

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155732	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/21/2013
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NAME OF PROVIDER OR SUPPLIER RIVEROAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1244 VAIL ST PRINCETON, IN 47670
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: June 12, 13, 14, 17, 18, 19, 20, 21, 2013</p> <p>Facility number: 004130 Provider number: 155732 AIM number: 200491050</p> <p>Survey team: Diane Hancock, RN TC Amy Winingger, RN Barbara Fowler, RN</p> <p>Census bed type: SNF 22 SNF/NF 35 Residential 31 Total 88</p> <p>Census payor type: Medicare 13 Medicaid 21 Other 54 Total 88</p> <p>Residential Sample: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F000000		
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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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	Quality review completed on June 29, 2013, by Jodi Meyer, RN			

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F000157 SS=D	<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 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 observation, interview, and record review, the facility failed to ensure the physician was immediately notified of a resident's suicide threat,</p>	F000157	Resident #104 no longer resides at the facility. There were no other residents affected by the alleged deficient practice and through corrective actions we will ensure residents with suicide threats	07/21/2013			

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	<p>for 1 of 34 residents in the Stage 2 sample who met the criteria for review of physician notification. (Resident #104)</p> <p>Finding includes:</p> <p>Resident #104 was observed sitting in a recliner reading the paper on 06/12/13 at 11:50 a.m.</p> <p>The clinical record of Resident #104 was reviewed on 06/18/13 at 12:11 p.m. The record indicated Resident #104 was admitted on 03/07/13 with diagnoses that included, but were not limited to, right total hip replacement, depression, anxiety, and hydrocephalus (fluid build up on the brain).</p> <p>The Admission MDS (Minimum Data Set Assessment) dated 03/14/13 indicated Resident #104 experienced mild cognitive impairment.</p> <p>A fax dated 05/13/13, addressed to the physician of Resident #104, was provided on 06/19/13 at 3:00 p.m. by UM (Unit Manager) #1. The fax included a handwritten note in the top left corner "notified [name of physician] 5/13/13." The fax further indicated, "FYI [for your information] Pt. [patient] has been angry and</p>		<p>have physicians notified immediately. Licensed nurses will be inserviced on procedure and requirement. DHS/designee will audit documentation for timeliness of physician notification of suicidal threats daily to ensure that timely M.D. response is achieved. Results of audits will be forwarded to QA committee for review of compliance and suggestions monthly x6 months and quarterly thereafter.</p>				

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	<p>irritated and stated, 'What if I killed myself' and pointed his finger to his head. I contacted Social Services." A return fax from the physician of Resident #104 included a date/time stamp of 05/14/13 at 10:58 a.m. During an interview on 06/19/13 at 3:10 p.m., Unit Manager #1 indicated the date/time stamp was when the return fax was received by the facility.</p> <p>A Mental Health Wellness Circumstance Investigation dated 05/13/13 indicated Resident #104 stated, "What if I killed myself..." The investigation further indicated the physician of Resident #104 was notified, but lacked any documentation of mode, date, or time.</p> <p>A Skilled Nursing Assessment and Data Collection form dated 05/13/13 indicated, "05/13/13 1600 [4:00 p.m.] Pt [patient] very upset could not get a hold of wife and stated she is lying to him pt is calmed down but talked about shooting himself. Notified family, [name of physician] and social services. Will continue to monitor."</p> <p>During an interview on 06/20/13 at 9:10 a.m., LPN #5 indicated, on 05/13/13 at approximately 4:00 p.m., Resident #104 was upset when the</p>				

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	<p>spouse did not answer the phone after repeated calls and made a negative statement in a frustrated tone. LPN #104 further stated, at that time, 'like what if this was an emergency'...I faxed Dr. [name] right before I left at 6:00 p.m., ...it was after office hours..."</p> <p>The policy and procedure for Guidelines for "Suicide Threats" provided by the DHS on 06/20/13 at 9:15 a.m. indicated, Purpose: to ensure resident suicide threats are taken seriously...2. The charge nurse shall notify the resident's attending physician, ..."</p> <p>During an interview on 06/20/13 at 9:15 a.m. the DHS (Director of Health Services) indicated the physician should have been notified immediately.</p> <p>During an interview on 06/20/13 at 11:20 a.m., the ED (Executive Director) indicated the physician should have been notified immediately by phone after the suicide threat was made by Resident #104.</p> <p>3.1-5(a)(2)</p>				

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F000164 SS=E	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>Based on observation, interview and record review, the facility failed to ensure privacy of personal information for 9 of 9 residents on the 300 unit, privacy during personal care for 1 of 10 residents on the 200 unit observed during Stage 1, and privacy during personal visit for 1 of 18</p>	F000164	Residents suffered no ill effects from the alleged deficient practice and through corrective action and inservicing we will ensure residents privacy is maintained. All residents have the potential to be affected and therefore through alterations in provisions of care, securing of personal information and inservicing will ensure that	07/21/2013

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	<p>residents interviewed during Stage 1, in the stage 1 sample of 30. (Resident #85, Resident #77, Resident #106, Resident #104, Resident #52, Resident #114, Resident #113, Resident #41, Resident #112, Resident #39, and Resident #55)</p> <p>Findings include:</p> <p>1. During the initial tour on 06/12/13 at 9:12 a.m., the 300 unit CNA Assignment Sheet with personal care information for Resident #85, Resident #77, Resident #106, Resident #104, Resident #52, Resident #114, Resident #113, Resident #41, and Resident #112 was observed to be in a wall file on the 300 unit with personal care information accessible to public view.</p> <p>2. The door of Resident #39 was observed to be closed to the hallway on 06/12/13 at 11:00 a.m. The door was then observed to be opened and CNA #5 was observed to be providing pericare to Resident #39 without the curtain pulled to the hallway.</p> <p>3. RCA (Resident Care Assistant) #5 was observed on 06/12/13 at 1:00 p.m. to enter the room of Resident #55 without knocking, announcing</p>		<p>privacy is maintained. All staff will be inserviced regarding personal information storage, care provisions and knocking. Systematic changes to ensure privacy is maintained includes placing assignment sheets in an expandable folder if in pocket on the wall, during provision of care to ensure room curtain pulled around the resident, knocking before entering resident room and staff will be inserviced on interpretive guidelines as it relates to privacy. DHS or designee will audit residents receiving care, personal information storage and staff actions 2/day 5x week for 2 weeks, then 5x week for 2 weeks and weekly thereafter. Results of audits will be submitted to QA committee monthly for 6 months and then quarterly for review and further recommendations.</p>				

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	<p>self, and without the permission of Resident #55.</p> <p>During an interview on 06/19/13 at 4:00 p.m., the DHS (Director of Health Services) indicated personal information should not be publicly accessible.</p> <p>During an interview on 06/19/13 at 4:05 p.m. the ED (Executive Director) indicated privacy curtains should always be used during personal care and staff should not enter a resident's room without knocking.</p> <p>3.1-3(o) 3.1-3(p)</p>			

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F000248 SS=D	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on interview, observation, and record review, the facility failed to provide activities to 1 of 3 residents reviewed for activities, in the sample of 6 residents who met the criteria for activities, in that the resident did not receive activities. (Resident #34)</p> <p>Finding includes:</p> <p>During an interview on 6/12/13 at 11:38 a.m., Resident #34 indicated she did not know if the facility had activities available in the evening and on weekends. Resident #34 indicated she did not attend activities but she would like to attend some of the programs. She indicated the staff did not encourage her to attend activities.</p> <p>Upon observation on 6/12/13 at 11:40 a.m., Resident #34 was lying in her bed.</p> <p>Upon observation on 6/14/13 at 9:40 a.m., Resident #34 was lying in her bed.</p>	F000248	Resident #34 had careplan reviewed and updated to include 1:1 activities when she chooses not to participate in group activity. All residents have the potential to be affected and through corrective actions we will ensure all residents receive activities based on assessment/careplans. All assessments/careplans will be reviewed by Resident Activity Director to ensure residents receive proper activities according to their assessment/plan. Executive Director or designee will audit careplans/assessments 6 random charts weekly for 2 months and then 2 charts weekly for 4 months. Results will be forwarded to QA monthly for 6 months and quarterly thereafter.	07/21/2013			

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	<p>Upon observation on 6/17/13 at 8:15 a.m., 12:10 p.m., and 2:35 p.m., Resident #34 was lying in bed.</p> <p>Upon observation on 6/18/13 at 8:00 a.m., 1:45 p.m., and 2:45 p.m., Resident #34 was lying in bed.</p> <p>The clinical record of Resident #34 was reviewed on 6/18/13 at 7:56 a.m. Resident #34 was admitted on 5/16/13 with diagnoses including, but not limited to, CVA (cerebral vascular accident) with right side hemiparesis, HTN (hypertension), expressive aphasia, and CHF (congestive heart failure).</p> <p>An activity care plan, dated 5/23/13, included the following interventions:</p> <ol style="list-style-type: none"> provide time for the resident to respond to various types of stimulation observe for dietary precautions due to the resident having a pureed diet with a 2000 cc fluid restriction, and honey-thickened liquids invite the resident's family to attend activities/socials with the resident encourage the resident to watch her favorite television (TV) shows praise the resident for any communication during activity 			

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	<p>f. offer simple choices to the resident in activity.</p> <p>A form, titled Resident Preference for Customary Routine and Activity Worksheet and dated 5/23/13, indicated Resident #34 interests included Solitaire (a card game), crafts, church, computer games, going on trips/shopping, watching TV, and crocheting or knitting. Resident #34 preferred to choose the clothes she wore, read books, be around pets/animals, keep up with the news, stay up past 8:00 p.m., receive snacks. The form indicated Resident #34 usually arose at 9:30 - 10:00 a.m. and her favorite food was pineapple milkshakes.</p> <p>The Activity Progress Note, dated 5/23/13 and obtained from the Medical Record Clerk (MRC) on 6/18/13 at 10:00 a.m., indicated Resident #34's interests included Solitaire (a card game), watching TV (especially Gunsmoke, Antique Roadshow, and CSI), playing on the computer, church, and crafts. The Activity Progress Note indicated on 6/4/13, Resident #34 had a verbal response to a dog visit.</p> <p>The "Daily Participation Log" for June, 2013, obtained from the Director of</p>			

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	<p>Resident Activity (DRA) on 6/18/13 at 10:30 a.m., indicated Resident #34 declined a visit on 5/23/13 but had enjoyed a dog visit on 6/5/13.</p> <p>During an interview with the DRA and TA (Transportation Associate) on 6/16/13 at 10:41 a.m., the DRA indicated Resident #34 required 1:1 activity visits. The DRA indicated Resident #34 had declined a visit from the activity department on 5/23/13. The DRA indicated Resident #34 was tired after physical therapy and did not want a visit at that time. The DRA indicated Resident #34 received sensory activity before meals in the dining room. The TA indicated Resident #34 had not been eating in the dining room but had been staying in her room for meals. The DRA indicated she did not realize the resident had not been eating in the dining room and therefore had not received any sensory activity. The DRA indicated the activity staff would need to increase the 1:1 visits with Resident #34.</p> <p>3.1-33(a)</p>			

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F000250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview, and record review, the facility failed to ensure social services were provided to a resident who made a suicide threat, for 1 of 1 resident who had a suicidal verbalization, in a Stage 2 sample of 34. (Resident #104)</p> <p>Finding includes:</p> <p>Resident #104 was observed sitting in a recliner reading the paper on 06/12/13 at 11:50 a.m.</p> <p>The clinical record of Resident #104 was reviewed on 06/18/13 at 12:11 p.m. The record indicated Resident #104 was admitted on 03/07/13 with diagnoses which included, but were not limited to, right total hip replacement, depression, anxiety, and hydrocephalus (fluid build up on the brain).</p> <p>The Admission MDS (Minimum Data Set Assessment) dated 03/14/13 indicated Resident #104 experienced mild cognitive impairment.</p>	F000250	Resident #104 no longer resides in the facility. Resident #104 is the only potential resident to be affected by the alleged deficient practice. All staff will be educated on suicidal threat procedures and licensed staff will be educated to immediately notify physician by phone, Director of Resident Services, Director of Health Services and Executive Director immediately. Director of Resident Services will initiate 15 minute checks and 1:1 as needed. Social Services or designee will monitor behaviors 5x week. Residents will be added to CAR meeting as needed. Results will be forwarded to QA monthly to address behaviors.	07/21/2013			

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	<p>A fax to the physician of Resident #104, dated 05/13/13, was provided on 06/19/13 at 3:00 p.m. by Unit Manager #1. The fax indicated, "FYI [for your information] Pt. [patient] has been angry and irritated and stated, 'What if I killed myself' and pointed his finger to his head. I contacted Social Services."</p> <p>A Mental Health Wellness Circumstance Investigation dated 05/13/13 indicated Resident #104 stated, "What if I killed myself...". The investigation lacked any documentation the Social Service person was notified.</p> <p>A Skilled Nursing Assessment and Data Collection form dated 05/13/13 indicated, "05/13/13 1600 [4:00 p.m.] Pt [patient] very upset could not get a hold of wife and stated she is lying to him pt is calmed down but talked about shooting himself. Notified ... social services. will continue to monitor."</p> <p>The Social Service Progress notes lacked any documentation between 05/09/13 and 05/14/13.</p> <p>An untimed Social Service progress note dated 05/14/13 indicated, "Staff</p>				

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	<p>report that res [resident] made negative statement yesterday evening...Worker talked to res this morning..."</p> <p>During an interview on 06/20/13 at 9:10 a.m., LPN #5 indicated, on 05/13/13 at approximately 4:00 p.m., Resident #104 "was upset when the spouse did not answer the phone after repeated calls and made a negative statement in a frustrated tone...I called social services, ..."</p> <p>During an interview on 06/20/13 at 11:08 a.m., the SSD (Social Services Designee) stated, "I was notified of the suicidal statement the next morning, on 05/14/13, during department head meeting.</p> <p>The policy and procedure for "Guidelines for Suicide Threats," provided by the DHS [Director of Health Services] on 06/20/13 at 9:15 a.m., indicated, "Purpose: to ensure resident suicide threats are taken seriously...8. Social Service staff shall be consulted to discuss the incident with the resident and provide ongoing assistance to prevent further occurrences of suicidal thoughts."</p> <p>During an interview on 06/20/13 at 9:15 a.m., the DHS indicated</p>						

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	<p>documentation was lacking in the clinical record related to assessment, follow-up, notifications, and monitoring of Resident #104 after a negative statement was made on 05/13/13. The DHS further indicated, at that time, the DHS, SSD, and the ED (Executive Director) should have been notified immediately.</p> <p>The Care Plan from 03/12/13 to 06/10/13 lacked any plan related to suicidal verbalizations.</p> <p>During an interview on 06/20/13 at 11:43 a.m., the SSD indicated there was not a care plan for suicidal verbalizations, but one would be made immediately.</p> <p>During an interview on 06/20/13 at 11:20 a.m., the ED indicated the policy for suicide threats was not followed, 15 minute checks were not initiated until 0600 on 05/14/13, the SD, DHS and ED were not notified until the next morning at department head meeting, and the physician should have been notified immediately by phone.</p> <p>3.1-34(a)</p>				

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F000253 SS=E	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interview, the facility failed to provide a clean and orderly environment, for 9 of 23 Stage 1 sampled rooms and 1 randomly observed room, in that paint was chipped and sinks were pulled away from the walls. This affected 15 residents who resided in those rooms. (Room 104, Room 105, Room 107, Room 112, Room 302, Room 303, Room 304, Room 308, Room 322, Room 312)</p> <p>Findings include:</p> <p>During initial tour on 6/12/13 at 9:15 a.m., the following was observed in resident rooms:</p> <ol style="list-style-type: none"> 1. Room 104 was observed to have paint chipped off of the bathroom wall. 2. Room 105 was observed to have paint chipped from around frame of the bathroom door and the bathroom wall had a large deep scratch with paint off. 3. Room 107 was observed to have 	F000253	<p>All residents have the potential to be affected. Rooms 104, 105, 107, 112, 302, 303, 304, 308 and 312 will be painted as needed and the sinks will be recaulked and repaired as necessary. All rooms will be checked monthly and upon moveout of a resident by the Director of Plant Operations to ensure painting and sinks are in good working order to ensure a comfortable interior. Executive Director or designee will check 4 rooms weekly for 2 months and then 2 rooms monthly x6 months. Results will be forwarded to QA for review of compliance.</p>	07/21/2013			

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	<p>the bathroom sink pulled away from the wall.</p> <p>4. Room 112 was observed to have the bathroom sink pulled away from the wall. The bathroom had plastic bins belonging to the residents under the left side of the sink.</p> <p>5. An interview with the Director of Plant Services (DPS), on 6/20/13 at 8:31 a.m., indicated he did not have a log kept for maintenance of the residents' rooms. The DPS indicated the residents' rooms were checked for any environmental services that may be required, when the resident was discharged or moved to another room. The DPS indicated maintenance was provided to the rooms when the room was scheduled to be deep cleaned.</p> <p>During an environment tour on 06/17/13 at 10:00 am. the following was observed:</p> <p>6. Room 302 bathroom sink was observed to be pulled away from the wall. The caulk between the wall and the sink was dried, yellowed and cracked.</p> <p>7. Room 303 bathroom sink was</p>			

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	<p>observed to be pulled away from the wall. The caulk between the wall and the sink was dried, yellowed and cracked.</p> <p>8. Room 304 bathroom sink was observed to be pulled away from the wall. The caulk between the wall and the sink was dried, yellowed and cracked.</p> <p>9. Room 308 bathroom sink was observed to be pulled away from the wall. The caulk between the wall and the sink was dried, yellowed and cracked.</p> <p>10. Room 311 bathroom sink was observed to be pulled away from the wall. The caulk between the wall and the sink was dried, yellowed and cracked.</p> <p>11. Room 312 bathroom sink was observed to be pulled away from the wall. The caulk between the wall and the sink was dried, yellowed and cracked.</p> <p>3.1-19(f)</p>			

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F000272 SS=D	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on observation, interview and record review, the facility failed to ensure 1 of 3 residents reviewed for pain, in the sample of 3 who met the criteria, were comprehensively</p>	F000272	Resident #26 has pain assessment completed and updated physician visit with careplan reflective of current orders and needs.All residents have the potential to be affected	07/21/2013

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	<p>assessed regarding pain, in that supporting assessments were not completed. (Resident #26)</p> <p>Findings include:</p> <p>On 6/13/13 at 9:50 a.m., Resident #26 was observed to be very stiff with a pained facial expression. The resident indicated he hurt all the time. When queried about any discomfort he was having, he indicated he had discomfort "24 hours a day" in his back and legs.</p> <p>On 6/14/13 15 12:31 p.m. Resident #26 indicated he always hurt, he was "just accustomed to it."</p> <p>On 6/17/13 at 9:35 a.m., the resident indicated he lived with pain, was always hurting. He indicated he took 3 pain pills a day or it would be worse. He indicated he didn't enjoy anything much anymore and was "just existing."</p> <p>Resident #26's clinical record was reviewed on 6/17/13 at 9:48 a.m. The resident was admitted to the facility on 10/31/12 with diagnoses including, but not limited to, hypertension, osteoarthritis, chronic pain, diabetes mellitus, and difficulty walking.</p>		<p>by the alleged deficiant practice and therefore have been interviewed and updates to assessments/careplans accordingly. Licensed nurses will be inserviced on pain assessments and documentation to ensure that daily/monthly pain assessments are complete and reflective of pain presence/relief and effects on daily routine or interests. DHS or designee will interview a random sample of 2 residents with pain or pain meds 5x week for 2 weeks, then 2 residents weekly for 3 months and 2 monthly thereafter. Results will be forwarded to QA committee monthly x6 months and quarterly thereafter for review and further suggestions.</p>				

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	<p>The Minimum Data Set [MDS] assessments dated 11/7/12, 2/5/13, and 4/23/13 indicated the resident had no pain. The MDS assessment dated 5/5/13 indicated the resident was on a scheduled pain medication, had occasional pain with no effect on sleep or activities of daily living, and the pain was mild.</p> <p>The resident had a physician's order, dated 4/24/13, for Oxycontin (narcotic pain medication) 10 milligrams by mouth three times a day for "chronic pain."</p> <p>The clinical record had a Monthly Nursing Assessment and Data Collection tool, dated 4/7/13, indicating the resident was on a scheduled pain regimen, but nothing about the frequency or intensity of the pain or whether or not it interfered with sleep or daily activities.</p> <p>The Monthly Nursing Assessment and Data Collection tool, dated 5/24/13, indicated the resident exhibited little interest in doing things. The pain assessment was incomplete, in that it only indicated the resident was on a scheduled pain regimen; it failed to indicate the presence of absence of pain, the frequency, intensity, or whether the</p>				

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	<p>pain interfered with sleep or daily activities.</p> <p>On 6/17/13 at 10:20 a.m., LPN #2 was interviewed regarding pain assessments. She indicated residents on daily charting were assessed daily. Otherwise, pain was addressed on the monthly assessments. She also indicated they asked residents during medication pass if they were in pain. She indicated Resident #26 did have complaints of pain, especially with any movement. He "has arthritis" and had pain in his knees and back.</p> <p>3.1-31(a)</p>				

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F000280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, interview and record review, the facility failed to ensure the care plan was revised to address pain management issues, change in discharge plan, and falls, for 3 of 34 Stage 2 sampled residents reviewed for care plans, in that the care plans were not revised to address changes in pain, changes in discharge planning, or falls. (Resident #38, #33, #104)</p> <p>Findings include:</p> <p>1. During interview, on 6/13/13 at 9:28 a.m., Resident #38 indicated she had back pain. She indicated she</p>	F000280	Resident #38 careplans have been reviewed/updated to reflect current pain relief, goals and interventions. Resident #33 has fall careplan updated. Resident #104 no longer resides in the facility. All department leaders and licensed nurses will be inserviced on careplanning and revision requirements to reflect current needs of resident. Systematic change is that the MDS Coordinator will update careplans during morning clinical review and as needed to capture current revisions. MDS Coordinator or designee will audit 4 random charts weekly x4 weeks and then 4 charts monthly for current careplanning interventions and	07/21/2013			

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	<p>had scoliosis, had a back brace she wore all the time, and wore pain patches all the time, but continued to have pain. She indicated she had falls recently.</p> <p>Resident #38's clinical record was reviewed on 6/14/13 at 11:22 a.m. The resident's Minimum Data Set (MDS) assessment, dated 3/19/13, indicated she had occasional mild pain.</p> <p>The record indicated the resident had experienced two falls as follows: 5/6/13 at 9:00 p.m., and 5/10/13 at 6:20 p.m. She complained of back and neck pain after the falls. A computerized tomography (CT) scan of the cervical spine was done on 5/13/13 and indicated the following impression: "There is severe intervertebral disc space narrowing at the C5-6 level, with mild retrolisthesis. Also severe intervertebral disc degeneration at the C6-7 level." "Multilevel degeneration, as above, negative for acute posttraumatic cervical osseous injury."</p> <p>A Monthly Summary, dated 5/25/13 at 10:00 a.m., included a pain assessment. The assessment indicated the resident was on</p>		goals based on resident orders, changes and wishes. Results of audits will be forwarded to QA committee monthly x6 months and quarterly thereafter for review and further suggestions.				

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	<p>scheduled pain regime, experienced moderate pain at an intensity of 6 to 8 out of 10, and vocalized pain in her back.</p> <p>Resident #38 had care plans for alteration in comfort related to arthritis, and for pain, dated 4/1/13. Goals included, but were not limited to, "pain/discomfort will be controlled..." "Resident will state/demonstrate relief or reduction in pain within one hour after receiving interventions."</p> <p>Physician's orders for pain medication, signed on 5/1/13, included the following: Acetaminophen 325 milligrams, two tablets by mouth three times a day. Fentanyl (narcotic pain medication) 100 micrograms per hour, one patch topically along with one patch with 25 micrograms per hour, to make a total of 125 micrograms per hour.</p> <p>On 6/14/13 at 11:45 a.m., Resident #38 was seated in the dining room. There was obvious curvature of her spine. She indicated she hurt all the time when up. she had a recent fall and "hurts all over." She indicated one leg was worse with "sciatic rheumatism." Did indicate some relief when she laid down. At that time,</p>			

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	<p>while up, the pain was rated at a level 8 out of 10.</p> <p>On 6/14/13 at 12:23 p.m., the resident still in the dining room awaiting lunch. Her head was down and she was holding her neck.</p> <p>The policy and procedure entitled "Guidelines for Pain Assessment and Management" (no date) was provided by the Administrator on 6/21/13 at 10:40 a.m. The procedure included, but was not limited to, the following: "Evaluate the effectiveness of pain management interventions and modify as indicated."</p> <p>There was no indication the care plan was revised to address the resident's increased pain at levels of 6 to 8 out of 10.</p> <p>2. Resident #33 was observed 6/12/13 at 9:30 a.m. sitting in a wheelchair with a pad alarm on the wheelchair.</p> <p>During an interview on 06/13/2013 at 10:37 a.m., RN #5 indicated Resident #33 had experienced a fall on 06/12/13 after an attempt to transfer independently. RN #5 further indicated, at that time, Resident #33 received an abrasion to the back left</p>						

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	<p>side of the head and was found on the floor by staff. RN #5 then indicated, at that time, the new intervention was to continue using the pad alarm.</p> <p>The clinical record of Resident #33 was reviewed on 06/17/13 at 9:45 a.m. The record indicated the diagnoses of Resident #33 included, but was not limited to, kidney cancer.</p> <p>The most recent annual MDS (Minimum Data Set Assessment), dated 5/29/13, indicated Resident #33 moderate cognitive impairment and had experienced no falls.</p> <p>A care plan for risk of falls dated 05/29/13 included, but was not limited to, "provide environmental adaptations."</p> <p>The most recent Fall Assessment, 05/18/13 at 6:00 a.m., indicated Resident #33 was a high risk to fall.</p> <p>A Fall Circumstance Assessment dated 06/12/13 indicated the intervention put in place after the fall of 06/12/13 was "continue pad alarm at all times."</p> <p>During an interview on 06/19/13 at 3:00 p.m., DHS (Director of Health</p>			

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	<p>Services) indicated the fall of Resident #33 on 06/12/13 had been discussed with the care plan team and it had been decided not to revise the plan of care with a new intervention.</p> <p>3. Resident #104 was observed sitting in a recliner reading the paper on 06/12/13 at 11:50 a.m.</p> <p>The clinical record of Resident #104 was reviewed at 06/18/13 at 10:23 a.m. The clinical record indicated Resident #104 had been admitted from home on 03/07/13 for a short term stay after having a right total hip replacement.</p> <p>The most recent MDS (Minimum Data Set Assessment), dated 03/14/13, indicated Resident #104 experienced mild cognitive impairment.</p> <p>The most recent PT (Physical Therapy) progress note dated 06/11/13 indicated, "Pt. (Patient) ... is to remain at the snf [Skilled Nursing Facility] until max rehab potential achieved..."</p> <p>A social services progress note, dated 05/30/13, indicated, "worker has talked with wife regarding lt [long term] plan of care for resident. Wife</p>			

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	<p>plans on res remaining longer term as resident is needing much assist with transfers and ambulation. She says she is not able to handle care at home unless [Resident #104] is able to transfer and ambulate more independently."</p> <p>A care plan dated 06/06/13 indicated a problem of, "resident/relative/ or representative expresses wish for return to home/apartment" with a goal to "return home with wife." Interventions included, but were not limited to, "provide services according to care plan in an effort to enhance optimum well being, discuss with resident family representative discharge planning process, arrange for transportation..." The care plan lacked any documentation r/t (related to) the change to needing long term placement.</p> <p>3.1-35(d)(2)(B)</p>				

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F000309 SS=G	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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 observation, interview and record review, the facility failed to ensure residents were assessed for and treated for on-going pain, for 2 of 3 residents reviewed for pain management in the sample of 3 who met the criteria. The residents indicated they were always in pain. (Residents #26, #38)</p> <p>Findings include:</p> <p>1. On 6/13/13 at 9:50 a.m., Resident #26 was observed to be very stiff and have a pained facial expression. He indicated he hurt all the time. He indicated he had discomfort 24 hours a day, mostly in his back and legs.</p> <p>On 6/14/13 at 12:31 p.m., Resident #26 was in the dining room for lunch. He indicated he was "just accustomed to having pain."</p> <p>On 6/17/13 at 9:35 a.m., the resident indicated he "lives with pain." Always hurting, takes 3 pain pills a day, or he</p>	F000309	Resident #26 had meds reviewed and careplan/assessment updated with staff inserviced on these needs. Resident #38 had meds reviewed and careplan/assessment updated with staff inserviced on these needs. All residents have the potential to be affected by the alleged deficient practice and therefore they have been reviewed to ensure pain is assessed and treated sufficiently. Licensed nurses will be inserviced on pain relief and medication management. DHS or designee will randomly interview residents identified with pain issues 2x a day 5 days a week x 2 weeks and 2 per week thereafter for tolerable levels of relief and functionality of normal routine. Results of audits will be forwarded to the QA committee monthly for 6 months and quarterly thereafter for review and further suggestions.	07/21/2013			

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	<p>thinks it would be worse. Thinks they've done all they can. Just "doesn't enjoy anything much anymore. Just existing."</p> <p>Resident #26's clinical record was reviewed on 6/17/13 at 9:48 a.m. The resident was admitted to the facility on 10/31/12 with diagnoses including, but not limited to, hypertension, osteoarthritis, chronic pain, diabetes mellitus, difficulty walking.</p> <p>The Minimum Data Set (MDS) assessments dated 11/7/12, 2/5/13, and 4/23/13 indicated no pain. The MDS dated 5/5/13 indicated the resident was on a scheduled pain medication, had occasional pain with no effect on sleep or activities of daily living, and the pain was mild.</p> <p>A Monthly Nursing Assessment and Data Collection tool, dated 5/24/13, indicated the resident exhibited little interest in doing things. The pain assessment on the monthly summary was not completed; it only indicated the resident was on a scheduled pain regime. None of the questions about frequency, intensity, interference with sleep or daily activities were answered.</p> <p>A 4/7/13 Monthly Summary also failed</p>			

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	<p>to address pain, only indicating the resident was on a scheduled pain regime.</p> <p>The resident had care plans for Alteration in Comfort related to arthritis, and for chronic pain, both initiated 11/8/12 and reviewed 5/15/13. Interventions included, but were not limited to, the following: Vitamin/mineral supplements Assist with activities of daily living Encourage consume diet Monitor for signs/symptoms of pain, swelling, redness Notify MD of changes... Pain meds per order Encourage exercise Handle gently... Position for comfort. Monitor and report to nurse, signs/symptoms of pain, worsening pain Report changes in location/type/frequency/intensity Provide comfort measures, relaxation techniques, repositioning... Administer, monitor effectiveness and for side effects from routine and as needed pain medication... Notify the resident's physician if they do not state/demonstrate relief or reduction of pain after one hour or receiving the first intervention.</p>			

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	<p>The resident had physician's orders for oxycontin 10 milligrams by mouth three times a day for chronic pain, dated 4/24/13.</p> <p>On 6/17/13 at 10:20 a.m., LPN #2 was interviewed regarding pain assessments. She indicated if the resident was on daily charting, they would assess pain daily. Otherwise, pain was addressed on the monthly assessment. She also indicated they asked residents during medication pass if they were in pain.</p> <p>She indicated Resident #26 did have complaints of pain, especially with any movement. He "has arthritis" and had pain in his knees and back.</p> <p>There was no indication the resident had a comprehensive assessment of his pain and care provided to address the on-going pain.</p> <p>2. During interview, on 6/13/13 at 9:28 a.m., Resident #38 indicated she had back pain. She indicated she had scoliosis, had a back brace she wore all the time, and wore pain patches all the time, but continued to have pain. She indicated she had falls recently.</p> <p>Resident #38's clinical record was</p>						

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	<p>reviewed on 6/14/13 at 11:22 a.m. The resident's Minimum Data Set (MDS) assessment, dated 3/19/13, indicated she had occasional mild pain.</p> <p>The record indicated the resident had experienced two falls as follows: 5/6/13 at 9:00 p.m., and 5/10/13 at 6:20 p.m. She complained of back and neck pain after the falls. A computerized tomography (CT) scan of the cervical spine was done on 5/13/13 and indicated the following impression: "There is severe intervertebral disc space narrowing at the C5-6 level, with mild retrolisthesis. Also severe intervertebral disc degeneration at the C6-7 level." "Multilevel degeneration, as above, negative for acute posttraumatic cervical osseous injury."</p> <p>A Monthly Summary, dated 5/25/13 at 10:00 a.m., included a pain assessment. The assessment indicated the resident was on scheduled pain regime, experienced moderate pain at an intensity of 6 to 8 out of 10, and vocalized pain in her back.</p> <p>Resident #38 had care plans for alteration in comfort related to</p>						

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	<p>arthritis, and for pain, dated 4/1/13. Goals included, but were not limited to, "pain/discomfort will be controlled..." "Resident will state/demonstrate relief or reduction in pain within one hour after receiving interventions." Interventions included, but were not limited to, the following: Vitamin/mineral supplements per orders Encourage to consume 70% of diet Assist with activities of daily living as needed Monitor for signs/symptoms of pain Notify MD of changes as needed Pain meds per order Encourage exercise balanced with rest and weight reduction to affected joints if needed... Report changes in pain location, type frequency intensity to physician Administer, monitor effectiveness and for side effects from routine and as needed pain medication.</p> <p>Physician's orders for pain medication, signed on 5/1/13, included the following: Acetaminophen 325 milligrams, two tablets by mouth three times a day. Fentanyl (narcotic pain medication) patch 100 micrograms per hour plus Fentanyl patch 25 micrograms per hour to total 125 micrograms per</p>			

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	<p>hour.</p> <p>On 6/14/13 at 11:45 a.m., Resident #38 was seated in the dining room. There was obvious curvature of her spine. She indicated she hurt all the time when up. she had a recent fall and "hurts all over." She indicated one leg was worse with "sciatic rheumatism." Did indicate some relief when she laid down. At that time, while up, the pain was rated at a level 8 out of 10.</p> <p>On 6/14/13 at 12:23 p.m., the resident still in the dining room awaiting lunch. Her head was down and she was holding her neck.</p> <p>There was no indication the effectiveness of the resident's pain regime was being assessed, with on-going pain at levels of 6 to 8 out of 10.</p> <p>3. The policy and procedure for "Guidelines for Pain Assessment and Management" (no date) was provided by the Administrator on 6/21/13 at 10:40 a.m. The purpose of the policy was "to ensure each resident's pain including its origin, location, severity, alleviating and exacerbating factors, current treatment and response to treatment will be</p>				

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	<p>assessed/reassessed and documented according to the needs of each individual."</p> <p>The procedure included, but was not limited to, the following: "Assessment of resident pain should be completed as part of the Admission Nursing Assessment...Ongoing assessment will be documented on the Monthly Nursing Summary..." "The assessment should include self report of pain or for those cognitively impaired and unable to self-report level of pain the assessor shall observe the resident..." "Initiate a Plan of care related to chronic, acute or breakthrough pain." "If there is a change in pain indicators or verbalizations from resident, a pain circumstance form will be completed to indicate changes and care plan update..." "Implement the care plan approaches to assist with pain management." "Evaluate the effectiveness of pain management interventions and modify as indicated."</p> <p>3.1-37(a)</p>				

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F000329 SS=G	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview and record review, the facility failed to ensure each resident was free from unnecessary drugs, for 2 of 10 residents reviewed for unnecessary drugs, in that one resident (Resident #104) was on multiple psychoactive medications without indications for their use and/or monitoring, and one resident (Resident #16) was given a non-steroidal anti-inflammatory medication with a history of gastrointestinal bleeding. Resident</p>	F000329	Resident #104 no longer resides at the facility. Resident #16 returned from the hospital with revised medication regimen which has been reviewed by primary physician and a pharmacist for interactions with noted intolerance to NSAIDS. All residents have the potential to be affected by the alleged deficient practice and have been reviewed by pharmacist for drug interaction possibilities, diagnosis for use and evaluation of necessity. Licensed nurses will be inserviced on medications and	07/21/2013			

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	<p>#16 was admitted to the hospital with gastro-intestinal bleeding.</p> <p>Resident #104, #16</p> <p>Findings include:</p> <p>1. On 6/14/13 at 3:30 p.m., Resident #16 was observed being prepared to be transported to the hospital. The Assistant Director of Nursing indicated the resident was being transferred due to reporting she was having bloody bowel movements.</p> <p>Resident #16's clinical record was reviewed on 6/17/13 at 9:00 a.m. The resident was admitted to the facility on 4/19/07. The resident's diagnoses included, but were not limited to, diverticulosis, hypertension, rehab, history of gastro-intestinal hemorrhage, anemia related to blood loss, gastric polyps, and history of pandiverticulitis.</p> <p>A physician's progress note, dated 5/18/13, indicated the resident's abdomen had mild tenderness mostly on the right side. He indicated the resident wasn't having significant abdominal pain. She was having neck pain and headaches. He opted to start her on Mobic (non-steroidal anti-inflammatory medication) for the</p>		<p>side effects monitoring as wekk as communicaiton of these to MD and pharmacist. Unit Manager or designee will monitor medicaiton orders received to communicate concerns of possible adverse reactions and or from potential drug interactions with NSAIDS. Pharmacist audit being forwarded to QA committee monthly x12 months for review and further suggestion.</p>				

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	<p>neck pain.</p> <p>The physician ordered Mobic 15 milligrams by mouth daily with food, on 5/15/13, due to cervical spine degenerative joint disease. The recapitulation of physician's orders, signed on 5/18/13, included, but was not limited to, an order for aspirin 81 mg by mouth daily for history of a cerebrovascular accident.</p> <p>The resident had a care plan, dated 1/26/13 and reviewed 4/2/13, for being at risk for bleeding due to a history of gastro-intestinal bleeding and hemorrhoids. Goals included being free from signs and symptoms of bleeding and hematocrit and hemoglobin levels at acceptable range. Interventions included, but were not limited to, assessing for signs of bleeding, and reporting to the physician any abnormal bleeding.</p> <p>Nurses' notes, dated 6/14/13 at 2:25 p.m., indicated the following, "Resident has been having rectal bleeding since this a.m. Resident notified this nurse @ 11:30 a.m. Stated she had been having problems since early morning. Stated she had been passing clots along with blood. Also has abd [abdominal] pain occurring. Received order from Dr.</p>				

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NAME OF PROVIDER OR SUPPLIER RIVEROAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1244 VAIL ST PRINCETON, IN 47670
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	<p>[name] to send to [name of hospital] ER [Emergency Room]."</p> <p>Unit Manager #1 was interviewed on 6/19/13 at 10:25 a.m. She indicated she thought the resident was put on the Mobic for arthritic pain. At 10:45 a.m., Unit Manager #1 indicated she had been told the resident was scoped at the hospital and diagnosed with diverticulitis and hemorrhoids.</p> <p>The Director of Nurses provided a copy of the Colonoscopy Procedure report, dated 6/18/13, on 6/20/13 at 4:00 p.m. The report indicated the preoperative diagnosis was hematochezia (bright red blood in stool). The postoperative diagnosis was diverticulosis and external hemorrhoids. The details of the scope indicated "...Large inflamed, external hemorrhoids are present. Multiple diverticula are noted in the left colon. Blood is present in transverse and left colon..."</p> <p>The 2010 Nursing Spectrum Drug Handbook was reviewed on 6/21/13 at 12:05 p.m. Regarding Meloxicam (Mobic), there was a "Boxed Warning." The warning included, but was not limited to, the following: "Drug increases risk of serious GI [gastrointestinal] adverse events,</p>			

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	<p>including bleeding, ulcers, and stomach or intestinal perforation. These events can occur at any time during use and without warning. Elderly patients are at greater risk." "Interactions Drug-drug...Aspirin: increased meloxicam blood level, increased risk of toxicity."</p> <p>2. Resident #104 was observed sitting in a recliner reading the paper on 06/12/13 at 11:50 a.m.</p> <p>The clinical record of Resident #104 was reviewed on 06/18/13 at 12:11 p.m. The record indicated Resident #104 was admitted on 03/07/13 with diagnoses which included, but were not limited to, right total hip replacement, depression, anxiety, and hydrocephalus (fluid build up on the brain).</p> <p>The admission MDS (Minimum Data Set Assessment), dated 03/14/13, indicated Resident #104 experienced mild cognitive impairment.</p> <p>A hospital history and physical, dated 03/04/13, indicated Resident #104 worked part-time on a farm prior to hip surgery.</p>						

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	<p>The May 2013 Physician Order Recap indicated the following: Ativan (antianxiety medication) 0.5 mg (milligrams) tid (three times daily) for anxiety was started on 03/13/13, Ultracet (pain medication) 37.5 mg two tablets po tid for pain was started on 3/13/13, Trazodone (antianxiety medication) was revised from 50 mg to 100 mg at hs (bedtime) with food for depression on 04/06/13, and Risperidone (antipsychotic medication) 0.25 mg bid (twice daily) was started on 04/20/13 for a behavioral disorder,</p> <p>The Behavior Symptoms Detail Report from 03/07/13 through 04/06/13 lacked any documentation of behaviors.</p> <p>The Nurse's Notes from 03/07/13 through 06/19/13 lacked any documentation of anxiety, pain, behaviors, or depression.</p> <p>A Mental Health Wellness Circumstance, Assessment and Inter-(sic), dated 03/08/13, indicated Resident #104 had an episode of verbally yelling out with mood swings with the following signs of depression: anxious, irritable, persistent anger, change in mood. The monitoring tool</p>						

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	<p>indicated no further behavior episodes occurred during the next 72 hours.</p> <p>A Mental Health Wellness Circumstance, Assessment and Inter-(sic), dated 03/13/13, indicated Resident #104 had a verbal episode of mood swings and repetitive verbalization with the following signs of depression: anxious, irritable, persistent anger. The monitoring tool indicated the behavior recurred once during the first 24 hours, but was successfully re-directed. The monitoring tool further indicated the behavior did not recur in the next 48 hours.</p> <p>A Skilled Nursing Assessment and Data Collection, dated 03/28/13, indicated Resident #104 had no mood or behavior issues.</p> <p>A Skilled Nursing Assessment and Data Collection, dated 03/31/13, indicated Resident #104 had no mood or behavior issues.</p> <p>A Skilled Nursing Assessment and Data Collection, dated 04/05/13, indicated Resident #104 had no mood or behavior issues.</p> <p>A Skilled Nursing Assessment and</p>						

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	<p>Data Collection, dated 04/07/13, indicated Resident #104 had no mood or behavior issues.</p> <p>A Mental Health Wellness Circumstance, Assessment and Inter-(sic), dated 04/20/13, indicated Resident #104 experienced the following signs of depression: anxious, irritable, and persistent anger. The monitoring tool indicated no further behaviors occurred in the following 72 hours.</p> <p>The Hospital Aftercare Instructions dated 06/18/13 included, but was not limited to, a recommendation for "review and minimize ...medication..." and diagnoses included, but were not limited to, " polypharmacy..."</p> <p>During an interview on 06/19/13 at 11:35 a.m., UM (Unit manager) #1 indicated there was no documentation of why the medications were started or changed. UM #1 further indicated, at that time, documentation in the clinical record was lacking and had been an issue for some time.</p> <p>During an interview on 06/19/13 at 10:45 a.m., the Director of Health Services (DHS) indicated Resident #104 had experienced behavior problems since admission to the</p>				

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	<p>facility.</p> <p>3.1-48(a)(3)</p> <p>3.1-48(a)(4)</p> <p>3.1-48(a)(6)</p> <p>3.1-48(b)(1)</p> <p>3.1-48(b)(2)</p>			

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F000332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5%, for 1 of 8 residents observed during medication pass, in that an insulin was given after a resident had refused her meal and medications were not given according to the physician orders. Two (2) medication errors were observed during 25 opportunities for error. This resulted in an error rate of 8%. (Resident #21)</p> <p>Findings include:</p> <p>The clinical record of Resident #21 was reviewed on 6/14/13 at 2:22 p.m. Resident #21 had diagnoses including, but not limited to, diabetes mellitus, hypertension (HTN), coronary artery disease (CAD), and obesity. The BIMS (Brief Interview for Mental Status) for Resident #21 was 15, indicating no cognitive impairment.</p> <p>Resident #21 had a recap physician's order, dated 5/2/13, for Humalog insulin 100 units/ml 10 units</p>	F000332	<p>Resident #21 suffered no ill effects from the alleged deficient practice and staff that administer medicine for her have been inserviced.LPN #1 and LPN#2 have completed medication administration course and have had a med pass observation completed. All other staff that pass meds will be inserviced.All residents receiving medication have the potential to be affected by the alleged deficient practice and through inservicing and observations will ensure medications are given as ordered.DHS or designee will perform medication pass monthly for 6 months and then quarterly. Continue will pharmacist audits every 60 days.Results of audits will be forwarded to QA committee monthly x6 months and then quarterly for review and further suggestion.</p>	07/21/2013			

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	<p>subcutaneous daily before meals.</p> <p>Resident #21 had a physician's order, dated 6/3/13, indicating Novolog insulin was to be started and the Humalog insulin was discontinued.</p> <p>Resident #21 had a recap physician's order, dated 5/2/13, for Metoprolol 25 mg orally two (2) times a day. The Metoprolol was to be held for a heart rate less than 60 or a systolic blood pressure less than 90.</p> <p>1. During a blood sugar check, on 6/17/13 at 12:10 p.m., Resident #21 indicated to LPN #2 she would not be eating lunch. Resident #21 indicated she had not eaten lunch for the past 2-3 days. LPN #2 educated Resident #21 regarding receiving insulin without eating and offered the resident substitute foods. Resident #21's blood sugar was 145 at 1210. LPN #2 indicated she would give Resident #21 her routine insulin and she would recheck her blood sugar at 1:30 p.m. Resident #21 indicated she would be leaving for the library at 1:30 p.m. LPN #2 indicated she would recheck her blood sugar prior to her departure.</p> <p>During the observation of a medication pass on 6/17/13 at 12:14 p.m., Licensed Practical Nurse (LPN) #2 was observed to be giving</p>			

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	<p>Resident #21 Novolog insulin 100 units/ml (milliliter) 10 units subcutaneous into the abdomen.</p> <p>During an interview on 6/17/13 at 2:05 p.m., LPN #2 indicated Resident #21's blood sugar at 1:15 p.m. was 98. LPN #2 indicated Resident #21 had taken peach yogurt to the library with her. LPN #2 indicated the dietician had been notified regarding Resident #21's refusal of lunch. LPN #2 indicated Resident #21 had informed her she was trying to lose weight.</p> <p>During an interview on 6/19/13 at 10:02 a.m., Resident #21 indicated she had eaten the peach yogurt at approximately 2:00 p.m. on 6/17/13, while at the library. Resident #21 indicated she did not have any symptoms of hypoglycemia and the dietician had not spoken with her. Resident #21 indicated she had not eaten lunch in an attempt lower her blood sugar and lose weight.</p> <p>During an interview on 6/19/13 at 10:16 a.m., LPN #1 indicated Novolog insulin was to be given 15 minutes prior to the resident eating.</p> <p>During an interview on 6/19/13 at 10:00 a.m. with the DoN (Director of</p>			

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	<p>Nursing) and the UM (Unit Manager), the DoN indicated Resident #21 had eaten a piece of chicken breast for lunch on 6/17/13. The UM indicated Resident #21 had eaten a chicken sandwich at approximately 1:00 p.m. on 6/17/13.</p> <p>During an interview on 6/19/13 at 11:10 a.m., Food Service Associate (FSA) #1 indicated Resident #21 had not eaten lunch but had been given peach yogurt to take with her to the library. FSA #1 indicated Resident #21 had eaten at suppertime on 6/17/13.</p> <p>During an interview on 6/19/13 at 12:13 p.m., the DoN indicated the dietician visited the facility weekly. The DoN indicated she had spoken with the dietician regarding Resident #21. The DoN indicated the dietician had educated Resident #21 in the past regarding her meal intake and would meet with Resident #21 next week.</p> <p>A form, titled "Meal Intake Detail Report," and obtained from RN #1 on 6/19/13 at 9:45 a.m., indicated Resident #21 lunch intake for 6/15/13, 6/16/13, and 6/17/13 was 100%.</p> <p>During an interview on 6/19/13 at</p>			

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	<p>12:15 p.m., the MDS (Minimum Data Set) Coordinator indicated she had spoken with the Certified Nursing Assistant (CNA) #1 who informed her she had documented 100% for Resident #21's lunch on 6/17/13. CNA #1 indicated she had assumed Resident #21 had eaten all of the yogurt at the library.</p> <p>2. During observation of a medication pass on 6/19/13 at 8:37 a.m., LPN #1 indicated she had obtained Resident #21's blood pressure (B/P) earlier. She indicated Resident #21 would not be receiving Metoprolol. LPN #1 indicated Resident #21 had a B/P of 124/54 and Resident #21 was not to receive the medication for a B/P less than 90.</p> <p>During further query of LPN #1 on 6/19/13 at 9:15 a.m., LPN #1 indicated she did not administer the Metoprolol to Resident #21 because her heart rate was less than 90. LPN #1 then indicated Resident #21 should have received the Metoprolol. Resident #21's heart rate was not documented on Resident #21's B/P record.</p> <p>3.1-25(b)(9)</p>			

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F000371 SS=E	<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, interview and record review, the facility failed to ensure food was stored in a sanitary manner, in 1 of 1 kitchen, in that food in the freezer was observed to be uncovered/opened. This had the potential to affect all residents in the facility who ate from frozen foods.</p> <p>Findings include:</p> <p>On 6/12/13 at 9:22 a.m., the following was observed in the walk-in freezer: -opened/unsealed plastic packages of breaded fish -opened/unsealed plastic packages of chicken tenders -opened/unsealed packages of waffles -a large container of orange sherbet with no lid or cover -a large container of rainbow sherbet with no lid or cover</p> <p>On 6/18/13 at 9:28 a.m., the walk-in freezer was observed to have one box of breaded fish filets with the</p>	F000371	All residents have the potential to be affected.All food will be stored in a sanitary manner. Frozen food items will be enclosed properly in packaging or placed in a proper container after opening.Director of Food Services or designee will spot check the freezer 4 times daily for 2 months and then 1x daily for 4 months.Results will be forwarded to QA monthly for 6 months for review of compliance.	07/21/2013			

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	<p>plastic bag open and fish exposed to the air.</p> <p>On 6/19/13 at 9:32 a.m., the walk-in freezer was observed again. There were opened plastic package of breaded fish filets and opened plastic package of sausage links in the freezer.</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p>			

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F000431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & 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, interview, and record review, the facility failed to ensure ophthalmic drops and ointment were dated when opened, in</p>	F000431	Residents #2,21,40,57,65 and 73 meds were dated according to the fill date and there were no ill effects suffered by these residents.All residents have the	07/21/2013

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	<p>1 of 3 medication carts checked for proper labeling and storage of medications. (Unit 100 medication cart) This affected 6 residents. (Resident #2, Resident #21, Resident #40, Resident #57, Resident #65, Resident #73)</p> <p>Finding includes:</p> <p>An observation of the 100 unit medication cart was made on 6/19/13 at 8:45 a.m. The following ophthalmic drops and ophthalmic ointments were observed to be opened but not dated when opened:</p> <p>Resident # 2 - Combigan Ophthalmic Solution and Travatan Z Ophthalmic Solution</p> <p>Resident #21 - Artificial Tears Ophthalmic Solution</p> <p>Resident #40 - Lumigan 0.01% Ophthalmic Solution</p> <p>Resident #57 - Travatan Z Ophthalmic Solution and Sodium Chloride 5% Ophthalmic Solution</p> <p>Resident # 65 - Artificial Tears Ophthalmic Solution and Artificial Tears Ointment x 2 tubes</p> <p>Resident #73 - Timilol 0.05% Ophthalmic Solution</p>		<p>potential to be affected by the alleged deficient practice and through inservicing will prevent recurrence. Nursing staff will be inserviced on appropriately dating when opening vials or bottles. DHS or designee will review eye meds and other bottle/multidose vials for appropriate date of opening on container 5x week x 2 week, 2x/week for 6 weeks and weekly thereafter. In addition pharmacy tech will audit med carts for appropriate storage of meds quarterly. Audits will be forwarded to QA committee monthly x12 months for review and to ensure compliance with requirement.</p>				

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	<p>During an interview on 6/19/13 at 8:45 a.m., LPN #1 indicated ophthalmic solutions and ophthalmic ointments are to be dated when they are opened. LPN #1 indicated ophthalmic solutions and ointments are good for 60 days after they are opened.</p> <p>A document titled, "Recommended Expiration Dates," dated 10/3/09, and obtained from the MDS (Minimum Data Set) Coordinator on 6/19/13 at 11:55 a.m., indicated ophthalmic solution and ointments are to be discarded six (6) months from the date opened.</p> <p>3.1-25(m)</p>			

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F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview and record review, the facility failed to</p>	F000441	Resident #19 suffered no ill effects and through corrective	07/21/2013			

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	<p>ensure infection control procedures were followed to prevent potential infection, for 1 of 5 residents observed receiving personal care, in that the CNA failed to change soiled gloves and wash hands prior to handling clean items. (Resident #19)</p> <p>Finding includes:</p> <p>On 6/18/13 at 9:40 a.m., CNA #6 was observed to provide personal care for Resident #19. The resident was incontinent of urine and bowel. The resident was wearing an incontinence brief and was laying in bed.</p> <p>The CNA donned gloves and proceeded to wash the front perineal area. She used one wash cloth, wiping and re-wiping over the same areas, with minimal attempt to use clean parts of the cloth.</p> <p>When gloves were visibly soiled, the CNA changed gloves; no handwashing was completed between the soiled and clean gloves. The CNA continued to clean feces from the resident's front and back perineal areas. When she was done, she wore the same gloves to get a clean incontinence brief and handle clean linens. When done, she removed the gloves, used alcohol gel on her hands</p>		<p>actions and inservicing including CNA #6 will ensure that resident care and handwashing procedures are carried out to prevent possible contamination. CNA#6 will have directed inservice with infection control procedures, observation of personal care for infection control procedures and handwashing, gloving and sanitizer use. All residents have the potential to be affected by the alleged deficient practice and through alterations in processes and inservicing will ensure corrective actions to prevent spread of infection are followed. Nursing staff will be inserviced on proper handwashing and glove usage procedures to prevent spreading infection including handwashing and glove application/changing. DHS or designee will monitor resident care that includes handwashing/glove usage after care and techniques of all care provided 5x/week for 3 weeks, 3xweek for 2 months and then weekly. Results of audits will be forwarded to QA committee monthly x6months and quarterly thereafter for review and further suggestions/comments.</p>				

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	and left the room. 3.1-18(b)(1)				

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F000514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on observation, interview, and record review the facility failed to ensure documentation was complete and accurate for 1 of 34 residents reviewed in stage 2, in that the cliinical record was incomplete following a threat of suicide, and the record lacked documentation of behaviors requiring the continued use of psychoactive medications for Resident #104.</p> <p>Findings include:</p> <p>The clinical record of Resident #104 was reviewed on 06/18/13 at 12:11 p.m. The record indicated Resident #104 was admitted on 03/07/13 with diagnoses which included, but were not limited to, Right Total Hip</p>	F000514	Resident #104 no longer resides in the facility. Resident #104 is the only potential resident to be affected by the alleged deficient practice. All staff will be educated on suicial threat procedures and licensed staff will be educated to immediately notify physician by phone, Director of Resident Services and Director of Health Services immediately. Director of Resident Services will initiate 15 minute checks and 1:1 as needed. All staff will be educated to report behaviors to resident charge nurse immediately and the nurse will document all behaviors timely. Director of Health Services or designee will monitor behavior charting in caretracker 5x week for 2 months and then 3x week for 4 months. Results will be forwarded to QA monthly to address behaviors.	07/21/2013			

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	<p>Replacement, depression, anxiety, and hydrocephalus (fluid build up on the brain).</p> <p>A Mental Health Wellness Circumstance Investigation dated 05/13/13 indicated Resident #104 stated, "What if I killed myself..." The investigation further indicated the physician of Resident #104 was notified but lacked any documentation of mode, date, or time. The investigation lacked any documentation the Social Service person or the DHS was notified.</p> <p>The Social Service Progress notes lacked any documentation between 05/09/13 and 05/14/13.</p> <p>During an interview on 06/20/13 at 9:10 a.m., LPN #5 indicated the documentation in the clinical record was lacking specific information related to the follow-up and monitoring of Resident #104 after a suicide threat.</p> <p>The policy and procedure for "Guidelines for Suicide Threats" provided by the DHS [Director of Health Services] on 06/20/13 at 9:15 a.m. indicated, Purpose: to ensure resident suicide threats are taken seriously... 7. Documentation of the</p>			

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	<p>incident will be recorded in the resident's medical record. The incident will be noted on the 24 hour report. Nursing documentation will be completed each shift to determine stabilization or further concerns of the resident..."</p> <p>During an interview on 06/20/13 at 9:15 a.m. the DHS indicated documentation was lacking in the clinical record related to assessment, follow-up, notifications, and monitoring of Resident #104 after a negative statement was made on 05/13/13.</p> <p>The clinical record lacked any documentation from 03/12/13 to 06/10/13 related to a plan for suicidal verbalizations.</p> <p>During an interview on 06/20/13 at 11:43 a.m. the SSD indicated there was not a care plan for suicidal verbalizations.</p> <p>During an interview on 06/20/13 at 12:27 p.m. LPN #6 indicated she had worked from 05/13/13 at 6:00 p.m. to 05/14/13 at 6:00 a.m. LPN #6 further indicated, at that time, Resident #104 slept without disturbance through the night with the door open to the hall for monitoring. LPN #6 then indicated</p>			
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	<p>she did not document anything related to the suicidal verbalizations of Resident #104.</p> <p>The Admission MDS (Minimum Data Set Assessment) dated 03/14/13 indicated Resident #104 experienced mild cognitive impairment.</p> <p>A hospital history and physical dated 03/04/13 indicated Resident #104 worked part-time on a farm prior to hip surgery.</p> <p>The May 2013 Physician Order Recap indicated the following: Ativan (antianxiety medication) 0.5 mg (milligrams) tid (three times daily) for anxiety was started on 03/13/13, Ultracet (pain medication) 37.5 mg two tablets po tid for pain was started on 3/13/13, Trazodone (antianxiety medication) was revised from 50 mg to 100 mg at hs (bedtime) with food for depression on 04/06/13, and Risperidone 0.25 mg bid (twice daily) was started on 04/20/13 for a behavioral disorder,</p> <p>The Behavior Symptoms Detail Report from 03/07/13 through 04/06/13 lacked any documentation of behaviors.</p>			

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	<p>The Nurse's Notes from 03/07/13 through 06/19/13 lacked any documentation of anxiety, pain, behaviors, or depression.</p> <p>A Mental Health Wellness Circumstance, Assessment and Inter-(sic), dated 03/08/13, indicated Resident #104 had an episode of verbally yelling out with mood swings with the following signs of depression: anxious, irritable, persistent anger, change in mood. The monitoring tool indicated no further behavior episodes occurred during the next 72 hours.</p> <p>A Mental Health Wellness Circumstance, Assessment and Inter-(sic), dated 03/13/13, indicated Resident #104 had a verbal episode of mood swings and repetitive verbalization with the following signs of depression: anxious, irritable, persistent anger. The monitoring tool indicated the behavior recurred once during the first 24 hours, but was successfully re-directed. The monitoring tool further indicated the behavior did not recur in the next 48 hours.</p> <p>A Skilled Nursing Assessment and Data Collection, dated 03/28/13, indicated Resident #104 had no mood</p>			

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	<p>or behavior issues.</p> <p>A Skilled Nursing Assessment and Data Collection, dated 03/31/13, indicated Resident #104 had no mood or behavior issues.</p> <p>A Skilled Nursing Assessment and Data Collection, dated 04/05/13, indicated Resident #104 had no mood or behavior issues.</p> <p>A Skilled Nursing Assessment and Data Collection, dated 04/07/13, indicated Resident #104 had no mood or behavior issues.</p> <p>A Mental Health Wellness Circumstance Assessment and Inter-(sic), dated 04/20/13, indicated Resident #104 experienced the following signs of depression: anxious, irritable, and persistent anger. The monitoring tool indicated no further behaviors occurred in the following 72 hours.</p> <p>During an interview on 06/19/13 at 11:35 a.m., UM (Unit manager) #1 indicated there was no documentation of why the medications were started or changed. UM #1 further indicated, at that time, documentation in the clinical record was lacking and had been an issue for some time.</p>				

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	<p>During an interview on 06/19/13 at 10:45 a.m., the DHS indicated Resident #104 had experienced behavior problems since admission to the facility.</p> <p>3.1-50(a)(1)</p>			

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F000518 SS=F	<p>483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS</p> <p>The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures.</p> <p>Based on interview and record review, the facility failed to ensure 2 of 4 staff interviewed in the laundry room were trained in emergency procedures related to the gas dryers, in that the staff were unable to identify where the emergency shut off was located for the gas dryers. This had the potential to affect 57 residents residing on the skilled nursing units. (Environmental Service Assistant, Environmental Service Supervisor)</p> <p>Findings include:</p> <p>During the environmental tour of the Laundry Department, on 6/18/13 at 10:22 a.m., the Environmental Service Assistant (ESA) #1 was queried as to where the emergency shut off mechanism was located in the event of a fire in the dryer. ESA #1 indicated she did not know where the shut off mechanism for the gas dryers was located. ESA #1 indicated there was no mechanism in the laundry room to shut off the gas dryers. ESA #1 indicated she would</p>	F000518	All residents have the potential to be affected and by inservicing our staff upon hire and monthly thereafter. We will ensure all laundry personnel can locate and turn off gas, water, and electric to the laundry room. A phone will be put in the laundry for emergency use. A boiler room key was placed in the laundry for emergency use. Laundry staff has been inserviced on gas, water and electric shut off in the facility. Executive Director will audit inservice record monthly to ensure compliance. Results will be forwarded to QA monthly x6 months and quarterly thereafter.	07/21/2013	

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	<p>notify 911 (an emergency response activation system) in the event of a fire. Upon further query, ESA #1 indicated there was no telephone in the laundry room but had a personal cell phone with her that she would need to use.</p> <p>During an interview on 6/18/13 at 11:55 a.m., the Environmental Service Supervisor (ESS) indicated she did not know where the mechanism for the gas was located. She further indicated if the laundry room had a fire, she would pull the fire alarm, obtain the key from the nurse on the unit to the boiler room, unlock the boiler room, and unlock the breaker box to shut off the electrical supply.</p> <p>During an interview on 6/18/13 at 12:05 p.m., the Director of Plant Services (DPS) indicated the emergency shut off mechanism for the gas dryer was located outside of the boiler room. The DPS indicated the boiler room was locked and the key was kept by the facility nurse. The DPS indicated staff could access the emergency gas shut off mechanism by going through the service entrance. The DPS indicated the staff were only inserviced on the location of the emergency shut off</p>						

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	<p>mechanism when they were hired. The DPS indicated he did not have a policy or procedure specific for a fire in the laundry area.</p> <p>During an interview 6/18/13 at 2:40 p.m., the Executive Director (ED) indicated the staff were not inserviced regularly on the shut off mechanisms for the gas dryers. The ED indicated a facility nurse had the keys to the boiler room which was kept locked. The ED indicated the staff would be inserviced immediately on the emergency shut off for the dryers and a key to the boiler room would be kept in the laundry room. The ED indicated a telephone would be placed in the laundry room.</p> <p>During an interview on 6/18/13 at 3:30 p.m., ESA #2 indicated the staff had to go through the boiler room to reach the emergency gas shut off mechanism.</p> <p>3.1-51(b)</p>			

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R000000	The following residential finding was cited in accordance with 410 IAC 16.2-5.	R000000			

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R000144	<p>410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents.</p> <p>Based on interview and record review, the facility failed to ensure 2 of 4 staff interviewed in the laundry room were trained in emergency procedures related to the gas dryers, in that the staff were unable to identify where the emergency shut off was located for the gas dryers. This had the potential to affect 31 residents residing on the assisted living unit. (Environmental Service Assistant, Environmental Service Supervisor)</p> <p>Findings include:</p> <p>During the environmental tour of the Laundry Department, located on a service hall between the skilled nursing unit and the assisted living unit, on 6/18/13 at 10:22 a.m., the Environmental Service Assistant (ESA) #1 was queried as to where the emergency shut off mechanism was located in the event of a fire in the dryer. ESA #1 indicated she did not know where the shut off mechanism for the gas dryers was located. ESA #1 indicated there was no mechanism in the laundry room to shut off the gas dryers. ESA #1 indicated she would</p>	R000144	<p>All residents have the potential to be affected and by inservicing our staff upon hire and monthly thereafter we will ensure all laundry personnel can locate and turn off gas, water, and electric to the laundry room. A phone line will be put in the laundry for emergency use. A boiler room key was placed in the laundry for emergency use. Laundry staff has been inserviced on gas, water and electric shut off in the facility. Executive Director will audit inservice record monthly to ensure compliance. Results will be forwarded to QA monthly x6 months and quarterly thereafter.</p>	07/21/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155732	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/21/2013
NAME OF PROVIDER OR SUPPLIER RIVEROAKS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1244 VAIL ST PRINCETON, IN 47670		
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	<p>notify 911 (an emergency response activation system) in the event of a fire. Upon further query, ESA #1 indicated there was no telephone in the laundry room but had a personal cell phone with her that she would need to use.</p> <p>During an interview on 6/18/13 at 11:55 a.m., the Environmental Service Supervisor (ESS) indicated she did not know where the mechanism for the gas was located. She further indicated if the laundry room had a fire, she would pull the fire alarm, obtain the key from the nurse on the unit to the boiler room, unlock the boiler room, and unlock the breaker box to shut off the electrical supply.</p> <p>During an interview on 6/18/13 at 12:05 p.m., the Director of Plant Services (DPS) indicated the emergency shut off mechanism for the gas dryer was located outside of the boiler room. The DPS indicated the boiler room was locked and the key was kept by the facility nurse. The DPS indicated staff could access the emergency gas shut off mechanism by going through the service entrance. The DPS indicated the staff were only inserviced on the location of the emergency shut off</p>				

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	<p>mechanism when they were hired. The DPS indicated he did not have a policy or procedure specific for a fire in the laundry area.</p> <p>During an interview 6/18/13 at 2:40 p.m., the Executive Director (ED) indicated the staff was not inserviced regularly on the shut off mechanisms for the gas dryers. The ED indicated a facility nurse had the keys to the boiler room which was kept locked. The ED indicated the staff would be inserviced immediately on the emergency shut off for the dryers and a key to the boiler room would be kept in the laundry room. The ED indicated a telephone would be placed in the laundry room.</p> <p>During an interview on 6/18/13 at 3:30 p.m., ESA #2 indicated the staff had to go through the boiler room to reach the emergency gas shut off mechanism.</p>			