

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155464	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/05/2015
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NAME OF PROVIDER OR SUPPLIER  ROCKVILLE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 768 N US HWY 41 ROCKVILLE, IN 47872
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00185442.</p> <p>Complaint IN00185442 Substantiated. Federal/State deficiencies related to the allegation are cited at F223, F225, and F226.</p> <p>Unrelated deficiency is cited.</p> <p>Survey Dates: November 4 and 5, 2015.</p> <p>Facility Number: 000492 Provider Number: 155464 AIM Number: 100291360</p> <p>Census Bed Type: SNF/NF: 25 Total: 25</p> <p>Census Payor Type: Medicare: 6 Medicaid: 14 Other: 5 Total: 25</p> <p>Sample: 3</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p>Preparation and/ or execution of this plan of correction in general, or any corrective actions set forth herein, in particular, does not constitute an admission or agreement by Rockville Nursing and Rehabilitation Center of the facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed solely because of provisions of federal and/or state laws.</p> <p>Rockville Nursing and Rehabilitation Center desires this plan of correction to be considered the facility's allegation of compliance effective 12/05/2015.</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 0223 SS=D Bldg. 00	<p>Quality review completed 11/9/15 by 29479.</p> <p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on observation, interview, and record review, the facility failed to ensure staff did not abuse a resident by holding a resident with rigid, spastic movements in place during a shower resulting in a large bruise on the resident's outer thigh for 1 of 1 resident reviewed for injury of unknown origin (Resident B).</p> <p>Finding includes:</p> <p>On 11/4/15 at 11:35 a.m., with the Director of Nursing (DON) present, three styles of shower chairs were observed in the facility. The DON indicated she did not know what chair was utilized for Resident B.</p>	F 0223	<p><b>F223</b> It is the standard of this facility that residents have the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>There was a potential for other residents to be affected by this alleged deficient practice.</p> <p>Immediately upon the conclusion of the bruise of unknown origin investigation, the three staff members who did not follow the facility abuse policy were terminated.</p> <p>A mandatory all-staff in-service on abuse, neglect, and reporting procedures was conducted on 11/09/2015.</p>	12/05/2015

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	<p>On 11/4/15 at 11:40 a.m., with the DON present, Resident B was observed in a low bed, with a floor matt next to the bed. The DON exposed the resident's right upper outer thigh. A very faint pinkish bruise approximately hand length, was observed on the resident's outer thigh. When the resident repositioned herself in bed her movements were very spastic. The resident's right leg jerked and her foot hit the footboard. The DON indicated the bruise had been 12.8 cm by 7.9 cm. The resident repositioned self in bed with very spastic movements.</p> <p>The Administrator was interviewed on 11/4/15 at 10:45 a.m. She indicated staff did not follow the facility's policy for reporting an injury of unknown origin immediately to the Administrator. She indicated an investigation was conducted on 10/25/15 and it was determined two staff members held Resident B in place by straddling her legs while seated in the shower chair resulting in a large bruise on the resident's right, upper, outer thigh. The Administrator indicated the DON assessed the injury on 10//26/15 at 11:30 a.m. and measured a bruise of 12.8 cm by 7.9 cm on Resident B's outer thigh.</p> <p>On 11/4/15 at 11:35 a.m., LPN # 5 was interviewed. The LPN indicated</p>		<p>A review of resident rights related to abuse and neglect, as well as reporting options will be addressed at the next Resident Council Meeting scheduled for 12/01/15. Residents will be encouraged to discuss or bring concerns to the administrator, or any staff member.</p> <p>CNA Assignment Sheets have been updated to include what type of shower chair each resident uses in the shower. Special instructions for each resident have also been updated. Changes in resident shower needs will be updated on the CNA Assignment Sheet and noted on the Nurse Communication Form.</p> <p>The Social Service Director or designee will conduct assessments via a questionnaire to ensure residents are free from abuse and neglect, and that any concerns have been reported appropriately on a residents scheduled to be reviewed on a monthly basis for 180 days and then as needed per QAPI committee recommendations.</p> <p>A weekly skin assessment is completed for all residents. Marks or bruising of unknown or suspicious nature will be reported to the DON and administrator for investigation. Residents who are observed to be showing signs</p>		

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	<p>Resident B had very spastic movements but could be showered in a safe manner by two staff. She indicated the resident used a regular shower chair and staff positioned themselves in front of and behind the resident. The LPN demonstrated placement of staff's hand on the shower seat between the resident's legs to prevent the resident from getting out of the chair if she suddenly lunged forward.</p> <p>During an interview with the DON, on 11/4/15 at 11:00 a.m., the DON indicated care was communicated via Certified Nurse Aide (CNA) assignment sheets and a Nurse communication form. The communication forms were provided by the DON on 11/4/15 at 11:00 a.m. and identified as current. The forms did not indicate specific instructions for assisting the resident with showers.</p> <p>On 11/6/15 at 12:27 p.m., a phone interview was conducted with Certified Nursing Assistant (CNA) #1. The CNA indicated she had not showered the resident prior to 10/25/15. She indicated she had not received special instructions on the technique required for the resident's safety other than to have one in front and one behind the resident. She indicated she and CNA #2 utilized the wider PVC type shower chair. She had</p>		<p>of distress, agitation, or fearfulness will be monitored todetermine if an abuse investigation should be initiated.</p> <p>The DON or designee will review CNA Assignment Sheets toensure resident shower needs are accurate weekly for a month, then monthly for 180days, and then as needed per QAPI committee recommendations.</p>	

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	<p>not been instructed in what type shower chair to use for Resident B.</p> <p>On 11/6/15 at 12:34 p.m., CNA #2 was interviewed by telephone. The CNA indicated she began working in the facility on 10/2/15. She indicated during orientation she assisted a staff member during Resident B's shower but had not been made aware of any special instructions or which type of chair should have been utilized. She indicated she had straddled the resident's legs to keep her in place during the shower on 10/25/15. The CNA indicated she had been provided with an assignment sheet, but it had not included the type of shower chair to use, nor any special instructions on showering techniques.</p> <p>Resident B's record was reviewed on 11/4/15 at 10:30 a.m. Diagnosis included but was not limited to Huntington's Disease. The Minimum Data Set (MDS) quarterly assessment, dated 8/25/15, indicated the resident required total assistance of two for transfers and bathing.</p> <p>A plan of care, with onset date of 4/16/15 provided by the DON on 11/4/15 at 11:00 a.m. addressed the problem of "... [resident's name] will yell/scream out during care as evidenced by screaming</p>			

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	<p>when getting out of bed to have a shower." Interventions included, but were not limited to, attempt to redirect behavior reassuring her that she is safe. If upset about taking a shower, offer bed bath instead.</p> <p>A plan of care, dated 4/20/15 addressed the problem of "...[resident's name] prefers to have showers in the morning, (number missing from copy) times a week or as needed. She reports that she likes to sleep in until 9 usually, and prefers to go to sleep around 8 at night." Interventions included: allow resident to sleep in and/or go to bed whenever she likes in order to respect her sleeping preferences. If at all possible, arrange shower schedule to accommodate resident's preferences.</p> <p>The facility's reportable incidents were reviewed on 11/4/15 at 11:00 a.m. An incident report, dated 10/26/15, indicated Resident B sustained a large bruise during a shower caused from staff trying to hold her in the shower chair.</p> <p>The facility's policy titled "HR-408: Abuse &amp; Neglect policy Effective/Revised Date: 9/01/14", provided by the Administrator on 11/4/15 at 10:30 a.m., indicated, "...POLICY Each resident has the right to be free</p>			

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	<p>from abuse, neglect, and misappropriation of resident property. All allegations will be reported according to State and Federal Law and investigated....Application This policy applies to all employees...Definitions : "Abuse" means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. This also includes the deprivation by an individual of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being..."Neglect" is the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness..."Injuries of unknown source" should be categorized as such when --An injury should be classified as an injury of unknown source when both of the following conditions are met: - the source of the injury was not observed by any person or the source of the injury could not be explained by the resident; AND - the injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma).... "</p> <p>3.1-28(a)</p>			

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F 0225 SS=D 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</p>			
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	<p>the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on observation, interview, and record review, the facility failed to ensure staff immediately reported an injury of unknown source to the Administrator for 1 of 1 allegation of an injury of unknown origin reviewed. (Resident B)</p> <p>Finding includes:</p> <p>On 11/4/15 at 11:40 a.m., with the DON present, Resident B was observed in a low bed, with a floor matt next to the bed. The DON exposed the resident's right upper outer thigh. A very faint pinkish bruise approximately hand length, was observed on the resident's outer thigh. When the resident repositioned herself in bed her movements were very spastic. The resident's right leg jerked and her foot hit the footboard. The DON indicated the bruise had been 12.8 cm by 7.9 cm. The resident repositioned self in bed with very spastic movements.</p> <p>The Administrator was interviewed on 11/4/15 at 10:45 a.m. She indicated staff did not follow the facility's policy for reporting an injury of unknown origin immediately to the Administrator. She indicated an investigation was conducted</p>	F 0225	<p><b>F225</b> It is the standard of this facility that 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>There was a potential for other residents to be affected by this alleged deficient practice.</p> <p>Immediately upon the conclusion of the bruise of unknown origin investigation, the three staff members who did not follow the facility abuse policy were terminated.</p> <p>A mandatory all-staff in service on abuse, neglect, and reporting procedures was conducted on 11/09/2015.</p> <p>A review of resident rights related to abuse and neglect, as well as reporting options will be addressed at the next Resident Council Meeting scheduled for 12/01/15. Residents will be encouraged to discuss or bring concerns to the administrator or</p>	12/05/2015			

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	<p>on 10/25/15 and it was determined two staff members held Resident B in place by straddling her legs while seated in the shower chair resulting in a large bruise on the resident's right, upper, outer thigh. The Administrator indicated the DON assessed the injury on 10/26/15 at 11:30 a.m. and measured a bruise of 12.8 cm by 7.9 cm on Resident B's outer thigh.</p> <p>The facility's reportable incidents were reviewed on 11/4/15 at 11:00 a.m. An incident report, dated 10/26/15, indicated Resident B sustained a large bruise during a shower caused from staff trying to hold her in the shower chair.</p> <p>The facility's policy titled "HR-408: Abuse &amp; Neglect policy Effective/Revised Date: 9/01/14", provided by the Administrator on 11/4/15 at 10:30 a.m., indicated, "...POLICY Each resident has the right to be free from abuse, neglect, and misappropriation of resident property. All allegations will be reported according to State and Federal Law and investigated....Application This policy applies to all employees...Definitions : "Abuse" means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. This also includes the</p>		<p>any staff member.</p> <p>A weekly skin assessment is completed for all residents. Marks or bruising of unknown or suspicious nature will be reported to the DON and administrator for investigation. Residents who are observed to be showing signs of distress, agitation, or fearfulness will be monitored to determine if an abuse investigation should be initiated.</p> <p>The Social Service Director or designee will conduct assessments via a questionnaire to ensure residents are free from abuse and neglect, and that any concerns have been reported appropriately on a resident's scheduled to be reviewed on a monthly basis for 180 days and then as needed per QAPI committee recommendations.</p>		

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F 0226 SS=D Bldg. 00	<p>deprivation by an individual of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being..."Neglect" is the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness..."Injuries of unknown source" should be categorized as such when --An injury should be classified as an injury of unknown source when both of the following conditions are met: - the source of the injury was not observed by any person or the source of the injury could not be explained by the resident; AND - the injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma).... "</p> <p>3.1-28(2)(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. Based on observation, interview, and record review, the facility failed to implement its written policies and procedures for preventing abuse and reporting an injury of unknown origin immediately to the Administrator for 1 of</p>	F 0226	<b>F226</b> It is the standard of this facility to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. There was a	12/05/2015

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	<p>1 resident reviewed for allegation of abuse (Resident B).</p> <p>Finding includes: On 11/4/15 at 11:35 a.m., with the Director of Nursing (DON) present, three styles of shower chairs were observed in the facility. The DON indicated she did not know what chair was utilized for Resident B.</p> <p>On 11/4/15 at 11:40 a.m., with the DON present, Resident B was observed in a low bed, with a floor matt next to the bed. The DON exposed the resident's right upper outer thigh. A very faint pinkish bruise approximately hand length, was observed on the resident's outer thigh. When the resident repositioned herself in bed her movements were very spastic. The resident's right leg jerked and her foot hit the footboard. The DON indicated the bruise had been 12.8 cm by 7.9 cm. The resident repositioned self in bed with very spastic movements.</p> <p>The Administrator was interviewed on 11/4/15 at 10:45 a.m. She indicated staff did not follow the facility's policy for reporting an injury of unknown origin immediately to the Administrator. She indicated an investigation was conducted on 10/25/15 and it was determined two</p>		<p>potentialfor other residents to be affected by this alleged deficient practice. Immediately upon the conclusion of thebruise of unknown origin investigation, the three staff members who did notfollow the facility abuse policy were terminated. A mandatory all-staff in service onabuse, neglect, and reporting procedures was conducted on 11/09/2015. A review of resident rights related toabuse and neglect, as well as reporting options will be addressed at the nextResident Council Meeting scheduled for 12/01/15. Residents will be encouraged to discuss orbring concerns to the administrator or any staff member. CNA Assignment Sheets have been updatedto include what type of shower chair each resident uses in the shower. Special instructions for each resident havealso been updated. Changes in residentshower needs will be updated on the CNA Assignment Sheet and noted on the NurseCommunication Form. The Social Service Director or designee will conduct assessmentsvia a questionnaire to ensure residents are free from abuse and neglect, andthat any concerns have been reported appropriately on a residents scheduled tobe reviewed on a monthly basis for 180 days and then as needed per QAPIcommittee recommendations. A weekly</p>		

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	<p>staff members held Resident B in place by straddling her legs while seated in the shower chair resulting in a large bruise on the resident's right, upper, outer thigh. The Administrator indicated the DON assessed the injury on 10//26/15 at 11:30 a.m. and measured a bruise of 12.8 cm by 7.9 cm on Resident B's outer thigh.</p> <p>On 11/4/15 at 11:35 a.m., LPN # 5 was interviewed. The LPN indicated Resident B had very spastic movements but could be showered in a safe manner by two staff. She indicated the resident used a regular shower chair and staff positioned themselves in front of and behind the resident. The LPN demonstrated placement of staff's hand on the shower seat between the resident's legs to prevent the resident from getting out of the chair if she suddenly lunged forward.</p> <p>During an interview with the DON, on 11/4/15 at 11:00 a.m., the DON indicated care was communicated via Certified Nurse Aide (CNA) assignment sheets and a Nurse communication form. The communication forms were provided by the DON on 11/4/15 at 11:00 a.m. and identified as current. The forms did not indicate specific instructions for assisting the resident with showers.</p>		<p>skin assessment is completed for all residents. Marks or bruising of unknown or suspicious nature will be reported to the DON and administrator for investigation. Residents who are observed to be showing signs of distress, agitation, or fearfulness will be monitored to determine if an abuse investigation should be initiated. The DON or designee will review CNA Assignment Sheets to ensure resident shower needs are accurate weekly for a month, then monthly for 180 days, and then as needed per QAPI committee recommendations.</p>	

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	<p>On 11/6/15 at 12:27 p.m., a phone interview was conducted with Certified Nursing Assistant (CNA) #1. The CNA indicated she had not showered the resident prior to 10/25/15. She indicated she had not received special instructions on the technique required for the resident's safety other than to have one in front and one behind the resident. She indicated she and CNA #2 utilized the wider PVC type shower chair. She had not been instructed in what type shower chair to use for Resident B.</p> <p>On 11/6/15 at 12:34 p.m., CNA #2 was interviewed by telephone. The CNA indicated she began working in the facility on 10/2/15. She indicated during orientation she assisted a staff member during Resident B's shower but had not been made aware of any special instructions or which type of chair should have been utilized. She indicated she had straddled the resident's legs to keep her in place during the shower on 10/25/15. The CNA indicated she had been provided with an assignment sheet, but it had not included the type of shower chair to use, nor any special instructions on showering techniques.</p> <p>Resident B's record was reviewed on 11/4/15 at 10:30 a.m. Diagnosis included but was not limited to Huntington's</p>			

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	<p>Disease. The Minimum Data Set (MDS) quarterly assessment, dated 8/25/15, indicated the resident required total assistance of two for transfers and bathing.</p> <p>A plan of care, with onset date of 4/16/15 provided by the DON on 11/4/15 at 11:00 a.m. addressed the problem of "... [resident's name] will yell/scream out during care as evidenced by screaming when getting out of bed to have a shower." Interventions included, but were not limited to, attempt to redirect behavior reassuring her that she is safe. If upset about taking a shower, offer bed bath instead.</p> <p>A plan of care, dated 4/20/15 addressed the problem of "...[resident's name] prefers to have showers in the morning, (number missing from copy) times a week or as needed. She reports that she likes to sleep in until 9 usually, and prefers to go to sleep around 8 at night." Interventions included: allow resident to sleep in and/or go to bed whenever she likes in order to respect her sleeping preferences. If at all possible, arrange shower schedule to accommodate resident's preferences.</p> <p>The facility's reportable incidents were reviewed on 11/4/15 at 11:00 a.m. An</p>			

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	<p>incident report, dated 10/26/15, indicated Resident B sustained a large bruise during a shower caused from staff trying to hold her in the shower chair.</p> <p>The facility's policy titled "HR-408: Abuse &amp; Neglect policy Effective/Revised Date: 9/01/14", provided by the Administrator on 11/4/15 at 10:30 a.m., indicated, "...POLICY Each resident has the right to be free from abuse, neglect, and misappropriation of resident property. All allegations will be reported according to State and Federal Law and investigated....Application This policy applies to all employees...Definitions : "Abuse" means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. This also includes the deprivation by an individual of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being..."Neglect" is the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness..."Injuries of unknown source" should be categorized as such when --An injury should be classified as an injury of unknown source when both of the following conditions are met: - the source of the injury was not</p>			

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F 0323 SS=D Bldg. 00	<p>observed by any person or the source of the injury could not be explained by the resident; AND - the injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma).... "</p> <p>3.1-28(a)</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 observation, interview, and record review, the facility failed to ensure adequate supervision for a safe living environment for Resident D.</p> <p>Finding includes:</p>	F 0323	<b>F323</b> It is the standard of this facility to ensure that the resident environment remains as free of accidents hazards as is possible: and each resident receives adequate supervision and assistance devices to prevent accidents. No resident	12/05/2015

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	<p>During the initial tour on 11/4/15 at 9:35 a.m., Resident D was observed independently ambulating to one of the shared bathrooms, outside of his room.</p> <p>On 11/4/15 at 3:00 p.m., the resident was observed in his room with a visitor. A long television cable was observed coiled behind the television, long call light cords were observed extending from two of the walls, plastic trash can liners were observed in the waste basket.</p> <p>Resident D's clinical record was reviewed on 11/4/15 at 12:00 p.m. A nursing note dated 10/16/15 at 4:40 p.m. indicated the resident had become aggressive, pushed nursing staff, stated he would kill himself, but first kill his wife, and blocked the door to his room with a recliner. The police were called and gained entry into the resident's room. The physician was notified and an order received to administer Haldol (antipsychotic) to calm the resident and to send to a hospital based mental health unit. The resident was transferred to the hospital and returned later in the evening with a diagnosis of anxiety and stress reactions.</p> <p>A pre-admission hospital discharge summary, dated 10/6/15, included information of the resident having had</p>		<p>was harmed by this alleged deficient practice. Resident D was transferred to specialty facility on 11/9/2015. Administrator, Director of Nursing, and Social Service Director reviewed the facility policy titled "Responding to Intent of Self Harm or Suicidal Threat" on 11/23/2015. Nursing staff will be retrained on facility policy titled "Responding to Intent of Self Harm or Suicidal Threat" by 12/05/2015. Residents admitted with behaviors of self-harm or suicidal threats shall be evaluated by the facility interdisciplinary team to develop a care plan to address the potential mood disorder and any intent to harm oneself. Residents with behaviors of self-harm or suicidal threats will be assessed by licensed nursing staff every shift for the effectiveness of the behavior care plan. Staff will conduct a thorough room search for any item that may be used as a weapon or self-harm device. All such objects will be removed from the resident's room and given to the DON for safekeeping. Staff will document the room search, items found and storage or removal of items. Staff may be requested to provide routine checks every 5-15 minutes to ensure resident safety. System will be monitored daily (M-For with notification of behavior) by review of 24 hour report, behavior log, and Nurses' Notes by DON</p>	

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	<p>increased aggressive behaviors at home prior to hospitalization. The documentation included, but was not limited to, the resident had a history of suicidal attempts by different means.</p> <p>The initial Minimum Data Set (MDS) assessment, dated 10/13/15, coded the resident with several days of feeling depressed, or hopeless, having little energy, and difficulty in concentrating on things. A plan of care that addressed the moods had not been developed.</p> <p>The Administrator and Director of Nursing (DON) were interviewed on 11/4/15 at 3:00 p.m. They indicated they did not know if there was a facility policy that addressed behaviors of self harm or suicide threat. The staff indicated they had not done anything differently after the resident's return to the facility.</p> <p>A facility policy and procedure titled "Responding to Intent of Self Harm or Suicide Threat," dated 9/1/14, provided by the Administrator on 11/5/15 at 9:30 a.m., included but was not limited to, "...To establish a process for to [sic] meet the psychosocial and emotional needs of the [sic] each resident and to identify risk of suicidal and/or parasuicidal thoughts, behaviors and action.</p>		<p>and SSD or designee to determine that behaviors are being monitored and care planned. Results will be monitored monthly by the QAPI committee every month for 180 days and then upon recommendation by the QAPI committee.</p>	

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	<p>The policy included, but was not limited to, "Definitions: Suicidal Ideation-Verbal expressions of thoughts of harming oneself that may or may not lack specific intent or associated actions and which are generally vague, passing thoughts related to poorly defined, circumstantial issues. "Procedures: 4. Each resident will be evaluated as a part of the MDS assessment to detect a possible mood disorder. 5. The severity of the PHQ-9 (Mood Interview section of the MDS) will be utilized to develop a care plan to address the potential depressive/mood disorder and any intent to harm oneself...13. In the event that the risk does not warrant hospitalization or transfer to more acute care, per designated staff, psychiatrist, or hospital, staff may be requested to provide routine checks every 5-15 minutes or as otherwise ordered by the physician. These checks are to be documented in the clinical record. These routine checks are to continue until the designated staff or psychiatrist deems these checks no longer necessary..." On 11/5/15 at 11:00 a.m., the DON indicated this had not been done.</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

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