

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/30/2012
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NAME OF PROVIDER OR SUPPLIER ST ANTHONY HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1205 N 14TH ST LAFAYETTE, IN 47904
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: November 26, 27, 28, 29 and 30, 2012</p> <p>Facility number: 000535 Provider number: 155604 AIM number: 100267250</p> <p>Survey team: Rita Mullen, RN Michelle Carter, RN Michelle Hosteter, RN William Greeney, Medical Surveyor Jane Kaiser, RN</p> <p>Census bed type: SNF/NF: 97 Total: 97</p> <p>Census payor type: Medicare: 11 Medicaid: 60 Other: 26 Total: 97</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on December 10, 2012 by Bev Faulkner,</p>	F0000		
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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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F0156 SS=B	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>						

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	<p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the</p>			

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	<p>individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on record review and interview, the facility failed to ensure Medicare Non-Coverage notifications were provided 2 days before the end of Medicare benefits for 2 of 3 residents reviewed who were discharged from therapy services. (Residents #130 and 133)</p> <p>Findings include:</p> <p>Review of Resident #133's record, on 11/30/12 at 11:00 A.M., found the resident had been discharged from therapy services on 7/17/12. Review of Resident #133's Notice of Medicare Provider Non Coverage, dated 7/16/12, indicated the resident was notified that therapy services would end on the next day. Interview with the Social Services Director</p>	F0156	<p>F156 NOTICE OF RIGHTS, RULES, SERVICES, CHARGES Residents 130 and 133 no longer reside in the building. Form CMS-10095 and CMS-10123 have been obtained for use in the center. Discharged residents prior to date of the survey all have the potential to be affected. The Social Service Director and the Social Service Department was re-educated by the Administrator on 12-12-12 on the use of the CMS-10123 and the CMS-10095 forms to be used to notify residents at the end of their benefit usage. Administrator educated Social Service Department on notification requirements of 48 hours prior to non-coverage and the resident's right to appeal. Residents being discharged from Medicare Part A will have the notice given by providing them form CMS-10123 and CMS-10095 forms. Social</p>	12/30/2012	

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	<p>(SSD), on 11/30/12 at 11:05 A.M., indicated the SSD was not aware that it was required residents receive at least 48 hours notice of Medicare Non-Coverage and their appeal rights.</p> <p>Review of Resident #130's record on 11/30/12 at 11:00 A.M., found the resident had been discharged from therapy services on 6/28/12. Review of Resident #130's Notice of Medicare Provider Non Coverage, dated 6/27/12, indicated the resident was notified that therapy services would end on the next day. Interview with the Social Services Director (SSD), on 11/30/12 at 11:05 A.M., indicated the SSD was not aware that it was required residents receive at least 48 hours notice of Medicare Non-Coverage and their appeal rights.</p> <p>Review of the Department of Health and Human Services Publication "Advance Beneficiary Notice of Non-coverage, dated April 2011, indicated "An ABN must be given when Medicare is expected to deny payment (entirely or in part) for the item or service because it is not reasonable and necessary under Medicare Program Standards or because it is considered custodial</p>		<p>Service Director or Designee staff will attend a weekly Medicare meeting with Therapy staff along with multi-disciplinary team to be notified of updates and changes with residents' status. Social Service Director or Designee will have Notice of Medicare Non-Coverage letters signed (at minimum) 48 hours prior to a resident discharging from the facility. For each resident utilizing Medicare benefits, Social Service staff will complete a Discharge Progress Checklist and a copy of the signed Notice of Medicare Non-Coverage will be kept in Social Service office and in Resident file. Trends of the audit results will be reported to the Quality Assurance Team each month for three months for recommendations. Compliance date: 12-30-12</p>		

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F0223 SS=A	<p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on interview and record review, the facility failed to prevent abuse for a resident left in the bed, on her side, and unable to change positions. This affected 1 of 2 residents reviewed for abuse in a sample of 2. (Resident #18)</p> <p>Findings include:</p> <p>During an interview with Resident #18 on 11/26/12 at 2:37 P.M., she indicated a CNA had left her lying on her side while going into the bathroom for something. "She was in there for a long time" and "I can't remember the CNA's name. I reported this to a nurse and things are fine now." She also indicated this was a few weeks ago.</p> <p>The clinical record of Resident #18 was reviewed on 11/27/12 at 9:30 A.M.</p> <p>A Quarterly Minimum Data Set</p>	F0223	<p>F223Resident # 18 was provided care at the time of the occurrence.</p> <p>Abuse allegations are reported immediately to the administrator for investigation. Current staff inserviced regarding abuse policy and procedure and the Elder Justice Act. New hires will be educated on the abuse policy and procedure at time of hire. Provide abuse policy and procedure education on a monthly basis for all employees for the next three months. Administrator or designee to interview 10 staff members on a monthly basis regarding their knowledge of the facility abuse policy and procedure. Results of all interviews will be reported to the QA committee on a monthly basis for further recommendations. Completion Date: 12/30/12</p>	12/30/2012	

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	<p>assessment, dated 9/6/12, indicated Resident #18 had a Brief Interview for Mental Status Score of 15 out of 15 and required the extensive assist of two staff for bed mobility.</p> <p>A copy of the computer training course "Preventing, Recognizing, and Reporting Resident Abuse" was received on 11/30/12 at 11:30 A.M., from the Director of Nursing, indicated "physical mistreatment" was a form of abuse. Examples included, but were not limited to, not giving assistance to a resident who needs help and allowing a resident to sit for hours in urine.... One of the ways to prevent abuse was education."</p> <p>During an interview with the Director of Nursing, on 11/30/12 at 11:30 A.M., she indicated the occurrence was investigated by the Unit Manager and the CNA was educated.</p> <p>3.1-27(a)(3)</p>				

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F0225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record</p>	F0225	F225 INVESTIGATE / REPORT	12/30/2012			

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	<p>review, the facility failed to investigate allegations of abuse and report to the facility Administrator. This affected 1 of 2 residents reviewed for allegation reporting and investigation of abuse in a sample of 2 (Resident #18) and 1 of 7 residents reviewed for falls in a sample of 7. (Resident # 27.)</p> <p>Findings include:</p> <p>1. During an interview with Resident #18 on 11/26/12 at 2:37 P.M., she indicated a CNA had left her lying on her side while going into the bathroom for something. "She was in there for a long time" and "I can't remember the CNA's name. I reported this to a nurse and things are fine now." She also indicated this was a few weeks ago.</p> <p>The clinical record of Resident #18 was reviewed on 11/27/12 at 9:30 A.M.</p> <p>A Quarterly Minimum Data Set assessment, dated 9/6/12, indicated Resident #18 had a Brief Interview for Mental Status Score of 15 out of 15 and required the extensive assist of two staff for bed mobility.</p> <p>During an interview with the Facility Administrator, on 11/30/12 at 10:45</p>		<p>ALLEGATIONS / INDIVIDUALS</p> <p>Administrator was notified of incidents involving residents #18 and #27. Resident #27's roommate was interviewed regarding incident involving resident #27. All residents currently residing in the facility have the potential to be effected.</p> <p>Staff was re-educated on the importance of immediately reporting allegations of abuse. Staff was also re-educated on the importance of investigating all allegations including interviewing other residents. Administrator or designee will review incidents/ accident reports, grievance reports and 24 hour report daily to ensure that immediate notification of all allegations has been reported. Administrator/designee will review allegations to ensure other residents were interviewed during the process of the investigation. Administrator or designee will interview 10 staff members weekly for four weeks, 10 staff members monthly for four months to ensure that there was immediate notification to the Administrator/Designee of allegations.</p> <p>Administrator/designee will review allegations of abuse to ensure other residents were interviewed during the process of the investigation. The Administrator/Designee will report results of the reviews to the Quality Assurance Committee for further recommendations</p>		

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	<p>P.M., he indicated "I don't recall a report from (Name of Resident) regarding a CNA leaving her on her side and spending a long time in the bathroom.... I don't find an investigation in the file. All reports of abuse are to come to me."</p> <p>A copy of the computer training course "Preventing, Recognizing, and Reporting Resident Abuse" was received on 11/30/12 at 11:30 A.M., from the Director of Nursing, indicated "physical mistreatment" was a form of abuse. Examples included, but were not limited to, not giving assistance to a resident who needs help and allowing a resident to sit for hours in urine.... One of the ways to prevent abuse was education."</p> <p>During an interview with the Director of Nursing, on 11/30/12 at 11:30 A.M., she indicated the occurrence was investigated by the Unit Manager and the CNA was educated. The Facility Administrator was not notified.</p> <p>2). During interview on 11/27/12 at 1:00 P.M., Resident #27 indicated she had a fall several days ago (could not identify the date), but didn't say anything to anyone because she</p>		<p>Compliance date: 12-30-12 Addendum: Administrator or designee will continue staff interviews monthly for 6 months with 100% threshold. The Administrator/Designee will report results of the interviews to the Quality Assurance Committee for further recommendations.</p>				

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	<p>didn't want the aides helping her transfer to the wheelchair and back to the bed at the time of the fall to get into trouble. She also indicated when she fell, she went down to the ground and her foot went under the bed. At the same time, the aide accidentally had her hand on the bed controls and was lowering the bed--it lowered onto her foot causing her injury. She indicated she suffered with the pain for several days until 11/25/12, when she couldn't take it any longer and called 911 herself to go the the hospital for treatment. She said her son was upset that she was injured and was questioning the facility about how it happened and why he was not notified sooner.</p> <p>During interview on 11/26/12 at 2:50 P.M., LPN # 11 indicated Resident #27 has right foot fracture and was sent to X-ray yesterday, 11/25/12 when the resident first complained of her pain to the staff.</p> <p>During interview on 11/29/12 9:35 A.M., the Unit Coordinator of Area 2, RN #4, indicated Resident #27 did have a repeat X-ray yesterday (11/28/12) and there was a fracture in good position, boot remains in place, and now the resident is allowed weight bearing. An order was placed</p>						

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	<p>for the resident to start P.T. (Physical Therapy) to ambulate.</p> <p>During interview on 11/29/12 at 4:45 P.M., the roommate of Resident #27, indicated the resident did not express any pain in her right foot, nor did she fall to the ground, have the bed lowered onto her foot, or call 911 for assistance at any time during the last week. She indicated the resident did not verbalize or demonstrate any pain or difficulty with standing on her leg until her son was visiting (11/25/12 afternoon). The roommate heard the resident's description of events and indicated this was not what she had heard and observed to happen.</p> <p>During interview on 11/30/12 at 10:30 A.M., CNA #12, who was the caregiver on the day the resident identified her right foot pain (11/25/12 evening), indicated she has cared for the resident on many occasions and has transferred her to the wheelchair and the resident is able to help a lot in the transfer. She cared for the resident Saturday, 11/24/12, and indicated there was no noted swelling of the right ankle or noted pain. She felt a gait belt was not necessary because of her previous experiences with caring for this resident. She indicated transferring the resident</p>			

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NAME OF PROVIDER OR SUPPLIER ST ANTHONY HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1205 N 14TH ST LAFAYETTE, IN 47904
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	<p>from bed to wheelchair on 11/25/12 about 2:30 or 3:00 P.M., the resident's foot slipped slightly, but she regained her balance. However, when the resident was seated in the wheelchair her left foot was wrapped around the left front wheel under wheelchair. The rest of the transfer to return to bed was uneventful. About an hour after the trip to the bathroom (11/25/12 at 4:30 P.M.), the resident complained of pain and slight swelling of the right lower leg and foot. Resident #27 was transported to the Emergency Room for evaluation about 5 to 5:30 p.m.</p> <p>During interview on 11/30/12 at 11:00 A.M., the Assistant Director of Nursing (ADON) who conducted the investigation, indicated she interviewed Resident #27 about her injury, but did not document the interview. She did not interview the roommate of the resident. She indicated she spoke with CNA #12, but did not question specifically what occurred during the transfer to discover a possible cause of the fracture. The ADON was not aware of the left foot getting caught under the wheelchair. No interviews of other residents that were cared for by CNA #12 were conducted.</p>			

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	<p>During interview on 11/30/12 at 11:10 A.M., the Unit Coordinator of Area 2, RN #4 indicated she questioned Resident #27 at several different times on 11/26/12 and each time the resident indicated she had no idea what had happened to cause the injury. She also spoke with the roommate at 3:30 p.m., on 11/27/12 about the incident</p> <p>Record review began 11/28/12 at 2:55 P.M., with the MDS (Minimum Data Set) quarterly assessment ,dated 10/21/12, indicating diagnoses including, but not limited to: Hypertension, Diabetes Mellitus(non-insulin), muscle weakness, Major Depressive Disorder, and Affective Psychosis. The MDS indicated: severe cognitive impairment, 1 person physical assist, assist with food setup, use of wheelchair, and no falls between July and October 2012.</p> <p>An x-ray report, dated 11/25/12, indicated a non-displaced fracture of the distal fibula</p> <p>A note, dated 11/26/12, indicated a fracture diagnosis, pain medication ordered, follow up MD appointment noted, and "Pathological fracture of right distal fibula."</p>						

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	<p>Review of the facility investigation of injury to Resident #27 (received on 11/29/12 at 11:00 A.M. from RN #4 the Unit Coordinator) indicated the initial report of unusual occurrence was faxed to the Indiana State Department of Health on 11/26/12 at 6 P.M., and investigation began.</p> <p>The investigation included a statement by CNA #12 who cared for the resident at the suspected time of injury (signed and dated 11/26/12). The document indicated, during the transfer of the resident to the bathroom and back around 2:30 P.M., the resident was a little unsteady but not anything she was concerned about. Resident got back to bed with no worries or complaints of foot pain.</p> <p>A facility document labeled "Abuse, Neglect, Misappropriation of Resident Property and State Reportables" obtained from the Administrator on 11/30/12 at 11:45 P.M., states at #15, "the facility will investigate all allegations thoroughly.....includinginterviewing other residents.</p> <p>3.1-28(d)</p>				

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F0226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to develop an Abuse Policy and Procedure for notification of the Administrator. This affected 1 of 2 residents reviewed for abuse investigations in a sample of 2. (Resident #18)</p> <p>Findings include:</p> <p>1. During an interview with Resident #18 on 11/26/12 at 2:37 P.M., she indicated a CNA had left her lying on her side while going into the bathroom for something. "She was in there for a long time" and "I can't remember the CNA's name. I reported this to a nurse and things are fine now." She also indicated this was a few weeks ago.</p> <p>The clinical record of Resident #18 was reviewed on 11/27/12 at 9:30 A.M.</p> <p>A Quarterly Minimum Data Set assessment, dated 9/6/12, indicated Resident #18 had a Brief Interview for</p>	F0226	<p>F226 CEVELOP / IMPLMENT ABUSE / NEGLECT POLICIES</p> <p>Administrator was notified of incident involving residents #18. All residents currently residing in the facility have the potential to be effected. Abuse policy was revised to include immediate notification of Administrator concerning all allegations of abuse. Staff will be in-serviced on changes. Quality Assurance team will review abuse policy monthly for 3 months to ensure inclusion of notification clause. Compliance date: 12-30-12 Addendum: Administrator or designee will interview 10 staff members weekly for four weeks, 10 staff members monthly for six months to ensure that there was immediate notification to the Administrator/Designee of allegations. Administrator or designee will continue staff interviews monthly for 6 months with 100% threshold. The Administrator/Designee will report results of the interviews to the Quality Assurance Committee for further recommendations.</p>	12/30/2012

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	<p>Mental Status Score of 15 out of 15 and required the extensive assist of two staff for bed mobility.</p> <p>During an interview with the Facility Administrator, on 11/30/12 at 10:45 P.M., he indicated "I don't recall a report from (Name of Resident) regarding a CNA leaving her on her side and spending a long time in the bathroom.... I don't find an investigation in the file. All reports of abuse are to come to me."</p> <p>A copy of the computer training course "Preventing, Recognizing, and Reporting Resident Abuse" was received on 11/30/12 at 11:30 A.M. from the Director of Nursing, indicated "physical mistreatment" was a form of abuse. Examples included, but were not limit to, not giving assistance to a resident who needs help and allowing a resident to sit for hours in urine.... One of the ways to prevent abuse was education.</p> <p>During an interview with the Director of Nursing, on 11/30/12 at 11:30 A.M., she indicated the occurrence was investigated by the Unit Manager and the CNA was educated. The Facility Administrator was not notified.</p> <p>2. The policy for abuse was reviewed</p>			

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	<p>on 11/29/12 at 2:30 P.M. In reviewing the policy no documentation could be found regarding immediate notification of the administrator of allegations of abuse.</p> <p>A request was made to the Administrator on 11/30/12 at 10:45 A.M., regarding policy that included notification of the Administrator.</p> <p>In an interview with the Administrator on 11/30/12 at 11:45 A.M., he indicated the abuse policy provided was the only one he had. The policy titled "Abuse, Neglect, Misappropriation of Resident Property & State Rules Reportables," dated 10/2010. The policy did not indicate notification of the Administrator.</p> <p>3.1-28(a)</p>				

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F0242 SS=A	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on interview and record review, the facility failed to allow a resident a choice regarding the type and frequency of bathing. This affected 1 of 7 residents interviewed regarding choice of type of bathing and frequency in a sample of 7. (Resident #94)</p> <p>Findings include:</p> <p>During an interview with Resident #94, on 11/27/12 at 8:52 A.M., he indicated he was not given a choice regarding the type or frequency of bathing he received. He indicated he received a shower once a week and a bed bath twice a week. He was not happy with his bathing schedule.</p> <p>The clinical record of Resident #94 was reviewed on 11/27/12 at 1:00 P.M.</p> <p>Diagnoses for Resident #94 included, but were not limited to aphasia</p>	F0242	F242Resident #94 was offered shower schedule per his preference. Interviewed residents in facility to determine their bathing schedule preferences and type of bath preferred. Residents will be interviewed at time of admission to determine bathing preferences. QA nurse will complete monthly interviews with 20% of residents to ensure residents receive their bathing activities as preferred. Monthly interviews will be reported to QA team on a monthly basis for further recommendations. Completion Date: 12/30/12	12/30/2012	

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	<p>(problems talking) and stroke. Resident #94 could answer questions with a yes or no, but could not elaborate.</p> <p>A Quarterly Minimum Data Set assessment, dated 9/6/12, indicated a Brief Interview for Mental Status score of 12 of 15 indicating moderate cognitive impairment. The resident required the extensive assist of one staff member for bathing.</p> <p>During an interview with RN #4, on 11/29/12 at 11:00 A.M., She indicated all the residents choose the day of baths or showers and the number of showers a week. "We meet quarterly and use the Abaqis system for care plan meetings and we go over the Care Plan." RN #4 was not aware Resident #94 did not like his bathing schedule.</p> <p>3.1-3(u)(1)(3)</p>			

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F0248 SS=D	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <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 interview, the facility failed to provide activities to meet residents needs for 1 of 3 residents, in a sample of 5 reviewed that met the criteria for activities. (Residents #94)</p> <p>Findings include:</p> <p>During an interview with Resident #94 on 11/27/12 at 9:01 A.M., he indicated there were no activities of interest offered on weekends and he liked to watch movies and listen to music. He preferred to spend time in his room.</p> <p>During an observation on 11/27/12 at 9:30 A.M., Resident #94 had a small collection of movie DVDs stacked by his TV set. Resident #94 indicated he could load the movie himself into the player.</p> <p>The clinical record of Resident #94 was reviewed on 11/27/12 at 1:00</p>	F0248	<p>F248 ACTIVITIES MEET INTERESTS / NEEDS OF EACH RESIDENT Resident #94 was notified of availability of library van. Resident #94's care plan was updated to reflect his personal interests for weekend activities. Resident #94 was provided DVD's of choice and offered library materials. Interviewed residents in facility to understand their personal interests for weekend activities. Care plans revised as needed. Informed residents of availability for Library materials. Residents were informed of the process for requesting additional weekend activities and materials. Informed residents of the availability of library material via Circulette (daily resident facility newsletter). Information will also be added to the monthly calendar of events. In addition to regularly scheduled weekend events, residents may request special weekend activities and or materials. Due to scheduling purposes, request for particular entertainers will required advanced notification. Ten percent of resident population will be</p>	12/30/2012			

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	<p>P.M. Resident #94 has a diagnoses of aphasia (difficulty speaking) and stroke.</p> <p>A Quarterly Minimum Data Set assessment, dated 9/6/12, indicated a Brief Interview for Mental Status score of 12 of 15 indicating moderate cognitive impairment.</p> <p>An Activity note, dated 9/6/12, indicated Resident #94 liked wheelchair rides outside, 1 to 1 visits and watching TV. Things identified as important to Resident #94 included, but were not limited to, choose clothes to wear, take care of belongings, choose bedtime, listening to music, being around animals, keeping up with the news, going outside and religious services.</p> <p>A Care Plan, dated 9/6/12, included, but was not limited to, take outside when able, offer brief visits, allow to choose clothes, a shower, bedtime, care for his things, talk about the news, invite to activities, likes Discovery channel, include in pet visits and encourage to attend activities.</p> <p>During an interview with the Activity Coordinator on 11/30/12 at 9: A.M., she indicated we can get movie</p>		interviewed weekly for four weeks then monthly for four months and quarterly thereafter. Quarterly audits to be reviewed by QA committee for further recommendation. Compliance date: December 30, 2012		

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	<p>DVDs, music CDs and talking books from the library van when they come if the resident asks for them. She also indicated there is a cut off temperature of 72 degrees for residents going outside, it was last August or September the last time he was taken outside to go around the outside of the building. Resident #94 was not aware of the library van and that he could request movies.</p> <p>3.1-33(a)</p>			

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F0250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <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.</p> <p>A. Based on record review and interview, the facility failed to have social services coordinate discharge plans for 1 of 3 residents reviewed for admission, transfer and discharge in a sample of 25. (Resident # 52)</p> <p>B. Based on record review and interview, the facility failed to track specific behaviors or the number of times behaviors occurred or track the interventions that were effective to decrease behaviors. This impacted 1 of 8 residents reviewed for behavior tracking in a sample of 8. (Resident #19)</p> <p>Findings include:</p> <p>A.1. The clinical record for Resident #52 was reviewed on 11/30/12 at 2:15 P.M. Diagnoses included, but were not limited to, weakness, pneumonia and atrial fibrillation. The clinical record indicated on admission, dated 8/1/12, she was private pay for primary payer and that she had Medicare Part A/B as well.</p>	F0250	<p>F250 PROVISION OF MEDICALLY RELATED SOCIAL SERVICES Resident #52 has a care plan for adjustment to facility and her plan has been documented in Social Service progress notes. Resident # 19 has expired. Facility audit will be completed for residents in the building to ensure that their long term plan is addressed on a care plan. A facility audit will be completed for all residents to ensure that interventions are listed on the Behavior care plan Social Service Director or Designee will complete Behavior Tracking sheet for each resident when resident behaviors are discussed in morning meeting. In addition, an interdisciplinary team review for behaviors will be completed for each resident. Social Service Director or Designee will audit 10% of behavior sheets weekly for 4 weeks to check for accuracy and interventions on the care plan, then audit 10% monthly x 4 months, and then quarterly audits to be reviewed by QA committee for discontinuation at that time. Compliance date: 12-30-12Addendum: Staff will continue to complete Behavior</p>	12/30/2012			

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	<p>The physician's orders indicated the following :</p> <p>8/1/12-Clarification order physical therapy (PT) six times a week every day for lower extremity therapeutic exercises, neuromuscular re-education, gait training & patient caregiver education for eight weeks.</p> <p>8/2/12 -Occupational therapy (OT) clarification order for therapy six times a week for eight weeks for therapeutic exercise therapy/functioning activities, neuromuscular re-education, activities of daily life (ADL's) retraining, patient and caregiver education.</p> <p>9/13/12 -discharged from occupational therapy.</p> <p>9/26/12 discharged from physical therapy.</p> <p>Physician progress notes indicated on 9/22/12 resident was stable regarding her chest pain and shortness of breath r/t pneumonia. The resident had a negative chest x-ray and atrial fibrillation and blood pressure were controlled.</p> <p>MDS (Minimum Data Set), dated</p>		<p>Occurrence Form for witnessed behaviors. Social Service Director / Designee will in-service staff on January 10, 2013 on the use of the Behavior Occurrence Form and behavior tracking program.</p>				

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	<p>8/1/12 and 8/31/12, indicated resident needing assistance with everything. The admission MDS for 8/7/12 indicated there was a plan to discharge resident to the community, but the areas marked as to where to return was left blank. The MDS information also indicated that no referral to return to community was done. The assessment indicated the resident participated in plan to discharge.</p> <p>The MDS for 11/4/12 indicated resident independent for all ADL's and needs setup help only.</p> <p>The social service notes indicated on 8/21/12 "...Therapy notified SS (Social Services) that they are planning for res (resident) discharge on Sunday 8/26/12. (sign for writer) spoke (sign for with) res -she feels this is a good goal-discussed home health and Medicare- res voiced understanding..." signed SSD (Social Services Director). The next entry was dated 10/18/12- "...Visit with resident after breakfast. Resident states she is independent with a lot of ADL care, but staff help her when she needs them. Resident prefers to go home, but does understand this is the right placement for her..." There were no other notes pertaining to</p>						

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	<p>discussion with family or resident regarding reason she was not discharging.</p> <p>In looking through the care plans, there was no care plan for discharge for Resident #52.</p> <p>LPN #3 indicated on 11/30/12 at 8:50 A.M., she believed the resident was here due to after being discharged from PT and OT she is receiving assistance with ADL's and medications. The family is looking for assisted living placement for her. The LPN indicated to refer to Social Services for more information.</p> <p>In an interview with the Social Services Director on 11/30/12 at 9:07 A.M., she indicated the resident was here per discussion with resident and resident's son. The son indicated they can't take care of her at home and that the family was looking for an assisted living placement. She indicated the social services notes should be the place to reflect her discussion with the family and their plans for discharge.</p> <p>B.1. The clinical record of Resident #19 was reviewed on 11/28/12 at 2:00 P.M.</p> <p>A Quarterly Minimum Data Set</p>			

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	<p>assessment, dated 8/25/12, indicated long and short term memory problems,</p> <p>A Social Service note, dated 2/2/12, indicated a behavior of yelling at other residents. Resident #19 was moved to quiet area.</p> <p>A Social Service note, dated 2/13/12, indicated a behavior of cussing, spitting, kicking and cursing at staff.</p> <p>A Social Service note, dated 2/16/12, indicated a behavior of cussing at staff during meal assist. Moved to quiet area. Has a history of cussing and hit staff.</p> <p>A Social Service note, dated 3/31/12, indicated a behavior of cussing at other residents.</p> <p>A Social Service note, dated 6/8/12, indicated a behavior of screaming/cursing/hitting at other residents before meals. Gets up-set with other residents. Intervention to not take to dining room until she is ready to start eating.</p> <p>A Social Service note, dated 7/22/12, indicated a behavior of hitting another residents in the hallway. Geriatric psych facility contacted.</p>			

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	<p>A Social Service note, dated 7/24/12, indicated Resident #19 was discharged from geriatric psych facility.</p> <p>A Care plan for the behavior of resisting care, dated 9/6/12, indicated the interventions of the following: offer daily bed bath at PM, use social service specific approaches if residents starts to resist. there were no Social Service specific approaches on the care plan.</p> <p>A Care Plan for anxiety, dated 10/5/09 and reviewed quarterly, indicated the following: offer resident a snack/drink, personal incontinence care, offer to lay down and resident to be taken into dining room last prior to meal being served.</p> <p>A Behavior Occurrence form, dated 6/8/12 at 5:20 P.M., indicated screaming cussing, hitting - Intervention - moved to quiet area, encouraged to sit and rest, removed from source of agitation. Response to intervention - hostile.</p> <p>A Behavior Occurrence form, dated 7/15/12 at 7:50 A.M., indicated cursing at staff and screaming. Taken back to room from dining room.</p>			

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	<p>Toileted and back to dining room.</p> <p>A Behavior Occurrence form, dated 7/27/12 at 8:50 A.M., indicated cussing at other residents - removed from source of agitation - intervention was successful. The number and type of behaviors was not tracked nor were the successful interventions tracked.</p> <p>During an interview, on 11/28/12 at 3:20 P.M., with the Director of Nursing, she indicated behaviors are tracked only for as needed medication administration. There was no behavior form or system to track specific behaviors of residents with behaviors.</p> <p>3.1-34(a)</p>			

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F0279 SS=E	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to develop and revise comprehensive care plans for behaviors to meet individual needs for 5 of 32 residents reviewed for care plans regarding behaviors. (Residents #12, 16, 19, 22 and 52)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #19 was reviewed on 11/28/12 at 2:00 P.M.</p> <p>A Quarterly Minimum Data Set</p>	F0279	<p>F279 DEVELOP COMPREHENSIVE CARE PLANS Resident #19 expired prior to receiving 2567 Resident #22 was offered a dental consultation to ensure dentures are fitting properly and a care plan added to reflect the consultation. Resident #3 had bladder assessment completed to reflect her current status and her care plan was revised to reflect the current bladder assessment. Resident #52 interviewed by Social Services Director regarding discharge plan; a care plan was added addressing her long term plan of care. Resident</p>	12/30/2012	

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	<p>assessment, dated 8/25/12, indicated long and short term memory problems,</p> <p>A Social Service note, dated 2/2/12, indicated a behavior of yelling at other residents. Resident #19 was moved to quiet area.</p> <p>A Social Service note, dated 2/13/12, indicated a behavior of cussing, spitting, kicking and cursing at staff.</p> <p>A Social Service note, dated 2/16/12, indicated a behavior of cussing at staff during meal assist. Moved to quiet area. Has a history of cussing and hit staff.</p> <p>A Social Service note, dated 3/31/12, indicated a behavior of cussing at other residents.</p> <p>A Social Service note, dated 6/8/12, indicated a behavior of screaming/cursing/hitting at other residents before meals. Gets up-set with other residents. Intervention to not take to dining room until she is ready to start eating.</p> <p>A Social Service note, dated 7/22/12, indicated a behavior of hitting another residents in the hallway. Geriatric psych facility contacted.</p>		#12 had a care plan added to address her behaviors and mental illness. Residents will be identified by a facility audit for behaviors and mental illness to ensure care plans are present including interventions to address specific behaviors. Care plans will be updated or implemented on those residents with behaviors or mental illness. Care plans will reflect interventions that are specific to those behaviors exhibited. A facility audit will be conducted on all residents for ill-fitting dentures. Dental consults will be offered to those residents observed to have ill-fitting dentures. Dental consents will be obtained from resident and/or Power of Attorney if consult is warranted. A facility audit will also be conducted on residents to determine if incontinence is present. Care plans will be revised to reflect current assessment. Residents that discharged in the past 30 days will be reviewed for presence of a discharge care plan and/or a care plan for adjustment to the facility in the incident a resident decided to reside in the facility. Care plans will be developed to address discharge planning at the time of the audit if needed. A Behavior Follow-up form will be revised to include the specific interventions then reviewed in the morning Management Meeting. Care plans will be reviewed in the		

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	<p>A Social Service note, dated 7/24/12, indicated Resident #19 was discharged from geriatric psych facility.</p> <p>A Care plan for the behavior of resisting care, dated 9/6/12, indicated the interventions of the following: offer daily bed bath at PM, use social service specific approaches if residents starts to resist. There were no Social Service specific approaches on the care plan.</p> <p>A Care Plan for anxiety, dated 10/5/09 and reviewed quarterly, indicated the following: offer resident a snack/drink, personal incontinence care, offer to lay down and resident to be taken into dining room last prior to meal being served.</p> <p>A Behavior Occurrence form, dated 6/8/12 at 5:20 P.M., indicated screaming cursing, hitting - Intervention - moved to quiet area, encouraged to sit and rest, removed from source of agitation. Response to intervention - hostile.</p> <p>A Behavior Occurrence form, dated 7/15/12 at 7:50 A.M., indicated cursing at staff and screaming. Taken back to room from dining room.</p>		<p>Management Meeting when a behavior is present. The care plans will be updated with specific interventions to address the behavior(s). Dental assessments will be completed at the time of admission to the facility. If an issue is present, a dental consult will be offered at the time of the audit. Care plans will reflect the initial dental assessment. A new admission audit will be revised to review care plans with the assessment to ensure the care plan is current. Assessments will be completed quarterly, at time of significant change or as needed. The care plan will be revised to reflect the current dental assessment. Incontinence care plans will be developed based on the initial bladder assessment upon admission. A new admission audit will be revised to review care plans with the assessment to ensure the care plan is current. Care plans for discharge will be developed at the time of admission. An Interdisciplinary Medicare Meeting will be held weekly to review discharges from Medicare. The care plan will be revised as needed to follow the discharge process. To ensure that the deficient practices do not occur, the Social Services Director or designee will conduct an audit on residents identified on the behavior log to ensure interventions are successful and to monitor reoccurrence of the</p>		

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	<p>Toileted and back to dining room.</p> <p>A Behavior Occurrence form, dated 7/27/12 at 8:50 A.M., indicated cussing at other residents - removed from source of agitation - intervention was successful. The number and type of behaviors was not tracked nor were the successful interventions tracked.</p> <p>The care plans did not indicate specific interventions for specific behaviors.</p> <p>2. During an interview with Resident #22, on 11/26/12 at 3:23 P.M., she indicated she had "loose lower dentures" and "about six months ago it (lower dentures)started hurting." She also indicated she had told the staff about her dentures not fitting right.</p> <p>The clinical record of Resident #22 was reviewed on 11/29/12 at 11:29 A.M.</p> <p>A Minimum Data Set assessment, dated 10/ 2012, indicated no dental problems.</p> <p>A Dietary note, dated 10/4/12, indicated no physical changes, feeds self, no oral/dental changes.</p>		<p>behavior. The Food Services Manager or designee will conduct an audit on residents with dentures. A dental consultation will be requested at the time of the audit. The Director of Nursing or designee will conduct an audit on residents found to be incontinent. The care plan will be revised if necessary to reflect the assessment. The Social Services Director or designee will conduct an audit on residents that are admitted to the facility under Medicare coverage to ensure discharge planning has been established and addressed in a care plan. These audits will be conducted on 10% of the population identified for weekly for 4 weeks, monthly for 4 months and quarterly thereafter. The audits will continue at the discretion of the Quality Assurance Committee.</p> <p>Compliance date: 12-30-12Addendum: Interdisciplinary Team was in serviced on the Care Plan process on December 28, 2012.</p>				

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	<p>A Care Plan for nutrition, dated 10/4/12, did not indicate the resident was experiencing chewing problems. There was no care plan addressing the resident's problem with loose, lower dentures.</p> <p>During an interview with LPN #10 on 11/29/12 at 10:50 A.M., she indicated Resident #22 had problems, in the past, with her dentures. "We tried all kinds of gels and cushions. The lower gums have receded and the lower dentures are loose and can make her gums sore. The family took the dentures and had them worked on but it didn't help. We had an order for an oral gel but she hasn't asked/used it in awhile. It was discontinued because of nonuse." The facility was aware of the denture problem, but had not developed a care plan.</p> <p>3. Resident #16's record was reviewed 11/28/12 at 2:30 P.M.</p> <p>A Bladder Incontinence Evaluation (Admission), dated 9/17/12, indicated the resident was admitted to the facility with a history of daily episodes of incontinence that had been present greater than a year.</p> <p>An Admission Minimum Data Set</p>						

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	<p>assessment for Resident #16, dated 9/24/12, indicated the resident was incontinent and there was an intermittent use of a catheter.</p> <p>Further review of the record indicated there was no evidence a care plan had been developed to address the incontinence.</p> <p>Interview with the Unit Coordinator (UC) for Resident #16, on 11/30/12 at 11:50 A.M., indicated no care plan had been developed for the identified need. The UC stated that "it had been overlooked."</p> <p>4. The clinical record for Resident #52 was reviewed on 11/30/12 at 2:15 P.M. Diagnoses included, but were not limited to, weakness, pneumonia and atrial fibrillation.</p> <p>The physician's orders indicated the following :</p> <p>8/1/12-Clarification order physical therapy (PT) six times a week every day for lower extremity therapeutic exercises, neuromuscular re-education, gait training & patient caregiver education for eight weeks.</p> <p>8/2/12 -Occupational therapy (OT) clarification order for therapy six times</p>						

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	<p>a weed for eight weeks for therapeutic exercise therapy/functioning activities, neuromuscular re-education, activities of daily life (ADL's) retraining, patient and caregiver education.</p> <p>9/13/12 -discharged from occupational therapy.</p> <p>9/26/12 discharged from physical therapy.</p> <p>Physician progress notes indicated on 9/22/12 the resident was stable regarding her chest pain and shortness of breath related to pneumonia. Resident had a negative chest x-ray and her atrial fibrillation and blood pressure were controlled.</p> <p>The MDS (Minimum Data Set), dated 8/1/12 and 8/31/12, indicated the resident needing assistance with all activities of daily living.</p> <p>The MDS for 11/4/12 indicated the resident was independent for all ADL's and needs setup help only.</p> <p>The social service notes indicated on 10/18/12- "...Visit with resident after breakfast. Resident states she is independent with a lot of ADL care, but staff help her when she needs</p>			

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	<p>them. Resident prefers to go home, but does understand this is the right placement for her...." There were no other notes indicating a plan for discharge. There were no notes pertaining to discussion with family or any other entities regarding discharge.</p> <p>There was no care plan regarding discharge plans of the resident.</p> <p>5. The clinical record for Resident # 12 was reviewed on 11/29/12 at 10 A.M. Diagnoses included, but were not limited to stroke with left sided weakness, mental retardation, myalgia, depression, schizoaffective psychiatric disorder, osteoarthritis, high blood pressure, schizophrenia, Iron def anemia, colitis, Renal insufficiency-chronic kidney disease stage III, and hypokalemia.</p> <p>The resident has received Seroquel 300 milligrams by mouth three times a day since November 2011.</p> <p>The annual MDS (Minimum Data Set), dated 4/9/12, indicated the resident has a diagnosis of schizophrenia or schizoaffective disorder.</p> <p>In reviewing care plans, there was no</p>						

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	<p>care plan for behaviors or diagnosis of schizoaffective disorder noted in chart.</p> <p>In an interview with LPN #3 on 11/29/12 at 2:05 P.M., she indicated all of the care plans for the resident are in the file cabinet with the room number.</p> <p>In an interview with the Social Service Director on 11/30/12 at 2:20 P.M., she indicated she could not find a care plan for schizophrenia for Resident # 12.</p> <p>3.1-35(a)</p>				

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F0329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <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 record review, observation and interview, the facility failed to manage resident's drug regimen's to be free of unnecessary medications related to lack of non-pharmacological interventions and lack of monitoring attempted gradual dose reductions (GDR) for 2 of 10 residents reviewed who met the criteria for unnecessary medications. (Resident # 12 and 46)</p>	F0329	<p>F329 DRUG REGIME IS FREE FROM UNNECESSARY DRUGS</p> <p>Resident #46 MD was consulted for GDR on anti-anxiety medication. Psych services consulted to review resident's current medications.</p> <p>Resident #12 MD was consulted for rationale on declining GDR for Seroquel. Resident #12 was also added to psych services</p>	12/30/2012			

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	<p>Findings include:</p> <p>1. Review of Resident #46's record on 11/29/12 at 10:30 A. M., indicated the resident had Physician Orders for Xanax (anti-anxiety medication) and Lexapro (anti-depressant).</p> <p>A note to "attending Physician/Prescriber," dated 4/27/11, indicated Resident #46 was taking Xanax 0.125mg...daily since 11/23/10. Would you consider a reduction to 0.125mg every other day at this time" The note indicated the physician's response was "Plan no changes. Patient will decompensate if decreased." There was no evidence in the record of a previous attempt at a GDR or other indication that justified the continued use of the medication.</p> <p>Interview with LPN #8 on 11/30/12 at 10:30 A.M., indicated the only tracking related to behaviors was done when a resident engaged in behaviors and it would have been completed on a behavior tracking form. LPN #8 indicated they would be in the chart and that Resident #46 had no behavior tracking forms in the record. This lack of behavior forms indicated the resident did not have behaviors, yet a GDR was not</p>		<p>Facility audit was completed to ensure GDR attempt was completed. Facility audit was completed to review care plans for appropriate interventions. GDR was requested from MD, if applicable. Care plans were corrected at time of audit.</p> <p>The Behavior Follow-up Form was updated to indicate if current interventions were effective. Care plans revised as needed. Unit Coordinators will follow up on GDR report to ensure response for rationale was received. Care plans will be revised as needed according to MD response</p> <p>Social Services Director or designee will audit 10% of residents on psychotropic medications to ensure GDR is obtained and interventions were effective, care plans being updated as needed. The audits will be conducted weekly for 4 weeks, monthly for 4 months and quarterly thereafter. Audits will continue at the discretion of Quality Assurance Committee.</p> <p>Compliance date: 12-30-12</p>		

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	<p>attempted.</p> <p>Additionally Resident #46's Care Plan, dated 8/10/11, included interventions to prevent the behavior from occurring which included:</p> <ol style="list-style-type: none"> 1. Staff supportive visits...to encourage her to reach her goals. 2. When anxious ask the resident if she would like to play Bridge. 3. "Offer back rub/hand hold/touch." 4. "Staff to provide... validation of resident's feelings" 5. Encourage (Resident #46) to eat meals in the (Main Dining Room) or around the nurse's station" <p>There was no evidence in the resident's record to indicate these interventions were systemically implemented, or monitored to determine if the interventions were effective or needed revision.</p> <p>During an interview with the Social Services Director (SSD), at 2:45 P.M. on 11/29/12, she indicated specific monitoring for proactive interventions designed to reduce the likelihood of behavior or symptoms of depression occurring were not reviewed or monitored to evaluate for effectiveness.</p>						

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	<p>2. The clinical record for Resident # 12 was reviewed on 11/29/12 at 10 A.M. Diagnoses included, but were not limited to stroke with left sided weakness, mental retardation, myalgia, depression, schizoaffective psychiatric disorder, osteoarthritis, high blood pressure, schizophrenia, Iron def anemia, colitis, Renal insufficiency-chronic kidney disease stage III, and hypokalemia.</p> <p>The resident has been receiving Seroquel 300 milligrams by mouth three times a day. The consultant pharmacist sent a letter to the physician indicating the following, "...We have discussed the resident's medications in our recent Behavior meeting. We are askedto review all psychoactive medications for gradual dosage reduction on a regular basis. She is currently taking ...Seroquel 300 mg TID -Schizoaffective Disorder/Schizophrenia. We previously had documentation from you stating that the above medications were clinically contraindicated to reduce, but we do update this on a yearly bases. Staff report she still remains stable on the above medications...." In the section of the letter where it indicates "Reduction of Above Medications</p>			

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	<p>is/are clinically contraindicated, the physician checked 'yes' by a box and gave no explanation as to why the reduction was clinically contraindicated and dated the form 3-14</p> <p>There was no documentation in the psych portion of the record indicating the resident was being followed by psychiatric services.</p> <p>The physician progress notes did not indicate any behaviors or psychiatric concerns from 12-21-11 through last entry on 9-20-12.</p> <p>The behavior occurrence forms indicated Resident #12 had episode of cursing and yelling at other residents during a meal service, The resident was removed from the dining room on 7/7/12.</p> <p>The nursing notes started in May 2012. The nursing notes for 7/8/12 indicated the resident refused to go to meals and yelled and cussed at staff. On 7/26/12, the resident had a conflict with another resident where she was yelling at other resident .</p> <p>The nurses notes on 7/7/12, 7/8/12 or 7/26/12 did not have any documentation regarding behaviors.</p>			

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	<p>The social services notes were reviewed from 8/10/11 to current. The entry for 7/9/12 indicated, "... behavior meting held today. talked with resident to educate on being nice to other residents better and not yelling, resident had no response..." There were no notes on 7/26/12. The most recent note from 10/18/12 indicated, "... no concerns..."</p> <p>3.1-48(a)</p>			
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F0334 SS=A	<p>483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p>				

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	<p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>Based on record review and interview, the facility failed to have evidence showing residents or their representatives received information regarding benefits and potential side effects of flu vaccines prior to administration for 1 of 5 residents (#2) sampled for influenza and pneumococcal vaccine.</p> <p>The findings include:</p> <p>Resident #2's record was reviewed, on 11/30/12 at 11:35 A.M. The record indicated the resident received the flu vaccine at the facility on</p>	F0334	F334Resident # 2 and the POA was informed regarding the risks and benefits of the influenza vaccine. Vaccination consent forms reviewed by Infection Control Nurse. Vaccination consent forms updated and will be signed yearly by resident or POA to ensure risks and benefits are explained. At time of administration of vaccinations, the Infection Control Nurse or designee will audit the consent forms to ensure all are signed and current for the year. The Infection Control Nurse or designee will report the results of all vaccination consent audits and report to QA committee for further	12/30/2012	

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	<p>10/1/12. The record did not indicate the resident or representative was informed of the benefits and potential side effects prior to the administration of this year's vaccine. The record indicated written informed consent had been obtained prior to the previous year's administration of vaccines.</p> <p>During an interview with the Infection Control Coordinator, on 11/30/12 at 1:30 P.M., she indicated consents are only obtained at admission and then annually when administered, the nurse administering indicates by signature on the annual resident information record that the "Resident/POA has been informed. Review of Resident #2's Immunization Record only indicated the nurse's signature. There was no evidence of when Resident #2 was informed or had given consent prior to this year's administration.</p> <p>3.1-13(a)</p>		<p>recommendations. Completion Date: 12/30/12</p>		

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F0371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to keep the ice machine in the kitchen free of dust and lint. This deficient practice had the potential to affect 97 of 97 residents who resided at the facility.</p> <p>Findings include:</p> <p>1. During the initial kitchen tour on 11/25/12 at 9:55 A.M., with the Dietary Manager (DM), visible dust was hanging on the ice machine under the open lid. The DM indicated the ice machine was cleaned by the ice machine contractor on a quarterly basis and was not a duty of kitchen staff. The DM verbally agreed the machine needed dusted.</p> <p>3.1-21(j)</p>	F0371	<p>F371 FOOD PROCUREMENT / STORE . PREPARE / SANITARY CDM immediately cleaned dust/lint off of ice machine lid. All residents had potential to be affected by dust/lint on lid of ice machine. Dietary staff will be educated on the importance of cleanliness of ice machine lid. Cleaning of ice machine lid will be added to daily cleaning schedule. Local commercial refrigerator company will perform preventive maintenance of ice machine quarterly or as needed. CDM or designee will inspect cleanliness of ice machine lid daily for four weeks, weekly for six months. Then the QA team will review to d/c of audit. Audit form will be signed off by CDM or designee. Compliance date: 12-30-12 Addendum: Insepection of the ice machine lid was permanently added to the daily cleaning checklist and will be reported to the QA Team for 6 months. Upon 6 months of 100% threshold the QA Team will review necessisty for further QA Team review.</p>	12/30/2012	

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F0411 SS=D	<p>483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care.</p> <p>A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.</p> <p>Based on observation, interview and record review, the facility failed to assist in obtaining routine dental care for 1 of 3 residents in a sample of 7 reviewed. (Resident #27)</p> <p>Findings include:</p> <p>During observation on 11/27/12 at 9:59 a.m., Resident #27 was noted dozing and her upper dentures were resting on her tongue and not engaged with the upper gum.</p> <p>During interview on 11/27/12 at 9:59 a.m., the resident indicated she needed new dentures,her dentures were very loose in her mouth and</p>	F0411	<p>F411 :ROUTINE / EMERGENCY DENTAL SERVICES IN SNFS Resident #27 was evaluated by Dentist in facility on 12/12/2012. A facility-wide audit of every resident will be completed to identify any residents with ill-fitting dentures and a dental consult will be offered. On quarterly MDS assessments, residents will be asked if they wish to be seen by a dentist and a consult form will be signed as needed. Social Service Director or Designee will audit 10% of residents with dentures weekly for four weeks, 10% of residents with dentures monthly for four months. Trends of the audit results will be reviewed by the Quality Assurance Team each month for recommendations. Compliance date: 12-30-12 Addendum:</p>	12/30/2012	

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	<p>sometimes she has sores in mouth on the gums from the movement. The dentures were noted to slip and were very loose when the resident talked during the interview.</p> <p>During interview on 11/28/12 at 11:50 a.m., with the Assistant Social Service Director, she indicated she was not aware that Resident 27's dentures were loose and sometimes caused mouth soreness. She was not aware of this resident having been seen by the dentist She said the dentist had just been to see residents at the facility.</p> <p>During interview on 11/29/12 at 9:35 a.m., with RN #4, she indicated the resident is very weak and also is resistant to care. She indicated the resident has at times refused to use her dentures and always refuses to use an adhesive for dentures. She also said the resident has refused to see a dentist.</p> <p>During interview on 11/30/12 at 2:15 p.m., the Social Service Director indicated the resident must have a</p>		Social Services Director / Designee will audit 10% of residents with dentures for 6 months. Upon 6 months of 100% threshold the QA Team will review necessity for further recommendations.		

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	<p>consent signed to see the dentist and she is not aware of this resident being seen for a routine dental evaluation since she became a resident.</p> <p>During interview on 11/30/12 at 2:20 p.m., Resident #27 indicated she would be very happy to have a dentist evaluate her dentures for fit as long as there is no cost to her. At this time, LPN #10 indicated the procedure is if nursing, family or resident indicates they want to see a dentist, the staff informs Social Service who makes the arrangements.</p> <p>Review of the MDS(Minimum Data Set) assessments for 4/7/12, 4/26/12, 7/24/12, and 10/21/12 indicated there was no documentation of any dental problems or any mention of denture use. There were no documented problems with chewing or swallowing.</p> <p>There was no documented dental evaluation found in this resident's chart.</p> <p>3.1-24(a)(1)</p>				

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F0428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on record review and interview, the facility failed to obtain a Physicians' rationale for not attempting a Gradual Dose Reduction (GDR) for 2 of 10 residents reviewed for pharmacy recommendations regarding GDRs in a sample of 10. (Residents #12 and 60)</p> <p>Findings include:</p> <p>1. The clinical record for Resident # 12 was reviewed on 11/29/12 at 10 A.M. The resident was admitted 11/1/01. Diagnoses included, but were not limited to stroke with left sided weakness, mental retardation, myalgia, depression, schizoaffective psychiatric disorder, osteoarthritis, high blood pressure, schizophrenia, Iron def anemia, colitis, Renal insufficiency-chronic kidney disease stage III, and hypokalemia.</p> <p>The resident has been receiving</p>	F0428	<p>F428 DRUG REGIME, REVIEW, REPORT, IRREGULAR, ACT ON</p> <p>Resident #12 MD was consulted for rationale on declining GDR for Seroquel. Resident #12 was also added to psych services. Resident #60 MD was consulted for rationale on declining GDR for Seroquel. Facility audit was conducted to ensure rationale is present on GDR when MD is declining Pharmacy recommendation. Rationale was obtained if rationale was not present on GDR. Revisions of Pharmacy GDR report to Physician to reflect rationale for declining GDR. GDR report will be placed in the clinical record once response received from MD. Care Plan will be updated according to MD's response. Unit Coordinators will ensure rationale is present on GDR report. Pharmacy or designee will audit 10% of Residents receiving psychotropic medication for GDR weekly times 4 weeks, monthly for 4 months, and quarterly thereafter. Trends of the audit results will be reviewed by the</p>	12/30/2012	

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	<p>Seroquel 300 milligrams by mouth three times a day. The consultant pharmacist sent an undated letter to the physician indicating the following, " ...We have discussed the resident's medications in our recent Behavior meeting. We are askedto review all psychoactive medications for gradual dosage reduction on a regular basis. She is currently taking ...Seroquel 300 mg TID -Schizoaffective Disorder/Schizophrenia. We previously had documentation from you stating that the above medications were clinically contraindicated to reduce, but we do update this on a yearly bases. Staff report she still remains stable on the above medications..." In the section of the letter where it indicates "Reduction of Above Medications is/are clinically contraindicated, the physician checked 'yes' by a box and gave no explanation as to why the reduction was clinically contraindicated and dated the form 3-14.</p> <p>There was no documentation in the psych portion of the record to indicate the resident was followed for psychiatric services.</p> <p>The physician progress notes did not</p>		<p>Quality Assurance Team each month for recommendations. Compliance date: 12-30-12</p>	

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	<p>indicate any behaviors or psychiatric concerns from 12-21-11 through last entry on 9-20-12.</p> <p>The behavior occurrence forms indicated Resident #12 had episode of cursing and yelling at other residents during a meal service, The resident was removed from the dining room on 7/7/12.</p> <p>The nursing notes started in May 2012. The nursing notes for 7/8/12 indicated the resident refused to go to meals and yelled and cussed at staff. On 7/26/12, the resident had a conflict with another resident where she was yelling at other resident .</p> <p>The nurses notes on 7/7/12, 7/8/12 or 7/26/12 did not have anything regarding behaviors.</p> <p>The social services notes were reviewed from 8/10/11 to current. The entry for 7/9/12 indicated, "... behavior meeting held today. Talked with resident to educate on being nice to other residents better and not yelling, resident had no response...." There were no notes on 7/26/12. The most recent note from 10/18/12 indicated, "... no concerns..."</p> <p>A request was made to LPN # 3 on</p>						

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	<p>11/29/12 at 4:50 P.M. for any information regarding Seroquel dosing and any changes with medication.</p> <p>On 11/30/12 at 9:55 A.M., LPN #3 provided physician's orders from 11/1/01 when Resident #12 received Seroquel 200 mg BID and Seroquel 100 mg daily. She indicated this was the only information she could find.</p> <p>2. The clinical record for Resident #60 was reviewed on 11/28/12 at 11:44 A.M.</p> <p>Diagnoses include, but were not limited to: hypertension, dementia, anxiety, depression, hearing loss, history of falls, senile dementia disorder with associated behavior symptoms.</p> <p>Records indicated pharmacy reviews were completed and signed monthly with the last review dated 10/28/12.</p> <p>The Pharmacist suggested to MD on 10/24/12 " trying a GDR of Seroquel for this resident."</p> <p>Records indicated a verbal order, dated 10/30/12, "GDR of Seroquel 50 mg BID contraindicated per MD." There was no clinical rationale</p>						

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	<p>documented.</p> <p>A physician order for Seroquel was 50 mg (milligrams) twice daily for over one year without change or documented GDR.</p> <p>3.1-25(i)</p>			

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F0514 SS=A	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to document exhibited behaviors and attempted interventions for a PRN (as needed) medication for 1 of 10 residents reviewed for documentation of exhibited behaviors and attempted interventions for the administration of a PRN medication. (Residents #151)</p> <p>Findings include:</p> <p>The clinical record for Resident #151 was reviewed on 11/28/12 at 3:00 P.M.</p> <p>Diagnoses for Resident #151 included, but were not limited to, anxiety, non-insulin dependent diabetes mellitus, hypertension, chronic kidney disease, Parkinson's</p>	F0514	F514 The clinical record for Resident # 151 was reviewed for any instances where the behaviors and prior interventions were not documented on a Behavior Occurrence Form prior to the administration of a PRN medication. Behavior Occurrence Forms were reviewed by the Interdisciplinary Team for PRN medication use to ensure interventions and behaviors were documented appropriately. Social Service Director or Designee will complete Behavior Tracking sheet for each resident when resident behaviors and PRN medication use are discussed in morning meeting. In addition, an interdisciplinary team review for behaviors and PRN medication use will be completed for each resident. Social Service Director or Designee will audit 10% of behavior sheets weekly	12/30/2012			

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	<p>disease, history of transient ischemic attack (TIA- mini-stroke), and insomnia.</p> <p>A Behavior Occurrence form, dated 10/27/12, and a time of behavior at 2100 (9:00 P.M.). Behavior demonstrated: "c/o (complains of) insomnia." Interventions Attempted: No interventions were indicated. Explanation of behavior; i.e. what caused or what happened just before the behavior: "c/o insomnia" Med (medication) given: "Ambien (anti-insomnia, sleep aid) 2.5mg"</p> <p>The electronic medication administration record (eMAR) indicated the resident received Ambien on 10/27/12 at 9:00 P.M.</p> <p>During an interview with the Director of Nursing (DON) at 3:20 P.M. on 11/28/12, she indicated any PRN (given as needed) such as anti-anxiety, anti-depressant, sleep aid, and/or pain medications were expected to be documented on a behavior sheet, prior to each administration, by the attending nurse. Documentation should include the displayed behaviors and non-pharmacological interventions attempted.</p>		<p>for 4 weeks to check for accuracy of documentation regarding PRN medication use and non-pharmacological interventions. The audits will be reviewed by the QA committee quarterly for further recommendations. Completion Date: 12/30/12 Addendum: Revising Behavior Occurrence Form to include documentation for attempted interventions prior to the administration of Psychotropic PRN medications. Staff will be in-serviced on January 10, 2013 on revisions of Behavior Occurrence Forms.</p>				

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	<p>During an interview the LPN #2, on 11/29/12 at 3:15 P.M., she indicated the attending nurse was expected to document exhibited behaviors and attempted interventions on a behavior sheet, before administering any PRN medications. LPN #2 indicated the Behavior Occurrence Form, dated 10/27/12, lacked proper documentation.</p> <p>3.1-50(a)(1)(2)</p>			