

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155246	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/17/2013
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NAME OF PROVIDER OR SUPPLIER  WATERS OF DUNELAND THE	STREET ADDRESS, CITY, STATE, ZIP CODE 110 BEVERLY DR CHESTERTON, IN 46304
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: May 13, 14, 15, 16, and 17th, 2013</p> <p>Facility Number: 000150 Provider Number: 155246 AIM Number: 100267000</p> <p>Survey Team: Shannon Pietraszewski, RN-TC Regina Sanders, RN Caitlyn Doyle, RN Jennifer Redlin, RN</p> <p>Census bed type: SNF/NF: 95 Total: 95</p> <p>Census Payor Type: Medicare: 12 Medicaid: 69 Other: 14 Total: 95</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on May 24,</p>	F000000	Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction and specific corrective actions are prepared and/or executed in compliance with state or federal laws. This Plan of Correction constitutes our credible allegation of compliance with the regulatory requirements.	

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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	2013, by Janelyn Kulik, RN.			

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F000156 SS=C	<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 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,</p>			

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	<p>and how to receive refunds for previous payments covered by such benefits. Based on observation, record review, and interview, the facility failed to ensure the posting of names, addresses, and telephone numbers of all pertinent State Client Advocacy Groups (State Survey and Certification Agency, State Licensure Office, State Ombudsman, Protection and Advocacy Network, and Medicaid Fraud Control Unit) were at eye level for residents in wheelchairs and with large print for reading. This had the potential to affect all 95 residents who reside at the facility and their visitors.</p> <p>1. Upon entering the facility on 5/13/13 at 8:30 a.m., the postings of the State Client Advocacy Groups were displayed at the entrance in an 8 x 10 frame, above wheelchair level and in small print.</p> <p>An interview with the Administrator on 3/16/13 at 3:50 p.m., indicated he will get it taken care of and would have the Ombudsman information put up by tomorrow morning.</p>	F000156	<p>It is the intent of this facility to ensure the posting of names, addresses, and telephone numbers of all pertinent State Client Advocacy Groups are at eye level for residents in wheelchairs and with large print for reading. I. The actions taken by the facility are as follows: A. The posting of State Client Advocacy Groups was lowered to eye level of those residents in wheelchairs. B. The font of the posting was increased to ensure the posting was legible. C. Resident #19 was provided information for Ombudsman and where the information was located within the facility. D. The Ombudsman information was placed on all 4 halls within the facility, as well as the front lobby. E. Any new required State information will be placed at eye level for those residents in wheelchairs and will have large legible font. II. The facility's actions taken to identify other residents are as follows: A. All residents would have the potential to be affected. III. The measures put into place by the facility are as follows: A. 100% audit was completed to ensure the posting of State Client Advocacy Groups were at eye level of residents who were in wheelchairs and had large legible font. IV. The facility will monitor actions as follows: A. The Administrator/Designee</p>	05/17/2013	

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	<p>2. During an interview on 5/16/13 at 9:40 a.m., Resident #19 indicated he did not know who the Ombudsman was or how to contact the Ombudsman.</p> <p>Observation of the Ombudsman information located at the front door on 5/16/13 at 9:50 a.m., indicated the sign was in front of 10 and approximately 5 and 1/2 feet from the floor, which would not be at eye level to a wheelchair bound resident. There was no name listed for the Ombudsman with the phone number.</p> <p>Interview with Administrator on 5/16/13 at 9:55 a.m., indicated he had frequented the Resident Council Meetings and had not personally informed the residents of who the new Ombudsman was.</p>		<p>will monitor monthly for sign location, level of posting, and font of posting. This will be an on-going process and will be included on the QA rounds. B. The Administrator/Designee will review a summary of the monthly monitoring in the Monthly QA meeting and quarterly QA meeting with the Medical Director. V. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 5-17-13.</p>		

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	3.1-4(a) 3.1-4(j)			

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F000225 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 record review and</p>	F000225	It is the facility's intent to comply	06/03/2013			

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	<p>interview, the facility failed to investigate an allegation of abuse and failed to notify the Indiana State Department of Health (ISDH) of the allegation of abuse, for 1 of 3 abuse allegations reviewed. (Resident #47)</p> <p>Findings include:</p> <p>During an interview on 5/13/13 at 11:35 a.m., Resident #47 indicated she had been treated roughly by staff. She indicated the situation had been handled by the Administrator, and the CNA involved had been terminated.</p> <p>Interview with the Administrator on 5/15/13 at 10:55 a.m., indicated there had been an allegation of rough treatment by Resident #47 involving a CNA dropping the resident versus lowering her to the floor during a transfer on 03/15/13. The Administrator did not indicate a date for the rough treatment allegation. The Administrator indicated the CNA was terminated.</p> <p>During an interview with Administrator and Director of Nursing (DoN) on 5/15/13 at 2:33 p.m., the DoN (Director of Nursing) indicated on 3/15/13, Resident #47 was transferred from a wheelchair to the bed and the resident's leg gave out</p>		<p>with the Federal regulation that requires the facility not to employ any individual found guilty of abusing, neglecting or mistreating residents. The facility further complies with ensuring all allegations of abuse are reported in accordance with facility policy and regulation. The facility ensures that all allegations are thoroughly investigated and takes every effort possible to ensure the resident(s) are protected during such allegation. I. The actions taken by the facility are as follows: A. The allegation of abuse by resident #47 was reported to ISDH on 5-30-13. B. The investigation for the allegation was completed on 5-30-13. II. The facility's actions taken to identify other residents are as follows: A. No other residents were identified. III. The measures put into place by the facility are as follows: A. All alert and oriented residents were interviewed related to abuse. B. All cognitively impaired residents recieved head to tow skin assessments. C. All staff inservice was held 5-22-13 and 5-23-13, on abuse policy and reporting procedures. IV. The measures put into place by the facility are as follows: A. DON/Designee will select 10% of residents on a weekly basis to interview related to abuse. B. All new employees will be inserviced on abuse, abuse policy and abuse reporting. C. The</p>		

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	<p>and the CNA lowered the resident to the floor. The DoN indicated Resident #47 transferred with one assist. The DoN indicated about a month later, on 4/12/13, Resident #47 requested that the CNA no longer care for her. The DoN indicated she did not know why the resident did not want the CNA to care for her. The DoN indicated the CNA had cared for the resident after the fall until the request was made on 04/12/13. The DoN indicated the first time the resident voiced a concern about the CNA was on 4/12/13. The DoN indicated no investigation had been completed after the resident had requested the CNA no longer take care of her.</p> <p>Further interview with the Administrator, indicated the CNA refused to switch assignments and was terminated on 4/12/13. The Administrator was not sure why Resident #47 no longer wanted the CNA to care for her on 4/12/13 and indicated an investigation had not been completed and the Indiana State Department of Health (ISDH) had not been notified of the rough treatment.</p> <p>Resident #47's record was reviewed on 5/16/13 at 9:03 a.m. A nursing</p>		<p>Administrator/Designee will report all allegations of abuse to the ISDH per the reporting requirements. D. The Administrator/Designee will review all reports of concern and ISDH reportable occurrences at the monthly QA meeting and the quarterly QA meeting with the Medical Director. V. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 6-3-13.</p>	

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	<p>note dated 3/15/13 at 9:30 p.m., indicated "Res [Resident] was being transferred from chair to bed and res stated that her legs were giving out. CNAs assisted res to floor. Total body assessments completed. No injuries noted."</p> <p>During an interview with the DoN on 5/16/13 at 10:29 a.m., the DoN indicated there was no investigation completed because there was no fall. The DoN indicated Resident #47 had been lowered to the floor, she did not fall.</p> <p>During an interview with Resident #47 on 5/15/13 at 3:37 p.m., Resident #47 indicated the CNA was transferring her from her wheelchair to bed and she slid down the CNA's leg to the floor. Resident #47 indicated she felt she was dropped by the CNA. Resident #47 indicated she told the CNA she felt she was dropped during the transfer. Resident #47 indicated no one interviewed her following the situation.</p> <p>Further interview with Resident #47 indicated a few weeks later she heard a rumor the CNA called off the day following the incident because Resident #47 fell on her leg. Resident #47 indicated at that time</p>			

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	<p>she no longer wanted the CNA to care for her and immediately reported the situation to the Administrator. Resident #47 indicated she met with Administrator on 04/12/13 and discussed her concerns and informed the Administrator she had been dropped. She (Resident #47) asked the Administrator why she had not been interviewed regarding the CNA dropping her. Resident #47 indicated the Administrator told her she had not been interviewed regarding the previous incident because he was told she fell instead of Resident #47's claim that she was dropped. Resident #47 indicated the Administrator handled the situation promptly that day and the CNA was terminated.</p> <p>Resident #47's record was reviewed on 5/16/13 at 9:03 a.m. The resident's admission Minimum Data Set (MDS) assessment dated 1/21/13 indicated the resident was cognitively intact.</p> <p>A facility policy on Abuse dated 7/1/11, and received as current from the Administrator, indicated "...The facility will initiate at the time of any finding of potential abuse or neglect an investigation to determine cause and effect, and provide protection to</p>			

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	<p>any alleged victims to prevent harm during the continuance of the investigation. The Administrator or the designee who is in charge of the facility, shall report any instances of suspected abuse, neglect, or misappropriation of resident property to the Department of Health as required...Suspected or substantiated cases of resident abuse, neglect, misappropriation of property, or mistreatment shall be thoroughly investigated and documented by the Administrator, and reported to the appropriate state agencies, physician, families, and/or representative as required by state guidelines..."</p> <p>3.1-28(d) 3.1-28(e)</p>			

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F000226 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 record review and interview, the facility failed to follow the facility's abuse policy related to reporting allegations of abuse to the Indiana State Department of Health (ISDH) for 1 of 3 abuse allegations reviewed. (Resident #47)</p> <p>Findings include: During an interview on 5/13/13 at 11:35 a.m., Resident #47 indicated she had been treated roughly by staff. She indicated the situation had been handled by the Administrator, and the CNA involved had been terminated.</p> <p>Interview with the Administrator on 5/15/13 at 10:55 a.m. indicated there had been an allegation of rough treatment by Resident #47 involving a CNA dropping the resident versus lowering her to the floor during a transfer on 03/15/13. The Administrator did not indicate a date for the rough treatment allegation. The Administrator indicated the CNA was terminated.</p>	F000226	<p>The facility's intent is to comply with the Federal requirements to develop and implement written policies and procedures that prohibit resident mistreatment, neglect, and misappropriation of resident property. I. The actions taken by the facility are as follows: A. The allegation of abuse by resident #47 was reported to ISDH on 5-30-13. B. The investigation of the allegation of abuse was also completed on 5-30-13. II. The facility's actions taken to identify other residents are as follows: A. No other residents were identified. III. The measures put into place by the facility are as follows: A. All alert and oriented residents were interviewed related to abuse. B. All cognitively impaired residents received head to toe skin assessments. C. An all staff inservice was held 5-22-13 and 5-23-13, on abuse policy and reporting procedures.IV. the facility will monitor actions as follows: A. DON/Designee will select 10% of residents on a weekly basis to interview related to abuse. B. All new employees will be inserviced on abuse, abuse policy , and abuse</p>	06/03/2013	

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	<p>During an interview with Administrator and Director of Nursing (DoN) on 5/15/13 at 2:33 p.m., the DoN (Director of Nursing) indicated on 3/15/13, Resident #47 was transferred from a wheelchair to the bed and the resident's leg gave out and the CNA lowered the resident to the floor. The DoN indicated Resident #47 transferred with one assist. The DoN indicated about a month later, on 4/12/13, Resident #47 requested that the CNA no longer care for her. The DoN indicated she did not know why the resident did not want the CNA to care for her. The DoN indicated the CNA had cared for the resident after the fall until the request was made on 04/12/13. The DoN indicated the first time the resident voiced a concern about the CNA was on 4/12/13. The DoN indicated no investigation had been completed after the resident had requested the CNA no longer take care of her.</p> <p>Further interview with the Administrator, indicated the CNA refused to switch assignments and was terminated on 4/12/13. The Administrator was not sure why Resident #47 no longer wanted the CNA to care for her on 4/12/13 and indicated an investigation had not</p>		<p>reporting. C. The Administrator/Designee will review all reports of concern and ISDH reportable occurrences at the monthly QA meeting and at the quarterly QA meeting with the Medical Director. D. The administrator will report all allegations of abuse to the ISDH per the reporting requirements. V. This constitutes our credible allegation of compliance with all regulatory requirements, our date of compliance is 6-3-13.</p>	

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	<p>been completed and the Indiana State Department of Health (ISDH) had not been notified of the rough treatment.</p> <p>During an interview with the DoN on 5/16/13 at 10:29 a.m., the DoN indicated there was no fall investigation completed because there was no fall. The DoN indicated Resident #47 had been lowered to the floor, she did not fall.</p> <p>During an interview with Resident #47 on 5/15/13 at 3:37 p.m., Resident #47 indicated the CNA was transferring her from her wheelchair to the bed and she slid down the CNA's leg to the floor. Resident #47 indicated she felt she was dropped by the CNA. Resident #47 indicated she told the CNA she felt she was dropped during the transfer. Resident #47 indicated no one interviewed her following the situation.</p> <p>Further interview with Resident #47 indicated a few weeks later she heard a rumor the CNA called off the day following the incident because Resident #47 fell on her leg. Resident #47 indicated at that time she no longer wanted the CNA to care for her and immediately reported the situation to the Administrator.</p>			

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	<p>Resident #47 indicated she met with Administrator on 04/12/13 and discussed her concerns and informed the Administrator she had been dropped. She (Resident #47) asked the Administrator why she had not been interviewed regarding the CNA dropping her. Resident #47 indicated the Administrator told her she had not been interviewed regarding the previous incident because he was told she fell instead of Resident #47's claim that she was dropped. Resident #47 indicated the Administrator handled the situation promptly that day and the CNA was terminated.</p> <p>A facility policy on Abuse dated 7/1/11, and received as current from the Administrator, indicated "...The facility will initiate at the time of any finding of potential abuse or neglect an investigation to determine cause and effect, and provide protection to any alleged victims to prevent harm during the continuance of the investigation. The Administrator or the designee who is in charge of the facility, shall report any instances of suspected abuse, neglect, or misappropriation of resident property to the Department of Health as required...Suspected or substantiated cases of resident abuse, neglect,</p>			

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	<p>misappropriation of property, or mistreatment shall be thoroughly investigated and documented by the Administrator, and reported to the appropriate state agencies, physician, families, and/or representative as required by state guidelines..."</p> <p>An interview with the Administrator on 5/16/13 at 1:10 p.m., indicated he is the Abuse Prohibition Coordinator and that staff are aware.</p> <p>3.1-28(a)</p>			

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F000242 SS=B	<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 record review and interview, the facility failed to ensure each resident's choice was honored related to bathing for 2 of 3 residents out of seventeen residents interviewed for choices. (Residents #14 &amp; #83)</p> <p>Findings include:</p> <p>1. An interview with Resident #14 on 5/13/13 at 2:53 p.m., indicated the resident was not able to choose how many times a week she could take a bath or shower.</p> <p>Interview with Resident #14 on 5/15/13 at 10:17 a.m., indicated the staff had offered her showers on certain days but she was unable to choose if she would like to take a shower or not on that day. Resident #14 indicated that she was not able to choose the days she would like to take a shower. She indicated she had not requested her shower to be</p>	F000242	<p>It is the intent of the facility to comply with the resident's right to make choices about aspects of thier life that are significant to the resident. I. The actions taken by the facility are as follows: A. Resident #14 was interviewed related to their choice for bathing. The resident chose to keep thier bathing on the same schedule. B. Resident # 83 was interviewed on their choice for bathing. This resident also chose to keep their bathing on the same schedule. II. The facility's actions taken to identify other residents are as follows: A.All interviewable residents were contacted related to their bathing choices. Five residents wished to make changes to their current bathing schedule. III. The measures put into place by the facility are as follows: A. An all staff inservice, on resident choices was held on 5-22-13 and 5-23-13. B. All interviewable residents were approached regarding their choice of the type of bathing they prefer, the time of their bathing and the frequency of thier</p>	06/03/2013			

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	<p>on a different day or at a different time and the choice was not offered to her by staff.</p> <p>Resident #14's record was reviewed on 5/14/13 at 3:44 p.m. The Resident's Admission Minimum Data Set (MDS) assessment dated 2/28/13, indicated the resident was cognitively intact and it was very important for her to choose between a tub bath, bed bath, or shower.</p> <p>2. During an interview on 5/13/13 at 2:13 p.m., Resident #83 indicated, she did not get to choose how many times a week she would like to take a bath or a shower. The resident indicated she received a shower twice a week and would like to take one everyday.</p> <p>On 5/15/13 at 8:15 a.m., the Minimum Data Set (MDS) Annual Assessment dated 1/7/13 was reviewed. The</p>		<p>bathing. C. All new admissions will be given the choice of type of bathing, frequency of bathing, and time of bathing. D. The bathing sheet will be given to Medical Records for proper placement on the shower schedule. IV. The facility will monitor actions as follows: A. The DON/Designee will audit the new admission bath schedules, the following working day after admission, to ensure the resident's choices are upheld. B. Social Service will interview 10% of interviewable residents weekly times two weeks, then monthly until 100 % compliance is achieved. C. The Administratoe/Designee will review all audits monthly at the QA meeting and quarterly at the QA meeting with the Medical Director. V. This constitutes our allegation of compliance with all regulatory requirements. Our date of compliance is 6-3-13.</p>	

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	<p>MDS indicated it was very important to the resident to choose daily preferences and the resident was cognitively intact.</p> <p>An interview with the Social Services Director on 5/15/13 at 8:42 a.m., indicated nursing puts the residents on a bathing schedule.</p> <p>An interview with the Director of Nursing (DON) on 5/15/13 at 9:00 a.m., indicated residents would have a set schedule for bathing by room number.</p> <p>3.1-3(u)(3)</p>			

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F000272 SS=D	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:                      Identification and demographic information;                      Customary routine;                      Cognitive patterns;                      Communication;                      Vision;                      Mood and behavior patterns;                      Psychosocial well-being;                      Physical functioning and structural problems;                      Continence;                      Disease diagnosis and health conditions;                      Dental and nutritional status;                      Skin conditions;                      Activity pursuit;                      Medications;                      Special treatments and procedures;                      Discharge potential;                      Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and                      Documentation of participation in assessment.</p> <p>Based on observation, record review and interview the facility failed to accurately complete a comprehensive assessment, related to a side rail assessment for 1 of 45 residents</p>	F000272	It is the intent of the facility to comply with the Federal regulations to conduct initial and periodic comprehensive, accurate, standardized reproducible assessments of	05/30/2013

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	<p>reviewed for comprehensive assessments in a total sample of 45. (Resident #67)</p> <p>Findings include:</p> <p>An observation of Resident #67's bed on 5/13/13 at 12:34 p.m., indicated the bed was made and empty. The quarter side rails were in the up position in the mid section of the bed on both sides.</p> <p>On 5/15/13 at 1:35 p.m., the resident was observed in bed with the side rails up, in the mid section of the bed on both sides.</p> <p>On 5/16/13 at 8:51 a.m., the resident was observed in bed lying on her right side, sleeping with the side rails up in the mid section of bed on both sides.</p> <p>On 5/16/13 at 9:33 a.m., the resident was observed sleeping in her bed, The side rails were up in the mid section of the bed on both sides.</p> <p>On 5/16/13 at 10:29 a.m., the resident was observed sleeping in the bed, with the side rails up in the mid section of bed on both sides.</p> <p>On 5/16/13 at 11:22 a.m., Certified Nursing Assistants (CNA) #16 was</p>		<p>each resident's functional capacity. I. The actions taken by the facility are as follows: A. A new siderail assessment was conducted for resident #67 on 5-16-13. B. The siderails on the bed of resident #67 were removed on 5-16-13. C. The POA was notified of the siderails being removed from resident #67 bed. The POA wanted the siderails placed back on the bed. Education was provided to the POA, on the risks of siderails. The resident is not capable of turning themself in the bed, is not ambulatory and cannot transfer without assistance of staff. The siderails were placed back on the bed on 5-17-13. II. The facility's actions taken to identify other residents are as follows: A. 100% audit of side rails, as a restraint, was completed. No other residents were identified. III. The measures put into place by the facility are as follows: A. 100% audit of residents of residents with side rails as restraints was conducted. B. New side rail assessments were completed on 100% of residents within the facility. C. An inservice was held on 5-20-13 and 5-21-13 on side rails and restraints. IV. The facility will monitor actions as follows: A. Side rail assessments will be completed upon admission, quarterly and as needed. B. DON/Designee will monitor side rails for accuracy upon admission, quarterly, and</p>				

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	<p>observed raising one side rail on the bed, then raised the bed up and lowered the head of bed. CNA #15 and #16 turned the resident from side to side to check for incontinence and to place a mechanical lift pad under the resident. The resident was then lifted from the bed to the geri-chair. The resident did not assist in any of the bed movement or the transfer to the geri-chair.</p> <p>Resident #67's record was reviewed on 5/16/13 at 8:23 a.m. Resident #67's diagnoses included, but were not limited to, progressive dementia with behaviors and organic psychosis.</p> <p>The Quarterly Minimum Data Set (MDS) Assessment dated 03/28/13, indicated the resident had severe cognitive impairment, was totally dependent for all activities of daily living (ADLS), required one person for assistance for bed mobility, and no side rails were being used.</p> <p>A side rail assessment dated 4/4/13, indicated the resident was to have 1/2 side rails for positioning and support.</p> <p>There was no side rail care plan in the resident's record.</p> <p>An interview with CNA #15 on 5/15/13</p>		<p>as needed. C. Administrator/Designee will review all audits monthly at the QA meeting and quarterly with the Medical Director. V. This constitutes our allegation of compliance with all regulatory requirements. Our date of compliance is 5-30-13.</p>				

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	<p>at 1:46 p.m., indicated the resident used the side rails so she would not fall out of bed, and did not use them for positioning or support.</p> <p>An interview with CNA #16 on 5/16/13 at 8:55 a.m., indicated she did not know why the resident had side rails and the resident always had them up while in bed. She indicated the resident did not use them for positioning or support and the resident did not move around in bed.</p> <p>An interview with the Director of Nursing on 5/6/13 at 10:32 a.m., indicated that the resident did not have a carnelian for side rails since the resident would hold onto the side rails when the staff turned her.</p> <p>An interview with CNA #16 on 5/16/13 at 11:25 a.m., indicated the resident's arms are always pulled to her chest and the resident did not use side rails to grab for positioning or support when turning or transferring from bed.</p> <p>3.1-31(a)</p>			

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F000280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, interview, and record review, the facility failed to, revise and update residents' care plans, related to interventions for behaviors and positioning, for 2 of 45 residents reviewed for care plan revisions and updates, in a total sample 45 residents. (Residents #26 and #88)</p> <p>Findings include:</p> <p>1. During an observation on 05/15/13 at 9:51 a.m., Resident #88 was sitting in the center of the four units, yelling about pigs, and yelling "don't come near me, I'll shoot you". LPN #1</p>	F000280	It is the intent of the facility to comply with Federal regulation to uphold the residents rights to participate in planning of care and treatment or changes in care and treatment. I. The actions taken by the facility are as follows:A. The care plan of resident #88 was updated 5-15-13.B. The care plan of resident #26 was updated on 5-15-13.C. 100% audit was completed on 5-28-13, by th IDT, to review behavior care lans and positioning care plans.II. The facility's actions taken to identify other residents are as follows:A. No other residents were identified.III. The measures put into place by the facility are as follows:A. Licensed nurses were	05/30/2013			

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	<p>attempted to redirect the resident to an activity. The resident refused to go and lifted her fist to LPN #1 and stated, "get out of here, your a pig too" LPN #1 walked away from the resident.</p> <p>During an observation at 05/15/13 at 9:57 a.m., Resident #88, grabbed at Admissions #3 and Yelled, "get out and don't come back", Admissions #3 then laughed and Resident #88 then yelled, "don't laugh". Nurse LPN #1 then offered the residents some orange juice. Resident #88 became upset and LPN #1 walked away from the resident.</p> <p>During an observation on 5/15/13 10:12 a.m. Resident #88 was moving her wheelchair so CNA #4 could not get past her. Resident #88 threatened to hit CNA #4 and CNA #4 laughed at the resident. Resident #88, raised her voice and stated to CNA #4, "don't laugh". CNA #4 then walked past the resident and then CNA #2 walked by the resident and indicated the resident had scratched her. RN # 5 intervned and spoke with the resident. The resident became upset with the Social Service Director as she was approaching her and RN #.</p>		<p>inserviced on 5-20-13 and 5-21-13 on revision of care plans, to reflect the resident's current plan of care.B. A 100% audit of the behavior and positioning care plans was conducted on 5-28-13, to ensure the care plans reflected the resident's current status.IV. The facility will monitor actions as follows:A. DON/Designee will review resident care plans, per MDS schedule, at weekly care plan meetings.B. DON/Designee will review all new admission care plans during morning clinical meeting.C. DON/Designee will update care plans with new interventions, treatments, etc., as they occur.D. Administrator/Designee will review all audits at the monthly QA meeting and the quarterly QA meeting with the Medical Director.V. This constitutes our allegation of compliance with all regulatory requirements. Our date of compliance is 5-30-13.</p>		

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	<p>During an observation on 5/15/13 at 10:31 a.m. Resident #88 remained agitated, and Activity Aide #6, laughed at the resident, which agitated the resident and she stated to Activity Aide #6, "you are going to get shot". The Front Office employee attempted to talk to resident and the resident hit her in arm twice, and yelled, "oh shut up". RN #7 then talked with the resident, and the resident calmed, then stated "don't bother me".</p> <p>During an observation on 5/15/13 10:40 a.m., Resident #88 was sitting in her wheelchair, in the hall, no resident around, no staff around, propelling own wheelchair through out the hallway. The resident looked at Activity Aide #6 and yelled "don't you go there, get out".</p> <p>During an observation on 05/15/13 at 10:47 a.m., Resident #88 was yelling at another resident, and stated, "you get out of here", and propelled her wheelchair down the hallway, and yelled, "don't come back here". CNA #8 and CNA #9 were walking behind the resident and giggled, after resident made the statement. Resident #88 then stated, "don't laugh at me". The Social Service Director intervned with the CNAs</p>			

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	<p>while RN #5 talked with the resident and calmed the resident.</p> <p>During an interview on 05/15/13 at 10:47 a.m., the Social Service Director indicated the staff were suppose to monitor the resident frequently when she is agitated. She indicated the behavior Resident #88 is exhibiting does not happen very often and if the staff would allow the resident personal space, the resident would usually calm. She indicated the more the staff tried to redirect her, the more agitated the resident became. She indicated the staff should not be laughing or giggling at the resident.</p> <p>Resident #88's record was reviewed on 5/16/13 at 10:42 a.m. The resident's diagnosis included, but was not limited to, dementia with behavioral disturbance.</p> <p>A care plan, dated 04/04/13, indicated the resident had a history of behaviors, received psychotropic medication, and could be combative at times with care. The interventions indicated, "1. provide med (medicine) as ordered 2. monitor mood &amp; behavior 3. Redirect &amp; reorient as needed 4. notify Dr. (sic) family of changes 5. observe for behavior</p>				

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	<p>triggers which might lead to combative behavior: quick approval, to (sic) many directions."</p> <p>The care plan lacked documentation to indicate the resident will usually calm when left alone. The care plan lacked documentation to indicate what interventions the direct care staff should take and lacked documentation for the staff not to giggle or laugh at the resident.</p> <p>During an interview on 5/16/13 at 10:30 a.m., the Social Service Director indicated the care plan had no interventions for the direct care staff and what to do when the behavior starts.</p> <p>2. On 5/13/13 at 11:45 a.m., Resident #26 was observed in the skilled dining room, reclined in a geri chair, with his head off to the right side of the chair. The resident received his meal at 12:05 p.m., and was starting to be fed by a family member while his head remained off the right side of the chair. At 12:18 p.m., the resident's family member indicated Resident #26's head always had to be repositioned frequently by the staff. During this time, the DoN and CNA #2 repositioned the resident.</p>			

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	<p>On 5/13/13 at 12:40 p.m., Resident #26's head had fallen back off to the right side of the geri chair. CNA #2 was at the table sitting across from the resident, feeding another resident. The wife continued to feed the resident in this position. There were other staffing personnel observed in the dining room, who did not attempt to repositioned the resident.</p> <p>On 5/15/13 at 9:00 a.m., Resident #26 was observed in his room, reclined in his geri chair with his head on metal edge of the chair. The resident was observed to have a concave cushion for his head which was flattened, a concave trunk cushion behind his back, and was sitting on a pommel cushion.</p> <p>On 5/15/13 at 10:00 a.m., Resident #26 was observed in bed. Resident #26 continued to favor his head to the right side, which was near the wall.</p> <p>On 5/15/13 at 3:45 p.m., Resident #26 was observed in bed. The top of the resident's head was pressed against the wall. Two large pillow was fluffed and tucked under the fitted sheet.</p>			

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	<p>Resident #26's record was reviewed on 5/15/13 at 9:00 a.m. Resident #26's diagnoses included, but were not limited to, Parkinson's, dementia, and acute respiratory failure.</p> <p>A care plan for risk for fall was initiated on 1/11/13. The approaches/interventions were not dated, but indicated to "reinforce safety awareness, resident lays self on floor to fix wheel chair at times-wiggles out. Wife aware-risk and benefits explained. Falling star program to increase supervision."</p> <p>An Occupational Therapy discharge note dated 2/8/13, indicated Resident #26 needed total assistance to hold food bowls/utensils and drinking cups. The resident had been in a "layback" chair, leans to the right at times and was observed to have had an increased extensor tone with a need for repositioning to improve posture and interaction with environment. The note also indicated the staff had been instructed on appropriate positioning and feeding, with a good understanding demonstrated.</p> <p>A Fall Risk Assessment dated 4/9/13, indicated the resident was a high risk for falls and the resident had fallen 1-2 times in the past three months.</p>			

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	<p>A care plan for physical mobility impaired due to diagnosis of Parkinson's was updated on 4/10/13. The approaches/interventions indicated "therapy per order, staff assist as indicated, educate on call light use and asking for assist, contact MD and family as indicated."</p> <p>A nursing note dated 4/19/13 at 8:30 p.m., indicated Resident #26 had "wiggled out of chair and had a fall. Res. (resident) needs to be positioned frequently and will "wiggle an wiggle."{sic}</p> <p>An interview with LPN #10 on 5/15/13 at 8:15 a.m., indicated the staff had tried multiple things with the resident for positioning and had been unsuccessful. LPN #10 indicated that if the resident was able to get his fingers to the end of the arm of the chair, he would pull himself down. LPN #10 indicated the geri chair had worked best for the resident and he did need frequent repositioning due to his continued "squirming".</p> <p>An interview with the SSD (Social Service Director) on 5/15/13 at 10:30 a.m., indicated Resident #26's wife did not want him to be moved closer to the nurses station. SSD indicated</p>			

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	<p>the staff was on alert about the resident's frequent positioning changes.</p> <p>An interview with the MDS (Minimum Data Set) Coordinator on 5/15/13 at 11:10 a.m., indicated she would update the care plans quarterly and the nurses can update the care plans at anytime when new orders were written. The MDS Coordinator indicated the resident should have had an updated care plan for positioning.</p> <p>3.1-35(d)(2)(B)</p>			

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F000309 SS=G	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure therapists communicated with the nursing staff of a resident who was displaying pain during therapy, nursing staff failed to assess and treat a resident for pain in a timely manner who was displaying facial grimacing, restlessness, and yelling in her room and/or in public view for 1 out of 7 residents reviewed and failed to ensure nursing staff notified the therapy department with a resident who had an increase in positioning problems for 1 out of 36 residents reviewed. (Resident #123 and #26)</p> <p>Findings include:</p> <p>1. On 5/13/13 from 12:00 p.m. to 12:30 p.m., Resident #123 was observed to be restless and was yelling out in the skilled dining room. The resident had facial grimacing. During this time, the DoN was observed walking over to the resident,</p>	F000309	It is the intent of the facility to comply with the Federal regulation that each resident must be provided with the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. We are requesting an IDR because of scope and severity. I. The actions taken by the facility are as follows: A. A new pain assessment was completed, 5-15-13, for resident #123. The MD was notified and a new pain medication was ordered. B. The behavior care plan was updated for resident #123 on 5-15-13. C. A new wheelchair was ordered for resident #26 on 5-29-13. D. OT screened resident #26 and the resident was added to the therapy case load. E. The bed alarm for resident #26 was reconnected and the call light was put into resident's reach. The bed was placed in its lowest position. F. The wife of resident #26 was educated on the bed alarm and the call light. The wife had	06/02/2013	

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	<p>patted her hand, reassured her, and then walked away. The resident was not asked if she was in pain. No other nurse or CNA had addressed the resident's yelling.</p> <p>On 5/13/13 at 2:30 p.m., Resident #123 was heard yelling out from her room.</p> <p>On 5/14/13 at 10:30 a.m., Resident #123 was heard yelling out from her room. The resident was observed to have facial grimacing and was restless in her geri chair.</p> <p>On 5/15/13 at 12:00 p.m., Resident #123 was observed yelling out in the skilled dining room.</p> <p>On 5/16/13 at 8:15 a.m., Resident #123 was observed in her room, partially sitting up in her geri chair, moving her legs up and down. The resident indicated she was in pain and she hurt all over. LPN #1 was informed, chuckled, and indicated the resident did get pain medication ordered last evening.</p> <p>On 5/16/13 at 9:20 a.m., Resident #123 was observed in her room, in her geri chair, partially sliding down with her right knee bent and left leg crossed over the right knee. The</p>		<p>removed the call light and unplugged the bed alarm, while in the facility visiting the resident. The spouse did not notify the staff when she left. G. A scoop mattress was ordered 5-29-13, for resident #26. II. The facility's actions taken to identify other residents are as follows: A. No other residents were identified. III. The measures put into place by the facility are as follows: A. Pain assessments were completed on all residents on 5-22-13. B. 100% audit of care plans, for residents who demonstrate behavior, was completed on 5-28-13. C. OT screened all residents who sit in recling chairs for positioning issues on 5-22-13. D. An audit of 100% of resident call lights to ensure cll lights were in reach, was conducted on 5-23-13. E. 100% of all residents with bed alarms was conducted on 5-23-13 to ensure alarms were in place and functioning. F. The staff was re-inserviced on call lights and alarms on 5-20-13 and 5-21-13. G. Nursing staff was reinserviced on pain, behaviors, care plans, call lights, bed alarms, and positioning on 5-20-13 and 5-21-13. H. Therapy was inserviced 5-30-13 on the new communication form which will be completed to alert nursing to pain issues during therapy session. VI. The facility will monitor actions as follows: A. The licensed nursing staff will complete pain</p>	

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	<p>resident continued to have facial grimacing. The resident indicated her pain was not better. The resident indicated she wanted to go to bed. A CNA on the unit was informed.</p> <p>Resident #123 record was reviewed on 5/15/13 at 2:10 p.m. The Resident diagnoses included, but were not limited to, presenile dementia with agitation, insulin dependent diabetes, malignant neoplasm of the breast (breast cancer), gait ataxia (shuffled walk), and anxiety. The resident was admitted to the facility on May 1, 2013.</p> <p>A care plan for pain related to impaired cognition was initiated on 5/10/13. The approach/intervention indicated to give pain medications as ordered.</p> <p>The May 2013 Physician Recapitulation orders and May 2013 MAR (Medication Administration Record) did not indicate pain medication had been ordered.</p> <p>An OT (Occupational Therapy) initial evaluation dated 5/2/13, indicated the resident had periodic pain but was unable to rate. The evaluation indicated the resident grimaced at the end of range of motion exercises to</p>		<p>assessments upon admission, quarterly, and prn. The nurses will notify the physician if the pain assessments indicate the resident's pain is not being controlled. B. Therapy will complete the pain communication form if a resident complains of pain during a therapy session. Therapy will give the completed form to the licensed nurse, who will follow-up with the physician. C. Therapy will perform screens on admission, quarterly and as needed. D. Nurses will observe all residents for call light and alarm placement during daily care rounds. Any issues will be addressed immediately. E. Nurses Aides, for each shift, will observe all residents on their assignment at the beginning and end of their shift, to ensure call lights and alarms are in place and functioning properly. Any issues will be addressed promptly. F. Social Services will audit all behavior care plans and update them as needed monthly. This will be on-going until 100% compliance is achieved. G. DON/Designee will monitor pain assessments upon admission, quarterly, and prn for completion and accuracy. H. Don/Designee will audit therapy communication forms, to ensure the issues have been addressed by the licensed nurse and the MD if applicable. I. The DON/Designee will audit all call light and bed alarm audits weekly, until 100% compliance is</p>	

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	<p>the bilateral upper extremities, especially the shoulders.</p> <p>A PT (Physical Therapy) initial evaluation dated 5/2/13, indicated the resident was unable to rate her pain. The evaluation indicated the resident had grimaced at the end of the range of motion to the bilateral lower extremities. A FACES scale was rated at 4/10 (0 being no pain and 10 being a lot of pain).</p> <p>Resident #123 record was reviewed again on 5/16/13 at 8:35 a.m. A physician order for Norco 5/325 mg (milligrams) 1 tab by mouth every four hours as needed prn for pain, was ordered at 9:30 p.m. on 5/15/13.</p> <p>An OT daily therapy note dated 5/13/13, indicated the resident was "calling out at times." The treatment diagnosis for therapy was joint pain to the shoulder.</p> <p>An OT daily therapy note dated 5/14/13, indicated during range of motion to all upper extremely joints, the resident was "calling out at the end range of shoulder joints." The treatment diagnosis for therapy was joint pain to the shoulder.</p> <p>A PT progress note dated 5/15/13,</p>		<p>achieved. J.The Department Heads will monitor call light placement and alarm placement during their daily rounds. Their audits will be completed and given to the CEO at the morning meeting M-F. K. The Administrator/Designee will review all audits at the monthly QA meeting and quarterly at the QA meeting with the Medical Director. V. This constitutes our allegation of compliance with all regulatory requirements. Our date of compliance is 6-2-13.</p>		

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	<p>indicated the resident would holler (yell) while performing ROM (range of motion) to BLE (bilateral lower extremities) but was unable to rate the pain and unable to describe her symptoms.</p> <p>An OT progress note dated 5/15/13, indicated "Pt (Patient) calling out at times...Pt. grimaces at end range PROM (passive range of motion) BUE's (bilateral upper extremities), esp. (especially) shoulders, though is unable to rate type or level of pain. Pt. generally has few verbalizations, but occasionally responds appropriately to simple questions." The treatment diagnosis for therapy was joint pain to the shoulder.</p> <p>An OT daily therapy note dated 5/16/13, indicated resident "calls out at times." The treatment diagnosis for therapy was joint pain to the shoulder.</p> <p>On 5/13/13 at 12:00 p.m., staff indicated the resident had been yelling out since admission.</p> <p>On 5/16/13 at 8:25 a.m., the DoN stated "that is how the resident communicates." In clarification, the DoN indicated when Resident #123 yells, it was how she communicated</p>			

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	<p>and the ADoN indicated the resident would yell out her answers when staff had asked her questions.</p> <p>On 5/16/13 at 9:45 a.m., PT #12 indicated the therapists would inform nursing staff of the resident's progress or anything significant to their daily care, but they do not inform them of their pain because they were already being assessed for their pain medication.</p> <p>On 5/16/13, at 11:45 a.m., LPN #1 indicated the resident had pre senile dementia and this contributed to her yelling out versus the resident being in pain. LPN #1 was not aware of the resident having pain during therapy. LPN #1 indicated the coccyx wound was superficial and shouldn't be painful and he had asked the resident in the past if she was in pain when she would yell out. LPN #1 indicated the resident would first say yes to pain and then a few minutes later she would say no, so she was "wishy washy" and due to her dementia, he didn't know if she was in pain. LPN #1 indicated the resident was not on pain medication in the hospital. LPN #1 also indicated the staff would need to maintain the residents dignity, as in keeping the resident in bed all day versus putting her to bed when she</p>			

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	<p>was in pain or uncomfortable. LPN #1 indicated the spouse informed him, the resident did not have breast cancer but a patch of skin cancer and he was upset with the breast cancer diagnosis, so the pain would not be cancer related. LPN #1 indicated he did not clarify the breast cancer diagnosis with the physician.</p> <p>Upon reviewing the resident's behavior record on 5/16/13 at 2:00 p.m., the DoN indicated, again, the resident did not have behaviors and it was the way she communicated. The DoN initiated the behavior monitoring record on 5/15/13 for socially inappropriate/disruptive behavior/sounds. The option to manage pain was not selected as an intervention.</p> <p>During an interview with the Administrator and the DoN on 5/17/13 at 9:00 a.m., the DoN indicated resident #123 had weekly pain assessments which indicated the resident did not have pain. The DoN also indicated communication between therapy and nursing was good and was not aware of therapy not informing the nursing staff reports of pain from residents.</p>				

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	<p>2. On 5/13/13 at 11:45 a.m., Resident #26 was observed in the skilled dining room, reclined in a geri chair, with his head off to the right side of the chair. The resident received his meal at 12:05 p.m., and was being fed by a family member, while his head remained off the right side of the chair. At 12:18 p.m., the resident's family member indicated Resident #26's head always had to be repositioned by the staff frequently. During this time, the DoN and CNA #2 repositioned the resident.</p> <p>On 5/13/13 at 12:40 p.m., Resident #26's head had fallen back off to the right side of the geri chair. CNA #2 was at the table sitting across the resident, feeding another resident. The wife continued to feed the resident in this position. There were other staffing personnel observed in the dining room, who did not attempt to repositioned the resident.</p> <p>On 5/15/13 at 9:00 a.m., Resident #26 was observed in his room, reclined in his geri chair, with his head on metal edge of the chair. The resident was observed to have had a concave cushion for his head that was flattened, a concave trunk cushion and was sitting on a pommel cushion.</p>			

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	<p>On 5/15/13 at 10:00 a.m., Resident #26 was observed in bed. Resident #26 continued to favor his head to the right side, near the wall.</p> <p>On 5/15/13 at 3:45 p.m., Resident #26 was observed in bed with the top of his head was pressed against the wall. The touch pad call light was on the bedside table, which was located at the foot of the bed and the bed pad alarm was observed to be unplugged. The resident's door was half way shut, and the resident could not be seen from the hallway. Two large pillows was observed to be fluffed and tucked under the fitted sheet, preventing the resident from getting out of bed.</p> <p>Resident #26's record was reviewed on 5/15/13 at 9:00 a.m. Resident #26's diagnoses included, but were not limited to, Parkinson's, dementia, and acute respiratory failure.</p> <p>A care plan for risk for fall was initiated on 1/11/13. The approaches/interventions were not dated, but indicated to "reinforce safety awareness, resident lays self on floor to fix wheel chair at times-wiggles out. Wife aware-risk and benefits explained. Falling star</p>				

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	<p>program to increase supervision."</p> <p>An OT (Occupational Therapy) note dated 1/24/13, indicated the resident had "an impairment of decreased postural awareness - slumped sitting posture and decreased cardiopulmonary condition - limited tolerance for activity."</p> <p>An OT note dated 1/25/13, indicated the resident was positioned in layback chair; was not able to tolerate an incrediback (concave fitting) wheel chair and was sliding out due to increased extensor tone.</p> <p>A Side Rail Assessment Screen dated 2/6/13, indicated the resident was not able to get out of bed unassisted, was not able to turn from side to side unassisted while in bed, did not attempt to get out of bed unassisted, and the resident did have alterations in safety awareness due to cognitive decline.</p> <p>An OT discharge note dated 2/8/13, indicated Resident #26 needed total assistance during meals. The resident had been in a "layback" chair, leans to the right at times and was observed to have had an increased extensor tone with a need for repositioning to improve posture</p>				

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	<p>and interaction with environment. The note also indicated the staff had been instructed on appropriate positioning and feeding, with a good understanding demonstrated.</p> <p>A Fall Risk Assessment dated 4/9/13 and 4/19/13, indicated the resident was a high risk for falls and the resident had fallen 1-2 times in the past three months.</p> <p>A care plan for physical mobility impaired due to diagnosis of Parkinson's was updated on 4/10/13. The approaches/interventions indicated "therapy per order, staff assist as indicated, educate on call light use and asking for assist, contact MD and family as indicated."</p> <p>A nursing note dated 4/19/13 at 11:30 a.m., indicated the resident was found on floor in front of the window, lying on his back, trying to fix his chair. The note indicated the resident stated, "I wiggled out of my chair to fix the wire under it."</p> <p>A nursing note dated 4/19/13 at 8:30 p.m., indicated Resident #26 had "wiggled out of chair and had a fall. Res. (resident) needs to be positioned frequently and will "wiggle an wiggle."</p>			

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	<p>A nursing note dated 5/10/13 at 7:00 p.m., indicated the resident was in his geri chair in his room, was "wiggling", and caught his leg and received a 7 cm (centimeter) by 2 cm abrasion to his front lower right leg.</p> <p>A CNA care plan was provided by the DoN on 5/16/13 at 1:00 p.m. The CNA care plan indicated the resident had a bed alarm only.</p> <p>An interview with LPN #10 on 5/15/13 at 8:15 a.m., indicated the staff had tried multiple things with the resident for positioning and have been unsuccessful. LPN #10 indicated that if the resident was able to get his fingers to the end of the arm of the chair, he would pull himself down. LPN #10 indicated the geri chair had worked best for the resident and he did need frequent repositioning due to his continued "squirming". LPN #10 indicated a bariatric bed was used for the resident due to his "squirming."</p> <p>An interview with the SSD (Social Service Director) on 5/15/13 at 10:30 a.m., indicated Resident #26's wife did not want him moved closer to the nurses station. SSD indicated the staff was on alert about the resident's frequent position changes.</p>			

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	<p>An interview with OT #11 on 5/15/13 at 11:30 a.m., indicated she had not been made aware of the resident's positioning problems. OT #11 indicated therapy did try an incrediback wheel chair (concave fitting) but was unsuccessful. OT #11 indicated no other cushions had been attempted. OT stated, "Resident may need to be re-screened if they are having to reposition him often".</p> <p>An interview with PT #12 on 5/15/13 at 11:45 a.m., indicated he had not been made aware of the resident's positioning problems. PT #12 indicated a high back wheel chair was borrowed from a resident (who wasn't using his) was attempted and failed. PT #12 indicated the resident was stiff and rigid. PT #12 indicated the Broada (prevents head from falling off chair) chair had not been attempted due to no availability of a chair. PT #12 indicated the staff had not informed therapy of the resident's positioning problems and with meal service. PT #12 indicated he would look to re-evaluate the resident.</p> <p>The DoN on 5/15/13 at 11:55 a.m., indicated the resident was being discussed in the morning meeting on "Tuesday" for a Broda chair. The</p>			

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	<p>DoN indicated the resident was constantly being repositioned, had head bolsters in his wheelchair, this was his third time being in the facility, and the resident's spouse can be interviewed about the frequent repositioning. The DoN indicated their corporation owns the equipment company.</p> <p>An interview with CNA #13 on 5/15/13 at 4:00 p.m., indicated other CNAs had told her to put pillows under the fitted sheets to keep the resident's legs in bed because he "squirms" so much. CNA #13 indicated she was not aware of the call light not being within the resident's reach or the bed alarm not being plugged in. CNA #13 indicated she was in the resident's room approximately 15 minutes prior and had cleaned the resident. CNA #13 indicated she frequently checks on the resident.</p> <p>An interview with the resident's spouse on 5/16/13 at 11:15 a.m., indicated she was not aware of the facility looking into ordering a Broda chair for the resident.</p> <p>An interview with CNA #14 on 5/16/13 at 11:30 a.m., indicated she was new to the facility and this was her first week on her own on the unit. CNA</p>			

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	<p>#14 indicated she was told by the night shift CNA, not to put pillows under the fitted sheet since it was considered a restraint. CNA #14 indicated other CNAs had been putting the pillows under the fitted mattress.</p> <p>3.1-37(a)</p>			

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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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. Based on observation, record review and interview, the facility failed to ensure a resident head was positioned correctly when up in a geri chair for meals/in his room, place the bed in lowest position, and bed alarm to be plugged in for 1 of 36 residents reviewed for accidents and supervision.</p> <p>Findings include:</p> <p>On 5/13/13 at 11:45 a.m., Resident #26 was observed in the skilled dining room, reclined in a geri chair with his head off to the right side of the chair. The resident received his meal at 12:05 p.m., and was starting to be fed by a family member while his head remained off the right side of the chair. At 12:18 p.m., the resident's family member indicated Resident #26's head never stays up and the staff has to reposition the resident frequently. During this time, the DoN and CNA #2 repositioned the resident.</p>	F000323	<p>It is the intent of the facility to comply with all Federal regulations related to ensuring the residents remain as free of accidents hazards as possible; and each resident receives adequate supervision and assistance devices to prevent accidents. I. The actions taken by the facility are as follows:A. Resident # 26 spouse was educated on not removing bed alarms and call lights, when in facility visiting the resident. The spouse left without telling the staff the alarm and call light was not in place and functioning.B. A new wheel chair for resident #26 was ordered 5-29-13.C. OT screened resident #26 for positioning and was placed on case load.D. Resident #26 bed alarm was reconnected and the call light was put within the resident's reach.E. Resident #26 bed was placed in lowest position.F. A new scoop mattress was ordered for resident #26 on 5-29-13.II. The facility's actions taken to identify other residents are as follows:No other residents were identified.III. The measures put into place by the facility are as follows:A. An audit of all call light was conducted on</p>	06/03/2013

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	<p>On 5/13/13 at 12:40 p.m., Resident #26's head had fallen back off to the right side of the geri chair. CNA #2 was at the table sitting across the resident, feeding another resident. The wife continued to feed the resident in this position. There were other staffing personnel observed in the dining room, who did not attempt to repositioned the resident.</p> <p>On 5/15/13 at 9:00 a.m., Resident #26 was observed in his room, reclined in his geri chair with his head on metal edge of the chair. The resident was observed to have a concave cushion for his head which was flattened, a concave trunk cushion and was sitting on a pommel cushion.</p> <p>On 5/15/13 at 10:00 a.m., Resident #26 was observed in bed. Resident #26 continued to favor his head to the right side, near the wall. The resident's bed was observed not to be in the lowest position.</p> <p>On 5/15/13 at 3:45 p.m., Resident #26 was observed down in his bed with the top of his head pressed against the wall. The bed pad alarm was observed to be unplugged. The resident's door was half way shut, and the resident could not be seen</p>		<p>5-23-13 to ensure lights were in place and functioning properly.B. An audit of all bed alarms was conducted on 5-23-13 to ensure all alarms were in place and functioning.IV. The facility will monitor actions as follows.A. The Department Heads will round the building daily M-F and will audit call light placement/functioning as well as alarm placement/functioning. The results of the audits will be given to the CEO at the morning meeting.B. Nurses will observe for call light placement and alarm placement during their daily care of residents. Any issues will be addressed promptly.C. Nurse Aides will observe for call light and alarm placement at the beginning and the end of their shift. Any concerns will be addressed promptly.D. DON/Designee will review all bed alarm and call light audits weekly, until 100% compliance is achieved.E. The Administrator will review all audits at the weekly QA meeting and the quarterly QA meeting with the Medical Director.V. This constitutes our allegation of compliance to all regulatory requirements. Our date of compliance is 6-3-13.</p>		

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	<p>from the hallway. Two large pillows was observed to be fluffed and tucked under the fitted sheet, preventing the resident from getting out of bed.</p> <p>Resident #26's record was reviewed on 5/15/13 at 9:00 a.m. Resident #26's diagnoses included, but were not limited to, Parkinson's, dementia, and acute respiratory failure.</p> <p>A care plan for risk for fall was initiated on 1/11/13. The approaches/interventions were not dated, but indicated to "reinforce safety awareness, resident lays self on floor to fix wheel chair at times-wiggles out. Wife aware-risk and benefits explained. Falling star program to increase supervision."</p> <p>An OT (Occupational Therapy) note dated 1/24/13, indicated the resident had "an impairment of decreased postural awareness - slumped sitting posture and decreased cardiopulmonary condition - limited tolerance for activity."</p> <p>An OT note dated 1/25/13, indicated the resident was positioned in layback chair; was not able to tolerate an incrediback (concave fitting) wheel chair and was sliding out due to increased extensor tone.</p>			

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	<p>A Side Rail Assessment Screen dated 2/6/13, indicated the resident was not able to get out of bed unassisted, was not able to turn from side to side unassisted while in bed, did not attempt to get out of bed unassisted, and the resident did have alterations in safety awareness due to cognitive decline.</p> <p>An OT discharge note dated 2/8/13, indicated Resident #26 needed total assistance at meals. The resident had been in a "layback" chair, leans to the right at times and was observed to have had an increased extensor tone with a need for repositioning to improve posture and interaction with environment. The note also indicated the staff had been instructed on appropriate positioning and feeding, with a good understanding demonstrated. The resident was referred to restorative program.</p> <p>A Fall Risk Assessment dated 4/9/13 and 4/19/13, indicated the resident was a high risk for falls and the resident had fallen 1-2 times in the past three months.</p> <p>A care plan for physical mobility impaired due to diagnosis of</p>			

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	<p>Parkinson's was updated on 4/10/13. The approaches/interventions indicated "therapy per order, staff assist as indicated, educate on call light use and asking for assist, contact MD and family as indicated."</p> <p>A nursing note dated 4/19/13 at 11:30 a.m., indicated the resident was found on floor in front of the window, lying on his back trying to fix his chair. The note indicated the resident stated, "I wiggled out of my chair to fix the wire under it."</p> <p>A nursing note dated 4/19/13 at 8:30 p.m., indicated Resident #26 had "wiggled out of chair and had a fall. Res. (resident) needs to be positioned frequently and will "wiggle an wiggle."[sic]</p> <p>A nursing note dated 5/10/13 at 7:00 p.m., indicated the resident was in his geri chair in his room, was "wiggling", and caught his leg and received a 7 cm (centimeter) by 2 cm abrasion to his front lower right leg.</p> <p>A CNA care plan was provided by the DoN on 5/16/13 at 1:00 p.m. The CNA care plan indicated the resident had a bed alarm only.</p> <p>An interview with LPN #10 on 5/15/13</p>			

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	<p>at 8:15 a.m., indicated the staff had tried multiple things with the resident for positioning and had been unsuccessful. LPN #10 indicated that if the resident was able to get his fingers to the end of the arm of the chair, he would pull himself down. LPN #10 indicated the geri chair had worked best for the resident and he did need frequent repositioning due to his continued "squirming". LPN #10 indicated a bariatric bed was used for the resident due to his "squirming."</p> <p>An interview with the SSD (Social Service Director) on 5/15/13 at 10:30 a.m., indicated Resident #26's wife did not want him to be moved closer to the nurses station. SSD indicated the staff was on alert about the resident's frequent position changes.</p> <p>An interview with OT #11 on 5/15/13 at 11:30 a.m., indicated she had not been made aware of the resident's positioning problems. OT #11 indicated therapy did try an incrediback wheel chair (concave fitting) but was unsuccessful. OT #11 indicated no other cushions had been attempted. OT #11 stated, "Resident may need to be re-screened if they are having to reposition him often".</p> <p>An interview with PT #12 on 5/15/13</p>						

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	<p>at 11:45 a.m., indicated he had not been made aware of the resident's positioning problems. PT #12 indicated a high back wheel chair was borrowed from a resident (who wasn't using his) was attempted and failed. PT #12 indicated the resident was stiff and rigid. PT #12 indicated the Broada (prevents head from falling off chair) chair had not been attempted due to no availability of a chair. PT #12 indicated the staff had not informed therapy of the resident's positioning problems and with meal service. PT #12 indicated he would look to re-evaluate the resident.</p> <p>The DoN on 5/15/13 at 11:55 a.m., indicated the resident was being discussed in the morning meeting on "Tuesday" for a Broda chair as well as two other residents. The DoN indicated the resident was constantly being repositioned, had head bolsters in his wheelchair, this was his third time being in the facility, and the resident's spouse can be interviewed about the frequent repositioning. The DoN indicated their corporation owned the equipment company.</p> <p>An interview with CNA #13 on 5/15/13 at 4:00 p.m., indicated other CNAs had told her to put pillows under the fitted sheets to keep his legs in bed</p>				

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	<p>where he "squirms" all the time. CNA #13 indicated she was not aware of the call light not being within reach to the resident or the bed alarm not being plugged in. CNA #13 indicated she was in the resident's room approximately 15 minutes prior and had cleaned the resident. CNA #13 indicated she frequently checks on the resident.</p> <p>An interview with the resident's spouse on 5/16/13 at 11:15 a.m., indicated she was not aware of the facility looking into ordering a Broda chair for the resident.</p> <p>An interview with CNA #14 on 5/16/13 at 11:30 a.m., indicated she was new to the facility and this was her first week on her own on the unit. CNA #14 indicated she was told by the night shift CNA, not to put pillows under the fitted sheet that it was considered a restraint. CNA #14 indicated other CNAs had been putting the pillows under the fitted mattress.</p> <p>An interview with the DoN on 5/17/13 at 9:00 a.m., indicated she did not have a fall policy and the Falling Star program was for residents who had a history of falls. The DoN indicated the residents were assigned to a staff</p>			

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	<p>member, who would evaluate the resident, review their care plans, and update staff on any changes related to the interventions.</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p>			

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F000329 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 and interview, the facility failed to ensure residents' were free of unnecessary medications, related to an antipsychotic medication administered to a resident without thoroughly assessing the reason for the behavior, and a lack of gradual dose reductions of antianxiety and antidepressant medications for 3 of 10 residents reviewed for unnecessary medications. (Residents #23, #37, and #83)</p>	F000329	<p>The facility's intent is to comply with regulations that requires each resident will be free from any unnecessary medications. I. The actions taken by the facility are as follows:A. The physician of resident #37 was contacted on 5-29-13. The resident's ordered Trazadone was reduced.B. Resident #83 was admitted from the hospital with prn Ativan for anxiety related to the dx. of COPD.C. The physician was contacted for resident #123 on 5-15-13 and the prn Haldol was discontinued. Pain medication for</p>	06/03/2013			

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	<p>Findings include:</p> <p>1. Resident #37's record was reviewed on 5/15/13 at 3:15 p.m. The resident was admitted into the facility on 05/23/11. The resident's diagnoses included, but were not limited to, insomnia, dementia, and depression.</p> <p>The Annual MDS (Minimal Data Set) Assessment, dated 2/21/13, indicated the resident was cognitively intact, had no mood or depression signs or symptoms, no behaviors, and received an antidepressant the past seven days.</p> <p>The care plan, dated 2/28/13, indicated the resident had insomnia and received an antidepressant. The interventions included, reduce lighting, reduce noise level, offer snacks, offer neck/back massage, observe medication reactions, and gradual dose reduction (GDR) per policy.</p> <p>A physician's order, dated 5/25/11, indicated trazadone(antidepressant) 50 mg (milligram) at bedtime.</p> <p>A physician's order, dated 8/24/11, indicated to increase the trazadone to</p>		<p>this resident was ordered.II. The facility's actions taken to identify other residents are as follows:No other residents were identified.III. The measures put into place by the facility are as follows:A. An audit of all residents on antipsychotic and psychotropic meds was conducted on 5-21-13 by the pharmacy consultant, for gradual dosage reductions and unnecessary medications.B. Licensed nurses were inserviced on 5-20-13 nad 5-21-13 for gradual dosage reductions, unnecessary meds, behavior forms, and pain assessments.C. DON/Designee as well as Social Seervice Director will review monthly all gradual dosage reductions and unecessary meds, per the pharmacy consultant report. Recommendations from this report will be promptly forwarded to the MD.D. The DON/Designee will review pain assessments upon admission, quarterly, and as needed.E. The DON/Designee will contact the physician of all recommended gradual dosage reductions.F. The Social Service Director/Designee will monitor all gradual dosage reductions, as ordered.IV. The facility will monitor actions as follows:A. The DON and Social Service Director will monitor all physician correspondence related to gradual dosage reductions.B. Social Service Director will monitor for adverse reactions to ordered medication, per behavior</p>	

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	<p>75 mg every bedtime.</p> <p>The resident's Physician's Recapitulation Orders, dated 4/13, indicated the resident was still receiving the trazadone 75 mg at bedtime for sleep.</p> <p>The Psychological Consult, dated 7/24/12, 8/28/12, 9/25/12, and 12/4/12, indicated the resident received the trazadone 75 mg every night for chronic sleep disturbance, and the area for GDR was checked to indicate the GDR was clinically contraindicated to prevent worsening function. There was a lack of documentation to indicate why a GDR would worsen the resident's functioning.</p> <p>The Psychological consult, dated 1/15/13, indicated the resident was on trazadone 75 mg every night for chronic sleep disturbance and resident was improving, and the consults, dated 2/19/13, 3/19/13, and 4/15/13, indicated the resident received the trazadone 75 mg every night for chronic sleep disturbance, and the area for GDR was checked to indicate the GDR was clinically contraindicated to prevent worsening function. There was a lack of documentation to indicate why a GDR</p>		<p>form.C. Nursing will monitor for adverse reactions to med every shift and notify MD if present.D. Licensed staff will promptly notify the physician of any mood or behavior changes.E. The Administrator/Designee will review all audits monthly at th QA meeting and quarterly at the QA meeting with the Medical Director.V. This constitutes our allegation of compliance to all regulatory requirements. Date of Compliance is 6-3-13.</p>		

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	<p>would worsen the resident's functioning.</p> <p>The Physician's/Nurse Practitioner progress notes, dated Dr./NP progress notes, dated December 5, 12, 19, 2012, January 2, 9, 23, 30, 2013, February 6, 13, 24, 20, 27, 2013, March 20 and 28, 2012, April 3, 10, 17, 2013, and May 1 and 15, 2013, lacked documentation for the reason for the trazadone or why a GDR was not completed.</p> <p>The Physician's progress note, dated March 13, 2013 indicated the resident had insomnia.</p> <p>The Pharmacy recommendations, received from the Medical Records Clerk as the only recommendations since 06/2012, indicated recommendations on 12/27/12, 1/25/13, 3/4/13 and 3/20/13. The Pharmacy recommendations lacked documentation for a recommendation to GDR the trazadone.</p> <p>The Nurses' Notes, dated 4/23/13 at 9 p.m., indicated the resident received antidepressants related to insomnia and gets 6-8 hours sleep per night, without signs and symptoms of fatigue.</p>			

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	<p>During an interview on 5/16/13 at 7:45 a.m., the Director of Nursing indicated she had notified the resident's Physician about the trazadone and the Physician indicated the trazadone was for appetite not for sleep.</p> <p>During an interview on 05/16/13 at 9:03 a.m., the Social Service Director indicated the Director of Nursing monitors the psychotropic mediations. She indicated she just monitors for resident behaviors, which the resident had no behaviors. She indicated she was not involved with the psychotropic medications.</p> <p>2. Resident #83's record was reviewed on 5/15/13 at 2:33 p.m. Resident #83's diagnoses included, but were not limited to, chronic obstruction pulmonary disease (lung disease) and depression.</p> <p>The Quarterly Minimum Data Set (MDS) Assessment, dated 4/5/13, for Resident #83 indicated resident was cognitively intact and received Antianxiety and Antidepressant medication 7 times within the last 7 days. Mood interview conducted and indicated resident had no symptoms of feeling down or depressed, having trouble concentrating on things, and not feeling fidgety or restless. The</p>						

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	<p>behavior assessment indicated the resident had no symptoms of psychosis and there were no behavioral, verbal or physical symptoms indicated.</p> <p>A care plan dated 4/5/13, indicated Resident #83 became anxious when she gets short of breath (SOB), and resident was to receive Ativan (antianxiety) as ordered.</p> <p>A pharmacy recommendation dated 9/26/12, indicated the Ativan was being given to the resident without a supporting diagnosis. The physician indicated on 10/3/12, the resident had anxiety.</p> <p>A pharmacy recommendation dated 2/27/13, indicated the resident had been on Ativan 0.5 mg (milligrams) twice a day since 7/18/12, and recommended a gradual dose reduction (GDR). The physician indicated on 3/10/13, he disagreed with the recommendation and indicated the resident had chronic COPD (congestive obstructive pulmonary disease) and emphysema. There was a lack of documentation to indicate why a GDR was contraindicated.</p> <p>On 5/15/13 at 2:49 p.m., the Social</p>			

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	<p>Service Director was interviewed and indicated there have been no behaviors reported to her and also indicated the facility does not monitor anyone receiving an anti-anxiety medication.</p> <p>An interview with the DON (Director of Nursing) on 5/15/13 at 3:30 p.m., indicated the resident was taking Ativan for COPD exacerbation and had not had any anxiety since being on the medication. The DON indicated the facility did not monitor the effectiveness unless the resident was having problems and the physician did not want to do a GDR. The DON reviewed Resident #83's record and had no further information regarding why the reduction of the Ativan was contraindicated.</p> <p>3. On 5/13/13 from 12:00 p.m. to 12:30 p.m., Resident #123 was observed to be restless and was yelling out in the skilled dining room. The resident had facial grimacing. During this time, the DoN was observed walking over to the resident, patted her hand, reassured her, and then walked away. The resident was not asked if she was in pain. No other nurse or CNA had addressed the resident yelling.</p> <p>On 5/13/13 at 2:30 p.m., Resident</p>			

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	<p>#123 was heard yelling out from her room.</p> <p>On 5/14/13 at 10:30 a.m., Resident #123 was heard yelling out from her room. The resident was observed to have facial grimacing and was restless in her geri chair.</p> <p>On 5/15/13 at 12:00 p.m., Resident #123 was observed yelling out in the skilled dining room.</p> <p>On 5/16/13 at 8:15 a.m., Resident #123 was observed in her room, partially sitting up in her geri chair, moving her legs up and down. The resident indicated she was in pain and she hurt all over. LPN #1 was informed, chuckled and indicated the resident did get pain medication ordered last evening.</p> <p>On 5/16/13 at 9:20 a.m., Resident #123 was observed in her room, in her geri chair, partially sliding down with her right knee bent and left leg crossed over the right knee. The resident continued to have facial grimacing. The resident indicated her pain was not better. The resident indicated she wanted to go to bed. A CNA on the unit was informed.</p> <p>Resident #123's record was reviewed</p>			

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	<p>on 5/15/13 at 2:10 p.m. Resident #123's diagnoses included, but were not limited to, presenile dementia with agitation, insulin dependent diabetes, malignant neoplasm of the breast (breast cancer), gait ataxia (shuffled walk), and anxiety. The resident was admitted to the facility on May 1, 2013.</p> <p>A care plan for pain related to impaired cognition was initiated on 5/10/13. The approach/intervention indicated to give pain medications as ordered.</p> <p>The May 2013 Physician Recapitulation orders and May 2013 MAR (Medication Administration Record) did not indicate pain medication had been ordered but had indicated to give 0.2 ml (milliliters) of Haldol 0.5 mg/2 ml, IM (intramuscular) every 6 hours as needed for agitation.</p> <p>Resident #123's record was reviewed again on 5/16/13 at 8:35 a.m. A physician order for Norco 5/325 mg (milligrams) 1 tab by mouth every four hours as needed for pain, was ordered at 9:30 p.m. on 5/15/13.</p> <p>A Behavior/Check off list for behaviors exhibited was completed</p>			

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	<p>on 5/13/13 at 7:30 a.m. The form indicated the resident was "yelling out..bucking in geri chair." The interventions attempted before Haldol was given at 6:30 a.m., was the resident was removed from the environment. At 7:00 a.m., "TV". No time indicated, but different staff tried to intervene. The Haldol was given at 7:30 a.m. At 9:00 a.m., the resident began to calm down.</p> <p>An OT daily therapy note dated 5/13/13, indicated the resident was "calling out" at times.</p> <p>An OT daily therapy note dated 5/14/13, indicated range of motion to all upper extremely joints, with the resident "calling out at the end range of shoulder joints."</p> <p>A Behavior Check off list for behaviors exhibited was completed on 5/14/13 at 10:00 p.m. The form indicated the resident was "excessive yelling and high amount of anxiety." The interventions attempted before Haldol was given at 8:00 p.m., was the resident was removed from the environment, at 8:15 p.m., "TV", at 8:30 p.m., different staff tried to intervene, and at 9:00 p.m., a snack was provided. Other interventions included repositioning and her brief</p>			

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	<p>was changed. The Haldol was administered at 9:00 p.m., and the resident was asleep by 10:00 p.m.</p> <p>A PT progress note dated 5/15/13, indicated the resident would holler (yell) while performing ROM (range of motion) to BLE (bilateral lower extremities) but was unable to rate the pain and unable to describe her symptoms.</p> <p>An OT progress note dated 5/15/13, indicated "Pt (Patient) calling out at times...Pt. grimaces at end range PROM (passive range of motion) BUE's (bilateral upper extremities), esp. (especially) shoulders, though is unable to rate type or level of pain. Pt. generally has few verbalizations, but occasionally responds appropriately to simple questions." The treatment diagnosis for therapy was joint pain to the shoulder.</p> <p>An OT daily therapy note dated 5/16/13, indicated resident "calls out at times." The treatment diagnosis for therapy was joint pain to the shoulder.</p> <p>On 5/13/13 at 12:00 p.m., a CNA indicated the resident yells out all the time and had been doing it since admission.</p>			

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	<p>An interview with the SSD (Social Service Director) on 5/15/13 at 10:20 a.m., indicated she believed nursing was looking at the resident's pain. The SSD indicated Psych was recently referred due to her being a new admit.</p> <p>On 5/16/13 at 8:25 a.m., the DoN stated "that is how the resident communicates." In clarification, the DoN indicated when Resident #123 yells, that was how she communicated and the ADoN indicated the resident would yell out her answers when staff would ask her questions.</p> <p>On 5/16/13 at 9:45 a.m., PT #12 indicated the therapists would inform nursing staff of the resident's progress or anything significant to their daily care, but they do not inform them of their pain because they were already being assessed for their pain medication.</p> <p>On 5/16/13, at 11:45 a.m., LPN #1 indicated the resident had pre senile dementia and this contributed to her yelling out versus the resident being in pain. LPN #1 was not aware of the resident having pain during therapy. LPN #1 indicated the coccyx wound</p>			

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	<p>was superficial and shouldn't be painful and he had asked the resident in the past if she was in pain when she would yell out. LPN #1 indicated the resident would first say yes to pain and then a few minutes later she would say no, so she was "wishy washy" and due to her dementia, he didn't know if she was in pain. LPN #1 indicated the resident was not on pain medication in the hospital. LPN #1 also indicated having to maintain the residents dignity, as in keeping the resident in bed all day versus putting her to bed when she was in pain or uncomfortable. LPN #1 indicated the spouse informed him, the resident did not have breast cancer but a patch of skin cancer and he was upset with the breast cancer diagnosis, so the pain would not be cancer related. LPN #1 indicated he did not clarify the breast cancer diagnosis with the physician.</p> <p>Upon reviewing the resident's behavior record on 5/16/13 at 2:00 p.m., the DoN indicated, again, the resident did not have behaviors and her yelling was the way she communicated. The DoN initiated the behavior monitoring record on 5/15/13 for socially inappropriate/disruptive behavior/sounds. The</p>			

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	<p>interventions/approaches were to move the resident to a quiet area, hold hand, turn on TV, turn off TV, and/or lay down for a nap. The option to manage pain was not selected. The psychoactive medication indicated was Depakote. Haldol 0.5 mg/ml, inject 0.2 ml every six hours as needed, was not listed as a psychoactive medication.</p> <p>A facility policy, dated 08/01/10, titled, "Behavior Management Psychotropic Medication Protocol", received from the Director of Nursing as current, indicated, "...Residents who receive antipsychotic, anti-depressant, sedative/hypnotic, or anti-anxiety medications are to be maintained at the safest, lowest dosage necessary to manage the resident's condition. Residents will be reviewed routinely for effectiveness and monitored for side effects of these medications and will receive gradual dose reductions, unless clinically contraindicated, in an effort to discontinue these drugs..."</p> <p>3.1-48(a)(6)</p>				

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F000356 SS=C	<p><b>483.30(e) POSTED NURSE STAFFING INFORMATION</b></p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> <li>o Facility name.</li> <li>o The current date.</li> <li>o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> <li>- Registered nurses.</li> <li>- Licensed practical nurses or licensed vocational nurses (as defined under State law).</li> <li>- Certified nurse aides.</li> </ul> </li> <li>o Resident census.</li> </ul> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> <li>o Clear and readable format.</li> <li>o In a prominent place readily accessible to residents and visitors.</li> </ul> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based observation, record review, and interview, the facility failed to post nurse staffing information in a clear and readable format in a place accessible to residents and visitors. This had the potential to affect all 95</p>	F000356	It is the intent of the facility to comply with the Federal regulation to post nurse staffing information in a clear and readable format in a place accessible to residents and visitors. I. The actions taken by	06/03/2013

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	<p>residents who live at the facility and their visitors.</p> <p>Findings include:</p> <p>On 5/13/13 at 12:00 p.m., an erasable board was observed hanging on the wall behind the nurses station above wheel chair level, where residents and/or their visitors cannot read easily.</p> <p>An interviewed with the Administrator on 5/16/13 at 4:50 p.m., indicated he would have the information placed so residents and visitors can read the information.</p> <p>3.1-13(a)</p>		<p>the facility are as follows:A. Nurse staffing information was placed in an accessible area to residents and visitors on 5-17-13.II. The facility's actions taken to identify other residents are as follows:All residents had the potential of being affected.III. The measures put into place by the facility are as follows:A. The Administrator/Designee will monitor monthly for the proper placement of the nursing staffing hours.B. The nursing staffing hours were moved to a readily accessible area for residents and visitors.IV. The Facility will monitor actions as follows:A. The Administrator/Designee will review all audits monthly at the QA meeting and quarterly at the QA meeting with the Medical Director.V. This constitutes our allegation of compliance to all regulatory requirements. Our date of compliance is 6-3-13.</p>	

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F000464 SS=E	<p>483.70(g) REQUIREMENTS FOR DINING &amp; ACTIVITY ROOMS The facility must provide one or more rooms designated for resident dining and activities.</p> <p>These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities.</p> <p>Based on observation and interview, the facility failed to provide sufficient space in the main dining room for meal times, related to residents being moved during meal time to allow food carts through, and allowing other residents in and out of the dining room freely during 1 of 1 meal time observed. This had the potential to effect 53 residents who eat meals in the main dining room. (main dining room)</p> <p>Findings include:</p> <p>1. During an observation on 5/13/13 at 12:19 p.m., in the Main Dining Room, the staff were serving the noon meal off a three tiered cart, with wheels. The area where the staff were to bring the food cart down the aisle to the end of the dining room was crowded with residents in wheelchairs sitting at the tables. The staff had to move the resident's wheelchairs, while they were eating to</p>	F000464	It is the facility's intent to comply with Federal regulation of providing sufficient space in the main dining room, for meal times, related to residents being moved during meal time to all for food carts through, and allowing for residents in and out of the dining room freely. I. The actions taken by the facility are as follows: A. Residents #16, resident #22 and resident # 78 asked if they would prefer to eat at a different table in the dining room. The residents chose to not move to a different table. B. The tables in the main dining room were arranged to ensure easy access for residents and meal carts to move in and out of the dining room. C. 100% audit of all residents who take their meals in the main dining room was conducted 5-15-13 to ensure safe entrance and exit from the dining room at meal times. II. The facility's actions taken to identify other residents are as follows: No other residents were affected. III. The measures put into place by the facility are as follows: A. Dietary and housekeeping staff were	06/03/2013			

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	<p>get the food cart to the back of the dining room to deliver the meal trays to the other residents.</p> <p>During the meal, Resident #16 could not exit the dining room independently due to the crowding of the dining room. The staff had to move other resident's out of the path so Resident #16 could leave the dining room.</p> <p>Findings include:</p> <p>2. During dining observation 5/13/13 at 12:10 p.m. Resident #78 and Resident #22 were observed sitting at a table in the back corner of the main dining room facing the wall. Resident #78 stated "We're in a hole we can't get out of." Resident #78 and Resident #22 indicated they were done eating and wanted to leave the dining room. The table in front of Resident #78 and Resident #22 had four resident's seated and there was no path for Resident #78 and Resident #22 to get out of the dining room without one of the residents at</p>		<p>inserviced on 5-20-13 and 5-21-13 for proper placement of tables to ensure safe entrance and exit into the main dining room during meal times. IV. The facility will monitor actions as follows: A. Dietary Manager/Designee will monitor daily for safe access for residents in and out of the main dining room B. Resident requested seating will be monitored on an as needed basis, per the resident request, by the Dietary Manager and Nursing. C. The Administrator/Designee will review audits monthly at th QA meeting and quarterly at the QA meeting with the Medical Director. V. This constitutes our allegation fo compliance. Date of compliance 6-3-13.</p>		

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	<p>the next table moving. Resident #22 stated "we have to wait until they're (referring to the residents at the next table) through."</p> <p>3.1-19(w)</p>			

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F000465 SS=E	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to ensure resident rooms were free from gauges in walls, splintered arm chairs and dressers, missing baseboards and clutter in the room for 3 of 4 wings observed.</p> <p>Findings include:</p> <p>On 5/16/13 from 3:15 p.m. to 3:40 p.m., an environmental tour was conducted with the Maintenance Supervisor and his assistant. The following was reviewed:</p> <p>Room 401-2: There were scratches/torn wallpaper behind the resident's recliner.</p> <p>Room 211-1: The baseboard by the closet had a long gauge taken out and base board missing by the closet and by the bathroom. The front of the dresser was splintered.</p> <p>Room 408-1: The corner wall by the bathroom door was gauged.</p> <p>Room 404-1: The wall by the closet was scraped with torn plaster and the</p>	F000465	<p>It is the intent of the facility to comply with all Federal regulations to provide a safe, functional and comfortable environment for the residents, staff and the public. I. The actions taken by the facility are as follows: A. The wallpaper was replaced for the resident in room #401-2. B. The base board was replaced in room #211-1. The family was contacted due to the resident's dresser being splintered. The family gave the facility permission to repair the dresser. C. The corner wall was repaired in room 408-1. D. The wall by the closet was repaired and the bedside chair was replaced in room 404-1. E. The baseboard and gorges were repaired in room 412-1. F. The gouges in the wall of room 413-2 was repaired. G. The resident who resides in room 308-2 was issued a letter from the Administrator related to having large plastic containers and other personal boxes in her room. The letter was dated and signed on 5-31-13. The resident was given 30 days to remove/rearrange belongings to provide a safe, uncluttered environment in her room. II. The facility's actions taken to identify other residents</p>	06/03/2013

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	<p>bedside chair had splintered arms.</p> <p>Room 412-2: A missing baseboard and gauges on the wall by the bathroom and by the closet.</p> <p>Room 413-2: The plastered walls were gauged outside the bathroom.</p> <p>Room 308-2: Resident side of the room was cluttered with large plastic containers and other personal boxes/belongings.</p> <p>An interview with the Maintenance Supervisor during this time indicated they are in the process of applying new kick plates and door guards on residents room. The 100 hall had been started. The Maintenance Supervisor made note of all the findings.</p> <p>3.1-19(f)</p>		<p>are as follows: No other residents were affected. III. The measures put into place by the facility are as follows: A 100% audit of resident rooms was conducted 5-31-13 to ensure all residents had a comfortable and safe environment. B. Repairs were initiated on the rooms which were cited during the survey. IV. The facility will monitor actions as follows: A. The Department Heads will make daily rounds and will monitor for environmental and safety issues. B. Any environmental issues noted while doing rounds will be promptly addressed with Maintenance or housekeepers. C. The Administrator will review results of the daily rounds and ensure the concerns are addressed by th appropriate department. D. All staff will fill out maintenance repair slips when concerns are noted. E. the Administrator/Designee will monitor the maintenance repair slips to ensure repairs are made in a timely manner. F. The Administrator/Designn will review results of all audits monthly at the QA meeting and quarterly at the QA meeting with the Medical Director. V. This constitutes out date of compliance to all regulatory requirements. Date of Compliance is 6-3-13.</p>				

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F000520 SS=G	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on record review and interview, the facility failed to identify non-compliance with investigations and reporting of all allegations of abuse, resident choices in relation to bathing, assessments for side rails, gradual dose reductions, the use of an antipsychotic medication versus assessing for pain, and communication between the therapy department and the nursing department in relation to pain and</p>	F000520	It is the intent of the facility to comply with all Federal regulations to identify non-compliance with investigations and reporting of allegations of abuse, resident choices in relation to bathing, assesments for side rails , gradual dose reductions, antipsychotic med use versus assessing for pain, and communication between therapy and nursing, in relation to pain and safety in positioning through the QA protocol. We are	06/03/2013

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	<p>safety in relation to positioning through the quality assurance protocol.</p> <p>Findings include: An interview with the Administrator and DoN on 5/17/12 at 9:00 a.m., indicated the facility's Quality Assurance Committee meets quarterly and consists of himself, the Director of Nursing, Assistant Director of Nursing, Department Heads, Pharmacy, as well as the Medical Director.</p> <p>The DoN indicated there was no action plan in place at this time with Quality Assurance. The DoN indicated all the month end reports of all the care areas are brought in for the quarterly meeting to review for trends. The DoN indicated, if there was a trend, an action plan would be developed, care plan would be updated as needed, the nursing staff would be notified by a 24 hour board and the nursing staff would give the CNA reports.</p> <p>The DoN indicated she had thought about making changes to choices with showers. The DoN indicated when she would receive the GDR from the pharmacy, she would notify the physicians and social service.</p> <p>The DoN indicated she was planning</p>		<p>requesting an IDR because of scope and severity. I. The actions taken by the facility are as follows:A. The allegation of abuse by resident #47 was reported to ISDH on 5-30-13. The investigation for the alegation was also completed on 5-30-13. B. Resident #14 was interviewed related to their choice for bathing. The resident chose to keep thier bathing on the same schedule. C. Resident #83 was interviewed on thier choice for bathing. This resident also chose to keep their bathing on the same schedule. D. A new side rail assessment was conducted for resident #67, The siderails on the bed of resident #67 were removed on 5-16-13. The POA was notified of the siderails being removed from resident #67 bed. The POA wanted the siderails placed back on the bed. Education was provided to the POA, on the risks of the siderails. The resident is not capable of turning themself in bed, is not ambulatory, and cannot transfer without assistance of staff. The sidrails were placed back on the bed on 5-17-13. E. The physician of resident # 37 was contacted on 5-29-13. The resident's ordered Trazadone was reduced. F. Resident #83 was admitted from the hospital with prn Ativan for anxiety related to the dx. of COPD. G.The physician was contacted for resient #123 on 5-15-13 and the prn Haldol was</p>				

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	<p>on involving the SSD more with GDR due to behavior management. The DoN indicated resident #123 had weekly pain assessments which indicated the resident did not have pain. The DoN also indicated communication between therapy and nursing was good and was not aware of therapy not informing the nursing staff reports of pain from residents.</p> <p>The Administrator indicated he was not aware of the policy indicating unsubstantiated allegations of abuse would not be reported to the state agency and he would review it with the corporation.</p> <p>1. During an interview on 5/13/13 at 11:35 a.m., Resident #47 indicated she had been treated roughly by staff. She indicated the situation had been handled by the Administrator, and the CNA involved had been terminated. Interview with the Administrator on 5/15/13 at 10:55 a.m. indicated there had been an allegation of rough treatment by Resident #47 involving a CNA dropping the resident versus lowering her to the floor during a transfer on 03/15/13. The Administrator did not indicate a date for the rough treatment allegation. The Administrator indicated the CNA was terminated.</p>		<p>discontinued. Pain medication for this resident was ordered. H. Resident #26 spouse was educated on not removing bed alarms and call lights, when in facility visiting the resident. The spouse left without telling the staff the alarm and call light was not in place and functioning. A new wheelchair for resident #26 was ordered 5-29-13 OT screened resident #26 for positioning and was placed on case load. Resident #26 bed alarm was reconnected and the call light was put within the resident's reach. Resident #26 bed was placed in lowest position. A new scoop mattress was ordered for resident #26. II.The facility's actions taken to identify other residents are as follows:A. No other residents were identified. B. All interviewable residents were contacted related to their bathing choices. Five residents wished to make changes to their current bathing schedule. C.All interviewable residents were contacted related to their bathing choices. Five residents wished to make changes to their current bathing schedule. D. 100% audit of side rails, as a restraint, was completed. No other residents were identified. E.No other residents were identified. F. No other residents were identified. G. No other residents were identified. III. The measures put into place by the facility are as follows: A. All alert and oriented</p>		

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	<p>During an interview with Administrator and Director of Nursing (DoN) on 5/15/13 at 2:33 p.m., the DoN (Director of Nursing) indicated on 3/15/13, Resident #47 was transferred from a wheelchair to the bed and the resident's leg gave out and the CNA lowered the resident to the floor. The DoN indicated Resident #47 transferred with one assist. The DoN indicated about a month later, on 4/12/13, Resident #47 requested that the CNA no longer care for her. The DoN indicated she did not know why the resident did not want the CNA to care for her. The DoN indicated the CNA had cared for the resident after the fall until the request was made on 04/12/13. The DoN indicated the first time the resident voiced a concern about the CNA was on 4/12/13. The DoN indicated no investigation had been completed after the resident had requested the CNA no longer take care of her.</p> <p>Further interview with the Administrator indicated the CNA refused to switch assignments and was terminated on 4/12/13. The Administrator was not sure why Resident #47 no longer wanted the CNA to care for her on 4/12/13 and indicated an investigation had not been completed and the Indiana</p>		<p>residents were interviewed related to abuse. All cognitively impaired residents received head to toe skin assessments. An all staff inservice was held 5-22-13 and 5-23-13 on abuse policy and reporting procedures. B. An all staff inservice , on resident chooices, was held on 5-22-13 and 5-23-13. All interviewable residents were approached regarding their choice of the type of bathing they prefer, the time of their bathing, and the frequency of their bathing. All new admissions will be given the choice of type of bathing, frequency of bathing, and time of bathing. The bathing sheet will be given to Medical Records for porper placement on the showed schedule. C. 100% audit of residents with side rails as restraints was conducted. New side rail assessments were completed on 100% of residents within the facility. An inservice was held 5-20-13 on side rails and restraints. D. Pain assessments were completed on all residents on 5-22-13. 100% audit of care plans, for residents who demonstrate behaviors, was completed on 5-28-13. OT screened all residents who sit in reclining chairs for positioning issues on 5-22-13. An audit of 100% of resident call lights to ensure call lights were in reach, was conducted on 5-23-13. 100% of all residents with bed alarms was conducted on</p>	

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	<p>State Department of Health (ISDH) had not been notified of the rough treatment.</p> <p>Resident #47's record was reviewed on 5/16/13 at 9:03 a.m. A nursing note dated 3/15/13 at 9:30 p.m. indicated "Res [Resident] was being transferred from chair to bed and res stated that her legs were giving out. CNAs assisted res to floor. Total body assessments completed. No injuries noted."</p> <p>During an interview with the DoN on 5/16/13 at 10:29 a.m., the DoN indicated there was no investigation completed because there was no fall. The DoN indicated Resident #47 had been lowered to the floor, she did not fall.</p> <p>During an interview with Resident #47 on 5/15/13 at 3:37 p.m., Resident #47 indicated the CNA was transferring her from wheelchair to her bed and she slid down the CNA's leg to the floor. Resident #47 indicated she felt she was dropped by the CNA. Resident #47 indicated she told the CNA she felt she was dropped during the transfer. Resident #47 indicated no one interviewed her following the situation.</p> <p>Further interview with Resident #47 indicated a few weeks later she heard a rumor the CNA called off the day</p>		<p>5-23-13 to ensure alarms were in place and functioning. The staff was re-inserviced on call lights and alarms on 5-20-13 and 5-21-13. Nursing staff was re-inserviced on pain, behaviors, care plans, bed alarms, and positioning on 5-20-13 and 5-21-13. Therapy was inserviced 5-30-13 on the new communication form which will be completed to alert nursing to pain issues during therapy session.</p> <p>E. An audit of all residents on antipsychotic and psychotropic meds was conducted on 5-21-13 by the pharmacy consultant, for gradual dosage reductions and unnecessary medication.</p> <p>Licensed nurses were inserviced on 5-20-13 and 5-21-13 for gradual dosage reductions, unnecessary meds, behavior forms, and pain assessments.</p> <p>DON/Designee as well as Social Service Director will review monthly all gradual dosage reductions and unnecessary meds, per the pharmacy consultant report.</p> <p>Recommendations from this report will be promptly forwarded to the MD. The DON/Designee will review pain assessments upon admission, quarterly and as needed. The DON will contact the physician of all recommended gradual dosage reductions. The Social Service Director/Designee will monitor all gradual dosage reductions, as ordered. IV. The facility will monitor actions as</p>		

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	<p>following the incident because Resident #47 fell on her leg. Resident #47 indicated at that time she no longer wanted the CNA to care for her and immediately reported the situation to the Administrator. Resident #47 indicated she met with Administrator on 04/12/13 and discussed her concerns and informed the Administrator she had been dropped. She (Resident #47) asked the Administrator why she had not been interviewed regarding the CNA dropping her. Resident #47 indicated the Administrator told her she had not been interviewed regarding the previous incident because he was told she fell instead of Resident #47's claim that she was dropped. Resident #47 indicated the Administrator handled the situation promptly that day and the CNA was terminated. Resident #47's record was reviewed on 5/16/13 at 9:03 a.m. The Resident's admission Minimum Data Set (MDS) assessment dated 1/21/13 indicated the resident was cognitively intact. A facility policy on Abuse dated 7/1/11, and received as current from the Administrator, indicated "...The facility will initiate at the time of any finding of potential abuse or neglect an investigation to determine cause</p>		<p>follows: A. DON/Designee will select 10% of residents on a weekly basis to interview related to abuse. All new employees will be inserviced on abuse, abuse policy, and abuse reporting. The Administrator/Designee will report all allegations of abuse to the ISDH per the reporting requirements. The Administrator/Designee will review all reports of concern and ISDH reportable occurrences at the monthly QA meeting and the quarterly QA meeting with the Medical Director. B. The DON/Designee will audit the new admission bath schedules, the following working day after admission, to ensure the resident's choices are upheld. Social Service will interview 10% of the interviewable residents weekly times two weeks, then monthly until 100% compliance is achieved. The Administrator/Designee will review all audits monthly at the QA meeting and quarterly at the QA meeting with the Medical Director. C. Side rail assessments will be completed upon admission, quarterly and as needed. DON/Designee will monitor side rails for accuracy upon admission, quarterly, and as needed. Administrator/Designee will review all audits monthly at the QA meeting and quarterly with the Medical Director. D. The licensed nursing staff will complete pain assessments upon</p>	

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	<p>and effect, and provide protection to any alleged victims to prevent harm during the continuance of the investigation. The Administrator or the designee who is in charge of the facility, shall report any instances of suspected abuse, neglect, or misappropriation of resident property to the Department of Health as required...Suspected or substantiated cases of resident abuse, neglect, misappropriation of property, or mistreatment shall be thoroughly investigated and documented by the Administrator, and reported to the appropriate state agencies, physician, families, and/or representative as required by state guidelines..."</p> <p>2. An interview with Resident #14 on 5/13/13 at 2:53 p.m., indicated the resident was not able to choose how many times a week she could take a bath or shower.</p> <p>An interview with Resident #14 on 5/15/13 at 10:17 a.m., indicated the staff had offered her showers on certain days but she was unable to choose if she would like to take a shower or not on that day. Resident #14 indicated that she was not able to choose the days she would like to take a shower. She indicated she had not requested her shower to be</p>		<p>admission, quarterly, and prn. The nurses will notify the physician if the pain assessments indicate the resident's pain is not being controlled. Therapy will complete the pain communication form if a resident complains of pain during a therapy session. Therapy will give the completed form to the licensed nurse, who will follow-up with the physician. Therapy will perform screens on admission, quarterly and as needed. Nurses will observe all residents for call light and alarm placement during daily care rounds. Any issues will be addressed immediately. Nurse Aides , for each shift, will observe all residents on their assignment at the beginning and end of their shift, to ensure call lights and alarms are in place and functioning properly. Any issues will be addressed promptly. Social Services will audit all behavior care plans and update them as needed monthly. This will be ongoing until 100% complaine is achieved. DON/Designee will monitor pain assessments upon admission, quarterly and prn for completion and accuracy. DON/Designee will audit therapy communication forms, to ensure the issues have been addressed by the licensed nurse and the MD was notified if applicable. The DON/Designee will audit all call light and bed alarm audits weekly, until 100% compliance is achieved. The Department Heads</p>				

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	<p>on a different day or at a different time and the choice was not offered to her by staff.</p> <p>Resident #14's record was reviewed on 5/14/13 at 3:44 p.m. The Resident's Admission Minimum Data Set (MDS) assessment dated 2/28/13, indicated the resident was cognitively intact and it was very important for her to choose between a tub bath, bed bath, or shower.</p> <p>3. During an interview on 5/13/13 at 2:13 p.m., Resident #83 indicated, she did not get to choose how many times a week she would like to take a bath or a shower. The resident indicated she received a shower twice a week and would like to take one everyday.</p> <p>On 5/15/13 at 8:15 a.m., the Minimum Data Set (MDS) Annual Assessment dated 1/7/13 was reviewed. The MDS indicated it was very important to the resident to choose daily preferences and the resident was cognitively intact.</p> <p>An interview with the Social Services Director on 5/15/13 at 8:42 a.m., indicated nursing puts the residents on a bathing schedule.</p> <p>An interview with the Director of Nursing (DON) on 5/15/13 at 9:00 a.m., indicated residents would have a set schedule for bathing by room</p>		<p>will monitor call light placement and alarm placement during their daily rounds. Their audits will be completed and given to the CEO at the morning meeting M-F. The Admistrator/Designee will review all audits at the monthly QA meeting and quarterly at th QA meeting with the Medical Director. V. This plan of correction constitutes our dredible allegation of compliance with all regulatory requirements.</p>	

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	<p>number.</p> <p>4. An observation of Resident #67's bed on 5/13/13 at 12:34 p.m., indicated the bed was made and empty. The quarter side rails were in the up position in the mid section of the bed on both sides.</p> <p>On 5/15/13 at 1:35 p.m., the resident was observed in bed with the side rails up, in the mid section of the bed on both sides.</p> <p>On 5/16/13 at 8:51 a.m., the resident was observed in bed lying on her right side, sleeping with side rails up in the mid section of bed on both sides.</p> <p>On 5/16/13 at 9:33 a.m., the resident was observed sleeping in her bed, The side rails were up in the mid section of bed on both sides.</p> <p>On 5/16/13 at 10:29 a.m., the resident was observed sleeping in the bed, with the side rails up in the mid section of bed on both sides.</p> <p>On 5/16/13 at 11:22 a.m., Certified Nursing Assistants (CNA) #16 was observed raising one side rail on the bed, then raised the bed up and lowered the head of bed. CNA #15 and #16 turned the resident from side to side to check for incontinence and to place a mechanical lift pad under the resident. The resident was then lifted from the bed to the geri-chair.</p> <p>The resident did not assist in any of</p>				

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	<p>the bed movement or the transfer to the geri-chair.</p> <p>Resident #67's record was reviewed on 5/16/13 at 8:23 a.m. Resident #67's diagnoses included, but were not limited to, progressive dementia with behaviors and organic psychosis. The Quarterly Minimum Data Set (MDS) Assessment dated 03/28/13, indicated the resident had severe cognitive impairment, was totally dependent for all activities of daily living (ADLS), required one person for assistance for bed mobility, and no side rails were being used.</p> <p>A side rail assessment dated 4/4/13, indicated the resident was to have 1/2 side rails for positioning and support. There was no side rail care plan in the resident's record.</p> <p>An interview with CNA #15 on 5/15/13 at 1:46 p.m., indicated the resident used the side rails so she would not fall out of bed, and did not use them for positioning or support.</p> <p>An interview with CNA #16 on 5/16/13 at 8:55 a.m., indicated she did not know why the resident had side rails and the resident always had them up while in bed. She indicated the resident did not use them for positioning or support and the resident did not move around in bed.</p> <p>An interview with the Director of Nursing on 5/6/13 at 10:32 a.m.,</p>			

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	<p>indicated that the resident did not have a care plan for side rails since the resident would hold onto the side rails when the staff turned her.</p> <p>An interview with CNA #16 on 5/16/13 at 11:25 a.m., indicated the resident's arms are always pulled to her chest and the resident did not use side rails to grab for positioning or support when turning or transferring from bed.</p> <p>5. Resident #37's record was reviewed on 5/15/13 at 3:15 p.m. The resident was admitted into the facility on 05/23/11. The resident's diagnoses included, but were not limited to, insomnia, dementia, and depression.</p> <p>The Annual MDS (Minimal Data Set) Assessment, dated 2/21/13, indicated the resident was cognitively intact, had no mood or depression signs or symptoms, no behaviors, and received an antidepressant the past seven days.</p> <p>The care plan, dated 2/28/13, indicated the resident had insomnia and received an antidepressant. The interventions included, reduce lighting, reduce noise level, offer snacks, offer neck/back massage, observe medication reactions, and gradual dose reduction (GDR) per policy.</p> <p>A physician's order, dated 5/25/11,</p>			

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	<p>indicated trazadone(antidepressant) 50 mg (milligram) at bedtime. A physician's order, dated 8/24/11, indicated to increase the trazadone to 75 mg every bedtime.</p> <p>The resident's Physician's Recapitulation Orders, dated 4/13, indicated the resident was still receiving the trazadone 75 mg at bedtime for sleep.</p> <p>The Psychological Consult, dated 7/24/12, 8/28/12, 9/25/12, and 12/4/12, indicated the resident received the trazadone 75 mg every night for chronic sleep disturbance, and the area for GDR was checked to indicate the GDR was clinically contraindicated to prevent worsening function. There was a lack of documentation to indicate why a GDR would worsen the resident's functioning.</p> <p>The Psychological consult, dated 1/15/13, indicated the resident was on trazadone 75 mg every night for chronic sleep disturbance and resident was improving, and the consults, dated 2/19/13, 3/19/13, and 4/15/13, indicated the resident received the trazadone 75 mg every night for chronic sleep disturbance, and the area for GDR was checked to indicate the GDR was clinically contraindicated to prevent worsening</p>			

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	<p>function. There was a lack of documentation to indicate why a GDR would worsen the resident's functioning.</p> <p>The Physician's/Nurse Practitioner progress notes, dated Dr./NP progress notes, dated December 5, 12, 19, 2012, January 2, 9, 23, 30, 2013, February 6, 13, 24, 20, 27, 2013, March 20 and 28, 2012, April 3, 10, 17, 2013, and May 1 and 15, 2013, lacked documentation for the reason for the trazadone or why a GDR was not completed.</p> <p>The Physician's progress note, dated March 13, 2013 indicated the resident had insomnia.</p> <p>The Pharmacy recommendations, received from the Medical Records Clerk as the only recommendations since 06/13, indicated recommendations on 12/27/12, 1/25/13, 3/4/13 and 3/20/13. The Pharmacy recommendations lacked documentation for a recommendation to GDR the trazadone.</p> <p>The Nurses' Notes, dated 4/23/13 at 9 p.m., indicated the resident received antidepressants related to insomnia and gets 6-8 hours sleep per night, without signs and symptoms of fatigue.</p> <p>During an interview on 5/16/13 at 7:45 a.m., the Director of Nursing indicated she had notified the</p>			

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	<p>resident's Physician about the trazadone and the Physician indicated the trazadone was for appetite not for sleep.</p> <p>During an interview on 05/16/13 at 9:03 a.m., the Social Service Director indicated the Director of Nursing monitors the psychotropic mediations. She indicated she just monitors for resident behaviors, which the resident had no behaviors. She indicated she was not involved with the psychotropic medications.</p> <p>6. Resident #83's record was reviewed on 5/15/13 at 2:33 p.m. Resident #83's diagnoses included, but were not limited to, chronic obstruction pulmonary disease (lung disease) and depression.</p> <p>The Quarterly Minimum Data Set (MDS) Assessment, dated 4/5/13, for Resident #83 indicated resident was cognitively intact and received Antianxiety and Antidepressant medication 7 times within the last 7 days. Mood interview conducted and indicated resident had no symptoms of feeling down or depressed, having trouble concentrating on things, and not feeling fidgety or restless. The behavior assessment indicated the resident had no symptoms of psychosis and there were no behavioral, verbal or physical</p>			

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	<p>symptoms indicated.</p> <p>A care plan dated 4/5/13, indicated Resident #83 became anxious when she gets short of breath (SOB), and resident was to receive Ativan (antianxiety) as ordered.</p> <p>A pharmacy recommendation dated 9/26/12, indicated the Ativan was being given to the resident without a supporting diagnosis. The physician indicated on 10/3/12, the resident had anxiety.</p> <p>A pharmacy recommendation dated 2/27/13, indicated the resident had been on Ativan 0.5 mg (milligrams) twice a day since 7/18/12, and recommended a gradual dose reduction (GDR). The physician indicated on 3/10/13, he disagreed with the recommendation and indicated the resident had chronic COPD (congestive obstructive pulmonary disease) and emphysema. There was a lack of documentation to indicate why a GDR was contraindicated.</p> <p>On 5/15/13 at 2:49 p.m., the Social Service Director was interviewed and indicated there have been no behaviors reported to her and also indicated the facility does not monitor anyone receiving an anti-anxiety medication.</p> <p>An interview with the DON (Director of</p>			

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	<p>Nursing) on 5/15/13 at 3:30 p.m., indicated the resident was taking Ativan for COPD exacerbation and had not had any anxiety since being on the medication. The DON indicated the facility did not monitor the effectiveness unless the resident was having problems and the physician did not want to do a GDR. The DON reviewed Resident #83's record and had no further information regarding why the reduction of the Ativan was contraindicated.</p> <p>7. On 5/13/13 from 12:00 p.m. to 12:30 p.m., Resident #123 was observed to be restless and was yelling out in the skilled dining room. The resident had facial grimacing. During this time, the DoN was observed walking over to the resident, patted her hand, reassured her, and then walked away. The resident was not asked if she was in pain. No other nurse or CNA had addressed the resident yelling.</p> <p>On 5/13/13 at 2:30 p.m., Resident #123 was heard yelling out from her room.</p> <p>On 5/14/13 at 10:30 a.m., Resident #123 was heard yelling out from her room. The resident was observed to have facial grimacing and was restless in her geri chair.</p> <p>On 5/15/13 at 12:00 p.m., Resident</p>			

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	<p>#123 was observed yelling out in the skilled dining room.</p> <p>On 5/16/13 at 8:15 a.m., Resident #123 was observed in her room, partially sitting up in her geri chair, moving her legs up and down. The resident indicated she was in pain and she hurt all over. LPN #1 was informed, chuckled and indicated the resident did get pain medication ordered last evening.</p> <p>On 5/16/13 at 9:20 a.m., Resident #123 was observed in her room, in her geri chair, partially sliding down with her right knee bent and left leg crossed over the right knee. The resident continued to have facial grimacing. The resident indicated her pain was not better. The resident indicated she wanted to go to bed. A CNA on the unit was informed.</p> <p>Resident #123's record was reviewed on 5/15/13 at 2:10 p.m. Resident #123's diagnoses included, but were not limited to, presenile dementia with agitation, insulin dependent diabetes, malignant neoplasm of the breast (breast cancer), gait ataxia (shuffled walk), and anxiety. The resident was admitted to the facility on May 1, 2013.</p> <p>A care plan for pain related to impaired cognition was initiated on 5/10/13. The approach/intervention indicated to give pain medications as</p>			

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	<p>ordered. The May 2013 Physician Recapitulation orders and May 2013 MAR (Medication Administration Record) did not indicate pain medication had been ordered but had indicated to give 0.2 ml (milliliters) of Haldol 0.5 mg/2 ml, IM (intramuscular) every 6 hours as needed for agitation. Resident #123's record was reviewed again on 5/16/13 at 8:35 a.m. A physician order for Norco 5/325 mg (milligrams) 1 tab by mouth every four hours as needed for pain, was ordered at 9:30 p.m. on 5/15/13. A Behavior/Check off list for behaviors exhibited was completed on 5/13/13 at 7:30 a.m. The form indicated the resident was "yelling out..bucking in geri chair." The interventions attempted before Haldol was given at 6:30 a.m., was the resident was removed from the environment. At 7:00 a.m., "TV". No time indicated, but different staff tried to intervene. The Haldol was given at 7:30 a.m. At 9:00 a.m., the resident began to calm down. An OT daily therapy note dated 5/13/13, indicated the resident was "calling out" at times. An OT daily therapy note dated 5/14/13, indicated range of motion to all upper extremely joints, with the</p>			

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	<p>resident "calling out at the end range of shoulder joints."</p> <p>A Behavior Check off list for behaviors exhibited was completed on 5/14/13 at 10:00 p.m. The form indicated the resident was "excessive yelling and high amount of anxiety." The interventions attempted before Haldol was given at 8:00 p.m., was the resident was removed from the environment, at 8:15 p.m., "TV", at 8:30 p.m., different staff tried to intervene, and at 9:00 p.m., a snack was provided. Other interventions included repositioning and her brief was changed. The Haldol was administered at 9:00 p.m., and the resident was asleep by 10:00 p.m. A PT progress note dated 5/15/13, indicated the resident would holler (yell) while performing ROM (range of motion) to BLE (bilateral lower extremities) but was unable to rate the pain and unable to describe her symptoms.</p> <p>An OT progress note dated 5/15/13, indicated "Pt (Patient) calling out at times...Pt. grimaces at end range PROM (passive range of motion) BUE's (bilateral upper extremities), esp. (especially) shoulders, though is unable to rate type or level of pain. Pt. generally has few verbalizations,</p>			

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	<p>but occasionally responds appropriately to simple questions." The treatment diagnosis for therapy was joint pain to the shoulder. An OT daily therapy note dated 5/16/13, indicated resident "calls out at times." The treatment diagnosis for therapy was joint pain to the shoulder.</p> <p>On 5/13/13 at 12:00 p.m., a CNA indicated the resident yells out all the time and had been doing it since admission. An interview with the SSD (Social Service Director) on 5/15/13 at 10:20 a.m., indicated she believed nursing was looking at the resident's pain. The SSD indicated Psych was recently referred due to her being a new admit.</p> <p>On 5/16/13 at 8:25 a.m., the DoN stated "that is how the resident communicates." In clarification, the DoN indicated when Resident #123 yells, that was how she communicated and the ADoN indicated the resident would yell out her answers when staff would ask her questions.</p> <p>On 5/16/13 at 9:45 a.m., PT #12 indicated the therapists would inform nursing staff of the resident's progress or anything significant to</p>			

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	<p>their daily care, but they do not inform them of their pain because they were already being assessed for their pain medication.</p> <p>On 5/16/13, at 11:45 a.m., LPN #1 indicated the resident had pre senile dementia and this contributed to her yelling out versus the resident being in pain. LPN #1 was not aware of the resident having pain during therapy. LPN #1 indicated the coccyx wound was superficial and shouldn't be painful and he had asked the resident in the past if she was in pain when she would yell out. LPN #1 indicated the resident would first say yes to pain and then a few minutes later she would say no, so she was "wishy washy" and due to her dementia, he didn't know if she was in pain. LPN #1 indicated the resident was not on pain medication in the hospital. LPN #1 also indicated having to maintain the residents dignity, as in keeping the resident in bed all day versus putting her to bed when she was in pain or uncomfortable. LPN #1 indicated the spouse informed him, the resident did not have breast cancer but a patch of skin cancer and he was upset with the breast cancer diagnosis, so the pain would not be cancer related. LPN #1 indicated he did not clarify the breast cancer</p>			

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	<p>diagnosis with the physician.</p> <p>Upon reviewing the resident's behavior record on 5/16/13 at 2:00 p.m., the DoN indicated, again, the resident did not have behaviors and her yelling was the way she communicated. The DoN initiated the behavior monitoring record on 5/15/13 for socially inappropriate/disruptive behavior/sounds. The interventions/approaches were to move the resident to a quiet area, hold hand, turn on TV, turn off TV, and/or lay down for a nap. The option to manage pain was not selected. The psychoactive medication indicated was Depakote. Haldol 0.5 mg/ml, inject 0.2 ml every six hours as needed, was not listed as a psychoactive medication. A facility policy, dated 08/01/10, titled, "Behavior Management Psychotropic Medication Protocol", received from the Director of Nursing as current, indicated, "...Residents who receive antipsychotic, anti-depressant, sedative/hypnotic, or anti-anxiety medications are to be maintained at the safest, lowest dosage necessary to manage the resident's condition. Residents will be reviewed routinely for effectiveness and monitored for side effects of these medications and</p>						

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	<p>will receive gradual dose reductions, unless clinically contraindicated, in an effort to discontinue these drugs..."</p> <p>8. On 5/13/13 at 11:45 a.m., Resident #26 was observed in the skilled dining room, reclined in a geri chair with his head off to the right side of the chair. The resident received his meal at 12:05 p.m., and was starting to be fed by a family member while his head remained off the right side of the chair. At 12:18 p.m., the resident's family member indicated Resident #26's head never stays up and the staff has to reposition the resident frequently. During this time, the DoN and CNA #2 repositioned the resident.</p> <p>On 5/13/13 at 12:40 p.m., Resident #26's head had fallen back off to the right side of the geri chair. CNA #2 was at the table sitting across the resident, feeding another resident. The wife continued to feed the resident in this position. There were other staffing personnel observed in the dining room, who did not attempt to repositioned the resident.</p> <p>On 5/15/13 at 9:00 a.m., Resident #26 was observed in his room, reclined in his geri chair with his head on metal edge of the chair. The resident was observed to have a concave cushion for his head which</p>			

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	<p>was flattened, a concave trunk cushion and was sitting on a pommel cushion.</p> <p>On 5/15/13 at 10:00 a.m., Resident #26 was observed in bed. Resident #26 continued to favor his head to the right side, near the wall. The resident's bed was observed not to be in the lowest position.</p> <p>On 5/15/13 at 3:45 p.m., Resident #26 was observed down in his bed with the top of his head pressed against the wall. The bed pad alarm was observed to be unplugged. The resident's door was half way shut, and the resident could not be seen from the hallway. Two large pillows was observed to be fluffed and tucked under the fitted sheet, preventing the resident from getting out of bed.</p> <p>Resident #26's record was reviewed on 5/15/13 at 9:00 a.m. Resident #26's diagnoses included, but were not limited to, Parkinson's, dementia, and acute respiratory failure. A care plan for risk for fall was initiated on 1/11/13. The approaches/interventions were not dated, but indicated to "reinforce safety awareness, resident lays self on floor to fix wheel chair at times-wiggles out. Wife aware-risk and benefits explained. Falling star</p>			

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	<p>program to increase supervision."</p> <p>An OT (Occupational Therapy) note dated 1/24/13, indicated the resident had "an impairment of decreased postural awareness - slumped sitting posture and decreased cardiopulmonary condition - limited tolerance for activity."</p> <p>An OT note dated 1/25/13, indicated the resident was positioned in layback chair; was not able to tolerate an incrediback (concave fitting) wheel chair and was sliding out due to increased extensor tone.</p> <p>A Side Rail Assessment Screen dated 2/6/13, indicated the resident was not able to get out of bed unassisted, was not able to turn from side to side unassisted while in bed, did not attempt to get out of bed unassisted, and the resident did have alterations in safety awareness due to cognitive decline.</p> <p>An OT discharge note dated 2/8/13, indicated Resident #26 needed total assistance at meals. The resident had been in a "layback" chair, leans to the right at times and was observed to have had an increased extensor tone with a need for repositioning to improve posture and interaction with environment. The</p>			

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	<p>note also indicated the staff had been instructed on appropriate positioning and feeding, with a good understanding demonstrated. The resident was referred to restorative program.</p> <p>A Fall Risk Assessment dated 4/9/13 and 4/19/13, indicated the resident was a high risk for falls and the resident had fallen 1-2 times in the past three months.</p> <p>A care plan for physical mobility impaired due to diagnosis of Parkinson's was updated on 4/10/13. The approaches/interventions indicated "therapy per order, staff assist as indicated, educate on call light use and asking for assist, contact MD and family as indicated."</p> <p>A nursing note dated 4/19/13 at 11:30 a.m., indicated the resident was found on floor in front of the window, lying on his back trying to fix his chair. The note indicated the resident stated, "I wiggled out of my chair to fix the wire under it."</p> <p>A nursing note dated 4/19/13 at 8:30 p.m., indicated Resident #26 had "wiggled out of chair and had a fall. Res. (resident) needs to be positioned frequently and will "wiggle an wiggle."[sic]</p> <p>A nursing note dated 5/10/13 at 7:00 p.m., indicated the resident was in his</p>			

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	<p>geri chair in his room, was "wiggling", and caught his leg and received a 7 cm (centimeter) by 2 cm abrasion to his front lower right leg.</p> <p>A CNA care plan was provided by the DoN on 5/16/13 at 1:00 p.m. The CNA care plan indicated the resident had a bed alarm only.</p> <p>An interview with LPN #10 on 5/15/13 at 8:15 a.m., indicated the staff had tried multiple things with the resident for positioning and had been unsuccessful. LPN #10 indicated that if the resident was able to get his fingers to the end of the arm of the chair, he would pull himself down. LPN #10 indicated the geri chair had worked best for the resident and he did need frequent repositioning due to his continued "squirming". LPN #10 indicated a bariatric bed was used for the resident due to his "squirming."</p> <p>An interview with the SSD (Social Service Director) on 5/15/13 at 10:30 a.m., indicated -</p> <p>Resident #26's wife did not want him to be moved closer to the nurses station. SSD indicated the staff was on alert about the resident's frequent position changes.</p> <p>An interview with OT #11 on 5/15/13 at 11:30 a.m., indicated she had not been made aware of the resident's positioning problems. OT #11 indicated therapy did</p>			

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	<p>try an incrediback wheel chair (concave fitting) but was unsuccessful. OT #11 indicated no other cushions had been attempted. OT #11 stated, "Resident may need to be re-screened if they are having to reposition him often".</p> <p>An interview with PT #12 on 5/15/13 at 11:45 a.m., indicated he had not been made aware of the resident's positioning problems. PT #12 indicated a high back wheel chair was borrowed from a resident (who wasn't using his) was attempted and failed. PT #12 indicated the resident was stiff and rigid. PT #12 indicated the Broada (prevents head from falling off chair) chair had not been attempted due to no availability of a chair. PT #12 indicated the staff had not informed therapy of the resident's positioning problems and with meal service. PT #12 indicated he would look to re-evaluate the resident.</p> <p>The DoN on 5/15/13 at 11:55 a.m., indicated the resident was being discussed in the morning meeting on "Tuesday" for a Broda chair as well as two other residents. The DoN indicated the resident was constantly being repositioned, had head bolsters in his wheelchair, this was his third time being in the facility, and the resident's spouse can be interviewed about the frequent repositioning. The DoN indicated their</p>			
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	<p>corporation owned the equipment company.</p> <p>An interview with CNA #13 on 5/15/13 at 4:00 p.m., indicated other CNAs had told her to put pillows under the fitted sheets to keep his legs in bed where he "squirms" all the time. CNA #13 indicated she was not aware of the call light not being within reach to the resident or the bed alarm not being plugged in. CNA #13 indicated she was in the resident's room approximately 15 minutes prior and had cleaned the resident. CNA #13 indicated she frequently checks on the resident.</p> <p>An interview with the resident's spouse on 5/16/13 at 11:15 a.m., indicated she was not aware of the facility looking into ordering a Broda chair for the resident.</p> <p>An interview with CNA #14 on 5/16/13 at 11:30 a.m., indicated she was new to the facility and this was her first week on her own on the unit. CNA #14 indicated she was told by the night shift CNA, not to put pillows under the fitted sheet that it was considered a restraint. CNA #14 indicated other CNAs had been putting the pillows under the fitted mattress.</p> <p>An interview with the DoN on 5/17/13 at 9:00 a.m., indicated she did not have a fall policy and the Falling Star program was for residents who had a history of</p>			

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	falls. The DoN indicated the residents were assigned to a staff member, who would evaluate the resident, review their care plans, and update staff on any changes related to the interventions. 3.1-52(a) 3.1-52(b)			