STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155206	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBURG HEALTH CARE CENTER	1010 HORNADAY RD BROWNSBURG, IN 46112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: February 6, 7, 8, 9, and 10, 2012 Facility Number: 000113 Provider Number: 155206 AIM Number: 100287670 Survey Team: Heather Lay, RN - TC Janet Stanton, RN Rita Mullen, RN Michelle Hosteter, RN (2/6, 2/7, 2012) Michelle Carter, RN Census Bed Type: SNF: 4 SNF/NF: 122 Total: 126 Census Payor Type: Medicare: 14 Medicaid: 86 Other: 26 Total: 126 Sample: 24 These deficiencies reflect state findings	F0000	Submission of this plan of correction shall not constitute or be construed as an admission by Brownsburg Healthcare Center that the allegations contained in the survey report are accurate or reflect accurately the provisions of Nursing care and services to the residents of Brownsburg Healthcare Center.	

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

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

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	cited in accordance with 410 IAC 16.2. Quality review completed 2/16/12 Cathy Emswiller RN			

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F0157 SS=D	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.			
	Based on record review and interview, the facility failed to notify a resident's physician and legal representative regarding a resident's increase in pain and refusal of treatment. The deficient practice impacted 1 of 1 record reviewed for lack of physician notification in a	F0157	It is the responsibility of the facility to notify the residents physician and legal representative regarding an increase in pain, change in condition or refusal of treatment. Resident #128 wore a knee brace as ordered on 1/4/12. She did not complain of any issues with the brace or knee	03/11/2012

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	sample of 24 residents reviewed. [Resident #128] Findings include: On 2/8/12 at 1:00 P.M., Resident #128's closed record was reviewed. Diagnoses included, but were not limited to, contractures, osteoarthritis, dementia, MRSA [Methicillin-resistant Staphylococcus aureus] right knee, history of right total knee replacement, and history of distal tibia and fibula fracture. A Physical Therapy "Discharge Summary" dated 11/23/12-1/4/12, included, but was not limited to, "Discharge information... Nursing has been educated on application and wearing schedule of bilateral knee braces... Patient [Resident #128] discharged this date [1/4/12] to nursing care to apply bilateral knee braces for contracture management..." A "Nurse's Notes" dated 1/4/12 at 2:00 P.M., included, but was not limited to, "N.O. [new order] for nursing to apply bilateral knee braces at P.M. care and off at A.M. care. POA [Power of Attorney] aware..." A "Care Plans" dated 1/4/12, included, but was not limited to, "Contractures of		pain until 1/11/12. All residents have the potential to be affected by this practice. Resident #128 was the only resident affected. Nursing staff have been inserviced on the policy: Significant Change of Condition: Physician Notification and to document the notification in the nurses notes with the response given by the physician, as well as documenting notification of the legal representative/family member of the resident.DON/designee will monitor the 24 hour report and all MD orders, Monday through Friday for any changes that indicate a change of condition in the resident. Any concerns which are identified will be addressed in the monthly Quality Assurance Meeting via a written action plan until resolution occurs.	

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	bilateral knees... Approach, dated 1/5/12: Apply bilateral knee braces with P.M. care, to be applied 7 days per week..." There were no entries in the "Nurse's Notes" between 1/4/12 - 1/11/12. A "Nurse's Notes" dated 1/11/12 at 8:00 P.M., included, but was not limited to, "Patient [Resident #128] refuses braces... crying no, no don't my legs hurt so bad... pain medication given..." A "Nurse's Notes" dated 1/12/12 at 9:00 P.M., included, but was not limited to, "Patient [Resident #128] continues to refuse knee braces this shift related to increased pain... pain medication given earlier... patient bed resting comfortably at this time..." A "Nurse's Notes" dated 1/13/12 at 9:00 P.M.,included, but was not limited to, "Patient [Resident #128] alert, calm, steadfastly refusing to wear knee braces... States my legs just hurt too much... Pain medication given..." No physician or family notification was documented for increased complaints of pain and refusal to wear bilateral knee braces starting 1/11/12 through 1/13/12. A "Nurse Practitioner" assessment dated			

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	1/14/12, no time, included, but was not limited to, "Chief Complaint: Right knee red, pain... Assessment: Right knee infection, right knee pain, Plan: Keflex 500 milligrams four times per day for 10 days, Tylenol for pain, and schedule with ortho [Orthopedics]..." A "Nurse's Notes" dated 1/14/12 at 1:30 P.M., included, but was not limited to, "N.O. [new order] received for Keflex 500 milligrams by mouth four times per day for 10 days right knee infection... Notified son [POA]..." A "Nurse's Notes" dated 1/15/12 at 3:00 P.M., included, but was not limited to, "Knee [Right Knee] is warm to touch and swollen... appears to have fluid on side of it... Temperature 98.9..." On 2/9/12 at 3:00 P.M. during daily exit with the Administrator and Director of Nursing [DON], the facility policy and procedure for notification of significant change, knee assessments for Resident #128 and documentation regarding notification of physician, physical therapy, and POA for Resident #128's increase in pain and refusal to wear bilateral knee braces [Resident's Son] on dates 1-11-12 to 1-13-12 were requested. On 2/10/12 at 9:10 A.M., the DON			

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	provided the facility policy and procedure titled, "Significant Change of Condition: Physician Notification" dated 12/3/08 and a written statement from LPN [Licensed Practical Nurse] #6. The policy and procedure included, but was not limited to, "Policy: The attending physician will be notified of a change in a resident's condition by a licensed staff member as warranted... Procedure: Physician notification is to include but is not limited to: Abnormal complaints of pain... The nurse will make an entry into the nurses notes regarding condition and that the physician has been notified..." A written statement from Licensed Practical Nurse #6 dated 2/10/12, no time, included but was not limited to, "[Resident #128] had no open areas to her right knee from 1-4-12 until discharge to the hospital... she started getting redness which is reason for her being sent to the hospital..." In an interview on 2/10/12 at 9:15 A.M. with the DON, she indicated physical therapy and Resident #128's physician should have been notified and assumed they had been; however, she could not find any documentation regarding notification.			

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	3.1-5(a)(3)			

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F0205 SS=D	Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.			
	Based on record review and interview, the facility failed to notify a resident or resident's legal representative in writing of the facility's bed-hold policy. The deficient practice impacted 1 of 1 record reviewed for lack of bed hold notification provided at time of transfer to the hospital in a sample of 24 residents reviewed. [Resident #128] Findings include: On 2/8/12 at 1:00 P.M., Resident #128's closed record was reviewed. Diagnoses included, but were not limited to, contractures, osteoarthritis, dementia, MRSA [Methicillin-resistant	F0205	It is the facility's responsibility to notify the resident or the resident's legal representative of the facility bed-hold policy. The bed-hold policy is sent with the resident to the hospital/physicians office when the resident leaves the facility. Families will be notified via mail of the bed-hold policy when the resident discharges or the first business day following discharge. All residents have the potential to be affected by the practice. All nursing staff have been inserviced on what to send to the hospital/physician office with the resident. Information sent with the resident will be the: Notice of Transfer or Discharge, Notice of Transfer or Discharge	03/11/2012

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	Staphylococcus aureus] right knee, history of right total knee replacement, and history of distal tibia and fibula fracture. A "Nurse's Notes" dated 1/24/12 at 9:30 A.M., included, but was not limited to, "N.O. [new order] received and noted to send [Resident #128] to [area hospital] emergency room to evaluate and treat right knee..." A "Minimum Data Set" [MDS] assessment dated 1/24/12, included, but was not limited to, "Entry/discharge reporting... discharge assessment-return not anticipated..." A "Resident Information" sheet dated 1/26/12 included, but was not limited to, "Current Pay Source: Medicaid/LOA [Leave of Absence] Hospital..." A "Social Progress Notes" dated 2/1/12, no time, included, but was not limited to, "On 1/31/12 unit 3 nursing staff notified Social Services that [Resident #128] was returning to the facility... Upon review of medication list the Director of Nursing [DON] stated the cost of the intravenous [IV] antibiotics would be $9000.00 per month well over the reimbursement rate per month for Medicaid and Medicare... The consensus was due to Indiana no longer having a bed hold requirement and		Request for Hearing, Bed Hold Readmission policy and Resident transfer Form. Forms are kept at each nurses station in a packet to send with each resident as needed.DON/designee will monitor all transfers/discharges for compliance and any concerns will be addressed via a written action plan in the monthly Quality Assurance Meeting until resolution occurs.	

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	we could not financially care for her [Resident #128] needs that we could not accept [Resident #128] back into the facility... Phone conversations with [area hospital Social Services department] occurred... Social Service #5 and DON suggested Resident #128 be considered for a Long-Term Acute Care [LTAC] facility however the Director of Social Service from [area hospital Social Service department] said that Resident #128 did not qualify [for LTAC placement] ... Social Service #5 and DON spoke with [Resident #128's] son/responsible party on speaker phone... Explained the situation... apologized and said if it weren't for the exorbitant cost we would love to have his mother back..." During daily exit conference on 2/8/12 at 3:15 P.M., the facility bed-hold policy and Resident #128's signed acknowledgement of facility bed-hold policy receipt was requested from the Administrator. On 2/9/12 at 9:00 A.M., the Administrator provided a copy of the facility "Bed Hold/Readmission Policy" no date. The policy included, but was not limited to, "Before a resident is transferred to a hospital or goes on therapeutic leave, the nursing staff will provide written information to the			

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	resident and a family member or legal representative that specifies the duration of the bed hold policy under the State Plan, during which time the resident is permitted to return and resume residence in the nursing facility... As of February 1, 2011, Medicaid does not reimburse facilities for bed holds... If a resident is discharged from the facility, the facility will permit the resident to return to the first available semi-private bed when the resident continues to qualify for Medicaid... If an appropriate bed is not available upon time of the return to the facility, the facility will assist with appropriate transfer to other facility... If a resident wants to reserve his/her bed, then resident must pay the facility the private pay rate for his/her bed while on leave from facility..." In an interview on 2/10/12 at 9:10 A.M. with the DON, she indicated there was not a signed acknowledgement from the resident or resident's legal representative regarding the facility's bed-hold policy. 3.1-12(a)(25)			

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F0206 SS=D	A nursing facility must establish and follow a written policy under which a resident whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, is readmitted to the facility immediately upon the first availability of a bed in a semi-private room if the resident requires the services provided by the facility; and is eligible for Medicaid nursing facility services.			
	Based on record review and interview the facility failed to permit a resident to return to the facility. The deficient practice impacted 1 of 1 record reviewed for refusal to readmit to the facility after transfer to the hospital in a sample of 24 residents reviewed. [Resident #128] Findings include: On 2/8/12 at 1:00 P.M., Resident #128's closed record was reviewed. Diagnoses included, but were not limited to, contractures, osteoarthritis, dementia, MRSA [Methicillin-resistant Staphylococcus aureus] right knee, history of right total knee replacement, and history of distal tibia and fibula fracture. A "Nurse's Notes" dated 1/24/12 at 9:30 A.M., included, but was not limited to, "N.O. [new order] received and noted to send [Resident #128] to [area hospital] emergency room to evaluate and treat right knee..." A "Minimum Data Set" [MDS]	F0206	It is the responsibility of the facility to readmit a resident from hospitalization or therapeutic leave that has exceeded the bed hold period immediately upon the first availability of a bed in a semi-private room if the resident requires the services provided by the facility and is eligible for Medicaid nursing facility services. It was felt by the facility Medical Director that Resident #128 required the services of a Long Term Acute Care (LTAC) at the time of her hospital discharge. Administration, Nursing Administration, Social Service, Medical Director and Nurse Practitioners have been inserviced on the policy of bed hold and resident readmission.The Administrator will monitor and any concerns will be addressed in the monthly Quality Assurance meeting via a written action plan until resolution occurs.	03/11/2012

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	assessment dated 1/24/12, included, but was not limited to, "Entry/discharge reporting... discharge assessment-return not anticipated..." A "Resident Information" sheet dated 1/26/12 included, but was not limited to, "Current Pay Source: Medicaid/LOA [Leave of Absence] Hospital..." A "Social Progress Notes" dated 2/1/12, no time, included, but was not limited to, "On 1/31/12 unit 3 nursing staff notified Social Services that [Resident #128] was returning to the facility... Upon review of medication list the Director of Nursing [DON] stated the cost of the intravenous [IV] antibiotics would be $9000.00 per month well over the reimbursement rate per month for Medicaid and Medicare... The consensus was due to Indiana no longer having a bed hold requirement and we could not financially care for her [Resident #128] needs that we could not accept [Resident #128] back into the facility... Phone conversations with [area hospital Social Services department] occurred... Social Service #5 and DON suggested Resident #128 be considered for a Long-Term Acute Care [LTAC] facility however the Director of Social Service from [area hospital Social Service department] said that Resident #128 did not qualify [for LTAC placement] ...			

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	Social Service #5 and DON spoke with [Resident #128's] son/responsible party on speaker phone... Explained the situation... apologized and said if it weren't for the exorbitant cost we would love to have his mother back..." During daily exit conference on 2/8/12 at 3:15 P.M., a list of Medicaid-Eligible female beds available for the dates of 1/24/12 to 2/8/12, the facility bed-hold policy, and Resident #128's signed acknowledgement of facility bed-hold policy receipt was requested from the Administrator. In an interview on 2/8/12 at 3:15 P.M., the Administrator indicated the facility could not financially care for Resident #128 and she [Resident #128] would be better off in a Long-Term Acute Care facility [LTAC]. On 2/9/12 at 9:00 A.M., the Administrator provided a copy of the facility "Bed Hold/Readmission Policy" no date. The policy included, but was not limited to, "Before a resident is transferred to a hospital or goes on therapeutic leave, the nursing staff will provide written information to the resident and a family member or legal representative that specifies the duration of the bed hold policy under the State			

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	Plan, during which time the resident is permitted to return and resume residence in the nursing facility... As of February 1, 2011, Medicaid does not reimburse facilities for bed holds... If a resident is discharged from the facility, the facility will permit the resident to return to the first available semi-private bed when the resident continues to qualify for Medicaid... If an appropriate bed is not available upon time of the return to the facility, the facility will assist with appropriate transfer to other facility... If a resident wants to reserve his/her bed, then resident must pay the facility the private pay rate for his/her bed while on leave from facility..." On 2/9/12 at 9:00 A.M., the Administrator provided a document titled, "Number of Female Beds Available" dated 2/8/12. The following dates and number of Medicaid-Eligible beds were available: 1/24/12 - 1/31/12, 8 female beds were available on each day. 2/1/12, 8 female beds available, 2/2/12, 6 female beds available, 2/3/12, 8 female beds available, 2/4/12 - 2/6/12, 7 female beds available, and 2/7/12 - 2/8/12, 8 female beds available. On 2/10/12 at 9:10 A.M., the DON			

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	provided a written statement from the facility Medical Director dated 2/9/12. The statement included, but was not limited to, "As Medical Director for [facility], I advised the DON not to accept [Resident #128] last week... I felt that her acuity was excessive for the facility. I felt she would have been better served by a LTAC..." 3.1-12(a)(27)(B)			

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F0250 SS=E	The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.			
	Based on record review and interview, the facility failed to develop a program to consistently monitor resident behaviors and behavior summaries to develop care plans addressing specific behaviors. This effected 8 of 15 residents reviewed for behaviors in a sample of 24. (Residents #27, 35, 37, 99, 105, 110, 121 and 122) Findings include: 1. The clinical record of Resident #99 was reviewed on 2/7/12 at 1:25 P.M. Diagnoses for Resident #99 included, but were not limited to, chronic pain, depression, anxiety, rheumatoid arthritis, chronic obstructive pulmonary disease and a history of narcotic abuse. An annual Minimum Data Set assessment (MDS), dated 12/6/11 indicated a Brief Interview for Mental Status (BIMS) score of 15 (Mentally intact). The Behavior Log, dated 12/7/11 at 6:00 P.M., indicted "Sent for this nurse to going pain pill, then began yelling & berating me stating I yelled @ her last night to wake her up. Explained to pt (patient) once again that I had knocked on	F0250	It is the facility policy that each resident receives medically related social service to attain or maintain their highest practicable physical, mental and psychosocial well-being.Behaviors have been reviewed for residents #27, 35, 37, 99 105, 110, 121, and 122. All resident have the potential to be affected by the practice. For Residents #27, #35, #37, #105, #110 and #122-staff have been inserviced on behavior documentation and the care plan and C.N.A. assignment sheet have been updated to reflect behaviors and individualized interventions for each resident. Resident # 99 and #121-behavior care plans have been implemented with C.N.A. assignment sheets updated and staff inserviced to documentation of interventions and effectiveness.A Behavior Management Program has been implemented to consistently track behaviors. The program includes the development of behavior summaries and care plans that address specific behaviors. All staff have been inserviced on the Behavior Management Program and how to document behaviors and interventions. Social Service will monitor the Behavior Tracking Log daily, Monday through Friday for any behaviors and any	03/11/2012

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	door, waited, knocked again, called to pt x 3, entered rm (room), touched pt on LLE (left lower extremity), called her name again & then said her name again louder, when she finally awakened/startled. Yelling @ this nurse that I'm a liar & that she's easy to wake up, that I don't respect her & she demands respect immediately & I will be really sorry when she tells the DoN (Director of nursing on me tomorrow as "[name of DoN] knows I always tell the truth." Pt then yelled @ me more for not taking back to her....." The Behavior Log, dated 1/26/12 on 3 -11 shift (no time recorded), indicated "Pt has had pain Rx [increased] in past [2] days. Has had msir/prn (sic) (morphine as needed) @ 1:30 P.M. today. [after] 3:30 P.M. pt was already sending for nurse. pt sitting in bed, chatting [with] son. States "by the way, I need a pain pill." Advised pt she had just had an increase, and just had a PRN @ 1:30 P.M. pt began yelling @ this nurse in front of her son [name of son] "Your not here to judge my pain, the doctor says I can have that when ever I want it." Explained to pt that I was not judging her pain but she had a pill @ 1:30 P.M. This nurse phoned MD for suggestion...."just leave it the way it is" This nurse informed pt of MD decision & that I would bring it when it was time.		concerns found in the process, and then will address them via a written action plan in the monthly Quality Assurance Meeting until resolution occurs.	

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	When nurse took Rx pt turned her face away & states "I don't want it. Take it back." @ HS (bed time) pt refused MS Contin 60 mg (milligrams), states "I don't want it. Take it back. I don't want it."..." A review of Physician orders, dated 1/24/12, indicated an order for morphine Contin ER 60 mg (milligrams) (a narcotic pain medication) two every 12 hours. A review of the Nursing notes for December 2011 to February 7, 2012, indicated the Resident refused all non-pharmacological interventions for pain control. A Care Plan for Pain, dated 10/6/10 and last up-dated 12/14/11, indicated Resident #99 refuses interventions other than pain meds. There was no Care Plan for behaviors. 2. The clinical record of Resident #105 was reviewed on 2/10/12 at 9:00 A.M. Diagnoses for Resident 105 included, but were not limited to high blood pressure and Alzheimer's Disease. A Quarterly MDS, dated 11/9/11, indicated a BIMS score of 3 (severely impaired).			

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	A Care Plan for Behaviors, dated 8/17/11 and reviewed on 11/15/11, indicated "Will propel self throughout facility in wheelchair. Resistant to care." A review of the Behavior Logs indicated the Resident's behaviors were last entered on November 6, 2011 on the 7 - 3 shift. The Behavior Log indicated "Resident would not stay in bed or wheelchair..." A Nursing note, dated 11/7/11 at 1:30 P.M., indicated "...personal alarm intact while in bed. Refused to get OOB (out of bed) this shift. Refused all 8 a & 12 p meds..." A Nursing note, dated 11/7/11 at 8:00 P.M., indicated "...Pt had period of extreme restlessness, would not sit in w/c (wheelchair), or stay in bed. Threw personal alarm across room. [Up] and [down] constantly...." A Nursing note, dated 12/4/11 at 2:30 P.M., indicated "Refused all meds, dropped them on the floor. Res (Resident) stated "No"." A Nursing note, dated 1/30/12 at 3:00 P.M., indicated "Refused to allow writer to place [left] wrist splint on. Hitting @ writer."			

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	A Nursing note, dated 1/31/12 at 11:00 A.M., indicated "Hitting @ staff when attempting to apply [left] wrist splint." A Nursing note, dated 2/6/12 at 3:00 P.M., indicated "Refused [left] wrist splint. Hitting @ staff." The Behavior Log was not used to track behaviors. 3. The clinical record of Resident #110 was reviewed on 2/9/12 at 2:00 P.M. Diagnoses for Resident #110 included,. but were not limited to, arthritis, high blood pressure and paranoid schizophrenia. A Significant change MDS assessment, dated 11/11/11, indicated a BIMS score of 10 (moderately impaired). There were no current Behavior Log sheets. The last Behavior Log entry was 5/14/11 at 7:30 A.M. to 12:00 P.M., indicated "Resident refused breakfast & lunch again saying snakes ate her guts out & she has to have an operation done..." A Weekly Progress note, dated 6/17/11, indicated "...food consumption - r/t (related to) thinks food poisoned." A Weekly Progress note, dated 11/4/11,			

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	indicated "...Res is refusing to eat the food her (sic) and said she is being poisoned." A Weekly Progress note, dated 12/30/11, indicated "...will say food is poisoned." 4. The clinical record of Resident #122 was reviewed on 2/7/12 at 9:15 A.M. Diagnoses included, but were not limited to, depression, dementia and high blood pressure. A Physician's order, dated 1/3/12, indicated Ativan 0.5 mg every 6 hours as needed for anxiety. A review of the Medication Administration Record for the month of January 2012, indicated Resident #122 was given Ativan 0.5 mg 13 times for anxiety. There was no Behavior Log, monitoring the dates and times the Resident became anxious. 5. On 2/7/12 at 9:50 A.M., Resident #27's record was reviewed. Diagnoses included, but were not limited to, depression, pain, constipation, dysphagia, and left hemiplegia. Tour of the facility was initiated on 2/6/12			

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	at 10:55 A.M. with Licensed Practical Nurse [LPN] #7. Resident #27 was identified as requiring assistance with feedings, thickened liquids, and as having behaviors. An "All Staff Behavior Log" with multiple dates included, but was not limited to, "7/8/11 at 9:30 A.M.: She [Resident #27] yelled out with care... 8/11/11, no time: Upset and yelling... 11/6/11, no time: Refused to eat unless her bed was flat... 12/20/11, no time: Cursing at staff on multiple occasions... 1/20/12, no time: Refused bed bath... 1/24/12, no time: Refused bed bath..." There were no interventions listed and no behavior care plan for Resident #27. On 2/7/12 at 4:00 P.M., requested from the Administrator and Director of Nursing [DON] a behavior care plan with individualized interventions for Resident #27. On 2/8/12 at 9:00 A.M., the DON provided a "Patient Care Plan" dated 2/7/12, no time. The care plan included, but was not limited to, "Problem: Yells out, resists care, verbally abusive to staff... Approaches: Explain procedure,			

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	approach calmly, allow to make choices..." 6. On 2/9/12 at 10:55 A.M., Resident #121's record was reviewed. Diagnoses included, but were not limited to, Alzheimer's disease, depression, dementia, anxiety, and hypertension. Tour of the facility was initiated on 2/6/12 at 10:55 A.M. with Licensed Practical Nurse [LPN] #7. Resident #121 was identified as having behaviors with medication management. A "Care Plans" for behaviors with an onset date of 5/4/11 included, but was not limited to, "Problem: Anxiety as evidenced by resistive to staff care, attempts to stand and transfer or ambulate from wheelchair unaware of own limits, can not understand own risk, yells out, dementia... Approaches: Attach busy apron to keep distracted, attempt to explain to resident he can not stand or ambulate, attempt to redirect, keep in common area with other residents..." An "All Staff Behavior Log" with multiple dates included, but was not limited to, "11-22-11, no time: Resident very combative... tried to hit CNA [Certified Nursing Assistant] in stomach twice... 11/26/11, no time: fighting			

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	during care... punching CNA, squeezing hands...12/17/11, 8:00 P.M.: punched CNA in right eye... 12/21/11, 8:30 A.M.: hit aide, punched aide in side... 1/1/12, 12:00 P.M.: very combative, hit and punched CNA in rib area..." There were no interventions in the behavior care plan for combative behavior. 7. In an interview during the initial orientation tour on 2/6/12 at 10:30 A.M., L.P.N. #4 indicated Resident #35 refused medication, would not eat or bites on the spoon, yells, hits, and pinches staff. The clinical record for Resident #35 was reviewed on 2/9/12 at 9:50 A.M. Diagnoses included, but were not limited to, senile dementia, depressive disorder, gastro-intestinal reflux disease, debility, and hypertension. A quarterly M.D.S. [Minimum Data Set] assessment, dated 11/14/11, indicated the resident was unable to complete the BIMS [Brief Interview for Mental Status] test, and was evaluated by the nursing staff to have moderately impaired cognitive skills for daily decision-making [made poor decisions and required cues and supervision]. In an interview on 2/6/12 at 11:35 A.M.,			

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	the M.D.S. Coordinator indicated all behaviors displayed by a resident would be documented in the "All Staff Behavior Log," located at the Nursing Station. She indicated any staff person could document behaviors they observed in the log book. The "Log" form requested date, time, "Description of Behavior & Interventions tried," the initials of the person entering the information, and the initials of the nurse reviewing the entries. Resident #35 had fourteen "All Staff Behavior Log" entries from 1/16/11 through 2/2/12. Each entry had a detailed description of the behavior displayed by the resident [hitting, cursing, kicking, pinching, biting]. The "Interventions tried" were not listed. A four-page "Social Work Assessment" form, dated 11/14/11, duplicated assessment items requested for completion of the M.D.S. assessment for communication, cognitive patterns, mood, and behaviors for a 7-day look-back period. The form indicated the resident had "no behavioral problems." There were no sections for summarizing, totaling, or addressing the behaviors documented on the Behavior logs, in order to determine trends or effectiveness			

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	of any interventions tried. 8. In an interview during the initial orientation tour on 2/6/12 at 11:00 A.M., L.P.N. #4 indicated Resident #37 was able to propel her wheelchair and wandered throughout the facility. She indicated staff kept a set of doors in the hallway closed so the resident would not go into other residents' room on another unit. The clinical record for Resident #37 was reviewed on 2/7/12 at 9:30 A.M. Diagnoses included, but were not limited to, history of a cerebral vascular accident [stroke], symbolic dysfunction [difficulty speaking], dementia, depression, and anxiety. A quarterly M.D.S. [Minimum Data Set] assessment, dated 11/13/11, indicated the resident had a BIMS [Brief Interview for Mental Status] score of "5" [0-5=severe impairment]; had little interest or pleasure in doing things, felt down, depressed, or hopeless, and had trouble falling asleep/staying asleep, or slept too much; and was receiving anti-anxiety and anti-depressant medications. In an interview on 2/6/12 at 11:35 A.M., the M.D.S. Coordinator indicated all behaviors displayed by a resident would			

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	be documented in the "All Staff Behavior Log," located at the Nursing Station. She indicated any staff person could document behaviors they observed in the log book. The "Log" form requested date, time, "Description of Behavior & Interventions tried," the initials of the person entering the information, and the initials of the nurse reviewing the entries. Resident #37 had seventeen entries on her "Behavior Log" between 1/13/11 through 2/6/12. Each entry had a detailed description of the behavior displayed by the resident [wandering into other residents' rooms, yelling, resisting care, combativeness]. An entry on 1/18/11 indicated interventions of "snacks, T.V., watch birds" were offered, but not effective. An entry on 1/24/11 indicated an intervention of "T.V., activities, etc." were offered, but not effective. An entry on 3/12/11 indicated "requested pain medication for a severe headache. Refused any other interventions." The "Interventions tried" for the other entries were not listed. A four-page "Social Work Assessment" form, dated 11/9/11, duplicated assessment items requested for completion of the M.D.S. assessment for			

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	communication, cognitive patterns, mood, and behaviors for a 7-day look-back period. The form indicated "No behaviors noted this assessment period. Was observed to wander in wheelchair." There were no sections for summarizing, totaling, or addressing the behaviors documented on the Behavior logs, in order to determine trends or effectiveness of any interventions tried. 9. In an interview on 2/10/12 at 9:25 A.M., the Social Service Director indicated a staff person from any department could write in the Behavior Log, and document behaviors they had observed or been involved with. Social Service and Nursing Departments were supposed to review all of the entries made in the log; and Social Service should also "glean" information about behaviors from the Nurse's Notes. She indicated she used this information to complete the M.D.S. and to develop interventions. In an interview at this same time, the Director of Nursing indicated the facility did not have a formal past or current behavior program that summarized and/or quantified behaviors on a monthly, quarterly, or other periodic basis, to assist in determining the frequency of behaviors, or the effectiveness of any interventions used.			

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	3.1-34(a)(2)			

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	155206		02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBURG HEALTH CARE CENTER	1010 HORNADAY RD BROWNSBURG, IN 46112

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F0279 SS=E	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).			
	Based on record review and interview, the facility failed to develop individualized care plans addressing specific behaviors and interventions to meet the needs of the residents. This impacted 9 of 24 residents review for care plans in a sample of 24. (Residents #27, 35, 37, 91, 99, 105, 110, 121 and 122) Findings include: 1. The clinical record of Resident #91 was reviewed on 2/8/12 at 2:10 P.M. Diagnoses included, but were not limited to, Alzheimer's Disease, dementia, congestive heart failure and back pain.	F0279	It is the policy of the facility to implement and follow a comprehensive care plan for each resident based on a comprehensive assessment of the resident.All residents have the potential to be affected by this practice. Care plans have been reviewed and updated to reflect individualized interventions on residents #27, 35, 37, 91, 99, 105, 110, 121 and 122. Social Service and Nuring staff have been inserviced on care plans and documentation of individualized interventions for each resident. Social Service/DON/MDS/Activities will monitor the Behavior Tracking Log and 24 hour reports for any behavior changes and other	03/11/2012

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	A Quarterly MDS assessment, dated 10/26/11, indicated a BIMS score of 6 (severe impairment). A Nursing note, dated 1/24/12 at 8:00 P.M., indicated "...noticed res (resident) had open sore on coccyx. measure 1 cm (centimeter) x 2 cm redden edges, yellow center. no drainage..." A Braden Scale skin assessment, dated 1/12/12, indicated a score of 20 (low risk for skin breakdown). A physician's note, dated 1/25/12, indicated "...She has been declining...She is on a pressure relief mattress and is encouraged to turn and reposition self every 2 hours. She does not like to change position and prefers to sit in her recliner all day....Despite all preventive measures she has developed a superficial open area to her coccyx...The area is deemed unavoidable...." A Social Service assessment, dated 1/25/12, indicated "[name of Resident #91] is seen this afternoon sitting in her recliner crocheting..." A Care Plan for Activities, date 8/3/11 and last up-dated on 1/25/12, indicated: Low motivation toward out of room		changes in the resident daily, Monday through Friday. Any concerns will be addrerssed via a written action plan in the monthly Quality Assurance Meeting until resolution occurs.	

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	leisure time pursuits, prefers in-room options (crocheting, watching TV. A Care Plan for Risk of skin breakdown, dated 8/3/11 and last reviewed on 1/27/12, indicated a risk for skin breakdown due to nutritional status, anticlotting meds and decreased compliance with turning in bed. Approach's included, but were not limited to, skin audit at least weekly, do not pull or slide in bed and encourage fluids. No new interventions were added to the care plan after the Resident developed the open area on the coccyx. During an interview with the Director of Nursing, on 2/10/12 at 9:00 A.M., she indicated the Resident had a foam cushion in the recliner, that was brought in by the family. The facility will have therapy evaluate the Resident for a proper cushion. 2. The clinical record of Resident #99 was reviewed on 2/7/12 at 1:25 P.M. Diagnoses for Resident #99 included, but were not limited to, chronic pain, depression, anxiety, rheumatoid arthritis, chronic obstructive pulmonary disease and a history of narcotic abuse. An annual Minimum Data Set assessment			

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	(MDS), dated 12/6/11 indicated a Brief Interview for Mental Status (BIMS) score of 15 (Mentally intact). The Behavior Log, dated 12/7/11 at 6:00 P.M., indicted "Sent for this nurse to going pain pill, then began yelling & berating me stating I yelled @ her last night to wake her up. Explained to pt (patient) once again that I had knocked on door, waited, knocked again, called to pt x 3, entered rm (room), touched pt on LLE (left lower extremity), called her name again & then said her name again louder, when she finally awakened/startled. Yelling @ this nurse that I'm a liar & that she's easy to wake up, that I don't respect her & she demands respect immediately & I will be really sorry when she tells the DoN (Director of nursing on me tomorrow as "[name of DoN] knows I always tell the truth." Pt then yelled @ me more for not taking back to her....." The Behavior Log, dated 1/26/12 on 3 -11 shift (no time recorded), indicated "Pt has had pain Rx [increased] in past [2] days. Has had msir/prn (sic) (morphine as needed) @ 1:30 P.M. today. [after] 3:30 P.M. pt was already sending for nurse. pt sitting in bed, chatting [with] son. States "by the way, I need a pain pill." Advised pt she had just had an increase, and just			

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	had a PRN @ 1:30 P.M. pt began yelling @ this nurse in front of her son [name of son] "Your not here to judge my pain, the doctor says I can have that when ever I want it." Explained to pt that I was not judging her pain but she had a pill @ 1:30 P.M. This nurse phoned MD for suggestion...."just leave it the way it is" This nurse informed pt of MD decision & that I would bring it when it was time. When nurse took Rx pt turned her face away & states "I don't want it. Take it back." @ HS (bed time) pt refused MS Contin 60 mg (milligrams), states "I don't want it. Take it back. I don't want it."..." A review of Physician orders, dated 1/24/12, indicated an order for morphine Contin ER 60 mg (milligrams) (a narcotic pain medication) two every 12 hours. A review of the Nursing notes for December 2011 to February 7, 2012, indicated the Resident refused all non-pharmacological interventions for pain control. A Care Plan for Pain, dated 10/6/10 and last up-dated 12/14/11, indicated Resident #99 refuses interventions other than pain meds. Approaches included, but were not limited to, address complaints of pain promptly, reposition frequently, pain			

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	assessment fro facility policy, ongoing assessment of pain status, and monitor for constipation. There was no indication of how to redirect the Resident, no information regarding the types of activities that might calm or reassure the Resident. During an interview with LPN #6, on 2/8/12 at 10:00 A.M., she indicated there was no care plan for behaviors. 3. The clinical record of Resident #105 was reviewed on 2/10/12 at 9:00 A.M. Diagnoses for Resident 105 included, but were not limited to high blood pressure and Alzheimer's Disease. A Quarterly MDS, dated 11/9/11, indicated a BIMS score of 3 (severely impaired). A review of the Behavior Logs indicated the Resident's behaviors were last entered on November 6, 2011 on the 7 - 3 shift. The Behavior Log indicated "Resident would not stay in bed or wheelchair..." A Nursing note, dated 11/7/11 at 1:30 P.M., indicated "...personal alarm intact while in bed. Refused to get OOB (out of bed) this shift. Refused all 8 a & 12 p meds..."			

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	A Nursing note, dated 11/7/11 at 8:00 P.M., indicated "...Pt had period of extreme restlessness, would not sit in w/c (wheelchair), or stay in bed. Threw personal alarm across room. [Up] and [down] constantly...." A Nursing note, dated 12/4/11 at 2:30 P.M., indicated "Refused all meds, dropped them on the floor. Res (Resident) stated "No"." A Nursing note, dated 1/30/12 at 3:00 P.M., indicated "Refused to allow writer to place [left] wrist splint on. Hitting @ writer." A Nursing note, dated 1/31/12 at 11:00 A.M., indicated "Hitting @ staff when attempting to apply [left] wrist splint." A Nursing note, dated 2/6/12 at 3:00 P.M., indicated "Refused [left] wrist splint. Hitting @ staff." A Care Plan for Behaviors, dated 8/17/11 and reviewed on 11/15/11, indicated "Will propel self throughout facility in wheelchair. Resistant to care." Approaches included, but were not limited to, offer reassurance, offer simple options, provide consistent daily routine and redirect as needed. There was no			

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	indication of how to redirect the Resident, no information regarding the types of activities that might calm or reassure the Resident. 4. The clinical record of Resident #110 was reviewed on 2/9/12 at 2:00 P.M. Diagnoses for Resident #110 included,. but were not limited to, arthritis, high blood pressure and paranoid schizophrenia. A Significant change MDS assessment, dated 11/11/11, indicated a BIMS score of 10 (moderately impaired). There were no current Behavior Log sheets. The last Behavior Log entry was 5/14/11 at 7:30 A.M. to 12:00 P.M., indicated "Resident refused breakfast & lunch again saying snakes ate her guts out & she has to have an operation done..." A Weekly Progress note, dated 6/17/11, indicated "...food consumption - r/t (related to) thinks food poisoned." A Weekly Progress note, dated 11/4/11, indicated "...Res is refusing to eat the food her (sic) and said she is being poisoned." A Weekly Progress note, dated 12/30/11,			

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	indicated "...will say food is poisoned." A Nursing note, dated 12/17/11 at 7:00 P.M., indicated "...requested pain pill - refused all other interventions..." A Nursing note, dated 1/13/12 at 4:00 P.M., indicated "one hydrocodone @ this time for c/o (complaint of) pain. other interventions res refused...." A Care Plan for Behaviors, dated 11/16/11, indicated Resident #110 had "paranoid schizophrenia. Ongoing history of refusing medications. has periods of refusing to respond to conversation. will make unrealistic statements. delusion and hallucinations, refusal of care." Approach's included, but were not limited to, Calm voice gentle touch, Meds as ordered, validate concerns then redirect as appropriate and redirect her delusion gently if she will allow. There was no indication of how to redirect the Resident, no information regarding the types of activities that might calm or reassure the Resident. 5. The clinical record of Resident #122 was reviewed on 2/7/12 at 9:15 A.M. Diagnoses included, but were not limited to, depression, dementia and high blood pressure.			

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	A Physician's order, dated 1/3/12, indicated Ativan 0.5 mg every 6 hours as needed for anxiety. A review of the Medication Administration Record for the month of January 2012, indicated Resident #122 was given Ativan 0.5 mg 13 times for anxiety. There was no Behavior Log, monitoring the dates and times the Resident became anxious. During an interview with the Director of Nursing, on 2/8/12 at 3:15 P.M., she indicated there was no care plan regarding the Residents anxiety. 6. On 2/7/12 at 9:50 A.M., Resident #27's record was reviewed. Diagnoses included, but were not limited to, depression, pain, constipation, dysphagia, and left hemiplegia. Tour of the facility was initiated on 2/6/12 at 10:55 A.M. with Licensed Practical Nurse [LPN] #7. Resident #27 was identified as requiring assistance with feedings, thickened liquids, and as having behaviors. An "All Staff Behavior Log" with multiple dates included, but was not			

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	limited to, "7/8/11 at 9:30 A.M.: She [Resident #27] yelled out with care... 8/11/11, no time: Upset and yelling... 11/6/11, no time: Refused to eat unless her bed was flat... 12/20/11, no time: Cursing at staff on multiple occasions... 1/20/12, no time: Refused bed bath... 1/24/12, no time: Refused bed bath..." There were no interventions listed and no behavior care plan for Resident #27. On 2/7/12 at 4:00 P.M., requested from the Administrator and Director of Nursing [DON] a behavior care plan with individualized interventions for Resident #27. On 2/8/12 at 9:00 A.M., the DON provided a "Patient Care Plan" dated 2/7/12, no time. The care plan included, but was not limited to, "Problem: Yells out, resists care, verbally abusive to staff... Approaches: Explain procedure, approach calmly, allow to make choices..." 7. On 2/9/12 at 10:55 A.M., Resident #121's record was reviewed. Diagnoses included, but were not limited to, Alzheimer's disease, depression, dementia, anxiety, and hypertension.			

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	Tour of the facility was initiated on 2/6/12 at 10:55 A.M. with Licensed Practical Nurse [LPN] #7. Resident #121 was identified as having behaviors with medication management. A "Care Plans" for behaviors with an onset date of 5/4/11 included, but was not limited to, "Problem: Anxiety as evidenced by resistive to staff care, attempts to stand and transfer or ambulate from wheelchair unaware of own limits, can not understand own risk, yells out, dementia... Approaches: Attach busy apron to keep distracted, attempt to explain to resident he can not stand or ambulate, attempt to redirect, keep in common area with other residents..." An "All Staff Behavior Log" with multiple dates included, but was not limited to, "11-22-11, no time: Resident very combative... tried to hit CNA [Certified Nursing Assistant] in stomach twice... 11/26/11, no time: fighting during care... punching CNA, squeezing hands...12/17/11, 8:00 P.M.: punched CNA in right eye... 12/21/11, 8:30 A.M.: hit aide, punched aide in side... 1/1/12, 12:00 P.M.: very combative, hit and punched CNA in rib area..." There were no interventions in the			

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	behavior care plan for combative behavior. 8. In an interview during the initial orientation tour on 2/6/12 at 10:30 A.M., L.P.N. #4 indicated Resident #35 refused medication, would not eat or bites on the spoon, yells, hits, and pinches staff. The clinical record for Resident #35 was reviewed on 2/9/12 at 9:50 A.M. Diagnoses included, but were not limited to, senile dementia, depressive disorder, gastro-intestinal reflux disease, debility, and hypertension. A quarterly M.D.S. [Minimum Data Set] assessment, dated 11/14/11, indicated the resident was unable to complete the BIMS [Brief Interview for Mental Status] test, and was evaluated by the nursing staff to have moderately impaired cognitive skills for daily decision-making [made poor decisions and required cues and supervision]. In an interview on 2/6/12 at 11:35 A.M., the M.D.S. Coordinator indicated all behaviors displayed by a resident would be documented in the "All Staff Behavior Log," located at the Nursing Station. She indicated any staff person could document behaviors they observed in the log book. The "Log" form requested date, time,			

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	"Description of Behavior & Interventions tried," the initials of the person entering the information, and the initials of the nurse reviewing the entries. Resident #35 had fourteen "All Staff Behavior Log" entries from 1/16/11 through 2/2/12. Each entry had a detailed description of the behavior displayed by the resident [hitting, cursing, kicking, pinching, biting]. The "Interventions tried" were not listed. An "Activity Assessment" dated 8/12/11 indicated the resident "did some sewing years ago;" liked Gospel and Old Country music; was not a "movie" person and had no favorite T.V. programs; read paperback novels "years ago" as well as a newspaper and magazines occasionally; attended Bible study and attended church; and didn't care for any sports. One Care Plan entry, dated 2/2/12, addressed a problem of "Depression, becomes resistant to care, fights against staff, throws things, yells out at staff." The "Goal" was listed as "Will be free of any indicators of depression, will allow staff to provide care." The "Approaches" [Interventions] were listed as: "Allow resident to make			

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	personal care decisions each day [listed twice]; assess for signs/symptoms of depression; approach calmly offer explanations at [sic] to what is being done; offer activities that promote usefulness; offer choices whenever possible to give feeling of control; use calm reassuring voice when approaching; Depakote [medication] as ordered...." Interventions specific to this resident were not listed. During the daily conference on 2/9/12 at 3:15 P.M., the Director of Nursing was given the opportunity to submit any additional documentation of specific interventions used/tried when Resident #35 was experiencing an episode of behaviors. At the exit on 2/10/12 at 1:15 P.M., no further documentation of planned interventions were provided for review. 9. In an interview during the initial orientation tour on 2/6/12 at 11:00 A.M., L.P.N. #4 indicated Resident #37 was able to propel her wheelchair and wandered throughout the facility. She indicated staff kept a set of doors in the hallway closed so the resident would not go into other residents' room on another unit.			

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	The clinical record for Resident #37 was reviewed on 2/7/12 at 9:30 A.M. Diagnoses included, but were not limited to, history of a cerebral vascular accident [stroke], symbolic dysfunction [difficulty speaking], dementia, depression, and anxiety. A quarterly M.D.S. [Minimum Data Set] assessment, dated 11/13/11, indicated the resident had a BIMS [Brief Interview for Mental Status] score of "5" [0-5=severe impairment]; had little interest or pleasure in doing things, felt down, depressed, or hopeless, and had trouble falling asleep/staying asleep, or slept too much; and was receiving anti-anxiety and anti-depressant medications. In an interview on 2/6/12 at 11:35 A.M., the M.D.S. Coordinator indicated all behaviors displayed by a resident would be documented in the "All Staff Behavior Log," located at the Nursing Station. She indicated any staff person could document behaviors they observed in the log book. The "Log" form requested date, time, "Description of Behavior & Interventions tried," the initials of the person entering the information, and the initials of the nurse reviewing the entries. Resident #37 had seventeen entries on her			

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	"Behavior Log" between 1/13/11 through 2/6/12. Each entry had a detailed description of the behavior displayed by the resident [wandering into other residents' rooms, yelling, resisting care, combativeness]. An entry on 1/18/11 indicated interventions of "snacks, T.V., watch birds" were offered, but not effective. An entry on 1/24/11 indicated an intervention of "T.V., activities, etc." were offered, but not effective. An entry on 3/12/11 indicated "requested pain medication for a severe headache. Refused any other interventions." The "Interventions tried" for the other entries were not listed. An "Activity Assessment," dated 8/12/11, indicated the resident enjoyed all kinds of music; did not have any favorite T.V. program, and only occasionally watched movies; and was Catholic and attended Bible study and Mass. There was no other specific information related to the resident's prior interests. One Care Plan entry, dated 11/9/11, addressed a problem of "Resident can be short-tempered, easily annoyed. Period of confusion where she believes others have said or done something to her that never occurred. Will curse, kick, etc." The "Goal" was listed as "Will be easily			

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	redirected during episodes of cursing." The "Approaches" [Interventions] listed were: "1:1 [one-to-one] visits to establish trust relationship; call by name each time approached; gentle touch; give choices in daily care; offer simple options; provide a non-threatening atmosphere; provide diversional activities to resident; provide quality listening time; Reapproach later; reward resident for positive socially accepted behavior." Interventions specific to this resident were not listed. During the daily conference on 2/10/12 at 11:30 A.M., the Director of Nursing and Director of Social Service were provided the opportunity to submit any further documentation of specific interventions used/tried when Resident #37 was experiencing episodes of behaviors. At the exit on 2/10/12 at 1:15 P.M., no additional information related to planned interventions was provided for review. 3.1-35(a) 3.1-35(b)(1)			

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F0329 SS=D	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on interview and record review, the facility failed to ensure a GDR [Gradual Dose Reduction] evaluation was completed for 1 of 15 residents reviewed who were receiving psychotropic medications; in a sample of 24 residents. [Resident #37] Findings include: In an interview during the initial orientation tour on 2/6/12 at 11:00 A.M., L.P.N. #4 indicated Resident #37 was able to propel her wheelchair and wandered "a lot" through out the facility,	F0329	It is the facility policy that each resident be free of unnecessary drugs and a Gradual Dose Reduction be attempted.All residents have the potential to be affected by this practice.Resident #37 has been seen by her new physician and medications have been evaluated. Both the physician and the residents daughter have been educated to the need for GDR's and if not warranted then correct documentation to prove why a GDR is not indicated for the resident. Nursing staff have been inserviced to document behaviors and any physical changes noted with dose reductions of	03/11/2012

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	and had periods when she would not eat. The clinical record for Resident #37 was reviewed on 2/7/12 at 9:30 A.M. Diagnoses included, but were not limited to, history of a cerebral vascular accident [stroke], symbolic dysfunction [difficulty speaking], dementia, depression, and anxiety. The last full/annual M.D.S. [Minimum Data Set] assessment was completed on 8/16/11. The most current M.D.S. was a quarterly assessment, dated 11/13/11. In an interview on 2/8/12 at 1:00 P.M., the M.D.S. Coordinator indicated the next M.D.S. would be a quarterly assessment, due on 2/18/12. The November, 2011 M.D.S. indicated the resident had a BIMS [Brief Interview for Mental Status] score of "5" [0-5=severe impairment]; had little interest or pleasure in doing things, felt down, depressed, or hopeless, and had trouble falling asleep/staying asleep, or slept too much; and was receiving anti-anxiety and anti-depressant medications. The February, 2012 physician order recap [recapitulation] sheet listed orders which included, but were not limited to, (order date--8/3/10) Sertraline [Zoloft--an anti-depressant medication] 50 mg. [milligrams] one tablet every night at		medications in order to prove or disprove the need for the medication. Side effects will be addressed on the psychotropic behavior monitoring sheets. After dose reductions are done the nursing staff will observe and document any changes in the resident for 2 weeks and ongoing through Behavior Tracking Logs and nurses documentation, to show if the reduction is effective or not.DON/designee will monitor dose reductions and any concerns will be addressed in the monthly Quality Assurance meeting via a written action plan until resolution occurs.	

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	bedtime; and (order date--11/8/10) Lorazepam [Ativan--an anti-anxiety medication] 0.5 mg. one every night at bedtime. On 11/18/10, the family had the resident evaluated by an independent geriatric psychiatric consultant. In the report, dated 11/18/10, the physician indicated the resident was currently [at that time] receiving Sertraline and Lorazepam. The "Plan" indicated the focus would be on the resident's comfort; and "in addition, we need to look closely at her medications. For example, she is on multiple psychoactive drugs, including Lorazepam, ... and Sertraline.... A risk-benefit analysis needs to be done to think about what is really going to be the safest option...." A "Note to Attending Physician/Prescriber" form, from the facility's pharmacy consultant and dated 1/20/11, requested evaluation and consideration of a GDR for the Zoloft. An unsigned and undated hand-written note on the form indicated "Please call Dr. [the psychiatric consultant's name] per family request." A second hand-written note, dated 1/26/11, indicated the form had been faxed to the psychiatric consultant.			

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	A return fax from the consultant psychiatrist, dated 1/27/11, indicated "Patient needs 12 months of stability prior to any attempt at dose reduction, due to risk of relapse." There was no indication the resident was evaluated in August of 2011, one year following the initial prescription, to determine if she had experienced 12 months of mood stability in order to attempt a GDR. A "Note to Attending Physician/Prescriber" form, from the facility's pharmacy consultant and dated 5/18/11, requested an evaluation and consideration of a GDR for the Lorazepam. A response from the facility attending physician, dated 5/31/11, indicated "Check with Dr. [the psychiatric consultant]." There was no documentation/evidence the Lorazepam had been evaluated and considered for a GDR attempt either before or after the consultant pharmacy request in May, 2011. During the daily conference on 2/7/12 at 3:45 P.M., the Director of Nursing was given the opportunity to submit any			

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	information/documentation related to evaluation of the psychotropic medications and consideration of a GDR for Resident #37. On 2/8/12 at 9:00 A.M., the Director of Nursing provided a copy of a "Nurse's Note," dated 2/8/12 at 7:00 A.M. The note indicated "Spoke with resident's [family member] regarding appointment with Dr. [psychiatric consultant]. Stated she will make, but had forgotten to do so. Faxed to Dr. [physician's name] need to re-assess meds and to state why or why not do a GDR." In an interview on 2/9/12 at 9:30 A.M., the Director of Nursing indicated that after extended research into the issue, she had discovered the family member, who was to have made an appointment, was distracted by other family issues and had simply forgotten to call the physician. In addition, through conversations with the consultant physician's office, she had discovered that he had moved out of state and no longer practiced in that office. Subsequent arrangements were made to have the resident evaluated. In the meantime, the attending physician's Nurse Practitioner had evaluated the resident, and indicated "[Family member] has requested medications not be changed as resident is stable on current doses...."			

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	3.1-48(a)(5)			

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F0364 SS=F	Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.			
	Based on observation and interview, the facility failed to ensure food served to residents from 1 of 1 kitchen, was kept at a palatable temperature for 126 of 126 residents that eat food served from the kitchen. [Resident #99] Findings include: An observation during the kitchen tray prep line on 2/6/12 at 6:45 A.M. the plate warmer was making a very loud humming noise and the Dietary Manager indicated it has made noise like that for a while. The machine was noted to have warm air inside of it and plate was warm to touch. An observation of breakfast was done on 2/6/12 at 7:25 A.M. CNA's (Certified Nursing Aides) received the carts with the breakfast food on them. The CNA's then shuffled several of the trays around, moving from shelf to shelf or from one cart to another before serving to residents. Two of the trays were noted to have the plate cover not completely covering the food when taken off of the cart and served to the resident A test tray was requested at 11:50 A.M.	F0364	It is the facility policy that food be served at the proper, palatable temperature. All residents have the potential to be affected by this practice. New seating charts have been developed in each dining room and given to dietary to ensure trays come out in the correct order. The Dietary Manager will check tray temperatures daily, Monday-Friday, to assure temperature is correct when trays are served to the residents. Nursing staff have been inserviced on tray service to each table, not to lift lids and shuffle trays and to follow the seating chart when bringing residents to the dining room for meals.Dietary Manager/DON/designee will monitor and any concerns will be addressed in the monthly Quality Assurance meeting via a written action plan until resolution occurs.	03/11/2012

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	on 2/7/12. Another observation was made on 2/7/12 at noon for lunch. CNA's again were shuffling trays around from shelf to shelf inside the cart and from cart to cart. The food temperatures from the test tray were tested after the last resident had received their food tray in the dining room in the back hall. The temperatures of the food are as follows on 2/7/12 at 12:15 P.M.: Turkey with gravy-130 degrees Green beans- 110 degrees Potatoes- 108 degrees Resident council minutes reviewed for November, December 2011, and January 2012. The minutes for the month of January 2012 indicated two the residents felt the food was cold In an interview with Resident # 99 on 2/7/12 at 1:30 P.M. resident indicated sometimes her food is cold. 3.1-21(c)(2)			