STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155779	A. BUILDING 00 B. WING	10/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PRAIRIE LAKES HEALTH CAMPUS	9730 PRAIRIE LAKES BLVD EAST NOBLESVILLE, IN 46060

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: October 3, 4, 5, 9 and 10, 2018 Facility number: 012305 Provider number: 155779 AIM number: 200987990 Census Bed Type: SNF/NF: 28 SNF: 22 Residential: 50 Total: 100 Census Payor Type: Medicare: 8 Medicaid: 1 Private: 73 Other: 1 Total: 83 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 15, 2018.	F 0000	**Prairie Lakes Annual Plan of Correction October 2018** Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during Recertification visit with exit on October 10, 2018. Please accept this Plan of Correction as the provider's credible allegation of compliance as of October, 2018. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:			

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

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	(i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident			

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	for the appropriateness of that medication. Based on observation, interview and record review the facility failed to attempt a gradual dose reduction for psychotropic medications for 2 of 5 residents review for unnecessary medication. (Resident 20, and 23) Findings include: 1. The clinical record for Resident 20 was reviewed on 10/05/18 09 a.m., Diagnoses for the resident included but were not limited to, Alzheimer's disease , major depression, and Parkinson's disease. Current signed physician's orders for the resident included, but were not limited to, the following orders: a. Cymbalta (an antidepressant medication) 60 mg. give one tab once a day. The order originated on 9/12/16. The resident had a 7/26/18, quarterly Minimum Data Set (MDS) assessment, which indicated the resident had severe cognitive impairment. The resident had a current, updated on 8/20/18, health care plan with the problem of " I use a antidepressant medication R/T [related to] my depression because I have signs and symptoms of loss of interest, self isolation and tearfulness. The goal for this problem was "I will be at a reduced risk for loss of interest, self - isolation, and tearfulness with these interventions in place. Interventions included, but were not limited to: rechanneling my behavior by engaging me in activities' related to current or prior interests. The care plan lacked an intervention for a gradual dose reduction.	F 0758	**F 758 Unnecessary Medications** 1.Resident's #20 and #23 were cited as being affected by this alleged deficient practice. The MD was contacted for both residents and GDR was requested. . 2.All residents receiving psychotropic medications have the potential to be affected. All residents receiving psychotropic medications were reviewed and the MD was notified of needed review for GDR if warranted. Nursing leadership has been educated on reviewing the use of psychotropic medications for the need for timely GDRs. 3.As a measure of quality assurance, the DHS or designee will review all residents receiving psychotropic medications monthly to ensure a GDR has been requested when warranted. 4.For quality assurance, the ED or designee will review audit results and subsequent corrective action at least quarterly in the campus Quality Assurance Committee meeting. The plan will be revised as warranted. If increased problems noted, audit frequency may increase. If no problems noted after six months, the frequency of audits may decrease.	10/26/2018

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	A care plan, dated 8/20/18, indicated she was at risk for developing adverse effects from the use of anti-depressant medications. Interventions included, but were not limited to: administer medications per orders, observe for any adverse effects and observe for mood response to medication. A Psychiatric Subsequent visit, dated 3/5/18, indicated but not limited to: Residents moods and behaviors remain stable. No new mood or behaviors noted in recent charting. A Psychiatric Subsequent visit, dated 8/10/18, indicated but not limited to: Residents mood and psychosis stable. A review of daily target behavior monitoring for every shift on the MARs (medication administration records) there were no depressive behaviors documented for the months of May, June, July, August, September or October (to current date). An interview on 10/5/18 at 1:38 p.m., the Assistant Director of Nursing indicated there had been no gradual dose reduction (GDR) for the Cymbalta in 2018 due to resident receiving GDR for Seroquel. An interview on 10/5/18 at 2:27 p.m., the Assistant Director of Nursing indicated there is no information regarding a GDR for Cymbalta since initial dose began 9/12/16. 2. During an observation, on 10/4/18 at 1:59 p.m., Resident 23 was in the hair salon smiling and engaging in pleasant appropriate conversation. During an observation, on 10/5/18 at 9:56 a.m., she			

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	was in activities in common area. She had no behaviors or symptoms of depressive behaviors, she was interacting appropriately. The clinical record was reviewed, on 10/4/18 at 10:56 a.m. Her diagnoses included, but were not limited to: Parkinson's disease, chronic lymphocytic leukemia, blindness, depression and anxiety. A quarterly MDS (minimum data set) assessment, dated 8/6/18, indicated she had moderate cognitive impairment and mild depression. She required the use of anti-anxiety and anti-depressant medications. A care plan, dated 12/20/17, indicated she was at risk for developing adverse effects from the use of anti-depressant medications. Interventions included, but were not limited to: administer medications per orders, observe for any adverse effects and observe for mood response to medication. A physician order, dated 7/3/17, indicated she was to receive Citalopram (anti-depressant) 20 milligrams daily. A review of target behavior monitoring every shift for on the MARs (medication administration record), there were no depressive behaviors documented for the months of July, August, September and October (to current date). An IDT (interdisciplinary team) review for behavior management note, dated 9/19/17, indicated she was agitated mostly when her routine was thrown off (i.e. bed is not made, cannot locate pants etc.).			

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	An IDT behavior meeting note, dated 10/23/17, indicated no new behaviors and no new recommendations. Will monitor monthly for GDR (gradual dose reduction) meeting. An IDT behavior note, dated 12/22/17, indicated the resident continued to be stable with no new behaviors noted. An IDT behavior note, dated 1/19/18, indicate the resident got anxious if not served immediately in the dining room. A Psychiatric Visit Note, dated 2/2/18, indicated a GDR evaluation for Celexa (Citalopram). GDR of psychotropic medications was not indicated at this time. The resident had intermittent periods of anxiety, currently endorsing depressive symptoms upon interview today. Follow up as needed. An IDT note for change of condition, dated 3/2/18, indicated she had anxiety last evening (3/1/18). The resident was eventually re-directed and calmed and vitals returned to normal limits. She had a diagnosis of general anxiety disorder. A nursing note, dated 3/2/18 at 12:33 p.m., indicated she was pleasant all morning. A nursing note, dated 3/3/18 at 8:00 a.m., indicated she slept most of the night, no symptoms of anxiety, distress, or discomfort noted through the shift. A nursing note, dated 3/5/18 at 2:30 a.m., indicated no increase anxiety noted this shift. Continue to monitor. An IDT review for behavior meeting, dated 3/20/18 at 11:22 a.m., indicated the resident was			

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	noted with increased anxiety related to being sick, all vitals within normal limits. Will continue to monitor resident in behavior meeting monthly. An IDT Review for behavior meeting, dated 4/27/18 at 1:47 p.m., indicated no new behaviors at this time. Will continue to follow monthly in behavior meeting. An IDT Behavior Meeting, dated 5/24/18 at 10:52 a.m., indicated the resident remained stable with no changes recommended at this time. Will continue to follow resident in behavior meeting monthly. An IDT review behavior meeting, dated 6/15/18 at 2:24 p.m., indicated the resident was stable with no new behaviors. Resident continued to eat meals in dining room and ambulated with walker. Will continue to monitor in behavior meeting monthly. A Psychiatric Visit Note, dated 6/25/18, indicated a GDR evaluation for Celexa (Citalopram). The decision was made to continue Celexa at the current dose for chronic depression and anxiety. An IDT Review for Behavior Meeting, dated 7/23/18 at 2:15 p.m., indicated she had no increase in behaviors. Will continue to monitor monthly in behavior meeting. An IDT Review for Behavior Meeting, dated 8/21/18 2:11 p.m., indicated she had no increase in behaviors. Resident did have an increase in falls-treated for UTI with antibiotic. Will continue to monitor monthly in behavior meeting. An IDT note, dated 9/17/18, indicated she had several recent falls and is having a hard time			

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	accepting loss of independence. Medications continue without change. Will continue to follow resident in behavior meeting monthly. During an interview with the Nurse Consultant, on 10/4/18 at 1:52 p.m., she indicated she did not find any record of GDR in record for Citalopram in the clinical record. During an interview with CRCA (certified residential care associate) 21, on 10/4/18 at 1:57 p.m., she indicated the resident had never shown any symptoms or behaviors of depression. During an interview with the ADHS (Assistant Director of Health Services), on 10/9/18 at 10:13 a.m., she indicated no GDR had been attempted for the Citalopram for Resident 23. There was no medically contraindicated note in the clinical record. A current policy titled Psychotropic Medication Usage and Gradual Dose Reduction was provided by the Administrator, on 10/5/18 at 8:15 a.m. This policy indicated, " ...PROCEDURES: 4. A gradual dose reduction (GDR) will be attempted for two separate quarters per the physician recommendation. GDR must be attempted annually thereafter, unless medically contraindicated ....". 3.1-48(a)(2) 3.1-48(b)(2)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include			

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	the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.			
	Based on observation and interview, the facility failed to ensure 1 of 4 medication carts were maintained in a secure manner to prevent potential access at all times by unauthorized users for the 200 Hall medication cart for 3 of 3 observations. Findings include: During an observation on 10/3/18 at 12:47 p.m., the medication cart on the 200 hall was unlocked and unattended. No staff was observed in the area. Staff nurse walked by cart at 1:02 p.m. and locked cart. During an observation on 10/4/18 at 8:27 a.m., the medication cart on the 200 hall was unlocked and unattended. No staff was observed in the area.	F 0761	**F761 Labeling/Storage of Biologicals** 1.No residents were cited as being affected by this alleged deficient practice. The nurse was immediately educated about leaving the medication cart unlocked. 2.All residents have the potential to be affected. Nurses will also be educated on ensuring that medication cart is locked with keys kept on the nurse's person at all times during her shift. 3.As a measure of ongoing compliance, the DHS or designee	10/26/2018

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	Staff nurse walked by cart at 8:29 a.m. and locked cart. During an observation on 10/9/18 at 8:32 a.m., the medication cart on the 200 hall was unlocked and unattended. No staff was observed in the area. Staff nurse walked by cart at 8:42 a.m. and locked cart. An interview on 10/3/18 at 1:02 p.m., the ADON indicated the medication carts should be locked at all times when not attended and in use. A policy regarding Medication Storage was requested from facility on 10/5/18, but was not provided prior to exit. 3.1-25(m)		will audit medication cart storage to ensure they are locked when unattended 5 x weekly x 4 weeks, 3x weekly x 4 weeks, then weekly x 4 weeks and monthly ongoing. 4.For quality assurance, the ED or designee will review audit results and subsequent corrective action at least quarterly in the campus Quality Assurance Committee meeting. The plan will be revised as warranted. If increased problems noted, audit frequency may increase. If no problems noted after six months, the frequency of audits may decrease.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers,			

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	visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the			

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	facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview and record review, the facility failed to properly clean and store nebulizer equipment following administration of medication for 1 of 1 residents receiving nebulizer treatments. (Resident 10) Findings include: Observation on 10/3/18 at 9:14 a.m., Resident 10's nebulizer equipment (mask/tubing) was sitting on a table, assembled with moisture present in med chamber without being placed in a plastic bag. Obervation on 10/4/18 at 8:36 a.m., Resident 10's nebulizer equipment (mask/tubing) was sitting on a table, assembled with moisture present in med chamber. Observation on 10/5/18 at 8:28 a.m., Resident 10's nebulizer equipment (mask/tubing) was sitting on a table, assembled with moisture present in med chamber without being placed in a plastic bag. An interview on 10/9/18 at 8:36 a.m., LPN 10 indicated that moisture was present in the medication chamber. She indicated the nebulizer equipment should be air dried following use. An interview on 10/9/18 at 8:39 a.m., ADON	F 0880	**F 880 Infection Prevention and Control** 1.Resident #10 was affected. Resident's nebulizer mask and tubing was immediately disposed of and replaced with new equipment. The staff nurse was immediately educated on appropriate cleaning and storage of nebulizer mask and tubing. 2.All residents receiving nebulizer treatments have the potential to be effected. All nursing staff will be educated on the appropriate cleaning and storage of nebulizer mask and tubing. 3. As a measure of ongoing compliance, the DHS or designee will complete an audit that includes observation of the cleaning and storing of nebulizer masks and tubing after use on 3 random residents at varied times. Said audit will be completed at varied times 5x a week for 4 weeks, then 2x a week for 4 weeks, then monthly ongoing. 4.For quality assurance, the ED	10/26/2018

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	confirmed that moisture was present in medication chamger and indicated equipment should be dried, unassembled on toweling to air dry. The record for Resident 10 was reviewed on 10/9/18 at 10:40 a.m., Diagnoses for the resident included but were not limited to: cough, dementia without behavioral disturbance, dysphagia, and GERD. Current signed physician's orders for the resident included, but were not limited to: Ipratropium-albuterol solution (respiratory medication) 2.5 mg. inhale 1 vial by nebulizer four times per day. The order originated 3/18/18. Review of the current facility policy, titled "Respiratory/Inhalation Treatments" provided by the ADON on 10/5/18 at 9:40 a.m., included, but was not limited to, "Policy: It is the policy of Trilogy Health Services to administer aerosol-breathing treatments, as ordered by the physician, by a licensed nurse. State regulatory guidelines will be followed for personnel training to ensure appropriate assessment, administration and documention." PROCEDURE:... ...12. Clean equipment and leave to air dry. Review of inservice material, titled "Inhaled Medications, Nebulizer Administration, Cleaning, and Storage" provided by the ADON 10/5/18 at 9:58 a.m., included, but was not limited to: "Allow to air dry on paper towel" "Store completely dry equipment in a plastic bag with resident's name and date on it."		or designee will review audit results and subsequent corrective action at least quarterly in the campus Quality Assurance Committee meeting. The plan will be revised as warranted. If increased problems noted, audit frequency may increase. If no problems noted after six months, the frequency of audits may decrease.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155779	A. BUILDING 00 B. WING	10/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PRAIRIE LAKES HEALTH CAMPUS	9730 PRAIRIE LAKES BLVD EAST NOBLESVILLE, IN 46060

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R 0000 Bldg. 00	16.2-3.1-18(a) This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: October 3, 4, 5, 9 and 10, 2018 Facility number: 012305 Residential Census: 50 Prairie Lakes Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed on October 15, 2018.	R 0000	**Prairie Lakes Annual Plan of Correction October 2018** Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during Recertification visit with exit on October 10, 2018. Please accept this Plan of Correction as the provider's credible allegation of compliance as of October, 2018. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	