STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	15E064		09/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE HAVEN HEALTH CARE CENTER	505 N GAVIN ST MUNCIE, IN 47303

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: 8/29, 30, 31, 9/1, 2, and 6, 2016 Facility number: 000311 Provider number: 15E064 AIM number:100285520 Census bed type: SNF/NF:0 SNF:0 NF: 39 Total: 39 Census payor type: Medicare:0 Medicaid:38 Other: 1 Total: 39 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. QR completed by 11474 on September 8, 2016.	F 0000	F-0000 This Plan of Correction is prepared and executed because it is required by the provisions of the State and Federal regulations, and not because Brookside Haven Care Center agrees with the allegations and citations listed on this statement of deficiencies. This Plan of Correction shall operate as Brookside Haven's written credible allegations of compliance. Brookside Haven Care Center respectfully request paper compliance on the attached Plan of Correction.	
F 0221	483.13(a)			

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

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

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SS=D Bldg. 00	RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Based on observation, interview and record review, the facility failed to assess a potential restraint to determine the necessity to treat a medical symptom(s) and ensure the device was the least restrictive means available for 3 of 4 residents reviewed for restraints. (Resident #36, #22, and #40) Findings include: 1. On the following dates and times, Resident #36 was observed with a lap buddy (a foam device which fitted under the arms of the chair and across the lap preventing standing) in place : 8/30/16 at 7:46 a.m., yelling "hey"; 8/30/16 at 9:35 a.m.; 8/30/16 at 10:17 a.m.; 8/30/16 at 10:42 a.m.; 8/30/16 at 12:17 p.m., yelling "hey"; 8/30/16 at 12:40 p.m.; 8/30/16 at 1:33 p.m.; 8/30/16 at 1:47 p.m., yelling "hey"; 8/30/16 at 1:54 p.m., yelling "hey"; 8/31/16 at 7:07 a.m., yelling "hey"; 8/31/16 at 7:43 a.m.; 8/31/16 at 8:14 a.m., yelling "hey"; 8/31/16 at 9:02 a.m., yelling "hey"; 8/31/16 at 10:20 a.m.;	F 0221	F-221 1) Completed restraint assessments on resident's #22, #26, #40, also to include resident #20 for clarification of physician order, update care plan, assessment of medical symptom necessity and the least restrictive means/reduction trial. Obtained orders for therapy to re-evaluate all resident's requiring restraints for the least restrictive device for that resident. 2) Any resident has the potential to be affected. Facility completed a pre-restraint assessment on all resident's, and those found to be affected (resident's #22, #26, #40 and #20)were assessed by Occupational Therapy to ensure the least restrictive device is in place. All new admissions will have a pre-restraint assessment completed and shall be reviewed quarterly during regular scheduled MDS assessment period 3) Quarterly reassessment of restraints will continue to ensure medical justification for the use of any restraint, to ensure necessity	10/05/2016

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	8/31/16 at 10:33 a.m.; 8/31/16 at 10:35 a.m., yelling "hey"; 8/31/16 at 10:57 a.m., pushed against the lap buddy using his arms; 8/31/16 at 11:04 a.m., yelling "hey"; 8/31/16 at 12:20 p.m.; 8/31/16 at 12:48 p.m., yelling "hey"; 8/31/16 at 12:58 p.m., 8/31/16 at 1:19 p.m., 8/31/16 at 3:04 p.m., 9/1/16 at 2:10 p.m., yelling "hey"; 9/1/16 at 2:14 p.m., pushed against the lap buddy using his arms and yelling "hey"; 9/1/16 at 2:47 p.m., yelling "hey"; 9/1/16 at 3:04 p.m., yelling "hey"; 9/1/16 at 3:25 p.m., yelling "hey"; 9/1/16 at 3:35 p.m., yelling "hey"; 9/2/16 at 7:23 a.m., yelling "hey"; 9/2/16 at 7:38 a.m., yelling "hey"; 9/2/16 at 7:48 a.m., yelling "hey"; 9/2/16 at 8:11 a.m., yelling "hey"; 9/2/16 at 8:24 a.m., yelling "hey"; 9/2/16 at 9:32 a.m.; 9/2/16 at 9:52 a.m., yelling "hey"; 9/2/16 at 10:59 a.m.; 9/6/16 at 7:04 a.m., yelling "hey"; 9/6/16 at 7:28 a.m., yelling "hey"; 9/6/16 at 7:42 a.m.; yelling "hey"; 9/6/16 at 9:23 a.m.; 9/6/16 at 10:27 a.m.; 9/6/16 at 11:06 a.m.; and 9/6/16 at 3:21 p.m. On the following dates and times, Resident #36 was observed walking with a staff member without concerns: 8/31/16 at 10:25 a.m., during the walk Resident #36 sat down on the ground, was assisted up and showed no signs of		and is the least restrictive device after trial for reduction completed. DON immediately in-serviced/re-educated all nurses on 9/26/16 on documentation regarding restraint usage. 4) Director of Nursing/Designee will monitor monthly all resident's with a restraint to ensure that the least restrictive device in place is appropriate and to ensure on-going compliance. Director of Nursing will report to the QA Committee during regular scheduled Quality Assurance Committee (QAA) meetings and will follow any recommendations as deemed necessary to ensure on-going compliance. (See exhibit "A") Completion date: 10/5/2016	

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	exhaustion such as shortness of breath, excessive perspirations, and no change in gait when ambulated the rest of the walk; 8/31/16 at 1:00 p.m.; 8/31/16 at 3:09 p.m.; 9/1/16 at 7:56 a.m.; 9/1/16 at 11:41 a.m., during the walk Resident #36 sat down on the floor, stood back up and showed no signs of exhaustion and continued to ambulate to his room; 9/1/16 at 1:54 p.m.; 9/2/16 at 8:48 a.m.; 9/6/16 at 8:13 a.m.; and 9/6/16 at 10:00 a.m. The clinical record for Resident #36 was reviewed on 9/2/16 at 7:53 a.m. Diagnoses for Resident #36 included, but were not limited to, severe intellectual disabilities, anxiety, bipolar, and Pica disorder. Resident #36's current signed physician's orders for mobility indicated use of a broda chair with lap buddy when the resident was exhausted. Resident #36 had an 8/21/14 order which indicated the resident "may be in a wheelchair with a lap buddy for rest periods when the resident paces to the point of exhaustion." Resident #36 had a quarterly Minimum Data Set (MDS) assessment dated 5/24/16. The assessment indicated			

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	Resident #36 was severely cognitively impaired, never or rarely made decisions, and never or rarely was understood. A "Pre-Restraining Assessment", dated 9/1/14 (11 days after initial restraint order), lacked a medical symptom(s) for the use of the lap buddy and an assessment to ensure the lap buddy was the least restrictive means for Resident #36. The assessment score indicated the resident was a "Good Candidate" for a restraint. Resident #36 had a 9/10/14 order which indicated to discontinue the wheelchair. The order further indicated the resident could be in a broda chair with a lap buddy for "rest periods when the resident paces to the point of exhaustion." Resident #36 had a health care plan, dated 6/3/16, for the problem of falls. One of the approaches for this problem was a broda chair with a lap buddy. Resident #36 had a health care plan, dated 6/3/16, for the problem of resident required total assist from the staff for his Activities of Daily Living. One of the approaches for this problem was a broda chair with a lap buddy. Resident #36 had a health care plan, dated 6/3/16, for the problem activities			

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	due to the resident's very short attention span and resident's inability to sit still for very long. One of the approaches for this problem was for him to "do his favorite activities such as walking and playing in water". A nurses note, dated 9/1/16 at 1:20 p.m., indicated the Social Services Designee witnessed Resident #36 "crawl over his lap buddy and fall out of his chair." The note further indicated the "Resident did get right up and walk down the hall." Resident #36's clinical record lacked an assessment with the medical justification for the use of the lap buddy and an indication the lap buddy was the least restrictive means to treat the fall symptom(s). During an interview on 9/2/16 at 11:09 a.m., CNA #1 indicated she had worked at the facility for 3 years and was familiar with Resident #36. CNA #1 indicated she did not know why Resident #36 had the lap buddy. She indicated the resident was to be checked every hour and released from the lap buddy every two hours. CNA #1 indicated interacting or walking Resident #36 would calm him down when he was yelling. CNA #1 indicated Resident #36 did very well when walked, but he needed to be			

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	supervised because he would go into other residents' rooms or grab food from other residents' trays. CNA #1 indicated she had worked evenings and interacting or walking with Resident #36 would calm him down in the evenings also. During an interview on 9/2/16 at 11:45 a.m., CNA #2 indicated she had worked here approximately 3 years and was familiar with Resident #36. CNA #2 indicated when the resident was admitted to the facility he would walk but kept ending up on the floor or in other residents' rooms. CNA #2 indicated Resident #36 would drink or eat "anything in sight." CNA #2 indicated Resident #36 did really well walking. She indicated the resident needed to be supervised because he would want to crawl onto furniture or go into other residents' rooms. CNA #2 indicated he would try and get other residents' food and get into bathrooms to play in the water. She indicated he was to be released every two hours for at least 15 minutes. CNA #2 indicated staff were to chart on the restraint in the ADL (Activities of Daily Living) binder. During an interview on 9/2/16 at 11:59 a.m., QMA #4 indicated she had worked at the facility for approximately 13 years and was familiar with Resident #36. She			

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	indicated Resident #36 was steady on his feet and could walk very quickly. QMA #4 indicated the resident needed to be supervised when walking because he would wander into other residents' rooms. QMA #4 indicated she did not really know why Resident #36 had the lap buddy. She indicated Resident #36 would try and get out of chair with lap buddy in place five or more times a day during day shift when she worked. QMA #4 indicated walking Resident #36 would sometimes help when he was yelling. She indicated the resident needed to be released every two hours and the release needed to be documented in the ADL binder. During an interview on 9/2/16 at 12:13 p.m., LPN #5 indicated she was an agency nurse and had been coming to the facility for two months. She indicated Resident #36 did okay when he walked, and liked to walk fast. LPN #5 indicated Resident #36 held her hand when they walked, but he also held her hand when she gave him his medications. LPN #5 indicated Resident #36 would sometimes sit down during a walk, but she did not know if it was because he was tired or just wanted to sit on the floor. During an interview on 9/6/16 at 1:07 p.m., the Director of Nursing (DON)			

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	indicated Resident #36's lap buddy was for exhaustion. She indicated Resident #36 would go into bathrooms and play in the water or eat things he should not since he has Pica. The DON indicated the lap buddy was not being used for exhaustion now since the resident did not have the lap buddy off enough to become exhausted. The DON acknowledged the lap buddy could not be used for behaviors such as wandering or the Pica disorder. During an interview on 9/6/16 at 2:15 p.m., LPN #3 indicated Resident #36's lap buddy was used for exhaustion. She indicated Resident #36 would hold her hand when they were walking and was "pretty steady." LPN #3 indicated she had never seen him exhausted from walking. She indicated Resident #36 would just sit down on the floor but it was more like a child wanting to sit not because he was tired.2. Resident #22 was observed in his wheelchair with a lap buddy in place moving in the hallways or dining area during the following dates and times: 8/29/2016 at 11:43 a.m.; 9/1/2016 at 11:47 a.m.; 11:53 a.m.; and 11:57 a.m. Resident #22's clinical record was reviewed on 9/01/2016 at 12:09 p.m. Resident #22's diagnoses included, but were not limited to, depression,			

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	delusions, and ischemic encephalopathy. Resident #22 had an 8/21/2016, physician's order to utilize a lap buddy when in the wheelchair. The order did not indicate what medical symptom was being treated by the use of the lap buddy restraint. Resident #22 had a 6/28/2016, quarterly, Minimum Date Set (MDS) assessment which indicated the resident used a limb restraint daily, was rarely or never understood, required cues or supervision for decision making, was able to stabilize himself when moving from sitting to standing if he was offered assistance from a human, and could walk if he was offered assistance from a human. Resident #22 had an 8/25/2016, "Pre-Restraining Assessment" (completed following a hospital stay) which lacked a medical symptom or condition being treated by the restraint and an evaluation to show the restraint was the least restrictive means available to treat any symptom. Resident #22 had an 8/25/16 "Physical Restraint Elimination Assessment" which indicated the resident was a "Good Candidate" for restraint elimination.			

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	Resident # had a, 7/8/16, care plan problem/need regarding the potential for falls. This care plan problem/need originated 3/10/16. Approaches to this problem included, but were not limited to, "utilize a lap buddy while in the wheelchair". The care plan problem/need also indicated the resident could not remove his lap buddy upon request. Resident #22's clinical record lacked: indication of the medical symptom or condition being treated by the use of the lap buddy and an evaluation to indicate the lap buddy was the most effective and least restrictive means available to treat a medical condition. During a 9/02/2016, 11:08 a.m., interview, CNA #1, indicated Resident #22 used a wheelchair with a lap buddy for safety. He was unstable when he stood because of his gait. He could ambulate with the assist of staff and he could not always remove his lap buddy himself. During a 9/02/2016, 11:37 a.m., interview, CNA #2, indicated Resident #22 used a lap buddy for his safety and without it he would attempt to stand. 3. Resident #40 was observed eating lunch in her high backed wheelchair with			

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	thigh straps in place during the following dates and times: 8/29/2016 at 12:20 p.m.; 8/31/2016 at 12:24 p.m.; and 9/1/2016 at 11:52 a.m. Resident #40's clinical record was reviewed on 8/31/2016 at 10:39 a.m. Resident #40's diagnoses included, but were not limited to, anxiety, depression and dementia with delusions. Resident #40 was admitted to the facility in September, 2015. Resident #40 had a current, 8/31/2016, physician's order for thigh straps when up in broda chair for positioning. This order originated 11/10/2015. Resident #40 had a 6/21/2016, quarterly, Minimum Date Set (MDS) assessment which indicated the resident was rarely or never understood, required supervision or cueing for decision making, required assistance from a human to balance when going from sitting to standing and walking, and used a chair that prevented rising type of restraint on a daily basis. Resident #40 had a 7/1/2016, care plan problem/need regarding fall risk. This care plan problem/need originated 9/22/2015. Approaches to this problem included, but were not limited to, "thigh straps when up in broda chair."			

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	Resident #40 had a 6/21/2016, "Physical Restraint Elimination Assessment" which indicated the resident was a "Good Candidate" for restraint elimination. Resident #40 had a 12/29/2015, "Physical Restraint Elimination Assessment" which indicated the resident had been switched from a lap buddy to thigh straps when in the wheelchair. The assessment lacked indication of any medical symptom being treated by the use of the thigh strap restraints or an evaluation that the thigh straps were the most effective and least restrictive means available to treat any symptom. During a 9/02/2016, 11:06 a.m., interview with CNA #1 indicated Resident #40 used a high back wheelchair with thigh straps for safety because she could not balance when she stood. During a 9/02/2016, 11:34 a.m., interview, CNA #2 indicated Resident #40 used a high backed wheelchair with thigh straps because she cold get out of her chair and fall or just crawl around. Resident #40 was observed resting quietly in bed during the following dates an times:			

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	8/30/2016 at 10:16 a.m., 8/31/2016 at 10:33 a.m., 11:05 a.m., 1:00 p.m. and 2:46 p.m. 9/01/2016 at 10:46 a.m. and 2:05 p.m. 9/02/2016 at 8:45 a.m. and 10:53 a.m. Resident #40 was observed calmly being assisted to eat her lunch on 8/29/2016 at 12:20 p.m., 8/31/2016 at 12:24 p.m., and 9/1/2016 at 11:52 a.m. During a 9/2/2016, 11:45 a.m., interview, the Director of Nursing and Administrator were queried regarding the medical symptom or condition being treated by the use of a restraint and an evaluation that each restraint use was the most effective and least restrictive means available to treat said medical symptom for Residents #36, #22 and #40. They were unable to answer. During a 9/6/2016, 11:00 a.m., interview, the MDS Coordinator indicated the "Pre-Restraining Assessments" were the only evaluation for the restraints and did not contain the medical symptoms being treated by the use of the restraint or indication that the restraint used was the least restrictive and most effective means to treat a medical symptom. A current, April 2014, facility policy, titled "Use of Restraints", provided by the Director of Nursing on 9/6/16 at 2:40			

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	p.m., indicated: "Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls... 1..."Physical Restraints" are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body...." 3.1-3(w) 3.1-26(a) 3.1-26(o)			
F 0250 SS=E Bldg. 00	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, interview and record review, the facility failed to provide medically related social services regarding effective behavior monitoring	F 0250	F- 250 1. Re-assessed behaviors of resident's #40, #14, #8 and #4 to ensure appropriate	10/05/2016

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	associated with psychopharmicalogical medication use for 4 of 5 residents reviewed for behavior monitoring (Residents #40, #14, #4 and #8) Findings include: 1. Resident #40 was observed eating lunch in her high backed wheelchair with thigh straps in place during the following dates and times 8/29/2016 at 12:20 p.m., 8/31/2016 at 12:24 p.m., and 9/1/2016 at 11:52 a.m. Resident #40's clinical record was reviewed on 8/31/2016 at 10:39 a.m. Resident #40's diagnoses included, but were not limited to, anxiety, depression and dementia with delusions. Resident #40 had a 6/21/2016, quarterly, Minimum Date Set (MDS) assessment which indicated the resident was rarely or never understood. Resident #40 had a 7/1/16, care plan problem/need regarding the need for Depakote to treat dementia with delusions. Approaches to this problem/need included, but were not limited to, "Monitor for efficacy and adverse reactions and Ongoing behavior monitoring." Resident #40 had a 7/1/16, care plan		psychopharmacological medications are being used. A Behavioral Intervention Monthly Flow Record will be updated with appropriate medical targeted behaviors with resident specific portrayal of psychopharmacological medication used on all residents. Also updated a daily Social Service Alert form which will be completed for all behaviors. (See Exhibit "B") 2. Any resident has the potential to be affected. Reviewed all resident's behavioral intervention flow records and completed a Comprehensive Behavioral Summary to ensure appropriate diagnosis and portrayal of targeted behaviors. 3. Behavioral Summary and monthly review will be completed on all residents to summarize the patterns and precipitating factors for the use of psychopharmacological medications. (See exhibit "C"). The Social Service Alert form will be completed on any behavior and placed in the Social Service mailbox at Nurses Station and will be reviewed daily during daily morning meetings. In-serviced/re-educated all staff on detailed charting regarding behaviors 9/26/16. 4. Director of Nursing/Social Service Designee/HFA will monitor Behavioral Intervention Flow Record daily x60 days, then 3x's per week x 60 days then weekly x's 2months. Social Service Designee will report to	

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	problem/need regarding the need for Seroquel to treat a delusion disorder. Approaches to this problem/need included, but were not limited to, "Monitor for efficacy and adverse reactions and Ongoing behavior monitoring." Resident #40 had a 7/1/16, care plan problem/need regarding the need for Lexapro to treat depression. Approaches to this problem/need included, but were not limited to, "Monitor for efficacy and adverse reactions and Ongoing behavior monitoring." Resident #40 had "Behavioral Intervention Monthly flow records for August and September 2016 which indicated the targeted/monitored behavioral indicator for each psychopharmacological mediation used were as follows: a. Seroquel (an antipsychotic medication) - grabbing at staff and others; removing clothing in common areas b. Lexapro (an antidepressant medication) - crying/tearful; sad facial expression, turned down mouth, furrowed brow c. Depakote (an anti-seizure medication used as a mood stabilizer) - Repetitively yells out staff and other peoples name		the QA Committee during regular scheduled Quality Assurance Committee (QAA) meetings and will follow any recommendations as deemed necessary to ensure on-going compliance. 5. Completion Date: 10/5/2016	

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	d. Libruim (an anti-anxiety medication) - yelling out in a loud tone over and over e. Remeron (an anti-depressant medication) - sad facial expression, turned down mouth, furrowed brow; decreased appetite. The "Behavior/ Intervention Monthly Flow Record" listed the behaviors to be monitored and had a code for frequency and offered interventions. The record did not contain space for descriptive narratives of the behavioral event. The form did not indicate, who was present when the behavior occurred, what event/action or activity had occurred prior to or during the event, the time the event occurred, any environmental factors such as noise or temperature. The information on the flow record did not contain information to assist in the assessment of causative/contributing factors in order to decrease, eliminate or better control the behavioral symptom(s). Resident #40's "Behavior /Intervention Monthly Flow Record" for August 2016 included, but was not limited to, the following: a. Resident #40 continuously grabbed others more than 50 of the 93 shifts. b. Resident #40 continuously removed clothing in common areas 4 of 93 shifts. c. Resident #40 continuously repetitively			

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	yelled out names more than 50 of the 93 shifts. d. Resident #40 continually had a sad facial expression more than 60 of the 93 shifts. e. Resident #40 continuously yelled out in loud tones more than 60 of the 93 shifts. Resident #40's clinical record lacked descriptive narrative documentation of the over 220 behavioral events listed on the August 2016 monthly flow record. Resident #40 was observed resting quietly in beds during the following dates and times: 8/30/2016 at 10:16 a.m., 8/31/2016 at 10:33 a.m., 11:05 a.m., 1:00 p.m. and 2:46 p.m. 9/01/2016 at 10:46 a.m. and 2:05 p.m. 9/02/2016 at 8:45 a.m. and 10:53 a.m. Resident #40 was observed calmly being assisted to eat her lunch on 8/29/2016 at 12:20 p.m., 8/31/2016 at 12:24 p.m., and 9/1/2016 at 11:52 a.m. 2. Resident #14's clinical record was reviewed on 9/01/2016 at 2:27 p.m. Resident #14's current diagnoses included, but were not limited to, history of traumatic brain injury, depression, anxiety, and dementia with agitation.			

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	Resident #14 had a 6/21/2016, significant change, Minimum Date Set (MDS) assessment which indicated the resident did display verbal behaviors and behaviors not directed towards others. The assessment indicated these behaviors did not impact others, did not impact the living environment, did not impact activities or socialization, did not impact care and did not result in accident, illness or injury. Resident #14 had a, 7/1/16, care plan problem/need regarding the use of Buspar due to anxiety. Approaches for this problem/need included, but were not limited to, "Consult MD twice annually regarding possible dose reduction and Ongoing behavioral monitoring." Resident #14 had a, 7/1/16, care plan problem/need regarding the use of Depakote due to a diagnoses of impulse control disorder. Approaches to this problem included, but were not limited to, "Observe for efficacy and adverse reactions and Ongoing behavior monitoring." Resident #14 had a, 7/1/16, care plan problem/need regarding the use of Ativan/Lorazapam due to anxiety. Approaches to this problem included, but			

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	were not limited to, "Ongoing behavior monitoring." Resident #14 had "Behavioral Intervention Monthly Flow Records for August and September 2016 which indicated the targeted/monitored behavioral indicator for each psychopharmacological mediation used were as follows: a. Welbutrin (an antidepressant medication) - "agitation and yelling out in common area." b. Lorazapam/Ativan (an anti-anxiety medication) - "anxiety and yelling out, cursing staff and others." c. Abilify (an antipsychotic medication) - "socially inapp [inappropriate] yelling out staff names over & over in common area" and "withdrawn/self isolation." d. Buspar (an anti- anxiety medication) - "crying/tearful." e. Depakote (an anti- seizure medication used as a mood stabilizer) - "physical aggression to staff and others and false accusations for staff & others." Resident #14's "Behavior /Intervention Monthly Flow Record" for August 2016 included, but was not limited to, the following: a. Resident #14 yelled out in the common area continuously more than 50 of 93 shifts.			

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	b. Resident #14 was socially inappropriate yelling out staff names over and over continuously for more than 60 of 93 shifts. Resident #14's clinical lacked descriptive narrative documentation of the over 110 behavioral events listed on the August 2016 monthly flow record. Resident #14 was observed seated calmly in her wheelchair interacting with others and her environment during the following dates and times: On 8/31/2016 at 10:34 a.m., 11:04 a.m., and 12:23 p.m. On 9/01/2016 at 10:48 a.m. and 2:03 p.m. On 9/02/2016 at 8:46 a.m. and 10:54 a.m. 3. On 8/29/16 at 2:26 p.m., Resident #4 was observed sitting in her room working on an activity on her over the bed table. She was calm with no maladaptive behaviors. On 8/30/16 at 9:11 a.m., Resident #4 was observed in bed facing the wall. On 8/30/16 at 9:21 a.m., Resident #4 was observed sitting in her wheelchair in front of the activity calendar. She was calm with no maladaptive behaviors. On 8/30/16 at 9:43 a.m., Resident #4 was observed participating in a singing activity. She was calm with no			

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	maladaptive behaviors. On 8/30/16 at 10:39 a.m., Resident #4 was observed participating in an exercise activity. She was calm with no maladaptive behaviors. On 8/30/16 at 11:05 a.m., Resident #4 was observed on the front porch of the facility with other residents. She was calm with no maladaptive behaviors. On 8/30/16 at 12:24 p.m., Resident #4 was observed in bed facing the wall. On 8/30/16 at 2:42 p.m., Resident #4 was observed in the activity area getting ready to play bingo. She was calm with no maladaptive behaviors. On 8/31/16 at 8:13 a.m., Resident #4 was observed in bed facing the wall. On 8/31/16 at 10:23 a.m., Resident #4 was observed listening and singing during a church service activity. She was calm with no maladaptive behaviors. On 8/31/15 at 12:36 p.m., Resident #4 was observed eating lunch. She was calm with no maladaptive behaviors. On 8/31/16 at 3:06 p.m., Resident #4 was observed in bed with her eyes closed.			

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	On 9/1/16 at 7:05 a.m., Resident #4 was observed talking to staff. She was calm with no maladaptive behaviors. On 9/1/16 at 10:46 a.m., Resident #4 was observed talking to another resident in the activity area. She was calm with no maladaptive behaviors. On 9/1/16 at 2:48 p.m., Resident #4 was observed playing bingo. She was calm with no maladaptive behaviors. On 9/2/16 at 7:37 a.m., Resident #4 was observed watching television in the dining/activity area. She was calm with no maladaptive behaviors. On 9/2/15 at 10:59 a.m., Resident #4 was observed participating in an activity. She was calm with no maladaptive behaviors. On 9/6/16 at 7:13 a.m., Resident #4 was observed in bed with her eyes closed. On 9/6/16 at 3:19 p.m., Resident #4 was observed playing bingo. She was calm with no maladaptive behaviors. The clinical record for Resident #4 was reviewed on 8/31/16 at 10:39 a.m. Diagnoses for Resident #4 included, but were not limited to, paranoid delusions,			

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	depression, anxiety, and seizure disorder. Current physician's orders for Resident #4 included, but were not limited to, the following orders: a. Zyprexa (an anti-psychotic medication) 10 mg, 1 tablet by mouth every bedtime. This order was a decrease on 8/29/16 from 15 mg every bedtime (started on 1/27/15). b. Seroquel (an anti-psychotic medication) 200 mg, 1 tablet by mouth 2 times a day. The original date of this order was 3/29/14. c. Effexor XR (an anti-depressant medication) 75 mg, 1 capsule by mouth once a day. The original date of this order was 3/29/14. Resident #4 had a quarterly Minimum Data Set (MDS) assessment dated 6/21/16. The assessment indicated Resident #4 was severely cognitively impaired and never or rarely made decisions. Resident #4 had a current, 7/1/16 dated, health care plan with the problem of the resident "requires the use of Zyprexa for the diagnosis of paranoid delusions". One of the approaches for this problem was "Ongoing behavior monitoring."			

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	Resident #4 had a current, 7/1/16 dated, health care plan with the problem of the resident "requires the use of Seroquel (quetiapine fumarate) due to dementia with paranoid delusions". Two of the approaches for this problem were "Monitor for efficacy of drug and Ongoing behavior monitoring." Resident #4 had a current, 7/1/16 dated, health care plan with the problem of the resident "requires the use of Effexor (venlafaxine hydrochloride) due to Depression (sic)". One of the approaches for this problem was "Ongoing behavior monitoring." Resident #4 had a "Behavior/Intervention Monthly Flow Record" for August 2016 which indicated the targeted/monitored behavioral indicator for each psychopharmacological medication used were as follows: a. Effexor XR (an antidepressant medication) - sad facial expression, crying, tearfulness b. Zyprexa (an antipsychotic medication) - physical aggression, slapping/hitting staff c. Zyprexa - verbally aggressive, curse at staff/calls staff names d. Seroquel (an antipsychotic medication) - paranoid delusions, staff			

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	giving her the wrong medications to poison her, her physician discontinued her medications Resident #4's "Behavior /Intervention Monthly Flow Record" for August 2016 included, but was not limited to, the following: a. Resident #4 continuously had the paranoid delusion of staff giving her the wrong medications more than 37 of 93 shifts. b. Resident #4 had the paranoid delusion of staff giving her the wrong medications 30 out of 31 night shifts. Resident #4's clinical record lacked descriptive narrative documentation of the over 67 behavioral events listed on the August 2016 monthly flow record.4. On 8/31/16 at 10:26 a.m., Resident #8 was observed sitting in the dining room listening to Bible study. On 8/31/16 at 10:37 a.m., Resident #8 was observed sitting in the dining room singing with a group of residents. On 8/31/16 at 11:01 a.m., Resident #8 was observed leaving the dining room in her wheel chair. Resident #8 had a Bible, a small flag, and her water pitcher in her			

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	hands while propelling herself with her feet. On 8/31/16 at 12:27 a.m., Resident #8 was observed sitting in her wheel chair in the dining room drinking and talking to the Director of Nursing. On 8/31/16 at 11:01 a.m., Resident #8 was observed leaving the dining room in her wheel chair with a plastic bag, a small flag and a water pitcher in her hand. On 9/1/16 at 7:48 a.m., Resident #8 was observed sitting in the dining room inquiring about having another type of eggs besides scrambled. The Activity Director indicated there were hard boiled eggs available. Resident #8 was pleased with the response. On 9/1/16 at 7:53 a.m., Resident #8 was observed taking a lid for her pitcher from the bag of dirty dishes outside the kitchen door. The Activity Director informed Resident #8 that the lid was dirty. Resident #8 began to talk louder indicating the lid was clean. The kitchen staff delivered a clean lid to Resident #8. Resident #8 calmed down and returned to her room. On 9/2/16 at 8:40 a.m., Resident #8 was observed resting in her bed with her eyes			

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	closed. The clinical record for Resident #8 was reviewed on 8/31/16 at 10:42 a.m. Diagnoses for Resident #8 included, but were not limited to, psychosis with aggressive behavior, depression, IDD (intellectual and developmental disability). Resident #8 had the following current physician's orders: a. Haldol (an anti-psychotic medication) 0.5 mg, 1 tablet by mouth 3 times a day. The original date of this order was 8/5/16. b. Zyprexa (an anti-psychotic medication) 10 mg, 1 tablet by mouth 2 times a day. The original date of this order was 8/5/16. c. Zoloft (an anti-depressant medication) 100 mg, 1 tablet by mouth daily. The original date of this order was 8/05/16. d. Ativan (an anti-anxiety medication) 1 mg, 1 tablet by mouth 3 times a day. The original date of this order was 8/19/16. Resident #8 had an 8/10/16, quarterly Minimum Data Set (MDS) assessment, which indicated the resident had severe cognitive impairment. Resident #8 had a current, initiated on			

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	15E064		09/06/2016

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	4/26/16, health care plan with the problem of "The resident requires the use of Haldol an anti- psychotic [sic] medication, resident has a diagnosis of psychosis." The goal for this problem was "Resident will exhibit no signs/symptoms of adverse reactions relative to use of Haldol thru next review." An approach for the use of Haldol was to "monitor efficacy of drug." Resident #8 had a current, updated on 819/16, health care plan with the problem of "I have episodes of believing others are talking about me". The goal for this problem was "The resident will be redirected thru next review." Resident #8 had a current, updated on 8/19/16, health care plan with the problem of "I exhibit verbal and physical aggression toward staff at times yelling and cursing as well as hitting and swinging at them especially when not hearing the answers in which she [sic] wants to hear". The goal for this problem was "I will be free of verbal and physical aggression through next review." Resident #8 "Behavior /Intervention Monthly Flow Record" for August 2016 indicated the facility was monitoring the following behaviors for the following medication uses:			

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	a. Haldol (an antipsychotic medication) - "verbal aggression, yells, curses, makes false accusations against staff and physical aggression, hits, kicks staff and others and yell, screams out in common areas." b. Lorazepam (an antidepressant medication) - "yells, curses, calls staff names and throwing meal tray, drink pitcher, helmet, etc." c. Sertraline (an anti-depressant medication) - "crying, tearful and increase agitation." Resident #8's "Behavior /Intervention Monthly Flow Record" for August 2016 included, but was not limited to, the following: a. Resident #8 had continuously increased agitation more than 44 of the 79 shifts. b. Resident #8 continuously threw her meal tray, drink, pitcher, and helmet, etc. 4 of 79 shifts. c. Resident #8 continuously had verbal aggression, yelled, cursed, and made false accusations against staff more than 50 of the 79 shifts.			

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	d. Resident #8 continuously had yelled, cursed, called staff names more than 45 of the 79 shifts. Resident #8's clinical record lacked descriptive narrative documentation of the over 315 behavioral events listed on the August 2016 monthly flow record. On 8/31/16, Resident #8's "Behavior/Intervention Monthly Flow Record" indicated "continuously had verbal aggression, yells, curses, made false accusations against staff." This was conflicting documentation as seen in the previous observations of Resident #8 on 8/31/16 in activities being calm. During an interview on 9/6/16 at 1:12 p.m., the Social Service Designee indicated that Resident #8's "increased agitation" was the louder she gets. During a 9/06/2016, 10:03 a.m., interview the Social Services Designee indicated the "Behavior/Intervention Monthly Flow Records" were where nurses documented the resident's targeted behaviors associated with psychopharmacological medication use. She indicated the flow records did not contain descriptive narratives of the behavioral events. When queried, she			

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	indicated the information of the flow records alone would not provide enough information to complete a thorough assessment of contributing factors. She also indicated nurses did not routinely make a narrative entry on the nurses note regarding behaviors which were being tracked. She indicated narrative documentation was traditionally used for newly identified concerns. She indicated staff appeared to be using the code for continuously incorrectly because this code indicated the behavior occurred without ceasing during the complete shift. During a 9/06/2016, 9:35 a.m., interview, the Director of Nursing (DON) indicated a C on the Monthly Behavior/Intervention Flow Record meant the resident displayed said behavior throughout the entire shift without stopping. The DON indicated the nurses appeared to be using continuously for routinely or frequently. Review of inservices records for the past year indicated the facility had held 2 inservices regarding behavior monitoring and management. The 2/1/2016 inservice content had a copy of the Behavior/Intervention Monthly Flow Record and indicated the method to fill out said form was reviewed with nurses.			

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	No other content was available for the 2/1/2016 inservice. A 6/15/2015 inservice content contained the behavior management policy and indicated the policy had been reviewed. A current, (undated) facility policy, titled " BEHAVIOR MANAGEMENT POLICY", provided by Social Service Designee on 9/6/16 at 1:33 p.m., indicated: "The facility will treat, will provide or make referrals to provide appropriate interventions in establishing a plan of treatment for those residents identified as needing 'Behavior Management'. Problem Behaviors are behaviors that may adversely affect the well-being of the resident, other residents, staff or visitors. Examples may include: physical behavior symptoms directed toward others, verbal symptoms directed toward others, other behavioral symptoms not directed toward others, rejection of care and wandering.... 1...All behavior incidents will be referred to Social Services via Social Service Alert Form...." 3.1-34(a)(1) 3.1-34(a)(2)			

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F 0314 SS=D Bldg. 00	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview, and record review, the facility failed to ensure necessary treatments were provided to promote healing and prevent new sores for 1 of 1 residents reviewed for pressure areas (Resident #42). Findings included: On 8/31/16 at 10:22 a.m., Resident #42 was observed resting on his back in his bed with the head of the bed raised. Resident #42 was observed eating a snack and drinking a Pepsi while resting in bed. On 8/31/16 at 10:40 a.m., Resident #42 was observed resting in same position as	F 0314	F- 0314 1. Director of Nursing and designee will complete head to toe skin assessment on all residents and documentation will be placed on appropriate tracking form, any skin issues or wounds to be tracked until healed. 2. Any resident has the potential to be affected. Completed head to toe skin assessments on all residents to verify appropriate treatments per skin issue. Resident #42 was referred to and accepted back to the wound clinic. Wound clinic sent resident #42 to a surgeon for a surgical debridement. Skin assessments sheets will be monitored daily for	10/05/2016

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	observed on 10:22 a.m. On 8/31/16 at 11:05 a.m., Resident #42 was observed sitting up in his wheel chair, he was sitting outside the Activity Director's door having a conversation. On 8/31/16 at 12:26 p.m., Resident #42 was observed sitting in the dining room eating lunch. On 8/31/16 at 12:50 p.m., Resident #42 was observed sitting in his wheel chair in his room watching the TV. On 8/31/16 at 1:23 p.m., Resident #42 was observed sitting in his wheel chair in his room watching the TV. On 9/1/16 at 8:21 a.m., Resident #42 was observed resting in his bed with his eyes closed, the head of his bed was elevated and his TV was on. On 9/1/16 at 10:51 a.m., Resident #42 was observed sitting in his wheel chair in front of the nurses station talking on the telephone and drinking a soda. On 9/1/16 at 12:05 p.m., Resident #42 was observed sitting in his wheel chair in his room watching the TV. On 9/1/16 at 12:05 p.m., Resident #42		any new skin issues. Measurements will also be completed weekly during weekly rounds . Director of Nursing will continue to report wound measurements during our regular scheduled SWAT meeting weekly. Facility physician/NP will re-evaluate wounds as indicated by weekly measurements. 3. Director of Nursing, along with Day Charge Nurse will complete wound rounds weekly, to determine any need in change of treatments or nutritional supplements. Skin Assessment sheets will be monitored daily for any new skin issues. Measurements will also be completed weekly during weekly rounds. Director of Nursing will continue to report wound measurements during our regular scheduled SWAT meeting weekly. Facility Physician/NP will reevaluate wounds as indicated by weekly measurements. DON immediately in-serviced/re-educated all nurses on 9/26/16 on detailed wound documentation with emphasis/importance of thoroughly documenting any refusals. 4. Director of Nursing will monitor daily all treatment dressing	

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	was observed sitting in his wheel chair in his room eating his lunch and watching the TV. On 9/2/16 at 8:39 a.m., Resident #42 was observed resting in his bed with his eyes closed, the head of his bed was elevated and his TV was on. On 9/2/16 at 9:53 a.m., Resident #42 was observed resting in bed. The DON (Director of Nursing) and the MDS (Minimum Data Set) Coordinator asked Resident #42 if his treatment to his coccyx could be completed. Resident #42 agreed and proceeded to roll himself to his right side. On 9/2/16 at 9:53 a.m.,a treatment observation of Residents #42's coccyx area was completed and measurements were requested. MDS Coordinator indicated measurements were not needed. The DON indicated measurements could be completed if requested. Measurements were completed as followed: a. The left ischium (where the buttock joins to the thigh), the width measured 7 cm., the length measured 7.5 cm., the depth measured 3.1 cm., and the wound was tunneling under the skin toward the upper area on the buttock measured 2.2		changes x60 days, then on-going weekly to ensure on-going compliance. (See Exhibit "D") Director of Nursing will report to the QA Committee during regular scheduled Quality Assurance Committee (QAA) meetings and will follow any recommendations as deemed necessary to ensure on-going compliance. 5. Completion date: 10/5/2016	

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	cm. b. The coccyx (tailbone), the width measured 8.7 cm., the length measured 8.4 cm., no depth or tunneling noted. The clinical record for Resident #42 was reviewed on 8/31/16 at 1:29 p.m. Diagnoses for Resident #42 included, but were not limited to, anxiety, spastic cerebral palsy, major depression disorder with psychotic features, and neuropathy. Resident #16 had the following current physician's orders: "Cleanse sacral area with hibiclens (an anti-microbial antiseptic skin cleanser), rinse with NS (normal saline) and pat dry. Apply xeroform gauze (a sterile, petrolatum gauze), and cover with an absorbent abdominal pad and secure with stretch tape. Treatment is indicated to be completed 2 times a day and PRN [as needed]. " Resident #42 had a current, 7/1/16, care plan problem/need regarding a stage 3 pressure ulcer on his left ischial fold. This care plan problem/need originated 6/15/16. The goal for this problem/need was "skin will be free from breakdown by next review."			

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	Resident #42 had a current, 7/1/16, care plan problem/need regarding exhibits "verbal and physical aggression and as I hit, kick and attempt to spit on staff when I am upset." This care plan problem/need originated 7/1/16. The goal for this problem/need was "I will be free [sic] physical aggression through next review." Resident #42's medication record, dated 8/6/16 through 8/30/16, indicated "cleanse sacral area with hibiclens (an anti-microbial antiseptic skin cleanser), rinse with NS (normal saline) and pat dry. Apply xeroform gauze (a sterile, petrolatum gauze), and cover with an absorbent abdominal pad and secure with stretch tape. Treatment is indicated to be completed 2 times a day and PRN [as needed]." On 8/10/16 from 6 a.m. to 2 p.m., Resident #42's MAR (Medication Administration Record) indicated the wound treatment was not completed. There was no indication noted related to treatment not being completed. On 8/12/16 from 10 p.m. to 6 a.m., Resident #42's MAR indicated the wound treatment was not completed. There was no indication noted related to treatment not being completed.			

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	On 8/19/16 at 6 a.m. to 2 p.m., Resident #42's MAR indicated the wound treatment was not completed. There was no indication noted related to treatment not being completed. On 8/24/16 at 6 a.m. to 2 p.m., Resident #42's MAR indicated the wound treatment was not completed. There was no indication noted related to treatment not being completed. During an interview on 9/2/16 at 11:03 a.m., CNA #1 indicated Resident #42 had refused care. CNA #1 indicated she would change co-workers or address him at a later time and he usually agreed. CNA #1 indicated the information regarding residents needs were located on the assignment sheets. During an interview on 9/2/16 at 11:54 a.m., CNA #2 indicated Resident #42 had refused care. CNA #2 indicated she would address him a few minutes later and he usually agreed. CNA #2 indicated he wanted things done his way and when he wanted it done. During an interview on 9/6/16 at 3:04 p.m., the DON indicated the facility did not use the forms indicated on the wound care policy. She indicated the "SKIN ASSESSMENT FLOW SHEET FOR			

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	WOUNDS OR SKIN ISSUES" was used for initial wound assessments, and the "WEEKLY PRESSURE ULCER QI LOG" was used for ongoing assessments. The DON could not show any documentation of weekly assessments completed from 8/6/16 through 8/25/16. During an interview on 9/6/16 at 3:55 p.m., the DON indicated a refusal of medication or treatment should be noted on the back of the MAR or in the Nurses Notes. A current, May 2013, facility policy, titled "Refusal of Treatment", provided by the Director of Nursing on 9/6/16 at 3:38 p.m., indicated: "Our facility shall honor a resident's request not to receive medical treatment as prescribed by his or her physician, as well as care routines outlined on the resident's assessment and plan of care... ....2. Treatment is defined as care provided for purposes of maintaining/restoring health, improving functional level, or relieving symptoms. ...3. If a resident refuses treatment, the Unit Manager, Charge Nurse, or Director of Nursing Services will interview the resident to determine what and why the resident is refusing in order to try to			

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	address the resident's concerns and explain the consequences. ...7. Documentation pertaining to a resident's refusal of treatment shall include at least the following: ...a. The date and time the staff tried to give a medication or treatment was attempted; b. The medication or treatment refused; c. The resident's response and reason(s) for refusal; ...g. The date and time the physician was notified as well as the physician's response...." 3.1-40(a)(2)			
F 0329 SS=E Bldg. 00	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic			

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	drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on observation, interview and record review, the facility failed to ensure residents who received psychopharmacological medication had gradual dose reductions or statements of contraindication that included a risk benefit analysis for 4 of 5 residents who met the criteria for unnecessary medications (Residents #40, #14, #4 and #21). Findings include: 1. Resident #40's clinical record was reviewed on 8/31/2016 at 10:39 a.m. Resident #40's diagnoses included, but were not limited to, anxiety, depression and dementia with delusions. Resident #40 was admitted to the facility in September 2015. Resident #40 had current physician's orders for the following psychoactive medications: a. Depakote 125 mg sprinkles (an anti-seizure medication also used as a mood stabilizer) give 2 tablets (250 mg)	F 0329	F-0329 1. Completed audit of psychopharmacological medications on resident's #40, #14, #4 and #21. Each individual Psych medication will be reviewed monthly by facility Pharmacist Consultant for GDR's and current drug regimen was verified with physician. 2. Any resident has the potential to be affected. Facility psychiatrist on 9/26/16 seen all resident's and reviewed all psychopharmacological medications records along with pharmacy GDR's to determine appropriate dosage of psychopharmacological medications. Facility IDT Team will review with facility psychiatrist on GDR's monthly to ensure on-going compliance. 3. Facility Pharmacist reviewed all psychopharmacological medications on 9/15/16 and his findings for GDR's will be reviewed by facility Psychiatrist on 9/26/16 and NP on regular scheduled visits along with	10/05/2016

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	2 times daily for dementia with delusions. This order originated 4/5/2016. b. Librium 5 mg give 1 capsule 2 times daily for anxiety. This dosage of Libruim began on 8/17/2016. c. Lexapro 20 mg give 1 tablet daily for depression. This dosage of Lexapro began 5/9/2016. d. Mirtazapine 7.5 mg (an antidepressant medication) give 1 tablet daily at bed time for depression and an appetite stimulant. The brand name for this medication was Remeron. e. Quetiapine fumarate 25 mg (an antipsychotic medication) give 1 tablet daily in the morning for delusional disorder. This order originated 9/22/15. The brand name for this medication was Seroquel. f. Quetiapine fumarate 50 mg give 1 tablet daily at bed times for delusional disorder. This order originated 9/22/15. Resident #40 had a 6/21/2016, quarterly, Minimum Date Set (MDS) assessment which indicated the resident was rarely or never understood. Resident #40 had a 6/2/2016, "Psychoactive Medication Quarterly Evaluation" which indicated the resident received Librium, Depakote, Lexapro, Remeron and Seroquel. The evaluation		the Director of Nursing. GDR's will be reviewed with the most effective reduction or a detailed statement of contraindicated that include a risk benefit analysis for the resident. DON in-serviced/re-educated all nurses on 9/26/16 on appropriate documentation regarding GDR's. 4. Director of Nursing will monitor monthly pharmacy GDR tracking report for all resident's Director of Nursing will report to the QA committee during regular scheduled Quality Assurance Committee (QAA) meetings and will follow any recommendations as deemed necessary to ensure on-going compliance. (See exhibit "E") 5. Completion Date: 10/5/2016	

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	indicated Resident #40 used these medications to treat anxiety, depression, dementia, delusions and agitation. Resident #40 had an 8/17/2016 "Physician's Note" which indicated the residents behaviors had worsened after the resident was taken off Librium and the medication would be restarted due to grabbing people and "crawling everywhere." Resident #40 had an 8/29/2016 psychiatry progress note that did not address the resident's use of Librium or Depakote and focused only on Lexapro, Remeron and Seroquel. Resident #40 had a 2/8/2016, pharmacy "Consultation Report" which recommended to "please consider a reduction of Seroquel with the eventual goal of discontinuation. For antipsychotic drug therapy, it is recommended that a.) the prescriber document an assessment of the risk verses benefits, indicating that it continues to be a valid therapeutic intervention for this individual...Rationale for this Recommendation: An FDA BOXED WARNING identifies an increased risk of mortality in elderly individuals receiving an antipsychotic medication for behaviors or psychotic symptoms of			

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	dementia...." The physician's response section of this report, dated 2/23/2016, did not include a risk verses benefit assessment. The rationale listed was "crawls, grab, behavior minimally controlled." The report did not indicate how this specific medication was needed to maintain or improve a medical condition. Resident #40 had a 3/7/2016, pharmacy "Consultation Report" which recommended to "please consider a reduction of Seroquel" which the resident had received since 9/22/2015. The physician's response section of this report dated 3/14/2016 did not include a risk verses benefit assessment. The rationale listed was "grabs yelling." The report did not indicate how this specific medication was needed to maintain or improve a medical condition. Resident #40 had a 7/8/2016, pharmacy "Consultation Report" which recommended to "please consider a reduction of Seroquel with the eventual goal of discontinuation. For antipsychotic drug therapy, it is recommended that a.) the prescriber document an assessment of the risk verses benefits, indicating that it continues to be a valid therapeutic intervention for this individual...Rationale for this			

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	Recommendation: An FDA BOXED WARNING identifies an increased risk of mortality in elderly individuals receiving an antipsychotic medication for behaviors or psychotic symptoms of dementia...." The physician's response section of this report, dated 7/26/2016, did not include a risk verses benefit assessment. The rationale listed was "Behaviors would worsened with decreased dose." The report did not indicate how this specific medication was needed to maintain or improve a medical condition. Resident #40's clinical record indicated the resident had never had an attempted dose reduction since the order originated. The statement of "worsened behaviors if decreased" was not supported with any resident specific clinical evidence. Resident #40 was observed resting quietly in bed during the following dates and times: 8/30/2016 at 10:16 a.m., 8/31/2016 at 10:33 a.m., 11:05 a.m., 1:00 p.m. and 2:46 p.m. 9/01/2016 at 10:46 a.m. and 2:05 p.m. 9/02/2016 at 8:45 a.m. and 10:53 a.m. Resident #40 was observed calmly being assisted to eat her lunch on 8/29/2016 at 12:20 p.m., 8/31/2016 at 12:24 p.m., and 9/1/2016 at 11:52 a.m.			

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	2. Resident #14's clinical record was reviewed on 9/01/2016 at 2:27 p.m. Resident #14's current diagnoses included, but were not limited to, history of traumatic brain injury, depression, anxiety, and dementia with agitation. Resident #14 had current, 8/31/2016, physician's orders for the following psychopharmacological medications: a. Abilify 20 mg (an antipsychotic medication) 1 tablet 1 time daily for dementia with agitation. This dosage and distribution of Abilify originated 7/7/2016. Prior to this dose Resident #14 had received 10 mg 2 times daily to total 20 mg daily. Resident #14 had been taking the 10 mg 2 times daily since 5/13/2013. b. Welbutrin SR 150 mg (an antidepressant medication) 1 tablet 2 times daily for depression. This order originated 9/27/2011. c. Buspar HCL 30 mg (an anti-anxiety medication) 1 tablet 2 times daily for depression. This order originated 8/22/2012. d. Depakote 125 mg sprinkles (an anti-seizure medication used as a mood stabilizer) give 4 capsules (500 mg) every morning for delusions. This order originated 6/16/2015. e. Depakote 125 mg sprinkles (an			

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	anti-seizure medication used as a mood stabilizer) give 6 capsules (750 mg) every morning for delusions. This order originated 6/16/2015. f. Lorazapam/Ativan 0.5 mg (an anti-anxiety medication) 1 tablet 3 times daily for anxiety. This order originated 8/16/16. Resident #14 had a 6/21/2016, significant change, Minimum Date Set (MDS) assessment which indicated the resident did display verbal behaviors and behaviors not directed towards others. The assessment indicated these behaviors did not impact others, did not impact the living environment, did not impact activities or socialization, did not impact care and did not result in accident, illness or injury. Resident #14 had a, 7/1/16, care plan problem/need regarding the use of Buspar due to anxiety. Approaches for this problem/need included, but were not limited to, "Consult MD twice annually regarding possible dose reduction and Ongoing behavioral monitoring." Resident #14's clinical record lacked an attempted gradual dose reduction or statement of contraindication that included a risk benefit analysis for the following psychopharmacological			

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	medications: a. Welbutrin originally ordered 9/27/2011 b. Buspar originally ordered 8/22/2012 c. Depakote originally ordered 8/16/2015. Resident #14 was observed seated calmly in her wheelchair interacting with others and her environment during the following dates and times: On 8/31/2016 at 10:34 a.m. and 11:04 a.m., 12:23 p.m. On 9/01/2016 at 10:48 a.m. and 2:03 p.m. On 9/02/2016 at 8:46 a.m. and 10:54 a.m. 3. On 8/29/16 at 2:26 p.m., Resident #4 was observed sitting in her room working on an activity on her over the bed table. She was calm with no maladaptive behaviors. On 8/30/16 at 9:11 a.m., Resident #4 was observed in bed facing the wall. On 8/30/16 at 9:21 a.m., Resident #4 was observed sitting in her wheelchair in front of the activity calendar. She was calm with no maladaptive behaviors. On 8/30/16 at 9:43 a.m., Resident #4 was observed participating in a singing activity. She was calm with no maladaptive behaviors. On 8/30/16 at 10:39 a.m., Resident #4 was observed participating in an exercise			

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	activity. She was calm with no maladaptive behaviors. On 8/30/16 at 11:05 a.m., Resident #4 was observed on the front porch of the facility with other residents. She was calm with no maladaptive behaviors. On 8/30/16 at 12:24 p.m., Resident #4 was observed in bed facing the wall. On 8/30/16 at 2:42 p.m., Resident #4 was observed in the activity area getting ready to play bingo. She was calm with no maladaptive behaviors. On 8/31/16 at 8:13 a.m., Resident #4 was observed in bed facing the wall. On 8/31/16 at 10:23 a.m., Resident #4 was observed listening and singing during a church service activity. She was calm with no maladaptive behaviors. On 8/31/15 at 12:36 p.m., Resident #4 was observed eating lunch. She was calm with no maladaptive behaviors. On 8/31/16 at 3:06 p.m., Resident #4 was observed in bed with her eyes closed. On 9/1/16 at 7:05 a.m., Resident #4 was observed talking to staff. She was calm with no maladaptive behaviors.			

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	On 9/1/16 at 10:46 a.m., Resident #4 was observed talking to another resident in the activity area. She was calm with no maladaptive behaviors. On 9/1/16 at 2:48 p.m., Resident #4 was observed playing bingo. She was calm with no maladaptive behaviors. On 9/2/16 at 7:37 a.m., Resident #4 was observed watching television in the dining/activity area. She was calm with no maladaptive behaviors. On 9/2/15 at 10:59 a.m., Resident #4 was observed participating in an activity. She was calm with no maladaptive behaviors. On 9/6/16 at 7:13 a.m., Resident #4 was observed in bed with her eyes closed. On 9/6/16 at 3:19 p.m., Resident #4 was observed playing bingo. She was calm with no maladaptive behaviors. The clinical record for Resident #4 was reviewed on 8/31/16 at 10:39 a.m. Diagnoses for Resident #4 included, but were not limited to, paranoid delusions, depression, anxiety, and seizure disorder. Current physician's orders for Resident #4 included, but were not limited to, the			

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	following orders: a. Zyprexa (an anti-psychotic medication) 10 mg, 1 tablet by mouth every bedtime. This order was a decrease on 8/29/16 from 15 mg every bedtime (started on 1/27/15). b. Seroquel (an anti-psychotic medication) 200 mg, 1 tablet by mouth 2 times a day. The original date of this order was 3/29/14. c. Effexor XR (an anti-depressant medication) 75 mg, 1 capsule by mouth once a day. The original date of this order was 3/29/14. Resident #4 had a current, 7/1/16 dated, health care plan with the problem of the resident "requires the use of Zyprexa for the diagnosis of paranoid delusions". One of the approaches for this problem is to "Consult MD [physician] twice annually regarding possible dose reduction." Resident #4 had a current, 7/1/16 dated, health care plan with the problem of the resident "requires the use of Seroquel (quetiapine fumarate) due to dementia with paranoid delusions". One of the approaches for this problem is to "Consult MD [physician] twice annually			

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	regarding possible dose reduction." Resident #4 had a current, 7/1/16 dated, health care plan with the problem of the resident "requires the use of Effexor (venlafaxine hydrochloride) due to Depression (sic)". One of the approaches for this problem is to "Consult MD [physician] twice annually regarding possible dose reduction." The "Last dosage reduction" dates were blank on the "Psychoactive Medication Quarterly Evaluation" forms for Resident #4 dated 3/29/16 and 6/21/16. Both evaluations listed Zyprexa 15 mg, by mouth every bedtime, Seroquel 200 mg, by mouth 2 times a day, and Effexor XR 75 mg, by mouth daily as the current medications for Resident #4. The clinical record for Resident #4 lacked gradual dose reductions or statements of contraindication for gradual dose reductions for Zyprexa and Seroquel. On 9/6/16 at 10:57 a.m., additional information related to gradual dose reductions (GDR) or statements of contraindication for gradual dose reductions for Resident #4's Zyprexa and Seroquel was requested of the Minimum Data Set (MDS) Coordinator.			

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	The facility failed to provide any additional information related to Resident #4's GDRs or statements of contraindication for gradual dose reductions as of exit on 9/6/16. 4. On 8/29/16 at 2:20 p.m., Resident #21 was observed in bed with her eyes open. She was calm with no maladaptive behaviors. On 8/30/16 at 9:05 a.m., Resident #21 was observed in bed with her eyes open. She was calm with no maladaptive behaviors. On 8/31/16 at 8:13 a.m., Resident #21 was observed in bed with her eyes closed. On 8/31/15 at 10:32 a.m., Resident #21 was observed in bed with her eyes open. She was calm with no maladaptive behaviors. On 8/31/16 at 1:05 p.m., Resident #21 was observed in bed with her eyes open. She was calm with no maladaptive behaviors. On 8/31/16 at 3:06 p.m., Resident #21 was observed in bed with her eyes closed. On 9/1/16 at 10:53 a.m., Resident #21			

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	was observed in the dining room. She was calm with no maladaptive behaviors. On 9/1/16 at 11:34 a.m., Resident #21 was observed in the dining room. She was calm with no maladaptive behaviors. On 9/1/16 at 2:48 p.m., Resident #21 was observed in bed with her eyes closed. On 9/2/16 at 7:42 a.m., Resident #21 was observed in bed with her eyes closed. On 9/2/16 at 10:57 a.m., Resident #21 was observed in bed with her eyes open. She was calm and making some repetitive noises. The clinical record for Resident #21 was reviewed on 9/1/16 at 7:49 a.m. Diagnoses for Resident #21 included, but were not limited to, paranoid schizophrenia, dementia, anxiety, and depression. Current physician's orders for Resident #21 included, but were not limited to, the following orders: a. Lexapro (an anti-depressant medication) 30 mg, via gastrostomy tube every morning. The original date of this order was 10/23/13.			

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	b. Klonopin (an anti-anxiety medication) 0.5 mg, via gastrostomy tube two times a day. The original date of this order was 6/20/16. c. Geodon (an anti-psychotic medication) 60 mg, via gastrostomy tube two times a day. The original date of this order was 6/30/16. Resident #21 had a current, 7/22/16 dated, health care plan with the problem of the resident "requires the use of Lexapro due to Depression (sic)". One of the approaches for this problem was to "Consult MD [physician] twice annually regarding possible dose reduction." Resident #21 had a current, 7/22/16 dated, health care plan with the problem of the resident "requires the use of Geodon (Ziprasidone) Due to the diagnosis of schizophrenia". One of the approaches for this problem was to "Consult MD [physician] twice annually regarding possible dose reduction." The "Psychoactive Medication Quarterly Evaluation" for Resident #21, dated 7/12/16, indicated the resident was on Lexapro 30 mg, every morning, Klonopin 0.5 mg, two times a day, and Geodon 60 mg, two times a day. The evaluation indicated Geodon had been reduced to 60			

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	mg, two times a day on 6/30/16. No other dates or information was documented for dose reductions for the Lexapro or Klonopin. The clinical record for Resident #21 lacked gradual dose reductions or statements of contraindication for gradual dose reductions for Lexapro and Klonopin. On 9/6/16 at 10:57 a.m., additional information related to gradual dose reductions(GDR) or statements of contraindication for gradual dose reductions for Resident #21's Lexapro and Klonopin was requested of the Minimum Data Set (MDS) Coordinator. The facility failed to provide any additional information related to Resident #21's GDRs or statements of contraindication for gradual dose reductions as of exit on 9/6/16. During a 9/6/16 at 8:50 a.m., interview. the DON indicated the did not have reductions of medications or statements of contraindication with risk benefit analysis for Residents #40, #14, #4 and #21 . Review of the current, revised 4/2007, facility policy, titled "Tapering			

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	Medications and Gradual Drug Dose Reduction", provided by the Director of Nursing on 9/6/16 at 3:38 p.m., included, but was not limited to, the following: "Policy Statement... ...2. All medications shall be considered for possible tapering. Tapering that is applicable to antipsychotic medications shall be referred to as gradual dose reduction. 3. Residents who use antipsychotic drugs shall receive gradual dose reductions and behavioral interventions unless clinically contraindicated in an effort to discontinue these drugs... ...10. Resident who use antipsychotic drugs shall receive gradual dose reductions,unless clinically contraindicated, in an effort to discontinue the use of such drugs... ...11. Within the first year after a resident is admitted on antipsychotic medication or after the resident has been started on an antipsychotic medication, the staff and practitioner shall attempt a GDR [Gradual Dose Reduction] in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, the facility shall attempt a GDR at least annually unless clinically contraindicated. 12. For any individual who is receiving an antipsychotic medication to treat			

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	15E064		09/06/2016

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	behavioral symptoms related to dementia, the GDR may be considered clinically contraindicated if:... ...b. The physician has documented the clinical rational for why any additional attempted dose reduction at that time would be likely to impair the resident's function or increase distressed behavior. 13. For any individual who is receiving an antipsychotic medication to treat a psychiatric disorder other than behavioral symptoms related to dementia (for example, schizophrenia bipolar mania, or depression with psychotic features), the GDR may be considered contraindicated if: a....the physician has documented the clinical rational for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying psychiatric disorder; or the resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility and the physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function nor cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder... ...15. Attempted tapering of psychopharmacologic medications other			

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	than antipsychotics or sedatives and hypnotics shall be considered as a way to demonstrate whether the resident benefiting for a medication or might benefit from a lower or less frequent dose. Tapering shall be done consistent with the following: a....the facility will attempt to taper the medication during at least two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, tapering will be attempted at least annually, unless clinically contraindicated...." 3.1-42(b)(2)			