STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155333	A. BUILDING 00 B. WING	11/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAOLI HEALTH AND LIVING COMMUNITY	559 W LONGEST ST PAOLI, IN 47454

(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
F0000	This visit was for the Investigation of Complaint IN00119319. Complaint IN00119319 Unsubstantiated, due to lack of evidence. Unrelated deficiencies are cited. Survey dates: November 26 and 27, 2012 Facility number: 000226 Provider number: 155333 AIM number: 100267730 Survey team: Anne Marie Crays RN Census bed type: SNF: 14 SNF/NF: 87 Total: 101 Census payor type: Medicare: 19 Medicaid: 72 Other: 10 Total: 101 Sample: 5 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.	F0000		

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

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	Quality review completed 11/28/12 Cathy Emswiller RN			

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F0222 SS=D	483.13(a) RIGHT TO BE FREE FROM CHEMICAL RESTRAINTS The resident has the right to be free from any chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Based on observation, interview, and record review, the facility failed to ensure an antipsychotic medication was not administered in an effort to control his behavior as a chemical restraint, for 1 of 1 residents reviewed for chemical restraints, in a sample of 5. Resident C Findings include: 1. On 11/26/12 at 9:35 A.M., during the initial tour, the Director of Nursing [DON] indicated Resident C was recently admitted to the facility. Resident C was observed lying in bed with his eyes closed. On 11/26/12 at 10:35 A.M., Resident C was observed lying in bed with his eyes closed. CNA # 1 performed care on the resident at that time. The resident appeared lethargic, and did not respond to his name until after several attempts were made. The clinical record of Resident C was reviewed on 11/26/12 at 1:50 P.M. The	F0222	This plan of correction is to serve as Paoli Health and Living Center's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Paoli Health and Living Center or their management companies that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. All residents with physician orders for an antipsychotic medication have been identified F222 483.13(a) RIGHT TO BE FREE FROM CHEMICAL RESTRAINTS 1. Resident #C is no longer receiving Haldol and has been reviewed by psych services for appropriateness of the antipsychotic. 2. and are not being administered in an effort to control behavior as a chemical restraint. 3. The systemic change includes: · Prior to administering a prn	12/27/2012

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	resident was admitted to the facility on 11/21/12 with diagnoses including, but not limited to, acute congestive heart failure, renal insufficiency, and weakness. Resident Progress Notes included the following notations: 11/21/12 at 1:38 P.M.: "Arrived at facility from home with family in W/C [wheelchair]. Oriented to room, call light. Head to toe assessment done with areas noted. Incont [incontinent] of bladder, upper dentures. Bruising noted to arms. Transfers 1 assist. O2 [oxygen] applied [sic] at 2 liters. MD awre [sic] and orders received. Pharmacy faxed. Dept [department] heads aware." An Admission Nursing Assessment, dated 11/21/12 at 3:28 P.M., indicated: "...Hearing, Moderate difficulty...Ability to Understand Others, Usually understands...Short-term Memory, Memory problem...Mood and Behavior, None of the Above...." Resident Progress Notes continued: 11/22/12 at 1:45 A.M.: "Res. [resident] yelling at roommate, removed resident from room, MD notified, order received, may give STAT Haldol [antipsychotic medication] 2 mg IM & routine abilify 5		(as needed) or one time dose of an antipsychotic medication, the nurse will contact the DON or her designee to discuss the resident's behavior and the non-drug interventions attempted. · All new admissions with orders for an antipsychotic medication will be reviewed by the facility psychologist (if ordered), pharmacy consultant and facility interdisciplinary team for adequate indication of use. The psychologist and pharmacy consultant will be notified by the Director of Nursing or designee for a review within 72 hours of admission. · All new orders are reviewed at the daily (Monday through Friday) clinical meeting. Any new orders for antipsychotic medications will have a review of the medical record for indications of use of the antipsychotic medication. Education will be provided to licensed nurses and Social Services regarding the systemic change. 4. The Unit Manager or designee will audit medication administration records daily, 5 days a week for administration of a prn or one time order for an antipsychotic. This audit will include a review of the progress notes for notification of the DON, or designee, if an antipsychotic is given on a prn or one time basis. This audit will continue 5 days a week for 30 days, then 2 days a week for 30 days, then weekly for a	

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	mg [antipsychotic medication] qd [every day], son notified. Son is on his way to attempt to calm resident down before Haldol is given." 11/22/12 at 2:45 A.M.: "Resident's son here & has been calmly talking to res for 30 minutes in dining room. Resident continues to make inflammatory statements & exhibit threatening behavior. Son states that he is going home & asked nurse to go ahead & give Haldol. STAT Haldol given." 11/22/12 at 5:30 A.M.: "Res got up out of bed & threw roommates's remote across room redirected res, MD notified, order received for STAT Haldol 2 mg, son notified." 11/22/12 at 7:49 A.M.: "Has been calm. Refused food, drink and meds [medications] therapy. In bed. 1 on 1 with staff." 11/22/12 at 11:10 A.M.: "Spoke with [physician] on rsd. [resident] behavior and Edema [swelling] to BLE [bilateral lower extremities]. New orders received for labs and UA [urinalysis]...." A Physician's order, dated 11/22/12 at 11:10 A.M., indicated: "[Change] Abilify to 10 mg po [by mouth] daily...Add dx		total of 12 months of monitoring. Any concerns will be addressed. Social Services will audit all new admission with orders for an antipsychotic medication for notification of the psychologist (if ordered) as well as the consult completion, 2 days a week for 30 days, then weekly thereafter for a total of 12 month of monitoring. Any concerns will be addressed. The Director of Nursing or designee will audit that all new admissions with an order for an antipsychotic and notification of the pharmacy consultant as well as a review by the interdisciplinary team for adequate indication of use, daily, 5 days a week for 30 days, then 2 days a week for 30 days, then weekly thereafter for a total of 12 months of monitoring. Any concerns will be addressed. The Director of Nursing or designee will audit that all new orders for an antipsychotic are reviewed at the daily (Monday through Friday) clinical meeting and for appropriate indications of use. This audit will continue 5 days a week for 30 days, then 2 days a week, then weekly thereafter for a total of 12 months of monitoring. Any concerns will be addressed. The results of the auditing will be discussed at the monthly QA meeting for a total of 12 months of monitoring. Frequency and duration	

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	[diagnosis] of Psychosis." Resident Progress Notes continued: 11/23/12 at 12:30 A.M.: "CNA walked by & saw resident's feet on floor, went into room & found res. sitting on floor...no apparent injury...." A Physician's note, dated 11/23/12, indicated, "Feels okay. Was combative yesterday...." 11/26/12 at 8:31 A.M.: "Up with 1 assist...Unable to stay awake during breakfast...Denies pain." 11/26/12 at 12:50 A.M.: "...After several bites held food in mouth...Spoke with son on his concern of the antipsychotic making him drowsy. Fax out to MD." On 11/27/12 at 9:35 A.M., during interview with RN # 1, she indicated she was the staff present when Resident C was admitted. RN # 1 indicated the resident was calm for her. RN # 1 indicated when she came in the next day, the night shift nurse informed her Resident C had been throwing things, cussing, and yelling. RN # 1 indicated she thought the resident had been unhappy about being at the facility.		will be increased as needed. Date of completion: December 27, 2012	

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	The clinical record of Resident C was reviewed again on 11/27/12 at 9:45 A.M. Resident Progress Notes, written by the Social Services Director [SSD], included: 11/26/12 at 3:31 P.M.: "Received call from nursing over the holiday at home on 11/22/12 in regards to resident with confusion and yelling at his roommate...Staff noted resident upset and yelling, intervened and resident was removed from the room. Staff provided 1:1 with resident but continued upset and yelling...New order received from physician for labs...and transfer to behavior unit if required. Units were contacted and information provided...but was determined unacceptable for placement r/t [related to] resident critical labs received, felt medical issues contributing to behavior issues...No further issues noted r/t becoming upset at roommate...." On 11/27/12 at 10:10 A.M., during interview with the SSD, she indicated she had not been at the facility since 11/21/12, and that is why she documented the administration of Haldol on 11/26/12. She indicated she had not seen Resident C on admission, and was not familiar with him. She indicated she was phoned on 11/22/12 during the early morning hours, and informed that Resident C was upset			

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	and yelling. The SSD indicated she asked staff if they had removed him from his room and did any interventions. The SSD indicated the staff had already administered the Haldol when they called her. The SSD indicated she had been unaware that the 2nd dose of Haldol was administered until she had reviewed the record. The SSD indicated the resident was probably angry at being at the facility. The SSD indicated the DON did inform the nurses after this incident that Haldol IM was not to be administered. On 11/27/12 at 10:45 A.M., during interview with the DON, she indicated staff had called her "the next day" regarding Resident C's behavior. The DON indicated the resident "did not want to be here." The DON indicated the nurse who obtained the order for the Haldol and Abilify was not a new nurse. The DON indicated, "We do have to look out for the safety of our residents." The DON indicated the son had requested to decrease the Abilify, and the physician was to be notified. 2. On 11/27/12 at 1:45 P.M., the visiting DON provided the current facility policy on "Use of Physical & Chemical Restraints," revised 10/06. The policy included: "Restraints shall be used for the safety and well-being of the resident(s)			

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	and only after other alternatives have been tried unsuccessfully...When drugs are used to restrain or control behavior or to treat a disordered thought process, the following shall apply: 1. The specific behavior of manifestation of disordered thought process to be treated with the drug is identified in the resident's clinical record. 2. The plan of care for each resident specifies data to be collected for use in evaluating the effectiveness of the drugs and the occurrence of adverse reactions...5. Prior to administering a PRN [as needed] antipsychotic medication, the nurse shall contact the DON or her designee to discuss the resident's behavior and the non-drug interventions attempted...." 3.1-3(w)			

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F0329 SS=D	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. 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.	F0329	F329 483.25(1) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 1. Resident #C is no longer receiving Haldol and has had a dose reduction in his Abilify. He was evaluated by the consulting psychologist and will be followed by psych services as well as the pharmacy consultant. The consulting psychologist feels the Abilify is a necessary medication for the resident's psychosis.2. All residents with Antipsychotic medications have been identified and have adequate indications for	12/27/2012
	Based on observation, interview, and record review, the facility failed to ensure adequate indications for the use of anti-psychotic medication, for 1 of 1 residents reviewed with psychotropic medications, in a sample of 5. Resident C Findings include:			

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	1. On 11/26/12 at 9:35 A.M., during the initial tour, the Director of Nursing [DON] indicated Resident C was recently admitted to the facility. Resident C was observed lying in bed with his eyes closed. On 11/26/12 at 10:35 A.M., Resident C was observed lying in bed with his eyes closed. CNA # 1 performed care on the resident at that time. The resident appeared lethargic, and did not respond to his name until after several attempts were made. The clinical record of Resident C was reviewed on 11/26/12 at 1:50 P.M. The resident was admitted to the facility on 11/21/12 with diagnoses including, but not limited to, acute congestive heart failure, renal insufficiency, and weakness. The record indicated Resident C was hospitalized from 11/2/12 to 11/6/12. A hospital discharge summary, dated 11/6/12, indicated, "...He is in good spirits and comfortable...No acute distress...Discharge medications: Lasix [for congestive heart failure]...Aspirin...Potassium...." The resident was discharged with home health care until his emergency admission to the facility on 11/21/12.		of use of an antipsychotic medication. 3. The systemic change includes:· Prior to administering a prn (as needed) or one time dose of an antipsychotic medication, the nurse will contact the DON or her designee to discuss the resident's behavior and the non-drug interventions attempted.· All new admissions with orders for an antipsychotic medication will be reviewed by the facility psychologist, pharmacy consultant and facility interdisciplinary team for adequate indication of use.· All new orders are reviewed at the daily (Monday through Friday) clinical meeting. Any new orders for antipsychotic medications will have a review of the medical record for indications of use of the antipsychotic medication. Education will be provided to licensed nurses and Social Services regarding the systemic change. 4. The Unit Manager or designee will audit medication administration records daily, 5 days a week for administration of a prn or one time order for an antipsychotic. This audit will include a review of the progress notes for notification of the DON, or designee, if an antipsychotic is given on a prn or one time basis. This audit will continue 5 days a week for 30 days, then 2 days a week for 30 days, then weekly for a total of 12 months of monitoring. Any concerns will be	

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	Admitting physician orders, dated 11/21/12, indicated the resident was to receive the following medications: Potassium, Aspirin, Lasix, and Digoxin [for irregular heart beat]. Resident Progress Notes included the following notations: 11/21/12 at 1:38 P.M.: "Arrived at facility from home with family in W/C [wheelchair]. Oriented to room, call light. Head to toe assessment done with areas noted. Incont [incontinent] of bladder, upper dentures. Bruising noted to arms. Transfers 1 assist. O2 [oxygen] applied [sic] at 2 liters. MD awre [sic] and orders received. Pharmacy faxed. Dept [department] heads aware." An Admission Nursing Assessment, dated 11/21/12 at 3:28 P.M., indicated: "...Hearing, Moderate difficulty...Ability to Understand Others, Usually understands...Short-term Memory, Memory problem...Mood and Behavior, None of the Above...." Resident Progress Notes continued: 11/22/12 at 1:45 A.M.: "Res. [resident] yelling at roommate, removed resident from room, MD notified, order received,		addressed.Social Services will audit all new admission with orders for an antipsychotic medication for notification of the psychologist (if ordered) as well as the consult completion, 2 days a week for 30 days, then weekly thereafter for a total of 12 month of monitoring. Any concerns will be addressed.The Director of Nursing or designee will audit that all new admissions with an order for an antipsychotic and notification of the pharmacy consultant as well as a review by the interdisciplinary team for adequate indication of use, daily, 5 days a week for 30 days, then 2 days a week for 30 days, then weekly thereafter for a total of 12 months of monitoring. Any concerns will be addressed.The Director of Nursing or designee will audit that all new orders for an antipsychotic are reviewed at the daily (Monday through Friday) clinical meeting and for appropriate indications of use. This audit will continue 5 days a week for 30 days, then 2 days a week, then weekly thereafter for a total of 12 months of monitoring. Any concerns will be addressed.The results of the auditing will be discussed at the monthly QA meeting for a total of 12 months. Frequency and duration will be increased as needed. Date of completion: December 27, 2012 Paper Compliance Being Requested.	

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	may give STAT Haldol [antipsychotic medication] 2 mg IM & routine abilify 5 mg [antipsychotic medication] qd [every day], son notified. Son is on his way to attempt to calm resident down before Haldol is given." 11/22/12 at 2:45 A.M.: "Resident's son here & has been calmly talking to res for 30 minutes in dining room. Resident continues to make inflammatory statements & exhibit threatening behavior. Son states that he is going home & asked nurse to go ahead & give Haldol. STAT Haldol given." 11/22/12 at 5:30 A.M.: "Res got up out of bed & threw roommates's remote across room redirected res, MD notified, order received for STAT Haldol 2 mg, son notified." 11/22/12 at 7:49 A.M.: "Has been calm. Refused food, drink and meds [medications] therapy. In bed. 1 on 1 with staff." 11/22/12 at 11:10 A.M.: "Spoke with [physician] on rsd. [resident] behavior and Edema [swelling] to BLE [bilateral lower extremities]. New orders received for labs and UA [urinalysis]...." A Physician's order, dated 11/22/12 at			

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	11:10 A.M., indicated: "[Change] Abilify to 10 mg po [by mouth] daily...Add dx [diagnosis] of Psychosis." Resident Progress Notes continued: 11/23/12 at 12:30 A.M.: "CNA walked by & saw resident's feet on floor, went into room & found res. sitting on floor...no apparent injury...." 11/26/12 at 8:31 A.M.: "Up with 1 assist...Unable to stay awake during breakfast...Denies pain." 11/26/12 at 12:50 A.M.: "...After several bites held food in mouth...Spoke with son on his concern of the antipsychotic making him drowsy. Fax out to MD." On 11/27/12 at 9:35 A.M., during interview with RN # 1, she indicated she was the staff present when Resident C was admitted. RN # 1 indicated the resident was calm for her. RN # 1 indicated when she came in the next day, the night shift nurse informed her Resident C had been throwing things, cussing, and yelling. RN # 1 indicated she thought the resident had been unhappy about being at the facility. The clinical record of Resident C was reviewed again on 11/27/12 at 9:45 A.M.			

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	155333	A. BUILDING 00 B. WING	11/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAOLI HEALTH AND LIVING COMMUNITY	559 W LONGEST ST PAOLI, IN 47454

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	Resident Progress Notes, written by the Social Services Director [SSD], included: 11/26/12 at 3:31 P.M.: "Received call from nursing over the holiday at home on 11/22/12 in regards to resident with confusion and yelling at his roommate...Staff noted resident upset and yelling, intervened and resident was removed from the room. Staff provided 1:1 with resident but continued upset and yelling...New order received from physician for labs...and transfer to behavior unit if required. Units were contacted and information provided...but was determined unacceptable for placement r/t [related to] resident critical labs received, felt medical issues contributing to behavior issues...No further issues noted r/t becoming upset at roommate...." On 11/27/12 at 10:10 A.M., during interview with the SSD, she indicated she had not been at the facility since 11/21/12, and that is why she documented the administration of Haldol on 11/26/12. She indicated she had not seen Resident C on admission, and was not familiar with him. She indicated she was phoned on 11/22/12 during the early morning hours, and informed that Resident C was upset and yelling. The SSD indicated she asked staff if they had removed him from his			

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	room and did any interventions. The SSD indicated the staff had already administered the Haldol when they called her. The SSD indicated she had been unaware that the 2nd dose of Haldol was administered until she had reviewed the record. The SSD indicated the resident was probably angry at being at the facility. The SSD indicated the DON did inform the nurses after this incident that Haldol IM was not to be administered. On 11/27/12 at 10:45 A.M., during interview with the DON, she indicated staff had called her "the next day" regarding Resident C's behavior. The DON indicated the resident "did not want to be here." The DON indicated the nurse who obtained the order for the Haldol and Abilify was not a new nurse. The DON indicated, "We do have to look out for the safety of our residents." The DON indicated the son had requested to decrease the Abilify, and the physician was to be notified. 2. On 11/27/12 at 11:15 A.M., a visiting Director of Nursing provided the current facility policy on "Antipsychotic Medication Use," revised April 2007. The policy included: "Antipsychotic			

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	medication therapy shall be used only when it is necessary to treat a specific condition...The Attending Physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, symptoms, and risks...Nursing staff will document in detail an individual's target symptom(s)...The Attending Physician will identify, evaluate and document, with input from other disciplines and consultants as needed, symptoms that warrant the use of antipsychotic medications...antipsychotic medications will not be used unless behavior symptoms are: a. Not due to a medical condition or problem...Not due to environmental stressors (e.g. alteration in the resident's customary location or daily routine, unfamiliar care provider...Not due to psychological stressors...anxiety or fear stemming from misunderstanding related to his or her cognitive impairment (e.g., the mistaken belief that this is not where he/she lives...)...." 3.1-48(b)(1)			

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