

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155726	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/02/2015
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NAME OF PROVIDER OR SUPPLIER RIVER TERRACE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 400 CAYLOR BLVD BLUFFTON, IN 46714
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F 000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: March 26, 27, 30, & 31, 2015 and April 1 & 2, 2015</p> <p>Facility number: 003575 Provider number: 155726 AIM number: 200395060</p> <p>Census bed type: SNF: 19 SNF/NF: 6 Residential: 47 Total: 72</p> <p>Census payor type: Medicare: 3 Medicaid: 10 Other: 59 Total: 72</p> <p>Sample: Residential: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157 SS=D Bldg. 00	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal</p>			
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	<p>representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to ensure a resident who experienced a change in condition, had the physician notified of the change in condition in a timely manner for 1 of 1 resident's reviewed with a change in condition.</p> <p>Resident #11</p> <p>Findings include:</p> <p>On 4/2/15 at 10 a.m. the clinical record of Resident #11 was reviewed. Diagnoses included, but were not limited to, the following: Pneumonia, general weakness, stroke, depression, chronic constipation and dementia. An MDS (minimum data set) assessment, dated 11/11/14, included but was not limited to the following: cognition was severely impaired; ambulation in room and corridor did not occur; extensive assistance required with transfer and bed mobility..."</p>	F 157	<p>1. Resident number 11 was sent to the hospital on 11/17/2014 by nursing staff in response to the change of condition noted on 11/16/2014. 2. DON and/or designee will review the 24-hour change of condition report daily. 3. In-service training was conducted for health care licensed nursing staff on 4/10/2015 to review the Change of Condition Reporting policy. See attachment A. 4. DON and/or designee will perform quality assurance audits of the nurses notes 5x per week for two weeks; 3x per week for one month; and weekly for one month; monthly for the following 3 months to ensure continued compliance. Results of the corrective actions will be reviewed during the next scheduled quarterly quality assurance meeting. See audit tool attachment B. 5. Systemic changes will be completed by 4/20/2015.</p>	04/20/2015

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	<p>A history and physical from (name of acute care hospital), dated 10/28/14, included but was not limited to, the following: "Admission date 10/28/14...History of present illness: Past medical history:...chronic constipation...decreased appetite...The patient's abdominal series shows...moderate stool in the rectum..."</p> <p>Nurse's Notes dated 11/5/14 indicated the resident was admitted to the facility on this date from (name of acute care hospital).</p> <p>An admission nursing assessment, dated 11/5/14, included but was not limited to, the following: "...appearance of abdomen: soft, flat, bowel sounds active x 4 quads (quadrants)..."</p> <p>A plan of care dated 11/5/14, addressed the following problem: "Constipation related to...approaches included, but were not limited to, the following: monitor for bowel movements and record, follow bowel protocol..."</p> <p>Nurse's Notes dated 11/9/14 at 8:40 p.m. included but were not limited to, the following: "...Res (resident) on day 3 BM list. MOM (milk of magnesia) given...abdomen soft and non tender." Documentation was lacking on the</p>			

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	<p>November 2014 MAR (medication administration record) of MOM having been given on 11/9/14 and/or 11/10/14.</p> <p>A physician order dated 11/10/14 included the following: "Give...Milk of Magnesia once a day prn (as needed) constipation."</p> <p>Nurse's Notes dated 11/15/14 at 10 a.m. indicated the following: "Dr. (name of physician) in to see resident. No new orders at this time." Documentation was lacking of the physician having been notified of the resident not having a BM from 11/11/14 - 11/15/14 (no BM documented on 11/15/14).</p> <p>On 4/1/15 at 2:15 p.m. the DON provided a copy of the record she kept in her office of resident BMs. This record was dated November 2014 and included, but was not limited to, the following: no BMs were documented for this resident on 11/11, 11/12, 11/13, 11/14 and 11/15.</p> <p>The physician progress note, dated 11/15/14, included but was not limited to, the following: "...constipation - Miralax..."</p> <p>A Nurse's Note dated 11/16/14 indicated the following: 9 p.m.: "Res (resident) refused meds (medications) at HS</p>			

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	<p>(bedtime). Emesis x 1, bile plus possible stool. Abdomen firm and round. BM (bowel movement) this morning. No c/o (complaints of) pain or discomfort." This was the last documentation for this resident on this day.</p> <p>The next Nurse' s Note was dated 11/17/14 at 7 a.m. and indicated the following: "...bowel sounds hypoactive x 4 quads (quadrants). Abdomen distended et (and) round, slight firmness noted...Res requires assist with transfers d/t (due to) weakness, denied wanting to get out of bed..." The next entry was at 7:20 a.m. and included, but was not limited to, the following: "MD (medical doctor) telephoned et (and) updated on weekend emesis, hypoactive bowels, loss of appetite reported over weekend...abdomen round et distended. N.O. (new order) received for KUB (x-ray of kidneys, ureter, bladder) et suppository if refuses MOM (Milk of Magnesia) or Miralax." At 11:10 a.m. the nurse's note indicated the following: "Resident up for shower...CNA (certified nursing assistant) reported BM et emesis. Resident vomited x 3 occurrences large amount of brown liquid emesis. Res also had small loose, dark brown/black stool. Abd (abdomen) firm and distended. Hypoactive bowel sounds. MD notified. N.O. to send to ER (emergency room) for</p>			

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	<p>eval (evaluation) et tx (treatment).</p> <p>On 4/1/15 at 1:30 p.m. the DON was interviewed. She indicated on 11/16/15 at 9 p.m., the physician should have been notified of the resident's vomiting bile and possible stool. She also indicated the physician should have been notified of the resident's change in condition of the resident's abdomen from soft on 11/15/14 at 11:30 p.m. to firm and round as documented on 11/16/14 at 9 p.m.</p> <p>On 4/1/15 at 2:05 p.m. the DON was interviewed. She indicated the resident did go 5 days without a BM, from 11/11/14 - 11/15/14.</p> <p>On 4/1/15 at 3:21 p.m. the Executive Director provided a current copy of the facility policy and procedure for "Change in condition reporting", dated 3/2014. This policy included, but was not limited to, the following: "It is the policy of (name of facility) to provide appropriate assessment...to consult with the resident's physician...whenever a resident displays a significant change in condition...A significant change would be defined as:...a significant change in the resident's physical...status; a need to alter treatment...a need to transfer...the resident from the facility...If a significant change in condition occurs: Immediately</p>			

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	<p>assess the resident...document the facts of the incident in the medical record, including nursing assessment findings...document notification of physician and family in medical record..."</p> <p>On 4/1/15 at 3:21 p.m. the Executive Director provided a current copy of the facility policy and procedure for "Bowel Protocol" dated 12/2013. This protocol included but was not limited to, the following: "CNA completes the 3 day bowel worksheet by reviewing the bowel tracking record and provided to nurse daily. Nurse-reviews the 3 day bowel worksheet provided by the CNA. Day 2 no BM...Day 3 no BM, offer prn laxative per physician orders and licensed nurse will assess abdomen for distension and firmness; listen to bowel sounds and document all findings; Day 4 no BM, repeat steps for Day 3; update physician on condition and follow physician orders."</p> <p>3.1-5(a)(2)(3)(4)</p>			

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F 282 SS=D Bldg. 00	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview and record review the facility failed to follow care plan interventions to prevent additional falls for 2 of 4 residents (Resident #29, Resident #23) who met the criteria for fall and/or fracture in the last 30 days.</p> <p>Findings include:</p> <p>1. Review of the clinical record for Resident #29 on 3/30/15 at 10:11 a.m., indicated the following: diagnoses included, but were not limited to, unsteady gait, hypertension, anxiety, and dementia of Alzheimer's type.</p> <p>A Fall Risk Assessment for Resident #29, dated 7/28/14, indicated she was at high risk for falls. Parameters present to determine her high risk for falls included: intermittent confusion/disorientation, 1-2 falls in the last 90 days, ambulatory/incontinent, jerking or</p>	F 282	<p>1. Both resident's #23 and #29 have had their Care Plans updated to reflect their current functional status. 2. DON and/or designee are reviewing all current Care Plan interventions to ensure that the interventions are appropriate based upon each residents functional, cognitive and ADL abilities. Care Plans will be updated upon this review. 3. In order to prevent deficient practice in the future, the Post-Fall tool has been revised; (both forms titled Falls with Injury Checklist and Falls without Injury Checklist) to include what invention will be initiated and which, if any, interventions need to be discontinued. In-service training education on the new form and obtaining root cause analysis for the fall will be completed by 4/20/2015. See attachment C; in-service record and updated forms. 4. DON and/or designee will review all falls monthly for 6 months. Fall prevention will also be a part of our next QAPI focus. An audit tool has been created to assist in the review</p>	04/20/2015

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	<p>unstable when turning, requiring assistive device, took at least 1 of the medications of anesthetics, antihistamines, antihypertensive, antiseizure, benzodiazepines, cathartics, diuretics, hypoglycemic, narcotics, psychotropic, and sedatives/hypnotics, and 1-2 predisposing diseases present of hypotension, vertigo, cerebral vascular accident, Parkinson's disease, loss of limb(s), seizures, arthritis, osteoporosis, fractures, and dementia.</p> <p>A Falls Management Investigation - Post Fall Tool for Resident #29, dated 9/14/14, indicated she was in her room in front of the television, sitting on her bottom with her legs out in front of her. The investigation also indicated her care plan was updated by making sure her walker was within reach.</p> <p>A Falls Management Investigation - Post Fall Tool for Resident #29, dated 10/20/14, indicated she was on her buttocks in a sitting position facing the door to her room in front of and to the west of her roommates bed. The investigation also indicated the intervention of making sure her walker was within reach at all times was in place prior to the incident.</p> <p>A Falls Management Investigation - Post</p>		<p>process, see attachment D. 5. The systemic changes will be completed by 4/20/2015.</p>				

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	<p>Fall Tool for Resident #29, dated 11/28/14, indicated she was found sitting with her legs straight out in front of her beside her bed. The investigation also indicated her care plan was updated by reminding the resident to use her call light when getting up at night.</p> <p>A Minimum Data Set (MDS) assessment for Resident #29, dated 1/16/15, indicated she required extensive assistance with the physical assistance of 1 staff for bed mobility and transfers and required limited assistance with the physical assistance of 1 staff for locomotion. The MDS also indicated the use of a walker and a wheelchair.</p> <p>A Fall Risk Assessment for Resident #29, dated 2/24/15, indicated she was at high risk for falls.</p> <p>A Nurses Notes for Resident #29, dated 3/15/15, indicated she was found on the floor sitting upright on her buttocks beside her bed. Her legs were extended straight in front with her feet under the bed. The note also indicated the resident indicated she was coming back from the bathroom and her feet slipped when she was trying to get into bed and she fell. The note further indicated an assessment was completed with no injuries noted. The note also indicated the resident was</p>			

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	<p>assisted up and in bed x 2 assist. The resident was encouraged to use her call light for assistance and to put her non-slip socks on.</p> <p>A Falls Management Investigation for Resident #29, dated 3/15/15, indicated she was found on the floor beside her bed in her room sitting upright on her buttocks, with her legs extended in front with her feet under her bed. The investigation also indicated she reported she slipped and fell while attempting to return to her bed from the bathroom. The investigation further indicated she was often confused, forgot her limits, had an unsteady gait and weakness, and tired easily. The investigation also indicated her care plan was updated by a floor alarm on at bedside when in bed. Interventions in place prior to the incident included: remind to call for assist, encourage use of walker/wheelchair, non-slip socks on at all times, personal items in reach, wheelchair with auto-lock breaks, monitor for unsteady gait, and provide adequate glare-free lighting, were in place prior to the fall.</p> <p>During an observation on 3/30/15 at 2:15 p.m., Resident #29 was observed resting in her bed. A 1/2 upper side rail was raised. Her recliner was approximately 6</p>			

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	<p>inches away from the side of her bed and the armrest of the recliner was approximately 8 inches across in width. The facility's call light system was part of a hand-held console, approximately 3 inches wide by 7 inches long, which also contained the remote control and volume control to her television. The cord to her call light was observed draped over the arm of her recliner with the console resting on the seat of the recliner. The call light section of the console was observed facing toward the opposite arm rest. Her walker was folded and tucked between her wardrobe and the wall. There was no floor alarm at her bedside.</p> <p>During an observation on 3/31/15 at 10:15 a.m., Resident #29 was observed resting in her bed with the 1/2 upper side rail raised. Her call light was again observed draped over the arm rest of her recliner, with the console resting on the seat of the recliner. The call light section of the console was observed facing toward the opposite arm rest. Her walker was folded and tucked between her wardrobe and the wall. There was no floor alarm at her bedside.</p> <p>A facility care plan for Resident #29, with a start date of 1/19/15, indicated the problem area of potential for falls related to unsteady gait, edema and lack of</p>			

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	<p>coordination. Approaches to the problem included, but were not limited to, encourage use of assistive device, provide activities that minimize the potential for falls while providing diversion and distraction, floors free from spills or clutter, personal items within reach, assist resident with picking items up off floor, remind to call for assist, monitor for unsteady gait, and non-skid socks at all times.</p> <p>A Temporary Problem List for Resident #29, dated 3/15/15, indicated the problem of a fall on 3/15/15. Approaches to the problem indicated: floor alarm while in bed and make sure walker in reach when in bed/at all times.</p> <p>The Director of Nursing (DON) was interviewed on 4/1/15 at 2:35 p.m. During the interview she indicated Resident #29's call light should have been placed close to her when she was resting in bed. She also indicated the intervention of her walker next to her bed should have been removed since she mostly used her wheelchair.</p> <p>The DON was interviewed on 4/1/15 at 3:22 p.m. During the interview she indicated the intervention of the floor alarm at the bedside of Resident #29 should have been removed as an</p>			

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	<p>intervention for falls. She also indicated the call light may not have been placed close to her while she was resting in bed since she was now transferring herself in and out of her bed more.</p> <p>2. Review of the clinical record for Resident #23 on 4/1/15 at 10:30 a.m., indicated the following diagnoses included, but were not limited to CVA (cerebrovascular accident, a stroke), dementia, HTN (hypertension), depression, pneumonia, hypokalemia and hyperlipidemia.</p> <p>A Minimum Data Set (MDS) assessment for Resident #23, dated 2/2/15, indicated the BIMS (Brief Interview for Mental Status) score was 02 which indicated severe cognitive impairment. The MDS assessment also indicated she required the physical assistance of 1 person for bed mobility, transfers and ambulation. The MDS assessment indicated her balance was not steady and she used a walker for mobility.</p> <p>Review on 4/1/15 at 10:30 a.m., of the clinical record for Resident #23 indicated she experienced falls on 3/2/15, 3/5/15 and 3/18/15. The intervention on her care plan to prevent falls, dated 1/19/15, included: encourage use of assistive</p>			

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	<p>device, walker; provide adequate, glare free lighting; personal items within reach and assist to wear non-skid footwear. The Temporary Problem List indicated the following: On 3/2/15, "...Fall...Maintain res (resident) safety. Keep free of falls...Approaches: Educated Res. and staff to reminders (sic) to ask for help when needed...observe for unassisted rising...." On 3/5/15, "...Fall...Keep res. safe and free of falls/injuries...Monitor Res more closely. Kept res close to staff at NS (Nurses' Station)..." On 3/18/15, "...Fall no injury..." The fall on 3/18/15 did not include approaches on the Temporary Problem List.</p> <p>Fall Risk Assessments for Resident #23 dated 1/2/15, 2/25/15, 3/2/15, 3/5/15 and 3/18/15, indicated she was at high risk for falls. The Parameters present to determine her high risk for falls included: intermittent confusion/disorientation; 1-2 falls in last 90 days per Fall Risk Assessments, dated 1/2/15, 2/25/15 and 3/2/15, 3 or more falls in last 90 days per Fall Risk Assessments; dated on 3/5/15 and 3/18/15; ambulatory/incontinent; poor vision with or without glasses; balance problem while standing, with sitting to standing, while walking, when turning; requires assistive device; took at least 1 of the medications of anesthetics,</p>			

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	<p>antihistamines, antihypertensive, anti-seizure, benzodiazepines, cathartics, diuretics, hypoglycemic, narcotics, psychotropic, and sedatives/hypnotics, and 2 or more predisposing diseases present of hypotension, vertigo, CVA, Parkinson's disease, loss of limb(s), seizures, arthritis, osteoporosis, fractures, and dementia.</p> <p>The Skilled Daily Nurses Notes for Resident #23 dated 3/2/15 at 2:50 p.m., indicated she was found sitting upright in front of the rocking chair. The note indicated the resident could not tell how she ended up on the floor. The note also indicated another resident told the nurses the resident had attempted to stand and slid forward out of the chair onto the floor. The note further indicated there were no injuries noted and 2 staff assisted the resident to the chair and reminded the resident to call for help if needed.</p> <p>The Skilled Daily Nurses Notes for Resident #23 dated 3/2/15 at 3:00 p.m., indicated implemented care plan for post fall intervention for staff to observe and monitor resident for any attempts to rise unassisted.</p> <p>A Falls Management Investigation provided by the DON on 4/1/15 at 2:00 p.m., for Resident #23 dated 3/2/15,</p>			

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	<p>indicated the resident was found on the floor in the television room directly in front of the glider chair. The investigation also indicated the room light was on, the resident did not use her walker as MD(Medical Doctor) ordered, she had an unsteady gait and impaired mobility/transfers. The investigation also indicated resident was confused before and after the fall and indicated a change of balance. The investigation also indicate the interventions of reminders, notable fall risk, blue dot and bracelet system, monitor her for attempts to get up without supervision/assistance were in place prior to the fall. Interventions put into place after the fall were: remind resident to call for help and remind staff to watch.</p> <p>The Skilled Daily Nurses Notes for Resident #23 dated 3/5/15 at 6:15 p.m., indicated while she was in view of 2 nurses the resident had fallen when she attempted to stand and walk. The note indicated there were no injuries and the resident was not able to say what she was doing. The note also indicated the 2 nurses assisted the resident back into her wheelchair and sat her at the nurses station.</p> <p>A Falls Management Investigation provided by the DON on 4/1/15 at 2:00</p>			

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	<p>p.m., for Resident #23 dated 3/5/15, indicated the resident was in the television room sitting in front of the wheelchair. The investigation also indicated the wheelchair was not locked, the room light was on. The investigation also indicated the resident did not respond when asked what she was doing when she fell. The investigation also indicated prior to fall the resident had an unsteady gait and impaired mobility and transfers. The resident's mental status was disoriented and confused before and after the fall and indicated a change of weakness/fatigue in her health status. The investigation also indicated the interventions of the staff to watch for unassisted rising and walking attempts were in place prior to the fall. Interventions put into place after the fall were: move resident closer to staff and checking for UTI (urinary tract infection) per physician's order.</p> <p>The Skilled Daily Nurses Notes for Resident #23 dated 3/18/15 at 8:10 p.m., indicated the resident was found on the floor in her room by the bed and was lying on her right side with her knees slightly bent with her head facing the window and resting on her hands. The note indicated the resident did not know what had happened. The note also indicated the nurse assisted to put on her</p>			

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	<p>night gown and non-slip socks. The note further indicated resident was encouraged to use her call light and the light was placed in reach. The bathroom light and a night light were turned on. The note further indicated the walker was at the bedside.</p> <p>A Falls Management Investigation provided by the DON on 4/1/15 at 2:00 p.m., for Resident #23 dated 3/18/15, indicated the resident was found on the floor in her room, lying on her right side, facing the window with knees slightly bent and her head resting on her hands. The investigation indicated the call light was not on, poor lighting, she did not use the walker and had on improper footwear of socks. The investigation also indicated the resident did not know how she fell. The investigation indicated she had an unsteady gait prior to the fall. The resident's mental status was disoriented and confused before and after the fall. The investigation also indicated interventions of floors free from clutter, personal items in reach, assist to wear non-skid footwear and encourage use of a walker were in place prior to the fall. Interventions put into place after the fall were: Turn on night-light and bathroom light, assist to put on non-slip socks, and walker parked by the bed.</p>			

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	<p>During an observation on 4/1/15 at 2:30 p.m., Resident #23 was observed resting in her bed on her left side, the walker was placed on the right side toward the end of the bed and it was pushed up by the window not in easy reach. The call light was on the bedside cabinet on the right side of the bed not in easy reach.</p> <p>During an observation on 4/1/15 at 3:15 p.m., Resident #23 was observed resting in bed on her left side and the walker was still placed on the right side and pushed up by the window. The call light reminded on the bedside cabinet on the right side of the bed not in easy reach.</p> <p>During an observation on 4/2/15 at 1:00 p.m., Resident #23's door to her room was only slightly opened, the privacy curtain was pulled 3/4 of the way and the resident was not visible from the door. The residents walker was by the window and a wheelchair was against the window towards the end of the bed not in easy reach. Observed the resident resting on her right side.</p> <p>An interview with a family member on 4/2/15 at 11:10 a.m. indicated Resident #23 has had dementia for 10 years and recently had a stroke. The family member indicated she usually does not talk and indicated she could not let</p>			

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	<p>anyone know if she needs to get up. The family member also indicated she does not walk much anymore.</p> <p>An interview with Certified Nursing Assistant (CNA) #3 on 4/2/15 at 11:25 a.m., indicated Resident #23 was a high fall risk. CNA #3 indicated she was not able to stay nearby to watch for the resident to stand up from her wheelchair and indicated the nurses station was close to the living room to keep an eye on the residents in there. CNA #3 indicated Resident #23 was capable of getting out of bed and does not call for assistance. She indicated when the resident was in her room she check on her when she passes by the room and indicated she has found the resident up in the bathroom or peeking out from the privacy curtain.</p> <p>An interview with the DON on 4/2/15 at 1:10 p.m., indicated Resident #23's cognition varies and educating the resident to call for help would not work most of the time. The DON indicated several staff go by the living room to observe the residents in there. She also indicated the staff does not stay in the area when Resident #23 was in the living room. The DON further indicated the resident was checked on by the staff when they go by her door.</p>			

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	<p>A current undated facility policy "Fall Prevention and Assessment", provided by the Administrator on 4/2/15 at 8:47 a.m., indicated "... As part of the initial assessment, the facility will help identify individuals with a history of falls and risk factors for subsequent falling...Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling...If the individual continues to fall, the staff will re-evaluate the situation and consider other possible reasons for the resident's falling (besides those that have already been identified) and will re-evaluate the continued relevance of current interventions...."</p> <p>This deficiency was cited on the annual recertification survey on 3/11/14. The facility failed to implement a plan of correction to correct the deficiency.</p> <p>3.1-35(g)(2)</p>			

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F 309 SS=D Bldg. 00	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review, the facility failed to ensure a resident with a change in condition was adequately assessed and monitored for 1 of 1 resident's reviewed with a change in condition.</p> <p>Resident #11</p> <p>Findings include:</p> <p>On 4/2/15 at 10 a.m. the clinical record of Resident #11 was reviewed. Diagnoses</p>	F 309	<p>1. Resident number 11 was sent to the hospital on 11/17/2014 by nursing staff in response to the change of condition noted on 11/16/2014. 2. Facility has revised the BM monitoring flow sheet. See attachment E. 3. DON will be conducting an in-service for all nursing staff which will be completed by 4/20/2015 and will include process and interventions for BM's and Irregular Bowel Patterns. See attachment E. 4. DON and/or designee will audit</p>	04/20/2015

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	<p>included, but were not limited to, the following: Pneumonia, general weakness, stroke, depression, chronic constipation and dementia. An MDS (minimum data set) assessment, dated 11/11/14, included but was not limited to the following: cognition was severely impaired; ambulation in room and corridor did not occur; extensive assistance required with transfer and bed mobility..."</p> <p>A history and physical from (name of acute care hospital), dated 10/28/14, included but was not limited to, the following: "Admission date 10/28/14...History of present illness: came in with complaint of upset stomach and vomiting and nausea since the past 1 week...Past medical history:...chronic constipation...decreased appetite...The patient's abdominal series shows...moderate stool in the rectum..."</p> <p>Nurses Notes dated 11/5/14 indicated the resident was admitted to the facility on this date from (name of acute care hospital).</p> <p>A Doctor's progress note, dated 11/5/14, included but was not limited to, the following: "New admit...recent hospital stay at (name of hospital) for...abdominal pain...bowels sluggish..."</p>		<p>the BM flow sheet and BM worksheet 3x per week for 1 month; 2x per week for next month, 1x per week the following 4 months and then during the next regularly scheduled QA meetings. This will ensure the plan of correction remains in place. Findings will be documented from the audit on attachment F. 5. Systemic changes will be implemented 4/20/15.</p>		

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	<p>An admission nursing assessment, dated 11/5/14, included but was not limited to, the following: "...appearance of abdomen: soft, flat, bowel sounds active x 4 quads (quadrants)..."</p> <p>A Physician orders, dated 11/5/14 included but were not limited to, the following: "Polyethylene Glycol (laxative) 17 grams...every Monday, Wednesday, Friday, constipation." Documentation was lacking on the admission orders of prn (as needed) MOM (milk of magnesia).</p> <p>A plan of care dated 11/5/14, addressed the following problem: "Constipation related to:...approaches included, but were not limited to, the following: monitor for bowel movements and record, follow bowel protocol..."</p> <p>A fax dated 11/9/14, to the physician indicated the following: "May we have below order d/t (due to) constipation: Give...Milk of Magnesia once a day prn (as needed) constipation."</p> <p>Nurses Notes dated 11/9/14 at 8:40 p.m. included but were not limited to, the following: "...Res (resident) on day 3 BM list. MOM (Milk of Magnesia) given...abdomen soft and non tender."</p>			

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	<p>Documentation was lacking on the November 2014 MAR (medication administration record) of MOM having been given on 11/9/14 and/or 11/10/14.</p> <p>Nurse's notes dated 11/10/14 at 4 p.m. included but were not limited to, the following: "MD response r/t (related to) constipation. N.O. (new order) received et noted."</p> <p>Physician order dated 11/10/14 included the following: "Give...Milk of Magnesia once a day prn (as needed) constipation."</p> <p>The BM worksheet for November 2014 indicated the resident had a small BM on 11/10/14.</p> <p>Documentation on the MAR indicated the prn MOM was given on 11/14/14 at 5 a.m. and 11/17/14 at 7 a.m.</p> <p>A NAR (Nutrition at Risk) note, dated 11/14/14, included, but was not limited to, the following: "...Her appetite is poor..."</p> <p>Nurses Notes dated 11/15/14 at 9 a.m. indicated the following: "Res refused am care et (and) AM (morning) meds..."</p> <p>Nurses Notes dated 11/15/14 at 10 a.m. indicated the following: "Dr. (name of</p>			

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	<p>physician) in to see resident. No new orders at this time." Documentation was lacking of physician having been notified of the resident not having a BM from 11/11/14 - 11/15/14 (no BM documented on 11/15/14, day 5 without a BM).</p> <p>On 4/1/15 at 2:15 p.m. the DON provided a copy of the record she kept in her office of resident BMs. This record was dated November 2014 and included, but was not limited to, the following: no BMs were documented for this resident on 11/11, 11/12, 11/13, 11/14 and 11/15.</p> <p>The physician progress note, dated 11/15/14, included but was not limited to, the following: "...constipation - Miralax..."</p> <p>Nurses notes dated 11/15/14 at 11:30 p.m. included, but were not limited to, the following: "Bo So (bowel sounds) active in all 4 quadrants. Abd (abdomen) soft, MOM (milk of magnesia) given." Documentation was lacking on the November 2014 MAR of MOM having been given on 11/15/14. Documentation was lacking on the response side of the MAR indicating if there was a result to the MOM being administered or not. Documentation was lacking on the ADL grid and/or the BM record of a result from the MOM administered on</p>			

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	<p>11/15/14.</p> <p>A Nurses note dated 11/16/14 indicated the following: 9 p.m.: "Res (resident) refused meds (medications) at HS (bedtime). Emesis x 1, bile plus possible stool. Abdomen firm and round. BM (bowel movement) this morning. No c/o (complaints of) pain or discomfort." This was the last documentation for this resident on this day.</p> <p>The next nurse 's note was dated 11/17/14 at 7 a.m. and indicated the following: "...bowel sounds hypoactive x 4 quads (quadrants). Abdomen distended et (and) round, slight firmness noted...Res requires assist with transfers d/t (due to) weakness, denied wanting to get out of bed..." The next entry was at 7:20 a.m. and included, but was not limited to, the following: "MD (medical doctor) telephoned et (and) updated on weekend emesis, hypoactive bowels, loss of appetite reported over weekend...abdomen round et distended. N.O. (new order) received for KUB (x-ray of kidneys, ureter, bladder) et suppository if refuses MOM (Milk of Magnesia) or Miralax." At 11:10 a.m. the nurse note indicated the following: "Resident up for shower...CNA (certified nursing assistant) reported BM et emesis. Resident vomited x 3 occurrences large</p>			

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	<p>amount of brown liquid emesis. Res also had small loose, dark brown/black stool. Abd (abdomen) firm and distended. Hypoactive bowel sounds. MD notified. N.O. to send to ER (emergency room) for eval (evaluation) et tx (treatment).</p> <p>A transfer sheet sent from the facility to the hospital on 11/17/14 included but was not limited to, the following: "...bowels (sic) hypoactive x 4, emesis x 3, liquid brown abdominal distension." Documentation was lacking of the resident's most recent BM.</p> <p>A history and physical, from the (name of acute care hospital) dated 11/17/14 from the ER (emergency room) included but was not limited to, the following: "...had been vomiting at the nursing home. Vomited about 2-3 times last night, but again this morning, she vomited again, so was sent to the emergency room for evaluation...has a lot of burping. Has not been eating hardly anything at all lately...Pt had only 1 bowel movement in the last 10 days. Pt not complained of any abd pain as per daughter...Past med history: chronic constipation, abd soft and non tender. Pt CT (Computerized Axial Tomography) scan of abd and pelvis have findings suggesting a bowel obstruction at approx. the level of mid transverse colon,</p>			

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	<p>possibly relating to an underlying annular neoplasm. Was admitted to med surg (medical/surgical unit) for IV (intravenous) hydration, surgery eval (evaluation) and ng (nasogastric) tube aspiration".</p> <p>A Consultation, dated 11/17/14, included but was not limited to, the following: "...female with a large bowel obstruction, probably secondary to an obstructing transverse colon mass...both daughters are realistic and would prefer to have their mother be comfortable...no surgery planned..."</p> <p>On 4/1/15 at 1:30 p.m. the DON was interviewed. She indicated the physician was not notified of the resident's change in condition of her abdomen. She indicated on 11/16/14, the physician should have been notified of the resident's vomiting bile and possible stool and the change in condition of the resident's abdomen from soft on 11/15/14 at 11:30 p.m. to firm and round as documented on 11/16/14 at 9 p.m. The DON indicated at this time, it is the facility practice when a medication is given to document it on the MAR.</p> <p>On 4/1/15 at 2:05 p.m. the DON was interviewed. She indicated the facility utilized a "BM worksheet" to monitor</p>			

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	<p>and/or document the resident's BMs. The DON indicated the hospital note, which indicated the resident went 10 days without a BM was not correct. She indicated the resident did go 5 days without a BM, from 11/11/14 - 11/15/14.</p> <p>On 4/1/15 at 2:15 p.m. the DON provided a copy of the resident's bowel movement record for November 2014. The record indicated the resident had a small BM on 11/10/14 and the next BM was on 11/16/14.</p> <p>On 4/1/15 at 3:21 p.m. the Executive Director provided a current copy of the facility policy and procedure for "Change in condition reporting", dated 3/2014. This policy included, but was not limited to, the following: "It is the policy of (name of facility) to provide appropriate assessment...to consult with the resident's physician...whenever a resident displays a significant change in condition...A significant change would be defined as:...a significant change in the resident's physical...status; a need to alter treatment...a need to transfer...the resident from the facility...If a significant change in condition occurs: Immediately assess the resident...document the facts of the incident in the medical record, including nursing assessment findings...document notification of</p>			

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	<p>physician and family in medical record..."</p> <p>On 4/1/15 at 3:21 p.m. the Executive Director provided a current copy of the facility policy and procedure for "Bowel Protocol" dated 12/2013. This protocol included but was not limited to, the following: "CNA completes the 3 day bowel worksheet by reviewing the bowel tracking record and provided to nurse daily. Nurse-reviews the 3 day bowel worksheet provided by the CNA. Day 2 no BM...Day 3 no BM, offer prn laxative per physician orders and licensed nurse will assess abdomen for distension and firmness; listen to bowel sounds and document all findings; Day 4 no BM, repeat steps for Day 3; update physician on condition and follow physician orders.</p> <p>On 4/2/15 at 11:30 a.m. the DON and MDS Coordinator were interviewed. They indicated it was documented on the MAR, the resident had MOM administered on 11/14/14. The back side of the MAR indicated for the MOM administered on 11/14/14 at 5 a.m., to "see BM record" for results or response. At the time, the BM record was reviewed and it indicated there was no BM on 11/14/14 or 11/15/14. It was documented the resident had a BM on day shift on 11/16/14. The MOM was only documented on the MAR as having been</p>			
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F 329 SS=D Bldg. 00	<p>given on 11/14/14 at 5 a.m. and on 11/17/14 at 7 a.m.</p> <p>3.1-37(a)</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</p>			

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	<p>drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review the facility failed to provide clinical rationale for the increase of a psychotropic medications for 1 of 5 residents (Resident #29) who met the criteria for unnecessary medication.</p> <p>Findings include:</p> <p>Review of the clinical record for Resident #29 on 3/30/15 at 10:11 a.m., indicated the following: diagnoses included, but were not limited to, depression, anxiety, and dementia of Alzheimer's type with associated mood disorder.</p> <p>A Social Service Progress Note for Resident #29, dated 6/11/14, indicated there were minimal signs/symptoms of depression and no other mood concerns or signs/symptoms of psychosis or behaviors. The note also indicated she was receiving Depakote 125 mg (milligrams) for dementia with associative mood disorder, Alprazolam 0.125 mg BID (twice a day) and PRN (as</p>	F 329	<p>1. Doctor was notified regarding new orders for resident #29. Medication has been reduced per doctors orders. 2. Behavior Management Team will review all residents currently on mood stabilizers and/or anti-psychotic medications. The team will review diagnosis and appropriate dosages per resident. See attachment G. 3. Staff was in-serviced on 4/10 regarding notification of DON/Social Service Director for new and/or changes to current mood stabilizers and/or anti-psychotic medications for proper documentation. See attachment H. 4. Social Services Director and/or designee will audit 30% of residents per month for 6 months. Gradual does reductions will also be reviewed monthly with the behavior management team. This will be reviewed at the next regularly scheduled QA meeting. See attachment I - audit tool. 5. Systemic changes will be in place by 4/20/2015.</p>	04/20/2015

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	<p>needed) for anxiety, and Venlafaxine 75 mg BID for depression. The note further indicated she remained on behavior management for pericare concerns and tearfulness. The note indicated the psychotropic medications were appropriate.</p> <p>A GDR (gradual dose reduction) request for Resident #29, dated 7/15/14, to decrease the Venlafaxine was not accepted by her physician. The physician indicated the continued use was in accordance with the current standard of practice and a GDR attempt was likely to impair the individual's function or cause psychiatric instability by exacerbating an underlying medical condition or psychiatric disorder.</p> <p>A Behavior Summary & Quarterly Review for Resident #29, dated 7/17/14 for the monitoring period of 5/20/14 to 7/17/14, indicated the facility was tracking the behaviors of hoarding, weeping/crying, screaming at others, and not wanting to shower. The review also indicated she was receiving Alprazolam 0.125 mg BID for anxiety, Depakote 125 mg daily for dementia associated with mood disorder, and Venlafaxine 75 mg BID for depression. The review further indicated she did not display any behaviors. The recommendation was</p>			

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	<p>made to discontinue the PRN Alprazolam due to non-use.</p> <p>A physician's order for Resident #29, dated 7/18/14, indicated to discontinue Alprazolam 0.125 mg 1 x (times) daily PRN due to non-use.</p> <p>A Nurse's Note for Resident #29, dated 8/17/14, indicated she was very tearful when a family member was trying to leave. The note also indicated the family member planned to contact her physician to discuss her medications.</p> <p>A physician's order for Resident #29, dated 8/18/14, indicated Depakote 125 mg HS (hour of sleep) due to increase in crying episodes and mood swings.</p> <p>A Social Service Progress Note for Resident #29, dated 8/26/14, indicated she was receiving Depakote 125 mg HS for dementia of Alzheimer's type with associated mood disorder, Alprazolam 0.125 mg BID for anxiety, and Venlafaxine 75 mg BID for depression. The note also indicated there were no signs/symptoms of depression, psychosis or behaviors noted or observed. The note further indicated she did have times when she got tearful, often when family were visiting or just left from a visit. The note also indicated psychotropic medication</p>			

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	<p>use was still appropriate.</p> <p>A physician's order for Resident #29, dated 9/15/14, indicated to discontinue Depakote 125 mg HS and to start Depakote 250 mg daily at HS.</p> <p>A GDR request for Resident #29, dated 9/29/14, was not accepted by her physician to decrease Alprazolam to 0.125 mg daily.</p> <p>A Behavior Summary & Quarterly Review for Resident #29, dated 10/16/14 for the review period of 7/17/14 to 10/16/14, indicated she displayed the behaviors of hoarding, weeping/crying, and not wanting to shower, but the frequency of the behaviors was not indicated. The review also indicated she received Alprazolam 0.125 mg BID for anxiety, Depakote 125 mg daily for dementia with mood disorder, and Venlafaxine 75 mg BID for depression. The review recommended to increase the Alprazolam to 0.25 mg BID due to continued resistance and crying.</p> <p>A physician's order for Resident #29, dated 10/17/14, indicated to increase Alprazolam to 0.25 mg BID for anxiety.</p> <p>A Behavior Monitoring Record for Resident #29, dated 10/22/14, indicated</p>			

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	<p>she was crying during dressing and grooming.</p> <p>A Social Service Progress Note for Resident #29, dated 11/21/14, indicated there were no signs/symptoms of depression, psychosis, or behaviors noted. The note also indicated the psychotropic medications were still appropriate.</p> <p>A Behavior Summary & Quarterly Review for Resident #29, dated 11/25/14 for the review period of 10/17/14 to 11/25/14, indicated she displayed 2 episodes of weeping/crying. The review also indicated she continues to cry for "no reason" or with ADL (activities of daily living) care. The review also indicated she received Alprazolam 0.25 mg BID for anxiety, Depakote 250 mg daily for dementia with mood disorders, and Venlafaxine 75 mg BID for depression. The review recommended to increase Depakote to 250 mg BID.</p> <p>A physician's order for Resident #29, dated 12/4/14, indicated to increase Depakote 250 mg BID.</p> <p>A Behavior Summary & Quarterly Review for Resident #29, dated 12/18/14 for the review period of 11/26/14 to 12/18/14, indicated she did not display</p>			

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	<p>any behaviors. The review also indicated a change in the Depakote from 250 mg daily to 250 mg BID.</p> <p>A Behavior Monitoring Record for Resident #29, dated 12/23/14, indicated the behavior symptoms of becoming weepy and crying during ADL assistance.</p> <p>Resident #29 was hospitalized from 1/4/15 to 1/12/15 for lethargy and increased confusion.</p> <p>A Skilled Daily Nurses Note for Resident #29, dated 1/18/15, indicated she became tearful when asking for her daughter and was informed her daughter was at home.</p> <p>A Social Service Progress Note for Resident #29, dated 1/19/15, indicated she displayed minimal signs/symptoms of depression and there were no other mood concerns or signs/symptoms of psychosis or behaviors. The note also indicated she received Depakote 250 mg BID for mood stabilization, Alprazolam 0.25 mg BID for anxiety, and Venlafaxine 75 mg BID for depression. The note further indicated the psychotropic medications were appropriate.</p> <p>A Skilled Daily Nurses Note for Resident #29, dated 1/20/15 at 6:30 a.m., indicated she was tearful during her shower. The</p>			

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	<p>note also indicated staff offered reassurance that was effective.</p> <p>A Skilled Daily Nurses Note for Resident #29, dated 1/20/15 at 3:00 p.m., indicated she was tearful. When asked, the resident indicated she missed her daughter. The note also indicated the emotional support given was helpful.</p> <p>A Social Service Progress Note for Resident #29, dated 2/10/15, indicated there were no signs/symptoms of depression, mood concerns, or behaviors noted. The note also indicated the psychotropic medications were appropriate.</p> <p>A Care Plan Conference for Resident #29, dated 2/26/15, indicated her mood was stable.</p> <p>A Social Service Progress Note for Resident #29, dated 3/5/15, indicated she does at times become "teary eyed" as she talked about family.</p> <p>A Behavior Summary & Quarterly Review for Resident #29, dated 3/19/15 and for the review period of 12/19/14 to 3/19/15, indicated she displayed the behavior of crying 3 times and the behavior of not wanting to shower 1 time. The review also indicated the problem</p>			

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	<p>with her hoarding was continuous with facility housekeeping keeping her room clear. The review further indicated she received Alprazolam 0.25 mg BID for anxiety, Depakote 250 mg BID for mood stabilization, and Venlafaxine 75 mg BID for depression.</p> <p>A facility care plan for Resident #29, with a start date of 1/19/15, indicated the problem area of alteration in mood related to anxiety, depression, Alzheimer's type with associated mood disorder as evidenced by tearfulness and headaches often after family visits. Approaches to the problem included, but were not limited to, provide reassurance and comfort, engage resident in activity of choice following family visits, and administer psych medications per MD orders.</p> <p>A facility care plan for Resident #29, with a start date of 1/19/15, indicated the problem area of episodes of refusing showers and care. She can become verbally aggressive or tearful when approached. Approaches to the problem included, but were not limited to, educate/remind on need for care, validate concerns about care and reassure her staff will be gentle and maintain her privacy, offer alternatives such as a bed bath or sponge bath when she is resistive,</p>			

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	<p>reapproach or alternate caregivers as needed, and encourage her to assist in care as able.</p> <p>A facility care plan for Resident #29, with a start date of 1/19/15, indicated the problem area of potential for drug related complications associated with use of psychotropic medications related to diagnosis of dementia of Alzheimer's type with associated mood disorder, anxiety and depression. Approaches to the problem included, but were not limited to, observe, document, and report to MD PRN signs/symptoms of drug related complications, monitor for target behaviors/symptoms and document per facility protocol, and consult with pharmacy and MD to consider dosage reduction when clinically appropriate.</p> <p>Certified Nursing Assistant (CNA) #1 was interviewed on 4/1/15 at 10:35 a.m. During the interview she indicated CNA's recorded any behaviors exhibited by the residents in the facility behavior book.</p> <p>Social Service was interviewed on 4/1/15 at 11:10 a.m. During the interview he indicated the Behavior Outlook & Quarterly Reviews were completed based on the documentation on the Behavior Monitoring Record and the Nurses Notes. He also indicated behaviors of residents</p>			

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	<p>were discussed routinely with the IDT (interdisciplinary Team).</p> <p>The Director of Nursing (DON) was interviewed on 4/1/15 at 3:25 p.m. During the interview she indicated the family of Resident #29 requested the Depakote be re-started due to her crying when they left after their visits. She also indicated the serum (blood) Valproic Acid level came back below normal limits and Resident #29's physician increased the Depakote. She further indicated she felt the physician did not remember the Depakote was ordered as a mood stabilizer and not for seizures. The DON also indicated staff were to document any episodes of tearfulness for Resident #29.</p> <p>A current facility policy "Psychopharmacological Medication Use", with a revision dated of 1/1/13 and provided by the Administrator on 4/2/15 at 8:47 a.m., indicated "...Where Physician/Prescriber orders a psychopharmacological medication for a resident, Facility should ensure that Physician/Prescriber has conducted a comprehensive assessment of the resident and has documented in the clinical record that the psychopharmacological medication is necessary...If Physician/Prescriber orders a</p>			

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F 431 SS=E	<p>psychopharmacological medication in the absence of a diagnosis or specific behavior listed in the State Operations Manual, Facility should ensure that the ordering Physician/Prescriber review the medication plan and considers a gradual dose reduction ("GDR") of psychopharmacological medications for the purpose of finding the lowest effective dose unless a GDR is clinically contraindicated...Physician/Prescriber should document the clinical rational for why any additional attempted dose reduction at that time would be likely to impair the resident's function or increase distressed behavior...."</p> <p>3.1-48(a)(4)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS</p>			

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Bldg. 00	<p>& BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation and interview, the facility failed to ensure the medication room was maintained in a secure manner for 1 of 1 medication rooms in the facility.</p>	F 431	1. No residents were directly affected by this practice. 2. There was no potential to affect other residents. DON has in-serviced QMA's and Licensed nursing staff on 4/2/2015 regarding the medication room and authorized	04/20/2015

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	<p>Findings include:</p> <p>On 3/27/15 at 9:04 a.m. the nursing unit was observed. Upon entry onto the unit via the only entrance, the nurses ' station was located on the right side of the hall. The only locked medication room on the unit was located adjacent to the nurses ' station with the entry door facing the nurses ' station. At 9:04 a.m. QMA (Qualified Medication Aide) #1 was observed to unlock the medication room door for the housekeeper. The Housekeeper was observed to enter the room by herself. The door to the medication room was kept open but the QMA was not in direct visual field of the medication room. The QMA was observed at the nursing station desk and at 9:07 a.m., she walked to the back portion of the nurses ' station, which was out of direction visualization of the medication room. The QMA then walked back out to the nurses ' station and at 9:11 a.m. was observed to entirely leave the area of the nursing station, again, out of direct visualization of the medication room. The door remained open 1/2 way, and the housekeeper was observed to clean the interior of the medication room, dusting, sweeping and mopping the floor, all while no staff was in direct visual field of her. At 9:11 a.m. the Housekeeper put up a "wet floor" sign</p>		<p>access. See attachment J</p> <p>3. Locking cabinets will be installed in the medication room as well as a new lock being placed on the refrigerator. See attachment K - receipts of cabinets and locks. 4. DON and/or designee will audit the locks in the medication room weekly for the next month; twice per month for the following month and then monthly for 4 months. See attachment L- audit tool for medication room. 5. Systemic changes will be in place by 4/20/2015.</p>				

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	<p>just outside of the opened med room door. At 9:14 a.m. the QMA #1 returned to the nurses ' station area. At 9:14 a.m., the housekeeper was observed to close the medication room door.</p> <p>On 3/27/15 at 11:40 a.m. the medication room was toured with LPN#12. The medication refrigerator was observed to have a pad lock on the outside of the refrigerator door. LPN #12 was observed to open the medication refrigerator by simply pulling the handle on the refrigerator door. At 11:41 a.m. LPN #12 was interviewed. She indicated no key was needed to open the medication refrigerator, "just pull the door open." The inside of the medication refrigerator was observed to have an EDK (emergency drug kit), eye drops and various suppositories. The open blue tote, which was observed on the counter in the medication room, was observed to be empty at the time. LPN #12 indicated this was the place expired, discontinued and medications of residents who were discharged were placed.</p> <p>On 4/1/15 at 3:31 p.m. the DON (Director of Nursing) was made aware of Housekeeper #1 having been observed in the medication room unsupervised. The DON indicated at this time, the housekeeper should not have been left</p>			

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	<p>unsupervised in the medication room. She indicated she was also aware the lock on the medication refrigerator did not actually lock the medication refrigerator.</p> <p>On 4/2/15 at 8 45 a.m. the Executive Director was interviewed. She indicated the facility did not have a policy and procedure regarding the medication room being adequately supervised and/or housekeeping being permitted unsupervised in the medication room.</p> <p>On 4/2/15 at 9:21 a.m. the medication room was toured with QMA #2. QMA #2 was interviewed. She indicated the unlocked cabinets on the wall, contained overflow medications for the residents. These medication were observed to be labeled by the pharmacy. The medication refrigerator was observed to be opened by pulling the handle on the refrigerator door and not utilizing a key to open the door. The following medications were observed in the medication refrigerator: Bisacodyl suppositories, 8 vials of Fluvirin, 30 vials of Hepatitis B Vaccine and 7 vials of Aplisol. The refrigerated EDK was observed to obtain the following medications: Acetaminophen Suppositories 650 mg, Bisacodyl Suppositories, Insulin (Humalog, Novolog, Novolin N Insulin, Novolin R Insulin, Novolin 70/30 Insulin, Lantus</p>			

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R 000 Bldg. 00	<p>Insulin, Lorazepam (antianxiety medication) Injectable, prochlorperazine Suppositories, and Promethazine Suppositories. In the door were the following: vial of Levemir insulin, vial of Novolog insulin, 2 bottles of Latanoprost eye drops , Humulin 70-30 insulin and a vial of Lantus insulin.</p> <p>This deficiency was cited on the annual recertification survey on 3/11/14. The facility failed to implement a plan of correction to correct the deficiency.</p> <p>3.1-25(m)</p> <p>River Terrace Health Care Center was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Survey.</p>	R 000		