

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/23/2015
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NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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(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
F 0000 Bldg. 00	<p>This visit was for the Recertification and State Licensure Survey</p> <p>Survey dates: September 16, 17, 18, 21, 22, and 23, 2015.</p> <p>Facility number: 000336 Provider number: 155376 AIM number: 100290170</p> <p>Census bed type: SNF/NF: 55 Total: 55</p> <p>Census payor type: Medicare: 3 Medicaid: 42 Other: 10 Total: 55</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed by 21662 on September 29, 2015.</p>	F 0000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations.	
F 0225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Bldg. 00	<p>ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review, facility failed to ensure allegations of</p>	F 0225	1. Statements from staff were obtained and included in the abuse allegation investigation	10/23/2015	

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	<p>resident physical and mental abuse allegations were thoroughly investigated, for 1 of 4 abuse allegations being investigated. (Resident #56)</p> <p>Findings include:</p> <p>During an interview on 9/17/15 at 11:49 a.m., Resident #56 indicated on 9/11/15 at approximately between 6:00 and 7:00 p.m., he had been physically and mentally abused. He indicated he had waited for LPN #1 to make three phone calls to an "upper management person" to ask if he had permission to go for a walk outside before he went outside. He indicated when no one returned LPN #1's call he signed himself out. He indicated two nurses at the North entrance nurses station told the nurse that brought him down there he could sign himself out as far as they knew, so he did. He indicated LPN #1 indicated she had to run to catch up with him and she told him when she caught up with him he did not have the "authority" to leave the facility. He indicated LPN #1 was speaking to the Director of Clinical Services (DCS) at that time, but refused to allow him to talk to the DCS. He indicated LPN #1 grabbed his left wrist and spun him around so hard he about lost his balance and fell. He indicated she "jammed" his left hand into her jacket pocket to get</p>		<p>related to resident #56. Resident shows no adverse affect from this alleged deficient practice. 2. All residents have the potential to be affected by the alleged deficient practice. Staff to be inserviced on facility abuse investigation policy and procedures. 3. Director of Clinical Services (DCS) will keep log with checklist of investigation procedures for reportable events. 4. DCS will review this log weekly x 4 weeks then monthly x3 months. DCS will report the findings to the QAPI meeting to ensure timeliness and completeness of investigations. The QAPI Committee will determine if additional education or auditing is required.</p>				

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	<p>"leverage" over him. He indicated he had signed himself out in the leave of absence book to go for a walk to get some fresh air. He indicated LPN #1 brought him back into the facility with his left hand in her pocket and she would not let loose until he was in the facility. When he went outside LPN #1 came running after him yelling "Stop him, Stop him." He indicated a wanderguard bracelet was placed on him when he was brought back into the facility and he was told it was a GPS system to find him because sometimes the nurses cannot find him when they try to give him his medications. He indicated he knew the bracelet was to sound the door alarm when he got out, so the staff knew he left the facility. He indicated he did not report he felt like he was abused.</p> <p>On 9/17/15 at 12:30 p.m., the abuse allegation was reported to the Executive Director (ED).</p> <p>During an interview on 9/18/15 at 9:53 a.m., the ED indicated the resident had been identified during their interviews with the residents regarding the abuse allegations. He indicated the resident had attempted to elope the facility, but he got out the first door (inside door) at the North entrance of the facility when LPN #1 took him by his arm and gently guided</p>			

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	<p>him by his arm and brought him back into the facility. He indicated he had reported this incident last week.</p> <p>During an interview on 9/18/15 at 2:45 p.m., the DCS indicated Resident #56 had attempted to exit the facility on 9/13/15. She indicated she had been at the facility that day and had just left the facility when the resident attempted to leave. She indicated Resident #56 had told the staff she indicated he could leave the facility to take a walk and he exited out the inside door to the facility between the inside and outside doors of the facility. The DCS indicated LPN #1 was coming into the facility in the outside door as he was going out the inside door and she gently took him by the arm and brought him into the facility.</p> <p>An Indiana State Department of Health (ISDH) Incident Report Form dated 9/21/15, provided by the ED on 9/22/15 at 11:47 a.m., indicated on 9/17/15 at approximately 12:30 p.m., the ED was informed during the annual survey that an anonymous complaint was filed by a resident who wished to remain anonymous. The resident indicated he was grabbed and made to do something he did not want to do. The resident did not give additional information or identify any staff member.</p>			

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F 0226 SS=D Bldg. 00	<p>An Indiana State Department of Health (ISDH) Incident Report Form dated 9/23/15, provided by the DCS on 9/23/15 at 10:00 a.m., indicated the residents who were verbal were interviewed on abuse and reporting abuse. Skin sweeps of all residents were completed on 9/17/15 and 9/18/15.</p> <p>During an interview on 9/23/15 at 1:58 p.m., the DCS indicated she did not get a phone interview from LPN #1 regarding the abuse allegation, which occurred on 9/13/15.</p> <p>During an interview on 9/23/15 at 2:57 p.m., the DCS indicated abuse education was completed after the abuse allegation was brought to the facility's attention on 9/17/15, but statements from staff were not obtained as part of the abuse allegation investigation.</p> <p>3.1-28(d)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident</p>			

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	<p>property. Based on interview and record review, the facility failed to follow and implement their abuse policy to ensure allegations of physical, mental and sexual abuse allegations were thoroughly investigated and failed to report abuse allegations to the Indiana State Department of Health (ISDH) in a timely manner for 2 of 4 abuse allegations reviewed. (Residents #56 and #34)</p> <p>Findings include:</p> <p>1. During an interview on 9/17/15 at 11:49 a.m., Resident #56 indicated on 9/11/15 at approximately between 6:00 and 7:00 p.m., he had been physically and mentally abused. He indicated he had waited for LPN #1 to make three phone calls to an "upper management person" to ask if he had permission to go for a walk outside before he went outside. He indicated when no one returned LPN #1's call he signed himself out. He indicated two nurses at the North entrance nurses station told the nurse that brought him down there he could sign himself out as far as they knew, so he did. He indicated LPN #1 indicated she had to run to catch up with him and she told him when she caught up with him he did not have the "authority" to leave the facility. He indicated LPN #1 was speaking to the</p>	F 0226	<p>1. Statements from staff were obtained and included in the abuse allegation investigation related to resident #56. The phone interview from LPN #1 was documented and included in the investigation paperwork. Resident shows no adverse affect from this alleged deficient practice. 2. All residents have the potential to be affected by the alleged deficient practice. Staff to be inserviced on facility abuse investigation policy and procedures – including timetables to report abuse allegations. 3. Director of Clinical Services (DCS) will keep log with checklist of investigation procedures for reportable events including time table of investigation. 4. DCS will review this log weekly x 4 weeks then monthly x3 months. DCS will report the findings to the QAPI meeting to ensure timeliness and completeness of investigations. The QAPI Committee will determine if additional education or auditing is required.</p>	10/23/2015			

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	<p>Director of Clinical Services (DCS) at that time, but refused to allow him to talk to the DCS. He indicated LPN #1 grabbed his left wrist and spun him around so hard he about lost his balance and fell. He indicated she "jammed" his left hand into her jacket pocket to get "leverage" over him. He indicated he had signed himself out in the leave of absence book to go for a walk to get some fresh air. He indicated LPN #1 brought him back into the facility with his left hand in her pocket and she would not let loose until he was in the facility. When he went outside LPN #1 came running after him yelling "Stop him, Stop him." He indicated a wanderguard bracelet was placed on him when he was brought back into the facility and he was told it was a GPS system to find him because sometimes the nurses cannot find him when they try to give him his medications. He indicated he knew the bracelet was to sound the door alarm when he got out, so the staff knew he left the facility. He indicated he did not report he felt like he was abused.</p> <p>On 9/17/15 at 12:30 p.m., the abuse allegation was reported to the Executive Director (ED).</p> <p>During an interview on 9/18/15 at 9:53 a.m., the ED indicated the resident had</p>			

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	<p>been identified during their interviews with the residents regarding the abuse allegations. He indicated the resident had attempted to elope the facility, but he got out the first door (inside door) at the North entrance of the facility when LPN #1 took him by his arm and gently guided him by his arm and brought him back into the facility. He indicated he had reported this incident last week.</p> <p>During an interview on 9/18/15 at 2:45 p.m., the DCS indicated Resident #56 had attempted to exit the facility on 9/13/15. She indicated she had been at the facility that day and had just left the facility when the resident attempted to leave. She indicated Resident #56 had told the staff she indicated he could leave the facility to take a walk and he exited out the inside door to the facility between the inside and outside doors of the facility. The DCS indicated LPN #1 was coming into the facility in the outside door as he was going out the inside door and she gently took him by the arm and brought him into the facility.</p> <p>An Indiana State Department of Health (ISDH) Incident Report Form dated 9/21/15, provided by the ED on 9/22/15 at 11:47 a.m., indicated on 9/17/15 at approximately 12:30 p.m., the ED was informed during the annual survey than</p>			

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	<p>an anonymous complaint was filed by a resident who wished to remain anonymous. The resident indicated he was grabbed and made to do something he did not want to do. The resident did not give additional information or identify any staff member.</p> <p>An Indiana State Department of Health (ISDH) Incident Report Form dated 9/23/15, provided by the DCS on 9/23/15 at 10:00 a.m., indicated the residents who were verbal were interviewed on abuse and reporting abuse. Skin sweeps of all residents were completed on 9/17/15 and 9/18/15.</p> <p>During an interview on 9/23/15 at 1:58 p.m., the DCS indicated she did not get a phone interview from LPN #1 regarding the abuse allegation, which occurred on 9/13/15.</p> <p>During an interview on 9/23/15 at 2:57 p.m., the DCS indicated abuse education was completed after the abuse allegation was brought to the facility's attention on 9/17/15, but statements from staff were not obtained as part of the abuse allegation investigation.</p> <p>2. On 9/21/15 at 9:13 a.m., the record review for Resident #34 was completed. Diagnoses included, but was not limited to, diabetes, anxiety, depression, obesity</p>			

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	<p>and history of non compliance.</p> <p>The nurses notes indicated:</p> <p>On 7/24/15 at 9:30 p.m., Resident #34 informed the staff that a male resident entered her room via wheelchair and at the time she was watering her plants. She went over to her straight back chair to sit down and watch TV. She indicated the male resident (Resident #44) rubbed her right shoulder and stated " I'd like to rub that" while pointing to the resident's right breast. She stated "I'm not that kind of girl". The male resident stated "lets get into bed." Resident #34 replied we can't because we will get kicked out of here. Resident #34 was asked by writer if she was upset or felt threatened in any way. Resident #34 denied any negative feelings or reaction to the situation. No injury evident. Resident denied feeling upset or threatened in any way. There was no erythema (redness) or bruising noted on her upper extremities. Resident #34 indicated that no other contact had been initiated. The male resident was taken out of the room to the nurses station area. In addition, three other staff members provided a written statement pertaining to the incident based on experience, and the Director of Clinical Services, and the Executive Director (ED) were notified of the event. The</p>			

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	<p>physician and the responsible party were notified. The resident was reminded to use her call bell if any untoward or similar situation occurred in the future. In the event she is too far from her call bell, the resident was aware to call out loudly as needed.</p> <p>The incident that involved Resident #44 and Resident # 34 was reported by the ADCS on 7/26/15 at 6:30 p.m., to the Indiana State Department of Health.</p> <p>On 9/22/15 at 9:23 a.m., the ED provided follow up information regarding Resident #34. He indicated at the time of the incident on 7/24/15, it was reported too late and there was some confusion amongst staff.</p> <p>A current policy titled "Resident Abuse" dated 11/30/14, provided by the ED on 9/23/15 at 4:22 p.m., indicated "... Procedure for Reporting Abuse... Once an allegation of abuse is reported, the Executive Director, as the abuse coordinator, is responsible for ensuring that reporting is completed timely and appropriately to appropriate officials in accordance with Federal and State regulations...</p> <p>Investigation of Abuse: The Abuse Coordinator or his/her designee shall investigate all reports or allegations of</p>			

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F 0247 SS=D Bldg. 00	<p>abuse. A Social Service representative may be offered in the role of resident advocate during any questioning of or interviewing of residents. Investigations will be accomplished in the following manner... Investigation: The Abuse Coordinator and/or Director of Clinical Services shall take statements from the victim, the suspect (s) and all possible witnesses including all other employees in the vicinity of the alleged abuse. He/she shall also secure all physical evidence. Upon completion of the investigation, a detailed report shall be prepared...."</p> <p>3.1-28(a)</p> <p>483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on interview and record review, the facility failed to provide notice to a resident that they were getting a new room mate for 1 of 3 residents reviewed for resident rights (Resident #3 and # 78).</p> <p>Findings include: On 9/17/15 at 2:11 p.m., Resident #3</p>	F 0247	<p>1. SSD spoke with resident #3 to ensure that there were no concerns with current room mate. Resident shows no adverse affect from this alleged deficient practice. 2. SSD will perform 100% audit to identify if any other residents were not appropriately notified prior to any room changes. Any residents identified not having the proper notification</p>	10/23/2015

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F 0250 SS=D Bldg. 00	<p>indicated she had one resident move in and another resident move out of her room and the facility had not notified her.</p> <p>Resident #78 moved in with Resident #3 on 8/29/15.</p> <p>On 9/23/15 at 8:50 a.m., in an interview with the Social Service Designee, she indicated the residents are notified verbally of a new room mate. She indicated she filled out a form regarding room change and placed in the Social Service tab of chart or may document in her Social Service notes.</p> <p>The Social Services documentation was reviewed and there was no documentation regarding a new room mate for Resident # 3.</p> <p>3.1-3(v)(2)</p> <p>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 initiate a behavior plan of care timely for</p>	F 0250	<p>for a room change will be spoken to and social services note recorded in chart. 3. SSD will record a note regarding the room change and notification in the resident charts. Nursing staff educated on room change protocol. 4. SSD will review all room changes weekly x 4 weeks then monthly x3 months and report the findings at the monthly QAPI meeting to ensure that proper notification is made to residents prior to room changes and that there is documentation in the resident chart. The QAPI team will determine if further action is needed and determine the continued time schedule for further monitoring.</p> <p>1. A behavior plan was put into place for resident #56 regarding potential harm to other residents do to a history of setting fires</p>	10/23/2015			

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	<p>potential harm to other residents from a resident with a history of setting fires for 1 of 2 residents reviewed for behavior. (Resident #56)</p> <p>Findings include:</p> <p>Resident #56's record was reviewed on 9/21/15 at 10:09 a.m. Diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease, Parkinson's, schizophrenia, bipolar, depression and Post Traumatic Stress Disorder.</p> <p>The "Admission/Readmission Data Collection" form dated 7/28/15 at 4:00 p.m., indicated Resident #56 was a new admission on that day. The form indicated his Cognitive Skills for Decision-Making was moderately impaired. The Safety area indicated the resident was unaware of his safety limitations due to a history of smoking with oxygen in use and causing a fire. The "Safe Smoking Evaluation" indicated the resident was unable to light his cigarette safely with a lighter, he was not able to smoke safely, unable to utilize the ashtray safely and properly, unable to extinguish his cigarette safely and completely when finished smoking. The resident was determined to be an unsafe smoker.</p>		<p>on9/21/2015. Resident #56 was also moved to a room where he did not have to have a roommate. 2. A 100% audit was completed on all smokers at the facility to ensure that they were safe and appropriate per facility smoking policy. 3. All new admission referrals will be evaluated for smoking as necessary. Those that are smokers will be evaluated for smoking safety and a behavior program put in place specific to each resident. SSD to keep an updated list of current smokers which will be reviewed monthly. 4. SSD to present list of smokers and behavioral plans at monthly QAPI meetings for the QAPI team to review effectiveness of behavioral plans. The QAPI team will review list of smokers and behavioral plan monthly for 3 months and quarterly thereafter. The QAPI team will determine if further action is needed and determine the continued time schedule for further monitoring.</p>				

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	<p>The Admission Nurses's Notes on this form dated 7/28/15 at 11:00 p.m., indicated the resident was mildly agitated about being admitted to the facility and he had burned down his trailer that morning when he set it on fire by smoking and burning incense while his oxygen was in use. He had set fire to a home in the past due to smoking and his room at an assisted living facility while smoking while his oxygen was in use. The resident had poor insight and judgement. He indicated he would check out of the facility if he could not go out to smoke.</p> <p>The "Admission/Readmission Data Collection" form dated 8/11/15 at 11:00 a.m., indicated the resident was a readmission to the facility. The form indicated his Cognitive Skills for Decision-Making was moderately impaired. The "Safety" area on the form indicated the resident was unaware of the safety limitations or resistant due to smoking. The "Safe Smoking Evaluation" indicated the resident was unable to communicate why the oxygen must always be shut off prior to lighting cigarettes, the resident was not able to communicate the risks associated with smoking consistently, he was unable to smoke safely, he was unable to utilize an</p>			

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	<p>ashtray safely and properly, he was unable to extinguish a cigarette safely and completely when he was finished smoking. The resident was determined to be an unsafe smoker and required supervision while smoking.</p> <p>A (Name of Hospital) History and Physical note dated 8/6/15, indicated the resident recently went through a house fire, which was potentially set by him, he was obsessed with smoking and he set his oxygen tubing on fire. The note indicated he was in a house fire in another state.</p> <p>A (Name of Hospital) Comprehensive Psychiatric evaluation dated 8/6/15, indicated the resident placed himself and others in danger due to his behavior, which posed a substantial risk of fire hazard. The note indicated he was placed in the facility after his trailer caught fire while he was burning incense and smoking. The note indicate he had a history of setting an assisted living apartment on fire by setting his oxygen tubing on fire. The note indicated at the time of the assisted living fire the resident wanted to make a point in that he wanted to feel it was proper for his smoking to be restricted and he wanted to demonstrate he could be allowed to behave independently. The note</p>			

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	<p>indicated he had a history of setting a home on fire in another state. The note indicated he was insistent he be able to go outside to smoke when he wanted to despite the fact he was oxygen dependent.</p> <p>A Psychiatric progress note dated 9/16/15, indicated the resident had a history of setting fires and was obsessed with smoking. The note indicated the staff indicated he refused to take his Abilify (an anti-psychotic) and he had become paranoid believing everyone was out to get him and treating him like a child regarding his smoking. The note indicated he knew the smoking times, but he could become demanding toward the staff to allow him to smoke when he wanted to.</p> <p>Resident #56's record lacked a plan, Care Plan or information regarding his risk for starting fires.</p> <p>During an interview on 9/21/15 at 2:45 p.m., LPN #6 indicated the non-supervised smokers keep their smoking materials on their person or in their rooms and the supervised smokers smoking materials were kept in a tackle box on the North end nursing station.</p> <p>During an interview on 9/21/15 at 2:47</p>				

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	<p>p.m., Resident #55 indicated he kept his cigarettes and lighter in his room in his top drawer.</p> <p>During an interview on 9/21/15 at 3:27 p.m., Resident #55 indicated he kept his lighter in his pants pocket at all times. He indicated he took his pants off at night and placed his pants with his lighter in the pocket in the seat of a recliner, which sat in between his and Resident #56's bed.</p> <p>During an interview on 9/21/15 at 3:56 p.m., the Social Service Designee (SSD) indicated she could not find a Care Plan that he had a history of a behavior of starting fires.</p> <p>During an interview on 9/21/15 at 4:31 p.m., LPN #6 indicated the resident would become anxious and paced when he was upset about not being able to smoke. She indicated he used refusing his medications as a bargaining measure, so he could smoke.</p> <p>During an interview on 9/21/15 at 5:01 p.m., RN #2 indicated the resident would assert his rights when he was upset about not being able to smoke when he wanted to smoke. She indicated he was becoming more assertive with his rights about smoking since he started refusing</p>			

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F 0278 SS=D Bldg. 00	<p>his Abilify.</p> <p>During an interview on 9/22/15 at 10:05 a.m., (name of Psychiatrist) indicated the resident had set two to three fires. He indicated he had the same concerns the resident had the possibility of setting a fire at the facility if he had access to a lighter or matches.</p> <p>3.1-34(a)</p> <p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money</p>			

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	<p>penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on interview and record review, the facility failed to ensure the Minimum Data Assessment (MDS) assessment was accurately coded for 2 of 22 residents being reviewed for accurate MDS assessments. (Residents #51 and #57)</p> <p>Findings include:</p> <p>1. Resident #51's record was reviewed on 9/22/15 at 2:16 p.m. Diagnoses included, but were not limited to, adult failure to thrive and bronchitis.</p> <p>The resident's quarterly MDS assessment dated 8/13/15, indicated he was on Hospice and he did not have a prognosis of six months or less.</p> <p>The resident had a physicians order dated 5/6/15, which indicated to re-admit him to hospice.</p> <p>A document titled "Plan of Care/Physicians Orders Continued" dated 5/6/15, indicated "The patient does not</p>	F 0278	<p>1. Both Resident #51's and Resident #57's MDS assessments were corrected. 2. A 100% audit of residents on hospice services and residents with terminal diagnoses was completed to ensure accuracy of documentation and that proper diagnoses to support the need of hospice services was documented. 3. SSD shall keep a list of residents on hospice services and review this list monthly to ensure that there is proper documentation to support the need for hospice services. 4. SSD will present the results of these reviews monthly to the QAPI meeting so that the QAPI team can review effectiveness of this intervention ensuring the need for hospice services. The QAPI team will review these findings monthly for 3 months. The QAPI team will determine if further action is needed and determine the continued time schedule for further monitoring.</p>	10/23/2015			

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	<p>want to return to the hospital or have any aggressive treatments. He is a DNR [Do Not Resuscitate] and is asking for comfort care only. Based on his diagnosis of CAD [Coronary Artery Disease], multiple cormorbidities and recent decline resulting in a bed to chair existence, I certify this patient has a prognosis of 6 months of less if this disease runs its normal course."</p> <p>During an interview on 9/23/15 at 11:56 a.m., regarding the hospice status of Resident #51 the Regional MDS Coordinator indicated the quarterly MDS assessment dated 8/13/15, was coded incorrectly and Hospice was noted on the MDS, but the resident did not have a prognosis of less than six months indicated on the MDS.</p> <p>2. The record of Resident #57 was reviewed on 9/21/15 at 1:47 p.m.</p> <p>A Quarterly Minimum Data Set (MDS) assessment, dated 07/07/15, indicated Resident #57 had a condition or chronic disease that may result in a life expectancy of less than 6 months.</p> <p>During an interview interview on 09/22/15 at 2:25 p.m., the Regional MDS Coordinator indicated it was a keystone error and Resident #57 should not have</p>			

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F 0280 SS=D Bldg. 00	<p>been documented as having a terminal prognosis.</p> <p>3.1-31(d)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on interview and record review, the facility failed to ensure a resident was included in their Care Plan meeting for 1 of 1 residents reviewed for Care Plan meetings. (Resident #3)</p> <p>Findings include:</p> <p>On 9/21/15 at 10:01 a.m., the record review for Resident #3 was completed.</p>	F 0280	<p>1. SSD spoke with resident #3 regarding her Care Plan meeting. Resident shows no adverse affect from this alleged deficient practice. 2. SSD will perform 100% audit to identify if any other residents were not properly notified of their Care Plan meetings. Any residents identified not having the proper notification for their Care Plan meeting will be spoken to and given an</p>	10/23/2015

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	<p>Diagnoses included, but were not limited to, obsessive compulsive and bipolar disorder, borderline personality, chronic pain syndrome.</p> <p>On 9/17/15 at 2:03 p.m., the resident indicated she was told a couple of weeks ago, that she was going to have a care plan meeting but they didn't tell her what day.</p> <p>A document titled Care Conference Record indicated on 8/15/15 the annual meeting was held and had three signatures from the Minimum Data Set Coordinator, the Social Services Designee (SSD) and the Activities Director. There was a box on the document which indicated resident and had a place for the resident signature, but it was blank. There were other Care Conference Record dated 2/11/15 and 5/8/15 which included the resident's signature.</p> <p>On 9/23/15 at 3:17 p.m., the SSD indicated she gave cards which invited the resident to the Care Plan meeting. She indicated they usually have the resident's signature on the Care Conference Record form if they are present at the meeting.</p> <p>3.1-35(c)(2)(C)</p>		<p>opportunity to attend a Care Plan meeting with asocial services note being recorded in chart. 3. SSD will create a Care Plan meeting calendar with Care Plan meeting schedules and utilize this calendar to record if the resident and families have been notified of the Care Plan meeting. 4. SSD will present the Care Plan calendar to monthly QAPI meeting so that the QAPI team can review effectiveness the Care Plan meeting calendar with regards to resident notifications of Care Plan meetings. The QAPI team will review list of smokers and behavioral plan monthly for 3 months. The QAPI team will determine if further action is needed and determine the continued time schedule for further monitoring.</p>				

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F 0314 SS=G Bldg. 00	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview and record review, the facility failed to implement pressure ulcer interventions for 1 of 1 residents reviewed for pressure ulcers (Resident #32). This deficient practice resulted in Resident #32 developing a Stage III pressure ulcer to his left gluteal fold (prominent fold that marks the upper limit of the thigh from the lower limit of the buttock).</p> <p>Findings include:</p> <p>The record of Resident #32 was reviewed on 09/22/15 at 09:30 a.m. Diagnoses included, but were not limited to, vascular dementia with depression, left sided heart failure, diabetes mellitus, cerebrovascular accident, general muscle</p>	F 0314	<p>The facility is disputing this deficiency as the resident had preventive measures in place including a low air-loss mattress, RHOHO cushion in the wheelchair and the pressure ulcer was unavoidable per unavoidable criteria and physician documentation. 1. Resident #32 remains on a low air loss mattress and continues to have a RHOHO cushion in his/her wheel chair. Resident #32 was seen by a dermatologist on 10/10/15. 2. A skin sweep was completed by the Director of Clinical Services, assistant Director of Clinical Services and licensed nursing staff. Any resident identified with skin break down was identified and reviewed by the interdisciplinary team to validate that appropriate wheel chair cushions, treatments and turning</p>	10/23/2015

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	<p>weakness, malaise and fatigue and bladder disorder.</p> <p>A 30-day scheduled Minimum Data Set (MDS) assessment, dated 8/25/15, indicated Resident #32 was at risk for pressure ulcers. It also indicated Resident #32 needed extensive assistance with bed mobility and transfers and was always incontinent of bowel and bladder. The assessment did not indicate Resident #32 was on turning/repositioning program.</p> <p>The physician's recapitulation orders for Resident #32, dated August 2015, included, but were not limited to, the following orders: 5/21/15 - Carrington moist barrier cream, apply topically to coccyx every shift after incontinence episodes 8/12/14 - ROHO cushion (helps with skin/soft tissue protection and support) in recliner at all times related to history of stage IV wound on right inner buttock</p> <p>The September 2015 recapitulation did not include orders for the ROHO cushion or barrier cream.</p> <p>A Braden scale assessment (a document for predicting pressure ulcer risk), dated 7/28/15, indicated the resident scored 14. This score indicated the resident was at moderate risk for developing a pressure</p>		<p>schedules are being documented.</p> <p>3. The policy and procedure for pressure ulcer prevention was reviewed by the Director of Clinical Services and no revisions were required. The Director of Clinical Services and Assistant Director of Clinical Services provided education to licensed nursing staff regarding pressure ulcer prevention, completion of weekly skin assessments, turning and repositioning and use of pressure reduction equipment. Licensed nursing staffs are responsible for validating that pressure ulcer prevention measures are completed each shift. (This in-service included education on the policy and procedure for pressure ulcer prevention) 4. The Director of Clinical Services and or assistant Director of Services will audit residents at risk for skin breakdown five times a week at various times and shifts to determine if appropriate pressure ulcer prevention measures are in place (including wheel chair cushions, turning schedules, treatments). This audit will include a minimum of ten residents during each audit. This audit will be completed weekly for eight weeks then monthly for two months. The results of these audits will be submitted to the QAPI Committee. The QAPI Committee will determine if additional education or auditing is required.</p>		

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	<p>ulcer.</p> <p>A Braden scale assessment, dated 8/25/15, indicated the resident scored 16. This score indicated the resident was at risk for developing a pressure ulcer.</p> <p>A non-pressure skin condition record, dated 09/10/15, indicated Resident #32 had excoriation (skin that is scraped or abraded) to his left gluteal fold, measuring 6.0 x 4.1 cm (centimeters). No drainage was present and the wound edges were red with a macerated (softening and breaking down of skin resulting from prolonged exposure to moisture) periwound (area around the wound) area.</p> <p>A pressure ulcer record for Resident #32 indicated the following: 09/17/15 - A stage 3 pressure wound (full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present, but does not obscure the depth of tissue loss. May include undermining and tunneling.) to the left gluteal fold, measuring 3.0 x 1.2 x 0.3 cm. The wound bed was red with granulation tissue (new connective tissue and tiny blood vessels that form on the surfaces of a wound during the healing process). Wound edges were red with red</p>			

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	<p>periwound area. There was moderate pink/red serosanguineous (fluid with small amounts of blood) drainage.</p> <p>09/23/15 - The wound was documented as a "...questionable..." healing stage 3, measuring 1.9 x 0.9 x less than 0.2 cm. The wound bed was dull yellow with slough (a layer of dead tissue separated from living tissue) with rolled edges and small serous (watery, transparent fluid) drainage. The periwound area was irregular.</p> <p>An undated care plan indicated Resident #32 had an ADL (Activities of Daily Living) self care deficit related to limited mobility, requiring the resident to be totally dependent on staff for bed mobility each shift.</p> <p>A pressure ulcer care plan, dated 4/29/15, indicated, "...Potential for skin breakdown r/t (related to) tensile skin not as strong as original..."</p> <p>A pressure ulcer care plan, dated 9/17/15, indicated Resident #32 had a stage 3 pressure ulcer on his left gluteal fold. Approaches included "...follow product list for appropriate treatment option as ordered...specialty bed...obtain labs...document weekly..."</p> <p>An Interdisciplinary Progress Note, dated</p>			

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	<p>09/23/15, indicated, "...Res (resident) remains on LAL (low air loss) mattress, is turned and repositioned, continues to receive barrier cream q (every) shift and PRN (as needed), roho cushion in wc (wheel chair)...on 9-10-15 res has excoriation identified on L (left) glut (gluteal) fold that measured 6.0 x 4.1 [cm] and presented as redness. Was tx [treated] c [with] routine barrier cream. On 9-17-15 excoriation resolved + (and) ulcer appeared 3.0 x 1.2 x 0.3 cm this site has appearance of st III (stage 3) pressure ulcer. It is not over a bony prominence but is on a dependent area...As of 9-23-15 site now measures 1.9 cm x 0.9 cm x 0.2 cm...site is dull yellow c (with) irregular edges..."</p> <p>During a wound measurement observation on 09/23/15 at 9:05 a.m., with the Regional Director of Clinical Services (Regional DCS) and LPN #7, Resident #32 was observed to have a wound measuring 1.9 x 0.9 x 0.2 cm. The wound base was 100% yellow with clear drainage. The Regional DCS indicated she was unsure if the wound was pressure.</p> <p>During an interview on 9/22/15 at 10:40 a.m., Licensed Practical Nurse (LPN) #7 indicated the wound on Resident #32's left gluteal fold appeared to be</p>			

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	<p>red/macerated on 9/10/15. She indicated the wound was intact, and then opened up on 9/17/15 and was classified as a stage III pressure wound. She indicated barrier cream to the reddened area had been used.</p> <p>During an interview on 09/13/15 at 4:50 p.m., the Director of Clinical Services (DCS) indicated the physician's order for the Roho cushion and barrier cream did not transfer to from the August physician's recapitulation and Medication Administration Record to the September physician's recapitulation and Medication Administration Record. She indicated there was no documentation to show that these interventions had been implemented for the month of September. There was also no documentation for other interventions, such as turning and repositioning.</p> <p>A document, titled "Guidelines for Unavoidable Wounds," dated 9/23/15, provided by the DCS at 4:50 p.m., indicated the resident had an unavoidable pressure wound.</p> <p>A current policy, titled "Unavoidable Pressure Ulcer," dated 11/30/14, provided by the DCS on 9/23/15 at 6:15 p.m., indicated, "...A determination that development of a pressure ulcer was</p>			

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F 0323 SS=D Bldg. 00	<p>unavoidable may be made only if routine preventative and daily care was provided consistently. Routine preventative care includes but is not limited to turning and proper positioning...providing good skin care...."</p> <p>3.1-40(a)(2)</p> <p>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 maintain a safe environment for residents when a resident who had a history of setting fires potentially had access to smoking materials for 1 of 1 residents reviewed for supervision. (Resident #56) (Resident #55)</p> <p>Findings include:</p> <p>Resident #56's record was reviewed on 9/21/15 at 10:09 a.m. Diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease, Parkinson's, schizophrenia, bipolar,</p>	F 0323	<p>1. Resident #56 was moved to another room so that he was not sharing a room with a smoker who had smoking materials. It must be noted that resident #56 has not been deemed a safe smoker (facility staff supervises his smoking times). 2. A 100% audit was completed on all smokers at the facility to ensure that they were safe and appropriate per facility smoking policy. 3. All new admission referrals will be evaluated for smoking as necessary. Those that are smokers will be evaluated for smoking safety and a behavior program put in place specific to each resident. SSD to keep an updated list of current smokers which will be reviewed</p>	10/23/2015

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	<p>depression and Post Traumatic Stress Disorder.</p> <p>The "Admission/Readmission Data Collection" form dated 7/28/15 at 4:00 p.m., indicated Resident #56 was a new admission on that day. The form indicated his Cognitive Skills for Decision-Making was moderately impaired. The Safety area indicated the resident was unaware of his safety limitations due to a history of smoking with oxygen in use and causing a fire. The "Safe Smoking Evaluation" indicated the resident was unable to light his cigarette safely with a lighter, he was not able to smoke safely, unable to utilize the ashtray safely and properly, unable to extinguish his cigarette safely and completely when finished smoking. The resident was determined to be an unsafe smoker.</p> <p>The Admission Nurses's Notes on this form dated 7/28/15 at 11:00 p.m., indicated the resident was mildly agitated about being admitted to the facility and he had burned down his trailer that morning when he set it on fire by smoking and burning incense while his oxygen was in use. He had set fire to a home in the past due to smoking and his room at an assisted living facility while smoking while his oxygen was in use.</p>		<p>monthly. 4. SSD to present list of smokers and behavioral plans at monthly QAPI meetings for the QAPI team to review effectiveness of behavioral plans with regards to resident and facility safety. The QAPI team will review list of smokers and behavioral plans monthly for 3 months and quarterly thereafter. The QAPI team will determine if further action is needed and determine the continued time schedule for further monitoring.</p>				

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	<p>The resident had poor insight and judgement. He indicated he would check out of the facility if he could not go out to smoke.</p> <p>The "Admission/Readmission Data Collection" form dated 8/11/15 at 11:00 a.m., indicated the resident was a readmission to the facility. The form indicated his Cognitive Skills for Decision-Making was moderately impaired. The "Safety" area on the form indicated the resident was unaware of the safety limitations or resistant due to smoking. The "Safe Smoking Evaluation" indicated the resident was unable to communicate why the oxygen must always be shut off prior to lighting cigarettes, the resident was not able to communicate the risks associated with smoking consistently, he was unable to smoke safely, he was unable to utilize an ashtray safely and properly, he was unable to extinguish a cigarette safely and completely when he was finished smoking. The resident was determined to be an unsafe smoker and required supervision while smoking.</p> <p>A (name of hospital) History and Physical note dated 8/6/15, indicated the resident recently went through a house fire, which was potentially set by him, he was obsessed with smoking and he set his</p>			

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	<p>oxygen tubing on fire. The note indicated he was in a house fire in another state.</p> <p>A (name of hospital) Comprehensive Psychiatric evaluation dated 8/6/15, indicated the resident placed himself and others in danger due to his behavior, which posed a substantial risk of fire hazard. The note indicated he was placed in the facility after his trailer caught fire while he was burning incense and smoking. The note indicated he had a history of setting an assisted living apartment on fire by setting his oxygen tubing on fire. The note indicated at the time of the assisted living fire the resident wanted to make a point in that he wanted to feel it was proper for his smoking to be restricted and he wanted to demonstrate he could be allowed to behave independently. The note indicated he had a history of setting a home on fire in another state. The note indicated he was insistent he be able to go outside to smoke when he wanted to despite the fact he was oxygen dependent.</p> <p>A Psychiatric progress note dated 9/16/15, indicated the resident had a history of setting fires and was obsessed with smoking. The note indicated the staff indicated he refused to take his</p>			

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	<p>Abilify (an anti-psychotic) and he had become paranoid believing everyone was out to get him and treating him like a child regarding his smoking. The note indicated he knew the smoking times, but he could become demanding toward the staff to allow him to smoke when he wanted to.</p> <p>During an interview on 9/21/15 at 2:45 p.m., LPN #6 indicated the non-supervised smokers keep their smoking materials on their person or in their rooms and the supervised smokers smoking materials were kept in a tackle box on the North end nursing station.</p> <p>During an interview on 9/21/15 at 2:47 p.m., Resident #55 (Resident # 56's roommate) indicated he kept his cigarettes and lighter in his room in his top drawer.</p> <p>During an interview on 9/21/15 at 3:27 p.m., Resident #55 indicated he kept his lighter in his pants pocket at all times. He indicated he took his pants off at night and placed his pants with his lighter in the pocket in the seat of a recliner, which sat in between his and Resident #56's bed.</p> <p>During an interview on 9/21/15 at 4:31 p.m., LPN #6 indicated the resident</p>			

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F 0329 SS=D Bldg. 00	<p>would become anxious and paced when he was upset about not being able to smoke. She indicated he used refusing his medications as a bargaining measure, so he could smoke.</p> <p>During an interview on 9/21/15 at 5:01 p.m., RN #2 indicated the resident would assert his rights when he was upset about not being able to smoke when he wanted to smoke. She indicated he was becoming more assertive with his rights about smoking since he started refusing his Abilify.</p> <p>During an interview on 9/22/15 at 10:05 a.m., (name of Psychiatrist) indicated the resident had set two to three fires. He indicated he had the same concerns the resident had the possibility of setting a fire at the facility if he had access to a lighter or matches.</p> <p>Resident #56's record lacked a plan, Care Plan or information regarding his risk for starting fires.</p> <p>3.1-45(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p>			

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	<p>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.</p> <p>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.</p> <p>Based on interview and record review the facility failed to ensure that specific target behaviors were identified for the use of psychotropic drugs for 3 out of 5 residents. The facility also failed to have an appropriate diagnosis for the use of a psychotropic drug for 1 of 1 resident reviewed for unnecessary medications. (Resident #14, #31 and #51)</p> <p>Findings include:</p> <p>1. On 9/22/15 at 10:51 a.m., the record review for Resident #14 was completed. Diagnoses included, but were not limited</p>	F 0329	<p>1. The interdisciplinary team reviewed resident#14, #31 and #51 and updated the behavior monitoring flow records to include specific targeted behavior. Licensed nursing staff reviewed resident #14, #31and #51's psychotropic drug orders with the physician and/or pharmacist to validate appropriate diagnoses were in place. 2. All residents with psychotropic medications were identified and reviewed by the interdisciplinary team. The interdisciplinary team reviewed medications for appropriate diagnoses as well as behavior management flow sheets to determine if specific targeted</p>	10/23/2015

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	<p>to bipolar disorder and anxiety.</p> <p>The Physician's Order Recapitulation for September 2015 indicated: Bupirone (an antianxiety medication) 10 milligrams (mg) 1 tablet three times daily ordered on 6/20/14. Clonazepam (an antianxiety medication) 0.5 mg 1 tab by mouth at HS (8/17/15)</p> <p>The physician's orders indicated:</p> <p>8/31/15 Seroquel (an antipsychotic medication) 12.5 mg 1 tablet twice daily 8/18/15 Seroquel decrease to 12.5 mg every PM on 9/17/15 discontinue Seroquel 5/31/15- decrease Seroquel to 12.5 mg total twice daily</p> <p>The Behavior Symptom Monitoring Flow Record indicated: May 2015- The resident had a history of extreme paranoia and was to be given medication of Seroquel 12.5 mg every evening. There were no documented behaviors.</p> <p>The Behavior Symptom Monitoring Flow records of June 2015 through September 2015 all had the behavior of paranoia, but no specific information of how the paranoia exhibited for this resident. 2. The record of Resident #31 was</p>		<p>behaviors were identified on the behavior flow records. Any discrepancies were corrected during this review. 3. The policy and procedure for behavior management was reviewed by the Director of clinical services and found to be acceptable. Licensed and unlicensed staff was educated by the Director of Nursing and or Assistant Director of Nursing regarding the behavior management program as well as the policy and procedure for behavior management. The interdisciplinary team was educated by the Director of Clinical Services regarding the behavioral management program including reviewing medications for appropriate diagnoses and implementing behavioral sheets that have specific targeted behaviors. 4. The Director of Clinical Services and or Director of Social Services will audit residents with psychotropic medications five times a week to determine if psychotropic medication diagnoses are appropriate and to validate that specific targeted behaviors are listed on the behavior flow monitoring sheet. This audit will include a minimum of ten residents during each audit. This audit will be completed weekly for 8 weeks then monthly for two months. The results of these audits will be submitted to the QAPI Committee. The QAPI Committee will determine if</p>				

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	<p>reviewed on 9/22/15 at 10:30 a.m. Diagnoses included, but were not limited to, bipolar disorder.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 04/17/15, indicated Resident #31 had not exhibited behaviors.</p> <p>A quarterly MDS assessment, dated 07/16/15, indicated Resident #31 had not exhibited behaviors and Resident #31 exhibited symptoms of feeling down, depressed, or hopeless for 1 day during the review period.</p> <p>A physician's order, dated 07/06/15, indicated, "...Clonazepam (a benzodiazapine medication used to treat bipolar disorder) 1 mg (milligram) tablet...give one tablet by mouth at bedtime...."</p> <p>A physician's order, dated 08/18/15, indicated, "...increase clonazepam [to] 2 mg po [by mouth] HS [at bedtime] [for] Bipolar Disorder...."</p> <p>A document, titled, "Behavior Symptom Monitoring Flow Record," dated June 2015 through July 2015, and September 2015, indicated monitoring of the following behaviors: mania - elevated mood, depressed mood and delusions of</p>		additional education or auditing is required	

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	<p>grandeur. Specific behaviors were not identified for monitoring purposes. No behaviors were documented on the flow sheets. August behavior flow records were not available.</p> <p>A quarterly social service progress review, dated 7/16/15, indicated ..."no behaviors noted...."</p> <p>During an interview on 09/23/15 at 02:50 p.m., the Social Services Designee (SSD) indicated behaviors were being documented on a continuous flow sheet prior to September 2015, therefore August 2015 behaviors would have been on the July 2015 flow sheet. The SSD indicated staff were to document behaviors on the flow sheet as they occurred. Documentation regarding behaviors and the increase in clonazepam was requested.</p> <p>During an interview on 09/23/15 at 5:33 p.m., the Director of Clinical Services (DCS) indicated Resident #31's last visit to the psychiatrist occurred on 03/26/15.</p> <p>As of 9/23/15 at 6:15 p.m., the facility was unable to provide documentation for Resident #31 showing any behaviors or the reason for the increase in clonazepam.</p>			

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	<p>3. Resident #51's record was reviewed on 9/22/15 at 2:16 p.m. Diagnoses included, but were not limited to, dementia with behavior disturbances, impulse control disease and generalized anxiety disorder.</p> <p>A physician order dated 9/1/15, indicated the resident's Zyprexa Zydis (an anti-psychotic medication that is placed under the tongue when administered) was discontinued and Zyprexa (an anti-psychotic tablet) 5mg (milligram) by mouth to be given daily at bedtime.</p> <p>A "Behavior Symptom Monitoring Flow Record" dated May, June and September 2015, indicated the behaviors being monitored were hitting and kicking, throwing items, hitting other residents, using racial slurs and entering other rooms. There were no behaviors marked on these behavior sheets when the record was reviewed.</p> <p>A physician progress note dated 8/11/15, indicated Resident #51 had severe dementia and his behaviors had improved and he was calmer. The note indicated he had not had any agitation. The impression area indicated he had progressive dementia and agitation, but he was doing "okay" at the moment.</p>			

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	<p>A document titled "Psychoactive Medication Evaluation" dated 6/2/15, indicated the resident was on an antipsychotic: Divalproex/Haldol. The Antipsychotic diagnosis for use was dementing illness with Behavioral symptoms and impulse control disorder. The residents behaviors for the antipsychotic was aggression, wandering, hitting, kicking, throwing items, hitting another resident using racial slurs.</p> <p>During an interview on 9/23/15 at 3:15 p.m., the Social Service Director (SSD) indicated she would have to research the rationale for why Resident #51 was prescribed the Zyprexa. She indicated the "Psychoactive Medication Evaluation" dated 6/2/15, was the most recent evaluation completed in the resident's record.</p> <p>During an interview on 9/23/15 at 5:31 p.m., the Director of Clinical Services (DCS) provided the resident's face sheet at that time and indicated the diagnosis for the Zyprexa medication being prescribed was Dementia with behavior disturbances.</p> <p>A current policy titled "Behavior Monitoring" dated 12/12/14, provided by the DCS on 9/23/15 at 6:08 p.m., indicated "Policy: Residents</p>			

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F 0431 SS=D Bldg. 00	<p>demonstrating behaviors that place the resident at risk, or interfere with care or other residents will be monitored and interventions initiated as an individualized approach to minimizing behavior. Procedure: Behavioral Monitoring: 1. Residents who exhibit behaviors will have a 'Behavior Symptom Monitoring Flow Record' completed. Documentation of behavior and interventions for those behaviors including non-pharmacological interventions will be completed with each behavior. 2. Note the date, time, and behavior symptom observed. Be as specific as possible: i.e.: kicking, biting, yelling, etc...."</p> <p>3.1-48(a)(3) 3.1-48(a)(4)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p>			

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	<p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based observation, interview and record review, the facility failed to properly label medications after an order change for 1 of 4 residents observed for direction change labels (Resident #8) and failed to ensure an open date was on a medication for 1 of 4 carts reviewed for proper medication storage. (Resident #8 and #41)</p> <p>Findings include:</p> <p>1. During an observation on 9/22/15 at 4:42 p.m., LPN #5 prepared medications</p>	F 0431	<p>1. A licensed nurse applied a direction change sticker to resident #8's medication and recorded the open date for resident #41's medication as the same date as delivery. 2. All residents receiving medications have the potential to be affected by this practice. Licensed nursing staff completed an audit of all medications carts to determine if any other concerns were identified regarding direction changes or newly opened medications. Any discrepancies were identified and corrected immediately. 3. The policy and</p>	10/23/2015

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	<p>for Resident #8. The nurse placed the medications into a plastic cup, which included Norco (a narcotic pain medication) 7.5/325 mg (milligrams) one tablet and Ropinirole (a medication for restless leg syndrome) 1 mg one tablet. During this observation, the medication card for the Norco provided from the pharmacy contained the following directions: Norco 7.5/325 mg give one tablet four times daily as needed.</p> <p>During reconciliation of the current physician orders for September 2015, indicated Norco 7.5/325 mg give one table four times a day while awake. The medication card lacked a "direction label change" to alert the nurse.</p> <p>During an interview on 9/22/15 at 4:42 p.m., LPN #5 indicated the directions for Resident #8's Norco was changed to four times a day while awake on 7/28/15. She indicated the medication care should have had a "direction change refer to chart label" to alert nurses.</p> <p>2. During an observation of the medication cart on 9/21/15 at 12:06 p.m., Resident #41's Fluticasone Propionate nasal spray (steroid antinflammatory nasal spray) 50 mcg (micrograms) was observed in the medication cart with no open date on the bottle. The prescription</p>		<p>procedure for storage of medications was reviewed by the Director of Clinical Services and found to be acceptable. The protocol for auditing medication carts was revised to include a weekly audit that will be completed by licensed nursing staff. The revised audit tool includes a review to validate that all medication changes have appropriate labels for direction change and that multidose vials/containers are dated when opened. The director of Nursing and/or Assistant Director of Nursing provided education to licensed nursing staff regarding the policy for storage of chemicals and biologicals as well as the revised medication audit tool and education regarding direction change labels and dating multi-dose vials/ multi use medications when opened as indicated. 4. The Director of Clinical Services and or assistant Director of Services will audit facility medication carts five times a week to determine if medications are dated when multi dose vials or containers are opened and that direction change stickers are placed on medication labels when a direction change has occurred. This audit will be completed weekly for 8 weeks then monthly for two months. The results of these audits will be submitted to the QAPI Committee. The QAPI Committee will determine if additional</p>	

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	fill date was 8/6/15. During an interview at that time LPN #6 indicated she dated medication with the open date as soon as she opened the inhalers and bottles. 3.1-25(k)(5) 3.1-25(k)(6)		education or auditing is required		