

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155428	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/16/2016
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NAME OF PROVIDER OR SUPPLIER MERIDIAN NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2102 S MERIDIAN ST INDIANAPOLIS, IN 46225
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit resulted in an Extended Survey-Immediate Jeopardy.</p> <p>Survey dates: March 7, 8, 9, 10, and 11, 2016 Extended Survey dates: March 14, 15, and 16, 2016</p> <p>Facility number: 000386 Provider number: 155428 AIM number: 100286820</p> <p>Census bed type: SNF/NF: 37 Total: 37</p> <p>Census payor type: Medicare: 2 Medicaid: 32 Other: 3 Total: 37</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Q.R. completed by 14466 on March 23, 2016.</p>	F 0000	<p>On March 16, 2016 a survey team from the ISDH completed an annual recertification survey at Meridian Nursing and Rehab. Enclosed please find the statement of deficiencies with the facility's plan of correction for these alleged deficiencies. Please consider this letter and plan of correction to be the facilities credible allegation of compliance. This letter is our request for a desk review to verify the facility has achieved substantial compliance with the applicable requirements as of the date set forth in the plan of correction as of April 15, 2016.</p> <p>Respectfully, Ethan Peak, Administrator</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F 0167 SS=C Bldg. 00	<p>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>Based on observation and interview, the facility failed to ensure the availability of the most recent surveys conducted by State surveyors. (Residents #30, #13, #17, and #52)</p> <p>Findings include:</p> <p>During an interview on 3/11/16 at 11:33 a.m., Resident #30 indicated no knowledge of the State Survey results being available.</p> <p>During an interview on 3/15/16 at 2:41 p.m., Resident #13 indicated he did not know where the State Survey results were located.</p> <p>During an interview on 3/15/16 at 4:35 p.m., Residents #17 and #52, indicated they did not know they could view the</p>	F 0167	<p>F167-Right to Survey results</p> <p>What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice:</p> <p>Labelingwas placed on the storage bin that contains the binder which holds the resultsof survey results. Current residents will be informed on where the results arelocated.</p> <p>How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective action(s) will be taken:</p> <p>Allresidents had the potential to be affected. Social Service Director waseducated on the importance of residents being informed of where the surveyresults are located.</p> <p>What measures willbe put into place or what systemic changes will be made to ensure that the</p>	04/15/2016
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F 0223 SS=K Bldg. 00	<p>results of State Surveys and was unaware of the location of the State Survey results.</p> <p>On 3/16/16 at 9:30 a.m., the results of State inspection were observed to be located in a binder, stored in a storage bin approximately 4 feet off of the ground on the wall next to the Administrator's office. The binder spine was upright in the storage bin, with the label "Survey Results" facing the ceiling (not visible). No notice indicating the survey results availability was observed posted near the binder.</p> <p>3.1-3(b)(1)</p> <p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p>		<p>deficient practice does not recur: Administrator will monitor the labeling of bin. A special resident council meeting will be held to inform all residents where the survey results are located. A sign placed by the front door notifying of location of binder. Binder is lowered on the wall to be wheelchair accessible.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The administrator/designee will monitor to ensure the special resident council meeting was held and report the completion to the QA team. The administrator/designee will monitor the labeling of survey results to ensure it remains in place by doing a weekly audit x 4 weeks and report the results to the QA team.</p> <p>By what date the systemic changes will be completed: 4/15/2016</p>	
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	<p>Based on observation, record review, and interview, the facility failed to ensure effective monitoring and interventions were in place to prevent Resident #22 from hitting other residents which resulted in 6 incidents of Resident #22 having hit other residents (Resident #9, #17 and 54) and 6 other residents who exhibited resident to resident altercations for 1 of 1 resident (Resident #22) and 6 extended residents (Residents #9, #19, #33, #54, #30, and #32) reviewed who exhibited aggressive behaviors towards other residents.</p> <p>The Immediate Jeopardy began on 2/1/16, when Resident #22 struck another resident. No documentation was found which indicated the care plan was updated or in what manner Resident #22 was being monitored. The only intervention found was, "Educated [Resident #22] on not striking others." The Administrator and Director of Nursing were notified of the Immediate Jeopardy on 3/7/16 at 5:35 p.m.</p> <p>Findings include:</p> <p>1. The clinical record of Resident #22 was reviewed on 3/7/16 at 3:30 p.m. Diagnoses for the resident included, but were not limited to, adjustment disorder, personality disorder, and major</p>	F 0223	<p>Abatement Plan for Meridian Healthcare center 3-8-16</p> <p>A. The identified resident is no longer at the facility as of 3-7-16. B. The Regional Director of Operations will in-service the Administrator and all Department Managers on the Facility Abuse Policy which will include protection of all facility residents. C. The Administrator/DON/Designee will then in-service remaining staff on the Facility Abuse Policy which will include the protection of all facility residents. D. The SSW/DON/Designee will educate all staff on the facility Behavior Program and 1:1 Resident Altercation Policy. E. The Facility Abuse Policy and Protocol was reviewed and found to be appropriate. F. The SSW/Designee will speak with all interviewable residents to determine if they have any concerns with other residents. G. All resident charts will be reviewed to determine if there are other potential residents that have had or could potentially cause harm to other residents. H. The Interdisciplinary team will meet to discuss the residents that have been identified as having the potential to cause harm and interventions that may need to be put in place, up to and including</p>	04/15/2016

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	<p>depression.</p> <p>An annual Minimum Data Set (MDS) assessment, dated 12/8/15, indicated the resident was cognitively independent in his ability to make decisions and independently mobile on the unit.</p> <p>A care plan for Resident #22, original date not documented, indicated he had a potential to demonstrate physical behaviors related to poor impulse control. The goal was that he would not harm self or others through the review date of 2/9/16. Interventions were:</p> <p>"Assess and anticipate resident's needs: food, thirst, toileting needs, comfort level, body positioning, pain etc." (initiated on 11/10/14)</p> <p>"Refer to psych [psychiatric] MD as indicated." (initiated on 11/17/15)</p> <p>"When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later." (initiated 1/16/15)</p> <p>On 3/7/16 at 12:30 p.m., Resident #17 and #22 were observed sitting at the same</p>		<p>discharge if appropriate.</p> <p>I. All identified residents will have their careplans updated, as needed, during the Interdisciplinary team meeting.</p> <p>J. The nursing 24 hour report sheets will bereviewed daily during the facility morning meeting along with the facilitygrievance binder to help assure all potential concerns have been addressedappropriately.</p> <p>K. Allsubsequent abuse allegations shall be reported by Administrator to RegionalDirector of Operations (RDO)</p> <p>L. RDOwill review all abuse allegation investigations to assure proper protection ofresidents and timely reporting. Anyidentified deficiencies in practice will be addressed immediately.</p> <p>M. FacilityAdministrator will review abuse allegations and investigations through FacilityQA process.</p> <p>N. RDOwill schedule a daily phone call with the Administrator and/or DON to discussany facility concerns, including any allegations of abuse, neglect,misappropriation, etc. The RDO willdetermine the frequency of continued calls after the first month, based onfindings of previous calls.</p> <p>O. DON/Admin/Designee will do shift to shift rounds and in-services at these times, on what type ofevents happen that need to be recorded and reported.</p> <p>P. Managersor Leadership will be in the building interviewing</p>	

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	<p>table in the dining room, beside each other. Resident #17 was observed to move away from the table, walk around the dining room, and sit back down at the table. At this time, Resident #17 was positioned across the table from Resident #22. Resident #22 was observed to self-propel his wheelchair to beside Resident #17 and then hit Resident #17 on the arm. Resident #17 yelled, "He hit me." The residents were immediately separated by staff who rushed into the dining room. Prior to Resident #22 having hit Resident #9, no staff were observed present in the dining room.</p> <p>On 3/7/16 at 1:00 p.m., Physical Therapist #1 indicated, after he talked with Resident #22 about this incident, Resident #22 and Resident #17 were disagreeing about the volume of the music being played in the dining room.</p> <p>Continued review of Resident #22's clinical record indicated:</p> <p>Nurse's notes (NN): 10/30/15 at 9:30 a.m., "Resident at this time hit [Resident #9] on the [right] arm after [Resident #9] stated to him that, 'm.....f....., what the f...are you looking at. Writer told [Resident #22] not to hit another resident..."</p>		<p>residents to ensure theirsafety and that they are well cared for.</p> <p>Q. Corporatestaff will be providing oversight and will be looking over all reports dailyuntil all in-services are done.</p> <p>Date of compliance: 3-9-16</p> <p>Addendum to abatement plan 3-8-16</p> <p>C. TheAdministrator/DON/Designee will then in-service remaining staff on the FacilityAbuse Policy which will include the protection of all facility residents. This in-service will also include review of 1:1 Resident altercation policy.</p> <p>H. The Interdisciplinary team will meet todiscuss the residents that have been identified as having the potential tocause harm. and interventions that may need to be put in place, up to and including discharge if appropriate. If not already in place, interventionswill be implemented and added to the resident's care plan that are residentspecific and the IDT will ensure all interventions are implemented.</p> <p>I. All identified residents will</p>	

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	<p>Incident Report (IR) #45: The residents were separated and Indianapolis Metropolitan Police Department (IMPD) was called. (Case #I153030954) Resident #9 was educated on improper language use. No injury was reported. NN: 11/5/15 at 6:45 p.m., "Resident has been aggressive today, resident smacked another resident [Resident #9] on arm..."</p> <p>IR #46: "Nurse heard [Resident #9] in the hallway and came to see what was happening and [Resident #9] said that [Resident #22] had smacked her on her upper right arm...residents separated, [Resident 22] educated on appropriate communication and appropriate behaviors of not hitting or grabbing other residents." IMPD was notified. (Case # I153092988) On 11/6/15 Resident #22 was moved to a different room a psychiatric referral was made and the resident again was educated on keeping his hands to himself and to not become physically aggressive with other people.</p> <p>No documentation was found which indicated the resident had been seen by psych until 1/19/16, for signs of anxiety as, indicated by the careplan dated 11/17/15.</p> <p>NN: 11/17/15 at 6:00 a.m. to 6:00 p.m., "[Resident] got upset and threw the</p>		<p>have their careplans updated, as needed, if appropriate interventions are not already in place, during the Interdisciplinary team meeting. Care Plan Interventions will be added to the C.N.A. assignment sheets and staff will be in-serviced on interventions as well as location of the resident care plans.</p> <p>J. The nursing 24 hour report sheets will be reviewed daily during the facility morning meeting along with the facility grievance binder to help assure all potential concerns have been addressed and followed up on until a resolution achieved. . appropriately.</p> <p>K. All subsequent abuse allegations shall be reported by Administrator to Regional Director of Operations (RDO) within 1hour.</p> <p>P. Managers or Leadership will be in the building interviewing residents to ensure their safety and that they are well cared for. Any resident that voices a concern with their safety or care provided, will have this concern reported to the Administrator immediately. The Administrator or SSW/Designee will personally meet with each of these residents, record concerns and assure interventions are implanted immediately to resolve the concern. The SSW/Designee will contact the RP/Guardian of all non-interviewable residents and review</p>	

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	<p>phone hand set at the nurse's station occupants..."</p> <p>NN: 1/9/16 at 10:00 a.m., "At 6:00 a.m. CNA [Certified Nursing Assistant] reported that resident grabbed her by the scrub top and necklace, breaking the necklace and scratching her while she was bending over to put foot rest [sic] on his [wheelchair]...Witness reported that she had to assist in loosening resident grip on CNA's top..."</p> <p>NN: 2/1/16 at 2:25 p.m., "Res[ident] involved in res[ident] to res[ident] [Resident #9] altercation. This res[ident] was the aggressor...placed on 15 minute checks..."</p> <p>IR #57: (Resident #9) was coming to the office when she alleged Resident #22 hit her on her arm and kicked her chair. The residents were separated and assessments completed. The incident was reported to IMPD, Case # I160321689. Resident #22 was educated on appropriate social behaviors and his behaviors would continue to be monitored.</p> <p>NN: 2/18/16 at 1:00 p.m. "Resident swatted at another resident [Resident #17] in the dining room [after] she accidentally bumped his [wheelchair]. When staff attempted to redirect, he</p>		<p>the facility grievance Policy and Procedure with them. Daily rounds will be made a member of themanagement team and/or nurse in charge on each shift. Residents will be given the opportunity to voice concerns and non-interviewable residents will be observed for changes incondition, mood, and behavior. Allresidents receive a skin assessment by a licensed nurse weekly and a C.N.A.make a skin observation during each shower which is then turned in to thecharge nurse.</p> <p>Staff will be tested forcompetency after abuse inservices. Anystaff member that does not demonstrate a clear understanding of the in-servicematerial will be re-educated until they do demonstrate a clearunderstanding. If not, they will besuspending pending further notice and education with potential for discharge ifunable to achieve a clear understanding. Staff will be randomly quizzed by theAdministrator/DON/SSW to ensure continued compliance. Re-education will be provided immediately ifa clear understanding is not voiced.</p>	

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	<p>knocked over his water and left the dining room."</p> <p>NN: 2/18/16 at 3:18 p.m. "Resident hit another resident [Resident #17] on the [left] breast when she walked past him and smiled at him...res[idents] were separated. Intervention successful."</p> <p>Social Service Director (SSD) note: 2/18/16 4:30 p.m., "Behavior: Resident [#22] was involved in incident with female peer [Resident #17]. This resident was in the hallway with this female peer. Female peer yelled that 'he hit me.'...Female peer had just been in writer's office stating that her bra was hurting her breast, same one that she said this resident hit. Writer spoke with resident he wouldn't say, but would just shrug his shoulders. Writer will continue to observe."</p> <p>On 2/9/16 a psychiatric evaluation was done for Resident #22. The evaluation indicated, "Staff reports that he is physically aggressive with female peers." The diagnosis was Personality Disorder with anxiety and depression. The plan, after the evaluation was completed, was to start the resident on a scheduled dose of antidepressant to help with his mood and behaviors and continue to provide psych support.</p>			

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	<p>NN: 3/5/16 at 11:15 a.m. Resident at this time got into a fight with another resident [Resident #54], a skin tear noted to left ear...resident is responsible for self, placed on 15 min checks, IMPD [Indianapolis Metropolitan Police Department] called and notified about incident, case # given..."</p> <p>3/7/16 at 11:55 a.m.: "Res[ident] in dining room in [wheelchair] he was exiting the dining room and forcefully shoved another resident [Resident #17] res will remain on 15 minute [checks] for safety."</p> <p>No documentation was found in the resident's record which indicated Resident #22's plan of care had been reviewed or updated after 2/9/16, with new interventions and effective ways of monitoring the resident's aggressive behavior, to ensure the safety of the other residents in the facility. On 3/7/16 at 4:05 p.m., the Director of Nursing did not indicate the care plan for the resident's physically aggressive behavior had been updated.</p> <p>No Behavior/Intervention Monthly Flow Records were found in the resident's record.</p>			

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	<p>On 3/7/16 at 4:00 p.m., the Administrator indicated the resident had been placed on 15 minute checks since the incident in the dining room at lunch time.</p> <p>On 3/7/16 at 5:00 p.m., the Administrator indicated the resident was now 1:1 (one staff person with him at all times) and they were seeking placement for him in a psychiatric facility.</p> <p>On 3/10/15 at 3:00 p.m. Certified Nursing Assistant (CNA) #11 indicated Resident #22, "Just snaps, it's a little scary."</p> <p>On 3/15/16 at 9:15 a.m., Resident #29 indicated she was aware some of the residents living at the facility very verbally and physically aggressive towards other residents and staff. She indicated, "I mostly stay in my room."</p> <p>On 3/16/15 at 11:50 a.m., Resident #44 indicated he was aware of Resident #22's verbal and physical aggressions toward other residents and staff.</p> <p>On 3/16/16 at 12:07 p.m., Resident #14 indicated she was very aware of Resident #22's verbal and physical aggressions toward staff and other residents.</p> <p>2a. The clinical record of Resident #9</p>			

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	<p>was reviewed on 3/15/16 at 10:10 a.m. Diagnoses for the resident included, but were not limited to, paranoid schizophrenia.</p> <p>Quarterly Minimum Data Set assessments, dated 1/13/16 and 12/5/15, indicated the resident was independent in her ability to make decisions.</p> <p>A care plan, initiated 2/14/16, indicated Resident #9 had a behavior problem related to frequent verbally abusive outbursts to staff and other residents.</p> <p>Another care plan, initiated 2/17/16, indicated the resident had potential to demonstrate verbally abusive behaviors related to ineffective coping skills ad poor impulse control.</p> <p>Nurse's note dated 10/30/15, indicated Resident #9, "was wheeling herself in her wheelchair in the hallway...when she saw [Resident #22] sitting in his wheelchair and she stated to him, 'm..... f.....what the f... are you looking at.'"</p> <p>Social Service Director (SSD) note, dated 10/30/15 at 12:30 p.m., indicated, "This AM this resident became verbally aggressive with male peer..."</p> <p>SSD note, dated 1/5/16 at 10:00 a.m.,</p>			

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	<p>indicated, "...This resident stated very loudly to anyone that would listen, 'My roommate smells bad, she needs to take a bath.'</p> <p>SSD note dated 3/4/16 at 5:40 p.m., indicated the resident refused to be seen by psych services.</p> <p>A nurse's note, dated 3/8/16 at 8:50 a.m., indicated Resident #9 was,"rolling fast in wheelchair, hit another resident with her wheelchair in the hand. Res[ident] was having periods of delusional episodes..."</p> <p>SSD note, dated 3/8/16 at 11:00 a.m., indicated, "This AM resident was in hallway making statements, '...Russian people like her smell bad. ' She was talking about a female peer. This resident was propelling self down hallway as she did so she bumped into the hand of the female peer. This resident stated, 'I pushed my way past that dumb B.... and ran into her hand. I don't like her and she don't like me.'"</p> <p>An Incident Report #66 dated 3/8/16, indicated Resident #9 was transported to (name of local hospital) for evaluation and treatment for psychotic episodes.</p> <p>No Behavior/Intervention Monthly Flow reports were found in the resident's</p>			

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	<p>record. The flow records were requested from the Director of Nursing on 3/15/16 at 10:30 a.m., but none were provided by survey exit on 3/16/16 at 7:00 p.m.</p> <p>b. The clinical record of Resident #19 was reviewed on 3/14/15 at 1:54 p.m. Diagnoses for the resident included, but were not limited to, dementia with behavioral disturbance.</p> <p>A quarterly Minimum Data Set assessment, dated 12/28/15, and an annual MDS, dated 9/29/15, indicated the resident was moderately impaired in his ability to make decisions.</p> <p>A careplan, initiated 9/26/14, indicated the resident had a mood problem related to depression, as evidenced by yelling out. This careplan was not updated with any new interventions from 10/2/14 through 1/11/16.</p> <p>A careplan, initiated 11/17/14, indicated the resident had potential to demonstrate physical behaviors such as hitting related to poor impulse control and anger. This careplan was not updated with any new interventions from 11/17/14 through 1/11/16.</p> <p>A nurse's note, dated 11/22/15, indicated, "Heard yelling in the dining room. Went</p>			

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	<p>to dining room and res[ident was yelling and cussing at another res... Writer was attempting to wheel res out of dining room. Res proceeded to hit this writer in the face and upper body several times. Explained to res that we wanted to separate him from the other res. Res continued yelling, 'I'm going to kick his a...'"</p> <p>Behavior/Intervention Monthly Flow Records for November and December, 2015, did not indicate the resident was being monitored for verbal or physical aggression.</p> <p>A Psychology Progress Note, dated 12/11/15, indicated resident was being seen for signs and symptoms of depression and aggression. The note indicated the resident was angry. Recommendations were, "Continue as is with reevaluation in approximately three months."</p> <p>A Psychiatric Evaluation, dated 2/19/16, indicated Resident #19, "Yells and curses at peers and staff, history of physical aggression."</p> <p>A Behavior Flow Record for January, 2016 was not found in the resident's record.</p>			

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	<p>Social Service Director (SSD) note, dated 2/22/16 at 4:00 p.m., indicated Resident #19 was in the hallway and started, "Yelling and cursing at male peer." Both residents were provided with 1:1 care.</p> <p>Behavior/Intervention Monthly Flow Record for February, 2015 did not indicate the resident was being monitored for verbal and physical aggression.</p> <p>SSD note, dated 3/7/16, indicated Resident #19 was involved in a verbal altercation with his roommate..."Staff heard yelling and came running to room to find both males standing face each other and cursing at one another..." The note indicated 1:1 care was provided at this time.</p> <p>c. The clinical record of Resident #33 was reviewed on 3/14/1 at at 9:18 a.m. Diagnoses for the resident included, but were not limited to, major depression, anxiety, and mood disorder.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 1/2/16, and an annual MDS assessment, dated 10/2/15, indicated Resident #33 was independent in her ability to make decisions.</p> <p>A careplan, initiated 3/20/15 and current through 6/20/16, indicated the resident</p>			

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	<p>had potential to demonstrate verbally abusive behaviors related to mental/emotional illness and poor impulse control, anger.</p> <p>Nurse's note (NN) dated 10/14/15 at 7:30 p.m., indicated Resident #33 was in a verbal altercation with another female resident (Resident #30). Resident #19 indicated she hit the other resident, but this was not verified. No signs or symptoms of injury. Residents separated.</p> <p>Review of Incident Report (IR) #42, dated 10/14/15, indicated it was found, after investigation, the residents did get into a physical fight hitting, scratching and pulling each others hair. The resident were separated immediately and removed from the situation. Preventative measures were, "The residents were educated on appropriate social behavior."</p> <p>NN dated 11/21/15 at 2:30 p.m., indicated the resident was screaming about her roommate's music, screaming, "I f..... Hate that b..... music, she blaes it all the f..... night long...resident screamed at other residents in the hallway..."</p> <p>NN dated 12/4/16 at 6:20 p.m., indicated, "Resident asked this nurse for a cigarette. Explained to resident the rules. Resident</p>			

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	<p>stormed off trying to get out the side door. Resident stated, 'I am walking to the f..... store.' Resident unable to get out door she starting hitting it with her fist screaming, 'f... your rules b...., I'm going to tear this f..... place up until you let me out, you f..... b.....' Resident ran toward this nurse, drew back her fist yelling, 'I will f... you up, call the police cause I plan on tearing everything up until I get my way b....' Tried one on one without success."</p> <p>NN dated 1/29/16 4:00 a.m. "Resident's anger escalated regarding her call light not being answered promptly. [Resident] struck/pummeled [Resident #32] on his back with her fists without provocation. Residents were separated. Police were phoned...no injuries were sustained by either resident. "</p> <p>NN dated 2/2/16 at 4:30 p.m., "Res was involved in a resident to resident altercation. She smacked another resident on the cheek..."</p> <p>Incident Report #58, dated 2/2/16, indicated a resident (Resident #31) began cussing and yelling in the hallway, and Resident #33 gently smacked Resident #31 on the cheek. Preventative measures included, Resident #19 was educated on appropriate ways to voice grievances</p>			

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	<p>about other residents, not touching other residents. A psych consult was to be requested.</p> <p>A Psychiatric Evaluation, dated 2/9/16, indicated resident was being seen for yelling, cursing and some physical aggression. Treatment changes included an increase in Depakote (a medication used for mood stabilization) and continued psych support.</p> <p>NN dated 3/7/16 at 9:45 a.m., resident started talking loudly and another resident asked her to be quiet, and Resident #33 called the other resident a "b..." and started going towards the other resident, who stood up from her wheelchair. Writer immediately stepped between the residents to separate them.</p> <p>NN dated 3/9/16 at 6:06 a.m. indicated Resident #33 was on 1:1 care due to increase in aggressive behaviors. The resident was still on 1:1 care at time of the survey exit on 3/16/16 at 7:00 p.m.</p> <p>Review of Behavior/Intervention Monthly Flow reports indicated the resident was not being monitored for aggressive behaviors until February, 2016. The February, 2015 flow sheet indicated 22 shifts with no evidence of monitoring, out of 87 total opportunities.</p>			

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	<p>d. The clinical record of Resident #54 was reviewed on 3/16/16 at 8:58 a.m. Diagnoses for the resident included, but were not limited to, end stage renal disease.</p> <p>On 3/16/16 at 2:08 p.m., the Social Service Director (SSD) indicated the resident had refused to be cognitively evaluated upon her admission 2/24/16, but the resident appeared alert and oriented and the SSD indicated she was, "probably" independent in her ability to make decisions.</p> <p>NN dated 3/3/16 at 4:15 p.m. indicated, "Resident was noted with verbally inappropriate behaviors, telling another resident that he was smelling pee and that he stinks, resident was asked not to tell anybody that they stink."</p> <p>SSD note dated 3/3/16 at 12:00 p.m. Resident #54 refused psych services.</p> <p>NN dated 3/5/16 at 11:15 a.m. " Resident at this time got into a fight with another resident, both got separated...no injury noted...15 minute checks initiated incident reported to IMPD..."</p> <p>Incident Report #62, dated 3/5/16, indicated Resident #54 was in the back</p>			

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	<p>hallway and told Resident #22 to get out of her way. Resident #22 hit Resident #54 on the arm...and then Resident #54 reached around the nurse and hit Resident #22 back in his face. Both residents were placed on 15 minute checks, and "educated about appropriate behavior."</p> <p>SSD note dated, 3/7/16, (no time documented) "This A.M. this resident was waiting to go outside to smoke. Words were exchanged between this resident and another female resident Both residents started yelling and cursing at each other. This resident stood up out of her wheel chair and started to raise her arms up in a manner that would suggest that she was going to hit other residents, fist swinging...DON was able to step between both residents before any contact was made..." One to one care was provided. The writer spoke with the Resident #54, who "'stated again...I will hit her if I have to..."</p> <p>NN dated 3/8/16 at 2:00 p.m. "Resident is unpleasant to all staff. Refuses care and meds. Is confrontational with staff and residents. She remains on 1:1. One female resident she is more vocal with. On 3/7/16 she and the female resident had words of calling each other "b...."</p> <p>NN dated 3/8/16 :00 p.m. "...She was in</p>			

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	<p>another altercation with the same other resident, attempted to charge this resident, and threatening to fight. The two were separated by staff, there no injuries. Will continue to monitor."</p> <p>NN dated 3/9/16 1:20 p.m. "She continues to be verbally abusive with staff, at times seeming to be physically aggressive..."</p> <p>NN dated 3/11/16 (no time documented) "Resident...continues to be rude and demanding. She swears at staff and other residents...remains on 1:1 precautions..."</p> <p>An Interim Care Plan for Physical and Verbal Aggression was not created for the resident until 3/9/16.</p> <p>Resident #54 remained on 1:1 care through survey exit date on 3/16/16 at 7:00 p.m.</p> <p>Review of the Behavior/Intervention Monthly Flow record for March, 2016, did not indicate verbal nor physical aggression was being monitored.</p> <p>e. The clinical record of Resident #30 was reviewed on 3/14/16 at 2:25 p.m. Diagnoses included, but were not limited to, schizophrenia, anxiety, and depression.</p>			

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	<p>Quarterly Minimum Data Set (MDS) assessments, dated 12/22/15 and 9/22/15, indicated Resident #30 was independent in her ability to make decisions.</p> <p>Nurse's Note (NN) dated 11/8/15 at 7:50 p.m. Another resident "was at nurses station on phone talking with his brother when this resident [#30] began yelling I want to talk..." This resident continued yelling as the other resident walked to a different hall. The nurse was between the residents at all times.</p> <p>NN dated 12/15/15 at 7:40 p.m. "Heard yelling in hallway this resident and [another resident] in hallway. Saw this resident walking fast down hallway walker lying on floor. [other resident] following resident yelling. Writer and other staff in between residents. IMPD notified."</p> <p>Social Service Director (SSD) note dated 12/16/15 at 10:00 a.m. "Behavior On 12/15/15 late evening staff heard yelling in hallway by nurses' station. This resident was having a verbal disagreement with a male peer over his use of resident phone. Words were exchanged between both residents. This resident became angry and pushed her walker towards male resident and threw</p>			

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	<p>her coat at him. Male resident responded by standing up from his...walker and pushing walker back at this resident walking towards her and yelling at her. Staff at this point was able to interject and separate both residents and provide 1:1 care to each."</p> <p>Psychiatric Evaluation dated 3/3/16, indicated the resident was being seen for "verbal aggressive with peers and staff..." The plan was to start Depakote (a mood stabilizing medication) and provide continued psych support.</p> <p>Review of Behavior/Intervention Monthly Flow records indicated:</p> <p>November, 2015: A Behavior/Intervention Monthly Flow record was not provided by survey exit 3/16/15 at 7:00 p.m.</p> <p>December, 2015: resident was monitored for aggression, interventions and effectiveness only 54 shifts out of the 93 opportunities.</p> <p>January, 2016: A Behavior/Intervention Monthly Flow record was not provided by survey exit 3/16/16 at 7:00 p.m.</p> <p>February, 2016: resident monitored for verbal aggression, interventions, and</p>			

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	<p>effectiveness only 54 shifts out of 87 opportunities.</p> <p>A careplan for the resident, initiated 3/9/16, indicated the resident had the potential to demonstrate verbally and physical abusive behaviors related to mental and emotional illness.</p> <p>f. The clinical record of Resident #32 was reviewed on 3/14/16 at 10:11 a.m. Diagnoses for the resident included, but were not limited to, encephalopathy (disease, damage, or malfunction of the brain).</p> <p>Quarterly Minimum Data Set (MDS) assessments, dated 1/19/16 and 12/11/15, indicated the resident was independent in his ability to make decisions.</p> <p>A careplan for Resident for Resident #32, initiated 12/4/14, and current through 6/10/16, indicated the resident had potential to demonstrate physical behaviors of hitting other residents and staff related to poor impulse control and anger. The careplan was not updated with any new interventions until 3/7/16.</p> <p>Nurses Note (NN) dated 10/26/15 at 9:40 a.m., "Resident became verbally and physically aggressive after another resident pushed a resident into his room.</p>			

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	<p>Resident hit another resident with his cane...Will continue to monitor." The Indianapolis Metropolitan Police Department was contacted.</p> <p>NN dated 1/25/16 at 4:00 p.m., "Resident spitting...over this resident's head. Resident asked other resident to stop. Resident denied hitting other resident states they only argued. Staff witnessed resident [#32] hitting other resident multiple times and needed to be pulled away from resident. Residents separated per protocol."</p> <p>NN dated 1/29/16 at 3:20 a.m., "Resident to resident altercation. [Resident #32] was attacked by a female peer. Resident punched him (resident #32) on the back with excessive force. [Resident #32] in a wheelchair took his cane and angrily pushed on and beat on [other resident's] door and vowed to get revenge....Police were called...No injuries..."</p> <p>Psychiatric Evaluation, dated 2/9/16, for anxiety with history of encephalopathy, staff reports that resident has been yelling and cursing at peers.</p> <p>Review of Behavior/Intervention Monthly Flow records indicated the resident was not monitored for verbal or physical aggression in November nor</p>			

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	<p>December, 2015, nor January, 2016. In February, he was monitored for verbal aggression only, 58 shifts out of 87 opportunities.</p> <p>On 3/15/16 at 10:00 a.m., the Social Service Director (SSD) indicated she is the person who initiates the Behavior/Intervention Monthly Flow records, and the nurses are supposed to document every shift whether or not the resident had a behavior, what interventions were attempted, and if the interventions were effective. She indicated both verbal and physical aggressions are considered behaviors and should be on Behavior Flow Sheets. She is aware the forms are not completed every shift like they are supposed to be.</p> <p>On 3/8/16 at 5:54 p.m., the Administer provided a policy titled, Behavior Management,dated December, 2015, and indicated it was the policy currently used by the facility. The policy indicated, "Each resident with identified behaviors...will be monitored for episodes of behaviors...A behavior management form for each resident with identified behaviors...will include target behaviors as well as interventions appropriate for redirection of the identified behavior...responsible for maintaining updated Care Plans on</p>			

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	<p>residents with identified behaviors...and interventions to redirect the behaviors. Updates should be made as often as needed..."</p> <p>On 3/7/16 at 5:34 p.m., the Administrator provided a policy titled, "Abuse & Neglect Policy." dated 9/1/14, and indicated it was the policy currently used by the facility. The policy indicated, "Each resident has the right to be free from abuse, neglect, and misappropriation of resident property...'Abuse' means the willful infliction of injury...'Physical abuse' includes hitting, slapping, pinching and kicking...Prevention...The clinical staff will assess, care plan and monitor residents with needs and behaviors that might lead to conflict tor neglect, such as residents with a history of aggressive behaviors..."</p> <p>The Immediate Jeopardy that began on 2/1/16 was removed on 3/7/16, when the facility provided the following Abatement Plan with Addendum, but the noncompliance remained at the lower scope and severity level of actual harm that is not Immediate Jeopardy which continued to involve more than a limited number of residents.</p> <p>Abatement Plan with Addendum:</p>			

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	<p>A. The identified resident is no longer at the facility as of 3/7/16.</p> <p>B. The Regional Director of Operations will in-service the Administrator and all Department Managers on the Facility Abuse Policy which will include protection of all facility residents.</p> <p>C. The Administrator/DON/Designee will then in-service remaining staff on the Facility Abuse Policy which will include the protection of all facility residents.</p> <p>D. The SSW/DON /Designee will educate all staff on the facility Behavior Program and 1:1 Resident Altercation Policy.</p> <p>E. The Facility Abuse Policy and Protocol was reviewed and found to be appropriate.</p> <p>F. The SSW/Designee will speak with all interviewable residents to determine if they have any concerns with other residents.</p> <p>G. All resident charts will be reviewed to determine if there are other potential residents that have had or cold potentially cause harm to other residents.</p> <p>H. The Interdisciplinary team will meet to discuss that residents that have been identified as having the potential to cause harm ad interventions that may need to be put in place, up to and including discharge, if appropriate.. All identified residents will have their care plans</p>			

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	<p>updated, as needed, during the Interdisciplinary meeting.</p> <p>J. The nursing 24 hour sheets will be reviewed daily during the facility morning meeting along with the facility grievance binder to help assure all potential concerns have been addressed appropriately.</p> <p>K. All subsequent abuse allegations shall be reported by Administrator to Regional Director (RDO)</p> <p>L. RDO will review all abuse allegation investigations to assure proper protection of residents ad timely reporting.</p> <p>M. Facility Administrator will review abuse allegations and investigations through Facility QA process.</p> <p>N. RDO will schedule a daily phone call with the Administrator and/or DON to discuss any facility concerns, including ay allegations of abuse, neglect, misappropriation, etc. The RDO will determine the frequency of continued calls after the first month, based on findings of previous calls.</p> <p>O. DON/Admin/Designee will do shift to shift rounds and in-services at these times, on what type of events happen that feed to be recorded and reported.</p> <p>P. Managers or Leadership will be in the building interviewing residents to ensure their safety and that they are well cared for.</p> <p>Q. Corporate staff will be providing</p>			

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	<p>oversight and will be looking over all reports daily until all in-services are done.</p> <p>Addendum to Abatement Plan 3-8-16</p> <p>C. The Administrator/DON/Designee will then in-service remaining staff on the Facility Abuse Policy which will include the protection of all facility residents. This in-service will also include review of 1:1 Resident altercation policy.</p> <p>H. The Interdisciplinary team will meet to discuss the residents that have been identified as having the potential to cause harm. If not already in place, interventions will be implemented and added to the resident's care plan that are resident specific and the IDT will ensure all interventions are implemented.</p> <p>I. All identified residents will have their care plans updated, if appropriate interventions are not already in place, during the Interdisciplinary team meeting. Care Plan Interventions will be added to the CNA assignment sheets and staff will be in-serviced on interventions as well as location of the resident care plans.</p> <p>J. The nursing 24 hour report sheets will be reviewed daily during the facility morning meeting along with the facility grievance binder to help assure all potential concerns have addressed and</p>			

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	<p>followed up on until a resolution achieved</p> <p>K. All subsequent abuse allegations shall be reported by Administrator to Regional Director of Operation (RDO) within 1 hour.</p> <p>P. Managers or Leadership will be in the building interviewing residents to ensure their safety and that they are well cared for. Any resident that voices a concern with their safety or are provided, will have this concern reported to the Administrator immediately. The Administrator or SSW/Designee will personally meet with each of these residents, record concerns and assure interventions are implanted immediately to resolve the concern The SSW/Designee will contact the RP/Guardian of all non-interviewable residents and review the facility grievance Policy and Procedure with them. Daily rounds will be made a member of the management team and/or nurse in charge of each shift. Residents will be given the opportunity to voice concerns and non-interviewable residents will be observed for changes in condition, mood, and behavior All residents receive a skin assessment by a licensed nurse weekly and a CNA make a skin observation during each shower which is then turned in to the charge nurse.</p>			

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	<p>Staff will be tested for competency after abuse inservices. Any staff member that does not demonstrate a clear understanding of the in-service material will be re-educated until they do demonstrate a clear understanding. If not, they will be suspended pending further notice ad education with potential for discharge if unable to achieve a clear understanding. Staff will be randomly quizzed by the Administrator/DON/SSW to ensure continued compliance. Re-education will be provided immediatly if a clear understanding is not voiced.</p> <p>Abatement plan sections G & H All residents were reviewed to determine potential residents that have had or could potentially cause harm to other residents.</p> <p>IDT determined that these residents have had caused harm to have the potential to cause harm to other residents: Resident names listed (Residents #22, #33, #19, #32, #54, #21, #18, #37, #23, and #30 . Interventions for each of the residents were included in the plan.</p> <p>3.1-27(a)(1)</p>			

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F 0225 SS=E Bldg. 00	<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>			

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	<p>Based on observation, record review, and interview, the facility failed to follow their policy to ensure the prevention of abuse for 7 of 8 residents reviewed for having verbal and physical aggressiveness toward other residents. (Residents #22, #9, #19, #33, #54, #30, and #32)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #22 was reviewed on 3/7/16 at 3:30 p.m. Diagnoses for the resident included, but were not limited to, adjustment disorder, personality disorder, and major depression.</p> <p>An annual Minimum Data Set (MDS) assessment, dated 12/8/15, indicated the resident was cognitively independent in his ability to make decisions and independently mobile on the unit.</p> <p>A care plan for Resident #22, original date not documented, indicated he had a potential to demonstrate physical behaviors related to poor impulse control. The goal was that he would not harm self or others through the review date of 2/9/16. Interventions were:</p> <p>"Assess and anticipate resident's needs: food, thirst, toileting needs, comfort</p>	F 0225	<p>Abatement Plan for Meridian Healthcare center 3-8-16</p> <p>A. The identified resident is no longer at the facility as of 3-7-16.</p> <p>B. The Regional Director of Operations will in-service the Administrator and all Department Managers on the Facility Abuse Policy which will include protection of all facility residents.</p> <p>C. The Administrator/DON/Designee will then in-service remaining staff on the Facility Abuse Policy which will include the protection of all facility residents.</p> <p>D. The SSW/DON/Designee will educate all staff on the facility Behavior Program and 1:1 Resident Altercation Policy.</p> <p>E. The Facility Abuse Policy and Protocol was reviewed and found to be appropriate.</p> <p>F. The SSW/Designee will speak with all interviewable residents to determine if they have any concerns with other residents.</p> <p>G. All resident charts will be reviewed to determine if there are other potential residents that have had or could potentially cause harm to other residents.</p> <p>H. The Interdisciplinary team will meet to discuss the residents that have been identified as having the potential to cause harm and interventions that may need to be put in place, up to and including</p>	04/15/2016

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	<p>level, body positioning, pain etc." (initiated on 11/10/14)</p> <p>"Refer to psych [psychiatric] MD as indicated." (initiated on 11/17/15)</p> <p>"When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later." (initiated 1/16/15)</p> <p>On 3/7/16 at 12:30 p.m., Resident #17 and #22 were observed sitting at the same table in the dining room, beside each other. Resident #17 was observed to move away from the table, walk around the dining room, and sit back down at the table. At this time Resident #17 was positioned across the table from Resident #22. Resident #22 was observed to self-propel his wheelchair to beside Resident #17 and then hit Resident #17 on the arm. Resident #17 yelled, "He hit me." The residents were immediately separated by staff who rushed into the dining room. Prior to Resident #22 having hit Resident #9, no staff were observed present in the dining room.</p> <p>On 3/7/16 at 1:00 p.m., Physical Therapist #1 indicated, after he talked</p>		<p>discharge if appropriate.</p> <p>I. All identified residents will have their careplans updated, as needed, during the Interdisciplinary team meeting.</p> <p>J. The nursing 24 hour report sheets will bereviewed daily during the facility morning meeting along with the facilitygrievance binder to help assure all potential concerns have been addressedappropriately.</p> <p>K. Allsubsequent abuse allegations shall be reported by Administrator to RegionalDirector of Operations (RDO)</p> <p>L. RDOwill review all abuse allegation investigations to assure proper protection ofresidents and timely reporting. Anyidentified deficiencies in practice will be addressed immediately.</p> <p>M. FacilityAdministrator will review abuse allegations and investigations through FacilityQA process.</p> <p>N. RDOwill schedule a daily phone call with the Administrator and/or DON to discussany facility concerns, including any allegations of abuse, neglect,misappropriation, etc. The RDO willdetermine the frequency of continued calls after the first month, based onfindings of previous calls.</p> <p>O. DON/Admin/Designee will do shift to shift rounds and in-services at these times, on what type ofevents happen that need to be recorded and reported.</p> <p>P. Managersor Leadership will be in the building interviewing</p>	

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	<p>with Resident #22 about this incident, Resident #22 and Resident #17 were disagreeing about the volume of the music being played in the dining room.</p> <p>Continued review of Resident #22's clinical record indicated:</p> <p>Nurse's notes (NN): 10/30/15 at 9:30 a.m., "Resident at this time hit [Resident #9] on the [right] arm after [Resident #9] stated to him that, 'm.....f....., what the f...are you looking at.' Writer told [Resident #22] not to hit another resident..."</p> <p>Incident Report (IR) #45: The residents were separated and Indianapolis Metropolitan Police Department (IMPD) was called. (Case #I153030954) Resident #9 was educated on improper language use. No injury was reported. NN: 11/5/15 at 6:45 p.m., "Resident has been aggressive today, resident smacked another resident [Resident #9] on arm..."</p> <p>IR #46: "Nurse heard [Resident #9] in the hallway and came to see what was happening and [Resident #9] said that [Resident #22] had smacked her on her upper right arm...residents separated, [Resident 22] educated on appropriate communication and appropriate behaviors of not hitting or grabbing other</p>		<p>residents to ensure theirsafety and that they are well cared for.</p> <p>Q. Corporatestaff will be providing oversight and will be looking over all reports dailyuntil all in-services are done.</p> <p>Date of compliance: 3-9-16</p> <p>Addendum to abatement plan 3-8-16</p> <p>C. TheAdministrator/DON/Designee will then in-service remaining staff on the FacilityAbuse Policy which will include the protection of all facility residents. This in-service will also include review of 1:1 Resident altercation policy.</p> <p>H. The Interdisciplinary team will meet todiscuss the residents that have been identified as having the potential tocause harm. and interventions that may need to be put in place, up to and including discharge if appropriate. If not already in place, interventionswill be implemented and added to the resident's care plan that are residentspecific and the IDT will ensure all interventions are implemented.</p> <p>I. All identified residents will</p>	

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	<p>residents." IMPD was notified. (Case # I153092988) On 11/6/15 Resident #22 was moved to a different room a psychiatric referral was made and the resident again was educated on keeping his hands to himself and to not become physically aggressive with other people.</p> <p>No documentation was found which indicated the resident had been seen by psych until 1/19/16, for signs of anxiety as indicated by the careplan dated 11/17/15.</p> <p>NN: 11/17/15 at 6:00 a.m. to 6:00 p.m., "[Resident] got upset and threw the phone hand set at the nurse's station occupants..."</p> <p>NN: 1/9/16 at 10:00 a.m., "At 6:00 a.m. CNA [Certified Nursing Assistant] reported that resident grabbed her by the scrub top and necklace, breaking the necklace and scratching her while she was bending over to put foot rest [sic] on his [wheelchair]...Witness reported that she had to assist in loosening resident grip on CNA's top..."</p> <p>NN: 2/1/16 at 2:25 p.m., "Res[ident] involved in res[ident] to res[ident] [Resident #9] altercation. This res[ident] was the aggressor...placed on 15 minute checks..."</p>		<p>have their careplans updated, as needed, if appropriate interventions are not already in place, during the Interdisciplinary team meeting. Care Plan Interventions will be added to the C.N.A. assignment sheets and staff will be in-serviced on interventions as well as location of the resident care plans.</p> <p>J. The nursing 24 hour report sheets will be reviewed daily during the facility morning meeting along with the facility grievance binder to help assure all potential concerns have been addressed and followed up on until a resolution achieved. . appropriately.</p> <p>K. All subsequent abuse allegations shall be reported by Administrator to Regional Director of Operations (RDO) within 1hour.</p> <p>P. Managers or Leadership will be in the building interviewing residents to ensure their safety and that they are well cared for. Any resident that voices a concern with their safety or care provided, will have this concern reported to the Administrator immediately. The Administrator or SSW/Designee will personally meet with each of these residents, record concerns and assure interventions are implanted immediately to resolve the concern. The SSW/Designee will contact the RP/Guardian of all non-interviewable residents and review</p>	

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	<p>IR #57: (Resident #9) was coming to the office when she alleged Resident #22 hit her on her arm and kicked her chair. The residents were separated and assessments completed. The incident was reported to IMPD, Case # I160321689. Resident #22 was educated on appropriate social behaviors and his behaviors would continue to be monitored.</p> <p>NN: 2/18/16 at 1:00 p.m. "Resident swatted at another resident [Resident #17] in the dining room [after] she accidentally bumped his [wheelchair]. When staff attempted to redirect, he knocked over his water and left the dining room."</p> <p>NN: 2/18/16 at 3:18 p.m. "Resident hit another resident [Resident #17] on the [left] breast when she walked past him and smiled at him...res[idents] were separated. Intervention successful."</p> <p>Social Service Director (SSD) note: 2/18/16 4:30 p.m., "Behavior: Resident [#22] was involved in incident with female peer [Resident #17]. This resident was in the hallway with this female peer. Female peer yelled that 'he hit me.'...Female peer had just been in writer's office stating that her bra was hurting her breast, same one that she said</p>		<p>the facility grievance Policy and Procedure with them. Daily rounds will be made a member of themanagement team and/or nurse in charge on each shift. Residents will be given the opportunity to voice concerns and non-interviewable residents will be observed for changes incondition, mood, and behavior. Allresidents receive a skin assessment by a licensed nurse weekly and a C.N.A.make a skin observation during each shower which is then turned in to thecharge nurse.</p> <p>Staff will be tested forcompetency after abuse inservices. Anystaff member that does not demonstrate a clear understanding of the in-servicematerial will be re-educated until they do demonstrate a clearunderstanding. If not, they will besuspending pending further notice and education with potential for discharge ifunable to achieve a clear understanding. Staff will be randomly quizzed by theAdministrator/DON/SSW to ensure continued compliance. Re-education will be provided immediately ifa clear understanding is not voiced.</p>	

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	<p>this resident hit. Writer spoke with resident he wouldn't say, but would just shrug his shoulders. Writer will continue to observe."</p> <p>On 2/9/16 a psychiatric evaluation was done for Resident #22. The evaluation indicated, "Staff reports that he is physically aggressive with female peers." The diagnosis was Personality Disorder with anxiety and depression. The plan, after the evaluation was completed, was to start the resident on a scheduled dose of antidepressant to help with his mood and behaviors and continue to provide psych support.</p> <p>NN: 3/5/16 at 11:15 a.m. Resident at this time got into a fight with another resident [Resident #54], a skin tear noted to left ear...resident is responsible for self, placed on 15 min checks, IMPD [Indianapolis Metropolitan Police Department] called and notified about incident, case # given..."</p> <p>3/7/16 at 11:55 a.m.: "Res[ident] in dining room in [wheelchair] he was exiting the dining room and forcefully shoved another resident [Resident #17] res will remain on 15 minute [checks] for safety."</p> <p>No documentation was found in the</p>			

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	<p>resident's record which indicated Resident #22's plan of care had been reviewed or updated after 2/9/16, with new interventions and effective ways of monitoring the resident's aggressive behavior, to ensure the safety of the other residents in the facility. On 3/7/16 at 4:05 p.m., the Director of Nursing did not indicate the care plan for the resident's physically aggressive behavior had been updated.</p> <p>No Behavior/Intervention Monthly Flow Records were found in the resident's record.</p> <p>On 3/7/16 at 4:00 p.m., the Administrator indicated the resident had been placed on 15 minute checks since the incident in the dining room at lunch time.</p> <p>On 3/7/16 at 5:00 p.m., the Administrator indicated the resident was now 1:1 (one staff person with him at all times) and they were seeking placement for him in a psychiatric facility.</p> <p>On 3/10/15 at 3:00 p.m. Certified Nursing Assistant (CNA) #11 indicated Resident #22, "Just snaps, it's a little scary."</p> <p>On 3/15/16 at 9:15 a.m., Resident #29 indicated she was aware some of the</p>			

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	<p>residents living at the facility very verbally and physically aggressive towards other residents and staff. She indicated, "I mostly stay in my room."</p> <p>On 3/16/15 at 11:50 a.m., Resident #44 indicated he was aware of Resident #22's verbal and physical aggressions toward other residents and staff.</p> <p>On 3/16/16 at 12:07 p.m., Resident #14 indicated she was very aware of Resident #22's verbal and physical aggressions toward staff and other residents.</p> <p>2a. The clinical record of Resident #9 was reviewed on 3/15/16 at 10:10 a.m. Diagnoses for the resident included, but were not limited to, paranoid schizophrenia.</p> <p>Quarterly Minimum Data Set assessments, dated 1/13/16 and 12/5/15, indicated the resident was independent in her ability to make decisions.</p> <p>A care plan, initiated 2/14/16, indicated Resident #9 had a behavior problem related to frequent verbally abusive outbursts to staff and other residents.</p> <p>Another care plan, initiated 2/17/16, indicated the resident had potential to demonstrate verbally abusive behaviors</p>			

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	<p>related to ineffective coping skills and poor impulse control.</p> <p>Nurse's note dated 10/30/15, indicated Resident #9, "was wheeling herself in her wheelchair in the hallway...when she saw [Resident #22] sitting in his wheelchair and she stated to him, 'm..... f.....what the f... are you looking at.'"</p> <p>Social Service Director (SSD) note, dated 10/30/15 at 12:30 p.m., indicated, "This AM this resident became verbally aggressive with male peer..."</p> <p>SSD note, dated 1/5/16 at 10:00 a.m., indicated, "...This resident stated very loudly to anyone that would listen, 'My roommate smells bad, she needs to take a bath.'</p> <p>SSD note dated 3/4/16 at 5:40 p.m., indicated the resident refused to be seen by psych services.</p> <p>A nurse's note, dated 3/8/16 at 8:50 a.m., indicated Resident #9 was,"rolling fast in wheelchair, hit another resident with her wheelchair in the hand. Res[ident] was having periods of delusional episodes..."</p> <p>SSD note, dated 3/8/16 at 11:00 a.m., indicated, "This AM resident was in hallway making statements, '...Russian</p>			

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	<p>people like her smell bad. ' She was talking about a female peer. This resident was propelling self down hallway as she did so she bumped into the hand of the female peer. This resident stated, 'I pushed my way past that dumb B.... and ran into her hand. I don't like her and she don't like me.'"</p> <p>An Incident Report #66 dated 3/8/16, indicated Resident #9 was transported to (name of local hospital) for evaluation and treatment for psychotic episodes.</p> <p>No Behavior/Intervention Monthly Flow reports were found in the resident's record. The flow records were requested from the Director of Nursing on 3/15/16 at 10:30 a.m., but none were provided by survey exit on 3/16/16 at 7:00 p.m.</p> <p>b. The clinical record of Resident #19 was reviewed on 3/14/15 at 1:54 p.m. Diagnoses for the resident included, but were not limited to, dementia with behavioral disturbance.</p> <p>A quarterly Minimum Data Set assessment, dated 12/28/15, and an annual MDS, dated 9/29/15, indicated the resident was moderately impaired in his ability to make decisions.</p> <p>A careplan, initiated 9/26/14, indicated</p>			

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	<p>the resident had a mood problem related to depression, as evidenced by yelling out. This careplan was not updated with any new interventions from 10/2/14 through 1/11/16.</p> <p>A careplan, initiated 11/17/14, indicated the resident had potential to demonstrate physical behaviors such as hitting related to poor impulse control and anger. This careplan was not updated with any new interventions from 11/17/14 through 1/11/16.</p> <p>A nurse's note, dated 11/22/15, indicated, "Heard yelling in the dining room. Went to dining room and res[id]ent was yelling and cussing at another res...Writer was attempting to wheel res out of dining room. Res proceeded to hit this writer in the face and upper body several times. Explained to res that we wanted to separate him from the other res. Res continued yelling, 'I'm going to kick his a...'"</p> <p>Behavior/Intervention Monthly Flow Records for November and December, 2015, did not indicate the resident was being monitored for verbal or physical aggression.</p> <p>A Psychology Progress Note, dated 12/11/15, indicated resident was being</p>			

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	<p>seen for signs and symptoms of depression and aggression. The note indicated the resident was angry. Recommendations were, "Continue as is with reevaluation in approximately three months."</p> <p>A Psychiatric Evaluation, dated 2/19/16, indicated Resident #19, "Yells and curses at peers and staff, history of physical aggression."</p> <p>A Behavior Flow Record for January, 2016 was not found in the resident's record.</p> <p>Social Service Director (SSD) note, dated 2/22/16 at 4:00 p.m., indicated Resident #19 was in the hallway and started, "Yelling and cursing at male peer." Both residents were provided with 1:1 care.</p> <p>Behavior/Intervention Monthly Flow Record for February, 2015 did not indicate the resident was being monitored for verbal and physical aggression.</p> <p>SSD note, dated 3/7/16, indicated Resident #19 was involved in a verbal altercation with his roommate..."Staff heard yelling and came running to room to find both males standing face each other and cursing at one another..." The note indicated 1:1 care was provided at</p>			

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	<p>this time.</p> <p>c. The clinical record of Resident #33 was reviewed on 3/14/1 at at 9:18 a.m. Diagnoses for the resident included, but were not limited to, major depression, anxiety, and mood disorder.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 1/2/16, and an annual MDS assessment, dated 10/2/15, indicated Resident #33 was independent in her ability to make decisions.</p> <p>A careplan, initiated 3/20/15 and current through 6/20/16, indicated the resident had potential to demonstrate verbally abusive behaviors related to mental/emotional illness and poor impulse control, anger.</p> <p>Nurse's note (NN) dated 10/14/15 at 7:30 p.m., indicated Resident #33 was in a verbal altercation with another female resident (Resident #30). Resident #19 indicated she hit the other resident, but this was not verified. No signs or symptoms of injury. Residents separated.</p> <p>Review of Incident Report (IR) #42, dated 10/14/15, indicated it was found, after investigation, the residents did get into a physical fight hitting, scratching and pulling each others hair. The</p>			

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	<p>resident were separated immediately and removed from the situation. Preventative measures were, "The residents were educated on appropriate social behavior."</p> <p>NN dated 11/21/15 at 2:30 p.m., indicated the resident was screaming about her roommate's music, screaming, "I f.... Hate that b..... music, she blaers it all the f..... night long...resident screamed at other residents in the hallway..."</p> <p>NN dated 12/4/16 at 6:20 p.m., indicated, "Resident asked this nurse for a cigarette. Explained to resident the rules. Resident stormed off trying to get out the side door. Resident stated, 'I am walking to the f.... store.' Resident unable to get out door she starting hitting it with her fist screaming, 'f... your rules b...., I'm going to tear this f..... place up until you let me out, you f..... b.....' Resident ran toward this nurse, drew back her fist yelling, 'I will f... you up, call the police cause I plan on tearing everything up until I get my way b....' Tried one on one without success."</p> <p>NN dated 1/29/16 4:00 a.m. "Resident's anger escalated regarding her call light not being answered promptly. [Resident] struck/pummeled [Resident #32] on his back with her fists without provocation.</p>			

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	<p>Residents were separated. Police were phoned...no injuries were sustained by either resident. "</p> <p>NN dated 2/2/16 at 4:30 p.m., "Res was involved in a resident to resident altercation. She smacked another resident on the cheek..."</p> <p>Incident Report #58, dated 2/2/16, indicated a resident (Resident #31) began cussing and yelling in the hallway, and Resident #33 gently smacked Resident #31 on the cheek. Preventative measures included, Resident #19 was educated on appropriate ways to voice grievances about other residents, not touching other residents. A psych consult was to be requested.</p> <p>A Psychiatric Evaluation, dated 2/9/16, indicated resident was being seen for yelling, cursing and some physical aggression. Treatment changes included an increase in Depakote (a medication used for mood stabilization) and continued psych support.</p> <p>NN dated 3/7/16 at 9:45 a.m., resident started talking loudly and another resident asked her to be quiet, and Resident #33 called the other resident a "b..." and started going towards the other resident, who stood up from her</p>			

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	<p>wheelchair. Writer immediately stepped between the residents to separate them.</p> <p>NN dated 3/9/16 at 6:06 a.m. indicated Resident #33 was on 1:1 care due to increase in aggressive behaviors. The resident was still on 1:1 care at time of the survey exit on 3/16/16 at 7:00 p.m.</p> <p>Review of Behavior/Intervention Monthly Flow reports indicated the resident was not being monitored for aggressive behaviors until February, 2016. The February, 2015 flow sheet indicated 22 shifts with no evidence of monitoring, out of 87 total opportunities.</p> <p>d. The clinical record of Resident #54 was reviewed on 3/16/16 at 8:58 a.m. Diagnoses for the resident included, but were not limited to, end stage renal disease.</p> <p>On 3/16/16 at 2:08 p.m., the Social Service Director (SSD) indicated the resident had refused to be cognitively evaluated upon her admission 2/24/16, but the resident appeared alert and oriented and the SSD indicated she was, "probably" independent in her ability to make decisions.</p> <p>NN dated 3/3/16 at 4:15 p.m. indicated, "Resident was noted with verbally</p>			

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	<p>inappropriate behaviors, telling another resident that he was smelling pee and that he stinks, resident was asked not to tell anybody that they stink."</p> <p>SSD note dated 3/3/16 at 12:00 p.m. Resident #54 refused psych services.</p> <p>NN dated 3/5/16 at 11:15 a.m. " Resident at this time got into a fight with another resident, both got separated...no injury noted...15 minute checks initiated incident reported to IMPD..."</p> <p>Incident Report #62, dated 3/5/16, indicated Resident #54 was in the back hallway and told Resident #22 to get out of her way. Resident #22 hit Resident #54 on the arm...and then Resident #54 reached around the nurse and hit Resident #22 back in his face. Both residents were placed on 15 minute checks, and "educated about appropriate behavior."</p> <p>SSD note dated, 3/7/16, (no time documented) "This A.M. this resident was waiting to go outside to smoke. Words were exchanged between this resident and another female resident Both residents started yelling and cursing at each other. This resident stood up out of her wheel chair and started to raise her arms up in a manner that would suggest that she was going to hit other residents,</p>			

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	<p>fist swinging...DON was able to step between both residents before any contact was made..." One to one care was provided. The writer spoke with the Resident #54, who "stated again...I will hit her if I have to..."</p> <p>NN dated 3/8/16 at 2:00 p.m. "Resident is unpleasant to all staff. Refuses care and meds. Is confrontational with staff and residents. She remains on 1:1. One female resident she is more vocal with. On 3/7/16 she and the female resident had words of calling each other 'b....'"</p> <p>NN dated 3/8/16 :00 p.m. "...She was in another altercation with the same other resident, attempted to charge this resident, and threatening to fight. The two were separated by staff, there no injuries. Will continue to monitor."</p> <p>NN dated 3/9/16 1:20 p.m. "She continues to be verbally abusive with staff, at times seeming to be physically aggressive..."</p> <p>NN dated 3/11/16 (no time documented) "Resident...continues to be rude and demanding. She swears at staff and other residents...remains on 1:1 precautions..."</p> <p>An Interim Care Plan for Physical and Verbal Aggression was not created for</p>			

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	<p>the resident until 3/9/16.</p> <p>Resident #54 remained on 1:1 care through survey exit date on 3/16/16 at 7:00 p.m.</p> <p>Review of the Behavior/Intervention Monthly Flow record for March, 2016, did not indicate verbal nor physical aggression was being monitored.</p> <p>e. The clinical record of Resident #30 was reviewed on 3/14/16 at 2:25 p.m. Diagnoses included, but were not limited to, schizophrenia, anxiety, and depression.</p> <p>Quarterly Minimum Data Set (MDS) assessments, dated 12/22/15 and 9/22/15, indicated Resident #30 was independent in her ability to make decisions.</p> <p>Nurse's Note (NN) dated 11/8/15 at 7:50 p.m. Another resident "was at nurses station on phone talking with his brother when this resident [#30] began yelling I want to talk..." This resident continued yelling as the other resident walked to a different hall. The nurse was between the residents at all times.</p> <p>NN dated 12/15/15 at 7:40 p.m. "Heard yelling in hallway this resident and [another resident] in hallway. Saw this</p>			

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	<p>resident walking fast down hallway walker lying on floor. [other resident] following resident yelling. Writer and other staff in between residents. IMPD notified."</p> <p>Social Service Director (SSD) note dated 12/16/15 at 10:00 a.m. "Behavior On 12/15/15 late evening staff heard yelling in hallway by nurses' station. This resident was having a verbal disagreement with a male peer over his use of resident phone. Words were exchanged between both residents. This resident became angry and pushed her walker towards male resident and threw her coat at him. Male resident responded by standing up from his...walker and pushing walker back at this resident walking towards her and yelling at her. Staff at this point was able to interject and separate both residents and provide 1:1 care to each."</p> <p>Psychiatric Evaluation dated 3/3/16, indicated the resident was being seen for "verbal aggressive with peers and staff..." The plan was to start Depakote (a mood stabilizing medication) and provide continued psych support.</p> <p>Review of Behavior/Intervention Monthly Flow records indicated:</p>			

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	<p>November, 2015: A Behavior/Intervention Monthly Flow record was not provided by survey exit 3/16/15 at 7:00 p.m.</p> <p>December, 2015: resident was monitored for aggression, interventions and effectiveness only 54 shifts out of the 93 opportunities.</p> <p>January, 2016: A Behavior/Intervention Monthly Flow record was not provided by survey exit 3/16/16 at 7:00 p.m.</p> <p>February, 2016: resident monitored for verbal aggression, interventions, and effectiveness only 54 shifts out of 87 opportunities.</p> <p>A careplan for the resident, initiated 3/9/16, indicated the resident had the potential to demonstrate verbally and physical abusive behaviors related to mental and emotional illness.</p> <p>f. The clinical record of Resident #32 was reviewed on 3/14/16 at 10:11 a.m. Diagnoses for the resident included, but were not limited to, encephalopathy (disease, damage, or malfunction of the brain).</p> <p>Quarterly Minimum Data Set (MDS) assessments, dated 1/19/16 and 12/11/15,</p>			

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	<p>indicated the resident was independent in his ability to make decisions.</p> <p>A careplan for Resident for Resident #32, initiated 12/4/14, and current through 6/10/16, indicated the resident had potential to demonstrate physical behaviors of hitting other residents and staff related to poor impulse control and anger. The careplan was not updated with any new interventions until 3/7/16.</p> <p>Nurses Note (NN) dated 10/26/15 at 9:40 a.m., "Resident became verbally and physically aggressive after another resident pushed a resident into his room. Resident hit another resident with his cane...Will continue to monitor." The Indianapolis Metropolitan Police Department was contacted.</p> <p>NN dated 1/25/16 at 4:00 p.m., "Resident spitting...over this resident's head. Resident asked other resident to stop. Resident denied hitting other resident states they only argued. Staff witnessed resident [#32] hitting other resident multiple times and needed to be pulled away from resident. Residents separated per protocol."</p> <p>NN dated 1/29/16 at 3:20 a.m., "Resident to resident altercation. [Resident #32] was attacked by a female peer. Resident</p>			

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	<p>punched him (resident #32) on the back with excessive force. [Resident #32] in a wheelchair took his cane and angrily pushed on and beat on [other resident's] door and vowed to get revenge....Police were called...No injuries..."</p> <p>Psychiatric Evaluation, dated 2/9/16, for anxiety with history of encephalopathy, staff reports that resident has been yelling and cursing at peers.</p> <p>Review of Behavior/Intervention Monthly Flow records indicated the resident was not monitored for verbal or physical aggression in November nor December, 2015, nor January, 2016. In February, he was monitored for verbal aggression only, 58 shifts out of 87 opportunities.</p> <p>On 3/15/16 at 10:00 a.m., the Social Service Director (SSD) indicated she is the person who initiates the Behavior/Intervention Monthly Flow records, and the nurses are supposed to document every shift whether or not the resident had a behavior, what interventions were attempted, and if the interventions were effective. She indicated both verbal and physical aggressions are considered behaviors and should be on Behavior Flow Sheets. She is aware the forms are not completed</p>			

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	<p>every shift like they are supposed to be.</p> <p>On 3/8/16 at 5:54 p.m., the Administer provided a policy titled, Behavior Management, dated December, 2015, and indicated it was the policy currently used by the facility. The policy indicated, "Each resident with identified behaviors...will be monitored for episodes of behaviors...A behavior management form for each resident with identified behaviors...will include target behaviors as well as interventions appropriate for redirection of the identified behavior...responsible for maintaining updated Care Plans on residents with identified behaviors...and interventions to redirect the behaviors. Updates should be made as often as needed..."</p> <p>On 3/7/16 at 5:34 p.m., the Administrator provided a policy titled, "Abuse & Neglect Policy." dated 9/1/14, and indicated it was the policy currently used by the facility. The policy indicated, "Each resident has the right to be free from abuse, neglect, and misappropriation of resident property...'Abuse' means the willful infliction of injury...'Physical abuse' includes hitting, slapping, pinching and kicking...Prevention...The clinical staff will assess, care plan and monitor</p>			

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F 0226 SS=E Bldg. 00	<p>residents with needs and behaviors that might lead to conflict tor neglect, such as residents with a history of aggressive behaviors..."</p> <p>3.1-28(c)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 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 observation, record review, and interview, the facility failed to ensure effective monitoring and interventions were in place to ensure residents were free from verbal and physical aggressive behaviors from other residents, according to their policy, for 7 of 8 residents reviewed for having verbal and physical aggressiveness toward other residents. (Residents #22, #9, #19, #33, #54, #30, and #32)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #22 was reviewed on 3/7/16 at 3:30 p.m.</p>	F 0226	<p>Abatement Plan for Meridian Healthcare center 3-8-16 A. Theidentified resident is no longer at the facility as of 3-7-16. B. TheRegional Director of Operations will in-service the Administrator and allDepartment Managers on the Facility Abuse Policy which will include protectionof all facility residents. C. TheAdministrator/DON/Designee will then in-service remaining staff on the FacilityAbuse Policy which will include the protection of all facility residents. D. TheSSW/DON/Designee will educate all staff on the facility Behavior Program and1:1 Resident Altercation Policy. E. TheFacility Abuse Policy and</p>	04/15/2016

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	<p>Diagnoses for the resident included, but were not limited to, adjustment disorder, personality disorder, and major depression.</p> <p>An annual Minimum Data Set (MDS) assessment, dated 12/8/15, indicated the resident was cognitively independent in his ability to make decisions and independently mobile on the unit.</p> <p>A care plan for Resident #22, original date not documented, indicated he had a potential to demonstrate physical behaviors related to poor impulse control. The goal was that he would not harm self or others through the review date of 2/9/16. Interventions were:</p> <p>"Assess and anticipate resident's needs: food, thirst, toileting needs, comfort level, body positioning, pain etc." (initiated on 11/10/14)</p> <p>"Refer to psych [psychiatric] MD as indicated" (initiated on 11/17/15)</p> <p>"When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later." (initiated 1/16/15)</p>		<p>Protocol was reviewed and found to be appropriate. F. TheSSW/Designee will speak with all interviewable residents to determine if theyhave any concerns with other residents. G. Allresident charts will be reviewed to determine if there are other potentialresidents that have had or could potentially cause harm to other residents. H. TheInterdisciplinary team will meet to discuss the residents that have beenidentified as having the potential to cause harm and interventions that may needto be put in place, up to and including discharge if appropriate. I. All identified residents will have their careplans updated, as needed, during the Interdisciplinary team meeting. J. The nursing 24 hour report sheets will bereviewed daily during the facility morning meeting along with the facilitygrievance binder to help assure all potential concerns have been addressedappropriately. K. Allsubsequent abuse allegations shall be reported by Administrator to RegionalDirector of Operations (RDO) L. RDOwill review all abuse allegation investigations to assure proper protection ofresidents and timely reporting. Anyidentified deficiencies in practice will be addressed immediately. M. FacilityAdministrator will review abuse allegations and investigations through FacilityQA</p>	

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	<p>On 3/7/16 at 12:30 p.m., Resident #17 and #22 were observed sitting at the same table in the dining room, beside each other. Resident #17 was observed to move away from the table, walk around the dining room, and sit back down at the table. At this time Resident #17 was positioned across the table from Resident #22. Resident #22 was observed to self-propel his wheelchair to beside Resident #17 and then hit Resident #17 on the arm. Resident #17 yelled, "He hit me." The residents were immediately separated by staff who rushed into the dining room. Prior to Resident #22 having hit Resident #9, no staff were observed present in the dining room.</p> <p>On 3/7/16 at 1:00 p.m., Physical Therapist #1 indicated, after he talked with Resident #22 about this incident, Resident #22 and Resident #17 were disagreeing about the volume of the music being played in the dining room.</p> <p>Continued review of Resident #22's clinical record indicated:</p> <p>Nurse's notes (NN): 10/30/15 at 9:30 a.m., "Resident at this time hit [Resident #9] on the [right] arm after [Resident #9] stated to him that, 'm.....f....., what the f...are you looking at.' Writer told</p>		<p>process. N. RDO will schedule a daily phone call with the Administrator and/or DON to discuss any facility concerns, including any allegations of abuse, neglect, misappropriation, etc. The RDO will determine the frequency of continued calls after the first month, based on findings of previous calls. O. DON/Admin/Designee will do shift to shift rounds and in-services at these times, on what type of events happen that need to be recorded and reported. P. Managers or Leadership will be in the building interviewing residents to ensure their safety and that they are well cared for. Q. Corporate staff will be providing oversight and will be looking over all reports daily until all in-services are done. Date of compliance: 3-9-16 Addendum to abatement plan 3-8-16 C. The Administrator/DON/Designee will then in-service remaining staff on the Facility Abuse Policy which will include the protection of all facility residents. This in-service will also include review of 1:1 Resident altercation policy. H. The Interdisciplinary team will meet to discuss the residents that have been identified as having the potential to cause harm. and interventions that may need to be put in place, up to and including discharge if appropriate. If not already in place, interventions will be implemented and added to the resident's care plan that are</p>		

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	<p>[Resident #22] not to hit another resident..."</p> <p>Incident Report (IR) #45: The residents were separated and Indianapolis Metropolitan Police Department (IMPD) was called. (Case #I153030954) Resident #9 was educated on improper language use. No injury was reported.</p> <p>NN: 11/5/15 at 6:45 p.m., "Resident has been aggressive today, resident smacked another resident [Resident #9] on arm..."</p> <p>IR #46: "Nurse heard [Resident #9] in the hallway and came to see what was happening and [Resident #9] said that [Resident #22] had smacked her on her upper right arm...residents separated, [Resident 22] educated on appropriate communication and appropriate behaviors of not hitting or grabbing other residents." IMPD was notified. (Case # I153092988) On 11/6/15 Resident #22 was moved to a different room a psychiatric referral was made and the resident again was educated on keeping his hands to himself and to not become physically aggressive with other people.</p> <p>No documentation was found which indicated the resident had been seen by psych until 1/19/16, for signs of anxiety as indicated by the careplan dated</p>		<p>residentspecific and the IDT will ensure all interventions are implemented. I. All identified residents will have their careplans updated, as needed, if appropriate interventions are not alreadyin place, during the Interdisciplinary team meeting. Care Plan Interventions will be added to theC.N.A. assignment sheets and staff will be in-serviced on interventions as wellas location of the resident care plans. J. The nursing 24 hour report sheets will bereviewed daily during the facility morning meeting along with the facilitygrievance binder to help assure all potential concerns have been addressed andfollowed up on until a resolution achieved. . appropriately. K. All subsequent abuse allegations shall bereported by Administrator to Regional Director of Operations (RDO) within 1hour. P. Managersor Leadership will be in the building interviewing residents to ensure theirsafety and that they are well cared for. Any resident that voices a concern with their safety or care provided,will have this concern reported to the Administrator immediately. The Administrator or SSW/Designee willpersonally meet with each of these residents, record concerns and assureinterventions are implanted immediately to resolve the concern. TheSSW/Designee will</p>		

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	<p>11/17/15.</p> <p>NN: 11/17/15 at 6:00 a.m. to 6:00 p.m., "[Resident] got upset and threw the phone hand set at the nurse's station occupants..."</p> <p>NN: 1/9/16 at 10:00 a.m., "At 6:00 a.m. CNA [Certified Nursing Assistant] reported that resident grabbed her by the scrub top and necklace, breaking the necklace and scratching her while she was bending over to put foot rest [sic] on his [wheelchair]...Witness reported that she had to assist in loosening resident grip on CNA's top..."</p> <p>NN: 2/1/16 at 2:25 p.m., "Res[ident] involved in res[ident] to res[ident] [Resident #9] altercation. This res[ident] was the aggressor...placed on 15 minute checks..."</p> <p>IR #57: (Resident #9) was coming to the office when she alleged Resident #22 hit her on her arm and kicked her chair. The residents were separated and assessments completed. The incident was reported to IMPD, Case # I160321689. Resident #22 was educated on appropriate social behaviors and his behaviors would continue to be monitored.</p> <p>NN: 2/18/16 at 1:00 p.m. "Resident</p>		<p>contact the RP/Guardian of all non- interviewable residentsand review the facility grievance Policy and Procedure with them. Daily rounds will be made a member of themanagement team and/or nurse in charge on each shift. Residents will be given the opportunity tovoice concerns and non-interviewable residents will be observed for changes incondition, mood, and behavior. Allresidents receive a skin assessment by a licensed nurse weekly and a C.N.A.make a skin observation during each shower which is then turned in to thecharge nurse. Staff will be tested forcompetency after abuse inservices. Anystaff member that does not demonstrate a clear understanding of the in-servicematerial will be re-educated until they do demonstrate a clearunderstanding. If not, they will besuspending pending further notice and education with potential for discharge ifunable to achieve a clear understanding. Staff will be randomly quizzed by theAdministrator/DON/SSW to ensure continued compliance. Re-education will be provided immediately ifa clear understanding is not voiced.</p>				

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	<p>swatted at another resident [Resident #17] in the dining room [after] she accidentally bumped his [wheelchair]. When staff attempted to redirect, he knocked over his water and left the dining room."</p> <p>NN: 2/18/16 at 3:18 p.m. "Resident hit another resident [Resident #17] on the [left] breast when she walked past him and smiled at him...res[idents] were separated. Intervention successful."</p> <p>Social Service Director (SSD) note: 2/18/16 4:30 p.m. "Behavior: Resident [#22] was involved in incident with female peer [Resident #17]. This resident was in the hallway with this female peer. Female peer yelled that 'he hit me.'...Female peer had just been in writer's office stating that her bra was hurting her breast, same one that she said this resident hit. Writer spoke with resident he wouldn't say, but would just shrug his shoulders. Writer will continue to observe."</p> <p>On 2/9/16 a psychiatric evaluation was done for Resident #22. The evaluation indicated, "Staff reports that he is physically aggressive with female peers." The diagnosis was Personality Disorder with anxiety and depression. The plan, after the evaluation was completed, was</p>			

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	<p>to start the resident on a scheduled dose of antidepressant to help with his mood and behaviors and continue to provide psych support.</p> <p>NN: 3/5/16 at 11:15 a.m. Resident at this time got into a fight with another resident [Resident #54], a skin tear noted to left ear...resident is responsible for self, placed on 15 min checks, IMPD [Indianapolis Metropolitan Police Department] called and notified about incident, case # given..."</p> <p>NN: 3/7/16 at 11:55 a.m.: "Res[ident] in dining room in [wheelchair] he was exiting the dining room and forcefully shoved another resident [Resident #17] res will remain on 15 minute [checks] for safety."</p> <p>No documentation was found in the resident's record which indicated Resident #22's plan of care had been reviewed or updated after 2/9/16, with new interventions and effective ways of monitoring the resident's aggressive behavior, to ensure the safety of the other residents in the facility. On 3/7/16 at 4:05 p.m., the Director of Nursing did not indicate the care plan for the resident's physically aggressive behavior had been updated.</p>			

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	<p>No Behavior/Intervention Monthly Flow Records were found in the resident's record.</p> <p>On 3/7/16 at 4:00 p.m., the Administrator indicated the resident had been placed on 15 minute checks since the incident in the dining room at lunch time.</p> <p>On 3/7/16 at 5:00 p.m., the Administrator indicated the resident was now 1:1 (one staff person with him at all times) and they were seeking placement for him in a psychiatric facility.</p> <p>On 3/10/15 at 3:00 p.m. Certified Nursing Assistant (CNA) #11 indicated Resident #22, "Just snaps, it's a little scary."</p> <p>On 3/15/16 at 9:15 a.m., Resident #29 indicated she was aware some of the residents living at the facility very verbally and physically aggressive towards other residents and staff. She indicated, "I mostly stay in my room."</p> <p>On 3/16/15 at 11:50 a.m., Resident #44 indicated he was aware of Resident #22's verbal and physical aggressions toward other residents and staff.</p> <p>On 3/16/16 at 12:07 p.m., Resident #14 indicated she was very aware of Resident</p>			

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	<p>#22's verbal and physical aggressions toward staff and other residents.</p> <p>2a. The clinical record of Resident #9 was reviewed on 3/15/16 at 10:10 a.m. Diagnoses for the resident included, but were not limited to, paranoid schizophrenia.</p> <p>Quarterly Minimum Data Set assessments, dated 1/13/16 and 12/5/15, indicated the resident was independent in her ability to make decisions.</p> <p>A care plan, initiated 2/14/16, indicated Resident #9 had a behavior problem related to frequent verbally abusive outbursts to staff and other residents.</p> <p>Another care plan, initiated 2/17/16, indicated the resident had potential to demonstrate verbally abusive behaviors related to ineffective coping skills ad poor impulse control.</p> <p>Nurse's note dated 10/30/15, indicated Resident #9, "was wheeling herself in her wheelchair in the hallway...when she saw [Resident #22] sitting in his wheelchair and she stated to him, 'm..... f.....what the f... are you looking at.'"</p> <p>Social Service Director (SSD) note, dated 10/30/15 at 12:30 p.m., indicated, "This</p>			

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	<p>AM this resident became verbally aggressive with male peer..."</p> <p>SSD note, dated 1/5/16 at 10:00 a.m., indicated, "...This resident stated very loudly to anyone that would listen, 'My roommate smells bad, she needs to take a bath.'</p> <p>SSD note dated 3/4/16 at 5:40 p.m., indicated the resident refused to be seen by psych services.</p> <p>A nurse's note, dated 3/8/16 at 8:50 a.m., indicated Resident #9 was, "rolling fast in wheelchair, hit another resident with her wheelchair in the hand. Res[ident] was having periods of delusional episodes..."</p> <p>SSD note, dated 3/8/16 at 11:00 a.m., indicated, "This AM resident was in hallway making statements, '...Russian people like her smell bad. ' She was talking about a female peer. This resident was propelling self down hallway as she did so she bumped into the hand of the female peer. This resident stated, 'I pushed my way past that dumb B.... and ran into her hand. I don't like her and she don't like me.'"</p> <p>An Incident Report #66 dated 3/8/16, indicated Resident #9 was transported to (name of local hospital) for evaluation</p>			

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	<p>and treatment for psychotic episodes.</p> <p>No Behavior/Intervention Monthly Flow reports were found in the resident's record. The flow records were requested from the Director of Nursing on 3/15/16 at 10:30 a.m., but none were provided by survey exit on 3/16/16 at 7:00 p.m.</p> <p>b. The clinical record of Resident #19 was reviewed on 3/14/15 at 1:54 p.m. Diagnoses for the resident included, but were not limited to, dementia with behavioral disturbance.</p> <p>A quarterly Minimum Data Set assessment, dated 12/28/15, and an annual MDS, dated 9/29/15, indicated the resident was moderately impaired in his ability to make decisions.</p> <p>A careplan, initiated 9/26/14, indicated the resident had a mood problem related to depression, as evidenced by yelling out. This careplan was not updated with any new interventions from 10/2/14 through 1/11/16.</p> <p>A careplan, initiated 11/17/14, indicated the resident had potential to demonstrate physical behaviors such as hitting related to poor impulse control and anger. This careplan was not updated with any new interventions from 11/17/14 through</p>			

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	<p>1/11/16.</p> <p>A nurse's note, dated 11/22/15, indicated, "Heard yelling in the dining room. Went to dining room and res[ident was yelling and cussing at another res...Writer was attempting to wheel res out of dining room. Res proceeded to hit this writer in the face and upper body several times. Explained to res that we wanted to separate him from the other res. Res continued yelling, 'I'm going to kick his a...'"</p> <p>Behavior/Intervention Monthly Flow Records for November and December, 2015, did not indicate the resident was being monitored for verbal or physical aggression.</p> <p>A Psychology Progress Note, dated 12/11/15, indicated resident was being seen for signs and symptoms of depression and aggression. The note indicated the resident was angry. Recommendations were, "Continue as is with reevaluation in approximately three months."</p> <p>A Psychiatric Evaluation, dated 2/19/16, indicated Resident #19, "Yells and curses at peers and staff, history of physical aggression."</p>			

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	<p>A Behavior Flow Record for January, 2016 was not found in the resident's record.</p> <p>Social Service Director (SSD) note, dated 2/22/16 at 4:00 p.m., indicated Resident #19 was in the hallway and started, "Yelling and cursing at male peer." Both residents were provided with 1:1 care.</p> <p>Behavior/Intervention Monthly Flow Record for February, 2015 did not indicate the resident was being monitored for verbal and physical aggression.</p> <p>SSD note, dated 3/7/16, indicated Resident #19 was involved in a verbal altercation with his roommate..."Staff heard yelling and came running to room to find both males standing face each other and cursing at one another..." The note indicated 1:1 care was provided at this time.</p> <p>c.. The clinical record of Resident #33 was reviewed on 3/14/1 at at 9:18 a.m. Diagnoses for the resident included, but were not limited to, major depression, anxiety, and mood disorder.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 1/2/16, and an annual MDS assessment, dated 10/2/15, indicated Resident #33 was independent</p>			

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	<p>in her ability to make decisions.</p> <p>A careplan, initiated 3/20/15 and current through 6/20/16, indicated the resident had potential to demonstrate verbally abusive behaviors related to mental/emotional illness and poor impulse control, anger.</p> <p>Nurse's note (NN) dated 10/14/15 at 7:30 p.m., indicated Resident #33 was in a verbal altercation with another female resident (Resident #30). Resident #19 indicated she hit the other resident, but this was not verified. No signs or symptoms of injury. Residents separated.</p> <p>Review of Incident Report (IR) #42, dated 10/14/15, indicated it was found, after investigation, the residents did get into a physical fight hitting, scratching and pulling each others hair. The resident were separated immediately and removed from the situation. Preventative measures were, "The residents were educated on appropriate social behavior."</p> <p>NN dated 11/21/15 at 2:30 p.m., indicated the resident was screaming about her roommate's music, screaming, "I f..... Hate that b..... music, she blaers it all the f..... night long...resident screamed at other residents in the hallway..."</p>			

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	<p>NN dated 12/4/16 at 6:20 p.m., indicated, "Resident asked this nurse for a cigarette. Explained to resident the rules. Resident stormed off trying to get out the side door. Resident stated, 'I am walking to the f..... store.' Resident unable to get out door she starting hitting it with her fist screaming, 'f... your rules b...., I'm going to tear this f..... place up until you let me out, you f..... b.....' Resident ran toward this nurse, drew back her fist yelling, 'I will f... you up, call the police cause I plan on tearing everything up until I get my way b....' Tried one on one without success."</p> <p>NN dated 1/29/16 4:00 a.m. "Resident's anger escalated regarding her call light not being answered promptly. [Resident] struck/pummeled [Resident #32] on his back with her fists without provocation. Residents were separated. Police were phoned...no injuries were sustained by either resident. "</p> <p>NN dated 2/2/16 at 4:30 p.m., "Res was involved in a resident to resident altercation. She smacked another resident on the cheek..."</p> <p>Incident Report #58, dated 2/2/16, indicated a resident (Resident #31) began cussing and yelling in the hallway, and</p>			

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	<p>Resident #33 gently smacked Resident #31 on the cheek. Preventative measures included, Resident #19 was educated on appropriate ways to voice grievances about other residents, not touching other residents. A psych consult was to be requested.</p> <p>A Psychiatric Evaluation, dated 2/9/16, indicated resident was being seen for yelling, cursing and some physical aggression. Treatment changes included an increase in Depakote (a medication used for mood stabilization) and continued psych support.</p> <p>NN dated 3/7/16 at 9:45 a.m., resident started talking loudly and another resident asked her to be quiet, and Resident #33 called the other resident a "b...." and started going towards the other resident, who stood up from her wheelchair. Writer immediately stepped between the residents to separate them.</p> <p>NN dated 3/9/16 at 6:06 a.m. indicated Resident #33 was on 1:1 care due to increase in aggressive behaviors. The resident was still on 1:1 care at time of the survey exit on 3/16/16 at 7:00 p.m.</p> <p>Review of Behavior/Intervention Monthly Flow reports indicated the resident was not being monitored for</p>			

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	<p>aggressive behaviors until February, 2016. The February, 2015 flow sheet indicated 22 shifts with no evidence of monitoring, out of 87 total opportunities.</p> <p>d. The clinical record of Resident #54 was reviewed on 3/16/16 at 8:58 a.m. Diagnoses for the resident included, but were not limited to, end stage renal disease.</p> <p>On 3/16/16 at 2:08 p.m., the Social Service Director (SSD) indicated the resident had refused to be cognitively evaluated upon her admission 2/24/16, but the resident appeared alert and oriented and the SSD indicated she was, "probably" independent in her ability to make decisions.</p> <p>NN dated 3/3/16 at 4:15 p.m. indicated, "Resident was noted with verbally inappropriate behaviors, telling another resident that he was smelling pee and that he stinks, resident was asked not to tell anybody that they stink."</p> <p>SSD note dated 3/3/16 at 12:00 p.m. Resident #54 refused psych services.</p> <p>NN dated 3/5/16 at 11:15 a.m. " Resident at this time got into a fight with another resident, both got separated...no injury noted...15 minute checks initiated</p>			

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	<p>incident reported to IMPD..."</p> <p>Incident Report #62, dated 3/5/16, indicated Resident #54 was in the back hallway and told Resident #22 to get out of her way. Resident #22 hit Resident #54 on the arm...and then Resident #54 reached around the nurse and hit Resident #22 back in his face. Both residents were placed on 15 minute checks, and "educated about appropriate behavior."</p> <p>SSD note dated, 3/7/16, (no time documented) "This A.M. this resident was waiting to go outside to smoke. Words were exchanged between this resident and another female resident Both residents started yelling and cursing at each other. This resident stood up out of her wheel chair and started to raise her arms up in a manner that would suggest that she was going to hit other residents, fist swinging...DON was able to step between both residents before any contact was made..." One to one care was provided. The writer spoke with the Resident #54, who "stated again...I will hit her if I have to..."</p> <p>NN dated 3/8/16 at 2:00 p.m. "Resident is unpleasant to all staff. Refuses care and meds. Is confrontational with staff and residents. She remains on 1:1. One female resident she is more vocal with.</p>			

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	<p>On 3/7/16 she and the female resident had words of calling each other "b...."</p> <p>NN dated 3/8/16 :00 p.m. "...She was in another altercation with the same other resident, attempted to charge this resident, and threatening to fight. The two were separated by staff, there no injuries. Will continue to monitor."</p> <p>NN dated 3/9/16 1:20 p.m. "She continues to be verbally abusive with staff, at times seeming to be physically aggressive..."</p> <p>NN dated 3/11/16 (no time documented) "Resident...continues to be rude and demanding. She swears at staff and other residents...remains on 1:1 precautions..."</p> <p>An Interim Care Plan for Physical and Verbal Aggression was not created for the resident until 3/9/16.</p> <p>Resident #54 remained on 1:1 care through survey exit date on 3/16/16 at 7:00 p.m.</p> <p>Review of the Behavior/Intervention Monthly Flow record for March, 2016, did not indicate verbal nor physical aggression was being monitored.</p> <p>e. The clinical record of Resident #30</p>						

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	<p>was reviewed on 3/14/16 at 2:25 p.m. Diagnoses included, but were not limited to, schizophrenia, anxiety, and depression.</p> <p>Quarterly Minimum Data Set (MDS) assessments, dated 12/22/15 and 9/22/15, indicated Resident #30 was independent in her ability to make decisions.</p> <p>Nurse's Note (NN) dated 11/8/15 at 7:50 p.m. Another resident "was at nurses station on phone talking with his brother when this resident [#30] began yelling I want to talk..." This resident continued yelling as the other resident walked to a different hall. The nurse was between the residents at all times.</p> <p>NN dated 12/15/15 at 7:40 p.m. "Heard yelling in hallway this resident and [another resident] in hallway. Saw this resident walking fast down hallway walker lying on floor. [other resident] following resident yelling. Writer and other staff in between residents. IMPD notified."</p> <p>Social Service Director (SSD) note dated 12/16/15 at 10:00 a.m. "Behavior On 12/15/15 late evening staff heard yelling in hallway by nurses' station. This resident was having a verbal disagreement with a male peer over his</p>			

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	<p>use of resident phone. Words were exchanged between both residents. This resident became angry and pushed her walker towards male resident and threw her coat at him. Male resident responded by standing up from his...walker and pushing walker back at this resident walking towards her and yelling at her. Staff at this point was able to interject and separate both residents and provide 1:1 care to each."</p> <p>Psychiatric Evaluation dated 3/3/16, indicated the resident was being seen for "verbal aggressive with peers and staff..." The plan was to start Depakote (a mood stabilizing medication) and provide continued psych support.</p> <p>Review of Behavior/Intervention Monthly Flow records indicated:</p> <p>November, 2015: A Behavior/Intervention Monthly Flow record was not provided by survey exit 3/16/15 at 7:00 p.m.</p> <p>December, 2015: resident was monitored for aggression, interventions and effectiveness only 54 shifts out of the 93 opportunities.</p> <p>January, 2016: A Behavior/Intervention Monthly Flow record was not provided</p>			

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	<p>by survey exit 3/16/16 at 7:00 p.m.</p> <p>February, 2016: resident monitored for verbal aggression, interventions, and effectiveness only 54 shifts out of 87 opportunities.</p> <p>A careplan for the resident, initiated 3/9/16, indicated the resident had the potential to demonstrate verbally and physical abusive behaviors related to mental and emotional illness.</p> <p>f. The clinical record of Resident #32 was reviewed on 3/14/16 at 10:11 a.m. Diagnoses for the resident included, but were not limited to, encephalopathy (disease, damage, or malfunction of the brain).</p> <p>Quarterly Minimum Data Set (MDS) assessments, dated 1/19/16 and 12/11/15, indicated the resident was independent in his ability to make decisions.</p> <p>A careplan for Resident for Resident #32, initiated 12/4/14, and current through 6/10/16, indicated the resident had potential to demonstrate physical behaviors of hitting other residents and staff related to poor impulse control and anger. The careplan was not updated with any new interventions until 3/7/16.</p>			

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	<p>Nurses Note (NN) dated 10/26/15 at 9:40 a.m., "Resident became verbally and physically aggressive after another resident pushed a resident into his room. Resident hit another resident with his cane... Will continue to monitor." The Indianapolis Metropolitan Police Department was contacted.</p> <p>NN dated 1/25/16 at 4:00 p.m., "Resident spitting...over this resident's head. Resident asked other resident to stop. Resident denied hitting other resident states they only argued. Staff witnessed resident [#32] hitting other resident multiple times and needed to be pulled away from resident. Residents separated per protocol."</p> <p>NN dated 1/29/16 at 3:20 a.m., "Resident to resident altercation. [Resident #32] was attacked by a female peer. Resident punched him (resident #32) on the back with excessive force. [Resident #32] in a wheelchair took his cane and angrily pushed on and beat on [other resident's] door and vowed to get revenge....Police were called...No injuries..."</p> <p>Psychiatric Evaluation, dated 2/9/16, for anxiety with history of encephalopathy, staff reports that resident has been yelling and cursing at peers.</p>			

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	<p>Review of Behavior/Intervention Monthly Flow records indicated the resident was not monitored for verbal or physical aggression in November nor December, 2015, nor January, 2016. In February, he was monitored for verbal aggression only, 58 shifts out of 87 opportunities.</p> <p>On 3/15/16 at 10:00 a.m., the Social Service Director (SSD) indicated she is the person who initiates the Behavior/Intervention Monthly Flow records, and the nurses are supposed to document every shift whether or not the resident had a behavior, what interventions were attempted, and if the interventions were effective. She indicated both verbal and physical aggressions are considered behaviors and should be on Behavior Flow Sheets. She is aware the forms are not completed every shift like they are supposed to be.</p> <p>On 3/8/16 at 5:54 p.m., the Administer provided a policy titled, Behavior Management, dated December, 2015, and indicated it was the policy currently used by the facility. The policy indicated, "Each resident with identified behaviors...will be monitored for episodes of behaviors...A behavior management form for each resident with identified behaviors...will include target</p>			

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F 0246 SS=D	<p>behaviors as well as interventions appropriate for redirection of the identified behavior...responsible for maintaining updated Care Plans on residents with identified behaviors...and interventions to redirect the behaviors. Updates should be made as often as needed..."</p> <p>On 3/7/16 at 5:34 p.m., the Administrator provided a policy titled, "Abuse & Neglect Policy." dated 9/1/14, and indicated it was the policy currently used by the facility. The policy indicated, "Each resident has the right to be free from abuse, neglect, and misappropriation of resident property...'Abuse' means the willful infliction of injury...'Physical abuse' includes hitting, slapping, pinching and kicking...Prevention...The clinical staff will assess, care plan and monitor residents with needs and behaviors that might lead to conflict tor neglect, such as residents with a history of aggressive behaviors..."</p> <p>3.1-28(a)</p> <p>483.15(e)(1) REASONABLE ACCOMMODATION OF</p>			

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Bldg. 00	<p>NEEDS/PREFERENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on record review, observation, and interview, the facility failed to ensure a resident's call light cord was within reach and usable for a resident (Resident #53).</p> <p>Findings include:</p> <p>A record review completed on 3/14/16 at 11:41 a.m., indicated Resident #53 was admitted to the facility on 3/7/16, with a left hip fracture.</p> <p>An Admission Nursing Assessment dated 3/7/16, indicated Resident #53 was alert and oriented with no cognitive impairment and had history of falls in the last 3 months. The assessment also indicated Resident #53 needed assistance of 1 person to transfer.</p> <p>On 3/8/16 at 12:58 p.m., Resident #53 was observed sitting in a chair next to the head of the bed with no call light in reach. Resident #53 indicated, "I cannot reach the light from where I am sitting."</p> <p>On 3/9/16 at 3:25 p.m., Resident #53 was observed lying in the bed with call light</p>	F 0246	<p>F 246</p> <p>Reasonableaccommodation of needs/preferences</p> <p>What Correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice:</p> <p>A new wireless call light system was installed on3/17/16. The wireless system allows for resident 53 to carry her pendant withher on her person.</p> <p>How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:</p> <p>All residents have the potential to be affected. A new wireless call light system wasinstalled on 3/17/16 and allows for each resident to have their own mobilepersonal pendant to carry on their person to allow for them to push the buttonfor assistance.</p> <p>What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not</p>	04/15/2016

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F 0279 SS=E Bldg. 00	<p>in reach. Resident #53 indicated, "I pull on it [call light cord] and sometimes it will go all of the way and sometimes it only goes halfway. I never know if it is on or not."</p> <p>On 3/11/16 at 12:11 p.m., Resident #53 was observed resting in bed with eyes closed. Resident #53's call light cord was observed handing down onto floor at the foot of th bed.</p> <p>On 3/16/16 at 5:15 p.m., the Administrator provided a policy titled Answering the Call Light, dated September 2003, and indicated it was the policy currently used by the facility. The policy indicated, "3. Ask the resident to return the demonstration so that you will be sure that the resident can operate the system... 5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident..."</p> <p>3.1-3(v)(1)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p>		<p>recur: A new wireless call light system was installed on 3/17/16and allows for each resident to have their own mobile personal pendant to carryon their person to allow for them to push the button for assistance. A Permanent call light system will begininstallation the week of 4/4/16.</p> <p>How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place: A weekly audit of 10 random resident call lights will beconducted by administrator/designee for 30 days from 3/17/16 to ensure properplacement effectiveness of the call light system. Staff in-service on call lights to be within reach anduseable for residents.</p> <p>By what date thesystemic changes will be completed: 4/15/2016</p>				

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	<p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to ensure care plans were developed for a resident who fell while intoxicated (Resident #22), residents with verbal and physical aggressiveness towards other residents (Residents (#9, #54, #33, and #30), a resident who used a lap tray for positioning (Resident #2), a resident who needed staff assistance to position herself in her wheelchair (Resident #21), and residents receiving psychotropic medications (Residents #52 and #35).</p> <p>Findings include:</p> <p>1. The clinical record review for Resident #22 was completed on 3/11/16 at 9:14 a.m. Diagnoses included, but were not limited to, hemiplegia (paralysis</p>	F 0279	<p>F 279</p> <p>Develop comprehensive care plans</p> <p>What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident 22 and 54 have been discharged to alternate facilities. Residents 9, 54, 33 and 30's care plans were reviewed and updated as appropriate for behaviors of verbal and physical aggression with interventions. Resident 2 care plan was reviewed and updated as appropriate for using a lap tray for positioning. Resident 21 had care plan reviewed and updated as appropriate for needing staff assistance for positioning in her wheelchair</p>	04/15/2016

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	<p>of one half of the body).</p> <p>An Interdisciplinary Post-Fall Assessment, indicated Resident #22 was inebriated and fell on 10/10/15. The assessment indicated the resident received a bleeding scratch to his back.</p> <p>An Interdisciplinary Post-Fall Assessment, indicated Resident #22 smelled strongly of alcohol and fell on 10/26/15, with no injury assessed.</p> <p>An Interdisciplinary Post-Fall Assessment, indicated Resident #22 was inebriated and fell on 2/6/16. The assessment indicated the resident struck the right back side of his head and was bleeding profusely.</p> <p>A review of Resident #22's careplans, lacked a careplan with interventions for an inebriated resident.</p> <p>During an interview on 3/15/16 at 1:38 p.m., the DON indicated staff would contact her when Resident #22 would return intoxicated and she would tell them what to do for the resident. The DON indicated there was no plan of care documented for the resident regarding inebriation.</p> <p>2 a. The clinical record of Resident #9 was reviewed on 3/15/16 at 10:10 a.m.</p>		<p>Residents 52 and 35 care plans were reviewed and updated as appropriate for receiving psychotropic medications.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents who receive psychotropic medications will have their care plans reviewed and updated as appropriate. All residents with behaviors of aggression will be identified by IDT and care plans will be updated as needed with appropriate interventions.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Care plans will be updated upon occurrence with interventions as needed. IDT will hold weekly care plan meetings to review care plans and ensure updates are completed as needed. Staff will be in-serviced starting the week of 4/4/16 on care plans and the need to update immediately.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be</p>	

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	<p>Diagnoses for the resident included, but were not limited to, paranoid schizophrenia.</p> <p>Quarterly Minimum Data Set (MDS) assessments, dated 1/13/16 and 12/5/15, indicated the resident was independent in her ability to make decisions.</p> <p>Resident #9 had 2 incidents of verbal abuse towards other residents, dated 10/30/15 and 1/15/16.</p> <p>A care plan, not initiated until 2/14/16, indicated Resident #9 had a behavior problem related to frequent verbally abusive outbursts to staff and other residents.</p> <p>Another care plan, not initiated until 2/17/16, indicated the resident had potential to demonstrate verbally abusive behaviors related to ineffective coping skills and poor impulse control.</p> <p>b. The clinical record of Resident #54 was reviewed on 3/16/16 at 8:58 a.m. Diagnoses for the resident included, but were not limited to, end stage renal disease.</p> <p>On 3/16/16 at 2:08 p.m., the Social Service Director (SSD) indicated the resident had refused to be cognitively</p>		<p>put into place:</p> <p>Weekly care plan meeting notes will be reviewed during monthly QA meeting for 90 days and monitored by DON/Admin.</p> <p>By what date the systemic changes will be completed: 4/15/2016</p>				

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	<p>evaluated upon her admission 2/24/16, but the resident appeared alert and oriented and the SSD indicated she was, "probably" independent in her ability to make decisions.</p> <p>The record indicated the resident had incidents of verbally aggressive behavior towards other residents on 3/3/16, 3/7/16, and 3/8/16, and an incident of physically aggressive behavior towards another resident on 3/5/16.</p> <p>An Interim Care Plan for physical and verbal aggressive behavior was not created for the resident until 3/9/16.</p> <p>c. The clinical record of Resident #33 was reviewed on 3/14/1 at at 9:18 a.m. Diagnoses for the resident included, but were not limited to, major depression, anxiety, and mood disorder.</p> <p>A care plan addressing the resident's potential for verbal and physical altercations with other residents was not found in her record</p> <p>The record indicated Resident #33 had physical altercations with another resident on 10/4/15, 1/29/16, and 2/2/16, and a verbal altercation on 11/21/15.</p> <p>A careplan, initiated 3/20/15 and current</p>			

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	<p>through 6/20/16, indicated the resident had potential to demonstrate verbally abusive behaviors related to mental/emotional illness and poor impulse control, and anger.</p> <p>d. The clinical record of Resident #30 was reviewed on 3/114/16 at 2:25 p.m. Diagnoses included, but were not limited to, schizophrenia, anxiety, and depression.</p> <p>The record indicated Resident #30 had a verbal altercation with another resident on 11/8/15, and a verbal/physical altercation with another resident on 12/15/15.</p> <p>A care plan addressing the resident's potential for verbal and physical behaviors was not initiated until 3/9/16.</p> <p>3. The clinical record of Resident #2 was reviewed on 3/14/15 at 3:00 p.m. Diagnoses for the resident included, but were not limited, cerebral palsy, abnormal posture, dementia, and seizure disorder.</p> <p>A physician's order, originally dated 1/20/15, indicated Resident #2 was to have a lap tray on her wheelchair while up to maintain proper positioning, due to the resident leans to her side and slides</p>			

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	<p>forward. The indication for the lap tray was cerebral palsy.</p> <p>A careplan for the resident with the lap tray was not initiated until 1/1/16, with interventions of releasing with meals and as needed for care, checking placement of tray to make sure positioning was correct, making sure the resident was in the proper position.</p> <p>4. The clinical record of Resident #21 was reviewed on 3/11/16 at 8:55 a.m. Diagnoses for the resident included, but were not limited to multiple sclerosis.</p> <p>On 3/8/16 at 11:00 a.m., and on all occasions of notice, the resident was observed slumped over the right side of her wheelchair and wheelchair arm.</p> <p>On 3/14/16 at 1:48 p.m., the Certified Occupational Therapy Assistant indicated the resident had refused many interventions to help with her wheel chair positioning, and was currently working with Resident #21, and was hoping some of the therapy would enable her to sit up straighter.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 12/12/15 indicated the resident was totally dependent on staff for bed mobility, transfer, and</p>			

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	<p>locomotion on the unit.</p> <p>A careplan for the positioning of the resident was not found in the resident's record.</p> <p>5 a. The clinical record of Resident #52 was reviewed on 3/11/16 at 9:35 a.m. Diagnosis for the resident included, but were not limited to, anxiety, bipolar, and depression.</p> <p>Recapitulated orders for March, 2016, indicated the resident was to receive clonazepam (an anxiety medication), Seroquel (an antipsychotic medication for bipolar disorder).</p> <p>A careplan addressing the risks and care of the resident receiving the psychotropic medications was not found in the resident's record. On 3/11/16 the Director of Nursing provided a careplan for psychotropic medications, created for Resident #52 on 3/11/16.</p> <p>b. The clinical record of Resident #35 was reviewed on 3/14/16 at 3:20 p.m. Diagnoses for the resident included, but were not limited to, dementia, anxiety, dementia with delusions, psychotic disorder.</p> <p>Recapitulated physician orders for</p>			

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F 0280 SS=D Bldg. 00	<p>March, 2016, indicated the resident was to receive Olanzapine (an antipsychotic medication used to treat mental disorders, sertraline (an antidepressant) and trazadone (an antidepressant) daily.</p> <p>A careplan addressing the risks and care of the resident receiving the psychotropic medications was not found in the resident's record. On 3/11/16 the Director of Nursing provided a careplan for psychotropic medications, created for Resident #35 on 3/11/16.</p> <p>3.1-35(a)(1)</p> <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>			

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	<p>Based on record review and interview, the facility failed to ensure careplans were revised with new interventions for residents with the potential to exhibit verbal or physical behaviors towards other residents. (Residents #32 and #19)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #32 was reviewed on 3/14/16 at 10:11 a.m. Diagnoses for the resident included, but were not limited to, encephalopathy (disease, damage, or malfunction of the brain).</p> <p>A careplan for Resident for Resident #32, initiated 12/4/14, and current through 6/10/16, indicated the resident had potential to demonstrate physical behaviors of hitting other residents and staff related to poor impulse control and anger.</p> <p>The record indicated Resident #32 demonstrated physically aggressive behaviors towards other residents on 10/26/15, 1/25/16, and 1/29/15.</p> <p>The careplan was not updated with any new interventions from initiation on 12/4/14.</p> <p>2. The clinical record of Resident #19</p>	F 0280	<p>F 280 Rightto participate in planning care</p> <p>What Correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice: Residents 32 and 19 care plans were reviewed and updatedas appropriate for behaviors of verbal and physical aggression withinterventions. Resident 19 was discharged on 3/8/16 to inpatient psychfor evaluation and treatment of aggressive behaviors. Resident 32 was discharged on 3/8/16 to inpatient psychper resident choice for evaluation and treatment.</p> <p>How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken: All residents with behaviors of aggression will beidentified by IDT and care plans will be updated as needed with appropriateinterventions.</p> <p>What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur: Care plans will be updated with each occurrence asappropriate and with</p>	04/15/2016

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F 0286 SS=C Bldg. 00	<p>was reviewed on 3/14/15 at 1:54 p.m. Diagnoses for the resident included, but were not limited to, dementia with behavioral disturbance.</p> <p>A careplan, initiated 9/26/14, indicated the resident had a mood problem related to depression, as evidenced by yelling out. This careplan was not updated with any new interventions from 10/2/14 through 1/11/16.</p> <p>A careplan, initiated 11/17/14, indicated the resident had potential to demonstrate physical behaviors such as hitting related to poor impulse control and anger. This careplan was not updated with any new interventions from 11/17/14.</p> <p>The record indicated the resident demonstrated physically aggressive behavior on 11/22/15, and had verbal altercations with other residents on 2/22/16, and 3/7/16.</p> <p>3.1-35(d)(2)(B)</p> <p>483.20(d) MAINTAIN 15 MONTHS OF RESIDENT ASSESSMENTS A facility must maintain all resident assessments completed within the previous</p>		<p>interventions as needed.</p> <p>IDT will hold weekly care plan meetings to review careplans and ensure updates are completed as needed.</p> <p>Staff will be in-serviced by DON/SSD/designee starting the week of 4/4/16 on care plans and the need to update each resident careplan.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>Weekly care plan meeting notes will be reviewed during monthly QA meeting for 90 days and monitored by DON/Admin.</p> <p>By what date the systemic changes will be completed: 4/15/2016</p>		

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	<p>15 months in the resident's active record. Based on record review and interview, the facility failed to ensure Minimum Data Set (MDS) assessments were maintained in residents' active records for the previous 15 months.</p> <p>Findings include:</p> <p>During clinical record reviews, MDS assessments were not available in the resident clinical records for review.</p> <p>During an interview on 3/16/16 at 4:01 p.m., the Administrator and Director of Nursing indicated MDS's are not kept in the resident's clinical record, they are kept in the MDS Coordinator's computer. To view a MDS assessment, a resident or employee would have to request a copy from the MDS Coordinator.</p>	F 0286	<p>F 286 Maintain 15 months of resident assessments</p> <p>What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The most recent MDS is available in all current resident charts.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All charts had the most recent MDS added to them.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Each new MDS that is completed will be placed in resident charts.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: A monthly audit of all charts will be conducted by MDS coordinator or designee for 90 days or until 100% compliance has been met. Results will be brought to monthly QA meeting.</p>	04/15/2016

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F 0312 SS=D Bldg. 00	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview, and record review, the facility failed to ensure a resident unable to carry out Activities of Daily Living (ADLs) independently received the necessary services to maintain hand hygiene (finger nail length) for 1 of 1 residents observed. (Resident #11)</p> <p>Findings include</p> <p>During an observation on 3/07/16 at 9:59 a.m., Resident #11's finger nails on both hands were at a length that touched the palm of the resident's contracted hands.</p> <p>Continued observation of Resident #11 March 07 to March 11, 2016; the finger nails were observed at a length that touched the palm of the resident's contracted hands</p> <p>During an interview on 3/14/16 at 4:28 p.m., the DON indicated the shower sheet</p>	F 0312	<p>By what date the systemic changes will be completed: 4/15/2016</p> <p>F 312 ADLcare provided for dependent residents</p> <p>What Correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice: Resident 11 finger nails were trimmed to appropriate length on 3/12/16.</p> <p>How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken: Nail hygiene will be offered to every resident on theirshower days and PRN per resident request.</p> <p>What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur: Shower sheets will be updated to include nail hygiene andnail</p>	04/15/2016

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F 0323 SS=G Bldg. 00	<p>assignment form the Certified Nursing Assistants (CNAs) use do not address the trimming of finger nails. She indicated she expected the CNA staff to perform finger nail hygiene during shower times for residents, but there is no documentation requirement.</p> <p>Resident #11's clinical record was reviewed on March 10, 2016 at 2:00 p.m.</p> <p>A care plan dated 11/26/13 and current through March 2016, indicated Resident #11 had an Activities of Daily Living (ADL) self care performance deficit and did not address interventions for hand hygiene (fingernail trimming).</p> <p>The quarterly Minimum Data Assessment (MDS), completed on 12/8/16, assessed Resident #11 required extensive assistance from staff with personal hygiene.</p> <p>3.1- 38(a)(3)(E)</p> <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 record review and interview,</p>	F 0323	<p>trimming. Care plans will be updated as appropriate for residentsneeding nail hygiene and for preferences of such service.</p> <p>How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place: Shower sheets will be reviewed by DON/designee daily andmaintained for at least 90 days. Eachmonth shower sheets will be brought to QA to review for resident trends. Nursing staff will be in-serviced during the week of4/4/16 on updated shower sheets and nail hygiene.</p> <p>By what date thesystemic changes will be completed: 4/15/2016</p>	04/15/2016

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	<p>the facility failed to ensure residents received adequate supervision for a resident who had a fall with injury while inebriated (Resident #22) which resulted in a laceration to head requiring 5 staples, a resident who demonstrated verbally and physically abusive behaviors to other residents (Resident #18), and a resident with the potential to have aggression and be exit seeking (Resident #37).</p> <p>Findings include:</p> <p>1. The clinical record review for Resident #22 was completed on 3/11/16 at 9:14 a.m. Diagnoses included, but were not limited to, hemiplegia (paralysis of one side of the body).</p> <p>An Interdisciplinary Post-Fall Assessment, indicated Resident #22 was inebriated and fell on 10/10/15. The assessment indicated the resident received a bleeding scratch to his back. The Interdisciplinary team's recommendation was to, "Educate resident and friend on intoxication side effects."</p> <p>An Interdisciplinary Post-Fall Assessment, indicated Resident #22 smelled strongly of alcohol and fell on 10/26/15, with no injury assessed. No documentation was found indicating a</p>		<p>hazards/supervision/devices</p> <p>What Correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice: Resident #22 was transferred to alternate placement. Resident 18 care plan is updated withappropriate care plans for behaviors and interventions. How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken: All residents with exit seeking behaviors, physicalaggression and becoming intoxicated will be identified by IDT and care planswill be reviewed and updated as appropriate. What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur: Care plans and interventions are to be updated withoccurrence as needed. Weekly care planmeetings will be conducted to ensure care plans are updated with newlyidentified behaviors and interventions as appropriate. Staff will be in-serviced on the week of4/4/16 on updating care plans. How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put</p>	

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	<p>recommendation from the Interdisciplinary team.</p> <p>A nurses note dated 2/6/16, indicated "...Resident has been found in w/c[wheelchair], unclothed, x3 [3 times], on way to bathroom...."</p> <p>An Interdisciplinary Post-Fall Assessment, indicated Resident #22 was inebriated and fell on 2/6/16. The assessment indicated the resident struck the right back side of his head and was bleeding profusely. The Interdisciplinary team's recommendation again, was "less alcohol consumption when LOA [leave of absence]."</p> <p>A nurses note dated 2/6/16 at 11:15 p.m., indicated, "...911 telephoned. Ambulance and police arrived to transport resident to nearby hospital to r/o [rule out] concussion, suture placement, and r/o [rule out] skull fracture..."</p> <p>A nurses note dated 2/7/16 at 4 a.m., indicated the resident returned from the hospital with 5 staples to his head.</p> <p>A review of Resident #22's clinical record, lacked a careplan with interventions for an inebriated resident.</p> <p>During an interview on 3/15/16 at 1:38</p>		<p>into place: Weekly care plan meeting notes will be reviewed during monthly QA meeting for 90 days and monitored by DON/Admin. By what date the systemic changes will be completed: 4/15/16 4/18/16 F323 update: Resident 37 had care plan and interventions reviewed by IDT and care plan with interventions were updated as appropriate. Resident has not shown any behaviors since 9/30/15, and no exit seeking behaviors over the past year. MDS/designee will initiate daily review of care plans during morning meeting by IDT to ensure updates and interventions are completed as needed. Weekly care plan meeting notes will be reviewed during monthly QA for 6 months. At that time IDT will determine effectiveness and if monthly review of weekly care plan meeting notes will continue and for amount of time.</p>		

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	<p>p.m., the DON indicated staff would contact her when Resident #22 would return intoxicated and she would tell them what to do for the resident. Upon Resident #22 returning from leave of absence to facility inebriate, staff would normally call the physician to get an order to hold his medications, place his mattress on the floor, and try to keep the resident in bed with a blanket. The DON indicated there was no plan of care with interventions documented for the resident regarding inebriation.</p> <p>2. The clinical record of Resident #18 was reviewed on 3/14/16 at 11:31 a.m. Diagnoses for the resident included, but were not limited to, schizophrenia, psychotic disorder, dementia, Parkinson's disease.</p> <p>A quarterly Minimum Data Set assessment, dated 11/19/15, indicated the resident was moderately impaired in her ability to make decisions. An annual Minimum Data Set assessment, dated 1/10/16, indicated the resident was severely impaired in her ability to make decisions.</p> <p>Review of nurses' and Social Service Director's (SSD) notes indicated:</p> <p>Nurse's note dated (NN) 9/4/15 at 6:10</p>			

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	<p>a.m.: "Res seen with arm around roommate in the doorway. Res asked to let roommate loose, res responded to request...."</p> <p>Social Service Director (SSD) note dated 10/27/15 at 11:30 a.m.: "Resident was in her room yelling about 6:30 a.m. She was sitting on her roommates's bed. Staff tried several different interventions - music, 1:1 care, food - all failed. Writer spoke with resident this morning. She has no recall of incident..."</p> <p>NN dated 12/19/15 at 7:00 a.m.: "Res[ident] was standing over her roommate yelling at her and chanting random things. Staff escorted res out of the room to dining room..."</p> <p>NN dated 3/1/16 at 1:00 p.m.: "Called to room at 12:30 p.m. by Certified Nursing Assistant (CNA). This res was trying to shut bedroom door, CNA reports res struck her roommate, but no injuries on full body skin assess....Began 15 minute checks, Indianapolis Metropolitan Police Department notified."</p> <p>A Psychiatric Evaluation was completed on Resident #18 on 3/3/16, for delusions, dementia with behaviors. The plan was to continue to monitor dementia with behaviors, continue to provide psych</p>				

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	<p>support.</p> <p>Behavior/Intervention Monthly Flow records for November and December, 2015, and February, 2016, did not indicate the resident was being monitored for physical or verbal aggressions. The flow record for January, 2016, was not provided by the end of survey 2/16/16 at 7:00 p.m.</p> <p>On 3/15/16 at 2:25 p.m., the Social Service Director indicated verbal and physical aggressions are considered behaviors and should be on the Behavior Flow Sheets.</p> <p>A careplan, created on 3/9/16, indicated the resident had the potential to demonstrate verbally and physically abusive behaviors.</p> <p>Another careplan, created 3/13/16, indicated the resident was physically attacking other residents and staff related to the cycling process of her disease.</p> <p>3. The clinical record for Resident #37 was reviewed on 3/10/16 at 4:17 p.m. Diagnoses included, but were not limited to, aggressive behaviors and psychotic disorder.</p> <p>A review of Behavior/Intervention</p>			

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	<p>Monthly Flow Records for December 1 through 31, 2015, indicated Resident #37 was being monitored for aggression and exit seeking behaviors.</p> <p>The Behavior/Intervention Monthly Flow Record lacked monitoring documentation for aggressive behavior for evening shift on December 1, 4, 5, 6, 7, 11, 12, 13, 14, 17, 18, 21, 23, 24, 25, 26, 27, 28, 29, 30, and 31, 2015.</p> <p>The Behavior/Intervention Monthly Flow Record lacked monitoring documentation for aggressive behavior for night shift on December 1, 2, 6, 7, 8, 14, 15, 19, 22, 24, 25, 26, 27, 28, 29, 30, and 31, 2015.</p> <p>The Behavior/Intervention Monthly Flow Record lacked monitoring documentation for exit seeking behavior for day shift on December 12, 13, 14, 15, 16, 17, 24, and 31, 2016.</p> <p>The Behavior/Intervention Monthly Flow Record lacked monitoring documentation for exit seeking behavior on evening shift on December 1, 4, 5, 6, 7, 11, 12, 13, 14, 17, 18, 21, 23, 24, 25, 26, 27, 28, 29, 30, and 31, 2015.</p> <p>The Behavior/Intervention Monthly Flow Record lacked monitoring documentation for exit seeking behavior on night shift</p>			

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F 0371 SS=F Bldg. 00	<p>on December 1, 2, 6, 7, 8, 14, 15, 19, 22, 24, 25, 28, 29, 30, and 31, 2015.</p> <p>On 3/14/16 at 12:24 p.m., the Director of Nursing (DON) indicated the Behavior Intervention Flow Records are supposed to be signed by nursing staff every shift.</p> <p>3.1-45(a)(2)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure the dishwasher sanitizing rinse solution was maintained according to the manufacturer's guidelines for proper washing and sanitizing of dishes and utensils for 37 of 37 residents served from the kitchen.</p> <p>Findings include:</p> <p>During an observation on 03/07/2016 at 10:22 A.M., the dishwashing machine sanitizing rinse solution reached 10 parts per million (ppm) chlorine. The manufacturer's guidelines provided by the</p>	F 0371	<p>F 371 foodprocedure, store/prepare/serve-sanitary</p> <p>What Correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice: On 3/7/16 a new bucket of solution replaced the currentbelow standard sanitizer on the same day.</p> <p>How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken: All residents have the potential to be affected. The solution will be tested</p>	04/15/2016

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F 0412 SS=D Bldg. 00	<p>Dietary Manager indicated the rinse cycle sanitizing solution needed to reach 50 ppm chlorine minimum</p> <p>During an interview on 03/07/2016 at 10:45 A.M., the Dietary Manager indicated the rinse cycle sanitizing solution did not reach 50 ppm chlorine to properly sanitize dishes and utensils at that time. The Dietary Manager indicated she would call (name of local company) to come and service the dishwashing machine.</p> <p>On 3/7/16 at 3 p.m., the (name of local company) Technician indicated the chlorine evaporated from the sanitizing solution, making the solution ineffective.</p> <p>On 03/1/16 at 04:40 P.M., the Administrator indicated it was the policy of the facility to follow manufacturer's guidelines for proper washing and sanitizing of dishes and utensils.</p> <p>3.1-19(i)(3)</p> <p>483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain</p>		<p>three times perday for proper levels.</p> <p>What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur:</p> <p>The solution has a proper fitting lid placed onto the bucket. The solution will be tested for proper ppmthree times per day for 30 days then daily.</p> <p>How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place:</p> <p>The Dietary manager/designee will monitor for proper ppmdaily. The results will be discussed inmonthly QA for 90 days or 100% compliance has been met for 30 days.</p> <p>By what date thesystemic changes will be completed: 4/15/2016</p>		

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	<p>from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</p> <p>Based on interview and record review, the facility failed to ensure an oral surgery consultation was scheduled for a resident with broken and decaying teeth (Resident #21).</p> <p>Findings include:</p> <p>The clinical record review for Resident #21 was completed on 3/14/16 at 9:32 a.m., and indicated a facility admission date of 6/4/15. Diagnoses included, but were not limited to, depressive disorder and seizure disorder.</p> <p>A Nursing Admission Assessment dated 6/4/15, indicated the resident had missing and broken teeth.</p> <p>A review of dental exams indicated Resident #21 was seen by a dentist on 10/20/15.</p> <p>On 3/16/16 at 2:23 p.m., the Director of Nursing (DON) indicated the dentist had seen patients at the facility on July 9, 10,</p>	F 0412	<p>F 412- Routine/Emergencydental services</p> <p>What Correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice: Resident 21 was seen on 3/30/16 for oral surgery.</p> <p>How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken: 1 out of 37 residents were affected. Upon admission nurses will complete admissionassessment for need of dental services.</p> <p>What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur: DON will review the admission assessment and will signoff the assessment was completed and any</p>	04/15/2016

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F 0458	<p>22, and August 21, 2015. The DON indicated the resident should have been seen on the 1st scheduled dental visit after admission and indicated she was missed.</p> <p>A review of a dental note dated 1/22/16, indicated, "Exam-inflamed tender tissues...Spoke with Social Services regarding need for oral surgery consultation..."</p> <p>During an interview on 3/14/16 at 10:21 a.m., the Social Service Director indicated she did not recall the dentist notifying her of the need for an oral surgery consultation to be scheduled.</p> <p>On 3/14/16 at 11:45 a.m., the Director of Nursing (DON) indicated the oral surgery consultation had been overlooked and had not been scheduled.</p> <p>On 3/16/16 at 12:11 p.m., the Administrator provided documentation indicating an oral surgery consultation for Resident #21 was scheduled for 3/22/16 at 10:00 a.m.</p> <p>3.1-24(a) 3.1-24(b)</p> <p>483.70(d)(1)(ii)</p>		<p>appointments needed have beenscheduled.</p> <p>How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place: Audit sheet of all new admissions will be put into placeverifying the assessments were reviewed and appointments were scheduled asneeded. Results will be brought to QAfor 3 months for review by IDT.</p> <p>By what date thesystemic changes will be completed: 4/15/16</p>	

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SS=E Bldg. 00	<p>BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms.</p> <p>Based on record review, observation, and interview, the facility failed to provide at least 80 square feet (sq ft) per resident in multiple resident rooms. This was evidenced in 2 of 20 resident rooms in the facility. (Rooms 9 and 10)</p> <p>Finding include:</p> <p>Facility documentation of room size dated 02/12/16, provided by the Administrator on 03/14/16 at 9:30 a.m., indicated the following room sizes of observed rooms:</p> <p>* 1. Room #9 3 beds 236" x 135" SNF/NF 73.75 sq ft per resident</p> <p>* 2. Room #10 3 beds 236" x 135" SNF/NF 73.75 sq ft per resident</p> <p>3.1-19(I)(2)</p>	F 0458	<p>F 458 Bedroomsmeasure at least 80 sq ft per resident</p> <p>What Correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice: Room waiver was requested before and during annual surveyand on 4/8/16.</p> <p>How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken: All 5 residents in rooms 9 and 10 are affected.</p> <p>What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur: Measurements are available any time for these rooms.</p> <p>How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place: Obtaining the room waiver from</p>	04/15/2016	

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F 0463 SS=D Bldg. 00	<p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH</p> <p>The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. Based on observation, interview, and record review, the facility failed to maintain a communication system equipped to keep the nurses' station capable of receiving calls from 3 resident rooms. (Resident #53, #9, #35, and #29)</p> <p>Findings include:</p> <ol style="list-style-type: none"> Resident #53 who resides in Resident Room #18. <p>The call light was tested, on 03/08/2016 at 3:25 p.m., for Resident #53 who resides in Resident Room #18 and the light in the hallway came on, but did not sound nor light up at the nurses desk.</p> <ol style="list-style-type: none"> Resident #9 who resides in Resident Room #19. <p>On 03/08/2016 at 3:25 p.m., the call light</p>	F 0463	<p>ISDH will show compliance in this area. Room waiver will be requested annually.</p> <p>By what date the systemic changes will be completed: 4/15/2016</p> <p>F 463 Resident call system-rooms/toilet/bath</p> <p>What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: A new wireless call light system was installed on 3/17/16. The wireless system allows for resident 53 to carry her pendant with her on her person.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. A new wireless call light system was installed on 3/17/16 and allows for each resident to have their own mobile personal pendant to carry on their person to allow for them to push the button for</p>	04/15/2016

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	<p>for Resident #9 who resides in Resident Room #19 was tested and the light in the hall way lights up but does not sound nor light up at the nurses station.</p> <p>3. Resident #29 and Resident #35 both which reside in Resident Room #20.</p> <p>On 03/09/2016 at 10:25 a.m., the call light for Residents #29 and #35, both which reside in Resident Room #20, was tested and the call light turns on outside of the room but not at nursing desk.</p> <p>During an interview with Certified Nursing Assistant (CNA) #10 on 03/09/2016 at 9:45 a.m., it was indicated call lights have been broken about 3 months and she has been working here for 6 months.</p> <p>During an interview with CNA #11 on 03/08/2016 at 4:36 p.m., it was indicated that call lights have been broken since CNA #11 started in August, 2015.</p> <p>During an interview on 3/16/16 at 2:00 p.m., the Administrator provided information that on 3/15/16 at 6:01 p.m., the call light notification at the nurses' station was down. Visual and audio notifications at the nurses station was not functioning for 17 of 20 rooms. The Administrator also provided a report</p>		<p>assistance.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>A new temporary wireless call light system was installed on 3/17/16 and allows for each resident to have their own mobile personal pendant to carry on their person to allow for them to push the button for assistance. A Permanent call light system will begin installation the week of 4/4/16 and will be completed by 4/15/16. The temporary wireless system will remain in place until permanent system is fully functioning.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>A weekly audit of 10 random resident call lights will be conducted for 30 days to ensure proper placement effectiveness of the call light system. Staff in-service on call lights to be within reach and useable for residents.</p> <p>By what date the systemic changes will be completed: 4/15/2016</p>		

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F 0465 SS=E Bldg. 00	<p>from SafeCare dated 11/2/2015, that indicated that there was trouble noted in the nurses call system and it was not fixed. The report indicated that there was voltage present at the annunciator at the nurses' desk but something internally has failed resulting in the call lights for Resident Rooms 18,19, and 20 no longer lighting up or buzzing at the nurses station when activated.</p> <p>3.1-19(u)(1)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed provide a safe, functional, sanitary, and comfortable environment for 16 of 20 resident rooms, 1 of 1 soiled utility rooms, 1 of 1 social service office, 1 of 1 laundry room, 1 of 1 clean linen closet, resident restrooms #2 and #4, and a mechanical lift.</p> <p>Findings include:</p> <p>1. Observation on 03/11/16 at 10:30 a.m., in resident room #1: a.) There was an object located behind</p>	F 0465	<p>F 465 – Safe/Functional/Sanitary/Comfortable environment</p> <p>What Correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice:</p> <p>Resident #22 had object behind bed removed on3/11/16. All resident rooms will be deepcleaned by 4/9/16, including wiping down base boards. Plastic storage bins will be placed inresident rooms for storage.</p>	04/15/2016

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	<p>the foot of the bed identified by the Director of Nursing (DON) as a "suction machine" belonging to resident #22. The machine was not covered. There was a liquid in the container identified by the DON as sputum. The DON indicated the last time the machine was used was 3/7/16, and resident 22 had been out of the building since the evening of 3/7/16.</p> <p>b.) There was a blue highback chair with had a heavy buildup of dirt and dust on the arms and the frame and was sticky to the touch.</p> <p>c.) The floor cove in between the closets was missing.</p> <p>d.) The doorframe around the closet did not adhere to the wall.</p> <p>e.) There was paper on the floor.</p> <p>f.) There was a box stored on the floor under the overbed table with a trash can on top of it.</p> <p>g.) There was a distinct build-up of dirt and old floor wax on the floor and baseboards along the outer edges of the room.</p> <p>2. Observation on 03/09/2016 at 10:36 a.m., in resident room #3:</p>		<p>Resident rooms will have drywall repair and new paint completed at a rate of 2 rooms per week with a completion date of 6/10/16.</p> <p>New baseboards for resident rooms will be installed by 6/10/16.</p> <p>Common area floors will be stripped and re-waxed along with resident rooms will be stripped and re-waxed starting the week of 3/16/16 with estimated completion date of 4/22/16.</p> <p>Soiled utility room will have hole in wall with missing tile repaired and patched by 4/15/16.</p> <p>Tile will be laid on the floor in the laundry room with drywall repaired by 4/15/16. Excess bins and other items were removed from the laundry room. The laundry room will be cleaned and swept daily to prevent lint and dust build up.</p> <p>The broken shelf in the clean linen closet was replaced on 4/6/16. All nursing supplies will be stored properly on shelves with nothing left on the floor.</p> <p>All bathrooms and equipment in them will be cleaned daily.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected.</p> <p>What measures will be put into place or what systemic changes will</p>	

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	<p>a.) The floor had areas where the floor had been wet and left to air dry.</p> <p>b.) There were track marks from the wheel chair across the floor.</p> <p>c.) There was a distinct build-up of dirt and old floor wax on the floor and baseboards along the outer edges of the room.</p> <p>3. Observation on 03/07/2016 at 03:21 p.m., in resident room #4:</p> <p>a.) The wall at the foot of resident (bed B) and the wall behind the bed had an area approximately 3' by 1' in size that was unpainted.</p> <p>b.) The west wall was painted yellow with a 2' by 1' unpainted white area.</p> <p>c.) There was paint chipped off the wall in three 1/2 inch areas.</p> <p>d.) There was three 1-2 inch brownish smears, a 1 - 3 inch red smear and a tile chipped on floor below residents head of bed.</p> <p>e.) There was a distinct build-up of dirt and old floor wax on the floor and baseboards along the outer edges of the room.</p>		<p>be made to ensure that thedeficient practice does not recur:</p> <p>Deep clean check lists are completed for each residentroom upon completion and turned into the Administrator. Weekly audit of painting of resident roomswill be completed by maintenance/designee for 10 weeks or until rooms arecompleted. A daily audit for laundry will be completed and turnedinto Administrator, by laundry staff, to ensure cleanliness of and aroundmachines to prevent excess items and dust from accumulating.</p> <p>How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place:</p> <p>Audits for Laundry, housekeeping and maintenance will becompleted as scheduled. Results will bebrought to QA for 3 months or 100% compliance is achieved.</p> <p>By what date thesystemic changes will be completed: 4/15/2016</p>	

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	<p>4. Observation on 03/07/2016 at 03:06 p.m., in resident room #5: a.) There were nails, nail holes, smudges and tape tears on the wall next to the bed.</p> <p>b.) There was a distinct build-up of dirt and old floor wax on the floor and baseboards along the outer edges of the room.</p> <p>5. Observation on 03/07/2016 at 02:01 p.m., in resident room #6: a.) The wall behind the head of bed is unpainted, from the television down to the floor.</p> <p>b.) Walls were soiled and there was a distinct build-up of dirt and old floor wax on the floor and baseboards along the outer edges of the room.</p> <p>6. Observation 03/07/2016 at 11:47 a.m., in resident room #7: a.) The closet doors were marred, scuffed, and dirty.</p> <p>b.) There was a distinct build-up of dirt and old floor wax on the floor and baseboards along the outer edges of the room.</p> <p>7. Observation 03/09/2016 at 09:02 a.m., in resident room #8: a.) The door had unpainted sections and</p>			

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	<p>scrapes.</p> <p>b.) There was a distinct build-up of dirt and old floor wax on the floor and baseboards along the outer edges of the room.</p> <p>8. Observation on 03/09/2016 at 11:32 a.m., in resident room #9:</p> <p>a.) The floors were dirty.</p> <p>b.) In the room the resident had a broken blue recliner that would not close all the way.</p> <p>c.) There was a distinct build-up of dirt and old floor wax on the floor and baseboards along the outer edges of the room.</p> <p>9. Observation on 03/09/2016 at 11:11 a.m., in Resident room #10:</p> <p>a.) There was a distinct build-up of dirt and old floor wax on the floor and baseboards along the outer edges of the room.</p> <p>b.) The nightstand beside resident 44's bed was soiled and dirty.</p> <p>10. Observation on 03/08/2016 at 11:05 a.m., in resident room #11:</p> <p>a.) The wall to the left and straight ahead were plastered, but not painted and</p>			

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	<p>smudged with dirt and stains.</p> <p>b.) There was a distinct build-up of dirt and old floor wax on the floor and baseboards along the outer edges of the room.</p> <p>11. Observation 03/08/2016 at 05:47 p.m., in resident room #12:</p> <p>a.) There was observed to be a small black refrigerator. In the refrigerator there was an open, undated, soda can in the rack on the inside of the door. There were containers of milk and juice, both undated, food crumbs and unidentified stains on the bottom sticky to touch. There was an area of white styrofoam with small black dots and debris littering it. The rubber insulator around the door was sticky and soiled.</p> <p>b.) There was a large box sitting at the foot of Resident 13's bed stuffed with clothing, knotted sheets, shoes, socks, and a rose colored plastic wash basin.</p> <p>c.) There was observed to be dirt and dust underneath Resident #13's bed.</p> <p>d.) Wall beside Resident #13's bed was marred and missing paint in some places.</p> <p>e.) There was a large box observed to be stored on the floor between the closets</p>			

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	<p>that was overflowing with clothes.</p> <p>f.) A highback chair with a heavily soiled frame was sticky to the touch.</p> <p>g.) There were drywall patches above air unit, above light at the foot of the bed and multiple along wall that connects to door.</p> <p>h.) There was a dirt/debris accumulation on base of bedside table.</p> <p>i.) Multiple scuffs/marks on wall to left of closet.</p> <p>j.) A visible drywall repair area above sanitizer dispenser on wall to left of closet.</p> <p>k.) Resident #32's wheelchair was observed to have rips and tears in material of both armrests and the padding underneath exposed.</p> <p>l.) There was a distinct build-up of dirt and old floor wax on the floor and baseboards along the outer edges of the room.</p> <p>12. Observation on 03/09/2016 a 10:09 a.m., in resident room #13: a.) There was a circular dry wall repair spot on the wall at the foot of the bed with approximately 12" in diameter.</p>			

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	<p>b.) Resident #1's wheelchair was observed to have dirt and debris on the bars underneath seat and on the wheels.</p> <p>c.) There was a dry wall repair area behind a recliner next to the door.</p> <p>d.) There was a distinct build-up of dirt and old floor wax on the floor and baseboards along the outer edges of the room.</p> <p>13. Observation on 03/07/2016 at 03:07 p.m., in resident room #14:</p> <p>a.) There was torn wallpaper.</p> <p>b.) The wall at the foot of the roommates bed had two holes at the bottom.</p> <p>c.) The wall to the left of the closet had several scuff marks.</p> <p>d.) The door stop was pushed into wall plaster.</p> <p>e.) There was a distinct build-up of dirt and old floor wax on the floor and baseboards along the outer edges of the room.</p> <p>14. Observation on 03/08/2016 at 10:30 a.m., in resident room #15:</p> <p>a.) There were scuff marks to the left of</p>			

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	<p>the closet door.</p> <p>b.) The base of the bedside table was soiled with a heavy dirt/debris accumulation.</p> <p>c.) There was also a large drywall repair spot behind resident chair on left wall.</p> <p>d.) There was a distinct build-up of dirt and old floor wax on the floor and baseboards along the outer edges of the room.</p> <p>e.) The restroom had dirt/hair/debris along the baseboards, light rusty discoloration on the back of the toilet around left side to front of toilet. Also has black markings on the floor. There was a tear in wallpaper under soap dispenser.</p> <p>15. Observation on 03/07/2016 at 02:17 p.m., in resident room #16:</p> <p>a.) There were multiple spots on wall where paint chipped and plaster was showing next to residents' bed.</p> <p>b.) There was a large spot at foot of bed.</p> <p>c) A Cardboard box used over light for lampshade.</p> <p>d.) There were two small sections of</p>			

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	<p>baseboard missing on the left side of the closet and scuff marks on top of remaining baseboards to left of the closet.</p> <p>e.) To the right side of room in front of door there was a rectangular discoloration on the floor.</p> <p>f.) There was a distinct build-up of dirt and old floor wax on the floor and baseboards along the outer edges of the room.</p> <p>16. Observation on 03/09/2016 at 10:22 a.m., in resident room #20: a.) The floor was soiled and stained.</p> <p>b.) There was a distinct build-up of dirt and old floor wax on the floor and baseboards along the outer edges of the room.</p> <p>17. During the environmental tour on 3/11/16 with the Administrator and Maintenance Supervisor the following was observed: a.) In the soiled utility room there were two wall tiles missing near the hopper. The drain cover in the hopper had loose, peeling, and missing paint. There was a reddish brown substance around the outer edges of the hopper drain cover. There were sections of the wall near the sink</p>			

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	<p>that was unpainted. There was wall damage close to the door frame approximately 3 feet by 1 inch.</p> <p>b.) The doorway of the social service office there was a heavy accumulation of dirt, dust, and old floor wax discoloring the tiles.</p> <p>c.) In the laundry room near the soiled side there were five soiled barrels, two five gallon buckets of paint, and a bucket of mop heads blocking the handwashing sink. There was silverware laying on the handwashing sink. There was an approximately 1" to 1.5" gap between the wall and the floor between the handwashing sink and dryers. Stored in the soiled area of the laundry room there was a four tier cart identified by administrator as clean bed and bath linen. In front of the washers there was an approximate 6' x 6' area of cement flooring that had missing and peeling paint. There was an area of approximate 6' x 2" by the washer where drywall was missing. On the clean side of the laundry room, behind the dryers there was a build up of dirt and dust on the floor, the pipes, and up the wall. There was two bags of clothes stored on the floor and one box beside the dryers. There was a fan that had a heavy accumulation of dirt and dist build up on the blades and covers</p>			

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	<p>blowing on the clean clothing. There was a 32 oz soft drink cup with moisture on the outside and a 12 oz can of soda sitting on the table with folded clothes. Behind the door stored on the floor a box full of blankets stacked approximately 2 ft: above the box against the wall. There was a distinct build-up of dirt and old floor wax on the floor and baseboards along the outer edges of the room.</p> <p>d.) In the clean linen storage closet there was 14 bags of adult briefs stored on the floor. There was two broken floor tiles. The floor was soiled with dirt and different color stains. The middle shelf was broken.</p> <p>e.) In resident restroom #2 there was dirt and debris on the floor.</p> <p>f.) On the reliant 450 resident lift the lift bar was soiled with multiple stains differentiating in color.</p> <p>g.) In resident restroom #4 the safety belt on the standup lift was heavily soiled with dirt and multiple stains. The doors on resident restrooms 1, 2, 3, 4 were soiled and marred with a black substance starting at the floor and going half way up the door.</p> <p>3.1-19(f)</p>			

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F 0468 SS=E Bldg. 00	<p>483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. Based on observation and interview, the facility failed to ensure all corridors in the facility were equipped with handrails on each side.</p> <p>Findings include:</p> <p>During the initial tour observation on 3/7/16 at 11:00 a.m., there were 2 areas where corridors that lacked hand rails. There was an approximate 2 feet (ft) space outside of Resident Room #4 that was completely devoid of a hand rail and an approximately 18" space between Resident Rooms #17 and #18 that lacked a hand rail. These areas were observed to be a common area utilized by all residents in the facility.</p> <p>During environmental tour on 3/11/16 at 10:30 a.m., with the Maintenance Director and Administrator, it was observed that in two areas of the facility there were corridors that lacked the hand</p>	F 0468	<p>F 468-Corridorshave firmly secured handrails What Correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice: New handrails were ordered for installation throughoutthe building on 4/5/16. How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken: All mobile residents have the potential to beaffected. New hand rails will beinstalled throughout the facility. What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur: New handrails will be installed throughout the facilityto ensure there is no gap or lack of handrails through common areas. Delivery of the handrails is estimated to beon or around May 6, 2016. Handrails willbe installed</p>	04/15/2016

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F 0514 SS=D Bldg. 00	<p>rails. There was an approximately 2 ft space outside of Resident Room #4 that was completely devoid of a hand rail and an approximately 18" space between Resident Rooms #17 and #18 that lacked a hand rail.</p> <p>During an interview with the Administrator on 3/11/16 at 12:20 p.m., it was indicated that the Administrator was aware of the devoid areas in the hand rails.</p> <p>3.1-19(f)(3)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p>		<p>by May 20, 2016. Compliance letter stating date of order and product ordered has been received. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Maintenance will update monthly at QA the status of handrails until the project is completed at full. Once handrails are installed a weekly audit conducted by maintenance/designee will be done for 4 weeks to ensure complete and proper installation of handrails throughout building. Results will be brought to QA. By what date the systemic changes will be completed: 4/15/2016</p>	

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	<p>Based on interview and record review, the facility failed to ensure a resident's clinical record was complete for a resident on a fluid restriction (Resident #14).</p> <p>Findings include:</p> <p>The clinical record for Resident #14 was reviewed on 3/11/16 at 11:07 a.m. Diagnoses included, but were not limited to, chronic renal failure.</p> <p>A review of Recapitulation Physician's orders for 3/1/16 through 3/31/16, indicated a Physician's order dated 12/5/15 (start date), indicated Resident #14 was to have a fluid restriction of 1500 milliliters (ml) per day.</p> <p>A review of the Fluid Intake Records lacked completed documentation of fluid amounts consumed by Resident #14 on night shift on January 16, 17, 18, and 26, February 16, and March 1, 2, 3, 4, 5, 6, 7, 9, 12, 13, and 14, 2016.</p> <p>A review of the Fluid Intake Records lacked complete documentation of fluid amounts consumed by Resident #14 on day shift on January 1, 2, 3, 4, 5, 6, 18, 23, 24, and 30, February 3, 9, and 12, and March 12, 2016.</p>	F 0514	<p>F514-ResidentRecords complete/Accurate/Accessible</p> <p>What Correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice: Resident 14 was missing fluid restriction documentation;daily audit will be put into place along with staff education on properdocumentation.</p> <p>How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken: Resident 14 is the only current resident to beaffected. Any additional residentsplaced on fluid restrictions will have their documentation audited for 30days.</p> <p>What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur: Fluid intake records will be audited by the DON ordesignee daily for 30 days and then weekly for 90 days or until 100% compliancehas been achieved. Staff will bein-serviced on the week of April 4 on fluid intake record documentation.</p> <p>How the correctiveaction(s) will be monitored to ensure the deficient</p>	04/15/2016

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F 0516 SS=B Bldg. 00	<p>A review of the Fluid Intake Records lacked complete documentation of fluid amounts consumed by Resident #14 on evening shift on January 1, 2, 3, 4, 6, 15, 16, 17, and 18, 2016.</p> <p>On 3/15/16 at 1:5 p.m., the Director of Nursing (DON) indicated the nurses are responsible for documenting the amount of fluids the resident receives each shift. They should be documenting the specific amounts of fluid taken each shift on the fluid intake record, not just initialing the Medication Administration Record (MAR).</p> <p>On 3/11/16 at 10:50 a.m., the Regional Director of Operations provided a policy titled Dialysis, Renal, dated 11/14/12, and indicated it was the current policy used by the facility. The policy did not contain information regarding dialysis residents with fluid restrictions.</p> <p>3.1-50(a)(1)</p> <p>483.75(l)(3), 483.20(f)(5) RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS A facility may not release information that is resident-identifiable to the public.</p> <p>The facility may release information that is resident-identifiable to an agent only in</p>		<p>practice will not recur, i.e., what quality assurance program will be put into place: Fluid intake records will be audited daily for 30 days and then weekly for 90 days or until 100% compliance has been reached. Results will be brought to QA for monthly review by IDT.</p> <p>By what date the systemic changes will be completed: 4/15/2016</p>		

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	<p>accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.</p> <p>The facility must safeguard clinical record information against loss, destruction, or unauthorized use.</p> <p>Based on observation, interview, and record review, the facility failed to safeguard clinical record information against loss, destruction, or unauthorized use.</p> <p>Findings include:</p> <p>On 3/7/17 at 3:45 p.m., the Assistant Director of Nursing (ADON) was observed to collect active resident clinical records; from an outside building on the facility grounds; that was in a state of progressive deterioration. The circumference of the building was observed to have gaps and holes in the siding where it meets the floor, because the boards had deteriorated completely in some areas.</p> <p>On 3/7/16 at 4:45 p.m., in an interview with the ADON, it was indicated the aforementioned out building housed discharged and active resident overflow clinical records.</p> <p>During an environmental tour on 3/11/16</p>	F 0516	<p>F 516- Releaseresident info, safeguard clinical records</p> <p>What Correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice:</p> <p>All resident information will be brought inside andsecured until new shed and proper security is obtained. Appropriate resident charts will be sent tocontracted vendor for long term storage.</p> <p>How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:</p> <p>All residents have the potential to be affected. All resident records will be brought insidefor appropriate storage and retention.</p> <p>What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur:</p> <p>The deteriorating storage shed was removed on 4/2/16, anew storage</p>	04/15/2016

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F 0520 SS=E Bldg. 00	<p>at 10:30 a.m., with the Administrator and Maintenance Director the following was observe. Once having entered the building outside daylight was visible through the noticeable holes and gaps in the side boards. There were 16 boxes measured by the maintenance director that were 10" by 15" by 12" in dimension. The Administrator indicated the boxes which held the clinical files and one box which was turned over on its side with a damaged lid, left clinical records exposed.</p> <p>In an interview with the Administrator, at this time, he indicated he was aware the boxes would not protect the clinical files from exposure to the elements and any possible damage.</p> <p>3.1-50(d)</p> <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</p>		<p>shed was delivered on 4/4/16 and will be erected by 4/15/16. Resident records will be behind double lockto prevent unauthorized use.</p> <p>How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place: MDS or designee will review storage procedure of thesheds weekly for 90 days and report results to monthly QA.</p> <p>By what date thesystemic changes will be completed: 4/15/2016</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155428	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/16/2016
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	<p>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 and implement a plan of action for identified concerns of residents with physical aggressive behaviors exhibited toward other residents twenty seven times from October 2015 to March 2016.</p> <p>Findings include:</p> <p>An Immediate Jeopardy began on 2/1/16, when Resident #22 struck another resident. No documentation was found which indicated the care plan was updated or in what manner the resident was being monitored. The Administrator and Director of Nursing were notified of the Immediate Jeopardy on 3/7/16 at 5:35 p.m.</p> <p>Resident #22 had 6 additional incidents of physical aggression against other residents between 10/30/15 and 3/7/16.</p>	F 0520	<p>F520- QACommittee members meet quarterly/plans</p> <p>What Correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice: QAA will meet and review past month's behaviors, careplan updates and previous month's behaviors for trends of similar behaviors andeffectiveness of interventions.</p> <p>How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken: All behaviors will be reviewed by SSD/designee, careplans will be reviewed weekly at care plan meeting, and the notes from weeklycare plan meeting will be</p>	04/15/2016

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	<p>Excluding Resident #22, 6 additional residents reviewed had 21 other incidents of verbal and physical aggressive altercations between 10/14/15 and 3/11/16.</p> <p>On 3/16/16 at 5:14 p.m., the Administrator indicated the Quality Assessment and Assurance (QA&A) Committee meets monthly. The QA&A Committee reviews each resident and their behaviors from the past month. They review interventions from past and present to see what has worked and what has not worked, to see what interventions can move forward with and put in place. The committee had not identified any patterns nor implemented updated interventions to prevent resident to resident physical and verbal altercations.</p> <p>3.1-52(b)(2)</p>		<p>brought into month QAA meeting.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>Behavior tracking will be brought to and reviewed during QAA monthly meetings. Weekly care plan meeting notes will be brought to and reviewed during monthly QAA meetings. QAA will review each resident with behaviors to identify a trend in behavior.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>QAA will document any identified trend with residents and review interventions that have been put into place for effectiveness. IDT will update care plans as appropriate.</p> <p>By what date the systemic changes will be completed: 4/15/2016</p>		