| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 155700 | A. BUILDING 00<br>B. WING | 06/21/2016 |

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| CATHERINE KASPER HOME | 9601 S UNION RD<br>DONALDSON, IN 46513 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey.<br><br>Survey dates: June 15, 16, 17, 20 and 21, 2016<br><br>Facility number: 002982<br>Provider number: 155700<br>AIM number: 200382090<br><br>Census bed type:<br>SNF/NF: 48<br>SNF: 30<br>Total: 78<br><br>Census payor type:<br>Medicare: 19<br>Medicaid: 23<br>Other: 36<br>Total: 78<br><br>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality Review completed by 14454 on June 24, 2016. | F 0000 | Please accept this Plan of Correction as our credible allegation of compliance. Submission of this Plan of Correction does not constitute admission of the allegations contained in the CMS 2567 for survey event ID 4MUR11 for July 15, 2016 | |

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

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| F 0272 SS=D Bldg. 00 | 483.20(b)(1)<br>COMPREHENSIVE ASSESSMENTS<br>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.<br><br>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:<br>Identification and demographic information;<br>Customary routine;<br>Cognitive patterns;<br>Communication;<br>Vision;<br>Mood and behavior patterns;<br>Psychosocial well-being;<br>Physical functioning and structural problems;<br>Continence;<br>Disease diagnosis and health conditions;<br>Dental and nutritional status;<br>Skin conditions;<br>Activity pursuit;<br>Medications;<br>Special treatments and procedures;<br>Discharge potential;<br>Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and<br>Documentation of participation in assessment. | | | |

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| | Based on interview and record review, the facility failed to assess a resident following a decline in continence for 1 of 3 residents reviewed for continence care. (Resident #92)<br><br>Findings include:<br><br>On 06/20/2016 at 9:30 A.M., a clinical record review was completed for Resident #92. Resident #92 was admitted on 9/10/2015 and readmitted on 3/8/2016. The diagnoses included, but were not limited to: hypertension, fracture of the left hand, osteoporosis, closed fracture of the cervical vertebra and fractured left femur.<br><br>An MDS (Minimum Data Set) assessment, dated 5/3/2016, indicated Resident #92 had declined in bladder continence from continent to frequently incontinent of her bladder.<br><br>A form titled "BOWEL AND BLADDER DIARY," dated 3/4/2016, indicated Resident #92 was planned to have a seven day bladder diary completed. The form showed no documentation from 3/8/2016 thru 3/10/2016.<br><br>During an interview, on 6/20/2016 at 11:25 A.M., the ADON (Assistant Director of Nursing) indicated there | F 0272 | 1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #92 has been reassessed for continence to determine interventions that will be provided and care plan updated. 2. How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. A facility wide audit will be conducted utilizing the last 2 MDS for each resident to determine if there has been a decline in urinary continence. All residents identified will be cared planned as necessary per policy. 3. What measures will be put into place or what system changes will be made to ensure that the deficient practice does not recur. An in-service will be presented to nursing staff regarding Bowel and Bladder Assessment policy and procedure on or before 8/12/16. See attachment ___ 4.How the corrective action will be monitored to ensure the deficient practice will not recur. What Quality Assurance Program will be put into place. Director of Nursing (DON) or designee will continue to utilize the MDS schedule to monitor the two most recent MDS assessments for decline in continence and ensure initiation of Bowel and Bladder Assessment policy and procedure as needed. The | 08/12/2016 |

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| | should have been a bladder assessment completed following a decline in continence. She further indicated she had not completed a bladder assessment for Resident #92 following the bladder continence decline.<br><br>During an interview on 6/20/2016 at 12:07 P.M., the MDS Coordinator indicated a bladder assessment was to be completed following a decline in bladder continence. She indicated this was not done for Resident #92.<br><br>On 6/21/2016 at 2:30 P.M., the ADON provided a policy titled "Bowel and Bladder Assessment," dated 7/9/2015, and indicated this was the policy currently used by the facility. The policy indicated "...1. The nurse supervisor (or designee) will initiate a seven (7) day bowel and bladder diary upon admission. The M.D.S. Coordinator (or designee) will initiate a seven (7) day bowel and bladder diary quarterly according to the M.D.S. schedule or with resident change of condition. 2. Upon completion of a seven (7) day bowel and bladder diary, the bowel and bladder evaluation grid will be initiated by nursing to assess if a resident qualifies for an Incontinence Management Program...."<br><br>3.1-31(e) | | auditing process will be weekly for two months, then bi-monthly for two months, then monthly for two months. Audits will be presented to Quality Assurance Committee for review until 100% compliance is achieve. Date of Compliance 8/12/16 | |

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| F 0279 SS=D Bldg. 00 | 483.20(d), 483.20(k)(1)<br>DEVELOP COMPREHENSIVE CARE PLANS<br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>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.<br><br>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).<br>Based on observation, record reviews and interviews, the facility failed to ensure a care plan was developed for 1 of 3 residents reviewed for incontinence. (Resident #47) | F 0279 | 1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #47's care plan has been reviewed and updated to reflect her incontinence. 2.How will other residents having the | 08/12/2016 |

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| | Finding includes:<br><br>On 6/20/16 at 9:02 A.M., a review of the clinical record for Resident #47 was conducted. The record indicated the resident was re-admitted on 1/12/16 after a hospital stay. The resident's diagnoses included, but were not limited to: bipolar, depression, vascular dementia, Alzheimer's disease and right hip fracture.<br><br>The nursing admission record indicated the resident was admitted to the facility after having a right hip fracture. The form indicated the resident was admitted with a Foley catheter.<br><br>A physician's order, dated 1/12/16, indicated to remove the Foley catheter when the resident was ambulatory. Another physician's order, dated 1/14/16, indicated to removed the Foley catheter and if no voiding (urination) after 8 hours, then re-anchor the Foley.<br><br>The Admission MDS ( Minimum Data Set) Assessment, dated 1/19/16, indicated the resident's BIMS (Brief Interview Mental Status) score was 13 (mild dementia). The Admission Assessment indicated the resident was frequently incontinent and no toileting program was initiated. A Significant change MDS | | potential to be affected by the same deficient practice will be identified and what corrective action will be taken. A facility wide audit of care plans will be conducted for residents who have been assessed to be incontinent. Care Plans will be reviewed and updated as needed to reflect individual resident needs and current status per policy. 3.What measures will be put into place or what system changes will be made to ensure that the deficient practice does not recur. An in-service will be presented to nursing staff and Care Plan Team regarding the facility Care Plan policy and procedure on or before 8/12/16. See attachment ___ 4. How the corrective action will be monitored to ensure the deficient practice will not recur What Quality Assurance Program will be put into place. Director of Nursing (DON) or designee will continue to utilize the MDS schedule to monitor the most recent MDS assessment for five residents identified with incontinence to ensure that a care plan is in place. The auditing process will be weekly for two months, then bi-monthly for two months, then monthly for two months. Audits will be presented to Quality Assurance Committee for review until 100% compliance is achieve. Date of Compliance 8/12/16 | |

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| | Assessment, dated 4/7/16, indicated the resident was always incontinent.<br><br>An Admission care plan, undated, indicated the resident had a Foley catheter with interventions to provide catheter care every shift.<br><br>An Activities of Daily Living-Functional/Rehabilitation Potential, dated 4/12/16 and updated on 4/30/16, indicated the resident experiences incontinent episodes of the bladder. The interventions included, but were not limited to: offer assist with toileting/incontinence care, report signs & symptoms of UTI (urinary tract infection) and update MD (Medical Doctor) of significant changes in incontinence. There was no care plan in place after the Foley catheter was removed on 1/15/16, until 4/12/16.<br><br>During an interview, on 6/20/16 at 3:15 P.M., the MDS Coordinator indicated the resident's care plan would be updated annually and with any significant change. The MDS Coordinator indicated the nursing staff had the capability to update care plans as needed.<br><br>During an interview, on 6/20/16 at 3:45 P.M., the Assistant Director of Nursing (ADON) indicated the care plans for | | | |

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| | incontinence had not been revised and updated timely to reflect the resident's frequent incontinence.<br><br>On 6/21/16 at 10:10 A.M., Resident #47 was observed being wheeled into her room and the resident's brief was changed by CNA #6. The brief was observed not to be saturated. CNA #6 indicated the resident wore a brief and was incontinent.<br><br>On 6/20/16 at 2:50 P.M., the ADON provided a policy titled "Care Plan Policy," undated, and indicated the policy was the one currently used by the facility. The policy indicated "...1. Each resident must have a care plan, within 24 hr [hour] of admit. Care plans will be reviewed with each MDS completion by the Care Plan Committee, during care plan conferences...4. Problems will be identified through completion of interdisciplinary assessments, interviews and observations, and Resident Assessment Instrument...."<br><br>3.1-35(a) | | | |

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| F 0280 SS=D Bldg. 00 | 483.20(d)(3), 483.10(k)(2)<br>RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br>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.<br><br>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.<br><br>Based on interview and record review the facility failed to revise a care plan following a decline in eating ability for 1 of 3 residents reviewed for care plans. (Resident #92)<br><br>Finding includes:<br><br>On 06/20/2016 at 9:30 A.M., a clinical record review was completed for Resident #92. Resident #92 was admitted on 9/10/2015 and readmitted on 3/8/2016. Her diagnoses included, but were not limited to: hypertension, macrocytic anemia with B12 deficiency, | F 0280 | 1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #92's care plan has been updated to reflect her current self performance for eating 2.How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. A facility wide audit of care plans will be conducted for all residents to ensure the the care plan is reflective of their current self performance for eating from the most recent MDS. 3.What measures will be put into place or what system changes will be | 08/12/2016 |

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| | fracture of the left hand, closed fracture of the cervical vertebra, fractured left femur and Fuchs' dystrophy to eyes.<br><br>An MDS (Minimum Data Set) assessment, dated 5/3/2016, indicated Resident #92 had a decline in self-performance - eating. The MDS assessment indicted she declined from limited assistance to extensive assistance.<br><br>A care plan, last revised on 4/20/2016, indicated Resident #92 "REQUIRES LIMITED ASSIST WITH EATING."<br><br>During an interview on 6/20/2016 at 2:15 P.M., the MDS coordinator indicated that the care plan had not been updated following Resident #92's decline in self-performance eating.<br><br>On 6/21/2016 at 2:30 P.M., the Assistant Director of Nursing provided a policy titled "CARE PLAN POLICY," undated, and indicated this was the policy currently used by the facility. The policy indicated "...1. Each resident must have a care plan, within 24 hr. [hours] of admit. Care plans will be reviewed with each MDS completion by the Care Plan Committee, during care plan conferences. After each care plan conference, the Care Plan Conference Sheet will be completed...." | | made to ensure that the deficient practice does not recur. An in-service will be presented to nursing staff and Care Plan Team regarding the facility Care Plan policy and procedure on 8/12/16. See attachment ___ . 4.How the corrective action will be monitored to ensure the deficient practice will not recur What Quality Assurance Program will be put into place. Director of Nursing (DON) or designee will continue to utilize the MDS schedule to review the most current MDS assessments regarding self performance for eating. The auditing process will involve five residents charts weekly for two months, then bi-monthly for two months, then monthly for two months. Audits will be presented to Quality Assurance Committee for review until 100% compliance is achieved. Date of Compliance 8/12/16 | |

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| | 2.1-35(d)(2)(B) | | | |
| F 0282 SS=D Bldg. 00 | 483.20(k)(3)(ii)<br>SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br><br>Based on observation, record review and interviews, the facility failed to ensure staff followed care plans regarding pressure ulcer relief for 1 of 3 residents reviewed for pressure ulcers. (Resident #21) In addition, the facility failed to follow care plan interventions regarding assessing blood pressure for 1 of 5 residents reviewed for unnecessary medications. (Resident #10)<br><br>Findings include:<br><br>1. The clinical record for Resident #21 was reviewed on 06/20/2016 at 9:27 A.M. Resident #21 was admitted to the facility on 08/17/10. The diagnoses included, but were not limited to: Alzheimer's disease and bradycardia. | F 0282 | 1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice. a. Resident #21's care plan has been revised. The C.N.A. assignment sheet has been updated to reflect care plan interventions regarding pressure ulcer relief. See attachment ___<br>b. Resident #10's care plan has been reviewed and revised. New orders received to obtain the residents blood pressure(B/P) twice a month and placed on MAR. Nurse to obtain a B/P reading on 1st and 16th of each month. See attachment ___<br>2.How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. a.A facility wide audit of care plans will be conducted for those residents | 08/12/2016 |

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| | A Braden Scale for Predicting Pressure Sore Risk assessment, completed on 05/02/16, indicated the resident had no impairment in her sensory perception, was often moist, was chairfast, was only slightly limited in mobility, had probable inadequate nutrition, and had potential problems with friction and scored a 15 which indicated she was not at high risk for pressure ulcer development.<br><br>Skin assessments in nursing progress notes, completed on 03/30/16 and 04/06/16, indicated the resident's skin was intact and she had no open areas.<br><br>A nursing progress note, dated 04/19/16, indicated a 3 cm (centimeter) by 2 cm red area was noted to the inner side of the resident's left heel. The physician was notified and heel protectors were implemented.<br><br>A nursing progress note, dated 04/21/16, indicated the resident continued to have a SDTI (Suspected Deep Tissue Injury: Purple or maroon localized area of discolored intact skin or blood filled blister due to damage of underlying soft tissue from pressure or shearing) on her left inner heel. The note indicated staff had previously attempted to float her heels on pillows when she was in bed but | | requiring pressure ulcer relief. Care Plans will be reviewed and updated as needed to reflect individual resident needs and current status per policy. .The C.N.A. assignment sheet has been updated to reflect care plan interventions regarding pressure ulcer relief. b.A facility wide audit of orders will be conducted for those residents requiring B/P reading more than once a month. Care Plans will be reviewed and updated as needed to reflect individual resident needs and current status per policy. B/P's readings for those residents requiring more than monthly assessment will be documented on the MAR. 3.What measures will be put into place or what system changes will be made to ensure that the deficient practice does not recur. An in-service will be presented to nursing staff and Care Plan Team regarding care plan interventions regarding pressure ulcer relief. Will also be located on the C.N.A. assignment sheet and education will be provided about the facility "B/P" policy and procedure. See attachment ___ 4.How the corrective action will be monitored to ensure the deficient practice will not recur. What Quality Assurance Program will be put into place. Director of Nursing (DON) or designee will audit five residents orders/care plans/C.N.A. assignment sheets weekly for two months, then | |

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| | she kicked the pillows away. Heel protectors were now being utilized.<br><br>A Weekly Pressure Ulcer Progress Report indicated the Suspected Deep Tissue Injury to the resident's left inner heel had resolved on 05/04/16.<br><br>A nursing progress note, dated 05/11/16, indicated the resident had an open blister area on her left heel, measuring 3 cm by 2.5 cm. The physician was notified and a treatment order for triple antibiotic ointment, telpha dressing and kerlix to open area daily was received.<br><br>On 06/20/16 from 9:25 A.M. to 11:55 A.M., Resident #21 was observed in a recliner in the front lobby sleeping. The foot rest was elevated and the resident's feet were noted to be hanging just off the end of the foot rest. The resident was noted to have snug black socks and black shoes on both feet and her ankles were crossed as she slept. At 10:00 A.M., Resident #21 did uncross her ankles. At 11:55 A.M., two staff members attempted to wake her up and had her wheelchair available but the resident was noted to be fairly lethargic, got a little belligerent twice so she was allowed to stay in her recliner and the staff indicated they would "save" her dinner tray. | | bi-monthly for two months, then monthly for two months, for those residents requiring pressure ulcer relief. Audits will be presented to Quality Assurance Committee for review until 100% compliance is achieve. Director of Nursing (DON) or designee will audit five residents care plans and MARs weekly for two months, then bi-monthly for two months, then monthly for two months, for those residents require B/P readings more than once a month. Audits will be presented to Quality Assurance Committee for review until 100% compliance is achieve. Date of Compliance 8/12/16 | |

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| | 155700 | A. BUILDING 00<br>B. WING | 06/21/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| CATHERINE KASPER HOME | 9601 S UNION RD<br>DONALDSON, IN 46513 |

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| | On 06/20/2016 at 2:00 P.M., Resident #21 was observed in her bed awake. There was an air mattress on her bed and she had a white loose non skid sock and a padded heel protector on her left foot, her right foot still had the long, snug black sock on it. During an interview, RN (Registered Nurse) #25 indicated she had removed the resident's black sock and exchanged it for a sock that was not as tight. RN #25 indicated the resident's heel had been wrapped while it was in the black shoe and sock earlier. The dressing was removed and there was a dime sized superficial light pinkish tan colored open area with dry scaly skin around the edges noted on the inside edge of the resident's left heel.<br><br>On 06/21/2016 at 9:45 A.M., Resident #21 was observed dressed, seated in her wheelchair leaning to the right asleep during an exercise activity. Her left foot has a loose white sock and heel protector on it and was placed on the foot rest of the wheelchair. The resident's right foot was in a regular black shoe and the snug black sock.<br><br>A care plan, initiated on 04/20/16, reviewed and revised on 05/04/16 and current through 07/20/16, regarding a bruise on the resident's left heel had interventions, including float heels when | | | |

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| | in bed and heel protectors to be worn at all times.<br><br>Another care plan, initiated on 05/17/16, and current through 08/17/16 regarding the pressure ulcer to the resident's left heel included the intervention to "elevate heels and use protectors."<br><br>2. The clinical record for Resident #10 was reviewed on 06/20/2016 at 1:27 P.M. Resident #10 was admitted to the facility on 01/06/15. The diagnoses, included, but not limited to: chronic coronary heart disease, atrial fibrillation, hypertension, chronic kidney disease and cardiac dysrhythia.<br><br>The current physician's orders for medications included, but were not limited to the following:<br>*Dilatiazem (a medication to treat high blood pressure) 120 mg (milligrams) one capsule daily,<br>*Furosemide (a diuretic which lowers blood pressure) 40 mg one tablet twice a day,<br>*Spironolactone (a diuretic utilized to treat high blood pressure) 25 mg 1/2 tablet twice a day<br><br>A blood pressure flow sheet, located in the Medication Administration Record (MAR) for Resident #10 had a blood | | | |

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| | pressure documented on 05/02/16. There was no further blood pressure recorded on the flow sheet for Resident #10.<br><br>The ADON (Assistant Director of Nursing) presented monthly physician visit forms for Resident #10 for 03/09/16, 04/06/16 and 05/11/16. These forms documented a blood pressure.<br><br>There was a nursing progress note, dated 06/09/16, which included a blood pressure assessment.<br><br>A care plan, initiated on 04/09/15 and current through 07/14/16, to address the resident's diagnosis of Congestive Heart Failure (CHF) had interventions to "monitor the resident's blood pressure weekly..."<br><br>A care plan, initiated on 03/03/15, reviewed on 04/14/16 and current through 07/14/16, regarding the resident's diagnosis of hypertension (elevated blood pressure) included interventions to "observe b/p (blood pressure) per protocol and as needed...."<br><br>During an interview on 06/20/16 at 3:21 P.M., the ADON indicated the resident had a previous physician's order to check his blood pressure more frequently but it had been discontinued and the blood | | | |

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| | pressure was only being assessed monthly.<br><br>The current facility policy and procedure, titled "Blood Pressure Procedure," undated, was provided by the ADON on 06/20/16 at 3:22 P.M. The policy indicated the following: "...6. A monthly blood pressure reading shall be sufficient unless otherwise ordered by physician...."<br><br>3.1-35(g)(2) | | | |
| F 0315 SS=D Bldg. 00 | 483.25(d)<br>NO CATHETER, PREVENT UTI, RESTORE BLADDER<br>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. | | | |

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| | Based on observations, record reviews and interviews, the facility failed to ensure the a resident's urinary continence was accurately assessed and care plan interventions developed to restore the bladder function for 2 of 3 residents reviewed for incontinence decline. (Resident #47 and Resident #92)<br><br>Findings include:<br><br>1. On 6/20/16 at 9:02 A.M., a review of the clinical record for Resident #47 was conducted. The record indicated the resident was re-admitted on 1/12/16 after a hospital stay. The resident's diagnoses included, but were not limited to: bipolar, depression, vascular dementia, Alzheimer's disease and right hip fracture.<br><br>The nursing admission record indicated the resident was admitted to the facility after having a right hip fracture. The form indicated the resident was admitted with a Foley catheter.<br><br>A physician's order, dated 1/12/16, indicated to remove the Foley catheter when the resident was ambulatory. Another physician's order, dated 1/14/16, indicated to removed the Foley catheter and if no voiding (urination) after 8 hours, then re-anchor the Foley catheter. | F 0315 | 1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #47 and #92 has been reassessed for urinary continence and care plans reviewed/revised to reflect individual resident needs and current status.<br>2. How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. A facility wide audit will be conducted utilizing the last 2 MDS for each resident to determine if there has been a decline in urinary continence. All residents identified will be reassessed to determined if interventions are needed and will be cared planned as necessary per policy. 3. What measures will be put into place or what system changes will be made to ensure that the deficient practice does not recur. An in-service will be presented to nursing staff and Care Plan Team regarding the facility Care Plan policy and procedure and the Bowel and Bladder Assessment policy and procedure on 8/12/16.<br>See attachment ___ 4.How the corrective action will be monitored to ensure the deficient practice will not recur What Quality Assurance Program will be put into place. Director of Nursing (DON) or designee will continue to utilize the MDS schedule | 08/12/2016 |

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| | The Admission MDS (Minimum Data Set) Assessment, dated 1/19/16, indicated the resident's BIMS (Brief Interview Mental Status) score was 13 (mild dementia). The Admission Assessment indicated the resident was frequently incontinent and no toileting program was initiated.<br><br>A Significant change MDS Assessment, dated 4/7/16, indicated the resident was always incontinent and her cognition was unable to be assessed, as resident could not answer screening questions.<br><br>An Admission care plan, undated, indicated the resident had a Foley catheter with interventions to provide catheter care every shift.<br><br>An Activities of Daily Living-Functional/Rehabilitation Potential, dated 4/12/16 and updated on 4/30/16, indicated the resident experienced incontinent episodes. The interventions included but were not limited to: offer assist with toileting/incontinence care, report signs & symptoms of UTI (urinary tract infection) and update MD (Medical Doctor) of significant changes in incontinence. | | to review the two most recent MDS assessments for decline in continence and ensure initiation of Bowel and Bladder assessment policy and procedure as needed. The auditing process will be weekly for two months, then bi-monthly for two months, then monthly for two months. Audits will be presented to Quality Assurance Committee for review until 100% compliance is achieve. Date of Compliance 8/12/16 | |

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| | A January Resident Care Record indicated upon admission the staff documented "cath" under continent of urine. On 1/14/16, the form indicted the resident was continent 5 times over 3 shifts and incontinent 5 times over 3 shifts. Subsequent days in January indicated the resident had 1-3 continent episodes over 3 shifts but 6-8 episodes of incontinence over 3 shifts. The March and April Resident Care Record for 2016, indicated the resident was totally incontinent of bowel and bladder.<br><br>A 3-day Bowel and Bladder Diary, dated 1/12-1/15 thru 1/18/16, indicated resident had a Foley catheter until 1/15/16. On 1/15/16 at 10 A.M. and 2 P.M., documentation indicated the resident was incontinent of bladder/urine and had not asked staff to use the toilet. The other time slots for staff to provide documentation from 12 A.M. to 11 P.M. were blank. On 1/16/16, "independent" was written to cover the entire day. On 1/17/16 at 7 A.M. and 11 A.M., documentation indicated the resident was incontinent of bladder and at 1 P.M. the resident was continent of bladder. All other time slots were blank on 1/17. On 1/18/16, the form indicated the resident was incontinent of bladder at 7 A.M., 10 A.M. and 1 P.M., the rest of the time slots were blank. | | | |

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| | A Bowel and Bladder Grid, dated 1/16/16, indicated the resident scored a 12. The form indicated a score of 9-15 declared the resident was a fair candidate for a bladder retraining program.<br><br>A Scheduled Toileting Every 4 hours form indicated on 1/15/16 starting at 8 am resident was to be toileted at 12 A.M., 4 A.M., 8 A.M., 12 P.M., 4 P.M. and 8 P.M. The form had missing documentation on the 1/23, 1/24, 1/25, 1/26, 1/27, 1/28, 1/30 and 1/31.<br><br>During an interview, on 6/20/16 at 3:15 P.M., the MDS Coordinator indicated the resident's care plan would be updated annually. The MDS Coordinator indicated the nursing staff had the capability to update care plans as needed.<br><br>During an interview on 6/20/16 at 3:20 P.M., the DON (Director of Nursing) indicated the Bowel and Bladder Diary should be completed (each time slot filled) to be able to assess the resident's incontinence.<br><br>During an interview, on 6/20/16 at 3:45 P.M. the Assistant Director of Nursing (ADON) indicated the care plan was not updated after the Foley catheter was removed to reflect the resident's frequent | | | |

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| | incontinence. She indicated the resident was not placed in a restorative plan for her incontinence issue.<br><br>On 6/21/16 at 10:10 A.M., Resident #47 was observed being wheeled into her room and the resident's brief was changed by CNA #6. The brief was observed not to be saturated. CNA #6 indicated the resident wore a brief and was incontinent.<br><br>On 6/20/16 at 2:50 P.M., the ADON provided a policy titled "Care Plan Policy," undated, and indicated the policy was the one currently used by the facility. The policy indicated "...1. Each resident must have a care plan, within 24 hr [hour] of admit. Care plans will be reviewed with each MDS completion by the Care Plan Committee, during care plan conferences...4. Problems will be identified through completion of interdisciplinary assessments, interviews and observations, and Resident Assessment Instrument...."<br><br>On 6/20/16 at 2:50 P.M., the ADON provided a policy titled "Bowel and Bladder Assessment," dated July 9,2015, and indicated the policy was the one currently used by the facility. The policy indicated "...Procedures: 1. The nurse supervisor (or designee) will initiate a seven (7) day bowel and bladder diary | | | |

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| | upon admission. The M.D.S. Coordinator (or designee) will initiate a seven (7) day bowel and bladder diary quarterly according to the M.D.S. schedule or with resident change of condition. 2. Upon completion of a seven (7) day bowel and bladder diary, the bowel and bladder evaluation grid will be initiated by nursing to assess if a resident qualifies for an Incontinence Management Program. 3. If a resident is deemed a fair/good candidate for Incontinence Management Program, a bowel and bladder continence and retraining evaluation will be completed...."<br><br>2. On 06/20/2016 at 9:30 A.M., a clinical record review was completed for Resident #92. Resident #92 was admitted on 9/10/2015 and readmitted on 3/8/2016. The diagnoses included, but were not limited to: hypertension, fracture of the left hand, osteoporosis, closed fracture of the cervical vertebra and fractured left femur.<br><br>An MDS (Minimum Data Set) assessment, dated 5/3/2016, indicated Resident #92 had declined in bladder continence from continent to frequently incontinent of her bladder.<br><br>A form titled "BOWEL AND BLADDER | | | |

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| | DIARY," dated 3/4/2016, indicated Resident #92 was planned to have a seven day bladder diary completed. The form showed no documentation from 3/8/2016 thru 3/10/2016.<br><br>During an interview, on 6/20/2016 at 11:25 A.M., the ADON (Assistant Director of Nursing) indicated there should have been a bladder assessment completed following a decline in continence. She further indicated she had not completed a bladder assessment for Resident #92 following the bladder continence decline.<br><br>During an interview on 6/20/2016 at 12:07 P.M., the MDS Coordinator indicated a bladder assessment was to be completed following a decline in bladder continence. She indicated this was not done for Resident #92.<br><br>On 6/21/2016 at 2:30 P.M., the ADON provided a policy titled "Bowel and Bladder Assessment," dated 7/9/2015, and indicated this was the policy currently used by the facility. The policy indicated "...1. The nurse supervisor (or designee) will initiate a seven (7) day bowel and bladder diary upon admission. The M.D.S. Coordinator (or designee) will initiate a seven (7) day bowel and bladder diary quarterly according to the | | | |

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| | M.D.S. schedule or with resident change of condition. 2. Upon completion of a seven (7) day bowel and bladder diary, the bowel and bladder evaluation grid will be initiated by nursing to assess if a resident qualifies for an Incontinence Management Program...."<br><br>3.1-41(a)(2) | | | |
| F 0323 SS=D Bldg. 00 | 483.25(h)<br>FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br>Based on observation, record review and interviews, the facility failed to respond to an alarm and provide adequate supervision to prevent falls for 1 of 3 residents reviewed for accidents. (Resident #50)<br><br>Finding includes:<br><br>The clinical record for Resident #50 was reviewed on 06/20/2016 at 11:22:05 A.M. Resident #50 was admitted to the facility on 07/19/11. The diagnoses | F 0323 | 1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #50's care planned interventions have been reviewed and revised to ensure safety of resident. Additional interventions specific to resident #50, nursing has initiated a bowel and bladder assessment to analyze if a routine toileting pattern can be established. Also, the activity department will assess if resident #50 would benefit from a routine structured activity plan Our call light/sensory | 08/12/2016 |

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| | included, but were not limited to: atrial fibrillation, hypertension, anxiety, depression, spinal stenosis, Alzheimer's disease, tremors, decreased fine motor skills and obsessive compulsive disorder.<br><br>During an interview on 06/17/16 at 9:33 A.M., RN (Registered Nurse) #28 indicated Resident #50 had fallen twice in the past month.<br><br>The most recent fall risk assessments, completed on 04/20/16, 06/10/16 and 06/12/16, indicated the resident's score indicated she was at high risk for falls.<br><br>A nursing progress note, dated 06/12/16 at 3:15 A.M., indicated her chair alarm went off and the resident was found on the floor at the foot of a recliner sitting on a pillow and the alarm. The resident did not incur any injuries as a result of the fall.<br><br>A nursing progress note, dated 06/10/16 at 12:15 P.M., indicated a housekeeper had eased the resident to the floor in the bathroom after noting the resident had lost her balance while pulling up her pants.<br><br>A nursing progress notes, dated 04/27/16, indicated the resident was trying to get up out of her recliner in her room and got | | fall alarm server has also highlighted the sensory alarm notifications in a different color (white). 2. How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. An audit of all residents with fall sensory alarms will be completed by reviewing current care planned interventions to ensure effectiveness for residents safety needs. 3. What measures will be put into place or what system changes will be made to ensure that the deficient practice does not recur. An in-service will be presented to nursing staff on the following: (a)response times to fall sensory alarms must be immediate and with sense of urgency. (b) Staff to know our call server Palatium has changed the background color to white when fall sensory alarm is activated on ipod, in essence, highlighting the notification. 4. How the corrective action will be monitored to ensure the deficient practice will not recur. What Quality Assurance Program will be put into place. Director of Nursing (DON) or designee will test staff response times to a fall sensory alarms and document findings twice weekly for two months, then weekly for two months, then bi-monthly for two months. Audits will be presented to Quality Assurance Committee for review until 100% compliance is | |

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| | 155700 | A. BUILDING 00<br>B. WING | 06/21/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| CATHERINE KASPER HOME | 9601 S UNION RD<br>DONALDSON, IN 46513 |

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| | her leg caught in the elevated foot rests of the recliner.<br><br>A care plan related to Resident #50's need for assistance with activities of daily living, initiated on 04/14/16, indicated the resident required extensive assist with bed mobility, transfers and toileting. The interventions included to assist the resident as needed.<br><br>A care plan related to Behavioral symptoms, initiated on 09/09/15, indicated the resident had a history of compulsive behavior such as picking up lint/paper from the floor. The interventions included to remind the resident it was not acceptable behavior, provided 1:1 supervision, remind the resident of safety and redirect to activity such as folding laundry or wiping the dining tables, or talk about raising her family of 10 children.<br><br>A care plan related to the resident risk for falling, initiated on 09/25/14, revised on 06/13/16, and current through 07/19/16, included interventions were added on the following dated:<br>06/12/16 - fell in bathroom asking for PT (physical therapy) screen<br>04/20/16 - fell out of recliner trial sleeping in bed at night instead of recliner | | achieve. Date of Compliance 8/12/16 | |

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| | 02/15/16 - review meds, staff education to make sure silent alarm is in both wheelchair and recliner, offer assist to be by 8:30 p.m., apply silent alarms due to recent falls to recliner and wheelchair due to impulsiveness and dementia<br>01/10/16 - fell, offer recliner after meals<br>01/25/16 - fell, offer routine toileting<br>11/23/15 - staff education regarding intervention of redirecting resident when she is picking items up from floor compulsively<br>10/18/15 - check resident frequently to verify nonskid socks on<br>10/14/15 - encourage to stay visible in living room as much as possible between meals<br>08/20/15 - make sure nothing on floor so she doesn't lean over trying to pick up on her own. Keep wheelchair next to recliner and in locked position<br>07/09/15 - toilet on routine toileting rounds<br>05/26/15 - dycem (a non-slip material) to wheelchair to prevent from sliding out of chair<br>09/25/14 - resident noted to unhook alarms - check q (every) 2 hours<br>02/09/15 - offer assist to recliner from wheelchair after meals<br>01/23/15 - observe frequently and place in supervised area when out of bed<br>09/25/14 - toilet per schedule at get up, lay down, before and or after meals and | | | |

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| | prn, transfer with 1 assist<br><br>On 06/17/16 at 10:30 A.M., Resident #50 was observed to transfer herself onto the toilet. She had left the room door and the privacy curtain open and was observed from the hallway. A chair alarm was noted on the back of the resident's wheelchair. No staff were in the hallway or seemed to be coming to check on the resident. After 4 minutes, CNA (Certified Nursing Assistant) #26 emerged from Room #258 carrying a finished meal tray. She was asked about the chair alarm and she indicated the alarm room number was sent to her and other nursing staff's walkie talkie so they could check on residents. She then started to proceed down the hall with the meal tray. At the request of the surveyor, she was asked to assist Resident #50.<br><br>On 06/20/2016 at 11:17 A.M., Resident #50 was observed to be 2/3 of the way down the D hall bent over and attempting to pick up an unidentified object off of floor. Although she had alarm on her wheelchair, no staff were noted to come to see about her positioning. After staying in the bent over position, touching the floor with her hands for approximately 1 and 1/2 minutes, she did sit back up in her wheelchair and proceeded towards the dining room. She | | | |

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| | was then noted to be going around dining room/lounge area fiddling with lazy Susan and decorative center pieces for the next 1/2 hour. At no time did staff come to check on her whereabouts or positioning in the wheelchair.<br><br>On 06/21/2016 at 10:46 A.M., Resident #50 was noted to be dozing, seated in her wheelchair in the dining room/lounge area. At 11:00 A.M., a housekeeper pushed the resident in her wheelchair into her room and left her in her room. At 11:06 A.M., Resident #50 transferred herself to the toilet. No staff were noted the area. At 11:09 A.M., CNA (Certified Nursing Assistant) #27, an aide from B hall, was noted slowly walking down D hall. She stopped to greet another resident and then did checked in on Resident #50. CNA #27 indicated at first she had no calls on her walkie talkie but then when asked about the chair alarm she indicated the alarms were noted on a cell phone. She pulled out the cell phone and it did indicated to check room #259. She indicated Resident #50 usually transferred herself but was to be assisted and did not fall very often as far as she knew but she was not usually assigned to D hall. She thought the CNA for D hall might have been on a break. At 11:14 A.M., the nurse for the unit checked on Resident #50 who was being assisted by | | | |

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| | CNA #27 in the bathroom.<br><br>During an interview on 06/21/16 at 4:00 P.M., the Administrator indicated the facility did not have a policy regarding the use and response to "silent alarms."<br><br>3.1-45(a)(2) | | | |
| F 0329<br>SS=D<br>Bldg. 00 | 483.25(l)<br>DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br>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.<br><br>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 | | | |

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| | residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.<br>Based on observation, record review and interview, the facility failed to ensure there adequate monitoring regarding medications for congestive heart failure and hypertension for 1 of 5 residents reviewed for unnecessary medications. (Resident #10) In addition, the facility failed to ensure there was adequate monitoring of abnormal movements for 1 of 5 residents receiving psychotropic medications (Resident #58)<br><br>Findings include:<br><br>1. The clinical record for Resident #10 was reviewed on 06/20/2016 at 1:27 P.M. Resident #10 was admitted to the facility on 01/06/15. The diagnoses, included, but not limited to: chronic coronary heart disease, atrial fibrillation, hypertension, chronic kidney disease and cardiac dysrhythia.<br><br>The current physician's orders for medications included, but were not limited to the following:<br>*Dilatiazem (a medication to treat high blood pressure) 120 mg (milligrams) one capsule daily,<br>*Furosemide (a diuretic which lowers | F 0329 | 1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #10's physician was notified and current medications for congestive heart failure (CHF) and hypertension were reviewed. The physician gave orders to obtain B/P twice monthly on 1st and 16th of each month. An AIMS assessment has been completed and updated for resident #58.<br>2. How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. An audit of all care plans/MARS will be conducted<br>for those residents who receive medications for CHF or hypertension to ensure monitoring in place. An audit of all charts for those residents who receive antipsychotic medication to ensure an AIMS assessment has been completed within last three months per facility policy.<br>3. What measures will be put into place or what system changes will be made to ensure that the deficient practice does not recur.<br>An in-service will be presented to nursing staff regarding the facility B/P policy and procedure. An in-service will be presented to | 08/12/2016 |

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| | blood pressure) 40 mg one tablet twice a day,<br>*Spironolactone (a diuretic utilized to treat high blood pressure) 25 mg 1/2 tablet twice a day<br><br>A blood pressure flow sheet, located in the Medication Administration Record (MAR) for Resident #10 had a blood pressure documented on 05/02/16. There was no further blood pressure recorded on the flow sheet for Resident #10.<br><br>The ADON (Assistant Director of Nursing) presented monthly physician visit forms for Resident #10 for 03/09/16, 04/06/16 and 05/11/16. These forms documented a blood pressure.<br><br>There was a nursing progress note, dated 06/09/16, which included a blood pressure assessment.<br><br>A care plan, initiated on 04/09/15 and current through 07/14/16, to address the resident's diagnosis of Congestive Heart Failure (CHF) had interventions to "monitor the resident's blood pressure weekly..."<br><br>A care plan, initiated on 03/03/15, reviewed on 04/14/16 and current through 07/14/16, regarding the resident's diagnosis of hypertension (elevated blood | | nursing staff regarding the facility Abnormal Involuntary Movement Scale (AIMS) policy and procedure. See attachment____ 4. How the corrective action will be monitored to ensure the deficient practice will not recur What Quality Assurance Program will be put into place. a.Director of Nursing (DON) or designee will audit five resident charts/MARs/Care Plans with CHF and or hypertension to ensure facility policy is followed. The auditing process will involve five residents charts weekly for two months, then bi-monthly for two months, then monthly for two months. Audits will be presented to Quality Assurance Committee for review until 100% compliance is achieve. b.Director of Nursing (DON) or designee will audit three resident charts who receive antipsychotic medication to ensure an AIMS assessment has been completed quarterly per facility policy. The auditing process will involve three residents charts weekly for two months, then bi-monthly for two months, then monthly for two months. Audits will be presented to Quality Assurance Committee for review until 100% compliance is achieve. Date of Compliance 8/12/16 | |

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| | pressure) included interventions to "observe b/p (blood pressure) per protocol and as needed...."<br><br>During an interview on 06/20/16 at 3:21 P.M., the ADON indicated the resident had a previous physician's order to check his blood pressure more frequently but it had been discontinued and the blood pressure was only being assessed monthly.<br><br>The current facility policy and procedure, titled "Blood Pressure Procedure," undated, was provided by the ADON on 06/20/16 at 3:22 P.M. The policy indicated the following: "...6. A monthly blood pressure reading shall be sufficient unless otherwise ordered by physician...."<br><br>2. On 6/21/16 at 9:11 A.M., record review indicated Resident #58's diagnoses included, but were not limited to "...anxiety, Alzheimer's disease, vascular dementia without behavioral disturbance, drug induced subacute dyskinesia and major depressive disorder...."<br><br>The resident's medication regimen included Clozaril 50 mg (milligrams) an antipsychotic to be given twice daily for tardive dyskinesia, ordered on 11/23/15. Prozac 20 mg an antidepressant to be | | | |

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| | given daily, ordered on 11/24/15. Clonazepam 1 mg to be given twice daily for anxiety and restless leg syndrome, ordered on 1/26/16. Lorazepam 0.25 mg an antianxiety medication to be given daily on Sunday, Monday, Tuesday, Thursday, Friday and Saturday, ordered on 4/22/16.<br><br>A care plan, initiated on 10/30/14 and revised on 4/21/15, indicated the problem: (Resident name) has a diagnosis of tardive dyskinesia for which an antipsychotic medication has been ordered. Interventions included but were not limited to: Contact MD (Medical Doctor) and psych services as needed. Contact Social Service as needed. Encourage activities of choice/preferences. Praise for participation. Encourage to ventilate feelings. Give positive and realistic feedback. Monitor for signs and symptoms of psychosis: hallucinations, delusions and agitation. Observe for side effects related to medication: drooling, hypotension and lethargy. Offer spiritual support as needed. Offer diversional activity as needed.<br><br>An Abnormal Involuntary Movement Scale (AIMS), dated 5/2/15, indicated Scoring Codes: 0=None, 1=Minimal/Normal, 2=Mild, 3=Moderate | | | |

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| | and 4=Severe. The AIMS assessment indicated a score of 4. No other AIMS assessments after 5/2/15 was located on the chart.<br><br>A Behavior/Intervention monthly flow record, dated June 2016, indicated no documented side effects was observed for the medication Clozapine.<br><br>On 6/21/16 at 9:28 A.M., Resident #58 was observed sitting in her wheelchair in the dining room participating in an exercise activity. The resident was conversing with other residents, her mouth was continuously moving like a chewing motion and her tongue protruded out over her lips as she talked. Her head was observed moving to the side as she spoke. Her speech was slow but understandable.<br><br>During an interview on 6/21/16 at 1:15 P.M., the Social Service Director (SSD) indicated the AIMS assessment should be done by nursing quarterly. She indicated the AIMS assessment is especially important for this resident because she is on an antipsychotic medication and has tardive dyskinesia. The SSD indicated the last AIMS assessment was completed on 5/2/15.<br><br>On 6/21/16 at 2:30 P.M., the | | | |

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| | Administrator provided a policy titled "Abnormal Involuntary Movement Scale (AIMS) Policy", undated, and indicated the policy was the one currently used by the facility. The policy indicated "...1. Conduct this assessment quarterly on nursing facility residents receiving antipsychotic medications...."<br><br>3.1-48(a)(3) | | | |
| F 0428<br>SS=D<br>Bldg. 00 | 483.60(c)<br>DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON<br>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.<br>Based on record review and interview, the facility failed to ensure a pharmacy recommendation was reviewed, clarified and responded to timely for 1 of 5 residents reviewed for unnecessary medications (Resident #73)<br><br>Finding includes: | F 0428 | 1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Pharmacy recommendation from June 2016 for resident #73 due to fall has been addressed. New orders received to reduce Trazodone from 75mg to 50mg po @ HS and to obtain BMP. 2. How will other residents having the potential to be affected by the same deficient | 08/12/2016 |

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| | The clinical record for Resident #73 was reviewed on 06/20/2016 at 10:36:19 A.M. Resident #73 was admitted to the facility on 06/03/14. The diagnoses, included, but were not limited to: schizoaffective disorder, polymyalgia, chronic pain and anxiety.<br><br>The current physician's orders for medications for Resident #73 included the following:<br>*Trazadone (an antidepressant) 150 mg (milligrams) 1/2 tablet at bedtime<br><br>A pharmacy review of her medications was completed on 06/10/16 by the pharmacist due to a resident fall. The recommendation made by the pharmacist was to check a BMP (Basic Metabolic Panel) blood test and to reduce the resident's Trazadone medication to 100 mg at bedtime.<br><br>There was no documentation the physician had been notified of the recommendations. A psychiatric nurse practitioner's evaluation, also dated 06/10/16, was provided but the assessment did not acknowledge the pharmacy recommendations.<br><br>During an interview on 06/21/16 at 3:30 P.M., the Director of Nursing (DON) indicated the resident had been reviewed | | practice will be identified and what corrective action will be taken. All pharmacy recommendations within last 30 days will be audited to ensure that pharmacy suggestions have been fully addressed and documented.<br>3. What measures will be put into place or what system changes will be made to ensure that the deficient practice does not recur.<br>An in-service will be presented to nursing staff regarding Pharmacy Services policy and procedure on 8/12/16. See attachment ___<br>4. How the corrective action will be monitored to ensure the deficient practice will not recur. What Quality Assurance Program will be put into place. Director of Nursing (DON) or designee will audit all pharmacy recommendations monthly for next six months to ensure that all pharmacy recommendations have been addressed and documentation provided. Audits will be presented to Quality Assurance Committee for review until 100% compliance is achieve. Date of Compliance 8/12/16 | |

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|---|---|---|---|
| | 155700 | A. BUILDING 00<br>B. WING | 06/21/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CATHERINE KASPER HOME | 9601 S UNION RD<br>DONALDSON, IN 46513 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| | at a Behavioral meeting, attended by both the pharmacist and the psychiatric nurse practitioner. She indicated she had no documentation the nurse practitioner had reviewed the recommendations and if she desired to order a BMP laboratory test. The DON indicated Resident #73 was only receiving 75 milligrams of Trazadone at bedtime so the pharmacy recommendation did not make sense.<br><br>On 06/21/16 at 3:30 P.M., the Administrator provided the facility policy and procedure, titled "Pharmacy Services Policy," undated, and indicated this was the one currently used by the facility. The policy indicated the following: "...The pharmaceutical services consultant reviews the drug regimen of each resident at least monthly. A report is made to each resident's attending physician and the director of nursing of any irregularities identified by the consultant. Action on the pharmaceutical services consultant's report shall be documented...."<br><br>There was no policy regarding where the documentation regarding physician response to pharmacy recommendations were to be documentation.<br><br>3.1-25(h) | | | |

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