

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155231	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/10/2014
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NAME OF PROVIDER OR SUPPLIER RANDOLPH NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 701 S OAK ST WINCHESTER, IN 47394
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: November 3, 5, 6, 7, and 10, 2014</p> <p>Facility Number: 000136 Provider Number: 155231 AIM Number: 100275450</p> <p>Survey Team: Karen Lewis, RN-TC Ginger McNamee, RN Toni Maley, BSW Tina Smith-Staats, RN (November 5, 6, 7, and 10, 2014)</p> <p>Census Bed Type: SNF/NF: 76 Total: 76</p> <p>Census Payor Type: Medicare: 7 Medicaid: 45 Other: 24 Total: 76</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by Debora</p>	F000000	<p>This Plan of Correction is our credible allegation of compliance. Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement of the facts alleged or conclusions set forth in this statement of deficiencies. The facility maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. The plan of correction and specific corrective actions are prepared and/or executed in compliance with the state and federal laws. Please accept this plan of correct as it constitutes our credible allegation of compliance with all regulatory requirements.</p> <p>Randolph Nursing Home is requesting a desk review for these citations.</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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F000155 SS=D	<p>Barth, RN.</p> <p>483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. Based on interview and record review, the facility failed to ensure a resident's "Code Status" order was in accordance with the resident's wishes for 1 of 1 resident which had recently experienced a cardiovascular event. (Resident #92)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #92</p>	F000155	Randolph Nursing Home IDR Request for F155 November 24, 2014 Randolph Nursing Home is requesting an IDR to remove F155. This facility is in compliance with the requirement that a "resident has the right to refuse treatment, to refuse to participate in experimental research and to formulate an advance directive and with our facility policy". Resident #92 admitted to this facility on 9/26/14	12/10/2014

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	<p>was reviewed on 11/7/14 at 9:44 a.m. Diagnoses included, but were not limited to, end stage renal disease, hypertension, atrial fibrillation, and history of respiratory failure.</p> <p>Resident #92's chart was marked "DNR", indicating the resident did not want to receive CPR (cardiopulmonary resuscitation) in the event the resident's heart would stop beating.</p> <p>A "PHYSICIAN FAX SHEET", dated 11/4/14, indicated during Resident #92's dialysis treatment, the dialysis staff were unable to "get a pulse on res (resident), CPR performed for < (less than) 1 min (minute) et (and) res (resident) currently stable."</p> <p>During an interview with Resident #92 on 11/7/14 at 10:10 a.m., he indicated he wanted CPR unless he was "brain dead". He further indicated he was happy with what the dialysis staff did on 11/4/14 in regards to performing CPR.</p> <p>During an interview with the Social Services Director, on 11/7/14 at 11:08 a.m., she indicated she had verbally gone over code status with Resident #92 during his admission. She indicated Resident #92 had become fatigued and asked for his daughter to sign the form</p>		<p>with a diagnosis of ESRD, Respiratory failure, aspiration pneumonia, and DVT's at which time he made a decision to have his daughter sign his code status paper for "Do Not Resuscitate". Resident was seen by the MD on 9/29/14 at which time the MD progress note states (He is a no code currently), and had a POST form completed at this time. Another progress not was written on 10/8/14 when the Resident had a change in health status at which time the MD discussed options with Resident and family of No treatment, hospice, or hospital with targeted treatment. Family and resident were in agreement with Do Not Resuscitate code status. Again the MD progress note dated 10/8/14 stated No CPR which has already been decided. Resident was sent to the hospital on 10/8/14, and returned on 10/17/14. The hospital History and Physical stated under the social history section He desires to be a Do Not Resuscitate with comprehensive care and this is what he was at the nursing home also. We will honor his wishes and his daughter is at bedside and also in agreement with this. An Order for DNR was obtained on 10/17/14 at the time of readmission. On 10/22/14 The MD visits the resident and the progress note again states he is a DNR. On 11/4/14 The resident went to Dialysis and while there</p>		

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	<p>for him. Resident #92's daughter signed the "INDIANA PHYSICIAN ORDERS FOR SCOPE OF TREATMENT", which had the box for "Do Not Attempt Resuscitation" marked as what the resident wished in case the resident had no pulse and was not breathing. The form was dated 9/26/14. The Social Services Director indicated she would clarify Resident #92's code status with Resident #92 and his daughter.</p> <p>Review of the current facility policy, dated 3/25/14, titled "Advance Directives", provided by the Assistant Director of Nursing on 11/7/14 at 12:07 p.m., included, but was not limited to:</p> <p>"...Social Services Director/designee determines on admission whether the resident has Advanced Directives. If not, the Social Services Director/designee, determines whether the resident wished to formulate an Advance Directive....</p> <p>...The Social Services Director/designee periodically provides education related to Advanced Directives. At any time the resident who wished to engage or change and (sic) Advance Directive, the Social Services Director/designee directs the resident or legal representative to the appropriate resource...</p>		<p>the dialysis center stated they could not get a pulse and CPR was provided for less than 1 minute. The MD was made aware and made no changes. On 11-5-14, the resident and daughter were invited to attend a care plan conference and discuss and review the residents code status. The resident declined to attend. The code status was reviewed with no changes made and the resident remained a DNR as per his and the families wishes. According to the 2567, the surveyor stated that on 11-7-14 the resident had told her he wanted to be a full code unless he was brain dead. Social Services went to the Resident's room and asked him if he wanted to change his code status, and the resident stated "Yes, I want everything done unless I'm brain dead". Social Services then notified the nurse so she could contact the MD to obtain an order for a full code status. Later on 11/7/14, Resident told Social Service Director he was confused by the questions asked by the other lady about code status. Nursing notified the resident's daughter and MD regarding his comment that he wanted everything done in regards to his code status unless brain dead and the full code status was observed. On 11/11/14 Social Service Director asked Resident if he wanted to be a full code or a DNR and resident again stated he</p>				

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	<p>...The Social Service Director/designee documents ongoing communication and status of any Advance Directives with the resident or legal representative, and the interdisciplinary team...."</p> <p>3.1-4(a)(4)(A)(ii)</p>		<p>wanted to be a DNR, and again stated that he had become confused about the questions asked from the previous lady related to code status. 11/12/14 MD was in to visit with Resident the DON asked the MD to speak with the resident again, to ensure that the resident understood what was being asked related to code status. The MD spoke with the resident again, and he stated to the MD that the resident wished to remain a DNR and had become confused by the questions being asked. The resident stated "I just want to be comfortable, yes, just let me go." The family and the resident both re-iterated to the MD that he wanted to continue with a DNR status and the MD wrote an order at this time for No Code, No transport to the hospital unless needed for comfort per patient and per POA. The resident has had varying levels of confusion during his BIMS score has gone from a 15 to a 9 during his admission. The facility contends that the residents code status was in accordance with the resident's wishes and that in the event a resident or responsible party makes their desire for a change in their code status that the facility directs the resident or legal representative to the appropriate resource and documents ongoing communication and status of any Advance Directives with the</p>		

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			<p>resident or legal representative and the Interdisciplinary team as directed in F155 and the facility policy and therefore no deficient practice should be cited. F 155</p> <p>·Resident #92 has had his code status reviewed and continues to desire a Do No Resuscitate code status.</p> <p>·An audit was completed of residents and their satisfaction with current code status as indicated in the medical record.</p> <p>·Residents have their code status reviewed upon admission, and then no less than quarterly, or when a request or desire is voiced, by a resident or responsible party as appropriate. Any desired changed would be implemented per procedure at this time. Social services was re-educated to the Advanced Directives policy.</p> <p>·The Social Services director or designee will complete an audit of 5 residents code status monthly times 6</p>		

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F000241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, interview and record review, the facility failed to protect resident's dignity regarding waits	F000241	months to determine that the residents current wishes in regards to Code status are accurately reflected in the medical record. Results will be presented to the Quality Assurance committee monthly and an action plan will be developed for any non-compliance. Completion Date: 12/10/14 F 241	12/10/2014			

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	<p>for meals and activities, and being repeatedly asked to sit down when desiring to leave an area for 4 of 4 residents reviewed for the provision of care and treatment in a dignified manner (Residents #64, #93, #45 and #67).</p> <p>Findings include:</p> <p>1. Resident #64's clinical record was reviewed on 11/10/14 at 2:31 p.m. Resident #64's current diagnoses included, but were not limited to, Alzheimer's Disease with delusions and depression. Resident #64 had a current, 9/20/14, quarterly, Minimum Data Set (MDS) assessment which indicated the resident had limited cognitive functioning and rarely or never made independent choices, usually understood others and was understood by others with some explanation and cueing and required limited to extensive assistance with activities of daily living.</p> <p>2. Resident #93's clinical record was reviewed on 11/7/14 at 9:12 a.m. Resident #93's current diagnoses included, but were not limited to, Alzheimer's Disease and fractured left</p>		<ul style="list-style-type: none"> · Residents #64, 93, 45, and 67 have had their activity programs reviewed along with care plans to assure appropriate activities are in place and occurring for these residents. Diversionary, sensory, and tactile materials are in the dining area and set up for residents as indicated to promote and maintain resident dignity and respect. · An audit of the activities programs, care plans, and activity calendar have been completed by the Activity Director/Designee to ensure all residents receive activities as appropriate and that care is provided in an environment to maintain or enhance dignity and respect. · The Activity Director/Designee will re-educate the activity and nursing staff on the protocol, and policy regarding offering, encouraging, assisting, and engaging with residents that are specific to meet each resident's needs in a manner that maintains or enhances each residents dignity and respect. · The Activity Director /Designee will audit activities to include before meal times 3 times daily for 4 weeks, then 3 times weekly for 4 weeks, then monthly for 4 months to ensure compliance. Results will be presented to the QA committee monthly and an action plan will be developed for any 	

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	<p>wrist. Resident #93 had been admitted to the facility within the past 90 days. Resident #93 had a current, 10/8/14, admission, Minimum Data Set (MDS) assessment which indicated the resident rarely or never made independent choices without prompting and cueing and required extensive assistance with activities of daily living.</p> <p>3. Resident #45's clinical record was reviewed on 11/7/14 at 10:09 a.m. Resident #45's current diagnoses included, but were not limited to, Alzheimer's Disease delusions and behavioral disturbances, depression and severe back pain. Resident #45 was admitted to the facility in the past 90 days.</p> <p>Resident #45 had a current, 10/9/14, admission, Minimum Data Set (MDS) assessment which indicated the resident was severely cognitively impaired and rarely or never made choices, rarely or never understood others and was rarely or never understood by others and required extensive to total assistance with activities of daily living.</p> <p>4. Resident #67's clinical record was reviewed on 11/7/14 at 10:00 a.m. Resident #67's current diagnoses</p>		<p>non-compliance.</p> <p>Completion Date: 12/10/14</p>	

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	<p>included, but were not limited to, dementia, anxiety and depression.</p> <p>Resident #67 had a current, 9/24/14, significant change, Minimum Data Set (MDS) assessment which indicated the resident usually understood others and was usually understood by others with cueing and prompting, rarely or never made independent choices and required limited to extensive assistance with activities of daily living.</p> <p>5. During an 11/3/14, 11:09 a.m. to 12:20 p.m., pre-meal activity observation in the secured Dementia Unit Dining/Activity Area the following occurred:</p> <p>On 11/3/14 at 11:09 a.m., 14 residents were seated at tables as if ready to dine. The TV was on the news. The volume of the TV was at a low level which did not allow an individual to understand all that was being said especially if anyone in the area was talking. Six residents were seated with their backs to the TV. None of the residents appeared to be watching the television program. Three residents were asleep. There were no diversionary, sensory or tactile materials any where in the area (such as puzzles, tools, magazines, books, toys or manipulative devices.) Residents #64, #93 and #45</p>			

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	<p>were seated in the area.</p> <p>At 11:19 a.m., Resident #64 stood and attempted to exit the area and was told, by an unidentified CNA, to sit down lunch would be soon. Resident #64 sat back down.</p> <p>At 11:29 a.m., Resident #64 stood and exited the area. Resident #64 was escorted back into the room (by an unknown CNA) almost immediately after exiting it. Resident #64 was told the meal was almost ready and instructed to sit down again.</p> <p>On 11/3/14 at 11:45 a.m., Resident #93 was served her meal. She had been seated at the table without activity participation or diversionary material from 11:09 a.m. to 11:47 a.m. (38 minutes). During this 38 minute wait, Resident #93 became restless, spoke in a high pitched voice and parroted Resident #67.</p> <p>On 11/3/14 at 11:52 a.m., Resident #64 was served her meal. She had been seated at the table without activity participation or diversionary materials from 11:09 a.m. to 11:52 a.m. (43 minutes).</p> <p>On 11/3/14 at 11:55 a.m., dependent</p>			

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	<p>Resident #45 was served her meal. Her meal sat in front of her uncovered until 11:57 a.m., when she was assisted to eat by staff. She sat at the table without activity participation or diversionary materials from 11:09 a.m. to 11:57 a.m. (48 minutes).</p> <p>6. During an 11/5/14, 9:19 a.m. to 9:58 a.m., activity observation in the secured Dementia Unit Dining/Activity Area the following occurred:</p> <p>On 11/5/14 from 9:19 a.m. to 9:28 a.m. (9 minutes), 10 residents sat in the activity area with no activity offered. The area lacked any form of diversion or sensory material (such as books, magazines, tools, games, puzzles). At 9:28 a.m., the Activity Director/ Alzheimer's Unit Manager indicated there would be piano music at 9:45 a.m., so everyone needed to get seated and ready. She then rearranged chairs and placed residents facing a piano. By 9:33 a.m., all residents were seated. The TV was on. Seven residents sat with their backs to the TV. No residents appeared to be watching the TV. Eleven residents were in the room. Residents #64, #93 and #45 were included in this group. At 9:42 a.m., Resident #64 stood and was told by the Activity Director to sit down there was going to be music soon. At 9:48</p>						

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	<p>a.m., Resident #64 again stood and was again told to sit down by the Activity Director. At 9:55 a.m., Resident #64 stood and was told for a third time to sit down. At no time after Resident #64 stood was she offered any form of diversionary materials to occupy herself while awaiting the music. The residents sat awaiting an event without any form of stimulation until 9:58 a.m. when piano music began. The residents sat in the activity area from 9:19 a.m. to 9:58 a.m. (39 minutes), with no activities or diversionary materials offered.</p> <p>7. During an 11/7/14, 9:23 a.m. to 11:32 a.m., activity observation in the secured Dementia Unit Dining/Activity Area the following occurred:</p> <p>At 11:12 a.m., Resident #64 stood up and asked to go to the bathroom. Activity Assistant #17 told her to sit down she could go in a minute. At 11:12 a.m., Resident #64 stood and indicated she wanted to go to her room and take a nap. Activity Assistant #17 told her not now and to please sit down. At 11:15 a.m., Resident #64 stood and left the area. At 11:16 a.m., Resident #64 was escorted back into the room by an unknown staff member. At 11:17 a.m., Resident #64 stood and asked to go to the bathroom. Activity Assistant #17 again told</p>			

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	<p>Resident #64 to sit down now, she would need to wait for help. Various staff members walked past the group activity from 11:07 a.m. until 11:19 a.m. (12 minutes), Activity Assistant #17 did not ask any of the staff members to assist Resident #64 to the bathroom. At 11:19 a.m., Resident #64 was taken from the room.</p> <p>On 11/7/14, at 10:23 a.m., Resident #45 was escorted by staff to her dining room table. Resident #45 was not provided any diversionary materials. Resident #45 then sat at the table until 11:53 a.m. (30 minutes), when she was assisted to eat.</p> <p>8. During an 11/7/14, 11:45 a.m. interview, Activity Assistant #17 indicated she did not think Resident #64 should stand and walk without a staff because she appeared unsafe.</p> <p>During an 11/7/14, 11:46 a.m. interview, Activity Assistant #17 indicated there were diversionary materials such as puzzles, books and such that could be put out in the common area at any time.</p> <p>During an 11/10/14, 1:47 p.m. interview, the Activity Director/Alzheimer's Unit Director indicated there were diversionary materials such as tools, books and puzzles which could be placed</p>				

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F000246 SS=D	<p>around in the common area. Resident #64 often got up and wanted to leave an area. Resident #64 was ambulatory but unsafe at times, so staff should be summoned to ensure Resident #64 left the area safely. Resident #45 expressed no wants and needs and was totally dependent on staff.</p> <p>3.1-34(a)</p> <p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on observation, interview and record review, the facility failed to allow a resident requiring assistance to make meal choices from the daily menu when dining in the Main Dining Room for 1 of 1 resident interviewed requiring assistance at meals. (Resident #14)</p> <p>Findings include:</p> <p>During an interview with CNA #11 on 11/10/14 at 9:32 a.m., she indicated dietary sent prepared trays and the residents were not offered the alternate items on the menu.</p>	F000246	<p>F 246</p> <ul style="list-style-type: none"> · Resident #14 is given a choice of meals. · Residents eating meals either in their room or in the dining room and regardless to the level of assistance needed are given an opportunity to chose from the selected menu. · Dietary and nursing staff have 	12/10/2014

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	<p>During an interview with the Certified Dietary Manager (CDM) on 11/10/14 at 10:06 a.m., she indicated all room trays were served the RD's (Registered Dietician's) daily special unless it was on their dislike list. She indicated any item on the dislike list substituted with a similar item from the alternate menu. She indicated only residents eating in the Main Dining Room were allowed to choose from the selective menued items.</p> <p>Resident #14 was observed receiving her lunch tray on 11/10/14 at 12:10 p.m., LPN #12 was assisting her. The resident indicated she did not want the meat served. The LPN scraped the spaghetti sauce off of the meat and placed it on the spaghetti noodles and proceeded to cut up the spaghetti for the resident. The resident began to feed herself the meal and the LPN stayed with her. Both Resident #14 and LPN #12 said the prepared tray was brought to the resident without the resident being given a choice from the selective daily menu.</p> <p>During an interview with the CDM at 12:16 p.m., she indicated all residents requiring assistance with meals received the RD daily special meal regardless of where they ate. She indicated the previous Administrator had made this</p>		<p>been re-educated regarding resident choice of meals. Menus will be reviewed with residents daily, for the next day, to determine their choice of meal items. Menus will then be returned to the kitchen in order to provide the requested food items as chosen by the resident.</p> <p>The Dietary Manager or designee will interview 3 residents daily 5 times per week times 2 months, and then monthly times 4 months who require assistance or eat in their rooms to determine if meal choices has been offered. Results will be brought to QA monthly, and an action plan will be developed for any non-compliance.</p> <p>Completion Date: 12/10/14</p>	

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F000247 SS=D	<p>decision and she thought it had been in effect since 12/2/13.</p> <p>Resident #14's clinical record was reviewed on 11/10/14 at 9:05 a.m. The resident had an order for a regular diet.</p> <p>The resident had a 8/5/14, significant change Minimum Data Set assessment. The assessment indicated the resident was cognitively intact.</p> <p>3.1-3(v)(1)</p> <p>483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on record review and interview, the facility failed to ensure family were notified and participated in a room relocation for 1 of 3 families interviewed. (Resident #65)</p> <p>Findings include:</p> <p>During an interview on 11/3/14 at 12:09 p.m., with Resident #65's son, he indicated himself or another family member visited daily. He indicated the resident was being transferred to another</p>	F000247	<p>F 247</p> <ul style="list-style-type: none"> · Resident #65 no longer resides in this facility. · Residents and/or the responsible parties will be notified of room changes prior to the room change being implemented by Social Services/designee and notification documented in the clinical record. · The Administrator and the Social Service Director were re-educated by the Regional Director 	12/10/2014

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	<p>long term care facility due to the facility moving Resident #65 to the 300 hall against the family's wishes. He indicated the facility first called to say they needed a private room and needed to move his father, but would try to keep the resident on the 100 hall. He indicated his mother told the facility they could not move the resident off of the 100 hall.</p> <p>During an interview with Resident #65's wife on 11/5/14 at 12:15 p.m., she indicated she had told the facility they could move the resident to another room on the 100 hall if they wanted to move him out of the private room. She indicated the she was not told of the resident being moved to the 300 hall until after he had been moved. She indicated the facility called to tell her the physician had been in and had changed the resident's feeding order and at the end of the conversation they told her the resident had been moved to a room on the 300 hall.</p> <p>During an interview with the Social Service Director on 11/7/14 at 11:08 a.m., she indicated the resident was moved to the 300 hall due to remodeling being done on the 100 hall. She indicated the Administrator made the decision to move the resident to the 300 hall. She indicated a letter had been sent</p>		<p>of Operations regarding proper procedure for notification of room changes. The Social Services Director is to notify residents responsible party of any room change and document same in the clinical record.</p> <p>The Executive Director or designee will audit all room changes weekly times 3 months and then 5 room changes times 3 months to ensure proper notification and documentation is present. All results will be presented in Q.A. monthly and appropriate action plans developed as needed.</p> <p>Completion Date: 12/10/14</p>	

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F000248 SS=E	<p>to all the family members of the residents on the 100 hall notifying them regarding room remodels on the 100 hall and the need to temporarily move the residents out of their rooms.</p> <p>During an interview with the Administrator on 11/7/14 at 12:03 p.m., she indicated she was aware of the family's feelings. She stated "Someone had to move from the 100 hall so we could have a room to move other residents into when we remodeled the rooms to cause less disruption to other residents. [Resident #65] was the resident we chose to move off the unit. We did not notify the family when we moved him."</p> <p>3.1-3(v)(1) 3.1-3(v)(2)</p> <p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on observation, interview and record review, the facility failed to provide activities for cognitively impaired residents, who could not</p>	F000248	F 248	12/10/2014			

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	<p>self-initiate activities, for 4 of 4 residents reviewed for activities (Residents #64, #93, #45 and #67).</p> <p>Findings include:</p> <p>1. During an 11/3/14, 11:09 a.m. to 12:20 p.m., pre-meal activity observation in the secured Dementia Unit Dining/Activity Area the following occurred:</p> <p>On 11/3/14 at 11:09 a.m., 14 residents were seated at tables as if ready to dine. The TV was on the news. The volume of the TV was at a low level which did not allow an individual to understand all that was being said especially if anyone in the area was talking. Six residents were seated with their backs to the TV. None of the residents appeared to be watching the television program. Three residents were asleep. There were no diversionary, sensory or tactile materials any where in the area (such as puzzles, tools, magazines, books, toys or manipulative devices.) Residents #64, #93 and #45 were seated in the area.</p> <p>On 11/3/14 at 11:10 a.m., the Activity Director/Dementia Unit Director read a devotion. The devotion was about 3 minutes long. Four to five residents attended all or part of the devotional.</p>		<ul style="list-style-type: none"> · Residents #64, 93, 45, and 67 have had their activity programs reviewed along with care plans to assure appropriate activities are in place and occurring for these residents. Diversionary, sensory, and tactile materials have been made available in the common areas on the Dementia unit. · An audit of the residents activities programs, care plans, and activity calendar have been completed by the Activity Director/Designee to ensure all residents activities as appropriate to meet the residents needs. · The activity Director/Designee will re-educate the activity and nursing staff on the protocol, and policy regarding offering, encouraging, assisting, and engaging with residents that are specific to meet each resident's needs. Education also included that diversionary, sensory, and tactile materials are available in the common area and are to be used when residents are in there or exhibiting behaviors. · The Activity Director /Designee will audit activities 3times daily for 4 weeks, then 3times weekly for 4 weeks, then monthly for 4 months to ensure compliance. Results will be presented to the QA committee monthly and an action plan will be developed for any non-compliance. 				

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	<p>Residents #64, #93 and #45 did not participate in the devotional nor were they spoken to by name during the devotions.</p> <p>On 11/3/14 at 11:14 a.m., the Activity Director/Dementia Unit Director asked residents questions about the election and current events. This activity lasted less than 3 minutes and 4 to 5 residents participated. Residents #64, #93 and #45 did not participate in the current events nor were they spoken to by name during this period.</p> <p>On 11/3/14 at 11:16 a.m., Resident #67 could be heard saying "help, help, help" loudly in another area of the unit.</p> <p>On 11/3/14 at 11:17 a.m., Resident #67 who continued to say "help, help, help" loudly was escorted into the dining/activity area and assisted to sit at a dining table.</p> <p>On 11/3/14 from 11:18 a.m. to 11:22 a.m.,(4 minutes) Resident #67 sat in a dining room chair with no diversionary or manipulative materials. She repeatedly called out phrases such as "help, help, help", "hey, hey", "hey wake-up", "hey you better get ice on it" and "hey you."</p> <p>The room became very loud and another resident began to move restlessly during</p>		Completion Date: 12/10/14	

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	<p>this period. No staff attempted to redirect or calm her during this four minute period. Resident #93 occasionally parroted what Resident #67 was saying. At 11:19 a.m., Resident #64 stood and attempted to exit the area and was told, by an unidentified CNA, to sit down lunch would be soon. Resident #64 sat back down.</p> <p>On 11/3/14 at 11:20 a.m., the Activity Director/Dementia Unit Director began to read a devotional story. The room was so loud only those within approximately 4 feet of the Activity Director could hear what she was saying. Only 3 to 4 residents appeared to participate in the activity. Residents #64, #93 and #45 did not participate in the activity nor were they spoken to directly during the event.</p> <p>On 11/3/14 from 11:22 a.m. to 11:31 a.m., (9 minutes) Resident #67 called out and spoke very loudly without staff intervention. Resident #67 called out such phrases as "help, help, help", "Can't take it cause I don't know it", "I can't do it because I don't have hands or legs" and "you forgot to comb your hair." Residents in the area became restless. Resident #93 began to move about and talk in a high pitched voice. Resident #93 at times parroted Resident #67 or said "Yip" loudly. At 11:29 a.m.,</p>						

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	<p>Resident #64 stood and exited the area. Resident #64 was escorted back into the room (by an unknown CNA) almost immediately after exiting it. Resident #64 was told the meal was almost ready and instructed to sit down again. An unidentified male resident spoke to Resident #67 trying to calm her on several occasions.</p> <p>On 11/3/14 at 11:31 a.m., the Activity Director/Dementia Unit Manger spoke to Resident #67 attempting to calm her.</p> <p>On 11/3/14 from 11:31 a.m. to 11:35 a.m., (4 minutes) Resident #67 continued to call out. Residents in the area were restless as this occurred. Resident #93 at times parroted and talked in a high pitched voice.</p> <p>On 11/3/14 at 11:35 a.m., (18 minutes without staff intervention) a staff member handed Resident #67 a book.</p> <p>On 11/3/14 from 11:35 a.m. to 11:44 a.m., (9 minutes) Resident #67 continued to call out. At 11:44 a.m. Resident #67 was offered her meal. She was cued to eat when her meal was offered.</p> <p>During Resident #67's periods of agitation, other residents sat at the table as if ready to dine. Many residents</p>						

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	<p>moved about as if agitated. Resident #93 became anxious stating she did not know what to do.</p> <p>On 11/3/14 from 11:44 a.m. to 11:50 a.m., Resident #67 continued to call out with her meal in front of her. At 11:50 a.m., a CNA sat down beside Resident #67 in an attempt to get her to eat. The CNA was unable to get Resident #67 to calm down and eat and she escorted the resident from the room at 11:57 a.m. The room quieted and residents stopped their restless movements and parroting by 12:00 p.m.</p> <p>On 11/3/14 at 11:45 a.m., Resident #93 was served her meal. She had been seated at the table without activity participation or diversionary material from 11:09 a.m. to 11:47 a.m. (38 minutes). During this 38 minute wait, Resident #93 became restless, spoke in a high pitched voice and parroted Resident #67.</p> <p>On 11/3/14 at 11:52 a.m., Resident #64 was served her meal. She had sat at the table without activity participation or diversionary materials from 11:09 a.m. to 11:52 a.m. (43 minutes).</p> <p>On 11/3/14 at 11:55 a.m., dependent Resident #45 was served her meal. Her</p>			

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	<p>meal sat in front of her uncovered until 11:57 a.m. when she was assisted to eat by staff. She sat at the table without activity participation or diversionary materials from 11:09 a.m. to 11:57 a.m. (48 minutes).</p> <p>2. During an 11/5/14, 9:19 a.m. to 9:58 a.m., activity observation in the secured Dementia Unit Dining/Activity Area the following occurred:</p> <p>On 11/5/14 from 9:19 a.m. to 9:28 a.m. (9 minutes), 10 residents sat in the activity area with no activity offered. The area lacked any form of diversion or sensory material (such as books, magazines, tools, games, puzzles). At 9:28 a.m., the Activity Director/ Alzheimer's Unit Manager indicated there would be piano music at 9:45 a.m., so everyone needed to get seated and ready. She then rearranged chairs and placed residents facing a piano. By 9:33 a.m., all residents were seated. The TV was on. Seven residents sat with their backs to the TV. No residents appeared to be watching the TV. Eleven residents were in the room. Residents #64, #93 and #45 were included in this group. At 9:42 a.m. Resident #64 stood and was told by the Activity Director to sit down, there was going to be music soon. At 9:48 a.m., Resident #64 again stood and was again</p>			

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	<p>told to sit down by the Activity Director. At 9:55 a.m., Resident #64 stood and was told for a third time to sit down. At no time after Resident #64 stood was she offered any form of diversionary materials to occupy herself while awaiting the music. The residents sat awaiting an event without any form of stimulation until 9:58 a.m., when piano music began. The residents sat in the activity area from 9:19 a.m. to 9:58 a.m. (39 minutes), with no activities or diversionary materials offered.</p> <p>3. During an 11/7/14, 9:23 a.m. to 11:32 a.m., activity observation in the secured Dementia Unit Dining/Activity Area the following occurred:</p> <p>Activity Assistant #17 offered an exercise activity from 9:23 a.m. to 9:53 a.m. Residents #64 and #45 were in the circle where the activity was offered. Resident #45 sat in her geri-chair with her eyes closed the majority of the activity. When her eyes were open, she did not watch the activity or track movement. Resident #64 and #45 were never spoken to by name. Residents #64 and #45 did not participate in the activity. Neither Resident #64 or #45 were offered any diversionary materials during this event (30 minutes).</p>						

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	<p>On 11/7/14 at 9:53 a.m., Activity Assistant #17 indicated it was time for snacks. From 9:55 a.m. to 10:14 a.m., snacks were offered. During the snack time no other diversionary materials were in the area. Residents, who were dependent on staff to eat, were not offered a drink or snack. Resident #45 was not offered a snack.</p> <p>At 10:14 a.m., Activity Assistant #17 got out a book of devotions. A resident read from the book. At 10:18 a.m., Activity Assistant #17 read a devotion and talked about it. Although Residents #45 and #64 were in the area, they were not spoken to by name or asked questions about the devotion. The devotional activity ended by 10:33 a.m.</p> <p>At 10:43 a.m., Activity Assistant #17 began a game of balloon toss. Residents #45 and #64 were seated in the circle for the game. Resident #45 was never spoken to or tossed a ball at any time during the game. At 11:07 a.m., Resident #64 stood up and asked to go to the bathroom. Activity Assistant #17 told her to sit down, she could go in a minute. At 11:12 a.m., Resident #64 stood and indicated she wanted to go to her room and take a nap. Activity Assistant #17 told her not now, and to please sit down. At 11:15 a.m., Resident #64 stood and</p>			

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	<p>left the area. At 11:16 a.m., Resident #64 was escorted back into the room by an unknown staff member. At 11:17 a.m., Resident #64 stood and asked to go to the bathroom. Activity Assistant #17 again told Resident #64 to sit down now, she would need to wait for help. Various staff members walked past the group activity from 11:07 a.m. until 11:19 a.m. (12 minutes). Activity Assistant #17 did not ask any of the staff members to assist Resident #64 to the bathroom. At 11:19 a.m., Resident #64 was taken from the room.</p> <p>On 11/7/14, at 10:23 a.m., Resident #45 was escorted by staff to her dining room table. Resident #45 was not provided any diversionary materials. Resident #45 then sat at the table until 11:53 a.m. (30 minutes), when she was assisted to eat.</p> <p>4. During an 11/7/14, 11:45 a.m. interview, Activity Assistant #17 indicated she did not think Resident #64 should stand and walk without a staff because she appeared unsafe.</p> <p>During an 11/7/14, 11:46 a.m. interview, Activity Assistant #17 indicated there were diversionary materials such as puzzles, books and such that could be put out in the common area at any time.</p>			

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	<p>During an 11/10/14, 9:43 a.m., interview CNA/Activity Assistant #14 indicated Resident #67 could be calmed using a warm teddy bear to snuggle. Resident #67 also could be calmed using headphones and a music player with music such as Elvis. The music player was part of a project with a local college.</p> <p>During an 11/10/14, 10:10 a.m. interview, RN #15 indicated Resident #67 said "help, help" when there was nothing wrong. She needed to be assessed for pain and redirected. RN #15 also indicated there was a book with directions for each resident about what to do.</p> <p>During an 11/10/14, 9:45 a.m. interview, CNA/Activity Assistant #14 indicated, Resident #93 became easily upset when those around her were loud and noisy.</p> <p>During an 11/10/14, 9:46 a.m. interview, CNA/Activity Assistant #14 indicated, Resident #45 rarely or never spoke and benefited from sensory group not traditional activities.</p> <p>During an 11/10/14, 10:11 a.m. interview, RN #15 indicated Resident #45 was 99% non verbal and rarely communicated. She also indicated Resident #45 was dependent on staff for</p>			

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	<p>all mobility issues.</p> <p>During an 11/10/14, 1:47 p.m. interview, the Activity Director/Alzheimer's Unit Director indicated there were diversionary materials such as tools, books and puzzles which could be placed around in the common area. Resident #67 called out "help, help" and could be redirected with intervention. Resident #64 often got up and wanted to leave an area. Resident #64 was ambulatory but unsafe at times so staff should be summoned to ensure Resident #64 left the area safely. Resident #45 expressed no wants and needs and was totally dependent on staff. Resident #93 was at times both an active and passive participant in activities. Resident #93 participates more with encouragement.</p> <p>5. Resident #64's clinical record was reviewed on 11/10/14 at 2:31 p.m. Resident #64's current diagnoses included, but were not limited to, Alzheimer's Disease with delusions and depression.</p> <p>Resident #64 had a 9/19/14, Activity Progress Note which indicated the resident needed assistance to and from activities and attended exercise, devotions, BINGO, special programs,</p>			

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	<p>worship and music.</p> <p>Resident #64 had a, 6/20/14, most current, "MDS 3.0 Activity Progress Note" which indicated the only independent activity involvement she was able to participate in was visits with family, guests and staff.</p> <p>Resident #64 had a current,10/1/14, care plan problem/need regarding activity needs related to Alzheimer's Disease and appearing restless. Approaches to this problem included, but were not limited to,"observe resident within group activities to assess anything which seems to help calm her."</p> <p>Resident #64 had a current,10/1/14, care plan problem/need regarding wandering. Approaches to this problem included, but were not limited to,"eliminate possibilities for residents wandering (bed, snack, bathroom, activity)."</p> <p>Resident #64 had a current,9/20/14, quarterly, Minimum Data Set (MDS) assessment which indicated the resident had limited cognitive functioning and rarely or never made independent choices, usually understood others and was understood by others with some explanation and cueing and required</p>			

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	<p>limited to extensive assistance with activities of daily living.</p> <p>6. Resident #93's clinical record was reviewed on 11/7/14 at 9:12 a.m. Resident #93's current diagnoses included, but were not limited to, Alzheimer's Disease and fractured left wrist. Resident #93 had been admitted to the facility within the past 90 days. Resident #93 had a current, 10/9/14, care plan problem/need regarding the need for activities due to Alzheimer's Disease. Approaches to this problem included, but were not limited to,"Assist resident to and from activities and assist as needed and Assure that resident attends all religious programs."</p> <p>Resident #94 had a current,10/10/14, care plan problem/need regarding the need to reside on a secured dementia unit. Approaches to this problem included, but were not limited to, "encourage resident to participate in daily activities and eat meals in hall dining area."</p> <p>Resident #93 had a, 10/8/14, "MDS 3.0 Activity Progress Note" which indicated the resident enjoyed faith based activities and they were important to her. Resident #93 was both active and passive in</p>			

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	<p>activities, needed assistance and the only independent activity involvement she was able to participate in was visiting with her family or minister.</p> <p>Resident #93 had a current, 10/8/14, admission, Minimum Data Set (MDS) assessment which indicated the resident rarely or never made independent choices without prompting and cueing and required extensive assistance with activities of daily living.</p> <p>7. Resident #45's clinical record was reviewed on 11/7/14 at 10:09 a.m. Resident #45's current diagnoses included, but were not limited to, Alzheimer's Disease delusions and behavioral disturbances, depression and severe back pain. Resident #45 was admitted to the facility in the past 90 days.</p> <p>Resident #45 had a current, 10/3/04, care plan problem/need regarding the need to reside on a secured dementia unit.</p> <p>Approaches to this problem included, but were not limited to, "encourage resident to participate in daily activities and eat meals in the main dining area."</p> <p>Resident #45 had a current, 10/13/14, care plan problem/need regarding fatigue associated with anemia and a vitamin D</p>			

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	<p>deficiency.</p> <p>Resident #45 had a current, 10/10/14, care plan problem/need regarding the need for activities due to Alzheimer's disease. Approaches to this problem included, but were not limited to, "assist resident to and from activities." The goal for this problem was "resident will attend out of room activities daily with assist from staff."</p> <p>Resident #45 had a, 10/8/14, "MDS 3.0 Activity Progress Note" which indicated she had no independent activity involvement, smiled, followed with her eyes and needed assistance for all activities.</p> <p>Resident #45 had a current, 10/9/14, admission, Minimum Data Set (MDS) assessment which indicated the resident was severely cognitively impaired and rarely or never made choices, rarely or never understood others and was rarely or never understood by others and required extensive total assistance with activities of daily living.</p> <p>8. Resident #67's clinical record was reviewed on 11/7/14 at 10:00 a.m.</p> <p>Resident #67's current diagnoses included, but were not limited to,</p>						

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F000250 SS=D	<p>dementia, anxiety and depression.</p> <p>Resident #67 had a current, care plan problem/need regarding 9/10/14.</p> <p>Approaches to this problem included, but were not limited to, "offer resident an activity such as snack, beverage, bathroom, bed."</p> <p>Resident #67 had a current, 8/19/14, care plan problem/need regarding dementia with behavioral disturbances which effects what activity she will attend.</p> <p>Approaches to this problem included, but were not limited to,"if resident becomes agitated, give her clothing magazine as this will calm her."</p> <p>Resident #67 had a current, 9/24/14,significant change, Minimum Data Set (MDS) assessment which indicated the resident usually understood others and was usually understood by others with cueing and prompting, rarely or never made independent choices and required limited to extensive assistance with activities of daily living.</p> <p>3.1-33(a)</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p>			

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	<p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, interview and record review, the facility failed to follow care plan interventions for residents with behavioral issues for 1 of 2 residents reviewed for behavior management (Resident #67) and the facility failed to develop and implement a behavior management program which addressed targeted behaviors for psychoactive medication use for 2 of 5 residents reviewed for psychoactive medication use (Resident #51 and #23).</p> <p>Findings include:</p> <p>1. Resident #67's clinical record was reviewed on 11/7/14 at 10:00 a.m. Resident #67's current diagnoses included, but were not limited to, dementia, anxiety and depression. Resident #67 had a current, care plan problem/need regarding 9/10/14. Approaches to this problem included, but were not limited to, "offer resident an activity such as snack, beverage, bathroom, bed."</p> <p>Resident #67 had a current, 8/19/14, care plan problem/need regarding dementia with behavioral disturbances which</p>	F000250	<p>F 250</p> <ul style="list-style-type: none"> · The Care plan interventions for resident #67 are implemented as per the plan of care. Resident #51 and 23 had their Behavior Management plans developed and implemented to address individual target behaviors by the IDT. · An audit was conducted for residents on the Behavior Management Program to ensure they had appropriate care plan interventions developed to meet their targeted Behavior Management needs and that those interventions were implemented as directed by the plan of care. · The Social Service Director, nursing and activity staff were re-educated to the Behavior Management Procedure and implementing care plan interventions. · The Social Services Director and/or designee will audit for appropriate behavior management interventions and the implementation of these interventions for 5 residents weekly times 4 weeks, then 5 residents monthly times 5 months. Results will be brought to QA monthly, and an action plan will be 	12/10/2014

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	<p>effects what activity she will attend.</p> <p>Approaches to this problem included, but were not limited to,"if resident becomes agitated, give her clothing magazine as this will calm her."</p> <p>Resident #67 had a current, 9/24/14, significant change, Minimum Data Set (MDS) assessment which indicated the resident usually understood others and was usually understood by others with cueing and prompting, rarely or never made independent choices and required limited to extensive assistance with activities of daily living.</p> <p>During an 11/3/14, 11:09 a.m. to 12:20 p.m., pre-meal activity observation in the secured Dementia Unit Dining/Activity Area the following occurred:</p> <p>On 11/3/14 at 11:16 a.m., Resident #67 could be heard saying "help, help, help" loudly in another area of the unit.</p> <p>On 11/3/14 at 11:17 a.m., Resident #67, who continued to say "help, help, help" loudly, was escorted into the dining/activity area and assisted to sit at a dining table.</p> <p>On 11/3/14 from 11:18 a.m. to 11:22 a.m. (4 minutes), Resident #67 sat in a dining room chair with no diversionary or</p>		<p>developed for any non-compliance.</p> <p>Completion Date: 12/10/14</p>				

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	<p>manipulative materials, she repeatedly called out phrases such as "help, help, help", "hey, hey", "hey wake-up", "hey you better get ice on it" and "hey you." The room became very loud and other residents began to move restlessly during this period. No staff attempted to redirect or calm her during this four minute period. Another resident occasionally parroted what Resident #67 was saying. At 11:19 a.m., Resident #64 stood and attempted to exit the area and was told, by an unidentified CNA, to sit down lunch would be soon. Resident #64 sat back down.</p> <p>On 11/3/14 at 11:20 a.m., The Activity Director/Dementia Unit Director began to read a devotional story. The room was so loud only those within approximately 4 feet of the Activity Director could hear what she was saying.</p> <p>On 11/3/14 from 11:22 a.m. to 11:31 a.m. (9 minutes), Resident #67 called out and spoke very loudly without staff intervention. Resident #67 called out such phrases as "help, help, help", "Can't take it cause I don't know it", "I can't do it because I don't have hands or legs" and "you forgot to comb your hair." Residents in the area became restless. An unidentified male resident spoke to Resident #67 trying to calm her on</p>			

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	<p>several occasions.</p> <p>On 11/3/14 at 11:31 a.m., the Activity Director/Dementia Unit Manger spoke to Resident #67 attempting to calm her.</p> <p>On 11/3/14 from 11:31 a.m. to 11:35 a.m. (4 minutes), Resident #67 continued to call out. Residents in the area were restless as this occurred. At times another resident parroted Resident #67 and talked in a high pitched voice.</p> <p>On 11/3/14 at 11:35 a.m., (18 minutes without staff intervention) a staff member handed Resident #67 a book.</p> <p>On 11/3/14 from 11:35 a.m. to 11:44 a.m. (9 minutes), Resident #67 continued to call out. At 11:44 a.m., Resident #67 was offered her meal. She was cued to eat when her meal was offered.</p> <p>During Resident #67's periods of agitation, other residents sat at the table as if ready to dine. Many residents moved about as if agitated.</p> <p>On 11/3/14 from 11:44 a.m. to 11:50 a.m., Resident #67 continued to call out with her meal in front of her. At 11:50 a.m., a CNA sat down beside Resident #67 in an attempt to get her to eat. The CNA was unable to get Resident #67 to</p>			
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	<p>calm down and eat. She escorted the resident from the room at 11:57 a.m. The room quieted and residents stopped their restless movements and parroting by 12:00 p.m.</p> <p>During an 11/10/14, 9:43 a.m., interview CNA/Activity Assistant #14 indicated Resident #67 could be calmed using a warm teddy bear to snuggle. Resident #67 also could be calmed using headphones and a music player with music such as Elvis. The music player was part of a project with a local college.</p> <p>During an 11/10/14, 10:10 a.m. interview, RN #15 indicated Resident #67 said "help, help" when there was nothing wrong. She needed to be assessed for pain and redirected. RN #15 also indicated there was a book with directions for each resident about what to do.</p> <p>During an 11/10/14, 1:47 p.m. interview, the Activity Director/Alzheimer's Unit Director indicated there were diversionary materials such as tools, books and puzzles which can be placed around in the common area. Resident #67 called out "help, help" and could be redirected with intervention.</p> <p>2. Resident #51's clinical record was reviewed on 11/6/14 at 1:45 p.m. The</p>						

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	<p>resident's diagnoses included, but were not limited to, atypical psychosis, depression with delusions, dementia with behavioral disturbances, dementia Alzheimer's type with psychosis, and paranoid.</p> <p>The resident's current physician orders included, but were not limited to, Zyprexa [for atypical psychosis] 5 mg one by mouth at bedtime; and sertraline [for depression] hcl 100 mg one every evening.</p> <p>Review of a 6/30/14, 3:28 p.m., Social Service Note indicated the resident was seen by in house psychiatric service on 6/23/14 with no changes to medications or treatment.</p> <p>Review of a 7/28/14 at 11:45 p.m., Social Service Note indicated Zyprexa [for atypical psychosis] was increased on 7/23/14. No changes at this time. Behavior meeting held.</p> <p>Review of a 8/1/14, 12:06 p.m., Social Service Note indicated the resident was seen by in house psychiatric service on 7/28/14, and no changes in medications were made.</p> <p>Review of a 7/23/14, Doctor's Progress Note indicated the resident's behaviors</p>			

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	<p>were much worse. He was hoarding, stealing, angry when being redirected, and had worse delusions. The note indicated the Zyprexa was increased.</p> <p>Resident #51's record indicated he was discharged to a psychiatric unit on 8/18/14 and readmitted to the facility on 9/4/14. The clinical record lacked any documentation of the resident exhibiting any behaviors prior to the hospitalization.</p> <p>During an interview with the Director of Nursing on 11/07/2014 at 8:34 a.m., she indicated she reviewed the resident's record and could find no documentation of the resident's behaviors prior to his discharge in the Nurse's Notes or the "Care Tracker".</p> <p>During an interview with the Social Service Director on 11/07/2014 at 8:55 a.m., she indicated Resident #51 had increased behaviors and was hoarding more. He had a bowel movement in the hallway and covered it up before he was sent out to the hospital. She further indicated CNA's were to document behaviors in the "Care Tracker". She indicated the CNA assignment sheets made the CNA's aware of the resident's behaviors being monitored. She</p>			

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	<p>indicated she ran the "Care Tracker" report everyday and behaviors were reviewed daily at the morning meetings. She indicated no behaviors for Resident #51 had been recorded in the "Care Tracker". 3. Resident #23's record was reviewed on 11/6/14 at 1:49 p.m. Resident #23's current diagnoses included, but were not limited to, major depression, Alzheimer dementia with behaviors, delusions and diabetes type II. Resident #23 had current October 2014 orders for the following psychoactive medications:</p> <p>a.) Celexa 20 mg (an anti-depression medication) take 1 tablet one times daily for depression. This order originated 9/3/14.</p> <p>b.) Divalproex Sodium 125 mg (a mood stabilizer medication) take 2 tablets (250 mg) 2 times a day for dementia with delusions. This order originated 1/11/13. Resident #23 had a current, 7/28/14, quarterly, Minimum Data Set (MDS) assessment which indicated the resident displayed no signs or symptoms of delirium, nor signs or symptoms of acute onset of mental status change during the assessment period.</p>			

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	<p>Resident #23 had a non-specific care plan dealing with the broad concern of Alzheimer dementia, depression and delusions. The care plan did not identify how these symptoms manifested themselves for this resident. The approaches to this problem were not resident specific or based on resident assessment, past life interests and current specific successful interventions used by staff. The care plan lacked a measurable goal: "Will be easily reoriented and will display no signs of depression."</p> <p>Resident #23's record lacked any care plan related to inappropriate sexual behavior.</p> <p>Review of Resident #23's Resident Progress Notes for June 16, 2014 through October 28, 2014, indicated the resident displayed one episode of sexually inappropriate behaviors towards staff on 8/19/14 at 11:00 p.m.</p> <p>Review of Resident #23's nurse aide behavior tracking for September 11/2014 through November 10, 2014, indicated the resident displayed one episode of sexually inappropriate behavior toward staff on 9/14/14 at 10:45 a.m. The behavior tracking lacked any monitoring</p>			

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	<p>for depression or delusions.</p> <p>Review of Resident #23's nurse aide assignment sheet indicated staff should monitor for sexually inappropriate behavior with staff. The intervention was to "remind resident that his behavior is inappropriate." The assignment sheet lacked any description of how the resident may have displayed depression or delusions. The assignment sheet lacked any interventions for staff to use for depression or delusions for Resident #23.</p> <p>During an interview on 11/7/14 at 9:46 a.m., the DON indicated the increased behaviors were related to the nursing note dated 8/19/14. She stated his roommate had requested to move because of the resident's behaviors: "he said he was tired of seeing his [Resident # 23] penis". She acknowledged there was no documentation of this in the resident's chart. She indicated she would look for any further documentation related to the resident's behaviors.</p> <p>During an interview on 11/7/14 at 10:00 a.m., the DON indicated the facility had behavioral meetings where residents who displayed inappropriate behaviors were discussed. She indicated a plan was developed to meet the resident's needs.</p>			
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	<p>She indicated she did not know if meeting minutes or notes were available but she would speak to the Social Service Director to find out.</p> <p>During an Interview on 11/7/14 at 3:00 p.m., the DON and ADON indicated there was no further information or documentation regarding the behaviors for Resident #23. The DON verbalized a need for CNA Care Tracker documentation to be "better". She also indicated the nurses should have documented the resident's behaviors in the nursing progress notes to correlate with the CNA care tracker documentation.</p> <p>During an interview on 11/10/14 at 2:11 p.m., RN #13 indicated there were no documented descriptions of how Resident #23 displayed depression nor was there any description of his delusions. She indicated she would "just see if he looked sad or stayed in his room more" to determine if the resident was depressed.</p> <p>During an interview on 11/10/14 at 10:40 a.m., the Social Services Director indicated she could not provide care plans specific to the identified targeted behavior or individualized resident</p>						

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	<p>approaches for Resident #23's behaviors.</p> <p>The facility did not complete an individual evaluation or use the information to formulate individualized approaches to behavior management. She also indicated Resident #23 had no care plan for sexually inappropriate behavior. The facility was unable to provide any notes from the behavioral meetings.</p> <p>During observations on 11/7/14 at 2:38 p.m. and 11/10/14 at 3:12 p.m., Resident #23 was calm and displaying no inappropriate behavior while watching television and talking with staff.</p> <p>4. The Director of Nursing provided the current 4/15/13, "Behavioral Assessment and Management" policy on 11/10/14 at 7:27 a.m. The policy indicated "...Any resident receiving a antipsychotic medication should have a behavior monitoring form. A behavior monitoring form can be utilized for any resident exhibiting behaviors. The behavior monitoring form assists in identifying the types of behaviors, time of day behavior occurred, how many times behavior occurs and can be utilized in determining potential dose reduction or discontinuation of antipsychotic, or other psychoactive medications. These behaviors may indicate unrecognized</p>			

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	<p>needs, preferences, or illness...."</p> <p>The revised 1/1/13, 3.8 Psychopharmacological Medication Use" policy was provided by the Director of Nursing on 11/10/14 at 7:27 a.m. The policy indicated the following: "...Procedure: 1. Facility should comply with the Psychopharmacologic Dosage Guidelines created by the Centers for Medicare and Medicaid Services ("CMS"), the State Operations Manual, and all other Applicable Law relating to the use of psychopharmacologic medications including gradual dose reductions...2. Facility staff should monitor the resident's behavior pursuant to Facility policy using a behavioral monitoring chart or behavioral assessment record for residents residents receiving psychopharmacological medication for organic mental syndrome with agitated or psychotic behavior(s). A sample behavioral monitoring chart is set forth on Appendix... 9: Behavior/Intervention Monthly Flow Record. Facility staff should monitor behavioral triggers, episodes, and symptoms. Facility staff should document the number and/or intensity of</p>			

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F000279 SS=E	<p>symptoms and the resident's response to staff interventions. 3.1-34(a)</p> <p>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.</p> <p>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.</p> <p>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).</p> <p>Based on interview and record review, the facility failed to develop care plans to address targeted behaviors and/or develop measurable care plan goals for residents who used psychoactive medications for 6 of 33 residents reviewed for care plan development. (Resident #64, #93, #45, #23, #68, and</p>	F000279	<p>F 279</p> <p>Residents #64, 93, 45, 23, 68, and 51 had their care plans reviewed and updated to reflect and address individual targeted behaviors, interventions and measurable care plan goals.</p>	12/10/2014

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	<p>#51)</p> <p>Findings include:</p> <p>1. Resident #23's record was reviewed on 11/6/14 at 1:49 p.m. Resident #23's current diagnoses included, but were not limited to, major depression, Alzheimer dementia with behaviors, delusions and diabetes type II.</p> <p>Resident #23 had current October 2014 orders for the following psychoactive medications:</p> <p>a.) Celexa 20 mg (an anti-depression medication) take 1 tablet one times daily for depression. This order originated 9/3/14.</p> <p>b.) Divalproex Sodium 125 mg (a mood stabilizer medication) take 2 tablets (250 mg) 2 times a day for dementia with delusions. This order originated 1/11/13.</p> <p>Resident #23 had a current, 7/28/14, quarterly, Minimum Data Set (MDS) assessment which indicated the resident displayed no signs or symptoms of delirium nor signs or symptoms of acute onset of mental status change during the assessment period.</p> <p>Resident #23's clinical record lacked any care plan related to inappropriate sexual</p>		<ul style="list-style-type: none"> · An audit was conducted for resident's on the Behavior Management Program to ensure that individual targeted behaviors are care planned, interventions developed, and measureable goals determined. · The Social Service Director and nursing staff was re-educated to the Behavior Management Procedure and to the care plan policy that included but was not limited to developing plans of care for targeted behaviors and that there must be measurable goals. · The Social Services Director and/or designee will audit behavior management programs to determine that targeted behaviors, interventions, and measureable goals have been determined in the plan of care for 5 residents weekly times 4 weeks, then 5 residents monthly times 5 months. Results will be brought to QA monthly, and an action plan will be developed for any non-compliance. <p>Completion Date: 12/10/14</p>				

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	<p>behavior.</p> <p>Review of Resident #23's Resident Progress Notes for June 16, 2014 through October 28, 2014, indicated the resident displayed one episode of sexually inappropriate behaviors towards staff on 8/19/14 at 11:00 p.m.</p> <p>During an 8/29/14, 9:00 a.m., Social Services Director indicated depression and delusions lacked target behaviors. She also indicated Resident #23 had no care plan for inappropriate behaviors toward staff.2. Resident #64's clinical record was reviewed on 11/10/14 at 2:31 p.m. Resident #64's current diagnoses included, but were not limited to, Alzheimer's Disease with delusions and depression.</p> <p>Resident #64 had a current, 9/20/14, quarterly, Minimum Data Set (MDS) assessment which indicated the resident had limited cognitive functioning and rarely or never made independent choices, usually understood others and was understood by others with some explanation and cueing and required limited to extensive assistance with activities of daily living.</p> <p>Resident #64 had a current, 8/12/14, care</p>			

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	<p>plan problem/need regarding the need for a memory care unit. The goal for this problem was "Resident will be made comfortable and live in a home-like environment provided by facility/staff." Resident #64 had a current, 8/1/14, care plan problem/need regarding wanting to help other residents get in and out of bed. The goal for this problem was "Resident will be easily redirected by staff."</p> <p>3. Resident #93's clinical record was reviewed on 11/7/14 at 9:12 a.m. Resident #93's current diagnoses included, but were not limited to, Alzheimer's Disease and fractured left wrist. Resident #93 had been admitted to the facility within the past 90 days. Resident #93 had a current, 10/8/14, admission, Minimum Data Set (MDS) assessment which indicated the resident rarely or never made independent choices without prompting and cueing and required extensive assistance with activities of daily living.</p> <p>Resident #93 had a current, 10/10/14, care plan problem/need regarding the need to reside on a secured dementia unit. The goal for this problem was "Resident will be made comfortable and live in a</p>			

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	<p>home-like environment provided by facility/staff."</p> <p>4. Resident #45's clinical record was reviewed on 11/7/14 at 10:09 a.m. Resident #45's current diagnoses included, but were not limited to, Alzheimer's Disease delusions and behavioral disturbances, depression and severe back pain. Resident #45 was admitted to the facility in the past 90 days.</p> <p>Resident #45 had a current, 10/9/14, admission, Minimum Data Set (MDS) assessment which indicated the resident was severely cognitively impaired and rarely or never made choices, rarely or never understood others and was rarely or never understood by others and required extensive to total assistance with activities of daily living.</p> <p>Resident #45 had a current, 10/13/14, care plan problem/need regarding the need to reside on a memory care unit. The goal for this problem was "Resident will be made comfortable and live in a home-like environment provided by facility/staff."</p> <p>Resident #45 had a current, 10/10/14, care plan problem/need regarding visual function. The goal for this problem was</p>						

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	<p>"resident will be able to maintain current level of orientation to surroundings."</p> <p>5. During an 11/10/14, 3:04 p.m. interview with MDS Coordinator #16, the Coordinator indicated the care plan goals for Residents #64, #93 and #45 were not measurable. She indicated the care plans were most likely written by the Social Services Director.</p> <p>During an 11/10/14, 3:15 p.m. interview, the Social Services Director indicated there was no means to measure the care plan goals for Residents #64, #93 and #45. She indicated she was unaware the goals needed to be measurable and believed her goals were developed with the assistance of her consultant.</p> <p>6. Resident #51's clinical record was reviewed on 11/6/14 at 1:45 p.m. The resident's diagnoses included, but were not limited to, atypical psychosis, depression with delusions, dementia with behavioral disturbances, dementia Alzheimer's type with psychosis, and paranoid.</p> <p>The resident's current physician orders included, but were not limited to, Zyprexa [for atypical psychosis] 5 mg one by mouth at bedtime; and sertraline [for depression] hcl 100 mg one every</p>						

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	<p>evening.</p> <p>The resident had a care plan conference on 9/24/14, to update his care plans. The resident had a care plan problem of "Resident has impaired cognition and inappropriate behaviors related to Alzheimer dementia with psychosis and depression with routine antidepressant and antipsychotic[.]" The goal was "Resident will be easily redirected when displaying inappropriate behavior. Will continue to find his own room independently." The problem lacked a measurable goal.</p> <p>7. The clinical record for Resident #68 was reviewed on 11/6/14 at 1:42 p.m. The diagnoses for Resident #68 included, but were not limited to, vascular dementia with psychosis, depression, anxiety, and delusions.</p> <p>Current physician's orders for Resident #68 included, but were not limited to the following orders:</p> <p>a. Lexapro (an anti-depressant medication) 20 milligrams (mg) by mouth once a day. The original date of this order was 7/18/14.</p> <p>b. Seroquel (an antipsychotic medication) 25 mg by mouth twice a day. This medication was ordered on 7/18/14.</p>			

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	<p>The dosage for this medication was decreased on 10/29/14.</p> <p>Resident #68 had a 10/10/14, quarterly, Minimum Data Set (M.D.S.) assessment which indicated the resident had severe cognitive impairment.</p> <p>Resident #68 lacked health care plans with specific targeted behaviors for the use of her antipsychotic and anti-depressant medications.</p> <p>During an interview with the Social Services Director on 11/10/14 at 3:26 p.m., she indicated Resident #68 did not have health care plans with targeted behaviors regarding his use of antipsychotic and anti-depressant medications.</p> <p>8. Review of the current facility policy, dated 7/21/13, titled "CARE PLAN", provided by the Director of Nursing on 11/10/14 at 2:43 p.m., included, but was not limited to:</p> <p>"Purpose: Provide an interdisciplinary communication tool for promotion and coordination of individual resident care to meet resident's medical, nursing, mental and psychological needs identified through comprehensive assessment....</p>			

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F000309 SS=D	<p>...3. Care plan goals will be reasonable and measurable objectives for maintenance or attainment of resident's highest practicable physical, mental, and psychosocial well being....</p> <p>...6. Upon resident assessment completion, individualized care plan will be updated to include any new information...."</p> <p>3.1-35(a)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview and record review, the facility failed to assess and monitor the dialysis dressing/catheter for 1 of 1 resident reviewed for dialysis services. (Resident #92)</p> <p>Findings include:</p> <p>The clinical record for Resident #92 was reviewed on 11/7/14 at 9:44 a.m.</p>	F000309	<p>F 309</p> <ul style="list-style-type: none"> · Resident #92's dialysis access site was assessed with no areas of concern noted. An order was obtained and transcribed to the MAR to assess the dialysis access site upon return from dialysis. · An audit was completed for residents on dialysis to determine 	12/10/2014

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	<p>Diagnoses included, but were not limited to, end stage renal disease, hypertension, atrial fibrillation, and history of respiratory failure.</p> <p>Current physician's orders, dated 11/4/14, included, but were not limited to, hemodialysis on Tuesday, Thursday, and Saturday.</p> <p>The "DIALYSIS COMMUNICATION FORM", to be completed by the facility upon return from dialysis included a check box for the dressing- intact, not applicable, or other.</p> <p>The dialysis communication forms dated 11/8/14, 11/6/14, 11/4/14, and 11/1/14, all lacked documentation of an assessment of Resident #92's dialysis dressing and/or dialysis catheter.</p> <p>The clinical record from 10/25/14 at 7:30 a.m., to 11/7/14 at 7:00 a.m., had six nursing note entries which documented an assessment of Resident #92's dialysis dressing/catheter.</p> <p>During an interview with the Assistant Director of Nursing on 11/10/14 at 11:49 a.m., she indicated the nursing staff should be monitoring Resident #92's dialysis dressing/catheter on dialysis and non dialysis days, not just upon return</p>		<p>that access sites are assessed and monitored. Orders were obtained to assess dialysis access sites upon return from dialysis and this order was transcribed to the MAR.</p> <p>· Nurses were re-educated to the expectation of assessment of dialysis access site upon return from dialysis and that orders are to be obtained and transcribed to the MAR to ensure this is completed.</p> <p>· The Director of Nursing/Designee to audit dialysis access assessments of residents who receive dialysis 3 times per week times4 weeks and then monthly times 5 months. Results will be brought to QA monthly, and an action plan will be developed for any non-compliance.</p> <p>Completion Date: 12/10/14</p>		

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F000329 SS=D	<p>from dialysis.</p> <p>Review of the website "http://dx.doi.org/10.1155/212/649735" on 11/12/14 indicated the following: "The International Journal of Nephrology 2012 (2012), article ID 649735, 9 pages...Monitoring and surveillance of vascular access are an integral part of the care of hemodialysis patient."</p> <p>3.1-37(a)</p> <p>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.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and</p>			

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	<p>behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to track and monitor behaviors for 2 of 5 residents reviewed for unnecessary medications. (Resident #51 and #23)</p> <p>Findings include:</p> <p>1. Resident #51's clinical record was reviewed on 11/6/14 at 1:45 p.m. The resident's diagnoses included, but were not limited to, atypical psychosis, depression with delusions, dementia with behavioral disturbances, dementia Alzheimer's type with psychosis, and paranoid.</p> <p>The resident's current physician orders included, but were not limited to, Zyprexa [for atypical psychosis] 5 mg one by mouth at bedtime; and sertraline [for depression] hcl 100 mg one every evening.</p> <p>Review of a 6/30/14, 3:28 p.m., Social Service Note indicated the resident was seen by in house psychiatric service on 6/23/14 with no changes to medications or treatment.</p> <p>Review of a 7/28/14 at 11:45 p.m., Social</p>	F000329	<p>F329</p> <ul style="list-style-type: none"> · Residents #51 and # 23 had a record review completed in order to determine if a GDR would be appropriate and that behaviors are tracked and monitored appropriately. · An Audit was conducted for residents on psychotropic medications to determine the need for GDR and to ensure that behaviors are being tracked, monitored and documented appropriately. · The Social Service Director and nursing staff were re-educated to the Behavior Management Procedure to include but not limited to tracking, monitoring, and documenting resident behaviors. · The Social Services Director and/or designee will audit for appropriate behavior documentation, monitoring, tracking and interventions for 5 residents weekly times 4 weeks, then 5 residents monthly times 5 months. Results will be brought to QA monthly, and an action plan will be developed for any non-compliance. 	12/10/2014

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	<p>Service Note indicated Zyprexa [for atypical psychosis] was increased on 7/23/14. "No changes at this time. Behavior meeting held."</p> <p>Review of a 8/1/14, 12:06 p.m., Social Service Note indicated the resident was seen by in house psychiatric services on 7/28/14, and no changes in medications were made.</p> <p>Review of a 7/23/14, Doctor's Progress Note indicated the resident's behaviors were much worse. He was hoarding, stealing, angry when being redirected, and had worse delusions. The note indicated the Zyprexa was increased.</p> <p>Resident #51's record indicated he was discharged to an inpatient psychiatric unit on 8/18/14 and readmitted to the facility on 9/4/14. The clinical record lacked any documentation of the resident exhibiting any behaviors prior to the hospitalization.</p> <p>During an interview with the Director of Nursing on 11/07/2014 at 8:34 a.m., she indicated she reviewed the resident's record and could find no documentation of the resident's behaviors prior to his discharge in the Nurse's Notes or the "Care Tracker".</p> <p>During an interview with the Social</p>		Completion Date: 12/10/14				

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	<p>Service Director on 11/07/2014 at 8:55 a.m., she indicated Resident #51 had increased behaviors and was hoarding more. He had a bowel movement in the hallway and covered it up before he was sent out to the hospital. She further indicated CNA's were to document behaviors in the "Care Tracker". She indicated the CNA assignment sheets made the CNA's aware of the resident's behaviors being monitored. She indicated she ran the "Care Tracker" report everyday and behaviors were reviewed daily at the morning meetings. She indicated no behaviors for Resident #51 had been recorded in the "Care Tracker".</p> <p>2. Resident #23's record was reviewed on 11/6/14 at 1:49 p.m. Resident #23's current diagnoses included, but were not limited to, major depression, Alzheimer dementia with behaviors, delusions and diabetes type II.</p> <p>Resident #23 had current October 2014 orders for the following psychoactive medications:</p> <p>a.) Celexa 20 mg (an anti-depression medication) take 1 tablet one times daily for depression. This order originated 9/3/14.</p> <p>b.) Divalproex Sodium 125 mg (an mood stabilizer medication) take 2 tablets</p>			

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	<p>(250 mg) 2 times a day for dementia with delusions. This order originated 1/11/13. Resident #23 had a current, 7/28/14, quarterly, Minimum Data Set (MDS) assessment which indicated the resident displayed no signs or symptoms of delirium nor signs or symptoms of acute onset of mental status change during the assessment period.</p> <p>Resident #23's record did not identify the specific behavioral symptoms or target behaviors being treated by the use of an anti-depressant medication or a mood stabilizer medication.</p> <p>During an interview on 11/10/14 at 2:11 p.m., RN #13 indicated there was no documented descriptions of how Resident #23 displayed depression nor was there any descriptions of his delusions. She indicated she would "just see if he looked sad or stayed in his room more" to determine if the resident was depressed.</p> <p>3. The Director of Nursing provided the current 4/15/13, "Behavioral Assessment and Management" policy on 11/10/14 at 7:27 a.m. The policy indicated "...Any resident receiving a antipsychotic medication should have a behavior monitoring form. A behavior monitoring form can be utilized for any resident</p>						

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	<p>exhibiting behaviors. The behavior monitoring form assists in identifying the types of behaviors, time of day behavior occurred, how many times behavior occurs and can be utilized in determining potential dose reduction or discontinuation of antipsychotic, or other psychoactive medications. These behaviors may indicate unrecognized needs, preferences, or illness...."</p> <p>The revised 1/1/13, 3.8 Psychopharmacological Medication Use" policy was provided by the Director of Nursing on 11/10/14 at 7:27 a.m. The policy indicated the following: "...Procedure: 1. Facility should comply with the Psychopharmacologic Dosage Guidelines created by the Centers for medicare and Medicaid Services ("CMS"), the State Operations Manual, and all other Applicable Law relating to the use of psychopharmacologic medications including gradual dose reductions...2. Facility staff should monitor the resident's behavior pursuant to Facility policy using a behavioral monitoring chart or behavioral assessment record for residents residents receiving psychopharmacological medication for organic mental syndrome with agitated or psychotic behavior(s). A sample behavioral monitoring chart is set forth on Appendix. 9:</p>			

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F000364 SS=E	<p>Behavior/Intervention Monthly Flow Record. Facility staff should monitor behavioral triggers, episodes, and symptoms. Facility staff should document the number and/or intensity of symptoms and the resident's response to staff interventions.</p> <p>3.1-48(a)(3) 3.1-48(a)(6)</p> <p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, interview and record review, the facility failed to prepare palatable food items regarding following recipes, temperature and taste for 5 of 14 residents interviewed regarding food satisfaction (Residents #14, #53, #18, #56 and #92).</p> <p>Findings include:</p> <p>1. During an 11/5/14, 9:48 a.m., interview with Resident #14, who was identified as reliable during the stage 1 survey process, the resident indicated the meat was tough and food did not taste good.</p>	F000364	F 364 · Residents #14, #53,#18, #56, #92 do receive food that is palatable and of the proper temperature · A Resident Council meeting was held to discuss resident satisfaction with meals. Topics discussed included food palatability and temperature to discuss measures the facility is taking to improve meal satisfaction.	12/10/2014			

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	<p>During an 11/5/14, 10:02 a.m., interview with Resident #53, who was identified as reliable during the stage 1 survey process, the resident indicated the meat was tough, the mashed potatoes were lumping and the food was not good.</p> <p>During an 11/5/14, 12:46 p.m., interview with Resident #18, who was identified as reliable during the stage 1 survey process, the resident indicated the food was often cold.</p> <p>During an 11/5/14, 1:04 p.m., interview with Resident #56, who was identified as reliable during the stage 1 survey process, the resident indicated the meat was tough and the food bland.</p> <p>During an 11/5/14, 12:49 p.m., interview with Resident #92, who was identified as reliable during the stage 1 survey process, the resident indicated the food was cold and too salty or too sweet.</p> <p>2. During an 11/10/14, 10:39 a.m. observation of the pureed process, Cook #18 did not follow the recipe for pureed veal. Cook #18 added the amount of beef base needed for 5 veal cutlets to the preparation of one cutlet. After the items were prepared, the food was tasted by Dietary Manger who indicated the veal</p>		<p>The dietary staff have been re-educated to the requirement that food is to be prepared as directed by the recipe and that it is palatable, attractive and at the appropriate temperature. Hot foods will remain on the steam table or in the steamer in smaller containers in order to better maintain temperature.</p> <p>The Dietary Manager or designee will interview 5 residents to determine if the meals are acceptable in taste and temperature weekly times 2 months, then 5 residents every 2 weeks times 2 months, then 5 residents monthly times 2 months. An audit will also be completed to determine that food is prepared by following the recipes, the food is palatable, and served at the appropriate temperature 5 times per week times 2 months, and then weekly times 4 months. Results will be brought to QA monthly, and an action plan will be developed for any non-compliance.</p> <p>Completion Date: 12/10/14</p>	

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	<p>was too salty.</p> <p>3. A sample test tray was obtained on 11/10/14 at 11:14 a.m. The veal cutlet was cold.</p> <p>4. On 11/10/14 at 11:17 a.m., the Dietary Manager obtained a second veal cutlet and tasted the center of the veal and stated it was cold. She additionally tested the veal cutlet and found the meat to be less than 120 degrees Fahrenheit.</p> <p>5. During an interview with the Certified Dietary Manager (CDM) on 11/10/14 at 10:06 a.m., she indicated all room trays were served the RD's (Registered Dietician's) daily special unless it was on their dislike list. She indicated any item on the dislike list was substituted with a similar item from the alternate menu. She indicated only residents eating in the Main Dining Room were allowed to choose from the selective menued items.</p> <p>6. Resident #14 was observed receiving her lunch tray on 11/10/14 at 12:10 p.m., LPN #12 was assisting her. The resident indicated she did not want the meat served. The LPN scraped the spaghetti sauce off of the meat and placed it on the spaghetti noodles and proceeded to cut up the spaghetti for the resident. The resident began to feed herself the meal and the LPN stayed with her. Both</p>			

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F000431 SS=B	<p>Resident #14 and LPN #12 said the prepared tray was brought to the resident without the resident being given a choice from the daily selective menu.</p> <p>7. Review of a 7/9/14, "Concern Form" from Resident Council minutes indicated a complaint was made of wanting more flavor for food. The facility response was to provide more "Mrs. Dash on the tables for the residents in the dining room."</p> <p>3.1-21(a)(1) 3.1-21(a)(2)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and</p>			

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	<p>cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation and interview, the facility failed to ensure drugs and biologicals used in the facility were disposed of when expired. This practice resulted in the expiration of 9 of 9 doses of Hepatitis B vaccine.</p> <p>Findings include:</p> <p>During the medication storage observation on 11/10/14 at 11:00 a.m., the following concerns were noted:</p> <ol style="list-style-type: none"> Four single dose syringes of Engerix-B (Hepatitis B Vaccine) with an expiration date of 12/9/13 were observed. Five single dose syringes of Engerix-B with an expiration date of 5/17/14 were 	F000431	<p>F 431</p> <ul style="list-style-type: none"> The 9 doses of Engerix-B were discarded. An audit of the Medication rooms and carts has been completed to ensure that no expired medications are present. Nurses have been re-educated regarding the policy for Storage and disposition of expired medications. Director of Nursing Service or designee will audit for expired medications weekly times 2 months, 	12/10/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155231		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/10/2014	
NAME OF PROVIDER OR SUPPLIER RANDOLPH NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 701 S OAK ST WINCHESTER, IN 47394			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>observed.</p> <p>During an interview on 11/10/14 at 2:11 p.m., the ADON indicated the vaccines should have been discarded at the time of their expiration. She also provided the vaccination monitoring sheets that required the expiration date to be documented at the time of vaccination.</p> <p>A review of the facility policy titled "5.3 Storage and Expiration of Medications, Biologicals, Syringes and Needles", dated 1/1/13, indicated as follows: " Applicability: This Policy 5.3 sets forth the procedures relating to the storage and expiration dates of medications, biologicals, syringes and needles. Procedure:...</p> <p>4. Facility should ensure that medications and biologicals: 4.1 Have an Expiration Date on the label; 4.2 Have not been retained longer than recommended by manufacturer or supplier guidelines;...."</p> <p>3.1-25(o)</p>		<p>then every 2 weeks times 2 months, then monthly times 2 months. Results will be brought to QA monthly, and an action plan will be developed for any non-compliance.</p> <p>Completion Date: 12/10/14</p>				