STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155493	A. BUILDING 00 B. WING	08/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS CARE CENTER	311 E FIRST ST FERDINAND, IN 47532

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: August 21, 22, 23, 24, 25, 26, 2016 Facility number: 000534 Provider number: 155493 AIM number: 100267220 Census bed type: SNF/NF: 62 SNF: 20 Total: 82 Census payor type: Medicare: 7 Medicaid: 38 Other: 37 Total: 82 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 9/2/16 by #02748.	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged, or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and executed solely because it is required by Federal and State law. This plan of correction is submitted in order to respond to the allegations of noncompliance cited during annual survey review concluding on August 26,2016 Please accept this plan of correction as the provider's credible aggregation of compliance effective on or before 9-25-2016 We respectfully request paper compliance.	

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

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F 0157 SS=D Bldg. 00	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). 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. The facility must record and periodically update the address and phone number of			

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	the resident's legal representative or interested family member. Based on observation, interview, and record review, the facility failed to ensure the physician was notified promptly when a resident on oral anticoagulants (blood thinner medication) had increased bruising for 1 of 1 residents reviewed on anticoagulants. (Resident #45) Findings include: On 8/22/16 at 9:04 A.M., during interview Resident # 45 voiced she had a large bruise on her left arm due to her left arm being pinned up against the side rail when her gown was changed. On 8/22/16 at 9:19 A.M., during interview, Resident #45's breakfast tray arrived and Resident #45 removed the blanket covering her arms to set up her tray. A large purple bruise was observed on the lateral and posterior right elbow area and the underside of her upper arm measuring approximately 12 to 14 inches. On 8/22/16 at 3:13 P.M., Resident #45's clinical record was reviewed. Resident #45 had been admitted to the facility on 10/17/12. Diagnoses included but were not limited to, unspecified atrial fibrillation, chronic diastolic heart failure, and chronic kidney disease stage 3. Her	F 0157	F 157 Resident #45's MD examined resident on 8/6/2016 and dictated a progress note related to bruising and coumarin therapy. **Completion Date 8-6-2016** All other residents have the potential to be affected by the deficient practice and through alterations in processes and in servicing will ensure physician notification is completed with change in condition. All changes in condition have been reviewed to assure documentation on notification complete **Completion Date 9-25-2016** All nurses have been in serviced concerning the campus procedure for physician notification guidelines. Systemic change is the nurses will utilize the Facility Activity Report to assure notifications complete with change in condition. **Completion Date 9-25-2016** The Facility Activity Report will be reviewed by nurse leaders in Clinical Care Meeting to ensure physician notification complete on 3 random residents as applicable 5x a week for a month then 3x week for a month then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for reviewand further suggestions/comments. **Completion Date 9-25-2016**	09/25/2016

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	current Quarterly Minimum Data Set assessment (MDS) dated 5/20/16, indicated a cognition score of 15 (cognition intact). The current physician order report dated 8/26/16, indicated, a Commanding order dated 8/19/16, for Commanding (anticoagulant medication) 3.5 mg (milligrams) once a day. The 8/26/16 medication flow sheet included, but was not limited to, (start date 3/31/16), "...Monitor for s/s [signs and symptoms] of bleeding (bleeding gums, black tarry stools, abnormal bruising) or increase in bruising. Special Instructions: Notify physician if symptoms occur Every shift; Nights, Days, Evenings..." Resident #45's current care plan included, but was not limited to the problem (start date 7/8/16) of, "... I am at risk for abnormal bleeding/bruising because I take blood thinners..." Goals included, " I would like to remain free of abnormal bleeding and bruising. I would also like to maintain the therapeutic levels of the medication." Approaches, included but were not limited to, "Monitor me for bleeding gums, nose bleeds, unusual bruising, black or tarry stools, and pink or discolored urine. Report any of these symptoms to my physician..."			

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	A lab report dated 8/3/16, indicated, a Prothrombin Time (PT) of 39.7 seconds which was documented as H (high) with normal limit values of (9.4-11.8) seconds. The report also included an International Normalized Ratio (INR) of 3.5 which was high documented as H (high) with normal limit values of (0.9-1.2). A progress note dated 8/3/16 at 4:50 P.M., indicated, "Order received to continue current Commanding dose, will recheck lab in 2 weeks." A progress note dated, 8/13/16 at 9:59 P.M., indicated, "Resident informed this nurse that she has a bruise to left elbow measuring 3 cm [centimeters] x 1 cm with knot measuring 3 cm x 2 cm noted both areas are black/blue/red in color-Dr. [physician's name] DHS [Director of Health Services] and family made aware of area- new orders noted for ice pack apply to left elbow PRN [when needed] Q [every] 15 mins [minutes] x 24 hours- will continue to monitor- resident is able to move elbow without pain/discomfort." A progress note dated, 8/14/16 at 2:05 A.M., indicated, "bruising continues to left elbow, denies discomfort/pain at this time scratches continue to abd [abdomen] areas kept clean and dry, will continue to			

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	monitor." A progress note dated, 8/14/16 at 3:10 P.M., indicated, "Cont [continue] to monitor bruising and abrasions with no s/s [signs or symptoms] of infection or signs of worsening of areas. Resident denies pain and shows no s/s. Can voice needs and pleasant and compliant with care. No other signs of abnormal bleeding at this time." A progress note dated 8/14/16 at 10:36 P.M., indicated, " Resident's left elbow bruise has increased in size measuring 7 cm x 6 cm bruise is black/blue-resident has voiced complaints of pain with Tylenol given with some effect noted- no s/s of infection noted to scratches to left abdomen fold- resident remains on Commanding 7.5 mg daily- will continue to monitor..." Documentation was lacking of physician notification regarding an increase in bruising and a new complaint of pain at bruise site for a resident receiving anticoagulant medication as the medication order flow sheet and care plan had instructed. A progress note dated 8/15/16 at 1:09 P.M., indicated, "TX [treatment] completed per order. Tylenol			

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	administered at 0900 for C/O [complaint of] pain to the L [left] elbow. No other concerns noted. Will continue to monitor." A progress note dated 8/15/16 at 5:28 P.M., indicated, "Resident complained left elbow pain-Tylenol given @ 4:35 PM-bruise continues to left elbow..." An ordered 2 week PT/INR (Prothrombin Time/ International Normalized Ratio) lab from the date of the previous PT/INR of 8/3/16, was obtained on 8/17/16 at 5:45 A.M. The lab report dated 8/17/16 at 5:45 A.M., indicated at PT greater than 150 seconds (9.4-11.8 seconds normal range). A progress note dated 8/17/16 at 1:55 P.M., indicated, " [Hospital name] lab called et [and] informed this nurse of resident having a critically high PT @ 173.2 et [and] INR was not obtained d/t [due to] too high. [Physician's name] notified of results et new orders rec'd [received] to hold Commanding et administer vitamin K 10 mg PO [oral] STAT [immediately]. Re-draw PT/INR et CBC [complete blood count] @ 2pm today et notify MD [physician] of results STAT. Will continue to monitor." A lab report dated (received specimen)			

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	8/17/16 at 2:18 P.M.,indicated a PT greater than 150 and unable to run or determine INR. A progress note dated 8/17/16 at 4:10 P.M., indicated, "Called lab results of PT-INR and CBC to [Physician's name]. Orders received to: continue to hold the Commanding- I discontinued the order; to give another Vitamin K 10 mg po in the a.m.; and to draw another PT/INR in the a.m." On 8/26/16 at 8:38 A.M., the Assistant Director of Nursing (ADON) provided a physician's progress note dated 8/16/16, which included, but was not limited to, "... she has two large ecchymoses, one quite large on the left upper posterior arm..." The physician's progress note had been documented 2 days after there had been a change in the bruising area of the left arm with an increase in bruising observed. On 8/26/16 at 8:52 A.M., the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) were made aware documentation was lacking of physician notification of an increase in the bruising of the left elbow on 8/14/16 at 10:36 P.M., in regard to reporting unusual bruising of a resident taking an anticoagulant as the medication flow			

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	sheet and care plan instructed. The DON and ADON were also made aware, the change in the bruising with an increase in the bruising size documented had been noted by the nurse who had initially observed the left elbow bruising on 8/13/16. On 8/14/16 ,a change in pain status had also been documented with no complaint of pain voiced on 8/13/16 when bruising initially was observed to complaints of pain with Tylenol use on 8/14/16, when the bruising had increased. On 8/26/16 at 10:32 A.M., during interview with the DON, she indicated, she understood the problem in regard to physician notification. On 8/26/16 at 11:40 A.M., the facility policy entitled, "Notification of Change in Condition [facility review date 7/22/2016]" was received and reviewed. The policy included, but was not limited to, "...The facility must inform the resident, consult with the resident's physician and if known notify the resident's legal representative when: ...2. A significant change in the resident's physical, mental or psychosocial status. 3. A need to alter treatment significantly..." 3.1-5(a)(2) 3.1-5(a)(3)			

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F 0246 SS=D Bldg. 00	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on observations, interview, and record review, the facility failed to ensure a room was individualized to meet the needs and preferences of a 1 of 1 residents reviewed for accommodation of needs. (Resident #4) Findings include: Resident #4 was observed on 8/21/16 at 1:14 P.M., laying in bed, watching a cooking show and appeared to be in no apparent distress. Resident #4 indicated she was receiving hospice services for end stage colon cancer that caused her to experience almost constant bowel incontinence and pain when up in a wheel chair so she loved to lay in bed a look out the window at birds and squirrels playing in the trees. She indicated she had moved to that room at the end of July after expressing a concern of having little to no privacy in her room. Resident #4 indicated she had received a	F 0246	F 246 Resident # 4 has been offered current open rooms in campus and resident has refused a room change at this time. The room the resident wants to move to is currently occupied. The campus has completed a concern form and will continue to offer rooms available and when room opens that residents desires campus will move resident. **Completion Date 9-25-2016** All residents have the potentialto be affected and therefore through alterations in provision of care and inservicing the campus will assure the resident has the right to reside andreceive services in the campus with reasonable accommodations of individualneeds and preferences, except when the health or safety of the individual orother residents would be endangered. Resident concerns will be documented on concern form to assure follow up. **Completion Date 9-25-2016** An in-service has been completed with all staff related to completing concern forms. Systemic change is the social service will complete	09/25/2016

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	roommate who's family would sit at the bedside even when the roommate was asleep. She indicated it was embarrassing for her to have someone in the room all day especially when she had to be changed. She indicated she had voiced the concern to the facility and they had suggested a move to a room with a roommate with less visitors and provided pictures of the view outside of Room #114. Resident #4 indicated when she came to the room she told them that day that it would not work for her as she could not hang her pictures where she could see them from her bed and she could not see her bird feeders or the trees outside from her bed. Resident #4 indicated "I lay here and all I can see is cars on the highway, seeing my birds and squirrels was my joy, who wants to see cars". She indicated she had received no response from the facility regarding her voiced of concerns. The clinical record was reviewed on 8/22/16 at 1:15 P.M. The diagnoses included, but were not limited to hypertension, irritable bowel syndrome, colon, cervical and skin cancer, radiation sickness, and insomnia. The care plans from 1/16/16 to current were reviewed and included, but were not		a room change notification form to assure resident/family in agreement with change. **Completion Date 9-25-2016** ED/Designee will audit room changes to assure resident/family in agreement with change 5x a week for amonth then 3x a week for a month then weekly with results forwarded to QAcommittee monthly x 6 months and quarterly thereafter for review and furthersuggestions/comments. **Completion Date 9-25-2016**	

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	limited to the following: Activities initiated 1/16/16 "I am a lady who loves to do activities in my room I do not like crowds... My goal is to do leisure activities daily in my room such as watching animal shows...watch the birds on my birdfeeder..." Acute care needs initiated 1/20/16 "I am suffering from cancer of the colon...I have decided not to pursue further treatment and desire comfort measures via hospice...My goal is to remain as comfortable as possible for as long as possible.." A care plan for bowel incontinence initiated 1/20/16 indicated, "I have problems with chronic diarrhea- due to diagnosis of IBS [irritable bowel syndrome] and has come about since I have a long history of recurrent bowel obstructions because of extensive radiation and multiple interabdominal surgeries..." The Minimum Data Set (MDS) assessment dated 7/12/16 indicated Resident #4 had a BIMS (Brief Interview for Mental Status) score of 15 indicating she was cognitively intact. The MDS further indicated it was very important for Resident #4 to be around animals, and			

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	participate in her favorite activities. During an interview with the Social Service Director (SSD) on 8/25/16 at 8:30 A.M., she indicated resident concerns were documented on a facility concern form and then the forms were forwarded to the appropriate department. The forms were reviewed daily in morning meeting to ensure appropriate responses. The SSD indicated she was aware of a concern about the room had been voiced by Resident #4 and she believed the Director of Nursing (DON) had talked with the resident and she had heard no more about it. During an interview with the DON on 8/25/16 at 8:52 A.M., she indicated Resident #4 had voiced a concern with her roommate having company in the room constantly. She indicated they had an empty room on the 100 unit so they had convinced her to move into it. She indicated everything was fine for about 5 days "the honeymoon phase" then Resident #4 started requesting to be moved back to her old room. She indicated she had told Resident #4 they would move her back when the room was available. The DON further indicated she had talked with Resident #4's son whom is her POA (Power of Attorney) and he had indicated, no change in room was			

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	necessary as she was ok where she was at. At that time, documentation of Resident #4's POA, activation of POA and the concern and the facility response was requested. During a confidential staff interview Staff #44 indicated Resident #4 had no behaviors and was cognitively intact. Staff #44 indicated Resident #4 was able to voice her own needs, was her own person, and made her own decisions. Staff #44 indicated they were aware of several times Resident #4 had expressed concerns over the room change starting the day she had moved and they were unaware if a response had been provided by the facility at this time. During an interview with the DON on 8/26/16 at 8:15 A.M., she indicated no concern form and or documentation could be provided to show the facility had heard and was working on Resident #4's concern with her room placement. She indicated a concern form had been filled out now and when the room became available Resident #4 would be moved back to her previous bed. The DON indicated, at that time, Resident #4 did not have a POA and made her own decisions. A policy titled "Guidelines for Service			

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	Concern Process" was provided by the facility on 8/26/16 at 10:00 A.M. It included, but was not limited to, "If a resident and/or family member communicates a concern to staff, a Concern Form would be completed and issues corrected at the time (if possible)...All Concern Forms are reviewed in Daily Stand UP meetings as part of follow up/resolution...Social Services will monitor for follow through and resolution with the Executive Director support...Follow up should occur....Social Service maintains the completed original copy of Concern Form..." 3.1-3(v)(1)			
F 0250 SS=D Bldg. 00	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, interview, and record review, the facility failed to ensure social services were provided in a timely manner (25 days) for 1 of 1 residents who met the criteria for review of suicidal ideation. (Resident #4) Findings included:	F 0250	**F 250** Resident # 4 physician has been notified of past suicide statements and suicide assessment. The resident will be placed on behavior management program if a behavior is identified. **Completion Date 9-25-2016** All residents have the potential to be affected by the alleged deficient	09/25/2016

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	155493	A. BUILDING 00 B. WING	08/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS CARE CENTER	311 E FIRST ST FERDINAND, IN 47532

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	1. Resident #4 was observed on 8/21/16 at 1:14 P.M., laying in bed, watching a cooking show, and appeared to be in no apparent distress. A hospice social service note dated 8/1/16 was provided by the DON on 8/25/16 at 10:15 P.M., it included, but was not limited to "...Pt [patient] does make comment three times during sw [Social Worker] visit suggesting she wants to take pills to die, 'I'm going to have my son bring in some pills and just put me out of my misery...consulted with FSN #55 and FSN [name of DON] re : pt remarks about suicide..." the visit note was signed by the DON. The clinical record was reviewed on 8/22/16 at 1:15 P.M. The diagnoses included, but were not limited to hypertension, irritable bowel syndrome, colon, cervical and skin cancer, radiation sickness, and insomnia. The facility progress notes from 4/1/16 to 8/22/16 lacked any documentation of concerns with behaviors. The facility behavior monitoring documentation from 7/8/16 to 8/24/16 was reviewed with no documented		practice and therefore through inservices, re education of staff, and audits the campus will ensure effective behavior management services are provided. The campus has reviewed behavior charting for all residents to assure no residents are displaying suicidal ideation. **Completion Date 9-25-2016** Social services have been inserviced on the campus policy for suicidal ideation. Nursing staff has been in serviced guidelines for Suicide Threats. Systemic change will include utilization of monitoring target behaviors via physician orders. **Completion Date 9-25-2016** SSD and /or designee will print group behavior detail report daily and monitor 3 random residents to assure behaviors and psychosocial needs were documented, monitored, and addressed 5x aweek for a month then 3x a week for a month then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review andfurther suggestions/comments **Completion Date 9-25-2016**	

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	behaviors. The care plans from 1/16/16 to current were reviewed and included, but were not limited to, the following: Activities initiated 1/16/16 "I am a lady who loves to do activities in my room I do not like crowds... My goal is to do leisure activities daily in my room such as watching animal shows...watch the birds on my birdfeeder..." Acute care needs initiated 1/20/16 "I am suffering from cancer of the colon...I have decided not to pursue further treatment and desire comfort measures via hospice...My goal is to remain as comfortable as possible for as long as possible.." The care plans lacked any care plan for behaviors or suicidal ideation. A hospice social service note dated 8/17/16 included, but was not limited to, "...no change- Pt is tearful and frustrated with obstacles to her goal...pt continues to make negative comments about her room..." The Minimum Data Set (MDS) assessment dated 7/12/16 indicated Resident #4 had a BIMS (Brief Interview			

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	for Mental Status) score of 15 indicating she was cognitively intact. The MDS lacked documentation of behavioral or mood disorders. The MDS further indicated it was very important for Resident #4 to be around animals, and participate in her favorite activities. During an interview with the DON on 8/25/16 at 10:45 A.M., she indicated she was aware of the statements made by Resident #4. She indicated it had been handled by the hospice social services and she was deemed at low risk for suicide so they felt no further actions were warranted at that time. During an interview with the Social Service Director (SSD) on 8/25/16 at 11:20 A.M., indicated the hospice social service worker had notified her of Resident #4's statements on 8/1/16. She indicated hospice had done a suicide risk assessment and deemed her at low risk and felt she was safe. The SSD indicated she had followed up with facility staff about Resident #4's mood and behaviors but, had not seen Resident #4. The SSD indicated she could provide no documentation of any follow up done by the facility. A policy titled "Guidelines for Suicide Threats" dated 5/11/16 was provided by			

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	the facility on 8/26/16. It included, but was not limited to, "...To ensure resident suicide threats are taken seriously and immediately reported...the charge nurse shall notify the resident's attending physician, Director of Health Services and responsible party of such threats...A staff member shall remain with the resident until the charge nurse arrives to exam the resident...Based on the resident assessment the charge nurse may assignee 1:1 supervision or 15 minute checks to ensure the resident's safety until further instructions are received from the resident's attending physician...Documenting of the incident will be recorded in the resident's medical record...Nursing documentation will be completed each shift to determine stabilization or further concerns of the resident...Social Service staff shall be consulted to discuss the incident with the resident and provide ongoing assistance to prevent further occurrences of suicidal thoughts...Care plan interventions will be implemented as appropriate to the resident's care needs..." An undated policy titled "Behavior Planning and Intervention" was provided by the facility on 8/25/16 at 4:00 P.M. It included, but was not limited to, the following: "...Treatment and medical/pharmological			

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	(sic) intervention. Every effort should be made to determine the etiology of the behavior displayed...consult with...res activity support... Home office Resident services director for suggestions and recommendations related to resident challenging behaviors. the following are suggested interventions and approaches in response to specified etiology: Altered perception of the current situation. Alter staffs behavior in order to avoid triggering predictable negative behaviors. modify resident perception of the staff's behavior by explanation of reassurance...validate the residents experience...Obtain a mental health or neurological consult...Level of arousal...provide the resident with an optimal level of stimulation, teach resident a formal means of relaxation...conduct guided relaxations exercises...channel discontent into constructive activity...Unawareness of context or consequences of actions...reinforce positive behavior by providing tangible rewards and verbal praise...assess for and treat depression...Impulse control...establish coping skills groups to help resident who are more cogently intact resolve problems ad cope with the stresses of life in the activity...rechanal (sic) behaviors by engaging residents in activities related to current or prior interests...".			

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	3.1-34(a)(1)			
F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to ensure the care plan and physician orders were followed in regard to the physician being notified promptly when a resident on oral anticoagulants (blood thinner medication) had increased bruising for 1 of 1 residents reviewed on anticoagulants. (Resident #45) Findings include: On 8/22/16 at 9:04 A.M., during interview Resident # 45 voiced she had a large bruise on her left arm due to her left arm being pinned up against the side rail when her gown was changed. On 8/22/16 at 9:19 A.M., during interview, Resident #45's breakfast tray arrived and Resident #45 removed the blanket covering her arms to set up her tray. A large purple bruise was observed	F 0282	F 282 Resident #45's MD examined resident on 8/6/2016 and dictated a progress note related to bruising and coumadin therapy.**Completion Date 8-6-2016** All other residents have the potential to be affected by the deficient practice and through alterations inprocesses and in servicing will ensure residents plan of care followed. **Completion Date 9-25-2016** All nurses have been in serviced concerning following residents plan of care. **Completion Date 9-25-2016** DHS/designee will review 3 random residents plan of care and ensure implemented as applicable on 3 random residents5x a week for a month then 3x week for a month then weekly with resultsforwarded to QA committee monthly x 6 months and quarterly thereafter for reviewand further suggestions/comments.**Completion Date 9-25-2016**	09/25/2016

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	on the lateral and posterior right elbow area and the underside of her upper arm measuring approximately 12 to 14 inches. On 8/22/16 at 3:13 P.M., Resident #45's clinical record was reviewed. Resident #45 had been admitted to the facility on 10/17/12. Diagnoses included but were not limited to, unspecified atrial fibrillation, chronic diastolic heart failure, and chronic kidney disease stage 3. Her current Quarterly Minimum Data Set assessment (MDS) dated 5/20/16, indicated a cognition score of 15 (cognition intact). The current physician order report dated 8/26/16, indicated, a Commanding order dated 8/19/16, for Commanding (anticoagulant medication) 3.5 mg (milligrams) once a day. The 8/26/16 medication flow sheet included but was not limited to (start date 3/31/16), "...Monitor for s/s [signs and symptoms] of bleeding (bleeding gums, black tarry stools, abnormal bruising) or increase in bruising. Special Instructions: Notify physician if symptoms occur Every shift; Nights, Days, Evenings..." Resident #45's current care plan included, but was not limited to the problem (start date 7/8/16) of, "... I am at risk for abnormal bleeding/bruising because I			

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	take blood thinners..." Goals included, "I would like to remain free of abnormal bleeding and bruising. I would also like to maintain the therapeutic levels of the medication." Approaches included but were not limited to, "Monitor me for bleeding gums, nose bleeds, unusual bruising, black or tarry stools, and pink or discolored urine. Report any of these symptoms to my physician..." A lab report dated 8/3/16, indicated, a Prothrombin Time (PT) of 39.7 seconds which was documented as H (high) with normal limit values of (9.4-11.8) seconds. The report also included an International Normalized Ratio (INR) of 3.5 which was high documented as H (high) with normal limit values of (0.9-1.2). A progress note dated 8/3/16 at 4:50 P.M., indicated, "Order received to continue current Commanding dose, will recheck lab in 2 weeks." A progress note dated, 8/13/16 at 9:59 P.M., indicated, "Resident informed this nurse that she has a bruise to left elbow measuring 3 cm [centimeters] x 1 cm with knot measuring 3 cm x 2 cm noted both areas are black/blue/res in color-Dr. [physician's name] DHS [director of Health Services] and family made aware			

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	of area- new orders noted for ice pack apply to left elbow PRN [when needed] Q [every] 15 mins [minutes] x 24 hours- will continue to monitor- resident is able to move elbow without pain/discomfort." A progress note dated, 8/14/16 at 2:05 A.M., indicated, " bruising continues to left elbow, denies discomfort/pain at this time scratches continue to abd [abdomen] areas kept clean and dry, will continue to monitor." A progress note dated, 8/14/16 at 3:10 P.M., indicated, "Cont [continue] to monitor bruising and abrasions with no s/s [signs or symptoms] of infection or signs of worsening of areas. Resident denies pain and shows no s/s. Can voice needs and pleasant and compliant with care. No other signs of abnormal bleeding at this time." A progress note dated 8/14/16 at 10:36 P.M., indicated, " Resident's left elbow bruise has increased in size measuring 7 cm x 6 cm bruise is black/blue-resident has voiced complaints of pain with Tylenol given with some effect noted- no s/s of infection noted to scratches to left abdomen fold- resident remains on Commanding 7.5 mg daily- will continue to monitor..."			

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	Documentation was lacking of physician notification regarding an increase in bruising and a new complaint of pain at bruise site for a resident receiving anticoagulant medication as the medication order flow sheet and care plan had instructed. A progress note dated 8/15/16 at 1:09 P.M., indicated, "TX [treatment] completed per order. Tylenol administered at 0900 for C/O [complaint of] pain to the L [left] elbow. No other concerns noted. Will continue to monitor." A progress note dated 8/15/16 at 5:28 P.M., indicated, Resident complained left elbow pain-Tylenol given @ 4:35 PM-bruise continues to left elbow..." An ordered 2 week PT/INR (Prothrombin Time/ International Normalized Ratio) lab from the date of the previous PT/INR of 8/3/16, was obtained on 8/17/16 at 5:45 A.M. The lab report dated 8/17/16 at 5:45 A.M., indicated at PT greater than 150 seconds (9.4-11.8 seconds normal range). A progress note dated 8/17/16 at 1:55 P.M., indicated, " [Hospital name] lab called et [and] informed this nurse of resident having a critically high PT @			

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	173.2 et [and] INR was not obtained d/t [due to] too high. [Physician's name] notified of results et new orders rec'd [received] to hold Commanding et administer vitamin K 10 mg PO [oral] STAT [immediately]. Re-draw PT/INR et CBC [complete blood count] @ 2pm today et notify MD [physician] of results STAT. Will continue to monitor." A lab report dated (received specimen) 8/17/16 at 2:18 P.M.,indicated a PT greater than 150 and unable to run or determine INR. A progress note dated 8/17/16 at 4:10 P.M., indicated, "Called lab results of PT-INR and CBC to [Physician's name]. Orders received to: continue to hold the Commanding- I discontinued the order; to give another vitamin K 10 mg po in the a.m.; and to draw another PT/INR in the a.m." On 8/26/16 at 8:38 A.M., the Assistant Director of Nursing (ADON) provided a physician's progress note dated 8/16/16, which included but was not limited to, "... she has two large ecchymoses, one quite large on the left upper posterior arm..." The physician's progress note had been documented 2 days after there had been a change in the bruising area of the left arm with an increase in bruising			

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	observed. On 8/26/16 at 8:52 A.M., the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) were made aware documentation was lacking of physician notification of an increase in the bruising of the left elbow on 8/14/16 at 10:36 P.M., in regard to reporting unusual bruising of a resident taking an anticoagulant as the medication flow sheet and care plan instructed. The DON and ADON were also made aware, the change in the bruising with an increase in the bruising size documented had been noted by the nurse who had initially observed the left elbow bruising on 8/13/16. On 8/14/16, a change in pain status had also been documented with no complaint of pain voiced on 8/13/16, when bruising initially was observed to, complaints of pain with Tylenol use on 8/14/16, when the bruising had increased. On 8/26/16 at 10:32 A.M., during interview with the DON, she indicated, she understood the problem of increased bruising in regard to following the care plan. On 8/26/16 at 11:40 A.M., the facility policy entitled, "Interdisciplinary Team Care Guideline (revised date 6/15)" was received and reviewed. The policy			

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	included but was not limited to, "... Purpose: To ensure appropriateness of services and communication that will meet the resident's needs, severity/stability of conditions, impairment, disability, or disease in accordance with state and federal guidelines... c. iii. Interventions should be reflective of the individual's needs and risk influence as well as the resident's strengths..." 3.1-35(g)(2)			
F 0323 SS=D Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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. Based on observation, interview, and record review, the facility failed to ensure effective interventions were implemented or adequate assistance was provided for 2 of 4 residents who met the criteria for review of accidents. (Resident #52, Resident #89) Findings include:	F 0323	F 323 Resident #52 and 89 plan of care and interventions for safety management have been reviewed and updated as necessary **Completion Date 9-25-2016** All other residents are at risk to be affected by the alleged deficiency and through alterations in processes and in servicing the campus will ensure that the resident environment	09/25/2016

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	1. During an interview on 8/23/16 at 11:13 A.M., LPN #8 indicated Resident #89 had experienced one fall in the previous 30 days. LPN #8 further indicated a staff member was tying the shoe of Resident #89 while the resident was standing in the hallway, the resident leaned over, fell backwards, and landed on the buttocks. The clinical record of Resident #89 was reviewed on 8/26/16 at 1:15 P.M. The record indicated the diagnoses of Resident #89 included, but were not limited to, bipolar disorder, dementia without behavioral disturbance, intermittent explosive disorder, osteoporosis, psychosis, delusional disorder, and impulse disorder. During an observation on 8/24/16 at 9:15 A.M., Resident #89 was observed to be ambulating with a rolling walker and the assistance of one staff member through the common lounge. The most recent Quarterly MDS (Minimum Data Set) dated 6/22/16 indicated Resident #89 experienced severe cognitive impairment, required supervision with set up assistance for walking in corridor, supervision with one person physical assist for locomotion on unit,		remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. All resident's plan of care for safety/transfer needs have been reviewed and updated if necessary. **Completion Date 9-25-2016** Nursing staff have been in serviced concerning resident's safety plan of care. Systemic change is changes that occur to safety plan of care will be reviewed daily in IDT to assure appropriate. **Completion Date 9-25-2016** DHS /designee will monitor 3 random residents at risk for accidents/incidents to assure safety interventions in place and interventions effective 5x a week for a month then 3x a week for a month then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments **Completion Date 9-25-2016**	

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	155493	A. BUILDING 00 B. WING	08/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS CARE CENTER	311 E FIRST ST FERDINAND, IN 47532

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	experienced unsteadiness when moving from a seated to a standing position, experienced no functional limitation, and had experienced no falls in the previous 3 months. A Significant Change MDS assessment dated 7/11/16 indicated Resident #89 experienced severe cognitive impairment, required the limited physical assistance of one staff for walking in room, corridor, and locomotion on unit, experienced unsteady balance, experienced functional limitation to one side of the upper body, and had a history of falls. A Care plan dated 6/22/16 for ADL's (Activities of Daily Living) indicated, "...Transfers independently, Ambulation independently ...current diagnoses are: Dementia, bipolar disorder with psychotic features...take...antipaychotic [sic] medications-which place me at risk for falls...am at risk for injury related to falls... I want the pathways kept free of clutter...I want the staff to assure that I have appropriate non-skid footwear on when I am up...I require assist of [sic] with transfers. I rely on a wheelchair and staff assist for locomotive needs..." Fall #1 A Nurse's note dated 6/30/16 at 11:45 A.M. indicated, "Res [resident] was			

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	sleeping on the couch prior to lunch. Staff woke her up to let her know it was time to go to the DR [dining room] to eat. Staff asked res if she needed to use the BR [bathroom] prior to going into the DR and Res stated no. Res then got up from the couch, started ambulating into the DR, grabbed at the DR chair in the opening of the DR entrance. She then stumbled causing the chair to overturn and her [sic] go to the floor. She caught her weight with her left hand. Fall was wittnessed [sic] from 2 staff members in DR and at nurses [sic] station. Res did not hit head [sic] she landed on her left side. Prior to res napping on couch she was engaged in activity. Res had gotten up per self as per plan of care." A Fall Event note dated 6/30/16 at 12:02 P.M., indicated Resident #89 did not have safety or adaptive equipment in use at the time of the fall. A Nurse's note dated 6/30/16 at 11:55 A.M. indicated, "...Intervention is to keep entry way of DR clear of any clutter or furniture..." A Nurse's note dated 6/30/16 at 2:10 P.M. indicated, "Results of Xray [sic] received [sic], fracture present..." An IDT (Interdisciplinary Team)			

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	Progress note dated 7/1/16 at 9:36 A.M. indicated, "idt [sic] review and agree with assessment and interventions" Fall #2 A Fall Event note dated 7/3/16 at 12:05 P.M. indicated Resident #89 experienced a witnessed fall in the hallway and further indicated, "...Staff was tyeing [sic] res shoestring [sic] res bent foreward [sic] and sat on floor...Resident has cognitive or memory impairment that effects safety and judgement...Immediate measures taken...1 assist at all times..." During an interview on 8/26/16 at 12:30 P.M. the DHS (Director of Health Services) indicated the dining room entryway was cluttered with furniture and Resident #89 stumbled while trying to navigate independently through the clutter. The DHS further indicated, at that time, Resident #89 did not require assistance to ambulate on the unit after the first fall and it was the usual practice of the facility to tie a resident's shoe while the resident was standing without balance support. 2. During an interview on 8/22/16 at 3:18 P.M. LPN #7 indicated Resident #52 had experienced two falls without injury in the last 30 days. LPN #7 further indicated			

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	Resident ambulated throughout the unit independently. The clinical record of Resident #52 was reviewed on 8/23/16 at 2:16 P.M. The record indicated the diagnoses of Resident #52 included, but were not limited to, Alzheimer's disease, dementia with behavioral disturbance, difficulty in walking, and muscle weakness. During an observation on 8/24/16 at 9:35 A.M. Resident #52 was observed sitting in a wheelchair in the common lounge. Resident #52 was then observed to independently exit the wheelchair and ambulate through the dining room with an unsteady gait. Resident #52 was observed to travel through the area by grasping chairs and tables to maintain balance. The Annual MDS (Minimum Data Set) assessment dated 9/23/15 indicated Resident #52 experienced severe cognitive impairment, required the extensive assistance of two staff for transfers, walking in the room and corridor, extensive assistance of one staff for locomotion on unit, experienced functional limitations to the bilateral upper and lower extremities, unsteady balance during transitions and walking, and had a history of falls.			

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	The most recent Quarterly MDS assessment dated 6/15/16 indicated Resident #52 experienced severe cognitive impairment, required extensive assistance of two staff for transfers, supervision when walking in the room and corridor, extensive assistance of one staff for locomotion on unit, experienced functional limitations to the bilateral upper and lower extremities, experienced unsteady balance during transitions and walking, and had a history of falls. The August 2016 Physician's Order Recap included, but was not limited to, an order for. "Res [resident] may be up ad lib [at liberty]" A Care Plan dated 6/24/16 for "Falls...continue to be @ [at] risk for falls and falls related injuries-I have dementia and walk continuously..." included the following interventions: "Administer medications as ordered by my MD, I have 1/2 siderails as enablers, I may be up ad lib, I walk so much that I get fatigued at times, please encourage and offer rest periods for me, Involve therapy as needed, Keep area free from clutter, Notify MD [Medical Doctor] as needed,			

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	Place towels on arms of shower chair prior to seating me in the shower chair, Please make sure that I have on appropriate footwear-I like to go without shoes and socks-I do forget to be safe many times. Please be sure that I have on at least gripper socks at all times, except for ADL [Activities of Daily Living] care, Please offer and utilize the sensory blanket to sit with when I am fatigued and prn [as needed] for rest periods, Please use a wheelhair [sic]-with dycem [an anti-slip device] in the seat-with antirollbacks [sic] and cushion during meals and prn-for safety." The Plan of Care lacked any documentation to indicate Resident #52 received staff assistance during walking in the room, corridor, or supervision during locomotion on the unit. A Care Plan dated 6/24/16 for "I am at risk for skin breakdown" included, but was not limited to, interventions of, "Please ensure that I have a defined perimeter pressure relieving mattress on bed. Fall #1 A Fall Event dated 7/15/16 at 12:22 P.M. indicated Resident #52 experienced an unwitnessed fall while ambulating in the hallway and further indicated, "...Res			

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	[resident] had just been toileted and was ambulating per self toward the lounge area...[another resident] notified that res was laying in floor...small bruise on RFA [right forearm], redness on left shoulder blade...Resident has cognitive or memory impairment that effects safety and judgement...has difficulty understanding and following directions...Immediate measures taken...after toileting res assist to seat in lounge...Incident occurred at 0935 AM [9:30 A.M.]..." A Nursing Progress note dated 7/15/16 at 12:30 P.M. indicated, "At this time [identifier of another resident] notified this nurse that this res was laying in floor of hallway. Went to hall...Res was assisted from floor to chair. Noted a 4 cm [centimeter] red area on left shoulder blade and a small 1.9 X 1 cm red bruise on right forearm in area where other res was attempting to assist res from floor...Intervention is to ambulate res to seat in lounge after toileting..." An ADL report provided by the DHS (Director of Health Services]) on 8/26/16 at 9:39 A.M. indicated Resident #52 was ambulating without staff assistance or supervision on 7/15/16 from 6:30 A.M. through 2:30 P.M. During an interview, at that time, the DHS indicated Resident #52 frequently ambulated independently			

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	throughout the hallways. The DHS then indicated, at that time, staff would occasionally assist Resident #52 by guiding the resident with their hands "palms up, that indicates the extensive assist of one was provided." A Nursing Progress note dated 7/15/16 at 8:29 P.M. indicated, "...has been up ad lib and gait steady..." The note lacked any documentation to indicate Resident #52 received staff assistance during walking in the room, corridor, or supervision during locomotion on the unit. The Nursing Progress notes from 7/15/16 at 8:30 P.M. through 7/18/16 at 11:01 A.M. were reviewed and lacked any documentation to indicate Resident #52 received staff assistance during walking in the room, corridor, or supervision during locomotion on the unit. An IDT (Interdisciplinary Team) Progress note dated 7/18/16 at 11:02 A.M. indicated, "idt [sic] review noted root cause resident walking to tv [television] lounge after toileting and turned around and walked down hall [sic] she lost balance in hall and went to floor, she is up ad lib with ambulation, she will be escorted by staff after toileting to tv lounge."			

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	A Nursing Progress note date 7/18/16 at 11:20 A.M. indicated, "Resident up and about secured unit without issue this am [sic] The note lacked any documentation to indicate Resident #52 received staff assistance during walking in the room, corridor, or supervision during locomotion on the unit. A CAR (Clinically At Risk) Progress note dated 7/21/16 at 8:14 A.M. indicated, "...Resident continues normal routine of ambulation about secured unit throughout the day per self..." The note lacked any documentation to indicate Resident #52 received staff assistance during walking in the room, corridor, or supervision during locomotion on the unit. Fall #2 A Nursing Progress note dated 8/22/16 at 1:25 P.M. indicated, "this nurse called to room by CNA, noted resident in floor at bedside on matt [sic] sitting on buttock with back leaned against bed at 90 degree angle...intervention is defined perimeter mattress." The note lacked any documentation to indicate a new intervention to ensure the safety of Resident #52 was implemented. A Fall Event dated 8/22/16 at 1:37 P.M. indicated Resident #52 experienced an			

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	unwitnessed fall in the from the bed and further indicated, "...fall. [sic] sitting [sic] on floor in room on mat...Resident has cognitive or memory impairment that effects safety and judgement...new interventions - Immediate measures taken...defined paremeter [sic] mattress..." The event lacked any documentation to indicate a new intervention to ensure the safety of Resident #52 was implemented. An IDT Progress note dated 8/23/16 at 8:15 A.M. indicated, "IDT review fall circumstance perimeter mattress in place on bed to help define edges of mattress. will [sic] DC [discontinue] floor mats now that perimeter mattress in place. Root cause contributed to coming to [sic] close to edge and rolling off and due to resident very mobile mat DC to lessen risk of tripping/loosing [sic] balance once up." The note lacked any documentation to indicate a new intervention to ensure the safety of Resident #52 was implemented. During an interview on 8/25/16 at 11:15 A.M. the DHS indicated the defined perimeter mattress had been discontinued at an unknown time because it was needed for another resident and Resident #52 had been free of falls for 30 days. The DHS indicated no documentation			

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	could be provided to indicate a new safety intervention was implemented when the defined perimeter mattress was removed because Resident #52 had been free of falls for 30 days. The Policy and Procedure for Falls Management Program Guidelines provided by the DHS on 8/26/16 at 11:06 A.M. indicated, "...Purpose...mitigate fall risk factors and implement preventative measures...Identified risk factors should be evaluated for the contribution they may have to the resident's likelihood of falling...Care plan interventions should be implemented that address the resident's risk factors..." 3.1-45(a)			
F 0329 SS=D Bldg. 00	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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.			

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	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. Based on observation, interview, and record review, the facility failed to ensure an anti-anxiety medication and an anti-depressant order were clinically indicated for 2 of 5 residents who met the criteria for review of unnecessary medications. (Resident #109, Resident #89) Findings include: 1. During an observation on 8/22/16 at 2:21 P.M., Resident #109 was observed sitting in a chair, in the common lounge with no apparent distress. The clinical record of Resident #109 was reviewed on 8/24/16 at 10:52 A.M. The record indicated the diagnoses of Resident #109 included, but were not limited to, dementia with behavioral	F 0329	F 329 Resident #109 and 89 physician order has been modified to include indication for use and non pharmacological interventions prior to administration. **Completion Date 9-25-2016** All residents have the potential to be affected by the alleged deficient practice therefore through systemic changes stated below the campus will ensure medications are administered with adequate indications for use. The campus has reviewed all resident's medication to assure have dx for use. **Completion Date 9-25-2016** An in service was provided to nursing staff concerning unnecessary drugs. Systemic change is for as needed medications to include medication task of prior interventions.	09/25/2016

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	disturbance. The Admission MDS (Minimum Data Set) assessment dated 7/13/16 indicated Resident #109 experience moderate cognitive impairment and no behaviors. The Quarterly MDS assessment dated 7/27/16 indicated Resident #109 experienced moderate cognitive impairment and no behaviors. An untimed Physician's Telephone Order dated 7/7/16 indicated a new order was received for, "Ativan [an anti-anxiety medication] 0.5 mg [milligrams]...one tablet po [by mouth] Q [every] 6 hrs [hours] prn [as needed] for aggitation [sic]" A Care Plan dated 7/14/16 for, "I have inappropriate behavioral symptoms..." included, but was not limited to, the following intervention, "...when I begin to become socially inappropriate; provide comfort measures for my basic needs such as [sic] pain, hunger, toileting, too hot/cold etc..." The August 2016 MAR (Medication Administration Record) indicated Ativan 0.5 mg was administered to Resident #109 as follows:		**Completion Date 9-25-2016** DHS/designee will perform audits of 3 random residents medications to assure the resident is free from unnecessary drugs 5x week x one month then 3x a week x one month then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments **Completion Date 9-25-2016**	

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	"8/2/16 at 9:57 A.M...Reason...cursing because staff wouldn't [sic] call mom, started banging fist on desktop", "8/4/16 at 6:05 P.M...Reason...aggitation [sic]", "8/6/16 at 4:59 P.M...Reason...agitation/wanting to go home" "8/7/16 at 2:13 P.M...." The record lacked any documentation to indicate a reason for the medication administration. The Nursing Progress notes from 8/2/16 through 8/16/16 were reviewed and lacked any documentation to indicate Resident #109 experienced agitation, Ativan was administered, or non-pharmacologic interventions were attempted prior the the medication administration. A Behavior Detail Report from 8/1/16 through 8/8/16 lacked any documentation to indicate Resident #109 experienced agitation. 2. During an observation on 8/24/16 at 9:30 A.M. Resident #89 was observed sitting in a chair in the common lounge in no apparent distress.			

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The clinical record of Resident #89 was reviewed on 8/26/16 at 1:15 P.M. The record indicated the diagnoses of Resident #89 included, but were not limited to, bipolar disorder, dementia without behavioral disturbance, intermittent explosive disorder, psychosis, delusional disorder, and impulse disorder. The record lacked any documentation to indicate Resident #89 had a history of depression or insomnia (persistent problem falling and staying asleep).

The most recent Quarterly MDS (Minimum Data Set) dated 6/22/16 indicated Resident #89 experienced severe cognitive impairment and no sleep disturbance.

A Significant Change MDS assessment dated 7/11/16 indicated Resident #89 experienced severe cognitive impairment and no sleep disturbance.

An untimed Physician's Telephone Order dated 8/9/16 indicated a new order was received for, "Trazodone [an anti-depressant medication]...50 mg [milligrams]; amt: [amount] 25 mg...at bedtime prn [as needed]...for sleep..."

The August 2016 MAR (Medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155493	A. BUILDING 00 B. WING	08/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS CARE CENTER	311 E FIRST ST FERDINAND, IN 47532

(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
	Administration Record) indicated Trazodone 25 mg was administered to Resident #89 on 8/11/16 at 11:25 P.M. with an effective result at 12:27 A.M. and on 8/15/16 at 8:40 P.M. with an ineffective result at 10:34 P.M. The MAR lacked any documentation to indicate non-pharmacologic interventions were attempted prior to the medication administration. A Nursing note dated 8/9/16 at 11:10 A.M., indicated Resident #89 was re-admitted to the facility, at that time, from a behavioral health unit. A Nursing note dated 8/10/16 at 5:41 A.M. indicated, "resident [sic] has rested well this night..." A Nursing note dated 8/11/16 at 5:34 A.M. indicated, "resident [sic] has rested well this night..." A Nursing note dated 8/12/16 at 10:45 P.M. indicated, "resident [sic] sitting quietly in TV lounge area, unable to res, c/o [complaint of] no sleep, trazadone [sic] given as ordered at this time, will continue to monitor" The note lacked any documentation to indicate non-pharmacological interventions were attempted prior to the medication administration.			

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	A Care Plan dated 8/13/16 for, "...I have difficulty sleeping and use an antidepressant [sic] to help to achieve an adequate nights [sic] sleep" included, but was not limited to, interventions of, "...Attempt non-pharmacological interventions..." The Nursing notes from 8/15/16 at 7:46 P.M. through 8/16/16 at 3:57 A.M. lacked any documentation to indicate Resident #89 experienced sleep disturbance, Trazodone was administered, or non-pharmacological interventions were attempted prior to the medication administration. A "Behavior and Mood Event...Insomnia/Sleep Disturbance Circumstance dated 8/15/16 at 11:37 A.M. indicated, "...PRN order received upon readmission from BHU [Behavioral Health Unit]...Since return from BHU Res has had a few nights that she has needed PRN Trazadone [sic] to help Res rest at night...Staff has reported to have dimmed the lights, put soothing music on and even tried to have it very quiet on the unit prevent [sic] over-stimulation prior to using prn sleep med...interventions effective...evaluation notes: no adverse effect from medication change, resident sleep pattern improved."			

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	An untimed Physician's Telephone Order dated 8/16/16 indicated a new order was received for, "Trazodone 50 mg; amt: 25 mg...at bedtime...evening...d/t [due to] insomnia" The 2016 PDR (Physician's Drug Reference) Nurse's Drug Handbook pages 1075-1076 indicated, "Trazodone...Major Depressive Disorder...Warnings/Precautions...May precipitate a mixed/manic episode in patients at risk for bipolar disorder...Patient counseling...notify physician if...changes in behavior...insomnia..." The Policy and Procedure for Behavior Planning and Intervention provided by the Regional Nurse Consultant on 8/25/16 at 3:15 P.M. lacked any documentation related to attempting non-pharmacological interventions prior to the administration of PRN anti-anxiety or anti-depressant medications. During an interview on 8/26/16 at 10:59 A.M., the DHS (Director of Health Services) indicated no documentation could be provided to indicate Resident #89 experienced a persistent problem falling and staying asleep or experienced signs of depression.			

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	3.1-48(a)(4) 3.1-48(a)(2)			
F 0469 SS=D Bldg. 00	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. Based on observation, interview, and record review, the facility failed to ensure the facility was free of pests, in that, ants were observed crawling on the counter top in the 400 medication room for 3 of 3 observations on 8/26/16, for the 2 of 2 medication rooms toured at the facility, 27 of 27 residents received medication from the 300/400 medication room. Findings include: On 8/26/16 at 10:10 A.M., the 400 unit medication room was toured with LPN #7. At that time, LPN #7 was made aware of an ant crawling on counter top in the medication room next to the medication refrigerator. LPN #7 indicated, at that time, she was unaware of ants in the medication room.	F 0469	F 469 All residents have the potentialto be affected by the alleged deficient practice and through alterations inprocesses and in servicing will ensure the campus is free of pests. **Completion Date 9-25-2016** The campus has been treated forants in the medication rooms. The campuscontinues with routine pest treatment. Systemic change is all staff have beenin serviced on what to do if ants are noted in the campus. **Completion Date 9-25-2016** ED/designee will completeenvironmental rounds daily to ensure campus is free of pests 5x a	09/25/2016

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	On 8/26/16 at 10:16 A.M., again touring the 400 medication room with LPN #7, 2 more black ants were observed crawling across the counter top next to the medication refrigerator. On 8/26/16 at 10:29 A.M., again touring the 400 unit medication room with LPN#7, 6 ants were observed crawling on counter top next to the medication refrigerator behind stacked packages of unopened incontinence wipes. On 8/26/16 at 10:29 A.M., Maintenance Staff #1 was present in 400 unit medication room and made aware of ants in 400 medication room. On 8/26/16 at 10:40 A.M., during interview with Maintenance Staff #1, he indicated pest control services had been provided at the facility in the past week. Maintenance Staff #1 indicated pest control had noted ants in the 400 unit nourishment room (connecting wall to the medication room). Maintenance Staff #1 indicated pest control had provided a spot treatment in the 400 unit nourishment room for the ants observed. Maintenance Staff #1 indicated, he had just now sprayed the 400 unit medication room after being made aware of ants in the 400 unit medication room.		week for amonth then 3x a week for a month then weekly with results forwarded to QAcommittee monthly x6 months and quarterly thereafter for review and furthersuggestions/comments **Completion Date 9-25-2016**	

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	On 8/26/16 at 10:46 A.M., Maintenance Staff #1 indicated when ants had been observed in the 400 unit nourishment room cabinet last week, unopened individual candy pieces had also been observed in the cabinet. Maintenance Staff #1 provided, at that time, a pest control service report dated 8/23/16. The report included, but was not limited to, "... Spot treated 400 nourishment room for trailing ants. Spot treated bathroom in 312 for reported roach..." On 8/26/16 at 12:09 P.M., the Administrator was made aware of ants observed in the 400 unit medication room. The Administrator indicated, at that time, that pest control services had been at the facility the past week. On 8/26/16 at 12:30 P.M., Maintenance Staff #1 provided a facility policy entitled "Pest control (undated)." The policy included but was not limited to, "... 1. The facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents... 6. Maintenance services assist, when appropriate and necessary, in providing pest control services." 3.1-19(f)(4)			

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