

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155039	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/02/2012
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 317 BLAIR PIKE PERU, IN 46970
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F0000	<p>This visit was for a Recertification and State Licensure Survey. This visit included Investigation of Complaint number IN00101922.</p> <p>Complaint number IN00101922- Unsubstantiated due to lack of evidence.</p> <p>Survey dates: January 30, 31 and February 1 and 2, 2012</p> <p>Facility number: 000014 Provider number: 155039 AIM number: 100288670</p> <p>Survey team: Christine Fodrea, RN, TC Julie Wagoner, RN Tim Long, RN (1-30, 2-1, and 2-2, 2012)</p> <p>Census bed type: SNF: 12 SNF/NF: 61 Total: 73</p> <p>Census payor type: Medicare: 11 Medicaid: 47 Other: 15 Total: 73</p>	F0000	Please accept this POC as our credible allegation of compliance.	
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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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	<p>Sample: 15</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on February 9, 2012 by Bev Faulkner, RN</p>			
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F0157 SS=D	<p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to notify the physician of the need to increase oxygen liter flow for 1 of 4 residents reviewed for oxygen delivery in a sample of 15. (Resident #16)</p> <p>Findings include:</p>	F0157	It is the intent of this facility to ensure that professional standards of practice are met and to notify MD of any change in condition that may or may not warrant a change in treatment plan. Resident #16's oxygen order was clarified on 1-30-12 and changed to oxygen @ 2-3 liters to	02/29/2012
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	<p>Resident #16's record was reviewed 1-30-2012 at 2:10 p.m. Resident #16's diagnoses included but were not limited to lung cancer, depression, and high blood pressure.</p> <p>A review of current physician's orders recapitulation, dated January 2012, indicated beginning 12-14-2011 oxygen was to be administered to Resident #16 at 2 liters per minute continuously to keep oxygen saturations above 90%.</p> <p>A review of nurse's notes, dated 1-4-2012 at 11:45 a.m., indicated Resident #16's oxygen saturations was 89%. The note further indicated the hospice nurse bumped up the liter flow of the oxygen to 3 liters per minute. There was no indication the nurse notified the physician.</p> <p>A review of nurse's notes, dated 1-4-2012 at 2:12 p.m. (14:12), indicated the hospice nurse again bumped Resident #16's oxygen liter flow to 3 liters per minute, this time as a nursing measure. There was no indication of the reason for the change on oxygen flow and there was no indication the physician had been notified of the need to increase the liter flow either then or earlier in the day.</p>		<p>keep sats above 90%. This resident suffered no negative consequences as a result of this finding. All residents have the potential to be affected by this deficient practice. Hospice was notified by DON on 1-31-12 that "standing orders" are not allowed and that the attending physician must be notified of any changes and orders written. A mandatory inservice will be held on 2/22/12 to review PHYSICIAN AND FAMILY NOTIFICATION OF CONDITION CHANGES. A copy of this policy was sent to GAH along with a letter stating our policy on standing orders. See Exhibit #1 and #2 Physician notification of condition changes will be monitored through daily review of the 24 Hour Condition Report and weekly QA - 24 HOUR CONDITION REPORT REVIEW weekly x 4 and monthly thereafter. See Exhibit #3 Any discrepancies will be corrected and findings submitted to the QA committee for review monthly. Nursing responsible QA Committee will monitor Completion date: 2/29/12</p>		

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	<p>In an interview on 1-31-2012 at 9:35 a.m., LPN # 1 indicated the hospice nurse should have notified the physician of the need for more oxygen.</p> <p>A current policy, dated 3-1-2003, titled Physician and Family Notification of Condition Changes provided by the Administrator on 2-2-2012 at 9 a.m., indicated "1. b. Notify the physician of any change in condition that may or may not warrant a change in treatment plan."</p> <p>3.1-5(a)(3)</p>			
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F0248 SS=E	<p>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.</p> <p>Based on observation, record review, and interviews, the facility failed to ensure an ongoing activities program was provided for 12 of 13 residents residing on the secured dementia unit with the potential of affect all residents housed on the dementia unit. (Resident #62, Resident #63, Resident #64, Resident #65, Resident #66, Resident #67, Resident #68, Resident #69, Resident #70, Resident #71, Resident #72, Resident #73)</p> <p>Findings include:</p> <p>During the initial tour of the secured dementia unit, conducted on 01/30/12 between 10:45 A.M. - 11:15 A.M., there were no structured activities observed. There were 4 residents (Resident #71, Resident # 72, Resident #66, Resident #67) observed seated in the dining room/lounge and one resident noted walking in the hallway. There were also residents noted to be lying in their beds in their rooms. On the activity calendar for January 30, 2012, an activity Cafe Royale was scheduled.</p>	F0248	<p>It is the intent of this facility to provide an on-going program of activities designed to meet the interests and the physical, mental and pyschosocial well being of each resident. The activity program on the dementia unit has been revised to ensure that there are on-going programs based on residents needs and interest. Staffing has been adjusted to ensure that activities are on-going and that nursing staff can focus on nursing duties and not interfere with scheduled activities. An Activity Calendar for March will follow the attached activity plan - Exhibit # 24 - but with specific activities detailed. Regularly scheduled facility activities will also be available for residents on the dementia unit (e.g. bingo, musical programs, etc.). Staff will be available to assist residents to these activities as well as provide activities for those residents remaining on the dementia unit. To ensure that this deficient practice does not continue - staffing has been adjusted to ensure that activities are scheduled on-going and not interrupted. This program will be monitored through the QA tools - ACTIVITY PARTICIPATION REVIEW - Exhibit #25 and</p>	02/29/2012			

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	<p>On 01/31/12 from 11:35 A.M. - 12:00 P.M., there were no structured activities noted to occur on the secured dementia unit. On the activity calendar for January 31, 2012, an activity Sentimental Reflections was scheduled. There were 3 residents in the dining room/lounge, (Resident #63, Resident #65 and Resident #69) a nurse was in the dining room talking on the telephone and working with a clinical chart, a nursing assistant was in a resident room with the door closed, and a housekeeper was cleaning resident rooms. The nursing assistant was noted to bring residents into the dining room and seat them at the table. At 11:50 A.M., a social service staff member entered the dining room/lounge, chatted for 3 minutes with a female resident about coffee and family visit the resident had recently experienced, and then the social service staff member left the unit. At 12:00 noon, the nursing assistant turned on soft background music and then proceeded to assist residents to the dining room chairs.</p> <p>At 1:10 P.M., there were 14 residents in the dining room/lounge eating lunch. At 1:20 P.M., an activity staff member entered the dining room/lounge and asked the residents if any of them desired to go help "fold towels." Only 1 resident expressed a desire to go help "fold towels." However, at 1:27 P.M., three</p>		<p>ACTIVITY PROGRAM REVIEW - Exhibit #26. These will be completed monthly and reviewed during monthly QA meetings. Any discrepancies will be corrected and findings submitted to the QA committee for review. Activity Director will be responsible QA Committee will monitor Completion Date: 2/29/12</p>				

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	<p>female residents (Resident #66, Resident #72 and Resident #68) exited the unit with the activity staff member to go to a "linen" activity. The activity staff member indicated they would just stay out of the unit to play Bingo after the linen folding activity. There were no structured activities for the residents that did not leave the unit.</p> <p>At 1:33 P.M., there were 7 residents (Resident #62, Resident #63, Resident #65, Resident #67, Resident #68, Resident #70 and Resident #72) left in the dining room/lounge and one visitor. There were no structured activities or any staff in the room. At 1:36 P.M., the nurse came back into the dining room/lounge, but no activity was provided for the 7 residents left in the room. At 2:00 P.M., Resident #66 came into the dining room/lounge and indicated she desired to go to Bingo and no one had came back (to the unit) to get her. She indicated if the Bingo had already started when she got there she did not want to play. Resident #66 was then escorted off of the unit to the Bingo activity. From 2:00 P.M. - 2:45 P.M., there were no structured activities provided for 9 residents (Resident #62, Resident #63, Resident #65, Resident #67, Resident #68, Resident #69, Resident #70, Resident #71, and Resident #72) who did not go off the unit for</p>						

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	<p>activities. There was soft music playing in the dining room/lounge, and the nurse was seated at a dining room table working on paperwork.</p> <p>On 02/01/12 at 8:47 A.M., there were 6 residents (Resident #62, Resident #64, Resident #68, Resident #71, Resident #72, and Resident #73) noted in the dining room/lounge. There were no activities and there were no staff in the room. The activity director was noted to be in the hallway taping new activity calendars onto individual resident room walls. A nursing assistant was noted to be ambulating a resident into their room, and the nurse was noted to have been in a resident room. At 8:50 A.M., the nurse entered the dining room/lounge and proceeded to clean up dirty breakfast dishes and then at 9:06 a.m., both the nurse and the nursing assistant had left the dining room/lounge. The nurse, employee #7, exited the dementia unit. There were 4 residents still in the dining room/lounge (Resident #62, Resident #68, Resident #71, and Resident #72). On the main activity calendar for February 1, 2012, an activity fancy nails was scheduled.</p> <p>At 9:10 A.M., the Certified Nursing Assistant, CNA, employee #5, came back to the dining room/lounge and put soft</p>			
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	<p>background music on for the residents. From 9:10 A.M. - 9:35 A.M., CNA #5 was noted to answer a resident's request for help to the bathroom, and help another resident ambulate out of the dining room/lounge. At 9:36 A.M., Resident #66 ambulated into the dining room/lounge and asked a visitor if they could help her put on a "Bluegrass" DVD. There was no video player noted and at 9:38 A.M., CNA #5 reentered the dining room lounge and informed Resident #66 she would put on a "Bluegrass" music CD as the DVD player was "put up." From 9:42 A.M. - 9:48 A.M., there were 3 residents unsupervised with no structured activities in the dining room/lounge. At 9:48 A.M., a therapist, Employee #6 entered the dining room/lounge and spoke with one of the 3 residents (Resident #64, Resident #70, and Resident #72) in the room. Employee #6 exited the room and unit at 9:52 A.M. From 9:52 A.M., there were no staff supervising the residents. At 9:54 A.M., LPN #7, entered the dining room/lounge and Resident #66 questioned her about the "Fancy Nails" activity. LPN #7 informed the resident the activity was scheduled for 10:00 A.M. At 9:57 A.M., LPN #7 started to read the newspaper to the 3 residents (Resident #64, Resident #70, and Resident #72) who were still sitting in the dining room/lounge. At 10:01 A.M., Resident # 72 was taken off</p>			
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	<p>the unit to smoke. At 10:11 A.M., Resident #66 questioned LPN #7 about the fingernail polishing activity and pointed out it was past 10:00 A.M. CNA #5, who had entered the room, was instructed to call activity staff to come to the unit and escort the residents to the "Fancy Nails" activity off of the unit. The CNA attempted to call but got no answer and in the meantime, the Food Service Supervisor, who had entered the unit to drop off menus, volunteered to escort residents off of the unit to the activity. Resident #66 was then escorted off of the unit to the "Fancy Nails" activity. LPN #7 continued to read the newspaper until 10:15. From 10:15 A.M. - 10:42 A.M., there was music again playing for the residents, but no structured activities. At 10:42 A.M., Resident #66 returned from the off unit "Fancy Nails" activity and Resident #72 exclaimed, "Hey, they are getting their nails done down there and I want my nails done." Resident #66 informed Resident # 72 that the nails activity had ended. LPN #7 informed Resident # 72 that she would paint her nails later for her and also informed Resident #66 that she would hook up the video player so she could watch the "Bluegrass" DVD she had requested earlier.</p> <p>At 11:05 A.M., LPN #7 got out fingernail</p>						

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	<p>polish and sat at a dining room table with Resident #72 and started to file and paint her fingernails. At 11:20 A.M., CNA #5 got out a wooden corn hole bean bag toss game and started playing with the 6 residents (Resident #62, Resident #64, Resident #68, Resident #71, Resident #70, and Resident #72) who where seated in the lounge part of the dining room/lounge room. At 11:24 A.M., CNA #5 left to go answer a call light. No staff were available to assist the resident's in continuing their game. Resident #68 was heard stating, "I'm not sure I could bend over enough to get them (bean bags)." LPN #7, turned around and instructed Resident #68 to wait for (CNA's name) to return. At 11:35 A.M., CNA #5 returned to the dining room/lounge and continued to play bean bag toss with the residents. At 11:40, LPN #7, who had finished painting Resident #72's fingernails, left the unit for her lunch break. At 11:41 A.M., CNA #5 left the bean bag toss game to assist another resident who had ambulated to the doorway of the dining room/lounge and requested assistance. CNA #5 did not return to the dining room lounge until 11:49 A.M. The 6 residents who were playing the bean bag toss game, just sat in chairs or on the sofa while no staff were there to facilitate the game. The main activity calendar reflected the activity Sentimental Reflections was to be</p>			
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	<p>happening.</p> <p>At 1:50 P.M., LPN #7 indicated there were 4 residents out with activities' staff and they were staying off of the unit for the "Movie." LPN #7 also indicated she was going to escort, Resident #72 off the unit to the activity. There were 3 residents in the dining room/lounge (Resident #67, Resident #65, Resident #73) and 1 male resident (Resident #71) ambulating in the hallway. CNA #5 had to leave the dining room lounge, to redirect Resident #69 out of another resident's room. Resident #67's visitors also entered the dining room/lounge. From 1:50 P.M. - 3:10 P.M., there were no structured activities provided for the residents on the secured unit.</p> <p>Interview with the Director of Nursing, on 02/02/12 at 10:15 A.M., indicated the facility had opened the dementia unit within the past year and LPN #7 was the Program Director of the dementia unit. She indicated when she had gone back to the unit she had observed lots of activities. She was unsure of the schedule of activities for the Dementia unit. She indicated because the dementia unit was not full, they were not allowed an activity staff member to work just on the dementia unit. She indicated the nursing staff were responsible for providing the</p>						

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	<p>structured activities for the unit.</p> <p>Review of the facility's Dementia unit application indicated an activity director was available to coordinate activities for the Alzheimer's/dementia care program/unit and the following therapeutic methods were to be used: are therapy, exercise, recreational therapy, music therapy, pet therapy, and reminiscence therapy. The application included the following statement: "The Boulevard (facility's name for the dementia unit) provides an activity based programming concept through primary care staff in an attractive dementia friendly environment." It was unclear how the time observed on the dementia unit was "activity based" as there were very few activities provided and most of those provided were not on the dementia unit.</p> <p>3.1-33(a)</p>				

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F0250 SS=D	<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 record review and interview, the facility failed to ensure the behavior management program was fully implemented, coordinated, and documented accurately to address behavioral issues for 2 of 7 residents reviewed for behaviors in a sample of 15. (Residents #11 and #45)</p> <p>Findings include:</p> <p>1. During the initial tour of the facility, conducted on 01/30/12 between 10:35 A.M. - 10:50 A.M., RN #8 indicated Resident #11 had fallen on the dementia unit and had fractured his hip. She indicated the resident was confused and required extensive staff assistance for mobility and daily needs.</p> <p>The clinical record for Resident #11 was reviewed on 01/31/12 at 2:00 P.M. The resident was admitted to the facility on 12/08/11 with diagnosis, including but not limited to, Alzheimer's dementia, depressive disorder, and diabetes.</p> <p>Nursing notes, dated 12/08/11- 12/13/11, indicated the resident was agitated, resistive to care, verbally and physically abusive to staff, and urinating in</p>	F0250	<p>It is the intent of this facility to ensure that the behavior management program for each resident is fully implemented, co-ordinated and documented accurately to address behavioral issues. Resident #11 and Resident #45 have had their behavioral management plans updated. Neither resident suffered any negative consequences as a result of this finding. See Exhibit #4 and #5. All residents have the potential to be affected by this deficient practice. To prevent this from occurring, all residents who are currently on a behavior management program and/or receiving psychoactive medications/pyschiatric services had completed assessment for medication use and care plan implementation and accuracy. A mandatory inservice will be held on 2/22/12 to include re-education on the behavior management system to include accurate documentation of behavioral issues and interventions. See Exhibit #6 BEHAVIOR MANAGEMENT AND ASSESSMENT. RMS will be presenting an inservice on 2/21/12 entitled "BEHAVIOR MANAGMENT - A BEST PRACTICE". See Exhibit #7 To prevent recurrence of this finding - residents on a behavior</p>	02/29/2012			

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	<p>inappropriate places. The physician was notified on 12/13/11 and ordered an injection of the antipsychotic medication, Haldol. The resident was then sent to an inpatient psychiatric facility on 12/14/11. The resident was readmitted to the dementia unit on 12/30/11 with new diagnosis of anxiety, and psychosis. The resident had been placed on an antianxiety medication, and antipsychotic medication, and an antidepressant medication.</p> <p>Nursing notes, dated 12/30/11 - 01/08/12, indicated the resident was again noted to be physically abusive to staff, paced, combative with care needs, unsteady on his feet, and exit seeking. The antipsychotic medication was increased on 01/01/12 and an injection of antianxiety medication was ordered on 01/03/12. In addition, another antidepressant medication was added to the resident's medication regimen.</p> <p>The behavior plans for Resident #11, initiated on 12/13/11, indication the resident was exhibiting ineffective coping with verbal and physical aggression related to sensory overload, unfamiliar environment, sensory deficits, sundowning...." The interventions included the following: "allow resident time to respond to directions or requests, approach the resident slowly and from the</p>		<p>management program will be reviewed in a weekly behavior management meeting to ensure that behaviors are being documented accurately and that interventions are being implemented appropriately and documented. This program will be monitored through weekly review of residents on a behavior management program in our weekly behavior management meeting. Monthly QA using BEHAVIOR AND ANTIPSYCHOTIC MEDICATION REVIEW - Exhibit #8 - will be completed monthly and reviewed during our monthly QA meetings x4 and then quarterly to ensure compliance. Any discrepancies will be corrected and findings submitted to the QA committee for review monthly. SS responsible QA committee will monitor Completion Date: 2-29-12</p>				

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	<p>front, be sure you have the resident's attention before speaking or touching, keep MD and responsible party updated as needed, refer for psychiatric care as needed, and use consistent routines for ADL (activities of daily living)." Another plan indicated the resident displayed inappropriate physical behavioral issues as exhibited by slapping, punching, grabbing and squeezing staffs hands. Typically happens in the evenings. Interventions included: "document physical behavior #1: slapping, punching, grabbing and squeezing staffs hands. Interventions (1) Approach in a calm, friendly manner (2) Explain task and give time to process (3) offer choices when available (4) if combative leave in a safe manner and approach later, notify physician as needed, and psych services to follow resident as needed."</p> <p>A mood plan for Resident #11, initiated on 01/03/12, indicated the resident displayed mood issues as exhibited by nervousness, restlessness, yells and curses at staff, wandering/exit seeking, delusions, such as , thinking he is being shot at or in a bar. Interventions included "Document mood behavior #1: nervousness, restlessness, yells and curses at staff, wandering/exit seeking, delusion, such as, thinking he is being shot at, or in a bar. Interventions (1)encourage to voice</p>						

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	<p>concerns (2) offer reassurance/support (3) offer a snack, drink, to toilet (4) diversional task, talk about his children, his old business, fishing, administer psych medications as ordered, monitor medication side effects at least daily on psychotropic medication record, notify physician as needed, listen to concerns an follow-up on these promptly as needed, provide support and encouragement PRN, ss (social services) to visit PRN, Psych services to follow resident as needed."</p> <p>Review of the computerized behavior and mood tracking record for December 2011 and January 2012, indicated the number of times a behavior occurred in a shift was documented but it was unclear exactly which behavior had occurred as there were several different behaviors and/or mood issues to be monitored and no way to document which one had occurred. Staff only had the opportunity to document 1 intervention attempt and the result so it was again not clear if staff were actually utilizing the entire behavior management plan to attempt to address Resident #11's behaviors.</p> <p>Interview with the Social Service Director, on 02/02/12 at 1:45 P.M., indicated the computerized behavior and mood monitoring documentation was unclear, did not allow for more than one</p>			
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	<p>intervention, had no place to separate verbal aggression and behaviors from physical aggression and behaviors, and only the nursing assistants were currently documenting on the system. The licensed nursing staff were documenting some of the behaviors in the nursing notes, but it was not coordinated with the documentation by the certified nursing assistants and it was impossible to tell exactly how many interventions had been attempted in an effort to manage behaviors.</p> <p>In addition, the Social Service Director was unable to determine how specific targeted behaviors, for which Resident #11 was receiving anti-anxiety, antipsychotic, and two antidepressive medications, were individually monitored on a daily basis, because the current system did not specify exactly which behavior the resident was displaying and whether all of the resident's behaviors were captured between the nursing progress notes, where the licensed nurses documented and the computerized mood/behavior charting, where the certified nursing assistants documented.</p> <p>2. Review of Resident #45's clinical record on 1/30/12 at 2:35 P.M., indicated diagnoses including, but not limited to, dementia with delusions. On 11/8/11, a</p>						

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	<p>physician's order was received to start Risperidone 0.25 milligrams (mg) daily at bedtime for psychotic behaviors. On 11/17/11, a physician's order was received to increase Risperidone to 0.5 mg daily at bedtime for psychotic features.</p> <p>On 1/9/12, Resident #45 a behavioral medicine evaluation and management note from a Nurse Practitioner (NP) indicated the resident "is very psychotic and hit a staff this last evening." The NP recommended the resident get a Urinalysis (U/A) for continued behaviors along with an increase of Risperidone from 0.5 mg daily to 0.5 mg twice daily for psychotic features. On 1/10/12, a physician's order was received to increase Risperidone to 0.5 mg twice daily for psychotic features and for an U/A.</p> <p>On 1/11/12, a physician's order was received for Cipro (an antibiotic medication) 500 mg twice daily for 7 days for an urinary tract infection (UTI).</p> <p>Review of the resident's progress notes did not indicate an incident where Resident #45 hit a staff member on 1/8/12 as noted by the NP on 1/9/12.</p> <p>A behavior incident was noted in the resident's progress notes on 1/7/12 in which Resident #45 was yelling and</p>			
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	<p>shaking his fist at another resident who got stuck against the resident's table while trying to enter the dining room. The progress note indicate staff explained to resident the behavior was inappropriate and the resident was easily redirected.</p> <p>Review of the resident's behavior tracking on 1/7/12 did not indicate any physical behavior or mood behavior.</p> <p>Review of Resident #45's behavior tracking from the start of Risperidone treatment for psychotic behavior on 11/8/11 did not indicate tracking of psychotic features. Resident #45 had behavior tracking for physical behavior and mood behavior. Physical behavior included: hitting; kicking, cursing, yelling at staff during care, shaking his fist and yelling at other residents. Mood behavior included: inappropriate sexual behavior shown by resident exposing self and/or masturbating without notifying staff he would like privacy, touching staff inappropriately, and making inappropriate sexual statements about staff.</p> <p>Interventions for physical behavior were: "1. approach in a calm friendly manner. 2. explain tasks and allow time to process. 3. if yelling at other residents explain behavior is inappropriate and remove resident in safe manner. 4. leave in a safe</p>				

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	<p>manner and reapproach later."</p> <p>Review of Resident #45's behavior tracking from 12/13/11 to 1/13/12, indicated on: 12/30/11, 4 incidents of physical behavior were noted at 2:14 P.M. and interventions of 1 and 2 were tried and the behavior worsened. The behavior tracking form did not indicate the nature of the physical behaviors. Review of the resident's progress notes indicated at 1:00 P.M. resident became combative with staff during care before lunch. Resident began hitting at staff, staff left room with resident in bed and call light in reach. Staff then reapproached resident and assisted resident up into wheelchair for lunch. No other progress notes from 12/20/11 involving Resident #45's behavior incidents; 12/31/11, 3 incidents of physical behavior were noted at 1:21 P.M. and interventions of 1 and 2 were tried and behavior was unchanged. The behavior tracking form did not indicate the nature of the physical behaviors. Review of the progress notes from 12/31/11 did not indicate any behavior episodes; 1/2/12, 2 incidents of physical behavior were noted at 2:42 P.M. and interventions of 1 and 2 improved the behavior. The behavior tracking form did not indicate the nature of the physical behaviors. Review of the progress notes from 1/2/12 did not indicate any behavior</p>						

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	<p>episodes; 1/5/12, 2 incidents of physical behavior were noted at 10:59 P.M. and intervention of 2 was tried and the behavior was unchanged. The behavior tracking form did not indicate the nature of the physical behaviors. Review of the progress notes on 1/5/12 indicated at 11:32 A.M., the resident was yelling at staff this AM related to roommates TV being on all night. Staff explained if resident would ask for it to be off or turned down we would attempt to accommodate but yelling at staff about it the next day is inappropriate. No other progress notes from 1/5/12 involving behavior episodes.</p> <p>An interview with the Social Service Director (SSD) on 2/2/12 at 11:35 A.M., indicated she could not find an incident report and did not know of an incident on 1/8/12 where Resident #45 hit a staff member. The SSD indicated for behavior incidents noted she would expect staff to attempt all interventions. The SSD director indicated the computer program for behavior tracking only allows up to 4 interventions. The SSD indicated the computer program does not allow physical behaviors to be separated from verbal behaviors for the behavior tracking.</p> <p>An interview with the NP on 2/2/12 at</p>			
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	<p>1:30 P.M., who recommended the Risperidone increase on 1/9/12, indicated on 1/9/12 a nurse told her the resident had hit a staff member on 1/8/12. The NP indicated she ordered the urinalysis based on a history of urinary tract infections and the resident's recent increase in behaviors. The NP indicated she would have waited to start the Risperidone increase until after the results of the urinalysis were received, to see if the resident had a urinary tract infection or not but staff indicated the resident's behaviors were bad enough to go ahead and start the medication increase.</p> <p>3.1-34(a)</p>			
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F0257 SS=E	<p>The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F</p> <p>Based on observation, interview and record review, the facility failed to maintain comfortable room temperatures on the assisted dining area. This had the potential to affect 20 of 20 residents dining in the assisted dining area in the facility population of 73.</p> <p>Findings include:</p> <p>During lunchtime observation on 1-30-2012 at 12:15 p.m., twenty residents were seated at tables in the assisted dining area; the ambient temperature in the assisted dining area was measured at 66 degrees.</p> <p>During lunchtime on 1-30-2012 at 12:16 p.m., Resident #21 was noted to comment the room was cold. Resident #34 responded that the room was cold.</p> <p>In a confidential interview on 1-30-2012 at 12:17 p.m., a family member sitting in the assisted dining area, indicated the assisted dining area was always cold.</p> <p>During suppertime observation on 1-30-2012 at 5:00 p.m., the ambient temperature in the assisted dining area was measured at 68 degrees.</p>	F0257	<p>It is the intent of this facility to provide comfortable and safe temperature levels (71 - 81 degrees) at all times. All residents who have meals in the assist dining room have the potential to be affected by this deficient practice. On 2-1-12 the thermostat in the assist dining room was adjusted and temperature has been monitored 2x daily. Temperatures have been maintained at an acceptable level since then. Temperatures in the assist dining room are checked 2x daily and documented to ensure temps remain within acceptable levels. Thermostats have locked covers to ensure that thermostats are not tampered with. Temperatures are monitored and documented 2x daily by maintenance (Mon-Fri) and by weekend managers on Sat & Sun. Documentation will be reviewed during monthly QA meetings for compliance. Exhibit #9 and #10 Any discrepancies will be corrected and findings submitted to the QA committee for review monthly. Maintenance responsible QA Committee will monitor</p> <p>Completion Date: 2-1-12</p>	02/06/2012			

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	<p>During an observation on 1-31-2012 at 9:00 a.m., the ambient room temperature in the assisted dining area was measured at 66 degrees.</p> <p>During an observation on 2-1-2012 at 8:45 a.m., the ambient room temperature was measured at 67 degrees.</p> <p>In an interview with the Assistant Director of Nursing, during the 2-1-2012 morning observation, she indicated Resident #34 and Resident #21 were each alert and oriented enough to know if they were cold and to be able to tell someone.</p> <p>In an interview on 2-1-2012 at 10:15 a.m., the Maintenance Director indicated there was a system to direct the maintenance effort, but the system did not indicate to take building temperatures. He further indicated the ambient temperature in the assisted dining area should be between 71 and 81 degrees.</p> <p>A review of the maintenance system information did not include direction for the maintenance staff to check ambient air temperatures in any part of the building.</p> <p>3.1-19(h)</p>						

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F0282 SS=G	<p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the care plan to prevent falls was followed for 1 of 7 residents reviewed for falls in a sample of 15 resulting in a fall with facial fracture. (Resident #71). The facility further failed to follow physician's orders for a laboratory order for 1 of 13 residents reviewed for lab draws in a sample of 15. (Resident #30)</p> <p>Findings includes:</p> <ol style="list-style-type: none"> During the initial tour of the facility, conducted on 01/30/12 between 10:45 A.M. - 11:15 A.M., LPN #7 indicated Resident #71 had fallen and had facial fractures, was confused, and had a shuffling gait when he ambulated. <p>The clinical record for Resident #71 was reviewed on 01/31/12 at 1:15 P.M. Resident #71 was admitted to the facility with diagnosis, including but not limited to, dementia with behavior disturbances, Parkinson's disease, osteoporosis, dysarthria, and anxiety state.</p> <p>Review of the initial care plan for falls, initiated on 11/18/11, indicated Resident #71 was at risk for falls due to a history of</p>	F0282	<p>It is the intent of this facility to ensure that the care and treatment of each resident is provided in accordance with each residents written plan of care. Resident #71's care plan has been reviewed and updated to reflect his current needs in relationship to fall prevention. Resident #30's CBC was drawn on 2-2-12 and was WNL. See Exhibit #11 All residents have the potential to be affected by this deficient practice. To ensure future compliance - a mandatory inservice will be held on 2/22/12 to review CARE PLAN DEVELOPMENT AND REVIEW - Exhibit #12 - to include communication to staff of interventions related to care. Care plan interventions are identified on CNA worksheets. Acute issues identified on the 24 Hour Condition Report will be monitored by the unit managers to ensure that the health care plan is updated and appropriate. Lab orders have been reviewed for accuracy and a calendar - Exhibit #13 - has been implemented to remind staff of routine lab orders. A LAB/X-RAY TRACKING TOOL - Exhibit #14 - has been implemented to ensure that labs are completed as ordered. This program will be monitored through the following</p>	02/29/2012			

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(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>falls, confusion with dementia, unsteady gait, poor trunk control, use of narcotics, shuffled gait related to Parkinson's, and knees bent when ambulating. A plan included the following interventions: "call light in reach. Explain use of it upon admission and reinforce as needed, encourage and assist with wearing non-skid footwear, ensure environment is free of clutter, assist with ambulation."</p> <p>Nursing progress notes, dated 01/16/12 at 9:50 P.M., indicated the resident had fallen in the hallway. Review of the post fall investigation, and interview with the Director of Nursing on 02/02/12 at 10:00 A.M., indicated a certified nursing assistance had given Resident #71 a shower and the resident had exited the shower room and walked into the hallway. The nursing assistant had gathered up the personal care items and was walking a few steps behind the resident with her arms full. The resident turned to look at the nursing assistant, lost his balance and fell hitting his face. Another staff member was entering the unit, but was unable to get to the resident in time to prevent the fall.</p> <p>The resident was sent to an acute care facility and was diagnosed with a fractured orbital and maxillary bones and a facial laceration requiring sutures.</p>		<p>QA: CARE PLAN REVIEW - Exhibit #15 and LABORATORY REVIEW - Exhibit #16. These will be completed monthly x4 and then quarterly. Any discrepancies will be corrected and findings submitted to the QA committee for review monthly. Nursing responsible QA Committee will monitor Completion Date: 2-29-12</p>				

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	<p>Resident #71 was observed on 01/30/12 at 12:37 P.M., ambulating with assistance from his room to the dining room. The resident was wearing slippers and was noted to shuffle his feet and keep his head pointed towards the floor. In addition, the resident was noted to have visible bruising along the left side of his face, nose, and under his chin. There were also sutures noted on the left side of his face.</p> <p>Interview with the Director of Nursing, on 02/02/12 at 10:15 A.M. indicated the resident did not require actual supervision for ambulation just supervision while he ambulated. She indicated the care plan intervention to provide assistance with ambulation is not what the resident needed at the time.</p> <p>2. Resident #30's record was reviewed on 2-1-2012 at 11:00 a.m. Resident #30's diagnoses included but were not limited to depression, high blood pressure, and diabetes.</p> <p>A current physician's order, dated January 2012, indicated a Complete Blood Count was to be drawn every 6 months . The original date of the order was 5-28-2010.</p> <p>A review of the laboratory results available on the chart did not indicate a</p>				

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	<p>Complete blood Count had been drawn within the last year.</p> <p>In an interview on 2-2-2012 at 9:27 a.m., the Director of Nursing indicated the lab test should have been drawn. She further indicated although there was no policy addressing following physician's orders, it was understood to follow the orders.</p> <p>3.1-35(g)(2)</p>			
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F0323 SS=G	<p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, record review, and interview, the facility failed to provide adequate supervision to prevent multiple falls for Resident #11. The last fall resulted in a fractured hip for Resident #11. The facility further failed to provide supervision to prevent fall that resulted in a facial fracture for Resident #71.</p> <p>In addition, the facility failed to provide adequate supervision for 13 of 13 residents on the Alzheimer's dementia unit. (Resident #62, Resident #63, Resident #64, Resident #65, Resident #66, Resident #67, Resident #68, Resident #69, and Resident #70, Resident #71, Resident #72, Resident #73, and Resident #74).</p> <p>Finding includes:</p> <p>1. During the initial tour of the facility, conducted on 01/30/12 between 10:30 A.M. - 10:50 A.M., RN #8 indicated Resident #11 had fallen on the dementia unit and had fractured his hip. She indicated the resident had been transferred to the skilled unit after his hospitalization to care for his fractured hip.</p> <p>The clinical record for Resident #11 was</p>	F0323	<p>It is the intent of this facility to provide an environment as free of accident hazards as possible; and to ensure that each resident receives adequate supervision and assistance devices to prevent accidents. Both resident #11 and Resident #71 have had their fall management plans reviewed and updated to reflect their current needs. Neither resident has had another fall. Staffing on the dementia unit has been adjusted to ensure that the 13 residents on the dementia unit have adequate supervision and assistance. All residents on the dementia unit have the potential to be affected by this deficient practice. A WALKING WORKSHEET - Exhibit #17 - will be completed on all residents residing on the dementia unit to determine risk for falls. Based on the assessment, care plans will be updated to reflect supervision/assistive devices needed to prevent falls. A mandatory inservice will be held on 2/22/12 to review FALL MANAGEMENT PROCEDURE - Exhibit #18 - and INTERVENTION/PROTOCOL LIST - Exhibit #19. All residents on the dementia unit have the potential to be affected by this deficient practice. Falls are</p>	02/29/2012			

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	<p>reviewed on 01/31/12 at 2:00 P.M. Resident #11 was admitted to the facility on 12/08/11 with diagnosis, including but not limited to, Alzheimer's dementia, osteoarthritis, and retinopathy.</p> <p>Review of an admission Fall Risk Assessment, completed for Resident #11 on 12/08/11, indicated the resident had a history of falls in the past 30 days, was confused, and had weakness. A care plan addressing falls was initiated on 12/08/11 with interventions to "keep the call light in reach and explain the use of it upon admission and reinforce as needed, encourage and assist with wearing non-skid foot-wear, and ensure the environment is free of clutter."</p> <p>Nursing progress notes, dated 12/09/11 at 2:47 A.M., indicated on 12/08/11 at 10:00 P.M., the resident had rearranged all of the furniture in his room and was found lying on the floor halfway underneath a bed. Review of a fall investigation for the incident indicated the facility was going to put rubber coasters under the wheels of the beds to prevent the resident from moving the beds, keep clutter out of the room, and monitor the resident's behaviors.</p> <p>Nursing progress notes, dated 12/09/11 at 11:28 A.M., indicated the resident was</p>		<p>reviewed daily to ensure appropriate interventions are in place. All falls will be reviewed weekly by the IDT in the Falls Management meeting. All falls will be reviewed to ensure that appropriate action has been taken to reduce fall risk and that the care plan has been updated and communicated to staff. This system will be monitored on a monthly basis using QA Tool - FALLS MANAGEMENT REVIEW - Exhibit #20. Any discrepancies will be corrected and findings submitted to the QA committee for reveiw monthly Nursing responsible QA will monitor Completion Date: 2-29-12</p>		

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	<p>found underneath his bed on 12/08/11 and on the floor in front of his recliner on 12/09/11 in the A.M. Review of a fall investigation, dated 12/09/11 at 11:00 A.M., indicated the resident was found on the floor in front of his recliner after having attempted to ambulate unassisted. A physical and occupational therapy evaluation was ordered.</p> <p>A physical therapy evaluation , completed on 12/09/11, indicated the resident was assessed to have impaired balance and lower extremity weakness that influenced his ability to walk safely. The assessment indicated the resident required at the time of the evaluation, stand by assist to safely move backwards, turn corners, and change directions using a rolling walker, and required stand by assistance to ambulate with the rolling walker, and contact guard assist to transfer from a seated position to a standing position.</p> <p>There were no interventions added to the fall care plan except to identify on 12/09/11 the PT and OT evaluations had been ordered.</p> <p>The resident was transferred to an acute care psychiatric hospital on 12/14/11 and remained there until 12/30/11.</p> <p>Nursing notes, dated 01/01/12 at 7:19</p>			

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	<p>P.M., indicated the resident was unsteady on his feet.</p> <p>Nursing note, dated 01/03/12 at 1:56 A.M., indicated the resident had an unwitnessed fall. Review of the post fall investigation, dated 01/03/12, indicated the resident had gotten up and fell trying to go to the bathroom. The interventions documented as having been in place were a low bed and mat of the floor, but the adjustments needing to be made were a low bed and mat on the floor.</p> <p>Interview with the Director of Nursing, on 02/02/12 at 3:45 P.M., indicated any resident who is a fall risk would have already been placed in a low bed with a mat on the floor. She indicated after the fall on 01/03/12, the intervention put in place was "every 2 hour monitoring." However, after review of the initial care plans, the resident was already being monitored, since 12/08/11, every two hours to address his incontinence issues. She indicated she had made a mistake and probably should have placed Resident #11 on every 1 hour monitoring.</p> <p>Nursing notes, dated 01/08/12 at 11:30 P.M., indicated "writer sitting at computer when hearing a 'crash' writer and aide went into res room and res was laying l side by other bed. When helping res to</p>				

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	<p>turn over onto back, res was saying how his leg hurt. res was able to stretch out leg but was wincing and saying that it did hurt. writer asked res what he was doing when he fell but res could not remember...."</p> <p>The resident was transferred to an acute care facility and diagnosed with a fractured left femur.</p> <p>There were no additional interventions implemented to prevent reoccurring falls and prevent injury for Resident #11.</p> <p>2. During the initial tour of the dementia unit, conducted on 01/30/12 between 10:45 A.M. - 11:15 A.M., LPN #7 indicated Resident #71 had fallen and had facial fractures, was confused, and had a shuffling gait when he ambulated.</p> <p>The clinical record for Resident #71 was reviewed on 01/31/12 at 1:15 P.M. Resident #71 was admitted to the facility on 11/17/11 with diagnosis, including but not limited to, dementia with behavior disturbances, Parkinson's disease, osteoporosis, dysarthria, and anxiety state.</p> <p>Review of the initial care plan for falls, initiated on 11/18/11 indicated the following interventions were included: "call light in reach. Explain use of it upon</p>						

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	<p>admission and reinforce as needed, encourage and assist with wearing non-skid footwear, ensure environment is free of clutter, assist with ambulation."</p> <p>Nursing progress notes, dated 01/16/12 at 9:50 P.M., indicated the resident had fallen in the hallway. Review of the post fall investigation, and interview with the Director of Nursing on 02/02/12 at 10:00 A.M., indicated a certified nursing assistance had given Resident #71 a shower and the resident had exited the shower room and walked into the hallway. The nursing assistant had gathered up the personal care items and was walking a few steps behind the resident with her arms full. The resident turned to look at the nursing assistant, lost his balance and fell hitting his face. Another staff member was entering the unit, but was unable to get to the resident in time to prevent the fall.</p> <p>The resident was sent to an acute care facility and was diagnosed with a fractured orbital and maxillary bones and a facial laceration requiring sutures.</p> <p>Resident #71 was observed on 01/30/12 at 12:37 P.M. ambulating with assistance from his room to the dining room. The resident was wearing slippers and was noted to shuffle his feet and keep his head</p>			

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	<p>pointed towards the floor. In addition, the resident was noted to have visible bruising along the left side of his face, nose, and under his chin. There were also sutures noted on the left side of his face.</p> <p>Resident #71 was observed on 01/31/12 at 11:40 A.M., lying on his bed in his room. The resident's feet were noted to be hanging over the side of his bed with one foot touching the ground. The resident was not in a low bed, nor was there a mat on the floor. In addition, the privacy curtain was pulled along the bottom of the bed and the resident's body and bed was not visible from the hallway, even though the door to his room was partially opened.</p> <p>3. During the initial tour of the secured dementia unit, conducted on 01/30/12 between 10:45 A.M. - 11:15 A.M., there were no structured activities observed. There were 4 residents (Resident #71, Resident # 72, Resident #66, Resident #67) observed seated in the dining room/lounge and one resident noted walking in the hallway. There were also residents noted to be lying in their beds in their rooms. Nursing staff were working on paperwork or attending to other residents during this time.</p> <p>On 01/31/12 from 11:35 A.M. - 12:00 P.M., there were no structured activities</p>				

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	<p>noted to occur on the secured dementia unit. There were 3 residents in the dining room/lounge, (Resident #63, Resident #65 and Resident #69). A nurse was in the dining room talking on the telephone and working with a clinical chart, a nursing assistant was in a resident room with the door closed, and a housekeeper was cleaning resident rooms. The nursing assistant was noted to bring residents into the dining room and seat them at the table. At 11:50 A.M., a social service staff member entered the dining room/lounge, chatted for 3 minutes with a female resident about coffee and family visit the resident had recently experienced, and then the social service staff member left the unit. At 12:00 noon, the nursing assistant turned on soft background music and then proceeded to assist residents to the dining room chairs.</p> <p>At 1:10 P.M., there were 14 residents in the dining room/lounge eating lunch. At 1:20 P.M., an activity staff member entered the dining room/lounge and asked the residents if any of them desired to go help "fold towels." Only 1 resident expressed a desire to go help "fold towels." However, at 1:27 P.M., 3 female residents (Resident #66, Resident #72 and Resident #68) exited the unit with the activity staff member to go to a "linen" activity. The activity staff member</p>			
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	<p>indicated they would just stay out of the unit to play Bingo after the linen folding activity. There were no structured activities for the residents that did not leave the unit. There was no nursing staff available to supervise the residents in the dining room/ lounge.</p> <p>At 1:33 P.M., there were 7 residents (Resident #62, Resident #63, Resident #65, Resident #67, Resident #68, Resident #70 and Resident #72) left in the dining room/lounge and one visitor. There were no structured activities or any staff in the room. At 1:36 P.M., the nurse came back into the dining room/lounge, but no activity was provided for the 7 residents left in the room. At 2:00 P.M., Resident #66 came into the dining room/lounge and indicated she desired to go to Bingo and no one had came back (to the unit) to get her. She indicated if the Bingo had already started when she got there she did not want to play. Resident #66 was then escorted off of the unit to the Bingo activity. From 2:00 P.M. - 2:45 P.M., there were no structured activities provided for 9 residents (Resident #62, Resident #63, Resident #65, Resident #67, Resident #68, Resident #69, Resident #70, Resident #71, and Resident #72) who did not go off the unit for activities. There was soft music playing in the dining room/lounge, and the nurse</p>			
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	<p>was seated at a dining room table working on paperwork.</p> <p>On 02/01/12 at 8:47 A.M., there were 6 residents (Resident #62, Resident #64, Resident #68, Resident #71, Resident #72, and Resident #73) noted in the dining room/lounge. There were no activities and there were no staff in the room. The activity director was noted to be in the hallway taping new activity calendars onto individual resident room walls. A nursing assistant was noted to be ambulating a resident into their room, and the nurse was noted to have been in a resident room. At 8:50 A.M., the nurse entered the dining room/lounge and proceeded to clean up dirty breakfast dishes and then at 9:06 A.M., both the nurse and the nursing assistant had left the dining room/lounge. The nurse, employee #7, exited the dementia unit. There were 4 residents still in the dining room/lounge (Resident #62, Resident #68, Resident #71, and Resident #72). Nursing staff left the residents in the lounge without supervision for 23 minutes.</p> <p>At 9:10 A.M., the Certified Nursing Assistant, CNA, employee #5, came back to the dining room/lounge and put soft background music on for the residents. From 9:10 A.M. - 9:35 A.M., CNA #5 was noted to answer a resident's request</p>						

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	<p>for help to the bathroom, and help another resident ambulate out of the dining room/lounge. At 9:36 A.M., Resident #66 ambulated into the dining room/lounge and asked a visitor if they could help her put on a "Bluegrass" DVD. There was no video player noted and at 9:38 A.M., CNA #5 reentered the dining room lounge and informed Resident #66 she would put on a "Bluegrass" music CD as the DVD player was "put up." From 9:42 A.M. - 9:48 A.M., there were 3 residents (unsupervised) with no structured activities in the dining room/lounge. At 9:48 A.M., a therapist, Employee #6 entered the dining room/lounge and spoke with one of the 3 residents (Resident #64, Resident #70, and Resident #72) in the room. Employee #6 exited the room and unit at 9:52 A.M. From 9:52 A.M., there were no staff supervising the residents. At 9:54 A.M., LPN #7, entered the dining room/lounge and Resident #66 questioned her about the "Fancy Nails" activity. LPN #7 informed the resident the activity was scheduled for 10:00 A.M. At 9:57 A.M., LPN #7 started to read the newspaper to the 3 residents (Resident #64, Resident #70, and Resident #72) who were still sitting in the dining room/lounge. At 10:01 A.M., Resident # 72 was taken off the unit to smoke. At 10:11 A.M., Resident #66 questioned LPN #7 about</p>			
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	<p>the fingernail polishing activity and pointed out it was past 10:00 A.M. CNA #5, who had entered the room was instructed to call activity staff to come to the unit and escort the residents to the "Fancy Nails" activity off of the unit. The CNA attempted to call but got no answer and in the meantime, the Food Service Supervisor, who had entered the unit to drop off menus, volunteered to escort residents off of the unit to the activity. Resident #66 was then escorted off of the unit to the "Fancy Nails" activity. LPN #7 continued to read the newspaper until 10:15. From 10:15 A.M. - 10:42 A.M., there was music again playing for the residents, but no structured activities. At 10:42 A.M., Resident #66 returned from the off unit "Fancy Nails" activity and Resident #72 exclaimed, "Hey, they are getting their nails done down there and I want my nails done." Resident #66 informed Resident # 72 that the nails activity had ended. LPN #7 informed Resident # 72 that she would paint her nails later for her and also informed Resident #66 that she would hook up the video player so she could watch the "Bluegrass" DVD she had requested earlier.</p> <p>At 11:05 A.M., LPN #7 got out fingernail polish and sat at a dining room table with Resident #72 and started to file and paint</p>						

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	<p>her fingernails. At 11:20 A.M., CNA #5 got out a wooden corn hole bean bag toss game and started playing with the 6 residents (Resident #62, Resident #64, Resident #68, Resident #71, Resident #70, and Resident #72) who where seated in the lounge part of the dining room/lounge room. At 11:24 A.M., CNA #5 left to go answer a call light. No staff were available to assist the resident's in continuing their game. Resident #68 was heard stating, "I'm not sure I could bend over enough to get them (bean bags)." LPN #7, turned around and instructed Resident #68 to wait for (CNA's name) to return. At 11:35 A.M., CNA #5 returned to the dining room/lounge and continued to play bean bag toss with the residents. At 11:40, LPN #7, who had finished painting Resident #72 's fingernails, left the unit for her lunch break. At 11:41 A.M., CNA #5 left the bean bag toss game to assist another resident who had ambulated to the doorway of the dining room/lounge and requested assistance. CNA #5 did not return to the dining room lounge until 11:49 A.M. The 6 residents who were playing the bean bag toss game, just sat in chairs or on the sofa while no staff were there to facilitate the game.</p> <p>At 1:50 P.M., LPN #7 indicated there were 4 residents out with activities' staff and they were staying off of the unit for</p>						

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	<p>the "Movie." LPN #7 also indicated she was going to escort, Resident #72 off the unit to the activity. There were 3 residents in the dining room/lounge (Resident #67, Resident #65, Resident #73) and 1 male resident (Resident #71) ambulating in the hallway. CNA #5 had to leave the dining room lounge, to redirect Resident #69 out of another resident's room. Resident #67's visitors also entered the dining room/lounge. There were no nursing staff supervising residents from 1:50 P.M. to 2:15 P.M.</p> <p>Interview with the Director of Nursing, on 02/02/12 at 10:15 A.M., indicated the facility had opened the dementia unit within the past year and LPN #7 was the Program Director of the dementia unit. She indicated when she had gone back to the unit she had observed lots of activities. She was unsure of the schedule of activities for the Dementia unit. She indicated the nursing staff were responsible for providing supervision for the unit.</p> <p>3.1-45(a)(2)</p>			
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F0329 SS=D	<p>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 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to ensure there were adequate indications for an increase in a psychotropic medication for 1 of 7 residents (#45) reviewed for psychotropic medications in the sample of 15.</p> <p>Findings include:</p> <p>1. Review of Resident #45's clinical record on 1/30/12 at 2:35 P.M., indicated diagnoses including, but not limited to, dementia with delusions. On 11/8/11, a physician's order was received to start</p>	F0329	<p>It is the intent of this facility to ensuer that each resident's drug regimen is free from unnecessary drugs. Resident #45's antipsychotic medication use has been reviewed with psychiatric services team and the medication prescribed has been determined to be medically necessary for this resident based on past behavioral history and present state of health. Resident #45 has suffered no negative consequences as a result of his current psychoactive medication regimen. Any resident receiving a psychotropic medication has the potential to be affected byt his deficient practice. To ensure that</p>	02/29/2012
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	<p>Risperidone 0.25 milligrams (mg) daily at bedtime for psychotic behaviors. On 11/17/11 a physician's order was received to increase Risperidone to 0.5 mg daily at bedtime for psychotic features.</p> <p>On 1/9/12, Resident #45 a behavioral medicine evaluation and management note from a Nurse Practitioner (NP) indicated the resident "is very psychotic and hit a staff this last evening". The NP recommended the resident get a Urinalysis (U/A) for continued behaviors along with an increase of Risperidone from 0.5 mg daily to 0.5 mg twice daily for psychotic features. On 1/10/12, a physician's order was received to increase Risperidone to 0.5 mg twice daily for psychotic features and for an U/A.</p> <p>On 1/11/12, a physician's order was received for Cipro (an antibiotic medication) 500 mg twice daily for 7 days for an urinary tract infection (UTI).</p> <p>Review of the resident's progress notes did not indicate an incident where Resident #45 hit a staff member on 1/8/12 as noted by the NP on 1/9/12.</p> <p>A behavior incident was noted in the resident's progress notes on 1/7/12 in which Resident #45 was yelling and shaking his fist at another resident who</p>		<p>psychoactive medications being used are appropriate to treat identified behaviors and diagnosis; monthly medication review is completed by the contracted consultant pharmacist and contracted psychiatric service. In addition, a monthly medication/behavior review is completed by members of the IDT in monthly behavior management meeting (including SS and DON). Exhibit #21. During these meetings - all areas related to the use of psychoactive medications is completed - including updating the care plan, appropriate reasons for use and need for GDR as applicable. A mandatory inservice will be conducted on 2/22/12 to review PSYCHOACTIVE MEDICATION USE POLICY - Exhibit #22 and importance of notification of SSD as soon as possible when a psychoactive medication is ordered/changed. This system will be monitored on a monthly basis through use of the QA Tool - PSYCHOPHARMACOLOGICAL MEDICATION REVIEW - Exhibit #23 by SSD. SS/Nursing responsible QA Committee will monitor Completion Date: 2-29-12 MANDATORY INSERVICE FOR NURSING ON 2-22-12 See Exhibit #27</p>		

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	<p>got stuck against the resident's table while trying to enter the dining room. The progress note indicated staff explained to resident that behavior was inappropriate and resident was easily redirected.</p> <p>Review of the resident's behavior tracking on 1/7/12 did not indicate any physical behavior or mood behavior.</p> <p>An interview with the Social Service Director (SSD) on 2/2/12 at 11:35 A.M., indicated she could not find an incident report and did not know of an incident on 1/8/12 where Resident #45 hit a staff member. The SSD indicated for behavior incidents noted she would expect staff to attempt all interventions. The SSD director indicated the computer program for behavior tracking only allows up to 4 interventions. The SSD indicated the computer program does not allow physical behaviors to be separated from verbal behaviors for the behavior tracking.</p> <p>An interview with the NP on 2/2/12 at 1:30 P.M., who recommended the Risperidone increase on 1/9/12, indicated on 1/9/12 a nurse told her the resident had hit a staff member on 1/8/12. The NP indicated she ordered the urinalysis based on a history of urinary tract infections and the resident's recent increase in behaviors.</p>				

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	<p>The NP indicated she would have waited to start the Risperidone increase until after the results of the urinalysis were received, to see if the resident had a urinary tract infection or not but staff indicated the resident's behaviors were bad enough to go ahead and start the medication increase.</p> <p>Review of the facility "Psychotropic Drug Use Policy," received 2/2/12 at 9:00 A.M., undated but indicated "expires on February 01, 2012" indicated: "Purpose: To ensure that medication regimen helps promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being, as identified by the resident and/or representative(s) in collaboration with the attending physician/psychiatrist and facility staff; each resident receives only those medications, in does and for the duration clinically indicate to treat the resident's assessed condition(s); non-pharmacological interventions are considered and used when indicated, instead of, or in addition to, medication; Clinically significant adverse consequences are minimized; and the potential contribution of the medication regimen to an unanticipated decline or newly emerging or worsening symptom is recognized and evaluated, and the regimen is modified when appropriate.</p>						

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	Psychotropic medications will only be used when medically indicated to treat a specific condition". 3.1-48(a)(4)				