

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155349	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/27/2014
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NAME OF PROVIDER OR SUPPLIER SAINT ANNE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1900 RANDALLIA DR FORT WAYNE, IN 46805
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: February 20, 21, 24, 25, 26, and 27, 2014.</p> <p>Facility number: 000240 Provider number: 155349 AIM number: 100274960</p> <p>Survey team: Diane Nilson, RN, TC Carol Miller, RN Rick Blain, RN Tim Long, RN</p> <p>Census bed type: SNF/NF: 120 SNF: 31 Residential: 86 Total: 237</p> <p>Census payor type: Medicare: 22 Medicaid: 63 Other: 152 Total: 237</p>	F000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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F000242 SS=D	<p>Residential sample: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on March 3, 2014 by Randy Fry RN.</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on interview and record review the facility failed to ensure 2 of 35 residents (#171, #78) reviewed for choices received an opportunity to make choices regarding frequency of bathing</p> <p>Findings include:</p> <p>1. Resident #171 was interviewed on 2/21/14 at 10:13 A.M. Resident #171 indicated she was never offered more than two showers a week.</p> <p>Review of a form provided by Social Service Director (SSD) #5 on</p>	F000242	<p>Paper review is being requested. If approved, paper compliance will be sent to ISDH by March 29, 2014 for each tag. F242 – Self-Determination – Right to make Choices 1. Residents #171 and #78 have been asked if they want more than two showers/baths per week. Based on these interviews, it has been determined that these residents do not wish to change their current schedule. 2. All residents are at risk of not being able to make a choice on frequency of showers/baths if they are uninformed. Our form has been updated to ensure</p>	03/29/2014	

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	<p>2/25/14 at 10:25 A.M., titled "MDS Questions" regarding preferences, indicated it was very important to Resident #171 to choose a tub bath, shower, bed bath or sponge bath and the resident preferred to have a shower or bath in the A.M. The form did not have any other questions regarding bathing preferences.</p> <p>Review of Resident #171's care plans did not indicate a care plan for preferences/choices for frequency of bathing.</p> <p>An interview with SSD #5 on 2/25/14 at 10:13 A.M. indicated she gathered the information for preferences for resident #171. SSD #5 indicated resident #171 had preferences for showers in the A.M. SSD #5 indicated she did not ask resident #171 about her preference for frequency of showers in a week. SSD #5 indicated resident #171 received showers on Mondays and Thursdays. SSD #5 indicated the information she compiled on the MDS Questions for preferences for Resident #171 were then forwarded to nursing.</p> <p>An interview with LPN # 6 on 2/25/14 at 11:05 A.M., indicated the nurses got the MDS preferences</p>		<p>residents know they can have as many showers / baths as they want per week. Nurses, utilizing this new form, will offer current residents (who are capable of making this choice) their choice of bathing frequency.</p> <p>3. The social workers will begin to utilize the updated form to interview newly admitted residents, offering them a choice of bathing frequency. Files will be maintained on each floor for nursing staff to implement residents' choice, and floor supervisors will monitor to ensure residents' choices are followed. In addition, and as a further measure to re-iterate the importance of resident's choices, all staff will be in-serviced on the importance of residents having choices.</p> <p>4. As a QA measure, floor supervisors will review three to six residents' questionnaires with CNA assignments, twice per month, to ensure that residents are being offered the proper choices, and that these choices are being honored and implemented.</p> <p>5. The system will be in place by March 29, 2014.</p>		

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	<p>form from the Social Service department. LPN #6 indicated they reviewed the MDS preferences and compared it to what the nursing department was currently providing for the residents and noted if changes for preferences were indicated they would go to the residents to clarify. LPN #6 indicated residents were offered two showers a week and if the residents wanted more showers they could ask for them. LPN #6 did not indicate the residents were offered the choice for more than two showers a week.</p> <p>An interview with the Director of Nursing Services (DNS) on 2/25/14 at 11:05 A.M. indicated upon admission the nurses asked the residents their preferences at home but she did not know if those preferences were documented.</p> <p>An interview with the DNS on 2/26/14 at 9:00 A.M. indicated there was no documentation for resident #171 being offered a choice on preferences on how many showers a week she would prefer.</p> <p>2. Resident #78 was interviewed on 2/21/14 at 10:50 A.M. Resident #78 indicated she was never offered more than two showers a week.</p>			

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	<p>Review of a form provided by SSD #5 on 2/25/14 at 10:50 A.M., titled "MDS Questions" regarding preferences, indicated it was not important at all for Resident #78 to choose a tub bath, shower, bed bath or sponge bath and the resident preferred to have a shower or bath in the A.M.. The form did not have any other questions regarding bathing preferences.</p> <p>Review of Resident #78's care plans did not indicate a care plan for preferences/choices for frequency of bathing.</p> <p>An interview with SSD #5 on 2/25/14 at 10:13 A.M. indicated she gathered the information for preferences for resident #78. SSD #5 indicated resident #78 had preferences for showers in the A.M. SSD #5 indicated she did not ask resident #78 about her preference for frequency of showers in a week. SSD #5 indicated the information she compiled on the MDS questions for preferences for Resident #78 were then forwarded to nursing.</p> <p>An interview with LPN # 6 on 2/25/14 at 11:05 A.M. indicated in general the nurses get the MDS</p>				

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	<p>preferences form from the Social Service department. LPN #6 indicated they reviewed the MDS preferences and compared it to what the nursing department was currently providing for the residents and noted if changes for preferences were indicated they would go to the residents to clarify. LPN #6 indicated residents were offered two showers a week and if the residents wanted more showers they could ask for them. LPN #6 did not indicate the residents were offered the choice for more than two showers a week.</p> <p>An interview with the Director of Nursing Services (DNS) on 2/25/14 at 11:05 A.M. indicated upon admission nurses asked the residents their preferences at home but she did not know if those preferences were documented.</p> <p>An interview with the DNS on 2/26/14 at 9:00 A.M. indicated there was no documentation for resident #78 being offered a choice on preferences on how many showers a week she would prefer.</p> <p>3.1-3(u)(1)</p>				

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interviews, the facility failed to develop health care plans for 2 of 6 residents, #164 and # 126, reviewed for behavior care plans.</p> <p>Findings include:</p>	F000279	<p>Paper review is being requested. If approved, paper compliance will be sent to ISDH by March 29, 2014 for each tag.</p> <p>F279 – Develop Comprehensive Care Plans</p> <ol style="list-style-type: none"> Care Plans have been updated for residents #164 and #126 and all are current. Nurses are to audit each 	03/29/2014

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	<p>1. Resident #164's record was reviewed on 2/25/14 at 11:00 a.m. Resident #164's diagnoses included, but were not limited to, dementia with behavioral disturbances, and delusions.</p> <p>The Physician's Order dated 12/3/13 indicated Resident #164 had received risperdal (antipsychotic) 1 milligram (mg) three times a day (tid).</p> <p>The Electronic Medication Administration Record dated 12/3/13 indicated Resident #164 had received risperdal 1 mg TID.</p> <p>On 2/26/14 at 10:00 a.m. an interview with LPN #3 indicated Resident #164 was on risperdal for delusions and every shift the nurses document in progress notes if the resident had any behaviors or medication side effects had occurred. LPN #3 reviewed the resident's Care Plans and was unable to find a Care Pan for the medication risperdal the resident had received.</p> <p>On 2/26/14 at 10:15 a.m. an interview with LPN #2 indicated she was unable to find a Care Plan for</p>		<p>residents' care plan to ensure that care plans are in place for each resident. A full census sheet will be used as a checklist to ensure that no residents are missed. This will be done for care plans for all disciplines, with an emphasis on behavior management needs.</p> <p>3A. The full Interdisciplinary Team "IDT" (consisting of dietary, Social Services, Activities, Nursing, and therapy) will be re-trained to carefully review care plans specific to their discipline prior to the health care plan meeting. These meetings are held upon admission, quarterly & upon significant changes. Meetings are held to ensure that interventions are addressed as appropriate. The review prior to the health care plan meeting is new. Each team member will also be re-trained to look at the holistic needs of each resident in light of their discipline.</p> <p>3B. The Behavior Team (formerly consisting of the behavior management nurse, social worker, and pharmacist), will now include the behavior management nurse, social worker, pharmacist, and floor nurse (newly added). This newly defined team will utilize the GDR Tracking Tool (provided by pharmacy) on a monthly basis, which has the diagnoses and medications to ensure all residents are identified and all behavior care plans and</p>				

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	<p>the medication risperdal.</p> <p>On 2/26/14 at 2:00 p.m. an interview with Director Nursing Service indicated the Nurses are responsible for writing care plans for the resident and indicated the resident should have had a Care Plan in place for the medication risperdal.</p> <p>On 2/26/14 at 2:15 p.m. an interview with the Minimum Data Set Coordinator indicated it was the responsibility of the Nurses and Social Services to write a Care Plan for the medication risperdal.</p> <p>2. Resident #126's clinical record was reviewed on 2/26/14 at 9:00</p>		<p>interventions related to diagnoses and antipsychotic medications are properly addressed. In our previous system, the floor nurse was not involved with the review of the GDR tracking tool.</p> <p>3C. In the old system, the behavior care plan was not actively reviewed during the Behavior Management meetings. In our new system, the social workers will begin to actively review relevant care plans at the Behavior Management meetings (in addition to the current discussions related to medications, behaviors, interventions, etc.)</p> <p>4A. To focus QA efforts specifically toward the behavior management area of the care plan, Social workers will set up a system to monitor each other's behavior health care plans by reviewing three to six residents once per month using updated information provided by the monthly GDR list. The distribution of the GDR list from the behavior management nurse will trigger each social worker to perform this QA task.</p> <p>4B. As a more general QA measure, MDS nurses will also monitor three to six residents twice a month, taking a comprehensive look at all care plans for all residents.</p> <p>5. Systemic changes will be completed by March 29, 2014.</p>		

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	<p>A.M. The record indicated the resident was admitted to the facility on 10/13/13 and had diagnoses including, but not limited to, dementia without behavioral disturbances, depression, persistent mental disorder.</p> <p>Review of Resident #126's admission Minimum Data Set (MDS) of 10/25/13 indicated "Behavioral Symptom: Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually). A resident is in the criteria met category if he/she shows an increase in physically abusive behaviors directed toward others (E0200A) since admission." Resident #126 scored a 0 for the seven day review period preceding 10/25/13. Resident #126's 90 day MDS of 1/25/14 indicated the resident scored a 2, indicating behaviors occurred 4 to 6 days, but less than daily for the 7 day review period preceding 1/25/14.</p> <p>Review of Resident #126's health care plans indicated a health care plan for: depression started on 11/4/13: social isolation prevention and providing cognitive stimulation; psychotropic medications. The</p>						

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	<p>resident did not have a health care plan addressing adverse behaviors identified in the MDS of 1/25/14.</p> <p>Review of an Interdisciplinary Team (IDT) meeting of 12/17/13 for resident #126 indicated "Staff has documented her being resistive with care. She will become angry. Leaving her alone helps some. She wants to do things on her own. She also was barricading herself in her room and her closet door is being locked. Recommendations: Will evaluate her for the behavior program."</p> <p>Review of the IDT meeting of 1/16/14 indicated "staff has documented some physical abuse. She is resistive to receiving care."</p> <p>An interview with LPN #2 on 2/26/14 at 11:20 A.M. indicated Resident # 126 was not in the behavior program. LPN #2 indicated Resident #126 had no behavior health care plan due to her behaviors improving. LPN #2 indicated a resident is automatically in the behavior program with a health care plan for behavior if they are on a psychotropic medication or if the "Dementia Protocol" does not work. LPN #2 indicated the IDT evaluates</p>			

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	<p>if a resident is not easily redirected and then they will go on a behavior program with a behavior care plan.</p> <p>On 2/26/14 at 1:00 P.M., LPN #2 provided a copy of the "Dementia Protocol". LPN #2 indicated the Dementia Protocol is a generalized protocol provided by a Psychologist who treats some of the residents in the facility.</p> <p>On 2/26/14 at 1:55 P.M., the Director of Nursing Services (DNS) provided copies of the progress notes for resident #126 specific to mood and behavior, incident based, between 12/17/13, when the IDT recommended an evaluation for the behavior program, and 2/26/14. Between 12/21/13 and 2/25/14 Resident #126 had 27 incidents of behavior where intervention attempts were unsuccessful with stopping the behaviors. The behaviors included Resident #126 being: combative, resistive, constant walking, kicking, scratching, yelling, pulling hair, angry, aggressive, attempting to hit staff with her walker, swinging her fists.</p> <p>An interview with LPN #2 on 2/26/14 at 2:10 P.M. indicated Resident #126 should have been placed on</p>						

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	<p>an individualized behavior program with a health care plan as the resident had multiple episodes of adverse behaviors where the general "Dementia Protocol" interventions were not effective.</p> <p>Review of the policy provided by the DNS on 2/26/14 at 1:55 P.M., titled "MDS Procedures", dated 02/2004, and last updated 11/2011, indicated in the section Health Care Plan: #2: "Health Care Plans will be printed with admission MDS annually and with significant changes".</p> <p>3.1-35(a)</p>			

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F000428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on record review and interview, the facility failed to ensure timely response to pharmacy recommendations for 2 of 5 residents (#82 and #11) reviewed for Unnecessary Medications.</p> <p>Findings include:</p> <p>1. The record for Resident #82 was reviewed, at 10:00 a.m., on 2/25/14. Diagnoses included, but were not limited to: Major depression, Depressive episode with psychotic features, delirium, unspecified psychosis, and dementia. Review of current physician orders, dated 1/29/14, indicated orders for Risperdal(Risperidone) (an antipsychotic medication), 0.25 milligrams (mg.) by mouth, daily. The order indicated this medication was originally ordered on 8/31/13.</p> <p>Review of a Pharmacy Consultation Report, dated 11/21/13, indicated</p>	F000428	<p>Paper review is being requested. If approved, paper compliance will be sent to ISDH by March 29, 2014 for each tag. F428 – Drug Regimen Review, Report Irregular, Act On 1. Pharmacist recommendations for residents #82 and #11 have already been addressed by the physician. 2. All pharmacist recommendations on all residents have been addressed by the physician. 3A. D.O.N. met/discussed with appropriate physicians to ensure that the pharmacist recommendations are addressed on the next physician visit. If not addressed on a visit by the MD, the reason will be documented by the physician. 3B. Nurses will be in-serviced to follow up with physician to ensure pharmacist recommendations are addressed on the next physician visit (following the Behavior Management meeting). If the recommendation is not addressed at that time by the doctor, the reason will be clearly documented on the recommendation form. 3C. Any</p>	03/29/2014			

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	<p>the resident was receiving Risperidone 0.25 mg. daily for behavioral or psychological symptoms of dementia since 8/31/13. The Recommendation indicated, "Please re-evaluate the need for the continued use of Risperidone, perhaps considering a gradual dosage reduction to 0.125 mg. daily, with the end goal of discontinuation of therapy if possible.</p> <p>Handwritten at the top of the page indicated, "faxed to (psychiatrist's name) Nov (November) and Dec (December) 12/21(2013)"</p> <p>The Physician's response was checked to indicate, "I decline the recommendation (s) above because GDR(gradual dose reduction) is clinically contraindicated for this individual."</p> <p>Underneath this area was documented, "Currently stable. "</p> <p>This recommendation was not signed by the physician until 1/15/14 (7 weeks after the original pharmacy recommendation)</p> <p>Review of another Pharmacy Consultation Report, dated 12/20/13, indicated the resident was recently reviewed during the facility's behavior management committee meeting on 12/20/13. The recommendation again indicated the</p>		<p>recommendations needing immediate attention will be communicated directly to the physician or faxed to the physician for an immediate response. 3D. Pharmacist recommendations will be faxed to the psychiatrist or outside physicians. If the recommendations are not addressed within one week, (tracked by the nurse), the house physician will address the recommendation on next physician visit. 4. Pharmacist recommendation binders have been set up on each floor. All documentation related to recommendations will be photocopied onto colored paper for ease of monitoring in these binders. Once the pharmacy recommendation has been addressed by the doctor (and signed copy put back into the binder), the 'extra' colored copy of the recommendation will be removed from the binder & destroyed. In other words, 'open recommendations' that have not yet been addressed by the doctor will be on colored paper and located in a binder dedicated to this purpose. The D.O.N. will follow up on the day of or the day after the physician visit to ensure compliance. 5. This systemic change will be completed by March 29, 2014.</p>				

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	<p>Risperdal GDR was requested in November.</p> <p>LPN #2, was interviewed, at 11:41 a.m., on 2/25/14. She indicated the resident was admitted to the facility on 7/24/13, from a hospital behavioral unit, and had physician orders for Risperdal upon admission to the facility. She indicated the resident was seen by the facility psychiatrist on 8/31/13, and he decreased the Risperdal from 0.5 milligrams daily to 0.25 milligrams daily. The LPN indicated the reason for the reduction in medication was due to the resident being more withdrawn and spending a lot of time in her room. She indicated the resident did well after the reduction, was out of her room more, and was going to activities. She indicated the behavior team met monthly and included herself, the social worker, and the pharmacist.</p> <p>:</p> <p>LPN #1 was interviewed, at 11:32 a.m., on 2/26/14, and indicated she had faxed the pharmacy recommendation, dated 11/21/13, to the house psychiatrist in November 2013, but did not receive any response regarding the pharmacy recommendation, so faxed the</p>						

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	<p>recommendation to him again on December 21, 2013, but again did not receive any response. She indicated after not receiving any response from the psychiatrist, the resident was seen by the house physician on January 15, 2014, and he addressed the pharmacy recommendation at this time, but did not want to decrease the dose of Risperdal. She indicated the facility policy was not to have the psychiatrist and house physician involved regarding orders, at the same time, so she did not contact the house physician since the psychiatrist was already involved. She further indicated the physician was usually not contacted right away after a pharmacy recommendation because the physician normally wanted to see the resident before addressing pharmacy recommendations.</p> <p>2. Resident #11's clinical record was reviewed on 2/25/14 at 2:30 P.M. The record indicated a recommendation by a Consultant Pharmacist on 9/12/13. The report indicated "Comment: From Behavior Management Committee". The report noted resident #11 "had received Lorazepam (an antianxiety medication) 0.5 mg (milligrams) bid (twice daily). The recommendation</p>			

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	<p>was: "Please consider a gradual dose reduction, perhaps decreasing to Lorazepam 0.5mg A.M. and 0.25mg P.M. while concurrently monitoring for re-emergence of target and/or withdrawal symptoms. If therapy is to continue at the current dose, please provide rationale describing a dose reduction as clinically contraindicated." The physician's response was: "I accept the recommendation above, please implement as written." The physician signed the Consultant Report but did not date the form.</p> <p>Review of the Physician's orders for resident #11 indicated on 10/24/13 to decrease P.M. Lorazepam to 0.25mg. The original pharmacy recommendation to decrease Lorazepam was made six weeks before on 9/12/13 and was not addressed by the physician until 10/24/13.</p> <p>An interview with RN #7 on 2/25/14 at 2:50 P.M. indicated pharmacy recommendations went to LPN #2 who gave the recommendation form to the charge nurse for that particular resident. The charge nurse would then place the recommendation on the Doctor</p>				

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	<p>board which the physician reviewed weekly.</p> <p>An interview with LPN #2 on 2/26/14 at 9:30 A.M. indicated for resident #11 they had to contact the daughter/POA before the medication reduction. RN #2 indicated sometimes the Physician waited until they actually saw the residents before addressing the pharmacy recommendations.</p> <p>Review of the resident nurse's notes did not indicate any attempts to contact the physician regarding the pharmacy recommendation to reduce Lorazepam from 0.5mg BID to 0.5mg AM and 0.25mg PM between the pharmacy recommendation on 9/12/13 and 10/24/13.</p> <p>Review of the physician progress notes between 9/12/13 and 10/24/13 did not mention the pharmacy recommendation to reduce Lorazepam from 0.5mg BID to 0.5mg AM and 0.25mg PM between the pharmacy recommendation on 9/12/13 and 10/24/13.</p> <p>An interview with the Director of Nursing Services on 2/26/14 at 11:30 A.M. indicated the facility had</p>			

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	no policy on pharmacy recommendations. 3.1-25(j)			