STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155549	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBEND LIVING CENTER	7524 E JACKSON ST MUNCIE, IN 47302

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F000000	This visit was for a Recertification and State Licensure Survey. Survey dates: February 26, 27, 28, March 1, and 4, 2013 Facility number: 000681 Provider number: 155549 Aim number: 100286100 Survey team: Karen Lewis, RN TC Ginger McNamee, RN (February 26, 27, March 1, and 4, 2013) Toni Maley, BSW (February 27, 28, March 1, and 4, 2013) Linn Mackey, RN Census bed type: SNF: 6 NF: 38 Total: 44 Census payor type: Medicare: 6 Medicaid: 36 Other: 2 Total: 44 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F000000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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F000248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.			
	Based on observation, interview, and record review, the facility failed to ensure residents, who lived on a secured dementia unit, were offered an activity program which addressed their identified dementia needs for 3 of 13 residents reviewed for diversional activities for dementia residents. (Residents # 48, #49 and #55) Findings include: 1.) During observations of The Cottage Dementia Unit on 2/28/13 from 8:30 a.m. to 10:05 a.m., 2/28/13 from 1:50 p.m. to 3:10 p.m. and 3/1/13 from 8:45 a.m. to 10:55 a.m., the following was noted: The living room/TV lounge area of the facility generally had 6 to 8 residents. The TV was on in the lounge. There were no manipulative devices or sensory stimulation materials offered to any resident in the lounge at any time. The residents did not have or	F000248	1. Residents #48, #49, and #55 experienced no negative outcomes and are offered an activity program which addresses their specific needs and interests.2. All residents residing on the secured dementia unit have the potential to be affected. Each resident has been reviewed and are offered an activity program which addresses their specific needs and interests.3. The facility's policy for Alzheimer/Related Dementia Unit Activity Program has been reviewed and no changes are indicated at this time (See Attachment A). Activity staff have been re-educated on the policy (See Attachment B). An Activity Log form as been initiated (See Attachment C).4. The Cottage Activity Assistant or designee will complete the Activity Attendance form on scheduled work days on an ongoing basis to ensure residents are attending activities of their interest. Should concern(s) be found, re-education will be provided. These forms will be reviewed in the facility's quarterly QA meetings for a minimum of 6	03/25/2013

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	use, games, books, music, stuffed animals or manipulative devices. Staff did not offer any of these materials to the residents or encourage any activity other than watching television. During any given observation, only two residents, seated in the TV area were awake at one time. At no time were the residents conversational with one another. On 3/1/13 at 9:50 a.m. L.P.N. #3 stated to all the residents in the lounge "Bingo will be at 10:00 a.m. I think they will have snacks." During a 3/1/13, 10:20 a.m. observation, BINGO was taking place in the main dining room. No residents from The Cottage Dementia Unit were present. 2.) Resident #55's record was reviewed on 2/28/13 at 9:00 a.m. Resident #55's current diagnoses included, but were not limited to, dementia with agitation, depression, anxiety and insomnia. Resident #55 was admitted to the facility on 2/2/13. Resident #55 had a current, 2/4/13,		months and the plan adjusted accordingly as indicated.	

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	care plan problem regarding depression. Approaches to this problem included, but were not limited to, "Encourage activities of choice and interest such as: watching TV (wrestling), checkers, music." Resident #55 had a current, 2/4/23, care plan problem regarding exit seeking. Approaches to this problem included, but were not limited to, "Encourage participation in activities of choice and interest such as: TV, music, checkers, and exercise." Resident #55 had a current, 2/4/13, care plan problem regarding anxiety. Approaches to this problem included, but were not limited to, "Encourage activities of preference such as: TV, music, checkers." Resident #55 had a current, 2/7/13, care plan problem/need regarding activity needs. The need indicated he enjoyed wrestling, sports, cars, cards, TV, music and going outdoors. Resident #55 had a, 2/7/13, "Activity Assessment" which indicated: "Identified Leisure Interest and Hobbies ... Cards and Games: checkers, ucher [sic] ...			

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	Music: country, oldies... Exercise/Sports: wrestling... Outings: travel, spending time outdoors ... Television: news, sports, other [blank] ... Talking/Conversing: with friends, with family ... Walking/Wheeling: Indoors, outdoors ..." During a 2/28/13, 8:30 a.m. to 9:30 a.m. observation, Resident #55 slept in a recliner in the TV lounge. During a 2/28/13, 1:50 p.m. to 2:45 p.m. observation, Resident #55 slept in a recliner in the TV lounge. The television was never tuned to news or sports during these observations. During a 3/1/13, 8:45 a.m. to 9:00 a.m. observation, Resident #55 was seated in a recliner looking about. From 9:00 a.m. to 9:45 a.m., Resident #55 was asleep in a recliner. Resident #55 awoke at 9:45 a.m., when resident #48 accidentally ran over his feet with the wheelchair. Resident #55 forcefully pushed Resident #48's wheelchair away from him. At 10:05 a.m., Resident #55 was once again asleep in the recliner. The television was never tuned to news or sports during these observations.			

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	3.) Resident # 49's record was reviewed on 3/1/13 at 1:00 p.m. Resident # 49's current diagnoses included, but were not limited to, delusions and behavioral disturbances, anxiety, end stage dementia with aggressive features, depression and Alzheimer's disease. Resident #49 had a current, 2/4/13, care plan problem regarding activity needs due to being unable to express needs. The problem indicated the resident enjoyed walking, reading, music, parties, cars, fishing and oil painting. Resident #49 had a current, 2/4/13, care plan problem regarding "exhibits socially inappropriate behaviors such as: will move furniture around/flip furniture over, attempts to push res [residents] in w/c [wheelchair], wanders into other res rooms." Approaches to this problem included, but were not limited to, "Attempt to ascertain the trigger for socially inappropriate outbursts" and "Attempt diversion, distraction, and reorientation to calm the resident such as: games, food/drink, walking." Resident #49 had a current, 2/4/13,			

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	care plan problem regarding wandering behaviors. The problem indicated "the wandering places the resident at significant risk of getting to a potentially dangerous place" and "The wandering significantly intrudes on the privacy or activities of others." Approaches to this problem included, but were not limited to, "Encourage movement and exercise to reduce anxiety, agitation, and restlessness, Involve the person in activities of interest such as: games, socialization, walking, and Redirect pacing or restless behavior." Resident #49 had a current, 2/4/13, care plan problem regarding increased agitation in the late afternoon and evening. Approaches to this problem included, but were not limited to, "Provide activities in the AM and encourage rest after lunch to reduce evening fatigue, provide exposure to the sun during the afternoon, if applicable." Resident #49 had a most current, 8/27/12, "Activity Assessment" which indicated: "Identified Leisure Interests and Hobbies: Cards and Games: card games ... Music: Gospel, classic ... Exercise/Sports: walking, fishing ...			

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	Outings: travel, restaurants Hobbies: cars, oil painting ... Social: parties, special events ... Reading/Writing: newspaper .... Talking/Conversing: with friends, with family, with staff, with peers ..." During an observation on 2/28/12 from 1:50 p.m. to 2:45 p.m., Resident #49 walked around the unit and walked into the nursing station a couple of times. During an 2/28/13, 2:55 p.m. observation, Resident #49 walked behind the nursing station and sat down in a chair and opened the desk drawer. Resident #49 rummaged through the drawer, which contained a screw driver, thumb tacks, nail clippers and other unidentified items. No staff were in the area. After a call for assistance, L.P.N. #1 entered the area and redirected Resident #49 from the area. Resident #49 exited the area with the nurse. During a 3/1/13, 8:45 a.m. to 8:55 a.m. observation, Resident #49 roamed about the unit touching things. At 8:55 a.m. Resident #49 was at the nursing station removing all the monitoring books from the desk top. LPN #3 intervened and redirected the resident away from the			

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	desk. At 8:56 a.m., Resident #49 began to roam the hallway. At 8:57 a.m., Resident #49 entered the unit kitchen area. Resident #56 yelled for Resident #49 to leave the area. Staff did not intervene. Resident #49 left the kitchen. During a 3/1/13, 9:05 a.m. observation, Resident #49 approached Resident #56, who was seated in the wheelchair at the kitchen door, Resident #49 held out his hand and said some words which did not make sense. Resident #49 stepped close to Resident #56 extending his hand. Resident #56 became upset asking Resident #49 to stay away from him. Resident #49 stepped closer. No staff members were visible in the area. The staff did not intervene. Resident #56 became more upset and shouted "Get the h--l out of here with that dumb s--t! Get out of here or I am going to kick your a--." Staff intervened and walked Resident #49 away from the area. During a 3/1/13, 12:45 p.m. observation, the Maintenance Supervisor, located Resident #49 in another resident's room. Resident #49 had shoved both chairs in front of the door. He had removed his socks. He was walking around the room			

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	carrying a balloon bouquet which belonged to the resident who lived in the room. 4.) Resident #48's record was reviewed on 2/28/13 at 8:37 a.m. Resident # 48's current diagnoses included, but were not limited to, depression, anxiety, and Alzheimer's dementia with behaviors, agitation and aggression. Resident #48 had a current, 1/14/13, care plan problem/need regarding short and long term memory loss and cognitive loss, was not able to stand still and wandered. The problem indicated the resident was interested in reading, music, spiritual activities and westerns on TV. Resident #48 had a current, 2/1/13, care plan problem regarding his inability to express his activity preferences. It indicated he enjoyed sports, TV (westerns mostly), reading, music, games, visiting and being outdoors. Resident #48 had a current, 2/4/13, care plan problem regarding physically abusive behaviors and becoming aggressive with staff. Approaches to this problem included,			

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	but were not limited to, "Attempt to use diversion, distraction, and reorientation to calm the resident such as: walking, going outside (on nice days), snack/fluids." Resident #48 had a,2/1/13, "Activity Assessment" which indicated: "Identified Leisure Interest and Hobbies: ... Music: gospel, country ... Educational: Informational ... Exercise/Sports: football, fishing ... Spiritual Activities: watch on TV ... Hobbies: pet visits ... Social: news and coffee, fresh baked cookies ... Reading/Writing: books, newspaper, magazines ... Television: news, movies, sports ... Talking/Conversing: with friends, with family ... Walking/Wheeling: indoors, outdoors ..." During a 2/28/13, 8:35 a.m. to 10:05 a.m. observation, Resident #48 moved restlessly about the unit in his wheelchair. He periodically moved his body up and down in the chair as if attempting to stand. He, at times, went over by the exit door and was redirect back to the TV by staff. Once during this time staff ambulated the resident about 15 feet. Other that this			

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	intervention, all other interventions were to redirect the resident back to the TV. At no time did the resident appear to be watching television. He did not turn his face toward the television or track the movement on the television with his eyes. The television was not tuned to a western or spiritual program. During a 2/28/13, 1:50 p.m. to 2:45 p.m. observation, Resident #48 moved restlessly about the unit in his wheelchair. He periodically moved his body up and down in the chair as if attempting to stand. He, at times, went over by the exit door and was redirect back to the TV by staff. At no time did the resident appear to be watching television. He did not turn his face toward the television or track the movement on the television with his eyes. The television was not tuned to a western or spiritual program. During a 3/1/13, 8:45 a.m. to 9:45 a.m. observation, Resident #48 roamed about the unit in his wheelchair. At 9:45 p.m. Resident #48 accidentally ran over Resident #55's feet with his wheelchair. No staff where in the area when this accident occurred. Resident #55 pushed Resident #48's wheelchair			

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	away with a forceful shove. At no time did the resident appear to be watching television. He did not turn his face toward the television or track the movement on the television with his eyes. The television was not tuned to a western or spiritual program. 5.) During a 3/4/13, 9:50 a.m. interview, the Administrator indicated the Dementia Unit [The Cottage] had 13 residents, who all had a diagnoses of dementia or a related disorder. Activities to meet the needs of The Cottage residents' occurred both on and off the secured unit. The previous Dementia Unit Director left her position in February. The previous Dementia Unit Director was not a scheduled employee of the facility and was instead a corporate consultant. The Director of Nursing became the Dementia Unit Director at this time. The goal of the facility is to have an extra C.N.A./Activity worker on the unit. The facility has not been able to maintain this position at this time but was trying to hire to fill the position. During a 2/28/13, 3:05 p.m. interview, C.N.A. #2, who was working on The Cottage Dementia Unit, indicated there were no specific behavior			

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	management plans. When a resident displayed behaviors, she addressed the behavior by trial and error and what she knew about the resident. Staff were to document all behaviors on a behavior form. She had not been instructed to monitor any specific behaviors. She indicated a C.N.A. on the unit was supposed to offer activities on the unit but the position was not currently filled. During a 3/1/13, 10:10 a.m. interview, C.N.A. #4, who was working on The Cottage Dementia Unit, indicated there was supposed to be a C.N.A. who offered activities to residents but that position was not filled at present. C.N.A. #4 stated "Activities are important but care comes first and I don't have time to do both. ... I have not done activities because I cannot do both. ...Mostly they watch TV or sleep." During a 3/1/13, 10:58 a.m., interview, L.P.N. #3, who was working on The Cottage Dementia Unit, indicated the facility was trying to develop a new program where a C.N.A. would do both activities and some care. However, the position had not yet been filled. He indicated it was difficult to provide nursing services care and offer activities. He			

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	indicated residents mostly watch TV and nap. 6.) Review of the 12/6/12, "Alzheimer's Dementia Special Care Unit" form, which was provided by the Administrator on 2/26/13, indicated the following: "a.) The dementia unit was called "The Cottage" b.) The Cottage housed 18 residents c.) The Cottage Unit had the following staffing needs: L.P.N. -1 days, 1 evenings, zero nights C.N.A.-1.5 days, 1.5 evenings, zero nights Q.M.A.- 1 nights Activity Director/Staff -1 days Social Worker- 1 days d.) The following therapy methods were to be used in the program/unit: Art therapy Exercise Recreational therapy Massage Pet therapy Reminiscence therapy" Review of an current, undated facility			

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	policy titled "Alzheimer/Related Dementia Unit Activity Program", which was provided by the Director of Nursing on 3/4/13 at 8:45 a.m., indicated the following: "Purpose: To provide a therapeutic outlet for excess energy and to help redirect inappropriate behaviors, while helping to maintain functioning skills and normalcy of routine: ...2.) Activities will be conducted 7 days per week. 3.) All staff members will assist with activities at various times to provide an interdisciplinary approach to care." 3.1-33(a)			

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NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302	

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F000250 SS=D	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 develop and implement a behavior management program which implemented specific resident centered approaches for residents who lived on The Cottage Dementia Unit. This deficient practice impacted 2 of 2 residents reviewed for behavior management (Residents # 48 and #49). Findings include: 1.) During a 2/28/13, 8:35 a.m. to 10:05 a.m. observation, Resident #48 moved restlessly about the unit in his wheelchair. He periodically moved his body up and down in the chair as if attempting to stand. He at times went over by the exit door and was redirected back to the TV by staff. Once during this time staff ambulated the resident about 15 feet. Other that this intervention, all other interventions were to redirect the resident back to the TV. At no time did the resident appear to watch television. He did not face the	F000250	1. Residents #48 and #49 experienced no negative outcomes and participate in a behavior management program which involves specific resident centered approaches for the behaviors they experience.2. All residents on the Cottage Dementia Unit have the potential to be affected. Each resident who was deemed in need of a behavior management program are currently participating in a program wich involves specific resident centered approaches for the behaviors they experience.3. The facility's policy for the Mood and Behavior Program (See Attachment D) has been reviewed and no changes are indicated at this time. Facility staff have been educated on the policy (See Attachment E). A Psychoactive Monitoring Log has been initiated (See Attachment F).4. The Social Service Director or Designee will be responsible for completing the Psychoactive Monitoring Log on schedule work days to ensure specific resident centered approaches are being attempted when behavior are experienced. This will be done for 3 residents daily for two weeks, two times weekly for two	03/25/2013

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	television or track movement with his eyes. During a 2/28/13, 1:50 p.m. to 2:45 p.m. observation, Resident #48 moved restlessly about the unit in his wheelchair. He periodically moved his body up and down in the chair as if attempting to stand. He at times went by the exit door and was redirected back to the TV by staff. At no time did the resident appear to watch television. He did not face the television or track movement with his eyes. During a 3/1/13, 8:45 a.m. to 9:45 a.m. observation, Resident #48 roamed about the unit in his wheelchair. At 9:45 a.m., Resident #48 accidentally ran over Resident #55's feet with his wheelchair. No staff where in the area when this accident occurred. Resident #55 pushed Resident #48's wheelchair away with a forceful shove. Resident #48's record was reviewed on 2/28/13 at 8:37 a.m. Resident # 48's current diagnoses included, but were not limited to, depression, anxiety, and Alzheimer's dementia with behaviors, agitation and aggression.		weeks, then weekly thereafter for a minimum of six months. A behavior management meeting will be held monthly for residents with a behavior management program on an ongoing basis. Should concern(s) be found, re-education will be provided. Results of these reviews will be discussed during the facility's quarterly QA meetings and the plan will be adjusted accordingly as indicated.	

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	Resident #48 had a current, 1/14/13, care plan problem/need regarding short and long term memory loss and has cognitive loss, not being able to stand still and wandering. The problem indicated the resident was interested in reading, music, spiritual activities and westerns. Resident #48 had a current, 2/1/13, care plan problem regarding his inability to express his activity preferences. It indicated he enjoyed sports, TV (westerns mostly), reading, music, games, visiting and outdoors. Resident #48 had a current, 2/4/13, care plan problem regarding physically abusive behaviors and becoming aggressive with staff. Approaches to this problem included, but were not limited to, "Attempt to use diversion, distraction, and reorientation to calm the resident such as: walking, going outside (on nice days), snack/fluids." 2.) During an observation on 2/28/12 from 1:50 p.m. to 2:45 p.m., Resident #49 walked around the unit and walked into the nursing station a couple of times. During an 2/28/13, 2:55 p.m.			

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	observation, Resident #49 walked behind the nursing station and sat down in a chair and opened the desk drawer. Resident #49 rummaged through the drawer, which contained a screw driver, thumb tacks, nail clippers and other unidentified items. No staff were in the area. After a call for assistance, L.P.N. #1 entered the area and redirected Resident #49 from the area. Resident #49 left the area with the nurse. During a 3/1/13, 8:45 a.m. to 8:55 a.m. observation, Resident #49 roamed about the unit touching things. At 8:55 a.m. Resident #49 was at the nurses station removing all the monitoring books from the desk top. LPN #3 intervened and redirected the resident away from the desk. At 8:56 a.m., Resident #49 began to roam the hallway. At 8:57 a.m., Resident #49 entered the unit kitchen area. Resident #56 yelled for Resident #49 to leave the area. Staff did not intervene. Resident #49 left the kitchen. During a 3/1/13, 9:05 a.m. observation, Resident #49 approached Resident #56, who was seated in the wheelchair at the kitchen door. Resident #49 held out his hand and said some words which			

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	did not make sense. Resident #49 stepped close to Resident #56 extending his hand. Resident #56 became upset asking Resident #49 to stay away from him. Resident #49 stepped closer. There were no visible staff in the area. Staff did not intervene. Resident #56 became more upset and shouted "Get the h--l out of here with that dumb s--t! Get out of here or I am going to kick your a--." Staff intervened and walked Resident #49 away from the area. During a 3/1/13, 12:45 p.m. observation, the Maintenance Supervisor located Resident #49 in another resident's room. Resident #49 had shoved both chairs in front of the door. He had removed his socks. He was walking around the room carrying a balloon bouquet which belonged to the resident who lived in the room. Resident # 49's record was reviewed on 3/1/13 at 1:00 p.m. Resident # 49's current diagnoses included, but were not limited to: delusions and behavioral disturbances, anxiety, end stage dementia with aggressive features, depression and Alzheimer's disease.			

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	Resident #49 had a current, 2/4/13, care plan problem regarding activity needs due to being unable to express needs. The problem indicated the resident enjoyed walking, reading, music, parties, cars, fishing and oil painting. Resident #49 had a current, 2/4/13, care plan problem regarding "exhibits socially inappropriate behaviors such as: will move furniture around/flip furniture over, attempts to push res [residents] in w/c [wheelchair], wanders into other res rooms." Approaches to this problem included, but were not limited to, "Attempt to ascertain the trigger for socially inappropriate outbursts, Attempt diversion, distraction, and reorientation to calm the resident such as: games, food/drink, walking." Resident #49 had a current, 2/4/13, care plan problem regarding potential for resident altercation due to wandering into other's room. Resident #49 had a current, 2/4/13, care plan problem regarding wandering behaviors. The problem indicated "the wandering places the resident at significant risk of getting to a potentially dangerous place and the wandering significantly intrudes on			

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	the privacy or activities of others." Approaches to this problem included, but were not limited to, "Encourage movement and exercise to reduce anxiety, agitation, and restlessness, Involve the person in activities of interest such as: games, socialization, walking and Redirect pacing or restless behavior." 3.) During a 3/4/13, 9:50 a.m., interview the Administrator indicated the Dementia Unit [The Cottage] had 13 residents, who all had a diagnoses of dementia or a related disorder. During a 2/28/13, 3:00 p.m. interview, L.P.N. #1, who was working on The Cottage Dementia Unit, indicated there was not a place where specific targeted behaviors were monitored. All behaviors were documented on a behavior form. The behavior form was then collected by the Social Service Director who used them to monitor behaviors. During a 2/28/13, 3:05 p.m. interview, C.N.A. #2, who was working on The Cottage Dementia Unit, indicated there were no specific behavior management plans. When a resident displayed behaviors, she addressed the behavior by "trial and error" and what she knew about the resident.			

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	Staff were supposed to document all behaviors on a behavior form. She had not been instructed to monitor any specific behaviors. During a 3/1/13, 10:10 a.m. interview, C.N.A. #4, who was working on The Cottage Dementia Unit, indicated she was unaware of any resident specific approach to behaviors. She just used "trial and error" when addressing resident behaviors. She indicated she just learned about each resident over time or was told about them by other CNAs. She indicated there were no behavioral approaches on CNA assignment sheets. She indicated she had never looked in the chart at a care plan. During a 3/1/13, 10:58 a.m., interview, L.P.N. #3, who was working on The Cottage Dementia Unit, indicated there was not behavior management program which gave resident specific guidance about how to manage behavior. Staff learned to manage each resident's behavior by "trial and error." There was no location to monitor specific target behaviors which were being treated by psychoactive medications. All behaviors were supposed to be documented on a behavior monitoring form. Staff may become accustomed			

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	to behaviors and not document about them. During a 3/1/13, 12:53 p.m. interview, The Social Services Consultant indicated all staff would go to the care plan to find what approach should be used to address resident behavior. During a 3/1/31, 12:55 p.m. interview, The Social Service Director indicated resident specific approaches to address resident specific behaviors were found on the care plan. She indicated there was no specific program in place to make these approaches available to direct care staff. She indicated a CNA would ask the nurse, who would go to the care plan and look at approaches and tell the C.N.A. what specific approaches to use for that resident. She indicated the facility had held behavioral inservices to train staff. She indicated she did not know when the last inservice was held. The content of a 4/13/12, Behavioral Inservice, provided by the Social Service Designee on 3/1/13 at 2:00 p.m., indicated the following: "Procedure for the Behavior and Mood Program ...4. A written plan of care will be			

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	developed to address the behavior(s) and/or mood(s) including interventions to address any noted intrinsic and/or extrinsic factors precipitation the behavior(s) and/or mood(s) by social service and/or the interdisciplinary team." "Behavioral and Mood Communication Memo Form Procedure ...3. Upon witnessing a behavior and/or mood, staff will complete the Behavior and Mood communication Memo." During a 3/1/13, 1:10 p.m. interview, the Director of Nursing indicated she had recently become the Unit Director for The Cottage Dementia Unit. She indicated she had believed the specific approaches to resident behaviors were on the C.N.A. assignment sheet. She indicated the facility did not want C.N.A.s to get into a resident's private clinical record to look at care plans. The facility should develop tools from the care plan for the C.N.A.s to use. The goal was to hire a C.N.A. to do activities on the dementia unit. 4.) A 2/28/13, 10:50 a.m., review of the "Behavior Monitoring Log" for the Dementia Unit indicated the following:			

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	a.) 12 Residents on the Dementia Unit had a behavior monitoring sheet. b.) The sheets were tally sheets with standard terms and did not have resident specific behaviors. c.) There were 11 tracked behaviors: rejection of care, socially Inappropriate, physical behavioral symptoms, verbal behavioral symptoms, insomnia, false accusations, exit seeking, wandering, signs and symptoms of depression, signs and symptoms of anxiety and hallucinations. Review of the 12/6/12, "Alzheimer's Dementia Special Care Unit" form, which was provided by the Administrator on 2/26/13, indicated the following: "a.) The dementia unit was called "The Cottage" b.) The Cottage housed 18 residents c.) The Cottage Unit had the following staffing needs: L.P.N. -1 days, 1 evenings, zero nights C.N.A.-1.5 days, 1.5 evenings, zero nights Q.M.A.- 1 nights Activity Director/Staff -1 days Social Worker- 1 days			

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	d.) The following therapy methods were to be used in the program/unit: Art therapy Exercise Recreational therapy Massage Pet therapy Reminiscence therapy" Review of the CNA assignment sheet, which was provided by the R.N. consultant on 3/1/13 at 3:00 p.m., indicated resident behaviors and approaches to behavioral management were not listed on the form. Review of an current, undated facility policy titled "Alzheimer/Related Dementia Unit Activity Program," which was provided by the Director of Nursing on 3/4/13 at 8:45 a.m., indicated the following: "Purpose: To provide a therapeutic outlet for excess energy and to help redirect inappropriate behaviors, while helping to maintain functioning skills and normalcy of routine:" 3.1-34(a)			

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F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.			
	Based on observation, interview, and record review, the facility failed to implement behavioral care plans for dementia residents for 2 of 2 residents reviewed for following behavioral plans of care in a sample of 33 residents whose care plans were reviewed. (Residents #48 and #49). Findings Include: 1.) During an observation on 2/28/12 from 1:50 p.m. to 2:45 p.m., Resident #49 walked around the unit and walked into the nursing station a couple of times. During an 2/28/13, 2:55 p.m. observation, Resident #49 walked behind the nursing station and sat down in a chair and opened the desk drawer. Resident #49 rummaged through the drawer, which contained a screw driver, thumb tacks, nail clippers and other unidentified items. No staff were in the area. After a call for assistance, L.P.N. #1 entered the area and redirected Resident #49	F000282	1. Residents #48 and #49 experienced no negative outcomes and behavioral care plans are in place.2. Any resident with behavioral issues has the potential to be affected. Their clinical record has been reviewed and behavioral care plans have been implemented as indicated.3. The facility's policy for the Mood and Behavior Program has been reviewed and no changes are indicated at this time (See Attachment D). The Social Service Director has been re-educated regarding this policy (See Attachment G). A Psychoactive Monitoring Form has been implemented (See Attachment F).4. The Social Service Director or Designee will be responsible for completing the Psychoactive Monitoring Form on schedule work days to ensure behavioral care plans are in place. This will be done for 3 residents daily for two weeks, two times weekly for two weeks, then weekly thereafter for a minimum of six months. Should concern(s) be found, re-education will be provided. Results of these reviews will be discussed during the facility's quarterly QA meetings and the plan adjusted	03/25/2013

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	from the area. During a 3/1/13, 8:45 a.m. to 8:55 a.m. observation, Resident #49 roamed about the unit touching things. At 8:55 a.m. Resident #49 was at the nurses station removing all the monitoring books from the desk top. LPN #3 intervened and redirected the resident away from the desk. At 8:56 a.m., Resident #49 began to roam the hallway. At 8:57 a.m., Resident #49 entered the unit kitchen area. Resident #56 yelled for Resident #49 to leave the area. No staff were visible. Staff did not intervene. Resident #49 left the kitchen. During a 3/1/13 9:05 a.m. observation, Resident #49 approached Resident #56, who was seated in the wheelchair at the kitchen door. Resident #49 held out his hand and said some words which did not make sense. Resident #49 stepped close to Resident #56 extending his hand. Resident #56 became upset asking Resident #49 to stay away from him. Resident #49 stepped closer. There were no staff were visible in the area. Staff did not intervene. Resident #56 became more upset and shouted "Get the h--l out of here with that dumb s--t! Get		accordingly as indicated.	

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	out of here or I am going to kick your a--." Staff intervened and walked Resident #49 away from the area. During a 3/1/13, 12:45 p.m. observation, the Maintenance Supervisor located Resident #49 in another resident's room. Resident #49 had shoved both chairs in front of the door. He had removed his socks. He was walking around the room carrying a balloon bouquet which belonged to the resident who lived in the room. During the above behavioral events, the staff did not offer behavioral approaches to reduce behaviors. They only redirected the resident. At no time was the resident offered games, food/fluids, a walk or socialization in accordance with the resident's plan of care. Resident # 49's record was reviewed on 3/1/13 at 1:00 p.m. Resident # 49's current diagnoses included, but were not limited to, delusions and behavioral disturbances, anxiety, end stage dementia with aggressive features, depression and Alzheimer's disease. Resident #49 had a current, 2/4/13,			

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	care plan problem regarding "exhibits socially inappropriate behaviors such as: will move furniture around/flip furniture over, attempts to push res [residents] in w/c [wheelchair], wanders into other res rooms." Approaches to this problem included, but were not limited to, "Attempt to ascertain the trigger for socially inappropriate outbursts" and "Attempt diversion, distraction, and reorientation to calm the resident such as: games, food/drink, walking." Resident #49 had a current, 2/4/13, care plan problem regarding wandering behaviors. The problem indicated "the wandering places the resident at significant risk of getting to a potentially dangerous place and the wandering significantly intrudes on the privacy or activities of others." Approaches to this problem included, but were not limited to, "Encourage movement and exercise to reduce anxiety, agitation, and restlessness, and Involve the person in activities of interest such as: games, socialization, walking, Redirect pacing or restless behavior." Resident #49 had a current, 2/4/13, care plan problem regarding increased agitation in the late afternoon and evening. Approaches			

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	to this problem included, but were not limited to, "Provide activities in the AM and encourage rest after lunch to reduce evening fatigue provide exposure to the sun during the afternoon, if applicable." 2.) During a 2/28/13, 8:35 a.m. to 10:05 a.m. observation, Resident #48 moved restlessly about the unit in his wheelchair. He periodically moved his body up and down in the chair as if attempting to stand. He, at times, went over by the exit door and was redirected back to the TV by staff. Once during this time staff ambulated the resident about 15 feet. Other that this one time intervention, all other interventions were to redirect the resident back to the TV. During a 2/28/13, 1:50 p.m. to 2:45 p.m. observation, Resident #48 moved restlessly about the unit in his wheelchair. He again periodically moved his body up and down in the chair as if attempting to stand. He at times went over by the exit door and was redirected back to the TV by staff. During a 3/1/13, 8:45 a.m. to 9:45 a.m. observation, Resident #48 roamed restlessly about the unit in his wheelchair. At 9:45 a.m., Resident			

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	#48 accidentally ran over Resident #55's feet with his wheelchair. No staff where in the area when this accident occurred. Resident #55 pushed Resident #48's wheelchair away with a forceful shove. At no time during the residents restless roaming did the staff offer walking or snacks/fluids in accordance with the residents preferences. Resident #48's record was reviewed on 2/28/13 at 8:37 a.m. Resident # 48's current diagnoses included, but were not limited to, depression, anxiety, and Alzheimer's dementia with behaviors, agitation and aggression. Resident #48 had a current, 2/4/13, care plan problem regarding physically abusive behaviors and becoming aggressive with staff. Approaches to this problem included, but were not limited to, "Attempt to use diversion, distraction, and reorientation to calm the resident such as: walking, going outside (on nice days), snack/fluids." 3.) During a 3/4/13, 9:50 a.m., interview the Administrator indicated			

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	the Dementia Unit [The Cottage] had 13 residents, who all had a diagnoses of dementia or a related disorder. During a 2/28/13, 3:05 p.m. interview, C.N.A. #2, who was working on The Cottage Dementia Unit, indicated there were no specific behavior management plans. When a resident displayed behaviors, she addressed the behavior by trial and error and what she knew about the resident. During a 3/1/13, 10:10 a.m. interview, C.N.A. #4, who was working on The Cottage Dementia Unit, indicated she was unaware of any resident specific approach to behaviors. She just used "trial and error" when addressing resident behaviors. She indicated she just learned about each resident overtime or was told about them by other CNAs. She indicated there were no behavioral approaches on CNA assignment sheets. She indicated she had never looked in the chart at a care plan. During a 3/1/13, 10:58 a.m., interview, L.P.N. #3, who was working on The Cottage Dementia Unit, indicated there was not behavior management program which gave resident specific guidance about how			

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	to manage behavior. Staff learned to manage each resident's behavior by "trial and error." During a 3/1/13, 12:53 p.m. interview, The Social Services Consultant indicated all staff would go to the care plan to find what approach should be used to address resident behavior. During a 3/1/31, 12:55 p.m. interview, The Social Service Director indicated resident specific approaches to address resident specific behaviors were found on the care plan. She indicated there was no specific program in place to make these approaches available to direct care staff. She indicated a CNA would ask the nurse, who would go to the care plan and look at approaches and tell the C.N.A. what specific approaches to use for that resident. She indicated the facility had held behavioral inservices to train staff. During a 3/1/13, 1:10 p.m. interview, the Director of Nursing indicated she had recently become the Unit Director for The Cottage Dementia Unit. She indicated she had believed the specific approaches to resident behaviors were on the C.N.A. assignment sheet. She indicated the Assistant Director of Nursing updated			

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	the C.N.A. assignment sheets. She indicated she had not yet reviewed the behavior management for The Cottage. She indicated the facility did not want C.N.A.s to get into a resident's private clinical record to look at care plans. The facility should develop tools from the care plan for the C.N.A.s to use. 4.) Review of the CNA assignment sheet, which was provided by the R.N. consultant on 3/1/13 at 3:00 p.m., indicated resident behaviors and approaches to behavioral management were not listed on the form. The content of a 4/13/12, Behavioral Inservice was provided by the Social Service Designee on 3/1/13 at 2:00 p.m., indicated the following: "Procedure for the Behavior and Mood Program ...4. A written plan of care will be developed to address the behavior(s) and/or mood(s) including interventions to address any noted intrinsic and/or extrinsic factors precipitation the behavior(s) and/or mood(s) by social service and/or the interdisciplinary team." "Behavioral and Mood			

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	Communication Memo Form Procedure ...3. Upon witnessing a behavior and/or mood, staff will complete the Behavior and Mood communication Memo." 3.1-35(g)(2)			

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F000329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on observation, interview, and record review, the facility failed to ensure residents who received psychoactive medications had identified targeted behaviors which were being treated by the medication, a method to monitor targeted behaviors and/or a completed statement of contraindication when gradual dose reduction were not attempted for 2 of 10 residents reviewed for unnecessary medications (Resident # 48 and #55).	F000329	1. Residents #48 and #55 experienced no negative outcomes and their behavior programs have identified targeted behaviors listed, monitoring of targeted behaviors is taking place and a statement of contraindication to reduce the psychoactive medications is present in their clinical records as indicated.2. All residents receiving psychoactive medications have the potential to be affected. Their clinical records have been reviewed and their behavior programs have identified	03/25/2013

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	Findings include: 1.) Resident #55's record was reviewed on 2/28/13 at 9:00 a.m. Resident #55's current diagnoses included, but were not limited to, dementia with agitation, depression, anxiety and insomnia. Resident #55 had a current physician's order for the following psychoactive medications: a.) Seroquel 50 mg (an antipsychotic medication) 1 tablet 2 times daily. This order originated 2/2/13. b.) Trazadone 50 mg (an antidepressant also used to treat insomnia) 1 tablet daily at bedtime for insomnia. This order originated 2/2/13. c.) Zoloft 50 mg (an antidepressant) 1 tablet daily at bedtime for depression. This order originated 2/8/12. This order was an increase from a 2/4/13 dose of 25 mg 1 daily at bedtime. Resident #55 had a 2/19/13, "Mood and Behavior Monthly Monitoring Summary" which had a section		targeted behaviors listed, monitoring of targeted behaviors is taking place and a statement of contraindication to reduce the psychoactive medications is present in their clinical records as indicated.3. The facility's policies for Anti-anxiety Drug Use, Anti-depressant Drug Use, Antipsychotic Drug Use, Seditive/Hypnotic Drug Use, and Mood and Behavior Program have been reviewed and no changes are indicated at this time (See Attachments H, I, J, K, D). The nurses and care plan team have been re-educated on the policies (See Attachment E). A Psychoactive Monitoring Form has been implemented (See Attachment F).4. The Social Service Director or Designee will be responsible for completing the Psychoactive Monitoring Form on schedule work days to ensure identified targeted behaviors are listed, monitoring of targeted behaviors is taking place and gradual dose reductions are requested and if denied a statement of contraindication to reduce the psychoactive medications is present in their clinical records as indicated. This will be done for 3 residents daily for two weeks, two times weekly for two weeks, then weekly thereafter for a minimum of six months. A behavior meeting will be held on a monthly basis to review all residents receiving psychoactive medications on an	

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	labeled "Review of Mood and Behavior Monthly Flow Record Form-Mood(s)/Behavior(s) and # of Episodes:" This section was blank. The form did not identify any behaviors were being monitored. Resident #55's record lacked identified targeted behaviors treated by the psychoactive medications. During a 2/28/13, 8:30 a.m. to 9:30 a.m. observation, Resident #55 slept in a recliner in the TV lounge. During a 2/28/13, 1:50 p.m. to 2:45 p.m. observation, Resident #55 slept in a recliner in the TV lounge. During a 3/1/13, 8:45 a.m. to 9:00 a.m. observation, Resident #55 was seated in a recliner looking about. From 9:00 a.m. to 9:45 a.m., Resident #55 was asleep in a recliner. Resident #55 awoke at 9:45 a.m., when resident #48 accidentally ran over his feet with the wheelchair. Resident #55 forcefully pushed Resident #48's wheelchair away. At 10:05 a.m., Resident #55 was once again asleep in the recliner. 2.) Resident #48's record was reviewed on 2/28/13 at 8:37 a.m.		ongoing basis. Should concern(s) be found, re-education will be provided. Results of these reviews will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly as indicated.	

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	Resident # 48's current diagnoses included, but were not limited to, depression, anxiety, and Alzheimer's dementia with behaviors, agitation and aggression. Resident #48 had a current, 1/30/13, physician's order for the following psychoactive medications: a.) Remeron 15 mg (an antidepressant) 1 tablet at bedtime. This order originated 5/18/12. b.) Risperdal 0.25 mg (an antipsychotic) 1 tablet 2 times daily. This order originated 8/2/12. c.) Lorazepam 0.5 mg (an anti-anxiety) 1/2 tablet (0.25 mg) 3 times daily. This order originated 5/18/12. Resident #48 had a ,10/18/12, "Risk-Benefit Acknowledgement Form" which indicated: "Antidepressant Medication ... Remeron 15 mg po [orally] at hs [bed time] ... Gradual dose reduction (GDR) is clinically contraindicated at this time due to one or more of the following reasons: The continued use is in accordance			

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	with relevant current standards of practice. The physician's clinical rationale for why an attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying psychiatric disorder as follows: Res behavior stabilized after addition of medication. A GDR at this time would most likely result in negative outcome." The statement did not indicate how a reduction would impair resident functioning or exacerbate an underlying psychiatric disorder. It did not assess the resident's condition. It simply stated behaviors could return. Resident #48 had a, 10/18/12, "Risk-Benefit Acknowledgement Form" which indicated: "Antipsychotic** Medication ... Risperdal 0.25 po [orally] bid [2 times daily] ... Gradual dose reduction (GDR) is clinically contraindicated at this time due to one or more of the following reasons: The continued use is in accordance with relevant current standards of practice. The physician's clinical rationale for why an attempted dose reduction would be likely to impair the			

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	resident's function or cause psychiatric instability by exacerbating an underlying psychiatric disorder as follows: Res [resident] behaviors currently stabiliting [sic]. A GDR at this time would most likely result in negative outcome. The statement did not indicate how a reduction would impair resident functioning or exacerbate an underlying psychiatric disorder. It did not assess the resident's condition. It simply stated behaviors could return. Resident #48 had a , 9/26/12, "Risk-Benefit Acknowledgment Form-Anti=Anxiety Medication" which indicated: "Lorazepam 0.5 mg (an anti-anxiety) 3x [times] daily... Gradual dose reduction (GDR) is clinically contraindicated at this time due to one or more of the following reasons: The continued use is in accordance with relevant current standards of practice. The physician's clinical rationale for why an attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying psychiatric disorder as follows:			

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	Res [resident] behaviors more stable with current medication regimen. GDR would most likely result in neg [negative] outcome." The statement did not indicate how a reduction would impair resident functioning or exacerbate an underlying psychiatric disorder. It did not assess the resident's condition. It simply stated behaviors could return. Resident #48 had a 2/19/13, "Mood and Behavior Monthly Monitoring Summary" which had a section labeled "Review of Mood and Behavior Monthly Flow Record Form-Mood(s)/Behavior(s) and # of Episodes:" This section was blank. The form did not identify any behaviors were being monitored. Resident #48 had a 1/9/13, "Mood and Behavior Monthly Monitoring Summary" which had a section labeled "Review of Mood and Behavior Monthly Flow Record Form-Mood(s)/Behavior(s) and # of Episodes:" This section was blank. The form did not identify any behaviors were being monitored. Resident #48 had a 12/5/12, "Mood and Behavior Monthly Monitoring Summary" which had a section			

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	labeled "Review of Mood and Behavior Monthly Flow Record Form-Mood(s)/Behavior(s) and # of Episodes:" This section was blank. The form did not identify any behaviors were being monitored. No November 2012 form was available. Resident #48 had a 10/17/12, "Mood and Behavior Monthly Monitoring Summary" which had a section labeled "Review of Mood and Behavior Monthly Flow Record Form-Mood(s)/Behavior(s) and # of Episodes:" This section was blank. The form did not identify any behaviors were being monitored. Review of the December 2012, January 2013 and February 2013 "Mood Behavior Monthly Flow Record" indicated the Resident #28 had displayed no behaviors in the three month period. Resident #48's record lacked identified targeted behaviors being treated by the 3 psychoactive medications or a method of monitoring targeted behaviors. During a 2/28/13, 8:35 a.m. to 10:05 a.m. observation, Resident #48			

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	moved restlessly about the unit in his wheelchair. He periodically moved his body up and down in the chair as if attempting to stand. He at times went over by the exit door and was redirected back to the TV by staff. Once during this time staff ambulated the resident about 15 feet. Other that this one time intervention, all other interventions were to redirect the resident back to the TV. During a 2/28/13, 1:50 p.m. to 2:45 p.m. observation, Resident #48 moved restlessly about the unit in his wheelchair. He again periodically moved his body up and down in the chair as if attempting to stand. He at times went by the exit door and was redirected back to the TV by staff. During a 3/1/13, 8:45 a.m. to 9:45 a.m. observation, Resident #48 roamed about the unit in his wheelchair. At 9:45 p.m., Resident #48 accidentally ran over Resident #55's feet with his wheelchair. No staff where in the area when this accident occurred. Resident #55 pushed Resident #48's wheelchair away with a forceful shove. 3.) During a 2/28/13, 3:00 p.m. interview, L.P.N. #1, who was working on The Cottage Dementia Unit,			

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	indicated there was not a place where specific targeted behaviors were monitored. All behaviors were documented on a behavior form. The behavior form was then collected by the Social Service Director who used them to monitor behaviors. During a 2/28/13, 3:05 p.m. interview, C.N.A. #2, who was working on The Cottage Dementia Unit, indicated there were no specific behavior management plans. When a resident displayed behaviors, she addressed the behavior by trial and error and what she knew about the resident. Staff were supposed to document all behaviors on a behavior form. She not had been instructed to monitor any specific behaviors. During a 3/1/13, 10:58 a.m., interview, L.P.N. #3, who was working on The Cottage Dementia Unit, indicated there was no location to monitor specific target behaviors which were being treated by psychoactive medications. All behaviors were supposed to be documented on a behavior monitoring form. Staff may become accustomed to behaviors and not document them. During a 2/28/13, 2:50 p.m. interview, The Social Services Consultant			

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	indicated specific targeted behaviors were not identified and monitored. 4.) Review of a current, undated, facility policy titled "Anti-anxiety Drug Use Policy," which was provided by the R.N. Consultant on 3/1/13 at 2:45 p.m., indicated the following: "Purpose: To ensure ant-anxiety drugs will be administer only when medically indicated to treat a specific condition and help promote or maintain a resident's highest practicable mental, physical, and psychosocial well-being. "Ongoing monitoring will occur to assess risk/benefit relationships of anti-anxiety drug therapy including the appropriateness of drug selection and dosage and to monitor adverse consequences related to anti-anxiety medication use-recognizing, evaluating and modifying the regimen when appropriate. "For any individual who is receiving an anti-anxiety medication, the GDR may be considered clinically contraindicated if: The continued use is in accordance with relevant current standards of practice and the physician has documented the clinical rationale for why an attempted dose reduction			

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	would be likely to impair the resident's function or cause psychiatric instability by exacerbating and underlying psychiatric disorder>' "...7. Delirium, dementia, and other cognitive disorders with associated behaviors that: -Are quantitative; and objectively documented -Are present -Are not due to preventable or correctable reasons: and -Constitute clinically significant distress or dysfunction to the residents or represent a danger to resident or others." Review of a current, undated, facility policy titled, "Sedative/Hypnotic Drug Use Policy," which was provided by the R.N. Consultant on 3/1/13, at 2:45 p.m., indicated the following: "Purpose: To ensure sedative/hypnotic drugs will be administered only when medically indicated to treat a specific condition and help promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being. "Ongoing monitoring will occur to assess risk/benefit relationships of anti-anxiety drug therapy including the			

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	appropriateness of drug selection and dosage and to monitor adverse consequences related to anti-anxiety medication use-recognizing, evaluating and modifying the regimen when appropriate. "Clinically contraindicated means: The continued use is in accordance with relevant current standards of practice and the physician has documented the clinical rationale for why an attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating and underlying psychiatric disorder." Review of a current, undated facility policy titled "Antidepressant Drug use Policy," which was provided by the R.N. Consultant on 3/1/13 at 2:45 p.m., indicated the following: "Purpose: To ensure that antidepressant drugs will be administered only when medically indicated to treat a specific condition and help maintain the resident's highest practicable mental, physical, and psychosocial well being. "The GDR may be considered contraindicated if: The continued use is in accordance			

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	with relevant current standards of practice and the physician has documented the clinical rationale for why an attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating and underlying psychiatric disorder." Review of a current, undated, facility policy titled"Antipsychotic Drug Use Policy," which was provided by the R.N. Consultant on 3/1/13 at 2:45 p.m., indicated the following: "Purpose: To ensure that anti-psychotic drugs will be administered only when medically indicated to treat a specific condition and help promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being. "Criteria: Since diagnosis do not warrant the use of Antipsychotic medications the clinical condition must also meet at least one of the following criteria (a or b or c): a. The symptoms are identified as being due to mania or psychosis ... b. The behavioral symptoms present a danger to the resident or to others... c. The symptoms are significant enough that the resident is experiencing one or more of the			

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	following: inconsolable or persistent distress...; a significant decline in function; and/or substantial difficulty receiving needed care... "For any individual who is receiving an Antipsychotic medication to treat behavioral symptoms related to dementia, the GDR may be considered clinically contraindicated if: The resident's target symptoms returned or worsened after the most recent attempt at GDR within the facility; AND The physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or increase distressed behavior." 3.1-48(a)(3) 3.1-48(a)(4) 3.1-48(b)(2)			

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