STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155480	A. BUILDING 00 B. WING	03/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKVILLE HEALTHCARE CENTER	11049 SR 101 BROOKVILLE, IN 47012

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F000000	This visit was for a Recertification and State Licensure Survey. Survey dates: March 4, 5, 7, 8, 11, and 12, 2013 Facility number: 000550 Provider number: 155480 AIM number: 100286110 Survey team: Barbara Gray RN TC Sharon Lasher RN Leslie Parrett RN Angel Tomlinson RN Census bed type: SNF/NF: 73 Total: 73 Census payor type: Medicare: 11 Medicaid: 45 Other: 17 Total: 73 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review 3/19/13 by Suzanne Williams, RN	F000000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance.The faciilty respectfully requests that this plan of correction be considered for paper compliance.	

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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F000222 SS=D	483.13(a) RIGHT TO BE FREE FROM CHEMICAL RESTRAINTS The resident has the right to be free from any chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.			
	Based on interview and record review, the facility failed to ensure a resident was free from chemical restraint use, related to the administration of multiple doses of ativan (antianxiety) medication, one dose of haldol (antipsychotic) medication and seroquel (antipsychotic) medication daily for 1 of 1 resident reviewed for chemical restraints (Resident #91). Finding include: 1.) Review of the record of Resident #91 on 3-11-13 at 10:20 a.m. indicated the resident's diagnoses included, but were not limited to, pneumonia, agitation, dementia, hypertension and diabetes. Resident #91 was admitted on 12-12-12 to the facility from the hospital and passed away on 12-25-12. The hospital discharge medication order dated 12-12-12 for Resident	F000222	F222 Requires the facility to ensure residents are free from chemical restraint use, related to the administration of multiple doses of antianxiety medication and antipsychotic medications.1. Resident #91 was monitored while at the facility for safety due to his behaviors. 2. All residents have the potential to be affected, thus, the following corrective actions were taken. All residents within the facility had their medications reviewed to ensure their medications had the proper dosage and indication for use. All new admits and re-admits will also have their medications reviewed to ensure their medications had the proper dosage and indication for use. 3 The policies and procedures for the use of antipsychotic drugs and antianxiety drugs were reviewed and no changes are indicated at this time. All staff was educated (See attachment H) on the antipsychotic drug use and antianxiety drug use policies and procedures. (See attachments A1 and A2) An emphasis was given to the staff to ensure the resident had a proper diagnosis for the use of	03/22/2013

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	#91 indicated the resident had an order for seroquel 12.5 milligram tablet every 6 hours prn (as needed) for agitation. The physician order for Resident #91 dated 12-12-13 indicated the resident was ordered ativan 0.5 milligrams by mouth every 8 hours prn for agitation, and seroquel 25 milligrams at bedtime routinely for dementia with behaviors. The telephone physician order dated 12-13-12 for Resident #91 indicated the resident's ativan was increased to 1 milligram every 6 hours prn for anxiety. The telephone physician order dated 12-15-12 for Resident #91 indicated the resident ordered haldol one milligram now for agitation. The telephone physician order dated 12-16-12 for Resident #91 indicated to discontinue the seroquel 25 milligrams at bedtime and increase it to seroquel 50 milligrams at bedtime for dementia with behaviors. The Minimum Data Set (MDS) assessment for Resident #91 dated 12-21-12 indicated the resident was severely impaired for cognitive skills		antipsychotic and antianxiety medications prior to giving the medication. 4. The DON or her designee will review all new orders, new admits and re-admit physician orders to ensure that all antipsychotic or antianxiety medications have proper indication for use that addresses their behaviors daily for four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly until compliance is obtained and maintained (See attachment B). The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action will be adjusted accordingly if warranted.	

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	for daily decision making, required extensive assistance of two staff to transfer and extensive assistance from two staff with walking in his room. The controlled drug record for Resident #91 indicated the resident received ativan 0.5 milligram (mg) 1 time on 12-12-12, ativan 0.5 mg 3 times on 12-13-12, ativan 1 mg 3 times on 12-14-12, ativan 1 mg 4 times on 12-15-12, ativan 1 mg 4 times on 12-16-12, ativan 1 mg 3 times on 12-17-12, ativan 1 mg 3 times on 12-18-12, ativan 1 mg 3 times on 12-19-12, ativan 1 mg 3 times on 12-20-12, ativan 1 mg 2 times on 12-21-12, ativan 1 mg 2 times on 12-22-12 and ativan 1 mg 3 times on 12-23-12. This indicated the resident received 34 doses of ativan in 12 days. The prn flow sheet for Resident #91 indicated the following for ativan medication administration: 12-12-12 the resident had increased agitation and no documented interventions attempted, 12-14-12 the resident had increased agitation and no documented interventions attempted, 12-16-12 the resident had increased agitation and "other" was circled as an intervention, 12-16-12 the resident			

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	had increased agitation and position change and "other" was circled as interventions, 12-23-12 the resident had agitation/anxiety and no interventions were documented. There was no other documentation on the flow sheet related to the other times the resident received the ativan. The mood and behavior communication memo for Resident #91 dated 12-15-12 at 12:00 a.m. indicated the resident was trying to climb out of bed and was calling out and removing his clothing. The possible trigger was the resident was in an unfamiliar environment. Interventions attempted were unsuccessful and prn medication was administered and successful. The mood and behavior communication memo for Resident #91 dated 12-15-12 at 6:00 a.m. indicated the resident was trying to climb out of bed, calling out and undressing. The possible trigger was unfamiliar environment. The interventions attempted were unsuccessful and prn medication was administered and successful. The mood and behavior communication memo for Resident #91 dated 12-15-12 at 3:30 p.m.			

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	indicated the resident had increased restlessness and was attempting to get out of bed. The interventions attempted were unsuccessful and prn medication was administered and successful. The mood and behavior communication memo for Resident #91 dated 12-15-12 at 4:00 p.m. indicated the resident status was unchanged and he had no improvement from the ativan administered. The resident was still very restless and trying to get out of bed. The resident had been toileted, repositioned and one to one given by nurse aide and the resident was still very restless. The mood and behavior communication memo for Resident #91 dated 12-15-12 at 5:00 p.m. indicated the resident was severely agitated and could not be calmed by intervention measures. The family was called but were not able to come to the facility at this time. The physician was called and order was received for haldol 1 mg Intramuscular (IM) injection. The mood and behavior communication memo for Resident #91 dated 12-15-12 at 5:45 p.m.			

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	indicated the resident's condition was unchanged, he continued to yell out and was attempting to crawl out of bed. The resident was assisted to the bathroom and then to his wheelchair. The resident was brought to the nursing station as an distraction. The resident's family was on their way to the facility. The mood and behavior communication memo for Resident #91 dated 12-15-12 at 7:00 p.m. indicated the family felt other family members visiting the resident may have been the cause of the resident's behaviors. The family member took the resident in his wheelchair to look at the birds. The resident seemed to be doing better. The resident was much calmer. The mood and behavior communication memo for Resident #91 dated 12-15-12 at 9:00 p.m. indicated after the resident's family left the resident became restless again. The interventions attempted were unsuccessful. The mood and behavior communication memo for Resident #91 dated 12-15-12 at 9:30 p.m. indicated ativan was given for restlessness. The interventions			

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	attempted were unsuccessful. The mood and behavior communication memo for Resident #91 dated 12-16-12 at 10:00 p.m. indicated the resident was yelling out. The interventions attempted were unsuccessful and prn medication was given and was successful. The mood and behavior communication memo for Resident #91 dated 12-16-12 at 3:30 a.m. indicated the resident had increased anxiety and increased agitation. The interventions attempted were unsuccessful and prn medication was given and was successful. The mood and behavior communication memo for Resident #91 dated 12-17-12 at 4:00 a.m. indicated the resident was yelling out and increased anxiety. The interventions attempted were unsuccessful and prn medication was given and was successful. There was no further mood and behavior documentation for Resident #91. The resident was in his room during all the behaviors except on 12-15-12 when the family took the resident to look at the birds. Interview with Resident #91's family			

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	member on 3-11-13 at 3:00 p.m. indicated the resident walked with a walker prior to coming to the nursing home. The family member indicated the resident had dementia and would become upset in unfamiliar places. The family member indicated the resident had lived with family prior to being hospitalized and coming to the facility. The family member indicated the facility had not talked with them about the resident using ativan. The family member indicated ativan was ineffective for the resident and did not help him at all. The family member indicated in 2012 the resident had been at another facility for rehabilitation and the facility had given him ativan. The family member indicated they requested for the resident not to receive ativan due to it made him restless through out the night and too lethargic during the day. The family member indicated the resident did not ever take ativan when he was home. The family member indicated the resident did take seroquel at home. The family member indicated the resident required to have someone sit with him 24 hours a day at home and could never be left alone. The family member indicated the resident was very confused. The family member indicated the resident liked to read but could not see to read			

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	now. The family member indicated the one thing that helped him be occupied and calm was sorting silverware and putting it in a divider. Interview with the Director Of Nursing (DON) on 3-11-13 at 3:30 p.m. indicated Resident #91 was extremely combative. When queried why the staff did not let the resident get out of bed or come out of his room, the DON indicated she could not say that the staff did not get him out of bed and up in wheelchair because it was not documented. The DON indicated the resident attempting to get out of bed was not his only behavior. The documentation did not address that he was combative. When queried why the resident was on seroquel without a diagnosis for it, the DON indicated the family told the facility that it was the only medication that helped the resident. The DON indicated the floor nurses and herself were responsible to monitor for side effects of antianxiety and antipsychotic medications. Interview with the DON and Assistant Director Of Nursing (ADON) on 3-12-13 at 11:30 a.m. indicated the reason Resident #91 was not brought out of his room was because he had Methicillin Resistant Staphylococcus			

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	Aureus (MRSA) (a contagious bacterial infection) and was on isolation precautions. The DON indicated the one time the facility brought the resident out to the nursing station the resident had to wear a mask. The DON indicated she thought the reason the staff did not get the resident up in a chair in his room was because he was high risk for falls, and they did not want to leave him alone in his room in a chair. The DON indicated when the resident was admitted to the facility he had an order for seroquel prn. The DON indicated she had the nurse call the Physician and have it changed to routine because the facility was not allowed to have antipsychotic medication ordered as a prn. The DON indicated when the resident was admitted, the facility knew he had problems with anxiety so we had ativan ordered for him. The DON indicated the Administrator, DON, ADON, nurse managers, therapy, and MDS nurses meet on Tuesdays and look at all residents falls and past interventions and medications with possible relation to falls. The ADON indicated when Resident #91 received the haldol it did not effect him at all and his family still had to come sit with him.			

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	The "2010 Nursing Spectrum Drug Handbook" indicated haldol was used to treat psychotic disorders, Tourettes syndrome and schizophrenia. The box warning for haldol indicated "drug increased mortality in elderly patients with dementia related psychosis." "Drug isn't approved for treatment of dementia-related psychosis." The adverse reactions to haldol included, but were not limited to, restlessness, confusion, vertigo, seizures and insomnia. The handbook indicated ativan was used to treat anxiety. The precautions indicated to use ativan cautiously with the elderly patients. The adverse reactions to ativan included, but were not limited to, agitation, disorientation, dizziness, incoordination and amnesia. The patient monitoring for ativan indicated "watch closely for Central Nervous System (CNS) depression." "Institute safety precautions as needed to prevent injury." "Monitor for signs and symptoms of overdose such as confusion." The drug handbook indicated seroquel was used for schizophrenia and bipolar disorder. The box warning for seroquel indicated "Elderly patients with dementia-related psychosis are at increased risk for death." "Don't give drug to patients with dementia-related psychosis." The adverse reactions to			

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	haldol included, but were not limited to, dizziness, sedation, cognitive impairment, hypotension and flu like symptoms. The antianxiety drug use policy, provided by medical records on 3-11-13 at 4:44 p.m. indicated the purpose was to ensure that anti-anxiety drugs will be administered only when medically indicated to treat specific condition and help promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being. Anti-anxiety drugs will not be used as a restraint. The facility assures that residents are being adequately monitored for adverse reactions such as: increased confusion and increased risk for falls. The antipsychotic drug use policy, provided by medical records on 3-11-13 at 4:44 p.m. indicated the purpose was 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. "Anti-psychotic drugs will not be used as a restraint." Inadequate indications for the use of antipsychotic			

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	medications included, but were not limited to, wandering, restlessness, impaired memory, mild anxiety, insomnia, inattention or indifference to surroundings, fidgeting, nervousness and verbal expressions. Monitoring/adverse consequences included, but were not limited to, falls and excessive sedation. 3.1-3(w) 3.1-26(m)			

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F000279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).			
	Based on observation, interview, and record review, the facility failed to implement a plan of care, for supervision during meals, for 1 of 26 residents reviewed for care plans. (Resident #21) Findings include: On 3/8/13 at 9:27 A.M., Resident #21 was observed sitting in her bed, with the head of her bed raised. She was eating breakfast in her bedroom alone, independently from her bedside table. Resident #21	F000279	F 279 Requires the facility to implement a plan of care, for supervision during meals1. Resident #21 was seen by Speech Therapy on 3/8/13. A new order was obtained per the recommendation of the speech therapist that the resident required no supervision.2. All residents have the potential to be affected, thus, the following corrective actions were taken. All residents within the facility had their meal service orders reviewed to ensure if a physician order for supervision was present that it was followed. Currently, no orders are present for supervision	03/22/2013

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	indicated she always took a long time to eat. She stated "I'm trying to get my speed more so, but it doesn't seem like it's working very good." Her meal tray consisted of milk, apple juice, coffee, cereal with milk, soft eggs, ground sausage, and cut up pancake. Her diet ticket laying on her tray indicated a Mechanical Soft diet. On 3/8/13 at 10:32 A.M., the Director of Nursing (DoN) indicated Resident #21 should have been supervised during her meal. Resident #21's record was reviewed on 3/8/13 at 10:37 A.M. Diagnoses included, but were not limited to, dementia, depression, history of tongue injury, chronic obstructive pulmonary disease, and hiatal hernia. A physician's recapitulation order for March, 2013, initiated 7/26/11, indicated Resident #21 to be supervised for meals. Resident #21's quarterly Minimum Data Set (MDS) assessment, dated 1/8/13, indicated she understood and had the ability to understand others. She scored 6 on her Brief Interview for Mental Status, indicating her cognitive status was severely impaired. She ate independently with		during meal service. If an order is obtained, then, on the CNA assignment sheet it will be noted for supervision during meals.3 The policy and procedure for physician's orders was reviewed and no changes are indicated at this time. All staff was educated (See attachment H) on the physician's order policy and procedure (See attachment C). The staff was also educated that if a resident is to be supervised during meal service that it will be noted on their CNA assignment sheet.4. The DON or her designee will monitor two meal services a day to ensure that residents are receiving supervision as ordered by the physician daily for four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly until compliance is obtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action will be adjusted accordingly if warranted.	

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	set up help only. She had signs and symptoms of a possible swallowing disorder, in that she complained of difficulty or pain with swallowing. A Nutrition Care Plan for Resident #21, updated 1/29/13, did not provide any interventions related to supervised meals. An interview with the Dietary Manager on 3/8/13 at 1:13 P.M., indicated Resident #21 should be supervised at meals. She indicated no information or interventions were documented on Resident #21's Nutrition Care Plan related to meal supervision. She indicated she reviewed and updated Resident #21's Nutrition Care plan on 1/29/13. The Care Plan Development and Review Procedure, provided by Medical Records on 3/11/13 at 4:33 P.M., indicated the following: "Purpose: To assure that a comprehensive care plan for each resident includes measurable objectives and timetables to meet the resident's medical and psychosocial needs. Policy: 1. An interdisciplinary team, in coordination with the resident and his/her family will develop a comprehensive care plan for each resident. 2. The comprehensive care			

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	plan has been designed to: Incorporate identified problem areas. Incorporate risk factors associated with identified problems. Build on the resident's strengths. Reflect treatment goals and objectives in measurable outcomes. Identify the professional services that are responsible for each element of care. Prevent the declines in the resident's functional status and/or functional levels. Enhance the optimal functioning of the resident by focusing on a rehabilitation program... 4. Care plans are revised as changes in the resident's condition dictate. Changes in the resident's care or condition must be addressed on the care plan (i.e. physician's orders, diet changes, therapy changes, behavior changes, ADL changes, skin problems, etc)... 7. Care plans are reviewed and revised as changes occur. Interdisciplinary team review will occur at least quarterly on all residents...." 3.1-35(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 follow a physician's order for supervised meals and update the physician's order to reflect the correct diet, for 1 of 26 residents reviewed for physician's orders. (Resident #21) Findings include: On 3/8/13 at 9:27 A.M., Resident #21 was observed sitting in her bed, with the head of her bed raised. She was eating breakfast in her bedroom alone, independently from her bedside table. Resident #21 indicated she always took a long time to eat. She stated "I'm trying to get my speed more so, but it doesn't seem like it's working very good." Her meal tray consisted of milk, apple juice, coffee, cereal with milk, soft eggs, ground sausage, and cut up pancake. Her diet ticket lying on her tray indicated a Mechanical Soft diet. On 3/8/13 at 10:32 A.M., the Director of Nursing (DoN) indicated a Mechanical Soft diet was the correct	F000282	F282 Requires the facility to follow a physician's order for supervised meals and update the physician's order to reflect the correct diet.1. Resident #21 had a clarification order to her diet. Resident is to receive a mechanical soft diet.2. All residents have the potential to be affected, thus, the following corrective actions were taken. All residents within the facility had their diet orders reviewed to ensure to matched the tray cards from dietary.3 The policy and procedure for physician's orders was reviewed and no changes are indicated at this time. All staff was educated (See attacment H) on the physician's order policy and procedure. (See attachment C)4. The DON or her designee will review all new orders, new admit and re-admit orders to ensure that the meal tray cards have the proper diet per physician's orders daily for four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly until compliance is obtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan	03/22/2013

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	diet for Resident #21 and she should have been supervised during her meal. Resident #21's record was reviewed on 3/8/13 at 10:37 A.M. Diagnoses included, but were not limited to, dementia, depression, history of tongue injury, chronic obstructive pulmonary disease, and hiatal hernia. A physician's order dated 7/26/11, indicated Resident #21 would be served a Mechanical Soft diet and be supervised at meals. A physician's recapitulation order for March, 2013, indicated Resident #21 was to be served a regular diet and was to be supervised for meals. Resident #21's quarterly Minimum Data Set (MDS) assessment, dated 1/8/13, indicated she understood and had the ability to understand others. She scored 6 on her Brief Interview for Mental Status, indicating her cognitive status was severely impaired. She ate independently with set up help only. She had signs and symptoms of a possible swallowing disorder, in that she complained of difficulty or pain with swallowing. A Dietary Progress Note for Resident		of action will be adjusted accordingly if warranted.	

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	#21 indicated the following: Resident #21's current diet was a Mechanical Soft and she required supervision at meals. Resident #21's weight was stable. A Nutrition Care Plan for Resident #21, updated 1/29/13, indicated Resident #21 received a Mechanical Soft diet. An interview with the Dietary Manager on 3/8/13 at 1:13 P.M., indicated Resident #21 received a Mechanical Soft diet and should be supervised at meals. She indicated no information or interventions were documented on Resident #21's Nutrition Care Plan related to meal supervision. She indicated she reviewed and updated Resident #21's Nutrition Care plan on 1/29/13. An interview with the DoN on 3/11/13 at 9:43 A.M., indicated Resident #21 had not had any episodes of choking. The DoN indicated Resident #21 had been weak and hospitalized in July 2011. Resident #21 returned from the local hospital on 7/26/11, with an order for a Mechanical Soft diet and supervision with meals. She indicated Resident #21's diet has not changed and that was Resident #21's correct diet order. She indicated			

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	Resident #21's March, 2013, recapitulation order was incorrect and should say Mechanical Soft diet instead of Regular diet. A Physician's Orders Procedure provided by Medical Records on 3/11/13 at 4:33 P.M., indicated the following: "Purpose: To ensure accurate and complete physician's orders. Procedure: 1. Transcribe new orders on physician's T/O form... 5. Transcribe new order on MAR or TAR as indicated. Follow order through to completion - make appointments, order labs, notify pharmacy, etc...." 3.1-35(g)(2)			

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F000311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. Based on observation, interview and record review, the facility failed to implement a restorative nursing program for 2 of 2 residents reviewed for activities of daily living. (Resident #55 and #96) Findings include: 1.) The record of Resident #55 was reviewed on 3/7/13 at 2:00 p.m. Resident #55's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, dementia and osteoporosis. Resident #55's MDS (Minimum Data Set) assessment, dated 2/8/13, indicated the resident needed extensive assistance with dressing. Resident #55's MDS assessment, dated 1/24/13, indicated the resident had been independent with dressing, with no help needed from staff. Resident #55's restorative care plan, dated 2/25/13, indicated "resident is being enrolled in the following	F000311	F311 Requires the facility to implement a restorative nursing program for activities of daily living.1. Residents #55 and #96 have improved to their prior functional ability with activity of daily living. 2. All residents have the potential to be affected, thus, the following corrective actions were taken. All residents within the facility were reviewed to ensure if there was a decline with their ADL status that they were placed on a restorative program or were referred to therapy.3 The policy and procedure for restorative nursing was reviewed and no changes are indicated at this time. Restorative staff, MDS staff and therapy staff was educated on the restorative nursing policy and procedure. 4. The DON or her designee will review all MDS completed to ensure if there is a decline in adl status that the resident is immediately placed on restorative nursing or therapy according to their decline; daily for four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly until compliance is obtained and maintained (See attachment D). The audits will be reviewed	03/22/2013

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	program, transfers, AROM (active range of motion) walking, dressing/grooming, PROM (passive range of motion) and eating/swallowing." Resident #55's document titled "Restorative Nursing Tracking Log" under the program "dressing/grooming" the area was blank indicating the program of dressing/grooming was not completed by the restorative program. During an interview on 3/8/13 at 9:00 a.m., Resident #55 indicated the CNAs help her get dressed but she does some of getting dressed herself. Resident #55, stated "I can do it but it takes me so much longer." During an interview on 3/8/13 at 2:00 p.m., Restorative CNA #13, stated "we work with (Resident #55) with ROM and walking but not with her dressing." During an interview on 3/11/13 at 11:17 a.m., CNA #14 stated "sometimes (Resident #55) helps with her dressing and sometimes I do it all." 2.) Review of the record of Resident #96 on 3-7-13 at 8:50 a.m. indicated		during the facility's quarterly quality assurance meetings and the plan of action will be adjusted accordingly if warranted.	

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	the resident's diagnoses included, but were not limited to, hypertension, restless leg syndrome, legally blind and dementia. The Minimum Data Set (MDS) assessment for Resident #96 dated 9-14-13 indicated the resident required limited assistance from staff and was highly involved with dressing. The MDS assessment for Resident #96 dated 12-11-12 indicated the resident required extensive assistance with from staff with dressing. The restorative program for Resident #96 with an original date of 9-20-12 indicated the resident was on a Active Range Of Motion (AROM) and walking program. The care plan for Resident #96 dated 9-26-12 and a review date of 12-18-12 indicated the resident required two people to assist with Activities Of Daily Living (ADL's) due to being legally blind, dementia and unsteady gait. The interventions included, but were not limited to, dress the resident in clothes that were clean. Interview with Resident #96 on 3-8-13			

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	at 9:05 a.m. indicated the staff assisted with her dressing. During observation of the resident at this time, she was sitting in a wheelchair and was dressed in slacks and a shirt. Interview with CNA #6 on 3-8-13 at 10:40 a.m. indicated she cared for Resident #96 and was familiar with the resident's needs. CNA #6 indicated the resident did require extensive assistance with dressing about 50 percent of the time. CNA #6 indicated she had noticed a decline with the resident's ability to do things for herself. Interview with Restorative Aide #7 on 3-8-13 at 1:10 p.m. indicated Resident #96 was on an ambulation and AROM program. Restorative Aide #7 indicated Resident #96 participated well in the restorative program. Restorative Aide #7 indicated therapy decided which restorative programs residents should be on. Interview with Certified Occupational Therapy Assistant (COTA) #8 on 3-11-13 at 9:40 a.m. indicated when Resident #96 was admitted to the facility therapy screened her and the resident was functional. COTA # 8			

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	indicated nursing should have made a referral to therapy regarding the resident's ability to dress herself had declined. COTA #8 indicated therapy had not received any referrals from nursing regarding this resident's decline in dressing. COTA #8 indicated the referral should have come from nursing staff that directly cared for the resident and it would typically be the resident's nurse. Interview with the MDS consultant #9 on 3-11-13 at 10:50 a.m. when queried who was responsible to monitor residents for decline with ADL's assistance and place the resident on an appropriate program to help improve their ability. The MDS consultant #9 indicated the Restorative Aides, MDS nurses and the nursing department meet weekly to ensure residents are doing well on their restorative program and to address residents who have had a decline. 3.1-38(a)(2)(A)			

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F000314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on interview and record review, the facility failed to implement interventions specific to preventing an unstageable pressure ulcer to the heel of 1 of 3 residents reviewed for pressure ulcers of 3 who met the criteria for pressure ulcers. Resident #79 entered the facility without any pressure ulcers. Findings include: The record of Resident #79 was reviewed on 3/11/13 at 1:00 p.m. Resident #79's diagnoses included, but were not limited to, recent left hip fracture, chronic obstructive pulmonary disease, dementia and congestive heart failure. Resident #79's MDS (Minimum Data Set), assessment, dated 12/24/12, indicated the following	F000314	F314 Requires the facility to prevent unstageable pressure ulcers to the resident who meet criteria for pressure ulcers.1. Resident #79 pressure ulcer was improving with the treatment ordered per the physician.2. All residents have the potential to be affected, thus, the following corrective actions were taken. All resident's Braden Scale were reviewed to ensure that all interventions were in place according to the score.3 The policy and procedure for skin management was reviewed and no changes are indicated at this time. All staff was educated (See attachment H) on the skin management policy and procedure as well as the Braden Scale assessment and scoring for preventative interventions. (See attachments E1 and E2)4. The DON or her designee will review all new admit and re-admit Braden scales plus 5 other resident's Braden Scales to	03/22/2013

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	- BIMS, (Brief Interview for Mental Status), 7; a score of 0-7 indicating severe impairment of cognition - bed mobility, extensive assistance with two + person physical assist - transfer, extensive assistance with two + person physical assist - number of unstageable pressure ulcers with suspected deep tissue injury in evolution, 1. Resident #79's care plan, dated 12/24/12, indicated "Problem, resident has a pressure area. Goal, pressure area will not open and heal without complications. Interventions, notify physician and responsible party, provide treatment as ordered, head to toe assessment weekly, provide pressure relieving device to reduce pressure, notify physician if area not improving and Z flow boot (pressure reducing) to left foot." Resident #79's "Admission Nursing Assessment," dated 12/17/12, indicated no pressure areas on admission. Resident #79's physician's orders, dated 12/24/12, indicated "skin prep (skin protecting dressing), left heel, every shift and Z flow boot to left heel, at all times."		ensure pressure ulcer interventions are in place to prevent pressure ulcers daily for four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly until compliance is obtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action will be adjusted accordingly if warranted.	

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	Resident #79's "Braden Scale for Predicting Pressure Sore Risk," dated 12/17/12, indicated a score of 18 with a score of 15-18, indicating, at risk for pressure ulcers and interventions including, but not limited to, "protect heels." Resident #79's "Pressure Ulcer Flow sheet" indicated the following: - 12/24/12, stage, DTI (suspected deep tissue injury), size, length and width, 1.5 cm (centimeters) x 1.5 cm, treatment/changes recommended, skin prep/z flow boot, description of site/location, left heel 1.5 cm deep purple - 12/31/12, stage, DTI, size, length and width, 1.5 cm x 1.5 cm, treatment/changes recommended, skin prep - 1/7/13, stage, DTI, size, length and width, 1.5 cm x 1.5 cm, treatment/changes recommended, skin prep During an interview on 3/12/13 at 12:35 p.m., the wound nurse indicated Resident #79 did not have any pressure ulcers when she was admitted to the facility and there was not a care plan for the prevention of any pressure areas until Resident #79 developed the area on her left heel on 12/24/12. The wound nurse stated			

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	"before the area on (Resident #79's) heel appeared we were preventing pressure on her heels by using a pressure reducing mattress, (the same mattress that are on all residents' beds) and turning (Resident #79)." 3.1-40(a)(1)			

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F000323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to thoroughly investigate falls for a resident who had five falls and was on multiple psychoactive medications, and failed to have fall interventions in place for a resident who had a history of falls, for 2 of 3 residents reviewed for falls of 3 residents who met the criteria for accidents (Resident #91 and Resident #39). Findings include: 1.) Review of the record of Resident #91 on 3-11-13 at 10:20 a.m. indicated the resident's diagnoses included, but were not limited to, pneumonia, agitation, dementia, hypertension and diabetes. The fall risk assessment for Resident #91 dated 12-12-12 indicated the resident had a history of falls, used an assistive device, had confusion, weakness and had an unsteady gait. Resident #91 was admitted to the	F000323	F323 Requires the facility to ensure the resident environment remains free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. 1. Resident #91 was discharged from the facility. Resident #31 had fall interventions reviewed and are in place.2. All residents have the potential to be affected, thus, the following corrective actions were taken. All resident's fall care plans were reviewed to ensure all fall interventions were in place. Antipsychotic medications as well as antianxiety medications that were ordered on residents were reviewed for adverse side effects.3 The policy and procedure for fall management was reviewed and no changes are indicated at this time. All staff was educated (See attachment H) on the fall management policy and procedure as well as the importance of ensuring that the interventions are in place and monitoring for adverse side effects of the resident's medication regimen. (See attachment F)4. The DON or her designee will review all post fall	03/22/2013

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	facility on 12-12-12 from the hospital and passed away on 12-25-12. The hospital discharge medication order, dated 12-12-12, for Resident #91 indicated the resident had an order for seroquel 12.5 milligram tablet every 6 hours prn (as needed) for agitation. The physician order for Resident #91 dated 12-12-13 indicated the resident was ordered ativan 0.5 milligrams by mouth every 8 hours prn for agitation, and seroquel 25 milligrams at bedtime routinely for dementia with behaviors. The telephone physician order dated 12-13-12 for Resident #91 indicated to increase ativan to 1 milligram every 6 hours prn for anxiety. The telephone physician order dated 12-15-12 for Resident #91 indicated the resident was ordered haldol one milligram now for agitation. The telephone physician order dated 12-16-12 for Resident #91 indicated to discontinue the seroquel 25 milligrams at bedtime and increase it to seroquel 50 milligrams at bedtime routinely for dementia with behaviors.		investigations ensuring that residents who are on antipsychotic or antianxiety medications are not having adverse drug reactions reactions; daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly until compliance is obtained and maintained. The DON or her designee will conduct rounds to ensure fall interventions are in place daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly until compliance is obtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action will be adjusted accordingly if warranted.	

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	The Minimum Data Set (MDS) assessment for Resident #91 dated 12-21-12, indicated the resident was severely impaired for cognitive skills for daily decision making, required extensive assistance of two staff to transfer and extensive assistance from two staff with walking in his room. The resident had falls since admission, two with no injury and one with an injury. The controlled drug record for Resident #91 indicated the resident received ativan 0.5 milligram (mg) 1 time on 12-12-12, ativan 0.5 mg 3 times on 12-13-12, ativan 1 mg 3 times on 12-14-12, ativan 1 mg 4 times on 12-15-12, ativan 1 mg 4 times on 12-16-12, ativan 1 mg 3 times on 12-17-12, ativan 1 mg 3 times on 12-18-12, ativan 1 mg 3 times on 12-19-12, ativan 1 mg 3 times on 12-20-12, ativan 1 mg 2 times on 12-21-12, ativan 1 mg 2 times on 12-22-12 and ativan 1 mg 3 times on 12-23-12. This indicated the resident received 34 doses of ativan in 12 days. The "post fall investigation worksheet" for Resident #91 dated 12-13-12 indicated the resident had a fall and had been in bed prior to the fall. The resident was confused and unaware			

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	of his surroundings and safety issues. The new interventions put in place to prevent/reduce recurrence and/or likelihood of injury indicated the specific space for medication review/change was not marked as done as an intervention. The interventions marked included, but were not limited to, resident on one to one until asleep. The nursing note for Resident #91 dated 12-13-12 at 4:00 p.m. indicated the resident was found on his knees on the blue pad next to his bed with the upper half of body on the bed. The "post fall investigation worksheet" for Resident #91 dated 12-15-12 indicated the resident had a fall from his wheelchair while sitting at the nursing station. The resident was extremely confused and wanted to take his clothes off. The new interventions put in place to prevent/reduce recurrence and/or likelihood of injury indicated the specific space for medication review/change was not marked as done as an intervention. The interventions marked included, but were not limited to, Physical therapy/Occupational therapy screen. The nursing note for Resident #91			

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	dated 12-15-12 at 11:40 p.m. indicated the resident was sitting at the nursing station in his wheelchair and leaned forward. The resident slid out of the wheelchair. The resident had a skin tear on his right hand measuring 0.01 centimeter (cm) by 0.4 cm by less than 0.01 cm. The "post fall investigation worksheet" for Resident #91 dated 12-18-12 indicated the resident had a fall and was in bed prior to the fall. The resident was extremely confused. The new interventions put in place to prevent/reduce recurrence and/or likelihood of injury indicated the specific space for medication review/change was not marked as done as an intervention. The interventions marked included, but were not limited to, 15 minute checks for 12 hours. The nursing note for Resident #91 dated 12-18-12 at 4:00 p.m. indicated the resident was found on the blue pad next to his bed. The resident had no injuries. The "post fall investigation worksheet" for Resident #91 dated 12-18-12 indicated the resident had a fall and was in bed prior to the fall. The resident was extremely confused.			

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	The new interventions put in place to prevent/reduce recurrence and/or likelihood of injury indicated the specific space for medication review/change was not marked as done as an intervention. The interventions marked included, but were not limited to, continue on 15 minute checks. The nursing note for Resident #91 dated 12-18-12 at 6:30 p.m. indicated the resident was found on the blue pad next to his bed. The resident was grimacing and complained of back pain. The resident was sent to the emergency room for treatment and evaluation. The local hospital emergency room report for Resident #91 dated 12-18-12 indicated the resident had altered level of consciousness. The resident had a fall out of bed a couple times at the nursing home. The resident had facial grimacing. The resident was moaning and stated that he wanted to go home. A CT scan was done and showed a large subdural hematoma. There were chronic and acute features as aspects of the hematoma. The "post fall investigation worksheet" for Resident #91 dated 12-20-12			

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	indicated the resident had a fall and was in bed prior to the fall. The resident was extremely confused. The new interventions put in place to prevent/reduce recurrence and/or likelihood of injury indicated the specific space for medication review/change was not marked as done as an intervention. The interventions marked included, but were not limited to, environmental changes and 15 minute checks for 12 hours. The nursing note for Resident #91 dated 12-20-12 at 8:00 p.m. indicated the resident was found on the floor pad next to his bed. The resident had an abrasion on his knee measuring 2 cm by 2 cm and an abrasion on his right hip measuring 3 cm by 3 cm. Interview with Resident #91's family member on 3-11-13 at 3:00 p.m. indicated the resident walked with a walker prior to coming to the nursing home. The family member indicated Resident #91 was capable of getting out of bed on his own. The family member indicated the resident would continuously get out of bed at home, and the resident did not have a purpose of where he was going but he was going "he just wanted to get up." The family indicated the resident			

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	had dementia and would become upset in unfamiliar places. The family member indicated the resident had lived with family prior to being hospitalized and coming to the facility. The family member indicated the facility had not talked with them about the resident using ativan, and indicated ativan was ineffective for the resident and did not help him at all. The family member indicated in 2012, the resident had been at another facility for rehabilitation and the facility had given him ativan. The family member indicated they requested for the resident not to receive ativan due to it made him restless throughout the night and too lethargic during the day. The family member indicated the resident did not ever take ativan when he was home. The family member indicated the resident required to have someone sit with him 24 hours a day at home and could never be left alone, because the resident was very confused. The family member indicated the resident liked to read but could not see to read now, and the one thing that helped him be occupied and calm was sorting silverware and putting it in a divider. Interview with the Director Of Nursing (DON) on 3-11-13 at 3:30 p.m.			

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	indicated the floor nurses and herself were responsible to monitor for side effects of antianxiety and antipsychotic medications. Interview with the DON and Assistant Director Of Nursing (ADON) on 3-12-13 at 11:30 a.m. indicated the reason Resident #91 was not brought out of his room was because he had Methicillin Resistant Staphylococcus Aureus (MRSA) (a contagious bacterial infection) and was on isolation precautions. The DON indicated the one time the facility brought the resident out to the nursing station the resident had to wear a mask. The DON indicated she thought the reason the staff did not get the resident up in a chair in his room was because he was high risk for falls and they did not want to leave him alone in his room in a chair. The DON indicated when the resident was admitted to the facility, he had an order for seroquel prn. The DON indicated she had the nurse call the Physician and have it changed to routine because the facility was not allowed to have antipsychotic medication ordered as a prn. The DON indicated when the resident was admitted, the facility knew he had problems with anxiety, "so we had ativan ordered for him." The DON			

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	indicated the Administrator, DON, ADON, nurse managers, therapy, and MDS nurses meet on Tuesdays and look at all residents falls and past interventions and medications with possible relation to falls. The DON indicated there was no documentation that the facility monitored the resident's medication use related to his falls. The ADON indicated when Resident #91 received the haldol, it did not affect him at all and his family still had to come sit with him. The antianxiety drug use policy, provided by medical records on 3-11-13 at 4:44 p.m., indicated the facility assures that residents are being adequately monitored for adverse reactions such as: increased confusion and increased risk for falls. The antipsychotic drug use policy, provided by medical records on 3-11-13 at 4:44 p.m., indicated the facility would monitor adverse consequences included, but were not limited to, falls and excessive sedation. 2.) Resident #39's record was reviewed on 3/7/13 at 11:10 A.M. He was admitted to the facility on 1/22/13. His diagnoses included, but were not limited to, non displaced fracture, concussion, balance			

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	problems, frequent falls, glaucoma, and hypertension. A local hospital note for Resident #39, dated 1/19/13, indicated Resident #39 fell down a flight of stairs injuring his neck. He had neck films and a CT of the spine, which showed a fracture of the right lateral masses at C6 and C7, with involvement of the articular facets. He had multilevel degenerative disk disease and facet arthropathy. He was placed in a C-Collar. He had been on his hands and knees in the Emergency Room and did not have an explanation for the physician as to why he was on the floor. He stated to the physician he had been having balance problems for the past 5-6 years. A Fall Assessment for Resident #39, dated 1/22/13, indicated he had a history of falls, used assistive devices, had confusion, had weakness, had an unsteady gait, had poor vision, and took several medications. A nurses note, dated 1/23/13 at 9:30 P.M., indicated Resident #39 was found crawling on the floor in front of his bathroom. He had indicated he was going to the bathroom and he did not fall. He had no injuries or complaint of pain.			

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	A Post Fall Investigation Worksheet, dated 1/23/13, indicated Resident #39 had informed staff he was going to the bathroom. He had informed staff he crawled around on the floor at his home for mobility. His sister also had indicated he crawled around on the floor at his home. He had a call light available and the intervention had not been effective. Resident #39's supervision modifications indicated a pad alarm. Resident #39's admission Minimum Data Set (MDS) assessment dated 1/29/13, indicated the following: Resident #39 understood and had the ability to understand others. He required limited assistance of 1 person for bed mobility and to walk in his room. He required extensive assistance of 2 persons for transfer. He was not steady, only able to stabilize with human assistance, for the following: Balance during transition and walking. Moving from a seated to standing position. Walking (with assistive device if used). Turning around and facing the opposite direction while walking. Moving on and off the toilet. Surface to surface transfer (transfer between bed and chair or wheelchair). He utilized a walker and wheelchair for			

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	mobility devices. He had a fracture related to a fall in the past 6 months. He had 1 fall since his admission. A nurses note, dated 2/12/13, indicated Resident #39 had been found on the floor in front of his wheelchair on his hands and knees. He had indicated he was going to the bathroom. He had no injuries. A Post Fall Investigation Worksheet, dated 2/12/13, indicated Resident #39 was attempting to crawl to the bathroom. The resident had informed staff he crawled at home. His pad alarm was sounding. He received no injuries and denied any complaint of pain. Resident #39's environmental modifications indicated a sign would be placed on his wall reminding him to use his call light. A Fall Care Plan for Resident #39, dated 2/4/13, included but were not limited to the following interventions: He would have frequently used items within reach. Added to the care plan 1/23/13-He would have a pad alarm at all times. Added to the care plan 1/24/13-He would have bilateral floor mats beside his bed. Resident #39's physician recapitulation orders for March, 2013,			

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	indicated he was to be up with assistance of at least 1 person, a pad alarm would be used at all times, and he would have floor mats to his bedside while in bed. On 3/5/13 at 1:44 P.M., Resident #39 was observed lying in bed, covered with a blanket. He indicated he thought he fell since he lived at the facility, but did not remember where, and wasn't really sure. He said he did not think he fell before he entered the facility, "I don't think so, I can't really remember." He had a thick blue floor mattress leaned up against the wall in his bedroom. His bedside table was up against the same wall, approximately 8 feet away from his bed. His water and TV remote were on the bedside table. He had a pad alarm on his bed and the cord was not connected to the alarm box that was lying under his bed. CNA # 1 entered the bedroom as Resident #39 was uncovering himself. He indicated he had to go to the bathroom. CNA #1 indicated he could drink independently. CNA #1 indicated he used the blue floor mat and she did not know why it was against the wall. CNA #1 indicated his alarm cord was not plugged into the alarm box underneath the bed and she plugged it in. RN #2 entered the bedroom to			

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	assist taking Resident #39 to the bathroom. He stood from his bed with the assist of CNA #1 and RN #2 holding him under his arms. He pivoted in a turning motion, taking several small steps to turn, with his knees slightly bent, and sat down in his wheelchair. He was unsteady, but able to bear weight. He was wheeled to the bathroom. He held the grab bar on the bathroom wall and stood with the 2 assist, pivoted, and sat down on the toilet. RN #2 left the bathroom. CNA #3 entered the bathroom to assist Resident #39 off the toilet and back to bed. He held the grab bar on the wall next to the toilet and stood with the 2 assist, pivoted, and sat down in his wheelchair. He was wheeled back to his bed. He stood with the 2 assist, holding him under his arms, and holding onto the top of his pants. He pivoted using small steps and sat down on his bed. He was positioned for comfort. The blue mat was laid on the floor next to his bed and his bedside table was positioned next to his bed. His pad alarm was connected and functioning. At that time CNA #3 indicated he was not transferred with the use of a gait belt because he could be assisted without it. She indicated a gait belt is used for more dependent residents.			

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	On 3/17/13 at 9:18 A.M., Physical Therapist #4 indicated staff should "always" place a gait belt on Resident #39 when they transfer him. He indicated staff knew to use a gait belt with transfers. The Transferring a Resident From Bed to Chair procedure, provided by the Director of Nursing on 3/8/13 at 2:47 P.M., indicated the following: "Purpose: To allow the resident to be out of his or her bed as much as possible and to encourage the resident to participate in activity and social activities. Procedure: ...8. Apply gait belt to waist if resident requires weight bearing assist." The Fall Management Procedure, provided by Medical Records on 3/11/13 at 4:33 P.M., indicated the following: "Purpose: To assess all residents for risk factors that may contribute to falling. To provide planned interventions identified by the team, as appropriate, for resident use in maintaining or returning to the highest level of physical, social, and psychosocial functioning as possible. Procedure: 1. Complete the fall risk assessment and care plan upon admission, readmission, quarterly, and with significant change in status.			

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	2. The interdisciplinary health care plan team will review the risk factors and determine if further assessment is needed. 3. The interdisciplinary health care plan team will determine which interventions are most appropriate for reducing the risk of falls and/or injuries related to fall. 4. The incident log will be updated daily along with the individual fall log. 5. Update the plan of care each time there is a change in intervention and communicate to staff." 3.1-45(a)(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 interview and record review, the facility failed to have appropriate diagnoses for the use of haldol and seroquel (antipsychotic medication) for 1 resident randomly reviewed for antipsychotic medication (Resident #91). Finding include: 1.) Review of the record of Resident #91 on 3-11-13 at 10:20 a.m. indicated the resident's diagnoses	F000329	F329 Requires the facility to ensure that each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose, excessive duration, or without adequate monitoring or without adequate indications for use.1. Resident #91 has been discharged from the facility.2. All residents have the potential to be affected, thus, the following corrective actions were taken. All residents within the facility had their medications reviewed to	03/22/2013

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	included, but were not limited to, pneumonia, agitation, dementia, hypertension and diabetes. Resident #91 was admitted to the facility on 12-12-12 from the hospital and passed away on 12-25-12. The hospital discharge medication order, dated 12-12-12, for Resident #91 indicated the resident had an order for seroquel 12.5 milligram tablet every 6 hours prn (as needed) for agitation. The physician order for Resident #91 dated 12-12-13 indicated the resident was ordered ativan 0.5 milligrams by mouth every 8 hours prn for agitation, and seroquel 25 milligrams routinely at bedtime for dementia with behaviors. The telephone physician order dated 12-15-12 for Resident #91 indicated the physician ordered haldol one milligram now for agitation. The telephone physician order dated 12-16-12 for Resident #91 indicated to discontinue the seroquel 25 milligrams at bedtime and increase it to seroquel 50 milligrams at bedtime routinely for dementia with behaviors.		ensure their medications had the proper indication for use. All new admits and re-admits will also have their medications reviewed to ensure their medications have the appropriate indication for use. 3 The policy and procedure for the use of antipsychotic drugs and antianxiety drugs were reviewed and no changes are indicated at this time. All nursing staff was educated (See attachment H) on the antipsychotic and antianxiety drug use policy and procedure. (See attachment A) An emphasis was given to the staff to ensure the resident had a proper diagnosis for the use of antipsychotic and antianxiety medications prior to giving the medication. 4. The DON or her designee will review all new orders, new admits and re-admit physician orders to ensure that all antipsychotic or antianxiety medications have proper indication for use that addresses their behaviors daily for four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly until compliance is obtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action will be adjusted accordingly if warranted.	

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	The Minimum Data Set (MDS) assessment for Resident #91 dated 12-21-12 indicated the resident was severely impaired for cognitive skills for daily decision making, required extensive assistance of two staff to transfer and extensive assistance from two staff with walking in his room. The mood and behavior communication memo for Resident #91 dated 12-15-12 at 5:00 p.m. indicated the resident was severely agitated and could not be calmed by intervention measures. The family was called but were not able to come to the facility at this time. The physician was called and an order was received for haldol 1 mg Intramuscular (IM) injection. During interview with the Director Of Nursing (DON) on 3-11-13 at 3:30 p.m., regarding the lack of diagnosis for the use of seroquel, the DON indicated the family told the facility that it was the only medication that helped the resident. The DON indicated the floor nurses and herself were responsible to monitor for side effects of antianxiety and antipsychotic medications. Interview with the DON and Assistant			

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	Director Of Nursing (ADON) on 3-12-13 at 11:30 a.m. indicated when the resident was admitted to the facility he had an order for seroquel prn. The DON indicated she had the nurse call the Physician and have it changed to routine because the facility was not allowed to have antipsychotic medication ordered as a prn. The ADON indicated when Resident #91 received the haldol, it did not affect him at all and his family still had to come sit with him. The "2010 Nursing Spectrum Drug Handbook" indicated haldol was used to treat psychotic disorders, Tourettes syndrome and schizophrenia. The box warning for haldol indicated "drug increased mortality in elderly patients with dementia related psychosis." "Drug isn't approved for treatment of dementia-related psychosis." The adverse reactions to haldol included, but were not limited to, restlessness, confusion, vertigo, seizures and insomnia. The drug handbook indicated seroquel was used for schizophrenia and bipolar disorder. The box warning for seroquel indicated "Elderly patients with dementia-related psychosis are at increased risk for death." "Don't give drug to patients with dementia-related psychosis." The adverse reactions to			

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	haldol included, but were not limited to, dizziness, sedation, cognitive impairment, hypotension and flu like symptoms. The antipsychotic drug use policy, provided by medical records on 3-11-13 at 4:44 p.m., indicated the purpose was 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. "Anti-psychotic drugs will not be used as a restraint." Inadequate indications for the use of antipsychotic medications included, but were not limited to, wandering, restlessness, impaired memory, mild anxiety, insomnia, inattention or indifference to surroundings, fidgeting, nervousness and verbal expressions. Monitoring/adverse consequences included, but were not limited to, falls and excessive sedation. 3.1-48(a)(4) 3.1-48(a)(1)			

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F000441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation and interview, the facility failed to use appropriate	F000441	F441 Requires the facility to establish and maintain an	03/22/2013

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	hand washing/sanitizing of hands or gloves before touching residents' food during meal service for 2 of 2 residents observed for meal service (Residents #64 & #8). Findings include: 1. On 3/4/13 at 12:10 p.m., CNA #10 was observed taking Resident # 64's tray to her in her room. CNA #10 set the lunch tray on the bed side table and removed the bread from the wrapper with her hands, and buttered the bread with no prior hand washing/ sanitation or glove use. Interview with CNA #10 on 3/4/13 at 12:20 p.m. indicated "yes, I know I did that, but I couldn't figure out how to do it without touching the bread." 2. During observation on 3/4/13 at 12:15 p.m., CNA #11 assisted Resident #8 with repositioning in bed for meal service. CNA #11 then began feeding Resident #8 with no hand washing or sanitization of her hands before feeding the resident. Interview with CNA #11 on 3/4/13 at 12:25 p.m. indicated "Yes, I know I didn't wash my hands when I should have. I get nervous when someone is watching me."		infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.1. Residents #64 and #8 were served their meals and the staff was instructed on hand washing.2. All residents have the potential to be affected, thus, the following corrective actions were taken. 3. The policy and procedure on hand washing was reviewed and no changes were indicated at this time. All staff was educated (See attachment H) on the policy and procedure of hand washing. (See attachment G)4. The DON or her designee will monitor two meal services a day to ensure that handwashing and proper handling of food is occurring daily times four weeks, weekly times four weeks, then every two weeks times two months then quarterly until compliance is obtained and maintained. (See attachment B) The audits will be received during the facility's quarterly assurance meeting and plan of action will be adjusted accordingly if warranted.	

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	3.1-18(l)			