STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155740	A. BUILDING 00 B. WING	01/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TIMBERCREST CHURCH OF THE BRETHREN HOME	2201 EAST ST NORTH MANCHESTER, IN 46962

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00284724. Complaint IN00284724 - Substantiated. No deficiencies related to the allegation were cited. Unrelated deficiency is cited. Survey dates: January 29 and 30, 2019 Facility number: 000448 Provider number: 155740 AIM number: 100275140 Census bed type: SNF/NF: 54 Residential: 119 Total: 173 Census payor type: Medicare: 2 Medicaid: 17 Other: 35 Total: 54 This deficiency reflects State Finding cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 4, 2019.	F 0000		
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			

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

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	drugs include, but are not limited to, drugs in the following categories: (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			

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	renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on observation, interview and record review, the facility failed to ensure residents were free from psychotropic medications without indication and monitoring for 2 of 3 residents reviewed for unnecessary medications. (Residents C and D) Finding include: 1. During the initial tour on 1/29/19 at 9:10 a.m., the Assistant Director of Nursing (ADON) indicated Resident C was actively dying. During an observation on 1/29/19 at 11:20 a.m., Resident C has remained asleep in bed. On 1/30/19 at 9:43 a.m., the resident was asleep in bed. The clinical record for Resident C began on 1/29/19 at 11:24 a.m. Diagnoses included, but were not limited to, hospice care, hallucinations, delusions, dementia with behavioral disturbances and anxiety. Medications included, but were not limited to, haloperidol (antipsychotic medication) lactate concentrate; 2 mg/mL; amt: 2 mg; oral at 5:00 p.m. and Seroquel (antipsychotic medications) 12.5 mg twice daily. A 1/16/19, significant change Minimum Data Set (MDS) assessment, indicated she sometimes understood others, and her daily decision making skills were severely impaired. The assessment indicated the resident required two person assistance for bed mobility, transfers, dressing	F 0758	1. Resident C and D were affected. Both residents had dose reductions preformed on psychotropic medications. No adverse effects noted. Behavior monitoring in place. Careplans reviewed and updated. 2. All residents have the potential to be affected. Nursing staff educated on psychotropic medication policy. All current residents psychotropic medications reviewed for diagnosis, side effect monitoring, and target behavior monitoring. 3. As a measure of ongoing compliance, the DON or designee will audit all psychotropic medications for 6 months to ensure all psychotropic medications have an approved diagnosis for use with interventions and behavior monitoring documentation present in the medical record. 4. As a measure of ongoing compliance, the DON or designee will audit all psychotropic medications for 6 months to ensure GDR is performed unless clinically contraindicated. 5. As a measure of ongoing compliance, the DON or designee	02/28/2019

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	and hygiene. She used a wheelchair for mobility. The PHQ-9 (a tool to measure depression) indicated a score of 3, which indicated minimal depression. Review of the November nurses notes indicated the following: 11/2/18 at 9:30 a.m., resident was anxious about all "these people in our house...." Writer reassured her things were alright 11/2/18 at 1:51 p.m., resident stated she wanted to go home with her parents. Spouse was consoling her. 11/2/18 at 5:18 p.m., resident sobbing because the Germans were coming. Staff were able to redirect. 11/3/19 at 1:49 a.m., resident crying because she wanted to see her mom, husband stated she was in heaven. 11/3/18 at 5:00 a.m., the resident fell in her room and was sent to the hospital. 11/3/18 at 8:54 a.m., the resident had a slight urinary tract infection and was started on an antibiotic and returned to the facility. 11/8/18 at 10:05 a.m., Interdisciplinary Team (IDT) meeting indicated the resident had an increase in tearfulness and delusional thinking. 11/22/18 at 4:30 p.m., transferred herself to her husbands recliner. Resident was crying and emotional support was given. 11/29/18 at 4:30 p.m., resident self-transferred and became agitated with staff. Upset that staff were not taking care of her infant son. 11/30/18 at 3:35 p.m., physician updated on increased crying, tearfulness and being combative. Review of the November Treatment Administration History, the resident had behavior management for tearfulness and depression. She had no behavioral monitoring for delusion and/or		will audit all psychotropic medications for 6 months to ensure all PRN psychotropic medications have a 14 day stop date or physician has documented rationale in the medical chart to extend use. 6. As a quality measure, the DON or designee will review any findings and corrective action at least quarterly in the campus QAPI meetings. The plan will be revised and updated as warranted. * Attachments uploaded	

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	hallucinations. The resident had a current health care plan, dated 12/18/18, which indicated a problem related to delusional disorder, requiring the used of Seroquel and Haldol to decrease distress related to delusional behaviors. Signs and symptoms of delusions include: believed she needs to care for her husband and tried to self transfer herself, believed there were people coming to get her. She was also receiving Haldol for agitation. The signs of agitation included, but were not limited to, resistive with care, hitting, kicking and biting staff. Interventions included, but were not limited to, "...give objects to hold...soothing tone...choose options...clear boundaries...one step verbal directions...maintain a calm environment." Review of the December nurses notes indicated the following: 12/2/18 at 12:39 a.m., resident wanted to get up and take care of the babies. Staff were able to redirect. 12/6/18 at 6:12 p.m., a new order was received to increase Zoloft (anti-depressant) to 150 mg daily. 12/8/18 at 7:20 p.m., resident stated "why are you keeping me here." A behavioral psychological evaluation, dated 12/10/18, indicated the resident had anxiety, confusion, depression, memory problems and delusions. The note indicated the resident was "actively delusional" but she denied hallucinations. The plan included to add Seroquel (psychotropic medication) 12.5 mg for delusions. Additional December nurses notes indicated the following: 12/11/18 at 12:00 p.m., resident attempting to take care of her husband, staff attempted to re-orient			

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	with no success. 12/11/18 at 3:55 p.m., resident upset that she had not seen her husband in over a year. Reassured resident her husband was in his room. 12/12/18 at 9:04 p.m., resident upset about not seeing her husband in over one year, stuffed cat given for comfort. 12/13/18 at 6:13 p.m., physician returned call and would not be starting Seroquel due to possible "lethal reaction" with Aricept (to treat dementia). 12/17/18 at 12:57 a.m., resident demanded the stuffed cat, cat was sitting on her chest. 12/17/18 at 7:06 a.m., resident combative with staff, kicking and grabbing. 12/17/18 at 8:10 a.m., new order received to start Seroquel 25 mg at night. 12/19/18 at 7:54 p.m., resident highly agitated and wanted to walk home. Resident hit and bit an aide. 12/24/18 at 10:46 a.m., nurse reported to physical of decreased behaviors since starting Seroquel and to consider increasing the medication. 12/24/18 at 8:26 p.m., telephone range at nurses station, resident was sure someone was calling about the spy ware that she needed to monitor her cat. Unable to redirect or console. 12/24/18 at 10:16 p.m., resident yelling she wanted to talk to her dad and she was calling the police. No intervention attempted. 12/27/18 at 9:02 a.m., physicians office notified of continued behavior of refusal with Activities of Daily Living (ADL) care and toileting. Resident continued to be resistive with care by hitting and biting staff. Requested to increase Seroquel for optimum therapy dose. 12/27/18 at 6:00 p.m., new order received to increase Seroquel to 25 mg twice daily. 12/29/18 at 5:24 a.m., resident indicated her husband and daughter had died, sobbing uncontrollably. Staff was unable to reassure or			

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	console the resident. 12/30/18, the resident was admitted to an in-patient psychiatric facility. Review of the December Treatment Administration History, the resident had one delusional behavior on 12/24/18 that people were trying to get her. A progress note, dated 1/8/19 at 2:53 p.m., indicated the psychiatric facility had taken the resident to the emergency room on 1/7/19 related to worsening conditions. She was diagnosed with a Cerebrovascular Accident (CVA). She returned to the facility under hospice care. The family decided to not pursue treatment. Resident C returned to the facility on 1/8/19 with an order for Seroquel 25 mg twice daily and Haldol 2 mg/mL, give 1 mL every four hours for agitation as needed. A behavioral psychological evaluation, dated 1/14/19, indicated the resident had no obvious negative impacting delusions but was still confused. A progress note, dated 1/15/19 at 5:03 p.m., indicated family was requesting Haldol be given every night with no change in the PRN dose. The Haldol order was changed on 1/15/19 to 2 mg at bedtime and Seroquel was decreased to 12.5 mg twice daily. A progress note, dated 1/16/19 at 4:14 p.m., indicated the hospice physician continued the Haldol dose tonight and to use PRN if she "awakens and starts to wander." She also recommended to use Ativan (anti-anxiety			

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medication) or Haldol if she woke up or was wandering around.

A progress note, dated 1/21/19 at 4:35 p.m., indicated the facility had discussed potentially trying Depakote (antiepileptic medication) and discontinuing Haldol. The pharmacist recommended to discontinue Haldol and start Depakote at 250 mg twice daily. At 7:37 p.m., the family was notified of the new order and had requested to hold the order until after the next days care plan meeting.

On 1/22/19 at 8:38 a.m., during a telephone conference, the family had requested to continue Haldol and felt the behaviors were improving.

Review of the January Treatment Administration History, the resident had one delusional behavior on 1/19/19 that she needed to care for her husband and/or people were coming to get her.

Review of a letter from the Hospice Medical Director, provided by the Director of Nursing (DON) on 1/30/19 at 10:43 a.m., indicated the following:
"On 1/8/19, patient was discharged from [name of facility] with an order for Haldol 2mg every fours hours PRN [as needed] for agitation....patient's behaviors continued, so Haldol 2mg was made routine....Haldol improved her quality of life and was prescribed for combativeness, agitation, and restlessness."

During an interview on 1/29/19 at 12:35 p.m., the Social Service Director indicated the delusions Resident C was having was related to her needing to help her husband or people trying to get her. Staff would write effective or not effective in the progress notes to indicate if the interventions

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	were successful or not. 2. On 1/30/19 9:40 a.m., Resident D was up in a Broda chair, seated at the nurses' station. On 1/30/19 at 10:43 a.m., Resident D was in her Broda chair during an exercise activity. The clinical record for Resident D was reviewed on 1/30/19 at 8:41 a.m. Diagnoses included, but were not limited to, hospice care, delusional disorder, depressive disorder and dementia without behaviors. A 11/28/18, quarterly MDS assessment, indicated she sometimes understood others, and her daily decision making skills were severely impaired. The assessment indicated the resident required two person assistance for transfers, dressing and hygiene. She used a wheelchair for mobility. The PHQ-9 indicated a score of 0, which indicated minimal depression. Review of the September nurses notes indicated the following: 9/2/18 at 4:07 p.m, a family member called and indicated the resident was paranoid. 9/9/18 at 3:58 p.m., resident stated "I just want to die...why can't I die." Resident positioned in recliner and call light in reach. 9/14/18 at 8:00 a.m, resident stated she was hallucinating and was tearful. The room tray was ordered per the residents request. 9/15/18 at 9:35 a.m., resident indicated this is the morning she was going to die. 9/23/18 at 8:35 a.m., resident stated she did not need help with anything because she was going to die today. Repositioned for comfort. 9/27/18 at 6:00 p.m., resident was yelling at other residents to stop eating, "you're going to			

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	die...they're killing us." Staff encouraged her to call her daughter. 9/27/18 at 6:20 p.m., resident yelling the food was being poisoned. The resident was brought to the nurses station. 9/27/18 at 8:25 p.m., hospice nurse in to evaluate. A new order was received to start Haldol 1 mg every four hours as needed for paranoia for the next twenty-four hours only. The order would be re-evaluated on the following day. 9/27/18 at 11:27 p.m, resident holding phone, mumbling about the police. Haldol 1 mg pulled from Emergency Drug Kit (EDK). 9/28/18 at 2:30 a.m., resident indicated she needed to get out of her room because there was a fire. Resident assisted to the bathroom then back to bed. 9/29/18 at 10:44 p.m., resident throwing cups, remote and phone off bed, able to get resident back to bed. 9/30/18 at 8:50 a.m., a new order was received for Haldol 1 mg every six hours for five days. 9/30/18 at 6:55 p.m., resident stated to staff "they are trying to poison me." A current health care plan, initiated 10/25/18, indicated the resident had a diagnoses of delusions and hallucination. She believed she was seeing thing that were not there, repeatedly yelling out and required the use of Haldol. Interventions included, but were not limited to, 1:1 with the resident, play relaxing music or hold her hand. Review of the October Treatment Administration History, the resident had behavior monitoring for hallucinations and delusions. She had no documented behaviors. Review of the October nurses notes indicated the			

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	following: 10/1/18 at 1:30 p.m., the resident indicated they were all going to be gassed and pointed to the residents family room. 10/11/18 at 4:02 p.m., resident noted to be seeing men in her room, anxious with rapid breathing. A new order was received to discontinue Haldol and start Seroquel 50 mg twice daily related to national shortage of Haldol. 10/15/18 at 7:13 p.m., indicated the resident was placed in the Broda chair for increased paranoia, continued to be combative during care. No intervention noted. Review of the November Treatment Administration History, the resident had behavior monitoring for hallucinations and delusions. She had one documented behavior. Review of the November nurses notes indicated the following: 11/4/18 at 1:37 a.m., resident unable to sleep, talking to people that were not there, does not seem upset. 11/5/18 at 12:00 a.m., resident at nurses station, talking to people who are not there. 11/13/18 at 3:50 a.m, resident upset that someone was going to kill her, resident provided with one on one and music. Review of the December Treatment Administration History, the resident had behavior monitoring for hallucinations and delusions. She had two documented behaviors on 12/26/18. Review of the January Treatment Administration History, the resident had behavior monitoring for hallucinations and delusions. She had no documented behaviors.			

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	A behavior management meeting on 1/14/19, indicated the resident had the following delusional disorders in December: 12/14/18, resistive to care, holding onto assist bar and refusing to let go. 12/26/18, resident has been looking up and down and talking almost nonstop. 12/30/18, resident in Broda chair, speaking to no one and fidgeting with her blanket. 12/30/18, intermittently reaches both arms up to the ceiling like she is reaching for something while asleep. On 1/29/19 at 6:34 p.m., the visiting hospice nurse was asked about a possible review of the Haldol per DON request. During an interview on 1/30/19 at 1:45 p.m., the DON indicated they did not have any behavior monitoring "action/reaction" for Resident D from September. They had made several attempts to contact the psychiatric facility to provide a diagnoses for the use of Seroquel or Haldol for Resident C. They were unable to obtain any documentation. They felt by Resident C attempting to get up and falling was a self-injury behavior. Review of a policy, titled "ANTIPSYCHOTIC DRUGS," dated 6/18/18, and provided by the DON on 1/30/19 at 1:40 p.m., indicated the following: "POLICY: Antipsychotic drug therapy shall be used only when it is necessary to treat a specific condition. ...2. An antipsychotic medication should be used only for the following conditions/diagnoses as documented in the record as as meets the definition(s) in in the DSM IV TR. a. Schizophrenia b. Schizo-affective disorder			

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	c. Delusional disorder d. Mood disorders (mania, bipolar... e. Schizophreniform disorder f. Psychosis...." Review of a policy, titled "[name of facility] BEHAVIOR MANAGEMENT POLICY," dated 9/19/18, and provided by the DON on 1/30/19 at 2:12 p.m., indicated the following: ...PROCEDURE: ...2. For residents who have been identified as having on-going symptoms and/or are receiving a psychoactive medication, they are reviewed on EMAR for signs/symptoms every shift by nursing. ...4. Social Service Designee will communicate recommended interventions to all staff via Resident's Care Plan...." 3.1-48(a)(3) 3.1-48(a)(4)			