

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155304	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/17/2015
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NAME OF PROVIDER OR SUPPLIER WATERS OF NEW CASTLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 N 16TH ST NEW CASTLE, IN 47362
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F 000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: February 11, 12, 13, 16 & 17, 2015</p> <p>Facility number: 000201 Provider number: 155304 AIM number: 100267910</p> <p>Survey team: Leslie Parrett RN TC Diana Sidell RN Angel Tomlinson RN Barbara Gray RN</p> <p>Census bed type: SNF: 4 SNF/NF: 56 Total: 60</p> <p>Census payor type: Medicare: 20 Medicaid: 26 Other: 14 Total: 60</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 000	<p>Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the 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>This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 3/19/2015</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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F 154 SS=D Bldg. 00	<p>Quality review completed on February 23, 2015 by Cheryl Fielden, RN.</p> <p>483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS</p> <p>The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.</p> <p>The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being.</p> <p>Based on interview and record review the facility failed to educate residents and their families on the risk of receiving antipsychotic medication risperidone for 2 of 5 residents who met the criteria for unnecessary medication of 5 residents reviewed for medications (Resident #65 and Resident #72).</p> <p>Findings include:</p> <p>1). Interview with Resident #65 on 2/12/15 at 11:00 a.m., indicated she did not know what medicine she was taking. The resident's response was slow and took several minutes to answer any questions. The resident had a flat affect.</p>	F 154	<p>F154</p> <p>It is the intent of this facility to ensure education is provided to residents and their families on the risk of receiving antipsychotic medication risperidone.</p> <p>1. Corrective action for affected residents:</p> <p>Resident #65's spouse was notified of the risk of risperidone. Resident #72's guardian was notified of the risk of risperidone.</p> <p>2. Other residents with the potential to be affected:</p>	03/19/2015			

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	<p>Review of the record of Resident #65 on 2/13/15 at 9:42 a.m., indicated the resident's diagnoses included, but were not limited to, Alzheimer's disease, muscle weakness, abnormality of gait, osteoarthritis, personal history of falls, hypertension, depression, adjustment disorder with anxiety.</p> <p>The physician recapitulation (recap) dated February 2015, for Resident #65 indicated the resident was ordered risperidone (antipsychotic medication) 1 milligram (mg) at 9:00 a.m., and 6:00 p.m., for Alzheimer's, dementia with agitation.</p> <p>The Quarterly Minimum Data Set (MDS) assessment for Resident #65 dated 12/17/14, indicated the resident had severe impairment for decisions of daily living, the resident had no indicators of psychosis or behavioral symptoms.</p> <p>Interview with Resident #65's family member on 2/16/15 at 9:35 a.m., indicated they were not aware the resident took risperidone. The family member indicated the facility had not talked to them about the resident's medications. The family member indicated they visit the resident every day for 4-5 hours. The family member indicated the resident was sleeping more</p>		<p>Audit completed for all residents identified with physician orders for risperidone, family notified of risk.</p> <p>3. Measures to prevent reoccurrence:</p> <p>DON/SSD/designee to audit medication orders upon admission to facility and new orders as written 3 times a week for 2 months, then 2 times a week for 2 months, then weekly for 2 months to ensure resident/family member education is provided regarding the risk of risperidone. The plan will be monitored by the Administrator weekly in the Behavior Management meeting to ensure 100% of all residents receiving risperidone and their family are educated on the side effects of the medication.</p> <p>4. Monitoring of corrective action to ensure the practice will not recur:</p> <p>The DON/SSD/designee will complete a summary of the audit to be reviewed in the quarterly QA meeting with the Administrator and medical director.</p>	

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	<p>than she use to. The family member indicated they had wondered about her sleeping all the time because she did not do that at home. The family member indicated they had lived with the resident 64 years before she was admitted to the facility. The family member indicated the resident always liked to walk around at home and "fiddle" with making the beds and things.</p> <p>Interview with Resident #65's family member on 2/16/15 at 2:30 p.m., indicated the staff told him the resident received her medicine because she wanders around the facility and they were afraid she would fall. The family member indicated when he visited the resident on 2/15/15 she slept all day, and it worried him that she was sleeping so much, he felt walking around the facility would be good exercise for her. The family member indicated he did not know anything about the medicine she was taking, but felt like the resident was "drugged up" a lot.</p> <p>Interview with the Director of Nursing (DON) on 2/17/15 at 2:09 p.m., indicated she was unable to find any documentation that Resident #65 or her family member had been educated on the risk of taking an antipsychotic medication.</p>		<p>5. The date the systematic changes will be completed: 3/19/2015</p>				

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	<p>2.) Review of the record of Resident #72 on 2/16/15 at 10:15 a.m., indicated the resident's diagnoses included, but were not limited to, acute delirium, dementia with behaviors, anxiety and psychotic disorder not specific.</p> <p>The physician recap for Resident #72 dated February 2015 indicated the resident was ordered risperidone 0.25 mg at 12:00 p.m., and risperidone 0.5 mg at 9:00 p.m.</p> <p>Interview with the DON on 2/17/15 at 2:15 p.m., indicated she was unable to find documentation that Resident #72 or her family were educated on the risk of taking an antipsychotic medication.</p> <p>The Nursing 2014 Lippincott drug handbook indicated risperidone indication for use was schizophrenia, bipolar, autistic disorder, Tourettes syndrome and obsessive compulsive disorder. The black box warning indicate fatal CV or infectious adverse events may occur in elderly patients with dementia. This drug is not safe or effective for these patients.</p> <p>3.1-3(n)(2)</p>			

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F 223 SS=D Bldg. 00	<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 interview, record review, and observation, the facility failed to ensure a resident was free from verbal abuse in that one incident of verbal abuse occurred in the facility. This affected 1 of 2 residents reviewed who fit the criteria for abuse. (Resident #58)</p> <p>Findings include:</p> <p>On 2/7/15 at 10:45 a.m., the Administrator provided an incident report, dated 10/7/2014. The incident report indicated: "10/7/14 RN [#12] was in the dining room during breakfast and state (sic) Resident (#58) threw a piece of toast at CNA (#11). CNA (#11) stated to Resident (#58) in a normal tone of voice, 'that is not appropriate, it is not okay', at that time RN (#12) state (sic) resident laughed. CNA (#11) stated to RN (#12) 'he shouldn't be here' and then referred to a behavior resident had toward a different staff person. CNA (#11) then stated to</p>	F 223	<p>F223</p> <p>It is the intent of this facility to ensure residents are free from verbal abuse.</p> <p>1. Corrective action for affected resident; CNA #58 was terminated 10/7/2014.</p> <p>2. Other residents with potential to be affected: All residents had the potential to be affected.</p> <p>3. Measures to prevent reoccurrence; Abuse education continues to be provided upon hire and will be increased from 3 times a year to 4 times a year. All staff in-service on abuse 3/5/15 and 3/6/15. Resident</p>	03/19/2015
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	resident in a normal tone of voice 'If you're going to act like that you don't need to be here', CNA (#11) then walked Resident (#58) out of the dining room (resident was in a wheelchair) and stated 'you need to be in a different kind of facility, you need to be in a psych unit, we don't take mental patients'. RN (#12) notified LPN (#13) in the hallway that CNA (#11) was taking resident (#58) to the TV lounge. RN (#12) states CNA (#11) returned to the dining room in a calm manner and helped another resident eat breakfast. LPN (#13) states she observed CNA (#11) taking resident to the TV lounge area, and once there CNA (#11) shook resident's wheelchair two times and while walking away from the Resident CNA (#11) stated 'piece of sh*t'. LPN (#13) approached resident (#58), resident appeared calm, no distress noted. CNA (#11) states the comments were not made to the resident, statement was made to the LPN (#13) in the dining room. CNA (#11) states resident was removed from the dining room and placed in the TV lounge area. CNA (#11) was under the impression the piece of toast was not being thrown at the CNA but at another resident. CNA states the resident's wheelchair was not shaken but rather was being maneuvered (sic) over the bump in the flooring where the carpet meets the tile. Type of Injury: No injury		<p>council meeting held 3/6/15 regarding reporting abuse. Audit completed for all residents with education provided regarding reporting abuse. DON/SSD/designee will conduct a random interview/observation of 10 residents weekly for 2 months, then 10 residents every 2 weeks for 2 months, then 10 residents monthly for 2 months to ensure the residents are free from verbal abuse and are educated on how to report abuse. Any voiced allegations of abuse will be reported to the Administrator immediately following the facility Policy regarding abuse prohibition.</p> <p>4. Monitoring of corrective action to ensure the practice will not recur;</p> <p>DON/designee will monitor all staff attendance for the inservice to ensure 100% participation. Inservice attendance will be reviewed in the quarterly QA meeting with the administrator and Medical Director. The result of the Resident interviews/observations will be reviewed with the Administrator and Medical Director in the Quarterly QA meeting.</p> <p>5. Date systematic changes will be completed ; 3/19/15</p>	

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	<p>or mental distress noted. Immediate Action Taken: DON (Director of Nursing) was notified of the incident, CNA (#11) was brought to DON office, employment was terminated. Social Service interviewed resident (#58) who stated he did not remember any negative comments being made. Resident spouse and physician notified of incident. Preventive Measures Taken: 10/7/14 all staff re-education on Abuse prohibition. Follow up: Follow up added -- 10/10/2014 social Service is interviewing resident daily, no signs and symptoms of distress noted, resident voices no complaints or concerns of the incident."</p> <p>Resident #58's record was reviewed on 2/17/2015 at 2:32 p.m. The record indicated Resident #58 was admitted with diagnoses that included, but were not limited to, dementia with behavioral disturbances, joint pain, generalized muscle weakness, anxiety, depressive disorder, psychosis, and mild cognitive impairment.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 8/10/14, indicated Resident #58 was cognitively intact, had moods of feeling down, depressed, or hopeless, trouble falling or staying asleep or sleeping too much, feeling tired or having little energy, had physical</p>			

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	<p>behavior symptoms directed toward others, and verbal behavioral symptoms directed toward others, had minimal difficulty with hearing, wore a hearing aid, vision was moderately impaired, wore corrective lenses, did not ambulate, used a wheelchair, and was transported with extensive assist of one.</p> <p>A care plan, with a start date of 4/12/14, indicated: "At risk for increased anxiousness r/t (related to) dx (diagnosis) with need for anxiolytic (medication that reduces anxiety). Goal: Resident will have decline in episodes of anxious behavior daily tnr (through next review). Date initiated: 2/21/14. Target date: 11/09/14 - Interventions: Allow ample time to complete tasks. Anxiolytic per order. Approach resident calmly. Encourage family involvement. Encourage out of room activities if appropriate. Encourage resident to assist with care as possible. Encourage to vent feelings. Let resident know what you are doing before care is given. Monitor for effectiveness of meds and interventions. Notify md, family and IDT (interdisciplinary team) of changes. Offer choices. Social Service to visit PRN (as needed). Validate and assist."</p> <p>A care plan, with a start date of 2/21/13, indicated: "Behaviors ie: throwing items,</p>			

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	<p>swatting at staff, yelling, throws items in dining room socially inapp (inappropriate) behavior, entering a females room and touching her inappropriately. Date Initiated: 2/21/13 revised on 10/21/14. Goal: behaviors trn. Res (resident) will not enter another resident's room trn. Res will not touch another resident trn. Interventions: Enc (encourage) family involvement. Notify MD and family as needed. Offer choices and allow time to make decisions. Reminisce with resident when able. Reorient to surroundings. Repeat self as needed. Res to sit a (at) private table."</p> <p>Progress notes, dated 10/7/14 at 11:05 a.m., indicated: "Res up in w/c in DR (dining room) this AM, res was eating breakfast, picked up piece of toast and threw it at a staff member, res redirected behavior being inappropriate, no additional behaviors noted so far this shift."</p> <p>On 2/17/2015, at 4:32 p.m., Resident #58 was observed in his room sitting in his wheelchair, eating snacks. Resident #58 indicated at that time he can't remember anyone being rude or mean to him.</p> <p>On 2/17/15, at 4:14 p.m., the Administrator provided an "Employee Action Form that indicated CNA #11 had</p>			

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	<p>been discharged from employment.</p> <p>A policy and procedure for abuse prohibition, with an issue date of 7/1/11, was provided by the Administrator on 2/16/15 at 10:14 a.m. The policy indicated, but was not limited to: "Guideline: It is the intent of this facility to maintain an environment free of abuse and neglect. The resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, involuntary seclusion, and misappropriation of their property (collectively, sometimes referred to as "events"). Residents will not be subjected to such events by anyone including, but not limited to, facility staff, other residents, consultants or volunteers, staff or other agencies serving the resident, family members or legal guardians, friends or other individuals. The facility shall comply with all federal and state requirements to screen, train, prevent, identify, investigate, protect and report, if applicable, any event that is not consistent with the usual operation of nursing facility or the standard care for certain resident...9. It is the responsibility of all staff to provide a safe environment for the residents. Resident care and treatments shall be monitored by all staff, on an ongoing basis, to assure residents are free from abuse, neglect, or</p>			

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F 241 SS=D Bldg. 00	<p>mistreatment. Care will be monitored to assure that there are not repeated failures to follow the resident's care plan and that no resident harm has occurred...."</p> <p>3.1-27(a)(1) 3.1-27(b)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview and record review, the facility failed to provide a resident dignity by placing her legs in bed upon request for 1 of 2 residents reviewed for abuse. (Resident #84).</p> <p>Findings include:</p> <p>During an interview with Resident #84 on 2/11/15 at 11:48 a.m., she indicated "I have been told by the Doctor not to be lifting my legs by myself." Last Wednesday or Thursday night" a female staff had taken her to the bathroom and assisted her back in bed. The female</p>	F 241	<p>F241 It is the intent of this facility to ensure dignity is provided to a resident by placing her legs in bed upon request. 1. Corrective action for affected resident; Staff had been directed to assist resident #84 put her legs into bed by DON on 2/4/15 and again by a Nurse on 2/7/15. Resident care plan updated to reflect resident desire to have staff place her legs into bed. CNA assignment for Resident #84 includes assisting resident with putting her legs in bed. 2. Other residents with potential to be affected; SSD interviewed all interviewable residents as to receiving needed assistance. 3. Measures to prevent reoccurrence;</p>	03/19/2015	

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	<p>staff had requested Resident #84 place her legs back in the bed and she informed the female staff she couldn't. The female staff requested Resident #84 place her legs back in bed several times and Resident #84 informed the female staff her Doctor had told her not to be lifting her legs. The female staff left the room and returned with another female staff who informed Resident #84 she could lift her legs in bed because she had seen her do it before. Resident #84 questioned that female staff "is that before or after I had my heart attack?" Both female staff left Resident #84's bedroom, leaving her legs hanging off of the side of the bed. The time was approximately 10:30 p.m., and a different female staff came into her bedroom approximately 2:00 a.m., and assisted her back to bed. Resident #84 stated she felt like "that was verbal abuse."</p> <p>During an interview with Resident #84 on 2/11/15 at 1:58 p.m., she indicated her daughter had reported the incident to the facility and the staff member her daughter had spoken with assured her she would speak with the staff involved. Resident #84 did not know any of the staff's names.</p> <p>During an interview with the Administrator on 2/11/15 at 2:40 p.m.,</p>		<p>Coaching/counseling for individual CNA involved. All staff in-service regarding Residents Rights and Dignity 3/5/15 and 3/6/15. . Resident council meeting held 3/6/15 regarding reporting abuse/residents rights. Audit completed for all residents with education provided regarding reporting abuse.</p> <p>DON/SSD/designee will conduct a random interview/observation of 10 residents weekly for 2 months, then 10 residents every 2 weeks for 2 months, then 10 residents monthly for 2 months to ensure the residents are being treated with respect and dignity and on how to report staff being discourteous. Any voiced allegations will be reported to the Administrator immediately following the facility Policy regarding abuse prohibition. 4. Monitoring of corrective action to ensure the practice will not recur; SSD completed follow-up visits with resident #84 on 2/12/15, 2/13/15, 2/16/17, and 2/17/15. SSD completed a follow-up with Resident's #84's daughter 2/17/15. Care Plan meeting held on 3/2/15 with Resident #84 and daughter, SSD, and DON. Care Plan meetings will continue to be held on a quarterly basis and as needed The results of the Resident interviews/observations will be reviewed with the Administrator and Medical Director in the Quarterly QA meeting. 5. Date systematic</p>	

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	<p>she indicated Resident #84's daughter had complained to the Social Service Director (SSD) her mother had requested assistance from staff to lift her legs in bed and the staff member replied to Resident #84 she had been able to do it before. Resident #84's daughter did not want her mother to request assistance for help more than once. The SSD had informed the Director of Nursing (DON) and the DON informed the CNA staff any time Resident #84 requested assistance to assist her and not encourage her to do it on her own. It was never mentioned to the Administrator, SSD or DON, Resident #84 had sat on the side of the bed until 2:00 a.m.</p> <p>During an interview with the SSD on 2/11/15 at 3:01 p.m., she indicated Resident #84's daughter had spoken to her on 2/4/15, informing SSD her mother had informed staff she could not lift her legs in bed and the staff had questioned Resident #84 "who told her she couldn't lift her legs up in bed anymore?" Resident #84 had felt staff were rude. SSD informed Resident #84's daughter she would mention the situation to the DON so the DON could address it with staff. Resident #84's daughter had been satisfied. Resident #84 nor her daughter had known any of the staff's names. SSD had filled out a Report of Concern and</p>		changes will be completed; 3/19/15	

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	<p>provided it to the Administrator for review after the incident had been addressed and followed up on.</p> <p>Resident #84's record was reviewed on 2/13/15 at 10:45 a.m. Diagnoses included but were not limited to, hypertension, atrial fibrillation, congestive heart failure, malaise, and hemiplegia.</p> <p>Resident #84's Quarterly Minimum Data Set (MDS) assessment dated 1/26/15, indicated she was understood and had the ability to understand others, her speech was clear, she was cognitively intact for her daily decision making skills, she required extensive assistance of 2 plus person for bed mobility, extensive assistance of 1 person for transfers, dressing and toileting, and limited assistance of 1 to walk.</p> <p>A physician's order for resident #84 dated 1/29/15, indicated Resident #84 had been admitted to Hospice Services.</p> <p>During a telephone interview with Resident #84's daughter on 2/16/15 at 9:18 a.m., she indicated the following: "The incident that got me mad was mom told me she told the girl to lift her legs and mom said she couldn't and the girl left and came back with another girl. The</p>			

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	<p>other girl said you can do it, I've seen you do it before and mom told her she couldn't. Mom said they both left the room and left her sitting there on the bed. Then about 2:00 a.m., a nurse came in to check on her and ask mom what she was doing and mom told her they they had left her sit there and she put mom to bed. I feel like they intentionally walked out and left her. Mom said it was about 10:00 p.m. to 10:30 p.m. Mom said the girl had taken her to the toilet and then returned her to bed. I don't remember what day it was and I went to (name of SSD) as soon as mom told me which I think was the morning after it happened. I don't want anybody fired or anything like that. I reported to (name of SSD) what I told you. When they took her to the bathroom she told mom she could lift her feet and then the other staff told mom the same thing. Then mom was laid down around 2:00 a.m. I don't think mom would sit up on the bed because she was mad. I would just let it go and if it happens again I will take action."</p> <p>Resident #84's daughter indicated she felt her mom was safe. "I'm not fearful for mom. I don't think they would do anything to harm my mom. The nurses are good and I don't think they would let anything like that happen. I don't feel mom is afraid. I think she feels safe, even with the same staff."</p>			

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	<p>During a telephone interview with CNA #7 on 2/16/15 at 11:49 a.m., regarding Resident #84, she indicated the following: "On the evening of February 6th the resident turned on her call light and (name of CNA #9) had taken res to the bathroom. When she turned her call light on I returned her to bed. She did everything for herself in the bathroom. She stood up and put self on bed. Then I said go ahead and swing your feet on the bed and she said no you have to do that for me and I ask why and said you always do that yourself and she just continued to say you have to do that for me. She never told me why she couldn't. I went and got (name of CNA #9) and we went back in room and (name of CNA #9) said lets get your feet in the bed. (Name of CNA #9) asked why she couldn't put her legs in bed and (name of Resident #84) said after her heart attack "you have to do everything for me." (Name of CNA #9) said you did everything for yourself when I took you to the bathroom but if you need help we can help you and (name of Resident #84) said "no, I will just sit here." I guess she was agitated we tried to get her to do it herself. That wasn't unusual she always did everything for herself. Once she said she wanted to sit there we went ahead and left the room. I didn't go back in her room. The incident</p>			
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	<p>happened around 11:30 p.m., and (name of LPN #10) and (name of LPN #8) sent me home around midnight because I was sick." CNA #7 indicated she had asked Resident #84 to place her legs in bed 2 or 3 times.</p> <p>During a telephone interview with LPN #8 on 2/16/15 at 11:59 a.m., she indicated the following: (Name of LPN #10) asked me to help take (name of Resident #84) to the bathroom and take her to bed. (Name of Resident #84) told us after we got her back in bed that someone hadn't helped her put her legs back in bed. I told her if you need help put your call light on and we will help you, that is what we are here for. I told her I was sorry that happened. She didn't say who it was that wouldn't help her. Resident didn't seem distraught. When we went in there she was just sitting on the side of the bed. She didn't have any injury noted. She was just sitting there quietly. I explained to her she needed to use her call light so someone can come in and help her."</p> <p>On 2/16/15 at 1:21 p.m., Resident #84 was observed seated upright in her wheelchair drinking a bottle of Ensure and water. She had oxygen running at 2 liters per minute from a concentrator. She indicated there had not been any</p>			

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	<p>further incidents with not receiving help when she requested. She denied being fearful or afraid of staff or other residents. She stated "I feel safe here."</p> <p>During a telephone interview with CNA #9 on 2/16/15 at 2:03 p.m., she indicated the following: "Resident pressed call light and I took her to the restroom. (Name of CNA #7) took resident off the toilet and put her back in bed. Then (name of CNA #7) came and got me because (name of Resident #84) was not wanting to put her feet in the bed. I went to the room and ask (name of Resident #84) what was going on and she said she couldn't get her feet in the bed. I told (name of Resident #84) she had no trouble getting her feet out of bed when I took her to the restroom. She swung her feet out of bed and stood up and got in the wheelchair without any assistance. (Name of Resident #84) said they told me whoever gets me up has to get my feet in and out of bed for me. I have no idea who they are she just said they. I assumed it was therapy staff. I believed she was still in therapy to get better and go home. I told her if she couldn't get her feet in the bed I would help her get her feet in the bed and she said "no, I'll just sit up." She seemed agitated. I asked her if she was sure that we couldn't help her get her feet back in the bed and she said</p>			

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	<p>"no, I'll just sit up." She seemed agitated and I didn't want her to become agitated anymore. I pushed her bedside table near her. Her room light was on, she had her call light, and she had her TV on with no sound like she always does. She didn't push her call light the rest of my shift for assistance. She always calls if she needs help. I walked by her room approximately 5 or 6 times within the 2 hours she sat up and she didn't request any help. I didn't approach her because she always used her call light and I knew if she needed anything or wanted to go to bed she would just call." CNA #9 indicated she did not feel Resident #84 was at risk for falling off the bed because she knew not to get up without assistance and made her needs well know .</p> <p>During a telephone interview with LPN #10 on 2/16/15 at 4:14 p.m.,she indicated the following: "It happened on a Friday night and I walked past (name of Resident #84) room. I noticed she was seated on the side of the bed. I walked in to see what she needed. She said she needed to go to the bathroom. I got (name of LPN #8) to help. We took her to the bathroom. Brought her back to bed. Put her back in bed. Put legs back in bed. Seen if she needed anything. She had complained that some of the CNA's hadn't been putting her legs back in the</p>			

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	<p>bed. After that me and (name of LPN #8) went and talked to (name of CNA #9) about the situation. (Name of CNA #7) was the other CNA but left early that night so I talked to her on Saturday when she came to work. Discussed with both staff resident wanted her legs lifted into the bed. The CNA's acknowledged we talked about it. Neither staff went into any detail about the incident. I haven't heard anymore about the staff not putting her legs back in bed."</p> <p>A Compliment and Concern Form provided by the SSD on 2/17/15 at 10:03 a.m., indicated the following: "Name of person filling a Compliment or Concern: (Name of Resident #84's daughter). Name of Person Affected: (Name of Resident #84). Name of Person(s) Involved: Resident and staff. Date of Occurrence: 2/2/15. Description of Compliment or Concern: Resident complained staff telling her to lift her legs into bed and when resident told staff she could not that staff asked her who told her that she can't lift her legs because staff feels that she can. Resident felt staff member was rude by asking her questions instead of just helping her. Follow-Up: Nursing staff educated to encourage lightly for resident to do things if resident states she can not staff will immediately do for resident. Staff educated to ask</p>			

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F 314 SS=D Bldg. 00	<p>resident what "they" (staff) can do for resident. 2/4/15."</p> <p>3.1-3(t)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview and record review the facility failed to turn and reposition a resident in bed for 4 hours and 18 minutes for a resident who acquired a stage two pressure ulcer (partial thickness skin loss) at the facility for 1 of 3 residents who met the criteria for pressure ulcer of 3 reviewed for pressure ulcer care and treatment (Resident #80).</p> <p>Findings include:</p> <p>Review of the record of Resident #80 on 2/13/15 at 1:00 p.m., indicated the resident's diagnoses included, but were</p>	F 314	<p>F314 It is the intent of this facility to ensure residents are turned and repositioned in bed.</p> <p>1. Corrective action for affected resident; Resident #80's Care plan has been updated to reflect turning every 2 hours and prn, CNA task assignment has been put into place to turn and reposition resident every 2 hours and prn. 2. Other residents with potential to be affected; Audit completed for all residents identified with the potential for skin breakdown with Care plan in place to have turning and repositioning every 2 hours and prn, CNA task assignments to turn and reposition every 2 hours put into place. 3. Measures to</p>	03/19/2015

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	<p>not limited to, cerebral vascular accident (CVA), dysphasia (difficulty swallowing), aphasia (inability to communicate), major depression, muscle weakness, chronic kidney disease, obesity and anxiety.</p> <p>The Admission Minimum Data Set (MDS) assessment for Resident #80 dated 9/24/14, indicated the resident was admitted with no unhealed pressure ulcers.</p> <p>The care plan for Resident #80 dated 9/4/14, indicated the resident was incontinent of his bladder and bowels and was at risk for skin impairment. The interventions included, but were not limited to, turn and reposition every two hours and as needed.</p> <p>The Braden scale skin assessment for Resident #80 dated 11/18/14, indicated the resident was at high risk for skin impairment.</p> <p>The Quarterly MDS assessment for Resident #80 dated 12/3/14, indicated the following: cognitive impairment-severely impaired, bed mobility-extensive assistance of two people, transfer- total dependence of two people, walk in room- did not occur.</p>		<p>prevent reoccurrence; Inservice on 3/5/15 and 3/6/15 for Nurses and CNA's regarding Preventive Skin Care and Turning and Positioning Program.</p> <p>DON/designee to audit compliance with Turning and Positioning Program 3 times a week for 2 months, then 2 times a week for 2 months, then weekly for 2 months, any concerns will be addressed and corrected as discovered. 4. Monitoring of corrective action to ensure the practice will not recur; The DON/designee will complete a summary of the audit to be reviewed with the Administrator and Medical Director at the quarterly QA meeting. 5. Date the systematic changes will be completed; 3/19/15</p>	

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	<p>The pressure ulcer condition monitoring sheet for Resident #80 indicated on 2/7/15, the resident acquired a stage two pressure ulcer in the facility on his coccyx measuring 0.9 centimeter (cm) by 0.2 cm by 0.1 cm. The most current measurement dated 2/16/15, indicated the resident had a stage two pressure ulcer on his coccyx measuring 1 cm by 0.3 cm by 0.1 cm.</p> <p>During observation on 2/16/15 at 9:23 a.m., Resident #80 was laying in bed on his right side with a pillow under his left side.</p> <p>During observation on 2/16/15 at 10:51 a.m., Resident #80 was laying in bed on his right side with a pillow under his left side.</p> <p>During observation on 2/16/15 at 11:00 a.m., Resident #80 was laying in bed on his right side with a pillow under his left side.</p> <p>During observation on 2/16/15 at 12:00 p.m., Resident #80 was laying in bed on his right side with a pillow under his left side.</p> <p>During observation on 2/16/15 at 1:15 p.m., Resident #80 was laying in bed on his right side with a pillow under his left</p>			

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F 323 SS=D Bldg. 00	<p>side.</p> <p>Interview with RN #6 on 2/16/15 at 1:35 p.m., indicated Resident #80 was on a turning schedule every two hours. RN #6 indicated it took between 2 to 3 staff to turn Resident #80. RN #6 indicated she was not aware Resident #80 had been in the same position since 9:23 a.m., RN #6 indicated she would go get the aides and turn the resident.</p> <p>Interview and observation on 2/16/15 at 1:41 p.m., RN #6 and CNA #3 assisted Resident #80 to his left side and provided incontinent care. Resident #80 had two small pink pressure ulcers on his left coccyx. The resident had indentation marks on the right side of all the way down his thigh and the entire right side of his back. RN #6 agreed the resident had indentation marks on his right thigh and the right side of his back. CNA #3 indicated she turned Resident #80 when she gave him his bath in the morning.</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident</p>						

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	<p>hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on record review, observation and interview the facility failed to put a care plan in place for a resident at high risk of falls until after a fall for 1 of 3 residents review for accidents out of 4 that met the criteria (Resident# 6).</p> <p>Findings include:</p> <p>Review of Resident# 6's record on 2/13/15 at 9:30 a.m., indicated admission date was 1/9/15 and her diagnoses included but were not limited to L4 compression fracture, L3-5 stenosis and spondylolisthesis, constipation, insomnia and depression.</p> <p>On 2/13/15 at 1:45 p.m., review of nursing notes dated 2/9/15 at 6:39 p.m., indicated Resident# 6 was "ambulating with staff from dining room back to room, started to sit down without any chair behind her. Assisted to floor by visitor (EMS personnel) AROM all extremities per usual ability. Bilateral hand grips equal, bilateral legs equal in length, with no internal/external rotation. all skin intact denies any discomfort No s/s of injury, MD and POA informed." Interdisciplinary team note dated 2/10/15 at 1:22 p.m., indicated "fall reviewed-</p>	F 323	<p>F323 It is the intent of this facility to ensure a care plan is in place for a resident at high risk of falls.</p> <p>1. Corrective action for affected resident; Regarding Resident #6 a fall care plan was put into place 2/13/15. 2. Other residents with potential to be affected; Audit completed for all residents identified with a risk of falls with care plan initiated as needed. 3. Measures to prevent reoccurrence; Inservice on 3/5/15 and 3/6/15 for Nurses regarding Fall Risk Assessment and Care Planning. DON/designee to audit completion of Fall Risk assessment and Care Plan at time of Admit, with quarterly MDS and after each fall prn weekly for 2 months, then bi-weekly for 2 months, then monthly for 2 months to ensure completion of assessment and care plan as needed. 4. Monitoring of corrective action to ensure the practice will not recur; DON/designee will complete a summary of the audit to be reviewed at the quarterly QA meeting with the administrator and medical director. 5. Date the systematic changes will be completed; 3/19/2015</p>	03/19/2015

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	<p>Resident will continue to ambulate with staff having wheel chair behind her until therapy feels she is safe to ambulate without assist long distances."</p> <p>2/13/2015 at 1:06 p.m., an interview with DON indicated "all Resident# 6's care plans are on the computer".</p> <p>Review of electronic file for care plans for falls indicated no care plan for falls on electronic files.</p> <p>On 2/13/15 at 1:15 p.m., review of Fall Risk Assessment dated 1/10/15 indicated a score of 13.</p> <p>Review of fall care plan presented by MDS coordinator on 2/13/15 at 2:15 a.m., indicated date initiated 2/10/15 and revision on 2/13/15, "Focus: Resident is at risk for falls due to recent fall. Goal - Resident will have no injuries due to falls date initiated: 2/10/15 Interventions - attempt to keep areas free of clutter date initiated: 2/10/15 keep call light in reach date initiated: 2/10/15 notify and update MD as needed date initiated: 2/10/15 pull wheel chair behind Resident when she is walking long distance with her walker date initiated: 2/10/15 therapies as ordered date initiated:</p>			

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	<p>2/10/15"</p> <p>On 2/14/15 at 2:00 p.m., review of Discharge Report from local hospital dated 1/9/15 at 5:00 p.m., indicated "Functional Cognitive Assessment: Functional/Cognitive Status... Cognition: difficulty concentrating, difficulty making decisions, difficulty remembering, Ambulation: difficulty walking Activities of Daily Living: difficulty bathing, difficulty dressing... General Finding: Functional/Cognitive Status Limitations noted below. Fall Risk/Mental Status Assessment: Fall Risk - Patient has a high risk for falls..."</p> <p>Review of a document provided by the Director of Nursing on 2/17/15 at 11:40 a.m., indicated "Resident Care Manual - Subject: Fall risk assessment - Guideline: It is the intent of the facility that all resident will have a Risk Assessment for falls performed on admission/readmission, with a significant change in condition, quarterly and annually... Procedure:... 7. a score of 10 or above indicates a high risk for falls. For residents who score 10 or above, develop a preventative care plan for falls..."</p> <p>3.1-45(a)(2)</p>			

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F 325 SS=D Bldg. 00	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on record review, observation, and interview, the facility failed to ensure a resident admitted with a low body mass index and low protein levels received a diet with supplements to improve his nutritional status. This affected 1 of 3 residents who fit the criteria for nutrition. (Resident #121)</p> <p>Findings include:</p> <p>During an interview, on 2/11/15 at 4:20 p.m., RN #6 indicated Resident #121 did not receive a high calorie/high protein nutritional supplement.</p> <p>On 2/13/2015, at 12:30 p.m., Resident #121 was observed sitting in bed with the head of his bed up, eating lunch.</p> <p>Meal consumption records for the noon</p>	F 325	<p>F325 It is the intent of this facility to ensure a resident admitted with a low body mass index and low protein levels receive a diet with supplements to improve nutritional status. 1. Corrective action for affected resident; Regarding resident #121 notification to MD 2/13/15 regarding resident ongoing decline in appetite with order received 2/16/15 for nutritional supplement. 2. Other residents with potential to be affected; Audit completed for all residents identified with low BMI and low Albumin/total protein levels with supplements ordered as needed. 3. Measures to prevent reoccurrence; In-service held 3/5/15 and 3/6/15 for Nurses regarding Registered Dietician notification of resident diagnosis of malnutrition upon admit to facility and with a resident change of condition that could result in an appetite decline. DON/designee</p>	03/19/2015

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	<p>meal on 2/13/15 indicated documentation he had consumed 0 - 25% of the meal.</p> <p>On 2/13/2015, at 2:13 p.m., Resident #121 was observed in bed and said he didn't have much of an appetite; that he used to weigh 130 pounds, but has lost some weight. He indicated he was trying to lose the edema in his arms; both arms were observed to be swollen with fluid under dry flaky skin of his arms. He was drinking water and could reach his water cup on his overbed table. He said he gets foods he likes.</p> <p>On 2/17/2015, at 9:19 a.m., Resident #121 was observed in bed, and indicated he eats what he wants. He said he was given one supplement since he was admitted, someone had brought it to him, but he didn't know why he was given the supplement. He said they gave him Ensure, and he drank Ensure at home sometimes.</p> <p>Resident #121's record was reviewed on 2/13/2015 at 1:35 p.m. The record indicated Resident #121 was admitted on 2/6/15, and had diagnoses that included, but were not limited to, a blood infection, atrial fibrillation, anemia, acute kidney failure, chronic kidney disease, severe protein - calorie malnutrition, disorders of magnesium metabolism, generalized</p>		<p>to audit new admit record for diagnosis of malnutrition to ensure RD notification. 4. Monitoring of corrective action to ensure the practice will not recur; DON/designee will complete a monthly summary based on the audit results to be reviewed in the quarterly QA with the Administrator and Medical Director. 5. The date systematic changes will be completed; 3/19/2015</p>	

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	<p>muscle weakness, and urinary obstruction.</p> <p>An admission oral/nutritional assessment, dated 2/6/15, indicated Resident #121 had his own teeth, tongue was pink, cheeks were pale, lips were pale, no pain in oral cavity, no chewing problems, no swallowing problems, and was prescribed a regular mechanical soft diet.</p> <p>An admission weight, obtained the day after admission on 2/7/15, indicated Resident #121 weighed 109 pounds and was 5' 6" tall which indicated his BMI (Body Mass Index) was 17.6.</p> <p>A social services history and psychosocial admission review, dated 2/11/15, indicated Resident #121 was cognitively intact, oriented to time, place, and person, had good long and short term memory, had no problem with verbal communication, and indicated "res (resident) reports feeling tired nearly every day r/t (related to) illness and hospitalization and res reports poor appetite nearly every day, res states his appetite has declined over the past year."</p> <p>A discharge summary from a local hospital, dated 2/6/15, indicated the resident was admitted to the hospital on 1/18/15, with diagnoses that included, but</p>			

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	<p>were not limited to, sepsis (blood infection) with MRSA, (Methicillin Resistant Staphylococcus Aureus), pneumonia, anemia secondary to anemia of chronic disease and upper gastrointestinal bleed, acute-on-chronic kidney failure, marked hypoalbuminemia (low protein) with low pre-albumin, severe protein-calorie malnutrition, anasarca (severe, generalized swelling) secondary to the above, hyponatremia (low salt levels in the blood), atrial fibrillation, weakness, and hypomagnesemia (low magnesium levels in the blood).</p> <p>Physician's admission diet orders included, but were not limited to, general diet mechanical soft, thin liquids, and magnesium 250 mg (milligrams) po (by mouth) qd (every day).</p> <p>A dietary care plan, dated 2/13/15, indicated: "Focus: Has DX (diagnosis): history of sudden cardiac death in 2005 with need for ICD (implanted cardiac defibrillator) that needs to have battery changed. At risk for cardiac event. Goal: Will have no c/o (complaints of) or episodes of chest pain daily TNR (through next review). Resident will be free of signs/symptoms of cardiac distress. Interventions: Diet per order. Labs per order. Medications per order.</p>			

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	<p>Monitor vital signs as needed. Notify MD and family prn (as needed). Observe for any c/o chest pain, cardiac distress, edema or chest pain. Refer to cardiology prn. Schedule for battery replacement as ordered."</p> <p>During an interview, on 2/17/2015 at 10:24 a.m., the Registered Dietitian indicated she "has not seen him up here yet, he is on [her] list for this week, and [she] saw him when he was in the hospital downstairs". She indicated it usually takes about 5 days, depending when they come in, to be evaluated and when admitted to this floor they like to start fresh, the orders don't get carried over, (from the hospital floor). The Registered Dietitian said she doesn't see residents until their admission 5 day [assessment] is due and a care plan is put in place on his admission 5 day [assessment] so by the time the 14 day [assessment] is due she puts it all together with the care plan.</p> <p>On 2/17/15 at 10:45 a.m., the Registered Dietitian provided a document for "Classification of Overweight and Obesity by BMI". The document indicated a BMI of 18.5 or below is considered underweight, and a BMI of greater than 18.5 to 24.9 is considered normal weight.</p>			

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F 329 SS=D Bldg. 00	<p>3.1-46(a)(1) 3.1-46(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview and record review the facility failed to have indications for the use of antipsychotic medication, failed to attempt a gradual dose reduction of an antipsychotic, failed to monitor the side effects of antipsychotic medication, failed to have indication for the use of PRN (as needed)</p>	F 329	F329 It is the intent of this facility to ensure there are indications for the use of antipsychotic medication, attempts are made for gradual dose reduction of an antipsychotic, to monitor the side effects of antipsychotic medications, to have indication for the use of PRN antianxiety	03/19/2015

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	<p>antianxiety medication and failed to document non pharmacological interventions attempted prior to antianxiety medication being administered for 2 of 5 residents who met the criteria for unnecessary medication use of 5 residents reviewed for medications (Resident #65 and Resident #72).</p> <p>Findings include:</p> <p>1.) During observation on 2/11/15 at 1:50 p.m., Resident #65 was asleep in her room in her chair. Resident #65's roommate stated "good luck talking to her all she does is sleep".</p> <p>During observation on 2/11/15 at 2:45 p.m., Resident #65 was asleep in her room in her chair.</p> <p>During observation on 2/12/15 at 10:00 a.m., Resident #65 was asleep in her room in her chair.</p> <p>Interview with Resident #65 on 2/12/15 at 11:00 a.m., indicated she did not know what medicine she was taking. The resident's response was slow and took several minutes to answer any questions. The resident had a flat affect.</p> <p>During observation on 2/13/15 at 9:40</p>		<p>medication, and to document non pharm logical interventions attempted prior to antianxiety medication being administered.</p> <p>1. Corrective action for affected residents; In regards to resident #65 order received 2/25/15 for resident to be seen by Harrison Psychological Consultations, Order received to discontinue Unisom sleep aid and prn Ativan. Order received to decrease daily risperdone dosage. Regarding Resident #72 order received to decrease daily risperdone dosage, order received to add diagnosis of psychotic disorder for use of risperidone, order received to discontinue prn Ativan. 2. Other residents with potential to be affected; Audit completed for all residents receiving risperidone and Ativan with diagnosis, gradual dose reduction, monitoring of side effects, indication for use of PRN medication and documentation of non-pharm logical interventions completed as needed. 3. Measures to prevent reoccurrence; In-service with Nurses on 3/5/15 and 3/6/15 regarding Facilities Behavior Management Psychotropic Medication Protocol. DON/SSD/designee to audit residents receiving psychotropic medications weekly times 4 weeks then monthly ongoing at the monthly Behavior Monitoring meetings with concerns being addressed to ensure required</p>	

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	<p>a.m., Resident #65 was asleep in her chair with her head down.</p> <p>During observation on 2/13/15 at 1:51 p.m., Resident #65 was asleep in her chair with her head down.</p> <p>During observation on 2/13/15 at 2:30 p.m., Resident #65 was asleep in her chair with her head down, there was live music entertainment directly outside the resident's room and the resident did not wake up during the activity.</p> <p>Review of the record of Resident #65 on 2/13/15 at 9:42 a.m., indicated the resident's diagnoses included, but were not limited to, Alzheimer's disease, muscle weakness, abnormality of gait, osteoarthritis, personal history of falls, hypertension, depression, adjustment disorder with anxiety.</p> <p>The physician recapitulation (recap) dated February 2015, for Resident #65 indicated the resident was ordered risperidone (antipsychotic medication) 1 milligram (mg) at 9:00 a.m., and 6:00 p.m., for Alzheimer's, dementia with agitation. The resident was ordered ativan 0.5 mg three times a day as needed for anxiety.</p> <p>Review of the Medication Administration</p>		<p>documentation is present and gradual dose reduction has been attempted. 4. Monitoring of corrective action to ensure the practice will not recur; The DON/SSD/designee will complete a summary of the audit to be presented at the Quarterly QA meeting with the Administrator and Medical Director. 5. Date the systematic changes will be completed; 3/19/15</p>	

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	<p>Record (MAR) for Resident #65 dated October 2014, indicated the resident received ativan 0.5 mg on 10/23/14 at 5:30 p.m., for signs and symptoms of anxiety and 3 failed non med interventions attempted. There was no documentation what the resident was doing or what interventions were attempted.</p> <p>Review of the Medication Administration Record (MAR) for Resident #65 dated November 2014, indicated the resident received ativan 0.5 mg on 11/17/14 at 1:00 p.m., 11/25/14 at 6:45 p.m., and 11/27/14 at 3:15 p.m., There were no documentation during these times of why the resident received the ativan or if any interventions were attempted prior to the use of the ativan.</p> <p>Review of the Medication Administration Record (MAR) for Resident #65 dated December 2014, indicated the resident received ativan 0.5 mg on 12/13/14 at 5:15 p.m., 12/14/14 at 4:00 p.m., 12/18/14 at 5:00 p.m., and 12/25/14 at 4:30 p.m., There was no documentation of what symptoms the resident was displaying or what interventions were attempted prior to administering the ativan.</p> <p>Review of the Medication Administration</p>			

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	<p>Record (MAR) and controlled drug form for Resident #65 dated January 2015, indicated the resident received ativan 0.5 mg on 1/8/15 at 5:30 p.m., and 1/24/15 at 5:00 p.m., There was no documentation of what signs and symptoms the resident was displaying or the interventions attempted prior to the ativan being administered.</p> <p>Review of the Medication Administration Record (MAR) for Resident #65 dated February 2015 indicated the resident received ativan 0.5 mg on 2/5/15 at 12:30 p.m., for increased anxiety.</p> <p>The progress note for Resident #65 dated 2/5/15 at 12:33 p.m., indicated the resident was given prn anxiety medication for increased anxiety. The resident was walking around the facility looking for her husband and stating she was looking for someone that she was going to visit with. There was no documentation of interventions attempted prior to the administration of the ativan.</p> <p>Review of the behavior intervention flow record for Resident #65's risperidone and ativan dated October 2014, November 2014, December 2014, January 2015, and February 2015, there was no documentation of behaviors, interventions, outcomes or side effects.</p>						

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	<p>The pharmacy recommendation for Resident #65 dated 10/14/15, indicated the resident had been receiving risperdal 1 mg twice a day since 4/2014. "Gradual dose reduction should be attempted at this time". "Please evaluate if the current dose can be reduced, if contraindicated please document reason". The physician marked "disagree" with an explanation of physician decision.</p> <p>The Quarterly Minimum Data Set (MDS) assessment for Resident #65 dated 12/17/14, indicated the resident had severe impairment for decisions of daily living, the resident had no indicators of psychosis or behavioral symptoms.</p> <p>During observation on 2/16/15 at 9:20 a.m., Resident #65 was asleep in her chair with her head down.</p> <p>Interview with Resident #65's family member on 2/16/15 at 9:35 a.m., indicated they were not aware the resident took risperidone. The family member indicated the facility had not talked to them about the resident's medications, they visit the resident every day for 4-5 hours. The family member indicated the resident was sleeping more than she use to, they had wondered about her sleeping all the time because she did</p>			

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	<p>not do that at home, they had lived with the resident 64 years before she was admitted to the facility. The family member indicated the resident always liked to walk around at home and "fiddle" with making the beds and things.</p> <p>During observation on 2/16/15 at 10:51 a.m., Resident #65 was asleep in her chair.</p> <p>Interview with the MDS coordinator on 2/16/15 at 11:25 a.m., indicated Resident #65 did not see psychiatric services.</p> <p>Interview with the MDS coordinator on 2/16/15 at 11:45 a.m., indicated the staff used the interventions on the careplan prior to administering ativan prn. When queried if the interventions were unsuccessful and the resident required ativan how was Interdisciplinary Team (IDT) going to determine what interventions were unsuccessful and what interventions would need to be attempted? The MDS coordinator stated "yes I see what your saying".</p> <p>During observation on 2/16/15 at 1:17 p.m., Resident #65 was walking around her room with a slow shuffling gait.</p> <p>Interview with the MDS coordinator on 2/16/15 at 12:01 p.m., indicated the</p>			

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	<p>facility had not attempted a gradual dose reduction on Resident #65's risperidone.</p> <p>Interview with Resident #65's family member on 2/16/15 at 2:30 p.m., indicated the staff told him the resident received her medicine because she wanders around the facility and they were afraid she would fall. The family member indicated when he visited the resident on 2/15/15 she slept all day, it worried him that she was sleeping so much and felt walking around the facility would be good exercise for her. The family member indicated he did not know anything about the medicine she was taking, but felt like the resident was "drugged up" a lot.</p> <p>During observation on 2/17/15 at 9:18 a.m., Resident #65 was asleep in her chair.</p> <p>During observation on 2/17/15 at 11:10 a.m., Resident #65 was asleep in her chair.</p> <p>During observation on 2/17/15 at 3:05 p.m., Resident #65 was asleep in her chair.</p> <p>During observation on 2/17/15 at 3:45 p.m., Resident #65 was asleep in her chair and the resident's family member</p>			

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	<p>was in the room with her.</p> <p>During observation on 2/17/15 at 4:33 p.m., Resident #65 was in bed asleep and the resident's family member was sitting in a chair in her room.</p> <p>Interview with CNA #1 on 2/17/15 at 11:50 a.m., indicated she had took care of Resident #65 since the resident was admitted to the facility. CNA #1 indicated she had not seen any behaviors from the resident except she wandered, but no behaviors toward staff or any other residents.</p> <p>Interview with CNA #2 on 2/17/15 at 11:55 a.m., indicated she had took care of Resident #65 since the resident was admitted to the facility. CNA #2 indicated she had not seen the resident have behaviors. CNA #2 indicated the resident did wander and she would direct her where her room was or take her to an activity. CNA #2 indicated Resident #65 slept a lot.</p> <p>Interview with CNA #3 on 2/17/15 at 12:05 p.m., indicated she had cared for Resident #65 since the resident was admitted to the facility. CNA #3 indicated she had not seen the resident have behaviors she wanders the halls. CNA #3 indicated she would walk with</p>			

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	<p>the resident and redirect her back to her room. CNA #3 indicated Resident #65 slept a lot in her chair.</p> <p>Interview with RN #4 on 2/17/15 at 1:45 p.m., indicated she had cared for Resident #65 since the resident was admitted to the facility. RN #4 indicated the only behaviors she had seen the resident have was wandering and one time refused her medications. RN #4 indicated the interventions she used with Resident #65 was to walk with her, remind her to sit in her chair and redirect her.</p> <p>Interview with the Director of Nursing (DON) on 2/17/15 at 2:09 p.m., indicated she had not had time to look for documentation for the reason Resident #65 received ativan prn. The DON indicated she was unable to find what specific interventions were attempted prior to giving the resident ativan. The DON indicated she was unable to find any documentation that Resident #65 or her family member had been educated on the risk of taking an antipsychotic medication. The DON indicated the indication for the use of the antipsychotic medication was Alzheimer's dementia with agitation.</p> <p>2.) During observation on 2/13/15 at 9:39</p>			

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	<p>a.m., Resident #72 was asleep in bed.</p> <p>During observation on 2/13/15 at 11:00 a.m., Resident #72 was asleep in bed.</p> <p>Interview with Resident #72 on 2/13/15 at 12:15 p.m., the resident was laying in bed awake. The resident indicated she was ok she was just sleepy. When queried if she was going to go eat lunch the resident indicated she may in a bit.</p> <p>During observation on on 2/16/15 at 10:50 a.m., Resident #72 was asleep in bed.</p> <p>During observation on 2/16/15 at 12:00 p.m., Resident #72 was asleep in bed.</p> <p>Review of the record of Resident #72 on 2/16/15 at 10:15 a.m., indicated the resident's diagnoses included, but were not limited to, acute delirium, dementia with behaviors, anxiety and psychotic disorder not specific.</p> <p>The physician recap for Resident #72 dated February 2015 indicated the resident was ordered risperidone 0.25 mg at 12:00 p.m., and risperidone 0.5 mg at 9:00 p.m.</p> <p>Review of the behavior intervention monthly flow record for risperidone for</p>			

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	<p>Resident #72 dated October 2014, November 2014, December 2014, January 2015, and February 2015, indicated no documentation of behaviors, interventions, outcome or side effects except on January 15, 2015 indicated the resident had insomnia and the interventions attempted were redirect, 1 on 1, gave food, approached in a calm manner and offered support, the interventions had a negative outcome.</p> <p>The Quarterly MDS assessment for Resident #72 dated 1/27/15, indicated the following: the resident had severely impaired cognitive skills for daily living, there were no signs of psychosis or behaviors.</p> <p>Interview with CNA #1 and CNA #2 ON 2/17/15 at 11:55 a.m., both CNA's indicated Resident #72 slept a lot. CNA #1 and CNA #2 woke Resident #72 up and told the resident it was time to get ready for lunch. CNA #1 put the resident's pants and shoes on while the resident remained in bed, the CNA's assisted the resident to sit on the side of the bed and then transferred the resident from the bed to wheelchair using a gaitbelt. Resident #72 did not open her eyes until she was sitting in the wheelchair. The resident was very difficult to arouse.</p>			

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	<p>During observation on 2/17/15 at 2:06 p.m., Resident #72 was sitting in a large group of residents in the TV room with music playing and an exercise activity occurring. Resident #72 was asleep in her wheelchair.</p> <p>Interview with the DON on 2/17/15 at 2:15 p.m., indicated she was unable to find documentation that Resident #72 or her family were educated on the risk of taking an antipsychotic medication. The DON indicated she was unable to find documentation that side effects of an antipsychotic medication were being monitored for Resident #72.</p> <p>The behavior management psychotropic medication protocol policy provided by the MDS coordinator on 2/16/15 at 2:00 p.m., indicated residents receiving antipsychotic medications will be reviewed routinely for effectiveness and monitored for side effects. Behaviors which by themselves do not justify the use of antipsychotic included, but were not limited to, wandering. Interventions for behaviors and response will be documented.</p> <p>The behavior program policy provided by the Administrator on 2/17/15 at 9:50 a.m., indicated behavior intervention</p>			

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F 371 SS=E Bldg. 00	<p>monthly flow record will be analyzed to determine frequency, patterns/trends, causal factors and effectiveness of approach. Side effects of psychoactive medication will be monitored using the behavior intervention monthly flow record.</p> <p>The Nursing 2014 Lippincott drug handbook indicated risperidone indication for use was schizophrenia, bipolar, autistic disorder, Tourettes syndrome and obsessive compulsive disorder. The black box warning indicate fatal CV or infectious adverse events may occur in elderly patients with dementia. This drug is not safe or effective for these patients.</p> <p>3.1-48(a)(2) 3.1-48(a)(3) 3.1-48(a)(4) 3.1-48(a)(6)</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 Based on observation and interview the facility failed to ensure the kitchen was</p>	F 371	F371	03/19/2015	

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	<p>sanitary and functional for 1 of 1 kitchens observed. This had the potential to affect 60 residents who were served from the kitchen.</p> <p>Findings include:</p> <p>On 2/11/15 at 9:28 a.m., a tour of the kitchen was conducted with the Food Service Director.</p> <p>During the tour, clean dishes draining on small racks and several small boxes were observed on 2 stainless steel shelves. The 2 shelves had large areas of a white substance stuck to them. The wall above and beside the stainless steel shelves had a dark substance running down the walls. A large floor fan was operating and was blowing toward the area where clean dishes came out of the dishwasher. The rear of the fan was near the 2 stainless steel shelves where clean dishes were stacked in the small racks. The cage of the fan contained a large amount of dark fuzzy substance. A large amount of a yellowish substance was splattered on a large mixer base. A ceiling vent in the ceiling above a large coffee machine had a large amount of dark fuzzy substance on it. 2 Plastic Wrap holders were sitting on 2 different stainless steel shelves and were covered with a rusty like substance. A walk-in-freezer had</p>		<p>It is the intent of this facility to ensure the kitchen is sanitary and functional.</p> <ol style="list-style-type: none"> Corrective action for affected residents; 2 stainless steel shelves were cleaned, wall beside the stainless steel shelves was cleaned, floor fan was cleaned, large mixer base was cleaned, ceiling vent was cleaned, 2 plastic wrap holders were cleaned and new aluminum parts have been ordered, the frost build up in the walk-in freezer has been removed. Other residents will potential to be affected; All residents receiving food from HCH dietary department could be affected. Measures to prevent reoccurrence; <p>HCH Dietary Manager/designee to complete a daily sanitation audit of the dish room, bake area mixer, cook's area mixer, ceiling vents, and walk in freezers, any noted concern will be immediately addressed. The plastic wrap stainless steel has been cleaned with new aluminum parts ordered. Administrator to audit the Dietary Department weekly for 2 months, bi-weekly for 2 months and then monthly for 2 months with</p>	

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	<p>thick frost build up on the floor in front of the freezer door and inside the door threshold. The Food Service Director indicated the white areas on the stainless steel shelves were caused by the small cardboard boxes containing gloves, aprons and hair nets, had stuck to the stainless steel. Housekeeping was responsible for cleaning the walls behind and beside the 2 stainless steel shelves and the walls really needed painted. The large floor fan was cleaned as needed and "it needs it." The yellowish substance on the mixer was from cornbread made "yesterday." The dark fuzzy substance in the ceiling vent was dust. Maintenance cleaned the ceiling vents as needed. The vent needed clean. There was a gap in the top of the freezer door gasket causing frost to build up.</p> <p>During an interview with the Food Service Director on 2/13/15 at 12:06 p.m., he indicated staff periodically cleaned the frost build up off the walk in freezer. There had been a gap in the freezer door gasket for months and "it separates and lets air through." He was going to have the gasket replaced but hadn't ordered it yet. The substance on the Plastic Wrap holders looked like rust. He was going to replace both of them.</p> <p>3.1-21(i)(3)</p>		<p>random monthly audits ongoing.</p> <p>4. Monitoring of corrective action to ensure the practice will not recur; HCH DM/designee to complete a summary of the audit to be presented to the Administrator monthly. Summaries will then be reviewed with the Medical Director at the quarterly QA meeting. Any patterns identified on the audit will be addressed via an Action Plan written by the QA Committee. The Action Plan will be monitored by the Administrator weekly until resolved.</p> <p>5. Date the systematic changes will be completed; 3/19/15.</p>		

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

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