

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 01/24/2014
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NAME OF PROVIDER OR SUPPLIER HEARTH AT WINDERMERE	STREET ADDRESS, CITY, STATE, ZIP CODE 9745 OLYMPIA DR FISHERS, IN 46038
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R000000	<p>This visit was for the Investigation of Complaint IN00141998.</p> <p>Complaint IN00141998 Substantiated. State deficiencies related to the allegations are cited at R0036, R0051, R0052, and R0096.</p> <p>Survey Dates: January 22 & 24, 2014</p> <p>Facility number: 002999 Provider number: 002999 AIM number: NA</p> <p>Survey Team: Mary Jane G. Fischer RN</p> <p>Census bed type: Residential: 92 Total: 92</p> <p>Census payor type: Other: 92 Total: 92</p> <p>Sample: 4 Supplemental Sample: 1</p> <p>These State findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality Review was completed by</p>	R000000	<p>DISCLAIMER:</p> <p>Preparation and implementation of this plan of correction does not constitute admission or agreement by the</p> <p>Hearth at Windermere of the truth of the facts, findings, or other statements</p> <p>as alleged by the preparer of the survey/inspection dated January 24, 2014. Hearth at Windermere specifically reserves</p> <p>the right to move to strike or exclude this document as evidence in any civil,</p> <p>criminal or administrative action not related directly to the licensing and/or</p> <p>certification of this facility or provider.</p> <p>The facility reserves the right to challenge the findings by way of</p>	

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

TITLE

(X6) DATE

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

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R000036	<p>Tammy Alley RN on January 31, 2014.</p> <p>410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on record review and interview the facility failed to ensure a resident's physician and family members were contacted, in that when a resident continued to display aggressive and threatening behaviors, the nursing staff failed to contact the resident's family for notification of the resident's behaviors, and failed to notify the resident's physician for possible intervention for 1 of 4 sampled resident's. (Resident "C").</p> <p>Findings include:</p>	R000036	<p>independent review procedures established by the agency.</p> <p>Resident C's physician and family were notified of the need for more extensive care based on resident's prior and current behaviors on January 23, 2014. Resident was assessed by a Behavioral Care Unit on January</p>	02/24/2014

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	<p>The record for Resident "C" was reviewed on 01-22-14 at 11:50 a.m. Diagnoses included, but were not limited to, Lewy Body dementia, Parkinsons, anorexia, and aphasia. These diagnoses remained current at the time of the record review. The resident was admitted to the facility on 08-26-13.</p> <p>The admission nursing evaluation, dated 08-26-13 indicated the resident's diagnoses included, but were not limited to, dementia with Lewy bodies and dementia with behavior disturbances.</p> <p>The record indicated the resident was seen by the attending physician on 08-28-13. The physician progress notes for this visit indicated, "At his previous facility, it was reported that he was a fall risk, demonstrated exit seeking behavior, took his clothes off at times and urinated on the floor at times. He has defecated on the floor on one occasion since admission here. He has had periods of agitation which appear to respond to Klonopin [an anticonvulsant medication]. Current outpatient prescriptions: Klonopin 0.25 mg [milligrams] disintegrating tablet - take 0.25 mg by mouth 2 [two] times daily as needed and</p>		<p>23, 2014 and admitted to the unit the same day. Resident remains in the Behavioral Care Setting and will be assessed for appropriateness of placement when he is finished with his treatment.</p> <p>2. All residents in the Keepsake unit have the potential to be affected. All nursing staff, including CNAs will receive training on Facility policies, state regulations, and nursing standards concerning notification of Physicians and families. All nursing staff, including CNAs will receive training on recognizing what is a significant change in a resident and reporting procedures.</p> <p>3. The Director of Nursing will have daily stand up meetings with CNA's and nurses to discuss hands on care and behaviors/conditions noticed by</p>				

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	<p>Seroquel [antipsychotic medication] 25 mg - take 25 mg by mouth 3 [three] times daily and 50 mg by mouth nightly. Assessment 1. Lewy Body dementia. Plan: Admit to Keepsake Village unit at the Hearth at Windermere. Requires 24 hour supervision on a secured unit. Continue present medications May use Klonopin as needed for agitation/anxiety. Continue present dose of Seroquel. Prognosis is guarded due to severity of dementia."</p> <p>A review of the Nurses Notes from the time of admission through December 29, 2013, the resident displayed the following behaviors, some of which required the use of the Klonopin.</p> <p>"08-23-13 - At 6:00 p.m., resident started strippin in the halway <sic> when CNA [certified nurses aide] assisted him to put back his clothes he attempted throwing punches to everybody around. Blocked. Redirected not effective - given time out not effected. Assisted resident back to his room - refused. Notified Nursing unit manager. Gave 25 mg Seroquel [scheduled] and Klonopin 0.25 mg [prn - as needed] refusing to take them at first but took it later.</p>		<p>the first line caregivers. The meetings will</p> <p>continue for 30 days to reinforce the training and taper off to once per week</p> <p>for 90 days of monitoring.</p> <p>4. After 90 days the DON will monitor by spot checking the behaviors, nursing notes and staff input in conjunction with care/service plan</p> <p>assessments. The Director of Nursing</p> <p>will monitor the unit daily by review of 24 hour report and that it is</p> <p>reflective of major issues, concerns and communications based on the daily</p> <p>meetings and/or weekly meetings.</p>				

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	<p>[Name of physician] spoke with [name of another physician] et [and] gave order to give resident another Klonopin 0.25 mg one time only."</p> <p>"08-27-13 3:45 p.m. This a.m. had inc. [incontinent] BM [bowel movement] behind his door et rolling in his hands. Requires frequent redirection."</p> <p>"08-30-13 2:00 p.m. This a.m. removing pictures from hallway walls, moving linen carts and [illegible word] given."</p> <p>"09-01-13 11:00 a.m. Has been very calm - follows redirections well but when kitchen was setting up DR [dining room] pt. [patient] grabbed knives in stab position became very verbal/angry could not redirect, body posture became stiff with blades of knives pointing at staff - got knives away - could not do 1:1 or redirect prn [as needed] Klonopin given with noon Seroquel."</p> <p>"09-01-13 10:00 p.m. Increased aggitation - 1:1 and numerous redirection <sic>not help pt. Went into Room [number documented of another resident's room] et [and] tore room up. Gave another Klonopin - into many rooms on unit</p>			

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	<p>ans <sic> phone by med cart."</p> <p>"09-07-13 at 12:00 p.m. Very restless - in and out of others room - taking pictures off walls - took off all clothes walking down hall naked 1:1 and redirection times 4 - Klonopin given."</p> <p>"09-07-13 8:00 p.m. Defecated on carpet in back of Unit. Taken to room et cleaned up and cleaned up floor - 1:1 and redirection times 5 without any results - Klonopin given."</p> <p>"09-15-13 10:00 a.m. Can not redirect - voiding in the flowers by the pillars, on the carpet, in the halls even after taken to BR [bathroom] 1:1 gave Klonopin."</p> <p>"09-15-13 2:00 p.m. No change in behaviors still voiding everywhere."</p> <p>"09-29-13 12 Midnight - Up in halls - waking up other pts. 1:1 redirected to bed times 4. 1:00 a.m. Very restless - 1:1 redirected - took to Act. [activity] room to watch TV. In and out of others rooms. 2:00 a.m. Klonopin given for increased agitation 1:1 and redirected back to bed. 5: 30 p.m. Redirected times 6 to table. Sat down at table times 10</p>						

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	<p>- becoming 'strong armed' with staff - sat on recliner. 1:1 and redirected again. Disrupting DR. In and about other pts. [patients] plates. Gave Klonopin."</p> <p>"09-30-13 1:30 a.m. Tore all clothes from closet and room to floor - [arrow up] and [arrow down] in others rooms waking up other pts. Put back to bed times 8 - sat on recliner would not sit - 1:1 and redirected times 10. Klonopin given at 1:30 a.m."</p> <p>"09-30-13 5:15 p.m. Tried to sit down for dinner times 6 finally ate a few bites - [arrow pointing upward] taking food off others plates - dragging chairs down hallway, 1:1 and redirected times 5 has stiff body posture. Sat in recliner but not happy there either - offered [illegible word] and dinner times 3. 6:30 p.m. Behavior [arrow pointing upward] ing, Klonopin given."</p> <p>"10-05-13 8:00 p.m. Took meds [medications] well all day - very nervous et sits on floor et picks paint off pillars in DR/Act [dining room/activity room] - voids on carpet. Has torn apart flowers/pots at ends of back hall - takes off clothes et walks around naked - In</p>			

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	<p>and out of pts rooms - disrupting others rooms."</p> <p>"10-06-13 7:00 p.m. Meds taken can not redirect - In and out of pts rooms - disruptive in rooms - needs to have [room number documented] a fixed so he can not open them - tears out all closets contents on floor of room no change from 10-05-14."</p> <p>"10-13-13 9:30 a.m. Eating off others plates on tables - ate 100 % of bkfst [breakfast] plus more bkfst I brought to him. Taking plates and glasses off tables - taking off table clothes - redirected times 5."</p> <p>"10-24-13 5:44 p.m. [Name of two Certified nurses Aides] noted resident was naked - had taken his clothes off - fighting with CNA's. [Name of CNA] reported he was clawing at [name of another CNA] who stated the left arm was clawed at. Redness noted to areas shown of left lower and upper arm."</p> <p>"11-02-13 at 12:30 p.m. Climbing on tables in DR before bkfst crawling on floor in every ones rooms - can not redirect - 1:1 taken to Act. [activity] room away from noise - no help. Klonopin given. At 8:30 a.m. ate well for bkfst - had large stool on</p>			

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	<p>carpet in room."</p> <p>"11-10-13 at 2:00 p.m. Had to take out of church since pt. [patient] in [room number documented] was talking [illegible word] mean to him - he was about to hit with fist. [Room number of other resident - Resident "E"] took 1/2 hour to calm down by staff. To give Klonopin angry non sensical verbage <sic>."</p> <p>"11-10-13 9:00 p.m. Pooped on recliner in DR - carpet in DR - hallway times 2. Halls and in [room number of another resident documented]."</p> <p>"11-14-13 9:30 p.m. Trying to hit staff with closed fists. Took 2 staff to help to bed...did not eat dinner or take dinner et noc [night] meds - too combative - in others room taking items."</p> <p>"11-16-13 9:00 p.m. Turned chairs over in DR et put chairs on tables after dinner. Family here after dinner - took off plates/food glasses and tablecloth from table et put in lobby. Family wants him to see podiatrist when he comes. Put on calendar for Monday."</p> <p>"1-19-2013 <sic> 8:00 p.m.</p>						

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	<p>Resident very restless since start of shift. Banging walls with fist. Redirected several times. Went to other peers room asked if he needs to use bathroom - took him to bathroom et stated 'no.' Continually pacing unit, pulled fire extinguisher from wall - attempted to pull out lock several times and got frustrated. Started banging it against wall. Writer able to grab the fire extinguisher with help of 2 CNAS. Defecated on the hallway after eating dinner. Given Klonopin at 7:00 p.m. Sleeping at present time."</p> <p>"11-28-13 7:00 p.m. went into [room number documented of another resident] defecated all over room - carpet - BR - [room number documented] bed - room so bad [resident who resided in this room] had to sleep in [room number documented of another available room]. Had stool all over himself - would not amb [ambulate] to his room for a shower. Took 3 staff and w/c [wheelchair] to get him to his room et 2 staff for shower - all 3 staff has stool on them from pt. being combative et crawling on the floor with stool all over him. Called DON [Director of Nurses], aware."</p> <p>"11-30-13 8:00 p.m. 1:1 times 4 -</p>			

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	<p>walked with pt. around unit times 2 until he sat on floor - have redirected several times - climbing on tables in DR - drawing fist back at staff - gave Klonopin at this time."</p> <p>"11-30-13 1:30 p.m. Went in [room number documented] et defecated all over room and BR."</p> <p>"12-01-13 9:00 a.m. Climbing on tables - shaking closed fist at staff - very agitated 1:1 times 5 minutes - walked around unit only to have him sit on floor et scoot down hallway - Klonopin given."</p> <p>"12-01-13 5:00 p.m. Taking all dirty laundry out of hampers et throwing on floor - very agitated - 1:1 time 8 minutes only made aggitation worse. Meds given and Klonopin with much difficulty - too agitated to sit down to eat...."</p> <p>"12-06-13 1:50 p.m. At 12:45 p.m. [arrow pointing upward] anxiety et difficult to redirect with several attempts et Klonopin 1/2 tab given as per order."</p> <p>"12-14-13 6:00 p.m. Climbing on sofa chairs, tables. Can not redirect Klonopin given for aggitation at 8:00 a.m. and 5:00 p.m."</p>						

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	<p>"12-15-13 8:00 p.m. Has been hitting with closed fists - laying on floor - moving furniture - very agitated all day can not redirect Klonopin given at 8:00 a.m. and 5:00 p.m."</p> <p>"12-28-13 12:00 p.m..... Very agitated - balling up fist at staff - into all rooms taking items from walls/rooms. Redirected so many times without problem solved. Klonopin given."</p> <p>"12-29-13 2:00 p.m. Crying all <sic> at noon. Running down halls at bkfst time 'the sewer gas is going to explode.' Tried to calm pt but only became more agitated. Meds given times 4 with Klonopin et spit meds on floor/table/self. Called family to talk to him 'my throat is cut.' Took him to a mirror to show him this was not true took meds at 5:00 p.m."</p> <p>The record lacked further Nurses Notes from 12-29-13 through 01-22-14. However a review of the January 2014 PRN (as needed) Medication Record indicated the following in regard to the resident being given Klonopin:</p> <p>01-01-14 2:13 a.m. - "reason:</p>						

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	<p>uncooperative with CNA." 01-03-14 6:00 p.m. - "reason: BLANK." 01-04-14 4:00 p.m. - "reason: urinating on floor increased anxiety. 01-17-14 6:00 p.m. - "reason: BLANK."</p> <p>A review of the "Monthly Behavior Monitoring Flowsheet for September 2013 indicated the nursing staff were tracking two "targeted behaviors" which included "increased anxiety - 73 episodes" over all three shifts (days - evening and nights)and "striking out - 7 episodes" over all three shifts.</p> <p>A review of the "Monthly Behavior Monitoring Flowsheet for October and November 2013 indicated the nursing staff were tracking three "targeted behaviors" which included "increased anxiety - 173 episodes" over all three shifts, "laying on the floor - 162 episodes" over all three shifts, and "climbing - 39 episodes" over all three shifts.</p> <p>A review of the "Monthly Behavior Monitoring Flowsheet for December 2013 indicated the nursing staff were tracking four "targeted behaviors" which included "increased anxiety/agitation - 26</p>						

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	<p>episodes" over all three shifts," "laying on the floor - 72 episodes" over all three shifts and "climbing - 37 episodes" over all three shifts.</p> <p>A review of the "Monthly Behavior Monitoring Flowsheet for January 2014, dated January 1, 2014 thru January 22, 2014 to include "day/evening and night shift," indicated the nursing staff were tracking five "targeted behaviors" which included "increased anxiety/agitation - with 65 episodes," "laying on the floor with 23 episodes," "climbing with 13 episodes," "defecating on floor - 19 episodes," and "refusing meds. 6 episodes." This record contained many areas which were blank and had omissions/blanks related to the resident's behaviors. In addition the record was "signed as completed," with "no behaviors," even though the evening shift nor night shift had yet occurred at the time of record review on 01-22-2014.</p> <p>The record contained only 1 additional physician progress note, dated 09-04-13 in which the physician indicated "Nursing staff reports increased agitation and inappropriate behavior in late afternoon and evening. Sleeps fairly</p>			

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	<p>well at night. Plan: increase Seroquel dose - orders written. Increase Lunch and dinner doses to 50 mg. Re-evaluate in 1 - 2 weeks."</p> <p>A re-evaluation progress note could not be located.</p> <p>During an interview on 01-22-14 at 2:25 p.m., the Unit Manager of the Keepsake Village Unit and the Administrator indicated they were unaware of the incident on 09-01-13 at 11:00 a.m., when the resident grabbed the knives and pointed them in a threatening manner. The Administrator indicated, "After you brought it to our attention, we checked the 24 hour reports and there was nothing documented by the nurses, and we review the 24 hour reports every morning."</p> <p>In additional the Unit Manager indicated she was unaware the nursing staff gave the medication, Klonopin, to the resident so frequently. Further interview on 01-22-14 at 3:45 p.m., during the Daily Exit Conference, the Unit Manager indicated the resident had at one time resided with a family member. "[Family member] told me she couldn't take care of him anymore because one night while</p>						

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	<p>sleeping, [name of Resident "C"] took the kitchen cabinets off the walls, and the ones he couldn't take off, he tore the rest of them off the walls. We didn't know that when he was admitted."</p> <p>The nursing staff failed to ensure the physician was aware of the resident escalation in the type and number of behaviors, in which the nursing staff administered Klonopin to the resident.</p> <p>A review of the facility policy on 01-22-14 at 3:00 p.m., and titled "Policy for Evaluating Resident - Admission criteria for Keepsake [Unit]," indicated the following:</p> <p>"If a resident has physically/abusive/combatative behaviors, they must be manageable through therapeutic approaches of low to moderate medication. Resident must be physically and mentally able to participate in the programming of the unit consistently everyday."</p> <p>A review of the facility policy on 01-22-14 at 2:50 p.m., titled "PHYSICIAN SERVICES POLICY," undated, indicated the following:</p>						

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	<p>"Purpose: To ensure that each resident receives proper medical care and to define the requirements and responsibilities for physicians admitted and caring for residents."</p> <p>"Standards: 7. Each resident shall be seen by the attending physician and the total medical care program shall be reviewed and appropriately revised as deemed necessary by the attending physician, but at least a minimum of every six (6) months and a written progress note made at the time of each resident visit." 17. The facility shall notify the attending physician of any accident, injury or significant change in a resident's condition that threatens the health, safety, or welfare of a resident, including but not limited to abnormal laboratory values, significant change in vital signs, symptoms of infection, changes in skin condition such as pressure ulcers, or weight fluctuations of 5% or more within a one month period or 10% within six months. 18. Specific criteria is developed and staff trained regarding physician notification upon change of resident condition."</p> <p>"PHYSICIAN SERVICES - The resident's physician is to be notified</p>						

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R000051	<p>of:</p> <p>1. Any accident, incident or emergency situation requiring medical care."</p> <p>A review of the facility "Resident Handbook," on 01-22-14 at 1:00 p.m., indicated the following: "Dignity - Residents have the right to physician and legal representative notification for a significant decline in their condition or a need to alter treatment significantly or to start a new form of treatment."</p> <p>This State finding relates to Complaint IN00141998. 410 IAC 16.2-5-1.2(u) Residents' Rights - Offense (u) Residents have the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident ' s medical symptoms. Based on record review and interview the facility failed to ensure a resident was not restrained, in that when a resident exhibited behaviors which included aggression, agitation, defecation in inappropriate places, posing a threat to other residents and staff with the use of closed fists, strong arming the staff, grabbing knives and pointed them in a threatening manner, and taking down a fire extinguisher in an</p>	R000051	<p>1. Resident C's physician and family were notified of the need for</p>	02/24/2014

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	<p>attempt to discharge, the nursing staff continued to use a chemical restraint for the behaviors, and did not involve the resident's physician for the care of the resident. This deficient practice effect 1 of 4 residents sampled with dementia and who resided on the secured Keepsake Unit. ("Resident C").</p> <p>Findings include:</p> <p>The record for Resident "C" was reviewed on 01-22-14 at 11:50 a.m. Diagnoses included, but were not limited to, Lewy Body dementia, Parkinsons, anorexia, and aphasia. These diagnoses remained current at the time of the record review. The resident was admitted to the facility on 08-26-13.</p> <p>The admission nursing evaluation, dated 08-26-13 indicated the resident's diagnoses included, but were not limited to, dementia with Lewy bodies and dementia with behavior disturbances.</p> <p>The record indicated the resident was seen by the attending physician on 08-28-13. The physician progress notes for this visit indicated, "At his previous facility, it was reported that he was a fall risk,</p>		<p>the need for a geri-psych evaluation based on the resident's behaviors noted on</p> <p>and prior to January 23, 2014. A representative from the Behavioral Care Center</p> <p>arrived January 23rd, 2014 to assess resident for placement and the</p> <p>Resident was admitted for treatment the same day.</p> <p>2. All residents on the</p>				

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	<p>demonstrated exit seeking behavior, took his clothes off at times and urinated on the floor at times. He has defecated on the floor on one occasion since admission here. He has had periods of agitation which appear to respond to Klonopin [an anticonvulsant medication]. Current outpatient prescriptions: Klonopin 0.25 mg [milligrams] disintegrating tablet - take 0.25 mg by mouth 2 [two] times daily as needed and Seroquel [antipsychotic medication] 25 mg - take 25 mg by mouth 3 [three] times daily and 50 mg by mouth nightly. Assessment 1. Lewy Body dementia. Plan: Admit to Keepsake Village unit at the Hearth at Windermere. Requires 24 hour supervision on a secured unit. Continue present medications May use Klonopin as needed for agitation/anxiety. Continue present dose of Seroquel. Prognosis is guarded due to severity of dementia."</p> <p>A review of the Nurses Notes from the time of admission through December 29, 2013, the resident displayed the following behaviors, some of which required the use of the Klonopin.</p> <p>"08-23-13 - At 6:00 p.m., resident</p>		<p>Keepsake unit have the potential to be affected</p> <p>by the deficient practice. All nursing staff will receive training on the state</p> <p>regulations, Facility policies on prn medications and the use of therapeutic</p> <p>interventions prior to the administration of a prn for behaviors/agitation. All</p> <p>nursing staff will receive training by</p> <p>February 24th, 2014. All nursing staff will receive also receive training</p>				

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	<p>started strippin in the halway <sic> when CNA [certified nurses aide] assisted him to put back his clothes he attempted throwing punches to everybody around. Blocked. Redirected not effective - given time out not effected. Assisted resident back to his room refused. Notified Nursing unit manager. Gave 25 mg Seroquel [scheduled] and Klonopin 0.25 mg [prn - as needed] refusing to take them at first but took it later. [Name of physician] spoke with [name of another physician] et [and] gave order to give resident another Klonopin 0.25 mg one time only."</p> <p>"09-01-13 11:00 a.m. Has been very calm - follows redirections well but when kitchen was setting up DR [dining room] pt. [patient] grabbed knives in stab position became very verbal/angry could not redirect body posture became stiff with blades of knives pointing at staff - got knives away - could not do 1:1 or redirect prn [as needed] Klonopin given with noon Seroquel."</p> <p>"09-01-13 10:00 p.m. Increased aggitation - 1:1 and numerous redirection <sic>not help pt. Went into Room [number documented of another resident's room] et [and] tore room up. Gave another</p>		<p>on the need to involve and consult the Resident's Physician on whether a PRN</p> <p>medication should be scheduled, re-evaluated for its effectiveness, and other</p> <p>interventions that may address the behaviors presented by residents. This</p> <p>training shall also be completed by February 24th, 2014.3.</p> <p>3. The DON will</p> <p>complete audits of the MAR's/nurses notes, of those resident receiving prn</p>	

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	<p>Klonopin - into many rooms on unit ans <sic> phone by med cart."</p> <p>"09-07-13 at 12:00 p.m. Very restless - in and out of others room - taking pictures off walls - took off all clothes walking down hall naked 1:1 and redirection times 4 Klonopin given."</p> <p>"09-07-13 8:00 p.m. Defecated on carpet in back of Unit. Taken to room et cleaned up and cleaned up floor - 1:1 and redirection times 5 without any results - Klonopin given."</p> <p>"09-15-13 10:00 a.m. Can not redirect - voiding in the flowers by the pillars, on the carpet, in the halls even after taken to BR [bathroom] 1:1 gave Klonopin."</p> <p>"09-29-13 12 Midnight - Up in halls - waking up other pts. 1:1 redirected to bed times 4. 1:00 a.m. Very restless - 1:1 redirected - took to Act. [activity] room to watch TV. In and out of others rooms. 2:00 a.m. Klonopin given for increased agitation 1:1 and redirected back to bed. 5: 30 p.m. Redirected times 6 to table. Sat down at table times 10 - becoming 'strong armed' with staff - sat on recliner. 1:1 and redirected</p>		<p>meds, five days a week for two weeks, then twice weekly for two weeks, then</p> <p>once weekly for 90 days of monitoring.</p> <p>4. After 90 days the DON will monitor MONTHLY by t checking the</p> <p>Keepsake Residents MAR's/nurses notes for appropriate documentation on prn</p> <p>medications used for the purpose of behaviors. Staff will be</p>				

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	<p>again. Disrupting DR. In and about other pts. [patients] plates. Gave Klonopin."</p> <p>"09-30-13 1:30 a.m. Tore all clothes from closet and room to floor - [arrow up] and [arrow down] in others rooms waking up other pts. Put back to bed times 8 - sat on recliner would not sit - 1:1 and redirected times 10. Klonopin given at 1:30 a.m."</p> <p>"09-30-13 5:15 p.m. Tried to sit down for dinner times 6 finally ate a few bites - [arrow pointing upward] taking food off others plates - dragging chairs down hallway 1:1 and redirected times 5 has stiff body posture. Sat in recliner but not happy there either - offered [illegible word] and dinner times 3. 6:30 p.m. Behavior [arrow pointing upward] ing, Klonopin given."</p> <p>"11-02-13 at 12:30 p.m. Climbing on tables in DR before bkfst crawling on floor in every ones rooms - can not redirect - 1:1 taken to Act. [activity] room away from noise - no help. Klonopin given. At 8:30 a.m. ate well for bkfst - had large stool on carpet in room."</p> <p>"11-10-13 at 2:00 p.m. Had to take</p>		<p>in-serviced yearly</p> <p>on the use of therapeutic approach/interventions and the use of prn medications</p> <p>in residents with behaviors.</p>	

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	<p>out of church since pt. [patient] in [room number documented] was talking [illegible word] mean to him - he was about to hit with fist. [Room number of other resident] took 1/2 hour to calm down by staff. To give Klonopin angry non sensical verbage <sic>."</p> <p>"1-19-2013 <sic> 8:00 p.m. Resident very restless since start of shift. Banging walls with fist. Redirected several times. Went to other peers room asked if he needs to use bathroom - took him to bathroom et stated 'no.' Continually pacing unit, pulled fire extinguisher from wall - attempted to pull out lock several times and got frustrated. Started banging it against wall. Writer able to grab the fire extinguisher with help of 2 CNAS. Defecated on the hallway after eating dinner. Given Klonopin at 7:00 p.m. Sleeping at present time."</p> <p>"11-30-13 8:00 p.m. 1:1 times 4 - walked with pt. around unit times 2 until he sat on floor - have redirected several times - climbing on tables in DR - drawing fist back at staff - gave Klonopin at this time."</p> <p>"12-01-13 9:00 a.m. Climbing on tables - shaking closed fist at staff -</p>						

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	<p>very agitated 1:1 times 5 minutes - walked around unit only to have him sit on floor et scoot down hallway - Klonopin given."</p> <p>"12-01-13 5:00 p.m. Taking all dirty laundry out of hampers et throwing on floor - very agitated - 1:1 time 8 minutes only made aggitation worse. Meds given and Klonopin with much difficulty - too agitated to sit down to eat...."</p> <p>"12-06-13 1:50 p.m. At 12:45 p.m. [arrow pointing upward] anxiety et difficult to redirect with several attempts et Klonopin 1/2 tab given as per order."</p> <p>"12-14-13 6:00 p.m. Climbing on sofa chairs, tables. Can not redirect Klonopin given for aggitation at 8:00 a.m. and 5:00 p.m."</p> <p>"12-15-13 8:00 p.m. Has been hitting with closed fists - laying on floor - moving furniture - very agitated all day can not redirect Klonopin given at 8:00 a.m. and 5:00 p.m."</p> <p>"12-28-13 12:00 p.m..... Very agitated - balling up fist at staff - into all rooms taking items from walls/rooms. Redirected so many</p>			

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	<p>times without problem solved. Klonopin given."</p> <p>"12-29-13 2:00 p.m. Crying all <sic> at noon. Running down halls at bkfst time 'the sewer gas is going to explode.' Tried to calm pt but only became more agitated. Meds given times 4 with Klonopin et spit meds on floor/table/self. Called family to talk to him 'my throat is cut.' Took him to a mirror to show him this was not true took meds at 5:00 p.m."</p> <p>The record lacked further Nurses Notes from 12-29-13 through 01-22-14. However a review of the January 2014 PRN (as needed) Medication Record indicated the following in regard to the resident being given Klonopin:</p> <p>01-01-14 2:13 a.m. - "reason: uncooperative with CNA." 01-03-14 6:00 p.m. - "reason: BLANK." 01-04-14 4:00 p.m. - "reason: urinating on floor increased anxiety. 01-17-14 6:00 p.m. - "reason: BLANK."</p> <p>A review of the "Monthly Behavior Monitoring Flowsheet for September 2013 indicated the nursing staff were tracking two "targeted</p>						

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	<p>behaviors" which included "increased anxiety - 73 episodes" over all three shifts (days - evening and nights) and "striking out - 7 episodes" over all three shifts.</p> <p>A review of the "Monthly Behavior Monitoring Flowsheet for October and November 2013 indicated the nursing staff were tracking three "targeted behaviors" which included "increased anxiety - 173 episodes" over all three shifts, "laying on the floor - 162 episodes" over all three shifts, and "climbing - 39 episodes" over all three shifts.</p> <p>A review of the "Monthly Behavior Monitoring Flowsheet for December 2013 indicated the nursing staff were tracking four "targeted behaviors" which included "increased anxiety/agitation - 26 episodes" over all three shifts," "laying on the floor - 72 episodes" over all three shifts and "climbing - 37 episodes" over all three shifts.</p> <p>A review of the "Monthly Behavior Monitoring Flowsheet for January 2014, dated January 1, 2014 thru January 22, 2014 to include "day/evening and night shift," indicated the nursing staff were tracking five "targeted behaviors"</p>						

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	<p>which included "increased anxiety/agitation - with 65 episodes," "laying on the floor with 23 episodes," "climbing with 13 episodes," "defecating on floor - 19 episodes," and "refusing meds. 6 episodes." This record contained many areas which were blank and had omissions/blanks related to the resident's behaviors. In addition the record was "signed as completed" even though the evening shift nor night shift had yet occurred for 01-22-2014.</p> <p>The record contained only 1 additional physician progress note, dated 09-04-13 in which the physician indicated "Nursing staff reports increased agitation and inappropriate behavior in late afternoon and evening. Sleeps fairly well at night. Plan: increase Seroquel dose - orders written. Increase Lunch and dinner doses to 50 mg. Re-evaluate in 1 - 2 weeks."</p> <p>A re-evaluation progress note could not be located.</p> <p>A review of the facility "Resident Handbook," on 01-22-14 at 1:00 p.m., indicated the following: "Dignity - Residents have the right to be free from any physical or</p>			

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R000052	<p>chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms."</p> <p>During an interview on 01-22-14 at 2:25 p.m, Unit Manager of the Keepsake Village Unit indicated she was unaware the nursing staff gave the medication, Klonopin, to the resident so frequently.</p> <p>The nursing staff failed to ensure the physician was aware of the resident escalation in the type and number of behaviors, in which the nursing staff continued to administer the medication Klonopin as a restraint to control the resident's behaviors for the purpose of convenience/discipline.</p> <p>This State finding relates to Complaint IN00141998.</p> <p>410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on record review and</p>	R000052		02/24/2014			

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	<p>interview the facility failed to ensure residents were not subjected to threats of physical abuse, in that when a resident was diagnosed with Lewy Body dementia, and dementia with behavioral disturbances and had been assessed with targeted behaviors which included agitation, aggression, showing a fist in a threatening manner to another resident with dementia, and entering other resident rooms, with destruction of personal belongings and defecating inappropriately, the nursing staff failed to ensure other residents were protected and not subjected to the aggression of Resident "C."</p> <p>This deficient practice had the potential to effect the other 27 residents who resided on the secured Keepsake Unit.</p> <p>Findings include:</p> <p>The record for Resident "C" was reviewed on 01-22-14 at 11:50 a.m. Diagnoses included, but were not limited to, Lewy Body dementia, Parkinsons, anorexia, and aphasia. These diagnoses remained current at the time of the record review. The resident was admitted to the facility on 08-26-13.</p>		<p>R 052</p> <p>1. Resident C's physician and family were notified of the need for an evaluation at a Behavioral Care Center, based on his behaviors noted prior to January 23, 2014. The resident was assessed by the Behavioral Center January 23, 2014 and admitted for treatment the same day.</p> <p>2. All residents on the Keepsake unit have the potential to be affected by the deficient practice. All nursing staff will be in-serviced on the facility policy regarding admission/discharge criteria for the Keepsake Unit.</p> <p>All nursing staff will also be in-serviced on appropriate reporting of behaviors. Training for both topics will be completed by February 24th,</p>	

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	<p>The admission nursing evaluation, dated 08-26-13 indicated the resident's diagnoses included, but were not limited to, dementia with Lewy bodies and dementia with behavior disturbances.</p> <p>The record indicated the resident was seen by the attending physician on 08-28-13. The physician progress notes indicated, "At his previous facility, it was reported that he was a fall risk, demonstrated exit seeking behavior, took his clothes off at times and urinated on the floor at times. He has defecated on the floor on one occasion since admission here." The physician also indicated the resident has had "periods of agitation."</p> <p>A review of the Nurses Notes from the time of admission through December 29, 2013, the resident displayed the following behaviors:</p> <p>"09-01-13 11:00 a.m. Has been very calm - follows redirections well but when kitchen was setting up DR [dining room] pt. [patient] grabbed knives in stab position became very verbal/angry could not redirect, body posture became stiff with blades of knives pointing at staff - got knives</p>		<p>2014.</p> <p>3. The Director of Nursing will have daily stand up meetings with CNAs and nurses to discuss behaviors/change of condition noticed by the front line caregivers. The meetings will continue for 30 days to reinforce the training and taper off to once per week for 90 days of monitoring.</p> <p>4. After 90 days, the DON will monitor monthly in the Keepsake unit the behaviors, 24 hour reports, nurse's notes and staff input. The Director of Nursing will monitor the unit daily by review of the 24 hour report and that it reflects any pertinent issues, concerns and communications based on the daily meeting, and/or weekly meetings.</p>				

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	<p>away - could not do 1:1 or redirect prn [as needed] Klonopin given with noon Seroquel."</p> <p>"09-01-13 10:00 p.m. Increased agitation - 1:1 and numerous redirection <sic>not help pt. Went into Room [number documented of another resident's room] et [and] tore room up. Gave another Klonopin - into many rooms on unit ans <sic> phone by med cart."</p> <p>"09-07-13 at 12:00 p.m. Very restless - in and out of others room - taking pictures off walls - took off all clothes walking down hall naked 1:1 and redirection times 4 Klonopin given."</p> <p>"09-15-13 10:00 a.m. Can not redirect - voiding in the flowers by the pillars, on the carpet, in the halls even after taken to BR [bathroom] 1:1 gave Klonopin."</p> <p>"09-29-13 12 Midnight - Up in halls - waking up other pts. 1:1 redirected to bed times 4. 1:00 a.m. Very restless - 1:1 redirected - took to Act. [activity] room to watch TV. In and out of others rooms. 2:00 a.m. Klonopin given for increased agitation 1:1 and redirected back to bed. 5: 30 p.m. Redirected times 6</p>			

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	<p>to table. Sat down at table times 10 - becoming 'strong armed' with staff - sat on recliner. 1:1 and redirected again. Disrupting DR. In and about other pts. [patients] plates. Gave Klonopin."</p> <p>"09-30-13 1:30 a.m. Tore all clothes from closet and room to floor - [arrow up] and [arrow down] in others rooms waking up other pts. Put back to bed times 8 - sat on recliner would not sit - 1:1 and redirected times 10. Klonopin given at 1:30 a.m."</p> <p>"09-30-13 5:15 p.m. Tried to sit down for dinner times 6 finally ate a few bites - [arrow pointing upward] taking food off others plates - dragging chairs down hallway, 1:1 and redirected times 5 has stiff body posture. Sat in recliner but not happy there either - offered [illegible word] and dinner times 3. 6:30 p.m. Behavior [arrow pointing upward] ing, Klonopin given."</p> <p>"10-05-13 8:00 p.m. Took meds [medications] well all day - very nervous et sits on floor et picks paint off pillars in DR/Act [dining room/activity room] - voids on carpet. Has torn apart flowers/pots at ends of back hall - takes off</p>			

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	<p>clothes et walks around naked - In and out of pts rooms - disrupting others rooms."</p> <p>"10-06-13 7:00 p.m. Meds taken can not redirect - In and out of pts rooms - disruptive in rooms - needs to have [room number documented] a fixed so he can not open them - tears out all closets contents on floor of room no change from 10-05-14."</p> <p>"10-13-13 9:30 a.m. Eating off others plates on tables - ate 100 % of bkfst [breakfast] plus more bkfst I brought to him. Taking plates and glasses off tables - taking off table clothes - redirected times 5."</p> <p>"11-02-13 at 12:30 p.m. Climbing on tables in DR before bkfst crawling on floor in every ones rooms - can not redirect - 1:1 taken to Act. [activity] room away from noise - no help. Klonopin given. At 8:30 a.m. ate well for bkfst - had large stool on carpet in room."</p> <p>"11-10-13 at 2:00 p.m. Had to take out of church since pt. [patient] [Resident "E"] in [room number documented] was talking [illegible word] mean to him - he was about to hit with fist. [Room number of other resident] took 1/2 hour to calm down</p>			

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	<p>by staff. To give Klonopin angry non sensical verbage <sic>."</p> <p>"11-10-13 9:00 p.m. Pooped on recliner in DR - carpet in DR - hallway times 2. Halls and in [room number of another resident documented]."</p> <p>"11-14-13 9:30 p.m. Trying to hit staff with closed fists. Took 2 staff to help to bed...did not eat dinner or take dinner et noc [night] meds - too combative - in others room taking items."</p> <p>"1-19-2013 <sic> 8:00 p.m. Resident very restless since start of shift. Banging walls with fist. Redirected several times. Went to other peers room asked if he needs to use bathroom - took him to bathroom et stated 'no.' Continually pacing unit, pulled fire extinguisher from wall - attempted to pull out lock several times and got frustrated. Started banging it against wall. Writer able to grab the fire extinguisher with help of 2 CNAS. Defecated on the hallway after eating dinner. Given Klonopin at 7:00 p.m. Sleeping at present time."</p> <p>"11-28-13 7:00 p.m. went into [room number documented of another</p>						

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	<p>resident] defecated all over room - carpet - BR - [room number documented] bed - room so bad [resident who resided in this room] had to sleep in [room number documented of another available room]. Had stool all over himself - would not amb [ambulate] to his room for a shower. Took 3 staff and w/c [wheelchair] to get him to his room et 2 staff for shower - all 3 staff has stool on them from pt. being combative et crawling on the floor with stool all over him. Called DON [Director of Nurses], aware."</p> <p>"12-28-13 12:00 p.m..... Very agitated - balling up fist at staff - into all rooms taking items from walls/rooms. Redirected so many times without problem solved. Klonopin given."</p> <p>A review of the "Monthly Behavior Monitoring Flowsheet for September 2013 indicated the nursing staff were tracking two "targeted behaviors" which included "increased anxiety - 73 episodes" over all three shifts (days - evening and nights)and "striking out - 7 episodes" over all three shifts.</p> <p>A review of the "Monthly Behavior Monitoring Flowsheet for October</p>						

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	<p>and November 2013 indicated the nursing staff were tracking three "targeted behaviors" which included "increased anxiety - 173 episodes" over all three shifts, "laying on the floor - 162 episodes" over all three shifts, and "climbing - 39 episodes" over all three shifts.</p> <p>A review of the "Monthly Behavior Monitoring Flowsheet for December 2013 indicated the nursing staff were tracking four "targeted behaviors" which included "increased anxiety/agitation - 26 episodes" over all three shifts," "laying on the floor - 72 episodes" over all three shifts and "climbing - 37 episodes" over all three shifts.</p> <p>A review of the "Monthly Behavior Monitoring Flowsheet for January 2014, dated January 1, 2014 thru January 22, 2014 to include "day/evening and night shift," indicated the nursing staff were tracking five "targeted behaviors" which included "increased anxiety/agitation - with 65 episodes," "laying on the floor with 23 episodes," "climbing with 13 episodes," "defecating on floor - 19 episodes," and "refusing meds. 6 episodes."</p>			

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	<p>The record contained only 1 additional physician progress note, dated 09-04-13 in which the physician indicated "Nursing staff reports increased agitation and inappropriate behavior in late afternoon and evening. Sleeps fairly well at night. Plan: increase Seroquel dose - orders written. Increase Lunch and dinner doses to 50 mg. Re-evaluate in 1 - 2 weeks."</p> <p>A re-evaluation progress note could not be located.</p> <p>During an interview on 01-22-14 at 2:25 p.m., the Unit Manager of the Keepsake Village Unit and the Administrator indicated they were unaware of the incident on 09-01-13 at 11:00 a.m., when the resident grabbed the knives and pointed them in a threatening manner.</p> <p>Further interview on 01-22-14 at 3:45 p.m., during the Daily Exit Conference, the Unit Manager indicated the resident had at one time resided with a family member. "[Family member] told me she couldn't take care of him anymore because one night while sleeping, [name of Resident "C"] took the kitchen cabinets off the walls, and the ones he couldn't take off, he tore</p>						

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	<p>the rest of them off the walls. We didn't know that when he was admitted."</p> <p>A review of the facility brochure for the Keepsake Village on 01-22-14 at 1:00 p.m., indicated "Every aspect of Keepsake Village at The Hearth at Windermere is tailored to meet the physical and emotional challenges of individuals living with dementia. We offer a calm, stress free environment with therapeutic and social stimulation, personal care assistance and medical evaluations."</p> <p>A review of the "Resident Handbook," on 01-22-14 at 12:30 p.m. indicated the "following services as needed which are included in the monthly rate: re-direction, counseling with Resident and/or family, or behavioral intervention by staff members."</p> <p>In addition, the "Resident Handbook" indicated, "Residents have the right to be free from sexual abuse, physical abuse, mental abuse, corporal punishment, neglect and involuntary seclusion. The facility shall exercise reasonable care for the protection of resident's property from loss and theft."</p>			

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R000096	<p>The nursing staff failed to ensure the protection of other resident's and their personal property, while Resident "C" continued to display aggressive and agitated behaviors.</p> <p>This State finding relates to Complaint IN00141998. 410 IAC 16.2-5-1.3(m)(1-2)(A-B)(i-iii) Administration and Management - Deficiency (m) The director of the Alzheimer's and dementia special care unit shall do the following: (1) Oversee the operation of the unit. (2) Ensure that: (A) personnel assigned to the unit receive required in-service training; and (B) care provided to Alzheimer's and dementia care unit residents is consistent with: (i) in-service training; (ii) current Alzheimer's and dementia care practices; and (iii) regulatory standards.</p> <p>Based on record review and interview the facility failed to ensure the Director of the Alzheimer's and dementia special care unit, employee #4, the protection of the residents who resided on the secured dementia unit, in that when a resident exhibited escalating behaviors the Director of the Alzheimer's Unit failed to intervene and ensure the Administrator and the resident's physician were aware</p>	R000096	<p>1. The Director of Nursing will assume management of the Keepsake Unit.</p> <p>2. All residents on the Keepsake unit have the potential to be</p>	02/24/2014			

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	<p>of the behaviors which posed a threat to other residents and staff for 1 of 4 residents reviewed for behaviors on the Keepsake Unit. (Resident "C").</p> <p>This deficient practice effected the other 27 residents who resided on this secured dementia unit.</p> <p>Findings include:</p> <p>The record for Resident "C" was reviewed on 01-22-14 at 11:50 a.m. Diagnoses included, but were not limited to, Lewy Body dementia, Parkinsons, anorexia, and aphasia. These diagnoses remained current at the time of the record review. The resident was admitted to the facility on 08-26-13.</p> <p>The admission nursing evaluation, dated 08-26-13 indicated the resident's diagnoses included, but were not limited to, dementia with Lewy bodies and dementia with behavior disturbances.</p> <p>The record indicated the resident was seen by the attending physician on 08-28-13. The physician progress notes for this visit indicated, "At his previous facility, it was reported that he was a fall risk,</p>		<p>affected by the deficient practice. The Unit Manager of the Keepsake</p> <p>dementia/special care unit will receive re-in-serving on the facility policy on</p> <p>admission/discharge criteria for the Keepsake unit and the policy for</p> <p>notification of physician and family when there is a change of condition. The Unit</p> <p>Manager will also be re-trained regarding (1) the appropriate use of prn</p> <p>meds/documentation in residents exhibiting behaviors, (2) the use of</p> <p>therapeutic interventions prior to the administration of a prn medication and</p> <p>(3) appropriate use of communication tools in relaying information to DON and</p> <p>administrator. Training will be completed by February 24th, 2014.</p> <p>3. The DON will have daily stand up meetings with the Unit Manager of</p>				

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	<p>demonstrated exit seeking behavior, took his clothes off at times and urinated on the floor at times. He has defecated on the floor on one occasion since admission here. He has had periods of agitation which appear to respond to Klonopin [an anticonvulsant medication]. Current outpatient prescriptions: Klonopin 0.25 mg [milligrams] disintegrating tablet - take 0.25 mg by mouth 2 [two] times daily as needed and Seroquel [antipsychotic medication] 25 mg - take 25 mg by mouth 3 [three] times daily and 50 mg by mouth nightly. Assessment 1. Lewy Body dementia. Plan: Admit to Keepsake Village unit at the Hearth at Windermere. Requires 24 hour supervision on a secured unit. Continue present medications May use Klonopin as needed for agitation/anxiety. Continue present dose of Seroquel. Prognosis is guarded due to severity of dementia."</p> <p>A review of the Nurses Notes from the time of admission through December 29, 2013, the resident displayed the following behaviors, some of which required the use of the Klonopin.</p> <p>"08-23-13 - At 6:00 p.m., resident</p>		<p>the Keepsake dementia/special care unit to discuss (1) change of condition/behaviors</p> <p>noted on the unit; (2) notification of physician/family when there is a change</p> <p>of condition or behaviors; (3) on-going training of Keepsake Unit staff; (4)</p> <p>the use of therapeutic interventions and appropriate documentation for prn</p> <p>medications. These meetings will occur five days a week for two weeks, then</p> <p>three times weekly for two weeks and</p> <p>then weekly for the next 90 days.</p> <p>4. After 90 days, the DON will be checking monthly the behaviors, 24</p> <p>hour report sheets, nurse's notes and staff input, in addition to the Change of</p> <p>Condition Audit Sheet (attachment b). The DON will monitor the unit daily by</p> <p>reviewing the 24 hour report to assure it reflects any pertinent</p>				

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	<p>started strippin in the halway <sic> when CNA [certified nurses aide] assisted him to put back his clothes he attempted throwing punches to everybody around. Blocked. Redirected not effective - given time out not effected. Assisted resident back to his room refused. Notified Nursing unit manager. Gave 25 mg Seroquel [scheduled] and Klonopin 0.25 mg [prn - as needed] refusing to take them at first but took it later. [Name of physician] spoke with [name of another physician] et [and] gave order to give resident another Klonopin 0.25 mg one time only."</p> <p>"08-27-13 3:45 p.m. This a.m. had inc. [incontinent] BM [bowel movement] behind his door et rolling in his hands. Requires frequent redirection."</p> <p>"08-30-13 2:00 p.m. This a.m. removing pictures from hallway walls, moving linen carts and [illegible word] given."</p> <p>"09-01-13 11:00 a.m. Has been very calm - follows redirections well but when kitchen was setting up DR [dining room] pt. [patient] grabbed knives in stab position became very verbal/angry could not redirect, body posture became stiff with blades of</p>		<p>issues/concerns and that they have been communicated to the Administrator and</p> <p>DON in a timely manner.</p>				

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	<p>knives pointing at staff - got knives away - could not do 1:1 or redirect prn [as needed] Klonopin given with noon Seroquel."</p> <p>"09-01-13 10:00 p.m. Increased aggitation - 1:1 and numerous redirection <sic>not help pt. Went into Room [number documented of another resident's room] et [and] tore room up. Gave another Klonopin - into many rooms on unit ans <sic> phone by med cart."</p> <p>"09-07-13 at 12:00 p.m. Very restless - in and out of others room - taking pictures off walls - took off all clothes walking down hall naked 1:1 and redirection times 4 - Klonopin given."</p> <p>"09-07-13 8:00 p.m. Defecated on carpet in back of Unit. Taken to room et cleaned up and cleaned up floor - 1:1 and redirection times 5 without any results - Klonopin given."</p> <p>"09-15-13 10:00 a.m. Can not redirect - voiding in the flowers by the pillars, on the carpet, in the halls even after taken to BR [bathroom] 1:1 gave Klonopin."</p> <p>"09-15-13 2:00 p.m. No change in</p>			

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	<p>behaviors still voiding everywhere."</p> <p>"09-29-13 12 Midnight - Up in halls - waking up other pts. 1:1 redirected to bed times 4. 1:00 a.m. Very restless - 1:1 redirected - took to Act. [activity] room to watch TV. In and out of others rooms. 2:00 a.m. Klonopin given for increased agitation 1:1 and redirected back to bed. 5: 30 p.m. Redirected times 6 to table. Sat down at table times 10 - becoming 'strong armed' with staff - sat on recliner. 1:1 and redirected again. Disrupting DR. In and about other pts. [patients] plates. Gave Klonopin."</p> <p>"09-30-13 1:30 a.m. Tore all clothes from closet and room to floor - [arrow up] and [arrow down] in others rooms waking up other pts. Put back to bed times 8 - sat on recliner would not sit - 1:1 and redirected times 10. Klonopin given at 1:30 a.m."</p> <p>"09-30-13 5:15 p.m. Tried to sit down for dinner times 6 finally ate a few bites - [arrow pointing upward] taking food off others plates - dragging chairs down hallway 1:1 and redirected times 5 has stiff body posture. Sat in recliner but not happy there either - offered [illegible</p>			

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	<p>word] and dinner times 3. 6:30 p.m. Behavior [arrow pointing upward] ing, Klonopin given."</p> <p>"10-05-13 8:00 p.m. Took meds [medications] well all day - very nervous et sits on floor et picks paint off pillars in DR/Act [dining room/activity room] - voids on carpet. Has torn apart flowers/pots at ends of back hall - takes off clothes et walks around naked - In and out of pts rooms - disrupting others rooms."</p> <p>"10-06-13 7:00 p.m. Meds taken can not redirect - In and out of pts rooms - disruptive in rooms - needs to have [room number documented] a fixed so he can not open them - tears out all closets contents on floor of room no change from 10-05-14."</p> <p>"10-13-13 9:30 a.m. Eating off others plates on tables - ate 100 % of bkfst [breakfast] plus more bkfst I brought to him. Taking plates and glasses off tables - taking off table clothes - redirected times 5."</p> <p>"10-24-13 5:44 p.m. [Name of two Certified nurses Aides] noted resident was naked - had taken his clothes off - fighting with CNA's. [Name of CNA] reported he was</p>						

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	<p>clawing at [name of another CNA] who stated the left arm was clawed at. Redness noted to areas shown of left lower and upper arm."</p> <p>"11-02-13 at 12:30 p.m. Climbing on tables in DR before bkfst crawling on floor in every ones rooms 0 can not redirect - 1:1 taken to Act. [activity] room away from noise - no help. Klonopin given. At 8:30 a.m. ate well for bkfst - had large stool on carpet in room."</p> <p>"11-10-13 at 2:00 p.m. Had to take out of church since pt. [patient] in [room number documented] was talking [illegible word] mean to him - he was about to hit with fist. [Room number of other resident] took 1/2 hour to calm down by staff. To give Klonopin angry non sensical verbage <sic>."</p> <p>"11-10-13 9:00 p.m. Pooped on recliner in DR - carpet in DR - hallway times 2. Halls and in [room number of another resident documented]."</p> <p>"11-14-13 9:30 p.m. Trying to hit staff with closed fists. Took 2 staff to help to bed...did not eat dinner or take dinner et noc [night] meds - too combative - in others room taking</p>			

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	<p>items."</p> <p>"11-16-13 9:00 p.m. Turned chairs over in DR et put chairs on tables after dinner. Family here after dinner - took off plates/food glasses and tablecloth from table et put in lobby. Family wants him to see podiatrist when he comes. Put on calendar for Monday."</p> <p>"1-19-2013 <sic> 8:00 p.m. Resident very restless since start of shift. Banging walls with fist. Redirected several times. Went to other peers room asked if he needs to use bathroom - took him to bathroom et stated 'no.' Continually pacing unit, pulled fire extinguisher from wall - attempted to pull out lock several times and got frustrated. Started banging it against wall. Writer able to grab the fire extinguisher with help of 2 CNAS. Defecated on the hallway after eating dinner. Given Klonopin at 7:00 p.m. Sleeping at present time."</p> <p>"11-28-13 7:00 p.m. went into [room number documented of another resident] defecated all over room - carpet - BR - [room number documented] bed - room so bad [resident who resided in this room] had to sleep in [room number</p>						

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	<p>documented of another available room]. Had stool all over himself - would not amb [ambulate] to his room for a shower. took 3 staff and w/c [wheelchair] to get him to his room et 2 staff for shower - all 3 staff has stool on them from pt. being combative et crawling on the floor with stool all over him. Called DON [Director of Nurses], aware."</p> <p>"11-30-13 8:00 p.m. 1:1 times 4 - walked with pt. around unit times 2 until he sat on floor - have redirected several times - climbing on tables in DR - drawing fist back at staff - gave Klonopin at this time."</p> <p>"11-30-13 1:30 p.m. Went in [room number documented] et defecated all over room and BR."</p> <p>"12-01-13 9:00 a.m. Climbing on tables - shaking closed fist at staff - very agitated 1:1 times 5 minutes - walked around unit only to have him sit on floor et scoot down hallway - Klonopin given."</p> <p>"12-01-13 5:00 p.m. Taking all dirty laundry out of hampers et throwing on floor - very agitated - 1:1 time 8 minutes only made aggitation worse. Meds given and Klonopin with much difficulty - too agitated to sit down to</p>						

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	<p>eat...."</p> <p>"12-06-13 1:50 p.m. At 12:45 p.m. [arrow pointing upward] anxiety et difficult to redirect with several attempts et Klonopin 1/2 tab given as per order."</p> <p>"12-14-13 6:00 p.m. Climbing on sofa chairs, tables. Can not redirect Klonopin given for aggitation at 8:00 a.m. and 5:00 p.m."</p> <p>"12-15-13 8:00 p.m. Has been hitting with closed fists - laying on floor - moving furniture - very agitated all day can not redirect Klonopin given at 8:00 a.m. and 5:00 p.m."</p> <p>"12-28-13 12:00 p.m..... Very agitated - balling up fist at staff - into all rooms taking items from walls/rooms. Redirected so many times without problem solved. Klonopin given."</p> <p>"12-29-13 2:00 p.m. Crying all <sic> at noon. Running down halls at bkfst time 'the sewer gas is going to explode.' Tried to calm pt but only became more agitated. Meds given times 4 with Klonopin et spit meds on floor/table/self. Called family to talk to him 'my throat is cut.' Took</p>						

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	<p>him to a mirror to show him this was not true took meds at 5:00 p.m."</p> <p>The record lacked further Nurses Notes from 12-29-13 through 01-22-14. However a review of the January 2014 PRN (as needed) Medication Record indicated the following in regard to the resident being given Klonopin:</p> <p>01-01-14 2:13 a.m. - "reason: uncooperative with CNA." 01-03-14 6:00 p.m. - "reason: BLANK." 01-04-14 4:00 p.m. - "reason: urinating on floor increased anxiety. 01-17-14 6:00 p.m. - "reason: BLANK."</p> <p>A review of the "Monthly Behavior Monitoring Flowsheet for September 2013 indicated the nursing staff were tracking two "targeted behaviors" which included "increased anxiety - 73 episodes" over all three shifts (days - evening and nights) and "striking out - 7 episodes" over all three shifts.</p> <p>A review of the "Monthly Behavior Monitoring Flowsheet for October and November 2013 indicated the nursing staff were tracking three "targeted behaviors" which included</p>			

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	<p>"increased anxiety - 173 episodes" over all three shifts, "laying on the floor - 162 episodes" over all three shifts, and "climbing - 39 episodes" over all three shifts.</p> <p>A review of the "Monthly Behavior Monitoring Flowsheet for December 2013 indicated the nursing staff were tracking four "targeted behaviors" which included "increased anxiety/agitation - 26 episodes" over all three shifts," "laying on the floor - 72 episodes" over all three shifts and "climbing - 37 episodes" over all three shifts.</p> <p>A review of the "Monthly Behavior Monitoring Flowsheet for January 2014, dated January 1, 2014 thru January 22, 2014 to include "day/evening and night shift," indicated the nursing staff were tracking five "targeted behaviors" which included "increased anxiety/agitation - with 65 episodes," "laying on the floor with 23 episodes," "climbing with 13 episodes," "defecating on floor - 19 episodes," and "refusing meds. 6 episodes." This record contained many areas which were blank and had omissions/blanks related to the resident's behaviors. In addition the record was "signed as completed"</p>						

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	<p>even though the evening shift nor night shift had yet occurred on January 22, 2014.</p> <p>The record contained only 1 additional physician progress note, dated 09-04-13 in which the physician indicated "Nursing staff reports increased agitation and inappropriate behavior in late afternoon and evening. Sleeps fairly well at night. Plan: increase Seroquel dose - orders written. Increase Lunch and dinner doses to 50 mg. Re-evaluate in 1 - 2 weeks."</p> <p>A re-evaluation progress note could not be located.</p> <p>During an interview on 01-22-14 at 2:25 p.m., the Unit Manager of the Keepsake Village Unit and the Administrator indicated they were unaware of the incident on 09-01-13 at 11:00 a.m., when the resident grabbed the knives and pointed them in a threatening manner. The Administrator indicated, "After you brought it to our attention, we checked the 24 hour reports and there was nothing documented by the nurses, and we review the 24 hour reports every morning."</p> <p>In additional the Unit Manager</p>						

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	<p>indicated she was unaware the nursing staff gave the medication, Klonopin, to the resident so frequently. Further interview on 01-22-14 at 3:45 p.m., during the Daily Exit Conference, the Unit Manager indicated the resident had at one time resided with a family member. "[Family member] told me she couldn't take care of him anymore because one night while sleeping, [name of Resident "C"] took the kitchen cabinets off the walls, and the ones he couldn't take off, he tore the rest of them off the walls. We didn't know that when he was admitted."</p> <p>The Director of the Alzheimers Special Care Unit, failed to ensure the oversight of the unit when a resident displayed behaviors which impacted the lives of other residents who resided on the unit and staff members who worked there to ensure the care provided to the residents was consistent with current Alzheimer's and dementia care practices.</p> <p>This State finding relates to Complaint IN00141998.</p>			