

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155767	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/14/2013
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NAME OF PROVIDER OR SUPPLIER SPRINGHURST HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 628 N MERIDIAN RD GREENFIELD, IN 46140
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: June 10-14, 2013</p> <p>Facility number: 005954 Provider number: 155767 AIM number: 201068810</p> <p>Survey Team: Beth Walsh, RN-TC Courtney Mujic, RN Karina Gates, Generalist</p> <p>Census Bed Type: SNF: 57 SNF/NF: 9 Residential: 46 Total: 112</p> <p>Census Payor Type: Medicare: 38 Medicaid: 5 Other: 69 Total: 112</p> <p>Residential Sample: 9</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 6/24/13 by Suzanne</p>	F000000	<p>This Plan of Correction shall serve as the credible allegatin of compliance with all state and federal requirements governing the management of this facility. We respectfully request paper compliance for this Plan of Correction.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	Williams, 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 interview and record review, the facility failed to ensure a resident's physician was notified per physician orders of high blood sugars for 1 of 10 residents reviewed for</p>	F000157	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: Resident #160 chart was reviewed during and after survey to ensure that	07/14/2013	

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	<p>unnecessary medication use. (Resident #160)</p> <p>Findings include:</p> <p>The clinical record for Resident #160 was reviewed on 6/13/13 at 11:00 a.m.</p> <p>The diagnoses for Resident #160 included, but were not limited to: diabetes mellitus.</p> <p>The June 2013 Physician's Orders for Resident #160 indicated Novolog (insulin) Flexpen 3 ML Syringe per sliding scale at 7:00 a.m., 11:00 a.m., 2:00 p.m. and hs (at night) as follows:</p> <p>150-200=2 Units 201-250=4 Units 251-300=6 Units 301-350=8 Units 351-400=10 Units</p> <p>The orders indicated to "call md if above 400."</p> <p>The June, 2013 MAR (medication administration record) for Resident #160 indicated the following blood sugar readings above 400:</p> <p>6/8/13, 2:00 p.m.= 490 6/9/13, 2:00 p.m. = 475</p>		<p>blood sugars above 400 were called to the physician. Nursing staff will be inserviced on the importance of monitoring blood sugars and physician notification. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:Charts of all residents with diagnosis of Diabetes Mellitus will be reviewed to ensure that "call physician parameter" orders are on the Medication Administration Record (MAR) and that physicians are notified of incidents outside the parameters (see attached Diabetes Mellitus Audit Tool). Nursing staff will be inserviced on the importance and diligent practice of monitoring blood sugars and physician notification.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:MARs will be reviewed Monday through Friday to ensure that physician is notified of any resident's blood sugars outside of established parameters. Charts of all residents with diagnosis of Diabetes Mellitus will be reviewed to ensure that "call physician parameter" orders are on the Medication Administration Record (MAR) and that physicians are notified of incidents outside the parameters. Nursing staff will be inserviced on the importance and diligent practice of monitoring</p>				

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	<p>6/9/13, hs = 482 6/10/13, 11:00 a.m. = 423</p> <p>There was no information in the clinical record to indicate Resident #160's physician was notified of the above readings.</p> <p>During an interview with Unit Manager #4 on 6/13/13 at 11:55 a.m., she indicated, she did not see where Resident #160's physician was notified of the above readings. She stated, "They should be notifying the M.D. I'll talk to the nurses."</p> <p>3.1-5(a)(3)</p>		<p>blood sugars and physician notification. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: MARs will be reviewed Monday through Friday to ensure that physician is notified of any resident's blood sugars outside of established parameters. The Director of Health Services will audit five resident records per week for four weeks, then monthly for 6 months to ensure physician notifications are complete. The results will be reviewed in the Quality Assurance Committee meetings for further recommendations. By what date the systemic changes will be completed: July 14, 2013.</p>		

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS 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 observation, interview and record review, the facility failed to ensure a resident receiving an antipsychotic and depression medication had care plans for their use for 1 of 10 residents reviewed for unnecessary medications. The facility also failed to ensure a dental care plan was developed for 1 of 3 residents reviewed for dental services of 3 who met the criteria for dental services. (Resident #160 and #48)</p> <p>1. The clinical record for Resident #160 was reviewed on 5/13/13 at</p>	F000279	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: The Interdisciplinary team met June 18th to review the ICARE Plan process to ensure we capture accurate information on the Care Plan. Resident #160 Care Plan has been reviewed and updated to include her use of antipsychotic and antidepressant medication. Resident #48 Care Plan has been updated to include her wishes regarding the dentist's recommendation for follow up with oral surgeon, as resident does not wish to proceed. How	07/14/2013	

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	<p>11:00 a.m.</p> <p>The diagnoses for Resident #160 included, but were not limited to: depression and delusional disorder with psychotic mood.</p> <p>The June, 2013 Physician's Orders for Resident #160 indicated olanzapine (antipsychotic medication) 5 mg tablet to be given once daily for delusional disorder and psychotic mood. The orders also indicated trazadone (antidepressant) 100 mg tablet to be given orally at bedtime for depression.</p> <p>Upon review of Resident #160's individualized care plan, no information related to her antidepressant use or antipsychotic use could be found.</p> <p>An interview was conducted with the MDS (minimum data set) Coordinator on 5/13/13 at 1:47 p.m. She indicated Resident #160 did not have any information on her olanzapine or trazadone use in her individualized care plan. She indicated her care plan should include information on her antipsychotic and antidepressant medication use regarding monitoring for side effects, pharmacy reviews, looking for reductions, following</p>		<p>other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: Charts of all residents with antipsychotic/antidepressant medications will be audited to determine proper inclusion in their Care Plan documentation (see attached Care Plan Audit Tool). Charts of all residents with dentist recommendations will be audited to determine proper inclusion in their Care Plan documentation (see attached Dental Visit Audit Tool). What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Changes or additions to resident's antipsychotic/antidepressant medications will be reviewed in morning clinical meetings Monday - Friday each week and updates will be made to their Care Plan. Dental recommendations will be reviewed in morning clinical meetings Monday - Friday to ensure follow up and inclusion in resident's Care Plan. The Social Service Director met with the new dentist to ensure he provided the proper copies of his visit and recommendations to both the social service and nursing department at the conclusion of his visit to ensure proper follow up and documentation at the campus. How the corrective actions will be monitored to</p>		

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	<p>physician orders, and monitoring of behaviors.</p> <p>2. Resident #48's clinical record was reviewed on 6/13/2013 at 10:10 am. Diagnoses included but were not limited to; congestive heart failure, cerebrovascular accident (stroke), chronic obstructive pulmonary disease, dementia, and osteoarthritis.</p> <p>An observation, on 6/10/2013 at 11:42 am, indicated Resident #48 had multiple missing teeth, and one visibly broken tooth in the middle front top of her mouth.</p> <p>An interview with Resident #48, on 6/10/2013 at 11:41 am, indicated she has been to the dentist recently. The Dentist said he was going to refer her to a specialist dentist, but she hasn't gone to that appointment yet. She's not sure why or what happened with that situation.</p>		<p>ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Director of Health Services and/or designee will audit 5 resident Care Plans each week for four weeks, then monthly for six months to ensure proper inclusion in resident care plans of antipsychotic/antidepressant medications and dental visit follow up recommendations. By what date the systemic changes will be completed: July 14, 2013</p>	

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	<p>An "Oral evaluation/recommended treatment" dentist note, dated 3/28/2013, indicated, "Soft tissue: Abnormal. Left buccal mucosa irregular, ulcer, 1 cm circular. Referral to oral surgeon. Note: biopsy request."</p> <p>An interview with Unit Manager #4, on 6/13/2013 at 11:40 am, indicated, "I have no idea what happened with that; she didn't get the referral to the oral surgeon because this is the first time I've seen this dental consult."</p> <p>Review of Resident #48's clinical record indicated no dental care plan could be found.</p> <p>An interview with medical records LPN #10, on 6/14/2013 at 3:10 pm, indicated there was not a dental care plan for Resident #48.</p> <p>An Interview with MDS Nurse #3, on 6/14/2013 at 3:20 pm, indicated she and the nursing staff are both responsible for ensuring a dental care plan is made, she isn't sure whether or not she had one, she will let me know. At 3:24 pm, she indicated Resident #48 does not have a dental care plan.</p>			

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	3.1-35(a)			

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F000325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on interview and record review, the facility failed to timely recognize and address a weight loss for 1 of 3 residents reviewed for nutrition of 11 who met the criteria for nutrition. (Resident #8)</p> <p>Findings include:</p> <p>The clinical record for Resident #8 was reviewed on 6/12/13 at 11:00 a.m. He was admitted to the facility on 5/4/13.</p> <p>The diagnoses for Resident #8 included, but were not limited to, the following: Alzheimer's, depression, and diabetes mellitus.</p> <p>The Weights Detail Report for Resident #8 indicated the following dates and weights in pounds for the month of May, 2013:</p>	F000325	<p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: Residents requiring weekly weights (loss of 5% or greater) will be weighed every seven days instead of "weekly" to ensure timely weights obtained. Residents with weekly weights will be reviewed in weekly Clinically At Risk meetings to ensure proper documentation and follow up on an ongoing basis. Weekly weights have been added to the MAR for routine documentation. The Registered Dietician will be provided weekly updates of resident weights to ensure timely follow up. Registered Dietician participated in the 7/3/13 Clinically At Risk meeting to ensure proper follow up and documentation for all residents on weekly weights. All nurses will be inserviced on timely notification to Director of Health Services and/or designee of unavailability of medications to ensure proper follow up. How</p>	07/14/2013	

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	<p>5/5/13 = 195.4 5/10/13 = 176.4 5/24/13 = 171.2 5/31/13 = 167</p> <p>The 5/4/13 Assessment Review and Considerations form indicated Resident #8 had the risk factor of being on a liquid diet that may contribute to a weight loss or gain.</p> <p>The 5/4/13 Nursing Admission Assessment & Data Collection included a Nutrition Plan of Care that indicated the intervention "observe weight q (every) week."</p> <p>The 5/14/13 Nutrition Assessment and Data Collection completed by the Registered Dietician (RD) indicated, "Needs prompting freq (frequently) to complete task. "Not very hungry."" The diagnosis/assessment portion of this assessment indicated, "Res (resident's) fecal impaction appears resolved per 5/10/13...Wt (weight) (symbol for "increased") non-significantly. Fair po (by mouth), but likely to (symbol for "increase") (symbol for "after") 5/10/13 diet (symbol for "up") grade." The only nutrition intervention indicated on this assessment was weekly weights. This assessment did not address the 9.7%, 19 pound, weight loss that</p>		<p>other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: Residents requiring weekly weights (loss of 5% or greater) will be weighed every seven days instead of "weekly" to ensure timely weights obtained. Weekly weights have been added to the MAR for routine documentation. Residents with weekly weights will be reviewed in weekly Clinically At Risk meetings to ensure proper documentation and follow up. Registered Dietician participated in the 7/3/13 Clinically At Risk meeting to ensure proper follow up and documentation for all residents on weekly weights. The Registered Dietician will be provided weekly updates of resident weights to ensure timely follow up. All nurses will be inserviced on timely notification to Director of Health Services and/or designee of unavailability of medications to ensure proper follow up. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Residents with weight loss (5% and greater) will be reviewed in weekly Clinically At Risk meetings with documentation of interventions and follow up. All nurses will be inserviced on timely notification to Director of Health Services and/or designee of</p>				

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	<p>occurred between 5/4/13 and 5/10/13 when Resident #8 went from a weight of 195.4 to 176.4.</p> <p>An interview was conducted with the RD on 6/12/13 at 2:47 p.m. She indicated, "On five fourteen (5/14/13), I did not see the five ten (5/10/13) weight. If I had seen it, I would have started with supplements and fortified foods at that point. I'm not sure why I didn't know about the five ten (5/10/13) weight of 176.4. Typically, I would have expected there to be a weight between five four (5/4/13) and five fourteen (5/14/13), since it was 10 days. There's also a five seventeen (5/17/13) weight missing...I would like not to see weight problems. I don't see 20 pound differences..."</p> <p>The 5/28/13 Nutrition Progress note indicated, "Wt (weight) loss/30 d (days). Dtr (daughter) states cont (continued) poor appetite. Would like ensure or ice cream. Agreed to request appetite stimulant. 5/23/13 - 171.2- cont (continued) decline. Rec (Recommendations) 1. 1-milkshake q (every) dinner - add 1 can ensure 2. ice cream at lunch. 3. 2.5 mg marinol bid (twice daily) appetite stimulant."</p>		<p>unavailability of medications to ensure proper follow up. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Assistant Director of Health Services and/or designee will participate in weekly Clinically At Risk meetings to ensure proper review, follow up and documentation of interventions on an ongoing basis. Weight loss will be monitored through monthly Quality Assurance meetings on an ongoing basis. Monthly Quality Assurance meetings will include review of medications not delivered timely for follow up actions and recommendations on an ongoing basis. By what date the systemic changes will be completed: July 14, 2013</p>		

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	<p>The physician's order for the Marinol was dated 5/31/13.</p> <p>The June, 2013 MAR (medication administration record) for Resident #8 indicated he did not receive his first dose of marinol until 5:00 p.m. on 6/5/13. The back of the MAR indicated, "6/4/13 Marinol 2.5 (symbol for "no") supply."</p> <p>During another interview with the RD on 6/13/13 at 10:15 a.m. she indicated she was unaware Resident #8 did not receive the appetite stimulant until 6/5/13. She stated, "Normally nursing would let me know."</p> <p>During an interview with Unit Manager #4 on 6/13/13 at 10:25 a.m. she stated, "I think what happened is the med (medication) needed a hard script (prescription) and the pharmacy sent it to the doctor instead of calling and letting us know, so we could get it. Nursing should have let me know it was not available so I could call and get it."</p> <p>The 6/12/13 Nutrition Progress Note indicated on 5/31/13, Resident #8's weight was down to 167 pounds and by 6/12/13, 7 days after receiving the appetite stimulant daily, his weight</p>			

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	<p>was up to 172.2 pounds. It indicated, "Res (resident's) appetite does not show sig (significant) improvement, although refusing meals less often."</p> <p>3.1-46(a)(1)</p>			

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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview, and record review, the facility failed to monitor and report potential adverse consequences of anti-psychotic use and the facility also failed to have an assessment for a resident receiving an anti-psychotic for 2 of 10 residents reviewed for unnecessary medications. (Resident #41 and #140)</p> <p>Findings include:</p>	F000329	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: Resident #41 continued to experience agitated behaviors on her previous dose of Zyprexa 7.5mg per day. Resident's psychiatrist increased her Zyprexa to 5mg in the AM and 5mg in the PM (for a total of 10mg per day) on May 28th. Between 5/28 and 6/5 resident continued with agitated behaviors as evidenced by nursing documentation on 5/31, 6/1, 6/2, 6/3 and 6/5 (without	07/14/2013			

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	<p>1. The clinical record for Resident #41 was reviewed on 6/14/13 at 10:30 a.m.</p> <p>The diagnoses for Resident #41 included, but were not limited to: agitation/behaviors.</p> <p>The 5/10/13 quarterly MDS (minimum data set) assessment indicated Resident #41's cognitive skills for daily decision making were severely impaired in that she never/rarely made decisions. It indicated the behaviors of inattention and disorganized thinking were "continuously present/does not fluctuate." It indicated she required extensive assistance of 2 plus persons for the following ADLs (activities of daily living): bed mobility, transfer, locomotion on unit, locomotion off unit, dressing, toilet use, and personal hygiene.</p> <p>The May and June 2013 nurses notes, social service notes, and behavior reports indicated Resident #41 had the following behaviors: biting, spitting, pinching staff in adl care, punching, hitting, smearing feces on self and CNA's (Certified Nursing Assistants), scratching, throwing food, cussing and screaming.</p>		<p>positive response to redirection) at which time the psychiatrist was again notified by nursing, resulting in an increase to a total of 12.5mg Zyprexa per day. Even though resident did experience increased lethargy after the increase to 12.5mg per day Zyprexa, during awake times her agitated behaviors continued as evidenced by nursing documentation on 6/5, 6/6, and 6/10. However, resident's Zyprexa order has been decreased to 5mg in the AM and PM for a total of 10mg per day on 6/21. She will be reviewed in weekly Clinically At Risk meeting for eight weeks to monitor the affect of the medication change. Resident #140 was admitted with Seroquel 25mg for psychosis with agitation on 4/23/13. Resident did not display any psychosis or agitation after admission. To capture potential gradual dose reductions, residents with admitting psychotropic orders will be reviewed in weekly Clinically At Risk meetings for four weeks to determine if need for medication continues and nursing will notify physician accordingly. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: Residents with changes in their psychotropic medications will be reviewed in morning Clinical meetings Monday through Friday and will</p>		

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	<p>The May 2013 MAR (medication administration record) indicated Resident #41 was taking a total of 7.5 mg of Zyprexa (antipsychotic medication) daily through 5/28/13. Beginning 5/29/13, this MAR indicated she was taking a total of 10 mg of Zyprexa daily. The June 2013 MAR continued at 10 mg of Zyprexa daily through 6/5/13. Beginning 6/6/13, the June 2013 MAR indicated she was taking a total of 12.5 mg daily, ongoing.</p> <p>An interview was conducted with Resident #41's physician on 6/14/13 at 1:58 p.m. regarding the time frame for determining whether Zyprexa is working/effective after an increase, specifically Resident #41's Zyprexa increase to 12.5 mg daily in June, 2013 so soon after the increase to 10 mg at the end of May, 2013. He indicated it usually took 8-12 weeks to get a full response. "She's just had so much trouble with agitation. I'm not sure if I did that or my nurse practitioner did it...It's not typical to increase so soon...I don't know what her specific behaviors were after this last increase. It's at the higher end of what I typically use....2.5-10 (mg) is what I typically use. In an ideal world, we'd wait 6-10 weeks before an</p>		<p>be monitored for adverse reactions and physicians notified accordingly. The consultant pharmacist will continue to monitor for gradual dose reductions for all residents involved and make recommendations accordingly. Residents with behaviors will be reviewed weekly in Clinically At Risk meetings with documentation of follow up or changes. Regarding resident #140, to capture potential gradual dose reductions, residents with admitting psychotropic orders will be reviewed in weekly Clinically At Risk meetings for four weeks. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Residents with behaviors will be reviewed weekly in Clinically At Risk meetings. Consultant Pharmacist will continue to monitor for gradual dose reductions for all residents involved and make recommendations accordingly. Upon admission, resident with psychotropic orders will be reviewed weekly in Clinically At Risk meetings for four weeks to determine if need for medication continues and nursing will notify physician accordingly. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Residents with</p>				

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	<p>adjustment...I don't remember what happened specifically in that 8 day time frame (from 5/29/13 to 6/6/13)."</p> <p>An interview was conducted with CNA #6 on 6/14/13 at 3:21 p.m. She indicated, "She's (Resident #41) been a lot sleepier in the last week or so, since her medication change. She's eating less now, 50% maybe. She used to eat the whole meal. I told (name of Unit Manager #4) on Monday or Wednesday about this. (Name of Unit Manager #4) said she thinks it's her medicine and she's going to check into it. She's still having these behaviors when she's up. Her behaviors are the same."</p> <p>During an interview with LPN #7 on 6/14/13 at 3:40 p.m., she indicated, "I have noticed her sleeping a lot more in the last 2 weeks. I work twice a week (on Resident #41's hall) for the past 2 months."</p> <p>During an interview with CNA #8 on 6/14/13 at 3:50 p.m. regarding any changes in Resident #41, she indicated, "She's sleepier. She can't help herself like she used to, stand or hold herself up in her chair like she used to. It's been over the past 2 weeks."</p>		<p>behaviors will be reviewed weekly in Clinically At Risk meetings. All new physician orders will be reviewed Monday - Friday in daily Clinical meetings to determine any psychotropic medication changes for further review and follow up. Psychotropic usage will be monitored monthly in Quality Assurance meetings on an ongoing basis. By what date the systemic changes will be completed: July 14, 2013</p>		

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	<p>During an interview with CNA #9 on 6/14/13 at 3:52 p.m., she indicated, "She's more lethargic. She's not eating well, maybe 40% of dinner. She's not even urinating as well, less. It's more difficult to transfer her. She's weaker, leaning more, she used to be able to help stand more. It's been over the last 2 weeks. I told (name of LPN #7)."</p> <p>An interview was conducted with Unit Manager #4 on 6/14/13 at 3:57 p.m. regarding Resident #41, she indicated, "We just changed her Zyprexa. Staff may have told me in passing about her symptoms but it didn't click. I would have informed the doctor...I will get a note out to the doctor today. I'm not saying staff didn't tell me. (Name of CNA #6) may have. I noticed she's been sleeping more. I just figured it was because of the increase in Zyprexa."</p> <p>Observations of Resident #41 were made throughout the day on 6/14/13. At 10:30 a.m., she was observed sleeping in the recliner in her room, leaning over to her right. At 3:20 p.m. and 3:40 p.m., she was observed lying in her bed, asleep.</p> <p>The 2011 PDR Nurse's Drug Handbook provided by the DON</p>						

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	<p>(Director of Nursing) on 6/14/13 at 11:45 a.m. indicated Zyprexa had the following adverse reactions: "postural hypotension, constipation, dry mouth, weight gain, somnolence (sleepiness), dizziness, personality disorder, akathisia (inner restlessness), asthenia (weakness, lack of energy and strength), dyspepsia (indigestion or upset stomach), tremor, increased appetite, abdominal pain, headache, insomnia."</p> <p>2. The clinical record for Resident #140 was reviewed on 6/13/13 at 10:30 a.m. The diagnoses for Resident #140 included, but were not limited to: dementia and psychosis with agitation.</p> <p>A review of June Physician Orders, for Resident #140, indicated an order for Seroquel (anti-psychotic) 25 mg (milligrams), 1 tablet twice daily. The order was initiated at admission, on 4/23/13.</p> <p>A review of a Social Service Progress Note, dated 4/29/13, indicated Resident #140 takes "Seroquel 25mg for Dx: (diagnosis) psychosis (symbol for with) agitation."</p> <p>No other documentation was located, in the clinical record, regarding an</p>			

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	<p>assessment or behaviors for the use of an anti-psychotic.</p> <p>During an interview with the Social Services Director (SSD) on 6/13/13 at 3:06 p.m., she indicated the IDT (inter-disciplinary team) looked at behaviors for residents weekly. Behaviors were also tracked in a computer system used by the facility. SSD also indicated IDT will review the need for anti-psychotic medication use, if there were no issues with behaviors. Further documentation regarding an assessment, for the use of an anti-psychotic, and behaviors for Resident #140 were requested at this time.</p> <p>On 11:30 a.m., on 6/14/13, the SSD indicated there was no assessment done for the need/indication of an anti-psychotic medication. She also indicated Resident #140 had no behaviors since his admission to the facility. She further indicated, the Resident was on Seroquel, at another nursing facility, prior to admission, but there was no "good" documentation, from that facility, on why the anti-psychotic medication was prescribed for Resident #140. The SSD also indicated Resident #140 was not in the range for a tapering dose of the anti-psychotic and was</p>			

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	<p>not going to be at the facility long enough to "really address the issue" for the need of an anti-psychotic medication. She also indicated IDT probably missed the need/use of the anti-psychotic medication for Resident #140, because the Resident did not have any behaviors since admission. The SSD indicated she was mostly focused on discharging the Resident and was more concerned with that, instead of his need/use for an anti-psychotic medication. She also indicated the facility practice was not to have an assessment or psychiatric evaluation, if the resident was an anti-psychotic or had a diagnosis related to the use of an anti-psychotic. An assessment or psychiatric evaluation was only done, if there were behaviors or a problem with the resident.</p> <p>3.1-48(a)(4)</p>				

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F000411 SS=D	<p>483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care.</p> <p>A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.</p> <p>Based on observation, interview, and record review, the facility failed to ensure dental recommendations were followed for a resident with dental problems, in that a resident did not receive dental services, for 1 of 3 residents reviewed for dental services out of a total of 3 who met the criteria for dental services. Resident #48.</p> <p>Findings include:</p> <p>Resident #48's clinical record was reviewed on 6/13/2013 at 10:10 am. Diagnoses included, but were not limited to; congestive heart failure, cerebrovascular accident (stroke), chronic obstructive pulmonary disease, dementia, and osteoarthritis.</p>	F000411	<p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: Resident #48 was seen by the campus' new dentist on 3/28/13. The dentist made recommendations for a follow up visit to an oral surgeon, but did not inform nursing of this recommendation, resulting in it being overlooked. Social Service Director has since met with the dentist and informed him of the proper procedure to ensure follow up to recommendations. In addition, the Social Service Director and/or designee will ensure nursing receives a copy of the dental recommendations and will assist in any follow up required. Per interview with the resident during the survey, resident declined the recommended follow up with an</p>	07/14/2013			

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	<p>During an observation, on 6/10/2013 at 11:42 am, Resident #48 had multiple missing teeth, and one visibly broken tooth in the middle front top of her mouth.</p> <p>An interview with Resident #48, on 6/10/2013 at 11:41 am, indicated she has been to the dentist recently. The dentist said he was going to refer her to a specialist dentist, but she hasn't gone to that appointment yet. She's not sure why or what happened with that situation.</p> <p>An "Oral evaluation/recommended treatment" Dentist note, dated 3/28/2013, indicated, "Soft tissue: Abnormal. Left buccal mucosa irregular, ulcer, 1 cm circular. Referral to oral surgeon. Note: biopsy request."</p> <p>An interview with Unit Manager #4, on 6/13/2013 at 11:40 am, indicated, "I have no idea what happened with that; she didn't get the referral to the oral surgeon because this is the first time I've seen this dental consult."</p> <p>An interview with Unit Manager #5, on 6/13/2013 at 2:34 pm, indicated, currently, the MD gives all the original copies of the consult notes to the nurse, and a copy to social services.</p>		<p>oral surgeon. How other residents having the potential to be affected by the deficient practice will be identified and what corrective actions will be taken: The Social Service Director met with the dentist and informed him of proper procedure to ensure follow up to recommendations. The Social Service Director and/or designee will provide nursing with a copy of the dental recommendations and assist nursing with any recommended follow up. Dental recommendations will be reviewed in morning Clinical meeting Monday - Friday to ensure follow up and inclusion in resident Care Plans. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Social Service Director and/or designee will meet with any new contracted residents services (i.e. dentist, podiatrist, psychiatrist, optometrist) to inform of proper procedures regarding any recommendations. Dental recommendations will be reviewed in morning Clinical meeting Monday - Friday to ensure follow up and inclusion in resident Care Plans. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Social Service Director and/or designee will</p>		

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	<p>The floor nurse, the Director of Health Services, and the Social Services Director (SSD), should be following up today with the recommendation for Resident #48 to see an oral surgeon. SSD should have been responsible for this missed recommendation. The Social Services Director should have followed up and will from now on continue to follow up on recommendations. When social services gets copies of consults they should call the nurse and make sure the nurse has the original. "Hopefully this was just a one time situation where it fell through the cracks."</p> <p>An interview with the Social Services Director, on 6/13/2013 at 3 pm, indicated, she spoke with Resident #48 and she (the resident) just said she didn't want any cosmetic changes, she doesn't want to go (to the oral surgeon appointment). What she thinks happened was that the dentist just gave her and the Director of Health Services the copies of the consult and the nurse probably never saw it. "Absolutely from now on I will be reviewing the consults monthly and follow-up with nursing to make sure recommendations are followed". She indicated, "I did not explain to her that the dentist wanted her (the resident) to see the oral surgeon due</p>		<p>monitor contracted resident services visits (dentist, podiatrist, psychiatrist, optometrist) to ensure proper procedures regarding any recommendations and will provide nursing a copy to ensure follow through. The Director of Health Services and/or designee will monitor and maintain a file of dental recommendations on an ongoing basis to ensure proper follow up of all recommendations has occurred. The recommendations, including follow up, will be reported through monthly Quality Assurance meetings on an ongoing basis. By what date the systemic changes will be completed: July 14, 2013</p>		

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	<p>to her mouth ulcer needing a biopsy. I'll go back in there and bring the recommendation to show her."</p> <p>An interview with the SSD, on 6/14/2013 at 11 am, indicated she explained to the resident the reason why the dentist wanted her to be seen by the oral surgeon, to have the biopsy of the ulcer. She indicated the resident refused to go to the appointment because "there isn't anything they can do to help me, I'm (age of resident) years old."</p> <p>A social services progress note, dated 6/13/2013 with no time specified, indicated, "...Asked about last appointment with dentist with recommendation for oral surgery/biopsy request. Both times resident stated not wanting to pursue. 2nd visit with review of form and specific wordage of "biopsy request" resident states "after all I'm (age of resident) years old!" No I don't want to go thru that."</p> <p>3.1-24(a)(2)</p>			

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NAME OF PROVIDER OR SUPPLIER SPRINGHURST HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 628 N MERIDIAN RD GREENFIELD, IN 46140			
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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	What corrective actions will be accomplished for those residents	07/14/2013			

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	<p>follow infection control procedures when administering medication, during a random observation. This had the potential to affect 1 of 1 resident randomly observed for infection control. (Resident #164).</p> <p>Findings include:</p> <p>The clinical record for Resident #164 was reviewed on 6/13/13 at 12:15 p.m. The diagnoses for Resident #164 included, but were not limited to: rhabdomyolysis hyponatremia, lumbar spinal canal stenosis, and leukocytosis.</p> <p>During a medication administration observation with LPN #1, on 6/13/13 at 11:45 a.m., a cart with gowns and gloves was observed outside of Resident #164's room. LPN#1 entered Resident #164's room without donning any gloves or a gown. LPN #1 administered medication to Resident #164, washed her hands, and exited Resident #164's room. There was no sign on the Resident's door that indicated a visitor should report to nurse's station before entering the room.</p> <p>During an interview with LPN #1, on 6/13/13 at 11:49 a.m., she indicated Resident #164 was in isolation for</p>		<p>found to have been affected by the deficient practice:LPN #1 was reminded of proper donning of gloves prior to entering an isolation room on the day of the survey noted as 6/13/13. Resident's wound remained covered during this administration of medication. An isolation sign (instructing visitors to report to nurses station) was placed at resident's door per policy during the survey.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:Nursing staff will be inserviced on Guidelines for Contact Precautions to ensure proper implementation of signage and use of gloves. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:Residents requiring Contact Precautions will be placed on an Isolation List for staff information and updated weekly. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:Infection Control Rounds will be conducted weekly by the Assistant Director of Health Services and/or designee for four weeks and monthly for 6 months to ensure proper procedures are implemented (see attached</p>		

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	<p>MRSA (Methicillin-resistant Staphylococcus aureus-a bacteria) in a wound.</p> <p>A review of the June Physician's Orders for Resident #164, indicated the Resident was taking IV (intravenous) Vancomycin (antibiotic) 2 times daily.</p> <p>A review of the Skilled Nursing Assessment and Data Collection notes, on the following dates, indicated Resident #164 was on isolation for MRSA: 5/23/13, 5/27/13, 6/3/13, and 6/6/13.</p> <p>On 6/13/13, at 12:45 p.m., the Assistant Director of Nursing indicated all staff were supposed to utilize gowns and gloves prior to entrance in a resident's room on contact isolation, no matter where the infection was.</p> <p>A review of a policy, titled Precaution Categories, received from the Assistant Director of Nursing, on 6/13/13 at 1:07 p.m., indicated, "...a. Examples of infections requiring Contact Precaution included but are not limited to:...wound infections or</p>		<p>Infection Control Rounding Tool). The rounds will be reviewed in monthly Quality Assurance meetings for recommendations and follow up. By what date the systemic changes will be completed: July 14, 2013</p>				

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	<p>colonization wit [sic] multi-drug resistant bacteria (VRE, MRSA, etc)." The policy also indicated, "c. Gloves and Hand washing</p> <p>1. Clean, non-sterile gloves should be worn when entering the room...3. Remove and discard gloves within the room and wash hands immediately [sic]</p> <p>...g. Isolation signs</p> <p>1. Place a sign (preferable orange) at the doorway instructing visitors to report to nurses [sic] station before entering the room."</p> <p>At 3:15 p.m., on 6/14/13, the DoN (Director of Nursing) indicated all staff should follow the precautions policy, which included placement of a sign on the Resident's door regarding visitors reporting to the nurse's station prior to entrance in the resident's room.</p> <p>During an interview with Unit Manager #5, on 6/14/13 at 3:30 p.m., she indicated Resident #164 was on Vancomycin for MRSA of their wound.</p> <p>3.1-18(j)</p>			

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R000000	The following state residential finding is cited in accordance with 410 IAC 16.2-5.	R000000	This Plan of Correction shall serve as the credible allegatin of compliance with all state and federal requirements governing the management of this facility. We respectfully request paper compliance for this Plan of Correction.		

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R000055	<p>410 IAC 16.2-5-1.2(y)(1-4) Residents' Rights - Deficiency (y) Residents have the right to be treated as individuals with consideration and respect for their privacy. Privacy shall be afforded for at least the following: (1) Bathing. (2) Personal care. (3) Physical examinations and treatments. (4) Visitations.</p> <p>Based on observation, interview, and record review, the facility failed to provide privacy while administering medication, during a random observation. This affected 1 of 1 resident randomly observed for privacy. (Resident #3)</p> <p>Finding include:</p> <p>The clinical record for Resident #3 was reviewed on 6/14/13 at 11:30 a.m. The diagnoses for Resident #3 included, but were not limited to: dementia, hypertension, and depression.</p> <p>During a medication administration observation with LPN #2, on 6/13/13 at 12:40 p.m., LPN #2 walked over to Resident #3 in the common area/cafe' and administered eye drops to Resident #3. 3 other individuals were also sitting in the room with Resident #3, while Resident #3's eye drops were administered.</p>	R000055	<p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: Per interview with the nurse who administered the Assisted Living resident's eye drops, the nurse asked the resident prior to administration if she wanted the eye drops administered where she was currently in the bistro, or did she want to go to her apartment for the administration. The nurse followed the resident's wishes and administered the eye drops in the bistro. The resident was provided the proper opportunity for administration of eye drops in a private place but resident chose (per resident's rights) to have them administered in a public place (Assisted Living bistro). The nurse was reminded of resident's rights to privacy with medication administration. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: Nurses will be inserviced on the resident's right for privacy during</p>	07/14/2013

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	<p>A review of the June Physician's Orders for Resident #3, indicated the Resident had an order for Refresh Optvie Advanced eye drops for four times a day, 2 drops into each eye.</p> <p>During an interview with the Assistant Director of Nursing, on 6/13/13 at 12:45 p.m., she indicated Nursing was supposed to take residents to their room when administering eye drops or insulin, whether the Resident resided in Assisted Living or in the Skilled section of the facility.</p> <p>A review of the the policy, Specific Medication Administration Procedures, received from the Assistant Director of Nursing, on 6/13/13 at 1:07 p.m., indicated, "...B. Provide privacy for resident."</p>		<p>administration of medications such as eye drops. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Director of Health Services and/or designee will monitor medication administration one time weekly for four weeks to ensure compliance (see attached Medication Administration Observation Report). How the corrective actions will be monitored to ensure the deficient practice will nto recur, i.e. what quality assurance program will be put into place: The weekly medication administration observations will be reviewed in Quality Assurance Committee meeting with recommendations for continued monthly medication pass observations if 100% compliance not achieved on each of the observations. If 100% compliance not achieved, Director of Health Services and/or designee will continue with monthly medication pass observations for 6 months, reporting results through Quality Assurance. Nursing staff not achieving 100% compliance on medication pass will receive one-on-one inservicing on proper medication pass practices. The Director of Health Services will continue with sporadic medication pass observations after 100% compliance achieved and report through Quality Assurance</p>	

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			Committee. By what date will the systemic changes be completed: July 14, 2013	