

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A014	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/04/2013
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NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992
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F000000	<p>This visit was for the Investigation of Complaint IN00125518. This visit resulted in a partially extended survey-immediate jeopardy.</p> <p>Complaint IN00125518 - Substantiated. Federal/state deficiencies related to the allegations are cited at F250 and F323.</p> <p>Survey dates: 4/1/13 through 4/4/13</p> <p>Facility number: 000274 Provider number: 15A014 AIM number: 100271660</p> <p>Survey team: Shelley Reed, RN</p> <p>Census bed type: NF: 94 Total: 94</p> <p>Census payor type: Medicaid: 94 Total: 94</p> <p>Sample: 10</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F000000	<p>This plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. Vernon Manor Children's Home desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on 04/25/2013</p>	

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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	Quality review 4/09/13 by Suzanne Williams, RN				

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F000250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based record review and interview, the facility failed to provide medically-related social services and behavior interventions related to aggressive behavior identified for 1 of 10 residents reviewed. (Resident E)</p> <p>Findings include:</p> <p>During record review on 4/1/13 at 3:00 p.m., the clinical record indicated Resident (E) was admitted to the facility on 2/8/13 from his home where he resided with his mother and sibling. The Minimum Data Set (MDS) assessment, dated 2/18/13, indicated Resident (E) was unable to complete the Brief Interview for Mental Status (BIMS). Resident (E) received the following Activities of Daily Living assistance: transfer-supervision with setup help only, ambulation-supervision with no physical help from staff, hygiene and bathing-supervision with setup help only, and toilet use-continent of bowel and bladder. Resident (E) was admitted weighing 147.3 lbs and stood 5'6" tall. He currently weighed</p>	F000250	<p>F250</p> <p>This facility strives to provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>- <u>Action taken for resident's identified as potentially affected</u></p> <p>Resident (E)'s care plan was reviewed and updated to include potential resident to resident aggressive behaviors with actions for recognition and interventions to promote positive outcomes. (EXHIBIT 1A-E)</p> <p>Resident (E) has been provided 1:1 monitoring. No acts of aggression have been exhibited toward other residents. All direct care providers for Resident (E) have been re-educated regarding behavior management plan, including management of aggression, documentation of interventions and outcome of interventions, as well as immediate notification of Executive Director of any resident to resident altercation. (EXHIBIT - 2 A-R)</p> <p>Resident (E) and his guardian were given a Notice of Transfer or Discharge on 4/2/13 and the</p>	04/25/2013	

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	<p>144.4 lbs.</p> <p>Further review of Resident (E)'s record indicated the following: a monthly behavior summary log dated March 2013, indicated Resident (E) had 79 aggression incidents, 121 cussing incidents and 15 resistant to care incidents. Resident (E) was last seen by a psychiatrist on 3/18/13 with a new order for Seroquel (antipsychotic medication) 50 mg and slowly increased to 150 mg. A new diagnosis of intermittent impulse control, post traumatic stress disorder, generalized stress/anxiety disorder, oppositional defiant disorder, and obsessive compulsive disorder by history of autism were noted. The physician included bipolar as a diagnosis, but Resident (E)'s mother refused the diagnosis. Seroquel was discontinued on 3/28/13, per mother's request, and the physician's services were discontinued. Resident (E) received the following medications for behaviors: Carbamazepine 100 mg/5 ml, 20 ml daily and 15 ml at night, Diazepam 10 mg three times daily, Lexapro 10 mg daily, Lamictal 25 mg daily, Lamotrigine 50 mg daily, Namenda 5 mg twice daily and Valporic acid 500 mg three times daily.</p>		<p>Ombudsman notified. The facility has actively been promoting discharge planning with the guardian. (EXHIBIT 3 A-B)</p> <p><u>Identification and corrective action for other residents with the potential to be affected:</u> All resident behavior documentation was reviewed by the interdisciplinary team to identify those with potential aggression or behaviors affecting others. (EXHIBIT -4) The individual care plans of residents identified were reviewed and updated , as indicated, to assure the care plan identifies the problems and needs of the individual. Behavior Management plans of residents with behaviors of aggression were included in the review process to assure communication of interventions for management of potential behaviors.</p> <p>- <u>Measures to prevent recurrence.</u> The individual care plan of each new resident admitted to this community and residents exhibiting behaviors will be reviewed by the interdisciplinary team in the daily clinical meeting to assure the care plan reflects the resident's current status, including the presence of aggression and interventions for management. (EXHIBIT 5). Additionally, the behavior committee will review the care plan</p>		

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	<p>An Omnibus Budget Reconciliation Act (OBRA) pre-admission screening level 2 assessment was performed on Resident (E) on 1/29/13. The assessment indicated Resident (E) would become angry and frustrated during the screening. The assessment indicated Resident (E) would need close supervision with limited change in environment and routine. The assessment indicated Resident (E) was impulsive and somewhat delusional and would act out aggressively. The assessment recommendations were Resident (E) would benefit from the following: structured routine, reorientation to reality on a regular basis, and a behavior management program to redirect him when he became aggressive.</p> <p>The initial care plan dated 2/11/13, included the following: short memory span, behavioral concerns, adjustment to new environment, aggression, cussing, and resist care. The care plan was last updated on 2/26/13. Resident (E) was not care planned for resident to resident altercations, resident to staff altercations, or verbal or physical abuse.</p>		<p>of residents exhibiting behaviors to ensure it reflects the resident's current status, including addressing aggression, interventions for behavior management, and any necessary revisions to the same. Staff education on 4/2/13 included providing behavior interventions, and monitoring outcomes to promote resident physical and psychosocial well being. This education was reinforced by providing education at the beginning of each shift to direct care providers for one week . Staff not on duty were contacted by phone beginning 4/2/13 and education provided to assure all direct care providers received the education. Behavior management education will be included in new hire orientation as well as annual staff education. This education will include utilization of the resident Behavior Plan , providing behavior interventions, and monitoring outcomes to promote resident physical and psychosocial well being.</p> <p><u>How will the facility monitor and who is responsible:</u> The Executive Director and/or Director of Nursing lead(s) the daily clinical meeting, which will include review of behavior events. Residents behavior events including aggression will be reviewed as well as the implementation and outcome of interventions to manage behaviors.</p>		

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	<p>During record review, 29 mood and behavior communication memos were noted from 2/13/13 through 3/29/13. Twelve of the 29 communication memos did not have any interventions attempted.</p> <p>A nursing note dated 3/7/13 at 9:25 a.m., indicated the Interdisciplinary Team (IDT) met to discuss current concerns. The note indicated Resident (E) was becoming increasingly non-compliant. No additional concerns were noted related to behavior or care plan adjustments. A nursing note dated 2/28/13 at 10:00 a.m., indicated the IDT team met to discuss current concerns. The note indicated slow progress noted with goals. No additional concerns were noted.</p> <p>During an interview on 4/3/13 at 5:30 p.m., Social Service Designee #5 indicated the last care plan meeting for Resident (E) was on 2/28/13. She indicated care plan meetings were quarterly and as needed. She indicated Resident (E) did not have any care planning for aggressive resident to resident behaviors.</p> <p>This Federal tag related to complaint IN00125518.</p>		<p>In addition, the individual resident behavior management plans and care plans are reviewed and updated during the monthly behavior committee meeting. The behavior committee findings are reported to the facility and regional Quality Assurance committee monthly for review and recommendation. The behavior committee monitoring results will be reviewed monthly, including the recommended 6 months, with continued ongoing reports monthly to the facility and regional Quality Assurance committees for review and recommendation as part of the annual Quality Assurance program.</p>				

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	3.1-34(a)				

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F000323 SS=K	<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 interview and record review, the facility failed to ensure a male resident (E) with physically and verbally aggressive behaviors, including hitting, punching, kicking and cussing and threatening others, was supervised during resident to resident interaction to protect and prevent incidents with 5 other residents who had contact with Resident E (Residents F, G, H, I and J) out of a sample of 10 residents reviewed.</p> <p>The immediate jeopardy began on 3/11/13 when the facility failed to supervise Resident (E) with physically aggressive behaviors during resident to resident contact. The Executive Director, Director of Nursing and Corporate Nurse were notified of the immediate jeopardy on 4/2/13 at 1:00 p.m. The immediate jeopardy was removed on 4/3/13, but noncompliance remained at a lower scope and severity level of pattern, no actual harm with potential for more than minimal harm that is not</p>	F000323	<p><u>F323</u> This facility maintains an environment as free of accident hazards as is possible; and each resident receives supervision and assistance devices to prevent accidents. _ <u>Action taken for resident's identified as potentially affected</u> Since 4/2/13 Resident (E) has been provided 1:1 monitoring. during which Resident (E) has not exhibited acts of aggression toward other residents. Resident (E)'s care plan was reviewed and updated to include potential resident to resident aggressive behaviors with actions for recognition and interventions to promote positive outcomes. (EXHIBIT 1 A-E) Residents F, G,H,I, and J were assessed on 4/2/13 for signs of psychosocial distress. A full skin assessment was also completed with no additional intervention indicated. Resident H was interviewed by the Executive Director on 4/4/13 with no concerns voiced.</p> <p><u>Identification and corrective action for other residents with the potential to be affected:</u></p>	04/25/2013			

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	<p>immediate jeopardy.</p> <p>Findings include:</p> <p>During record review on 4/1/13 at 3:00 p.m., the clinical record indicated Resident (E) was admitted to the facility on 2/8/13 from his home where he resided with his mother and sibling. The Minimum Data Set (MDS) assessment dated 2/18/13, indicated Resident (E) was unable to complete the Brief Interview for Mental Status (BIMS). Resident (E) received the following Activities of Daily Living (ADL) assistance: transfer-supervision with setup help only, ambulation-supervision with no physical help from staff, hygiene and bathing-supervision with setup help only and toilet use-continent of bowel and bladder. Resident (E) was admitted weighing 147.3 lbs and stood 5'6" tall. He currently weighed 144.4 lbs.</p> <p>A mood and behavior communication memo dated 3/21/13 at 2:00 a.m., indicated Resident (E) asked CNA #1 for a salad. She explained that he was NPO (nothing by mouth) after 11:00 p.m. Resident (E) screamed at the top of his lungs, grabbed his money and went to the vending machine. Resident (E) grabbed CNA</p>		<p>All residents were reviewed by the interdisciplinary team to assure identification of residents with potential to have aggression or behaviors affecting others. (EXHIBIT -4) The individual care plans of residents identified were reviewed and updated , as indicated, to assure the care plan identifies the problems and needs of the individual. The Behavior Management plan of residents with aggression were included in the review process.</p> <p><u>Measures to prevent recurrence.</u> Staff re- education was provided 4/2/13 regarding behaviors and interventions to protect residents from harm, documenting the effectiveness of behavior management interventions and immediate notification of the Executive Director any time there is a resident to resident altercation. The education included the importance of documenting interventions and their effectiveness to promote communication with others and reinforce behavior management plans. Education included notifying the Executive Director and/or Director of Nursing any time there is a behavior of resident to resident altercation. (EXHIBIT -2 A-R) Ongoing education of staff will be provided through new employee orientation and annual education of behavior</p>				

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	<p>#1's shirt and punched her in the stomach. He went back to his room, but returned to the nurses' station and indicated he "would kill us tomorrow." He returned to his room, but returned to nurses' station a few minutes later stating "he would kill us" and began to throw books at the staff behind the nursing station. Resident (E) then walked into another resident's room and attacked Resident (G) by grabbing him in the face. The CNA attempted to remove the resident. He then grabbed her hands and dug his fingernails into her hands. Resident (E) bit CNA #1 on her shoulder, leaving a bite mark, bruising and abrasions to her lower legs. Resident (G) was assessed by staff and the incident was reported to ISDH. Resident (E) was provided 1:1 observation without improvement. The physician was notified and a new order to transport Resident (E) to a behavior unit was received. Resident (E) was transferred to the behavior unit at 4:15 a.m. Resident (E) returned to the facility on 3/21/13 at 11:00 p.m.</p> <p>During record review on 4/2/13 at 4:30 p.m., the Minimum Data Set (MDS) assessment dated 2/12/13, indicated Resident (G) was unable to complete the Brief Interview for</p>		<p>management system and resident rights.</p> <p>Behavior reports and nurses notes pertaining to behaviors will be reviewed in the clinical meeting each weekday. The interdisciplinary team reviews documentation to assure communication and implementation of interventions to prevent reoccurrence and protect other resident's and staff from adverse effects of resident behavior. (Exhibit 5)</p> <p><u>How will the facility monitor and who is responsible:</u></p> <p>The Executive Director will assure ongoing communication in clinical meeting with the Interdisciplinary team regarding behavior management, assessment of interventions and behavior reporting. The behavior intervention outcome monitor as well as behavior committee findings will be reviewed in the Quality Assurance meeting monthly times 6 months and ongoing. Behavior management events and outcome are included in the ongoing annual Quality Assurance process of monthly review.</p>		

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	<p>Mental Status (BIMS). Resident (G) had no speech, was rarely understood, and rarely understands with short and long term memory impairment. Resident (G) received the following Activities of Daily Living (ADL) assistance: transfer-total dependence with two person physical assist, ambulation-did not occur, dressing-total dependence with one person physical assist, hygiene and bathing-total dependence with one person physical assist. Resident (G) also had bilateral impairment of lower and upper extremities. Resident (G) was incontinent of bowel and bladder. Resident (G) weighed 111 lbs and was 5'9" tall. Resident (G) had diagnoses that included, but were not limited to, cerebral palsy, asthma, seizure disorder and aphasia.</p> <p>A mood and behavior communication memo dated 3/11/13 at 11:45 a.m., indicated Resident (E) was walking by Resident (F), who was sitting in the hallway. Resident (E) walked up behind Resident (F) and kicked him in the back twice. Resident (E) indicated to the staff that other residents should not sit on the floor. Residents were separated and Resident (E) went into a staff member's office. No other interventions were attempted. The</p>						

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	<p>incident was reported to ISDH on 3/11/13.</p> <p>During record review on 4/2/13 at 3:05 p.m., the Minimum Data Set (MDS) assessment indicated Resident (F) was unable to complete the Brief Interview for Mental Status (BIMS). Resident (F) had no speech, sometimes understood, and never understands with short and long term memory impairment. Resident (F) received the following Activities of Daily Living (ADL) assistance: transfer-limited assistance with one person physical assist, ambulation-limited assistance with one person physical assist, dressing-total extensive assistance with one person physical assist, hygiene and bathing-total dependence with one person physical assist. Resident (F) also had bilateral impairment of lower extremities. Resident (F) was occasionally incontinent of bowel and bladder. Resident (F) currently weighed 110.5 lbs. Resident (F) had diagnoses that included, but were not limited to, mental retardation, seizure disorder, aphasia and gastroesophageal reflux disease.</p> <p>A mood and behavior communication memo dated 3/9/13 at 1:00 p.m.,</p>			

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	<p>indicated Resident (E) was redirected several times out of Resident (I)'s room. Resident (E) laughed and indicated he "could go wherever he wanted to go." Resident (E) was redirected to the activity room and indicated the staff needed to get Resident (I) a "training bra because her nipples were showing." No other interventions were attempted.</p> <p>During record review on 4/2/13 at 4:15 p.m., the Minimum Data Set (MDS) assessment dated 3/14/13, indicated Resident (I) was unable to complete the Brief Interview for Mental Status (BIMS). Resident (I) had no speech, sometimes understood, and sometimes understands with short and long term memory impairment. Resident (I) received the following Activities of Daily Living (ADL) assistance: transfer-independent with no physical help from staff, ambulation-independent with no physical help from staff, dressing-limited assistance with one person physical assist, hygiene and bathing-limited assistance with one person physical assist. Resident (I) was continent of bowel and bladder. Resident (I) currently weighed 93 lbs. and was 4 ' 9 " tall. Resident (I) had diagnoses that included autism and aphasia.</p>				

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	<p>A mood and behavior communication memo dated 2/15/13 at 5:00 a.m., indicated Resident (E) cussed at staff following a telephone call to his mother. He asked to call his mother again and jumped onto the nurses' station. He was asked to get down by LPN #3. Resident (E) got down from the station and chased LPN #3 hitting, kicking and cursing at her. LPN #3 was assisted by LPN #4. At 6:00 a.m., Resident (E) was redirected to his room for medication administration. Resident (E) indicated he was going to "kill him" and pointed to Resident (H) who resided in the same room. Resident (E) was removed from the room and placed in the dining room for observation. At 6:30 a.m., Resident (E) indicated he would again "kill" LPN #3 and Resident (H). He then picked his nose, causing it to bleed. Resident (E) then licked the blood and indicated "likes to lick other people's blood."</p> <p>A mood and behavior communication memo dated 3/24/13 at 5:15 a.m., indicated Resident (E) said he could keep Resident (H) up all night because he would not forgive Resident (E). Resident (E) indicated it was a "free country and if I wanna</p>			

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NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992
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	<p>hurt somebody, I will." Resident (E) continued to threaten to keep Resident (H) up awake all night. Interventions were attempted and were unsuccessful.</p> <p>During record review on 4/2/13 at 4:20 p.m., the Minimum Data Set (MDS) assessment dated 2/28/13, indicated Resident (H) scored a 15 of 15 for the Brief Interview for Mental Status (BIMS). A BIMS score of 15 indicated the resident was cognitively intact. Resident (H) had no behaviors or memory impairment. Resident (H) received the following Activities of Daily Living (ADL) assistance: transfer-total dependence with two person physical help from staff, ambulation- did not occur, dressing-total dependence with one person physical assist, hygiene and bathing-total dependence with one person physical assist, toilet use-total dependence with bowel and indwelling catheter for bladder. Resident (H) had bilateral impairment of both upper and lower extremities. Resident (H) currently weighed 144 lbs. and was 70 " tall. Resident (H) had diagnoses that included, but were not limited to, quadriplegic, C1-C4 fracture, depression, hypertension and gastrostomy tube placement.</p>			

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	<p>During an interview on 4/3/13 at 8:50 a.m., Resident (H) indicated he had some safety concerns related to Resident (E). He indicated he feels vulnerable while he is in bed because he cannot get away. He indicated he feels safer in his wheelchair because he is then able to be mobile. He indicated Resident (E) is unpredictable. He indicated Resident (E) will have a good night then have a bad night another time.</p> <p>A mood and behavior communication memo dated 3/4/13 at 8:30 a.m., indicated Resident (E) was in his room during staff care of his roommate, Resident (J). Staff was attempting to get Resident (J) up in his room and Resident (E) got out of bed and said "here, I will get [Resident (J)] up." Resident was redirected with physical activity and conversation.</p> <p>During record review on 4/2/13 at 2:00 p.m., the Minimum Data Set (MDS) assessment dated 1/23/13, indicated Resident (J) was unable to complete the Brief Interview for Mental Status (BIMS). Resident (J) had no speech, rarely understood, and rarely understands with short and long term memory impairment. Resident (J) received the following</p>						

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	<p>Activities of Daily Living assistance: transfer-total dependence with two person physical help from staff, ambulation- did not occur, dressing-total dependence with one person physical assist, hygiene and bathing-total dependence with one person physical assist and toilet use-incontinent of bowel and bladder. Resident (J) had bilateral impairment of lower extremities. Resident (J) had diagnoses that included, but were not limited to, infantile cerebral palsy, aphasia, legally blind, seizures and gastrostomy tube placement.</p> <p>Further review of Resident (E)'s record indicated the following: A monthly behavior summary log dated March 2013, indicated Resident (E) had 79 aggression incidents, 121 cussing incidents and 15 resistant to care incidents. Resident (E) was last seen by a psychiatrist on 3/18/13 with a new order for Seroquel (antipsychotic medication) 50 mg and slowly increased to 150 mg. New diagnoses were added of intermittent impulse control, post traumatic stress disorder, generalized stress/anxiety disorder, oppositional defiant disorder, and obsessive compulsive disorder by history of autism. The physician included bipolar as a diagnosis, but Resident (E)'s mother</p>						

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	<p>refused the diagnosis. Seroquel was discontinued on 3/28/13, per mother's request, and the physician's services were discontinued. Resident (E) received the following medications for behaviors: Carbamazepine 100 mg/5 ml, 20 ml daily and 15 ml at night, Diazepam 10 mg three times daily, Lexapro 10 mg daily, Lamictal 25 mg daily, Lamotrigine 50 mg daily, Namenda 5 mg twice daily and Valporic acid 500 mg three times daily.</p> <p>The initial care plan, dated 2/11/13, included the following; short memory span, behavioral concerns, adjustment to new environment, aggression, cussing, and resist care. The care plan was last updated on 2/26/13. Resident (E) was not care planned for resident to resident altercations, resident to staff altercations, or verbal or physical abuse.</p> <p>An Omnibus Budget Reconciliation Act (OBRA) pre-admission screening level 2 assessment was performed on Resident (E) on 1/29/13. The assessment indicated Resident (E) would become angry and frustrated during the screening. The assessment indicated Resident (E) would need close supervision with</p>			

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	<p>limited change in environment and routine. The assessment indicated Resident (E) was impulsive and somewhat delusional and would act out aggressively. The assessment recommendations were Resident (E) would benefit from the following: structured routine, reorientation to reality on a regular basis, and a behavior management program to redirect him when he became aggressive.</p> <p>A social service progress note dated 2/14/13 at 5:45 a.m., indicated staff reported Resident (E) was attempting to get behind the nurses' station. He indicated to the nurse he wanted to "fight her." Another nurse was walking by Resident (E) when he grabbed her arm and twisted it. Another nurse asked if he would like to watch a movie and he then grabbed her arm and twisted it.</p> <p>A social service progress note dated 2/20/13, indicated on 2/19/13 at 9:30 a.m., Resident (E) became upset and grabbed stuff off a cart and began throwing items at the nurse.</p> <p>A social service progress note dated 2/25/13, indicated on 2/23/13 at 2:30 a.m., Resident (E) indicated to a nurse he was going to "bitch slap her"</p>				

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	<p>then grabbed her and began kicking her.</p> <p>A social service progress note dated 3/5/13 at 12:30 p.m., indicated Resident (E) was taking knives and forks off trays and said he would "stab" someone if he had to. He then went into his room and returned with clippers and said he would "stab" someone with the file. Resident was then only able to have plastic utensils. He indicated to the Social Service Designee that he "can do whatever he wants and get away with it" and "he could kill someone and get away with it because he is retarded." At 12:40 p.m., Resident (E) blocked a nurse from door and pushed her away from door. The nurse tried to move and he pushed her again. He then grabbed her wrist and arm, digging his nails into her arm.</p> <p>During an interview on 4/1/13 at 2:48 p.m., LPN #3 indicated Resident (E) does not belong in the facility. He is higher functioning and other residents cannot defend themselves against him.</p> <p>During an interview on 4/2/13 at 7:06 a.m., LPN #6 indicated Resident (E) should not be in the facility. He has hurt staff and she is very cautious</p>				

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	<p>around him.</p> <p>During an interview on 4/2/13 at 7:20 a.m., LPN #4 indicated Resident (E) will just "snap." She indicated he has had resident to resident and resident to staff behaviors.</p> <p>During an interview on 4/2/13 at 7:35 a.m., LPN #7 indicated she is fearful for other residents who cannot defend themselves against Resident (E).</p> <p>Review of a current facility policy dated 1/07, titled "Behavior Management," which was provided by the Social Service Designee on 4/3/13 at 11:55 a.m., indicated the following:</p> <p>"...5. Upon review of referrals and assessing the underlying causes of the behavior symptoms, a behavior management plan will be developed. The behavior management plan will specify the problem (behavior symptoms), goal, and individualized approaches (proactive and reactive).</p> <p>6. A behavior Monitoring Record (facility specific) will be used to document each observed episode of the targeted behavior. It will reflect the following in information: *Date</p>				

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	<p>*Time *Behavior *Precipitating events *Staff intervention *Outcome...."</p> <p>During an observation on 4/3/13 at 8:50 a.m., two staff members were present in Resident (E)'s room. Resident asleep in bed.</p> <p>The abuse protocol task was initiated on 4/3/13 at 8:20 a.m. During the abuse investigation, RN #12, CNA #13, LPN #6, CNA #15, CNA #14, and LPN #4 indicated they had been inserviced on Resident (E) behavior monitoring and interaction with other residents.</p> <p>The immediate jeopardy that began on 3/11/13 was removed on 4/3/13 when the facility issued a 30 day notice to Resident (E), provided continuous monitoring by one or two staff members until discharge, provided psychosocial assessments on Residents F, G, H, I and J and identified residents with potential behaviors that may affect other residents, reviewed and updated resident care plans, initiated staff education on 4/2/13 for behaviors recognition that may affect other residents for psychosocial, physical or</p>				

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	<p>other behaviors and began reviewing daily behavior reports and nursing notes, but the noncompliance remained at the lower scope and severity level of pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy, because education of staff and monitoring was ongoing.</p> <p>This Federal tag related to complaint IN00125518.</p> <p>3.1-45(a)(2)</p>				