Measures Taken: A) Inspection of all shelves and kitchen was completed by Dietary Manager and Administrator to identify all areas of concern. 4. How Monitored: A) Daily check-off sheets were given to the Dietary Service Manager (DSM) to be utilized by her and her staff to ensure compliance. B) Floor stripping/buffing schedule was given to plant operations director and housekeeping director to be utilized to ensure compliance. C) Administrator/Designee will</p> | 03/17/2014 | |

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| | <p>and wax the floor. The Dietary Manager indicated half of the kitchen had been stripped and waxed the previous week. The Dietary Manager indicated they had had problems with "gnat-like bugs," but it had been much better recently.</p> <p>During interview with the Administrator, on 2/27/14 at 4:00 P.M., he indicated he had identified the previous week that the kitchen needed to be cleaned, but they had not got around to completing it.</p> <p>This Federal tag relates to Complaint IN00144563.</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p> | | <p>complete audits three times a week for four weeks and once a week thereafter. Results would be monitored and reviewed at the monthly and quarterly QA meetings. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. We are here by requesting a desk review. Our date of compliance is, March 17, 2014.</p> | | |

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| F000514 SS=D | <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on observation, interview and record review, the facility failed to ensure documentation was complete, accurate, and organized regarding a fall, physician notification, condition changes, and delusions for 3 of 4 residents reviewed for documentation, in a sample of 7. Resident B, Resident D, Resident C</p> | F000514 | <p>Preparation and/or execution of the plan of correction in general, or this corrective action in particular does not constitute an admission agreement by the facility of facts alleged or conclusions 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 laws.</p> <p>F514 – SSD</p> | 03/17/2014 | |

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| | <p>Findings include:</p> <p>1. On 2/27/14 at 11:10 A.M., the clinical record of Resident B was reviewed. The resident was admitted to the facility on 12/23/13 with diagnoses including, but not limited to, dementia and general muscle weakness.</p> <p>The resident was admitted from the hospital with a physician's order for Risperdal 0.25 mg (an anti-psychotic) once daily.</p> <p>Progress Notes included the following notations:</p> <p>1/2/14 at 1:29 P.M.: "...D/C [discharge] plan uncertain. Family is hopeful to return home [sic] but depends on progress...Working with therapies at this time...."</p> <p>1/7/14 at 4:41 A.M.: "Noted red/bumpy rash to bil. [bilateral] breasts...Res. [resident] states it itches. [Name of physician] notified."</p> <p>1/7/14 at 2:59 P.M.: "New orders received to increase risperdal, treatment to breast rash, and diet change. [Family] notified of changes."</p> | | <p>Records-complete/accurate/accessible</p> <p>It is the intent of this facility to ensure that all records are complete/accurate and accessible.</p> <p>1. Actions Taken:</p> <p>A) Resident B was assessed to ensure no negative outcomes.</p> <p>B) Residents C and D are no longer, nor were they at time of survey, residents of this facility; therefore no corrective action can be taken.</p> <p>2. How other residents have the potential to be affected:</p> <p>A) A 100% audit was completed on all residents on Antipsychotics for documented diagnosis and s/s of medication. No other residents identified.</p> <p>A 100% Audit was completed on all falls in last 30days for proper/accurate documentation in the clinical record. No other residents identified.</p> <p>An audit was completed on all records for changes of condition for last 30 days for proper documentation in the clinical record. No other residents identified.</p> <p>3. Measures taken:</p> <p>A) Nurses and Social Services will be in-serviced related to documenting accurate and complete documentation in the clinical record.</p> <p>4. How Monitored:</p> <p>A) Social Service/Designee will Audit Behavior logs for s/s behaviors and bring results to the daily CQI Meeting.</p> | | | | |

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| | <p>A physician's order, dated 1/7/14, indicated, "Risperdal [increase] to 0.25 mg po [by mouth] bid [twice daily]. Dx [diagnosis] confusion, hallucinations due to dementia [and] brain atrophy."</p> <p>Documentation regarding the resident hallucinating or having delusions was not found in the clinical record.</p> <p>On 2/27/14 at 11:35 A.M., Resident B was observed lying in bed. Resident B was pleasant, and appeared to be tired. She indicated she was "fighting a cold."</p> <p>On 2/27/14 at 11:55 A.M., during interview with LPN # 1, she indicated she usually worked on Resident B's unit. LPN # 1 indicated she did not know why the resident's Risperdal was increased.</p> <p>On 2/27/14 at 3:10 P.M., the Social Services Director (SSD) was interviewed. The SSD indicated her and the Director of Nursing (DON) monitor the residents' psychotropic medication. The SSD indicated she was unsure why Resident B's Risperdal was increased. The SSD indicated there should have been some notes explaining why it was</p> | | | | <p>B) DON/Designee will audit all falls and changes in condition in the daily CQI meeting and in the weekly fall meeting for accurate documentation.</p> <p>C) Any inconsistent results will be immediately clarified and corrected appropriately. Results will be monitored and reviewed at the monthly and quarterly QA Meeting for determination of ongoing monitoring.</p> <p>5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. We are here by requesting a desk review. Our date of compliance is March 17, 2014.</p> | | |

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| | <p>increased. The SSD indicated she was "kind of surprised we missed that. We review orders every morning."</p> <p>On 2/28/14 at 10:50 A.M., Resident B was observed lying abed, asleep.</p> <p>On 2/28/14 at 12:00 P.M., Resident B's clinical record was again reviewed. The DON indicated at that time that the January behavior monitoring form would be in the clinical record, and the February behavior monitoring form would be in the Medication Administration Record (MAR). Documentation of a monitoring form for January or February for the Risperdal was not found in the resident's MAR.</p> <p>2. The clinical record of Resident D was reviewed on 2/27/14 at 2:35 P.M.</p> <p>Progress Notes included the following notations:</p> <p>2/11/14 at 6:02 P.M.: "...Transfers with one assist feeds self surgical site on head clean and dry...no c/o [complaints] voiced."</p> <p>2/11/14 at 10:05 P.M.: "Dyson [sic] placed in wheelchair."</p> | | | |

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| | <p>2/12/14 at 3:01 A.M.: "...Transfers with two assist and walker...No c/o related to previous falls. Will monitor."</p> <p>2/12/14 at 3:30 A.M.: "[Name of physician] notified of previous fall no injury."</p> <p>2/12/14 at 8:22 A.M.: "Called to res [resident] room d/t [due to] having weakness et [and] slurred speech...Able to answer to name, but unable to say how he is doing...Unable to grasp with L [left] hand. L arm is completely flaccid. Called [physician] at this time et updated of res condition. N.O. [new order] received et noted to send to ER to eval et tx [evaluate and treat]."</p> <p>2/12/14 at 8:40 A.M.: "Ambulance here to transport res...."</p> <p>2/12/14 at 10:15 A.M.: "[Name] from [hospital] E.R. called...is going to be transferred to [name of hospital] in Evansville."</p> <p>2/12/14 at 1:39 P.M.: "Entered residents [sic] room after hearing alarm sound. Resident was standing beside bed holding on to walker before I could cross room resident</p> | | | |

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| | <p>attempted to take a step and slipped in urine on floor striking R [right] shoulder on heater."</p> <p>2/12/14 at 2:53 P.M.: MD noted fax regarding falls from last evening with no N.O."</p> <p>A transfer form, dated 2/12/14 and untimed, indicated, "2 falls on 2/11/14 evening, [Left] side weakness, slurred speech...."</p> <p>On 2/27/14 at 4:00 P.M., the Director of Nursing (DON) was interviewed regarding the documentation in the resident's chart; that the resident had apparently fallen on 2/11/14, but there was no documentation of falls on that date. Documentation also indicated the resident was transferred to the hospital on 2/12/14 at 8:40 A.M., but there was documentation of a fall that afternoon.</p> <p>On 2/28/14 at 10:20 A.M., during interview, the DON indicated the nurse documenting the falls was a "fairly new nurse," and did not document correctly. The DON indicated she had the nurse document an incident report on 2/12/14 regarding the 2 falls on</p> | | | |

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| | <p>2/11/14, and that the incident reports then transferred to the progress notes sections electronically. The DON provided incident reports which indicated the resident fell on 2/11/14 at 6:30 P.M. and 9:00 P.M. The DON indicated the 6:30 P.M. fall documentation was unable to be retrieved from the computer system, and that the facility was contacting the software company.</p> <p>At that time, the DON also provided a physician fax form, which indicated the physician was notified by fax of the resident's falls on 2/12/14 at 4:33 A.M. The physician noted the fax and it was returned to the facility on 2/12/14 at 3:57 P.M. The incident report, dated 2/11/14 at 9:00 P.M., indicated, "Agencies/People Notified, Physician [name] 2/11/2014 21:00 [9:00 P.M.]." The DON indicated the night shift nurse faxed the physician of the resident's falls on 2/12/14 and so he would not have been notified on 2/11/14 at 9:00 P.M.</p> <p>3. The closed clinical record of Resident C was reviewed on 2/27/14 at 1:45 P.M.</p> <p>Progress Notes included the following notations:</p> | | | |

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| | <p>1/28/14 at 9:44 P.M.: "Rsd [resident] c/o [complains of] SOB [shortness of breath] O2 sat [saturation] @ 92% on RA [room air]. Rsd insisted on oxygen, 2L via n/c [nasal cannula] was put on. O2 sats went to 92%. Will cont [continue] to monitor. Family notified."</p> <p>The next Progress Note was dated 1/29/14 at 1:58 P.M., and indicated, "MD noted fax with N.O. [new order] for CXR [chest x-ray]. Message left with sister."</p> <p>1/29/14 at 2:54 P.M.: "...CXR done. Continues on O2 at 2 LPM [liters per minute], and HHN's [hand held nebulizers] routine."</p> <p>Documentation of the resident's condition was not found in the clinical record from 1/28/14 until 1/29/14 at 3:00 P.M.</p> <p>1/29/14 at 3:00 P.M.: "O2 sat still low 70-72% increased O2 to 3 LPM will monitor, feet appear cyanotic...Respirations rapid encouraged him to breathe slower and deeper."</p> <p>On 3/4/14 at 11:40 A.M., the Assistant Director of Nursing</p> | | | |

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| | <p>(ADON) indicated she would look in the "fax book" for any documentation regarding Resident C from 1/28-1/29/14. The ADON indicated when physicians are faxed, the staff keep the fax on their "24 hr board" until the physician responds. Then the faxes are placed in the fax book. The ADON acknowledged the faxes aren't kept in any kind of order, i.e.. alphabetical or by room number or by date. The ADON indicated when the book gets full, the Medical Records staff would keep the records in her office. The ADON indicated the faxed records don't go in the residents' charts.</p> <p>On 3/4/14 at 12:05 P.M., the DON provided a fax regarding Resident C, dated 1/29/14 at 9:45 A.M. The fax indicated, "Res is having SOB et [and] increased respirations. Also states his back has been hurting. Last CXR on 1/2/14 showed early infiltrate to R [right] lung base. No N.O. at that time. SAO2 80% on RA this AM, up to 90% with 2L O2 per N/C. 150/68, 96.2, 88, 30. Would you like another CXR at this time? Please advise...."</p> <p>Documentation of the resident's condition at that time was not found in the clinical record.</p> | | | |

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| | <p>This Federal tag relates to Complaint IN00143979.</p> <p>3.1-50(a)(1) 3.1-50(a)(2) 3.1-50(a)(3)</p> | | | |