

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/23/2013
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NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN 46011
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint #IN00141184.</p> <p>Survey dates: December 16,17,18,19, 20 and 23, 2013</p> <p>Facility number: 000005 Provider number: 155005 AIM number: 100270840</p> <p>Survey team: Tina Smith-Staats, RN TC Karen Lewis, RN (December 16, 17, 18,19 and 23, 2013) Toni Maley, BSW Karen Koeberlein, RN (December 16,17,18, 19 and 20, 2013)</p> <p>Census bed type: SNF: 27 SNF/NF: 126 Total: 153</p> <p>Census payor type: Medicare: 20 Medicaid: 104 Other: 29 Total: 153</p>	F000000	<p>January 11, 2014 Long Term Care Division, 4th Floor2 NorthMeridian StreetIndianapolis,IN 46204 RE: ManorCareHealth Services of Anderson 1345 N. Madison Ave. Anderson, IN46011 Dear Kim Rhoades: Please note our Plan of Correction for the Recertificationand State Licensure Survey in conjunction with Complaint # IN00141184 completedon December 23, 2013. Our date ofalleged compliance is January 22, 2014. We respectfully request a desk review. Should you have questions or need additional information,please contact me at 765.644.2888. You may also contact me via email at421admin@hcr-manorcare.com . Sincerely, Nicole Fields, HFAAdministrator</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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	<p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2.</p> <p>Quality review completed by Debora Barth, RN.</p>			

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F000250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, interview and record review, the facility failed to ensure residents who received psychoactive medications had behavior monitoring and management plans that specifically identified the targeted behavior(s) being managed by each medication and had individualized approaches to each behavior/mood state need for 2 of 5 residents reviewed for psychoactive medication use and behavior monitoring and management associated with medication use (Residents #169 and #28).</p> <p>Findings include:</p> <p>1. Resident #169's record was reviewed on 12/18/13 at 2:00 p.m. Resident #169's current diagnoses included, but were not limited to, dementia with behavioral disturbances, anxiety and Alzheimer's disease.</p> <p>Resident #169 had current December 2013 orders for the following</p>	F000250	<p>INFORMAL DISPUTE RESOLUTION F250 483.15(g) (1) Provision of MedicallyRelated Social Service The facility must provide medically-related social servicesto attain or maintain the highest practicable physical, mental and psychosocialwell-being of each resident. The facility respectfully denies and disputes the allegationthat it was deficient with regard to F250 and requests that the deficiencyidentified as F250 be deleted from the public record for reasons set forthherein. The statement of deficiency cites that the facility failedto ensure residents who received psychoactive medications had behaviormonitoring and management plans that specifically identified the targetedbehavior(s) being managed by each medication and had individualized approachesto each behavior/mood state need.</p> <p>· Each behavior had a care plan, which is thebehavior management plan, present and each care plan had individualizedapproaches. The level of specificity requested by the surveyor is beyondstandard practiceo Exhibit1 demonstrates</p>	01/22/2014	

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	<p>psychoactive medications:</p> <p>a.) Buspar 5 mg (an anti-anxiety medication) take 1 tablet two times daily. This order originated 1/25/13.</p> <p>b.) Geodon 20 mg (an anti-psychoactive medication) take 1 tablet daily at bedtime. This order originated 5/14/13.</p> <p>c.) Ativan 0.5 mg (an ant-anxiety medication) ½ tablet (equal 0.25 mg) every morning. This order originated 9/04/13.</p> <p>d.) Nortriptyline 10 mg (an antidepressant being used to treat insomnia) 1 tablet every other night. This order originated 10/30/13 and was a decrease from a dose of 10 mg each night.</p> <p>e.) Remeron 15 mg (an antidepressant being used to stimulate appetite) 1 tablet daily at bedtime. This order originated 2/11/13.</p> <p>An untitled document, provided by Social Service Director #2 on 12/23/13 at 8:20 a.m., indicated Resident #169 received psychoactive medications for specific targeted behaviors as follows: Geodon-Target behavior-Paranoia</p>		<p>Resident 169 behavior management plan for use of Buspar andAtivan. This information was part of the electronic Medical Record which the surveyor had access to during the survey process. o Exhibit2 demonstrates Resident 169 behavior management plan for use of Geodon.</p> <p>This information was part of the electronic Medical Record which the surveyor had access to during the survey process. o Exhibit3 demonstrates Resident 169 behavior management plan for use of Nortriptyline. This information was part of the electronic Medical Record which the surveyor had access to during the survey process. o Exhibit4 demonstrates Resident 28 behavior management plan for use of Cymbalta, Xanaxand Depakote. This information was part of the electronic Medical Record which the surveyor had access to during the survey process. o Exhibit5 demonstrates Resident 28 behavior management plan for use of Haldol. This information was part of the electronic Medical Record which the surveyor had access to during the survey process o Surveyor notes that both Residents no noted maladaptive behaviors during a three month period and that her observation was that the Residents did not have behaviorsymptoms. o The lack</p>		

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	<p>related to food being poisoned and refusing medication, Nortriptyline-Target behavior-Insomnia, Remeron-Appetite stimulant. A second untitled document, provided by Social Service Director #3, indicated Resident #169 received the anti-anxiety medications Buspar and Ativan for increased agitation, aggression and paranoia when she became restless or anxious. "Res (resident) has had noted episodes of going up and down halls laying on floor and exit seeking when more restless or anxious. Resident also has noted episodes of blocking doorways so residents can't go into rooms." The form also indicated these behaviors were displayed in August and early September. Resident #169 lacked a care plan to specifically address paranoia related to the belief food was being poisoned, which was the specific target behavior for the use of Geodon. Resident #169 lacked a care plan to specifically address lying on the floor and/or blocking doorways which was the target behavior for the use of</p>		<p>of behavioral symptoms demonstratesthat the behavior management plans were effective and did not requireadditional specificity in the behavior management plan. States that there was not an individualizedevaluation for behavior symptoms. Each Resident has behavior CAAs presentwhich is the CMS approved assessment for behavioral symptoms, in the EMR andshe was provided with a copied example as well. The Residents also have initialassessment completed by Social Services and Activities as well as assessmentscompleted by psychiatric and psychological providers as necessary.o Exhibit6-12 demonstrates individual evaluation via behavioral CAA for Resident 169.This information was part of the electronic Medical Record which the surveyorhad access to during the survey processo Exhibit13 demonstrates individual evaluation via behavioral CAA for Resident 28o Exhibit14-20 demonstrates individual evaluation via psychiatric and psychologicalservices on Resident 169 and 28. A copy of this information was provided to thesurveyor from the Medical Chart.o Exhibit21-24 demonstrates individual evaluation completed by Social Services andActivities upon admission on Resident 169 and</p>		

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	<p>Buspar and Ativan.</p> <p>Resident #169 had non-specific care plans dealing with the broad concern of paranoia and delusions. The care plan did not identify how these symptoms manifested themselves for this resident. The approaches to this problem were not resident specific and based on resident assessment, past life interests and current specific successful interventions used by staff.</p> <p>Review of Resident #169's Resident Progress Notes for October, November and December 2013 indicated the resident displayed one episode of aggression towards staff during this 3 month period.</p> <p>Review of Resident #169's nurse aide behavior tracking for October, November and December 2013 lacked any documented maladaptive behaviors during this 3 month period.</p> <p>Resident #169 had a 10/24/13, quarterly, Minimum Data Set assessment which indicated the resident displayed no maladaptive behaviors during the assessment period.</p> <p>During observations on 12/16/13 at 11:45 a.m., 12/16/13 at 2:00 p.m. and</p>		<p>28. This information was part of the electronic Medical Record which the surveyor had access to during the survey process. Sites a policy, but in fact it was information given from Omniview in relation to pharmacist guidance for dose reductions. This is not facility policy. Omniview has tools intended for pharmacists and it is not a part of facility policy and procedure. Omniview uses it as a tool/guide to direct pharmacists. This is not intended to guide the facility. This was provided secondary to surveyor request for information on how a pharmacist recommends a dose reduction. It was never intended to reflect facility policy. In Summary resident #169 and #28 received medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being. We respectfully requested that F250 be deleted from the public record. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The behavior monitoring and management plan was reviewed for resident #169 to include specifically identified targeted behaviors being managed by each psychoactive medication with individualized approaches to each behavior/mood. The</p>				

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	<p>12/18/13 at 12:10 p.m., Resident #169 was calm and displaying no maladaptive behaviors.</p> <p>2. Resident #28's record was reviewed on 12/20/13, 9:19 a.m. Resident #28's current diagnoses included, but were not limited to, Alzheimer's disease, hypertension and anxiety.</p> <p>Resident #28 had current December 2013 orders for the following psychoactive medications:</p> <p>a.) Xanax 0.5 mg (an anti-anxiety medication) take 1 tablet two times daily. This order originated 9/25/13.</p> <p>b.) Cymbalta 30 mg (an anti-depressant medication) take 1 tablet daily. This order originated 3/10/13.</p> <p>c.) Haldol 0.5 mg (an anti-psychotic medication) three times daily. This order originated 9/13/13.</p> <p>d.) Depakote 125 mg (an anti-seizure medication used as a mood stabilizer) take 2 caps (to equal 250 mg) two times daily.</p> <p>An untitled document provided by Social Service Director #2, on 12/23/13 at 8:20 a.m., indicated Resident #169 received psychoactive</p>		<p>behavior monitoring and management plan was reviewed forresident #28 to include specifically identified targeted behaviors beingmanaged by each psychoactive medication with individualized approaches to eachbehavior/mood. How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective actions will be taken; Patients receiving psychotropic medications to managebehaviors have the potential to be affected. They have had their behavior monitoring and management plan reviewed toinclude specifically identified targeted behaviors being managed by eachpsychoactive medication with individualized approaches to each behavior/mood. What measures will beput into place or what systemic changes will be made to ensure that the samedeficient practice does not recur; Initial audit of 100% of residents receiving psychoactivedrugs will be completed to ensure presence of behavior monitoring and managementplan to include specifically identified targeted behaviors being managed byeach psychoactive medication with individualized approaches to eachbehavior/mood. Please see Attachment A. Each new admission will be reviewed by the Interdisciplinaryteam during</p>				

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	<p>medications the following target behaviors were identified for the use of each medication:</p> <p>a.) Xanax -she was easily upset with change in treatment schedule. Resident also became anxious with transition from one activity to another such as dinner ending.</p> <p>b.) Haldol- delusions-Resident was frequently delusional as to her environment, thinking she was at home and needed to get up or at dinner and it was time to leave. This contributed to falls and placed her in danger. She had also been paranoid with staff.</p> <p>Resident #28 lacked care plans to address upset with changes in treatment and transitions which were target behaviors associated with the use of Xanax.</p> <p>Resident #28 lacked a care plan regarding delusions as to her environment which was a target behavior in relation to the use of Haldol.</p> <p>Resident #28 had non-specific care plans dealing with the broad concern of paranoia. The care plan did not identify how these symptoms</p>		<p>morning QAA meeting to validate that target behaviors are identified and care plans are in place to identify individualized approaches for behavior/mood. Care plans will be reviewed and revised as needed based on patient's individual needs. Social Service staff will be educated in regards to specificity of the behavior monitoring and management plans. Please see Attachment B. 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 Social Service Director or designee will conduct weekly review for four weeks of Care Plans for a minimum sample of nine residents with behavioral symptoms to ensure that the behavior monitoring and management plans include specifically identified targeted behaviors being managed by each psychoactive medication with individualized approaches to each behavior/mood. Any concerns that are discovered during these reviews will be addressed immediately. Please see Attachment C. Audit findings will be presented to the QAA Committee weekly for 4 weeks and monthly thereafter for a minimum of 6 months. The QAA Committee will review findings and determine the need for further monitoring and/or education per</p>		

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	<p>manifested themselves for this resident. The approaches to this problem were not resident specific and based on resident assessment, past life interests and current specific successful interventions used by staff. Resident #28 had none specific care plans dealing with the broad concern of anxiety and depression. The care plan did not identify how these symptoms manifested themselves for this resident. The approaches to this problem were not resident specific and based on resident assessment, past life interests and current specific successful interventions used by staff</p> <p>Review of Resident #28's Resident Progress Notes for October, November and December 2013 indicated the resident had displayed no maladaptive behaviors during this period.</p> <p>Review of Resident #28's nurse aide behavior tracking for October, November and December 2013 lacked any documented maladaptive behaviors during this 3 month period. During observations on 12/16/13 at 11:50 a.m., 12/16/13 at 2:10 p.m. and 12/18/13 at 12:15 p.m., Resident</p>		the QAA process.				

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	<p>#28 was calm and displaying no maladaptive behaviors.</p> <p>3. During a 12/23/13, 8:30 a.m. interview, Social Services Director #2 indicated she could not provide care plans specific to the identified targeted behavior or individualized resident approaches for said behaviors. The facility did not complete an individual evaluation or use the information to formulate individualized approaches to behavior management.</p> <p>4. A current ,1/1/13, facility policy titled "Psychopharmacological Medication Use", which was provided by the Director of Nursing on 12/23/13 at 11:00 a.m., indicated the following: "Facility staff should monitor the resident's behavior pursuant to Facility policy using a behavior monitoring chart or behavioral assessment record for residents receiving psychopharmacological medication for organic mental syndrome with agitated or psychotic behavior(s). ..."</p> <p>3.1-34(a)</p>			
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F000257 SS=D	<p>483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS</p> <p>The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F</p> <p>Based on observation and interview, the facility failed to ensure the temperatures in common areas were warm and comfortable for 2 of 17 residents interviewed regarding comfortable room temperatures (Resident # 37 & 33).</p> <p>Findings include:</p> <p>During a 12/17/13, 1:36 p.m., interview, Resident #37 indicated the Family Tree Dining Room was very cold and people often wore jackets or covered themselves in blankets.</p> <p>During a 12/17/13, 8:44 p.m., interview, Resident #33 indicated the Family Tree Dining Room was very cold at breakfast time.</p> <p>Temperatures were tested during the following dates and times and the following was noted:</p> <p>Family Tree Dining Room by window and exit door: 12/18/13, 1:39 p.m. 56 degrees F (Fahrenheit). A cold breeze could be</p>	F000257	<p>INFORMAL DISPUTE RESOLUTION F257 483.15(h)(6) Comfortable & Safe TemperatureLevels The facility must provide comfortable and safe temperaturelevels. Facilities initially certifiedafter October 1, 1990 must maintain a temperature range of 71 -81 degrees F. The facility respectfully denies and disputes the allegationthat it was deficient with regard to F257 and requests that the deficiencyidentified as F257 be deleted from the public record for reasons set forthherein. The statement of deficiency cites that the facility failedto ensure temperatures in common areas were warm and comfortable. The surveyor asked the Maintenance Director to accompany heron rounds through the family tree dining room to check air temps. When theyarrived at the family tree dining room she stated that she had observed thedining room being too cold. She stated that she had checked the temp by placinga meat thermometer on the floor under one of the tables on the north side ofthe dining room. She recorded a temp in the mid 50's. At that time the</p>	01/22/2014			

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	<p>felt</p> <p>12/18/13, 3:35 p.m. 65 degrees F. 12/23/13, 8:10 a.m. 50 degrees F.</p> <p>Family Tree Dining one foot above the floor 12/18/13, 1:42 p.m. 68 degrees F. A cold breeze could be felt. 12/18/13, 3:38 p.m. 70 degrees F. 12/23/13, 8:12 a.m. 64 degrees F.</p> <p>During a 12/23/13, 9:30 a.m. environmental tour and interview with the Maintenance Supervisor, he indicated he did not do routine temperature checks of the environment. He adjusted temperatures when residents complained. The thermostat to regulate heat in the Family Tree Dining room was approximately 56 feet from the courtyard door. The courtyard door was frequently opened to the smoking area. The facility had not put any intervention in place to address the cool air which came into the Family Tree Dining area when the courtyard door was opened.</p> <p>3.1-19(h)</p>		<p>maintenance director expressed concern about the type of thermometer being used and the fact that placing the probe on VCT tile would give inaccurate temp. The surveyor then wanted to check the thermostat for the dining room which was noted to be at 78 degrees. During the tour the maintenance director used an electronic non-contact thermometer that showed the temperature in the dining room was 71-72 degrees. This device was offered to the surveyor to validate air temperatures. She declined the offer and advised that the facility would see her findings in writing. In Summary we find that air temperatures were maintained within the acceptable range and the method used by the surveyor to observe air temperatures was not appropriate. We respectfully request that F257 be deleted from the public record. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The thermostat was adjusted to maintain comfortable temperature levels. Staff will interview resident #37 and #33 frequently to ensure that they are comfortable and provide them with appropriate attire as needed to maintain comfort. How other residents having the potential to be affected by the same deficient practice will be identified and what</p>		

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			<p>corrective actions will be taken; Other residents have the potential to be affected. Temperatures will be kept within the acceptable temperature parameters as dictated in the regulations. What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur; Maintenance Director or designee will take air temperatures in the family tree dining a minimum of twice per day 5 days a week to ensure proper temperature. Please see Attachment D. 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; Audit findings will be presented to the QAA Committee weekly for 4 weeks and monthly thereafter for a minimum of 6 months. The QAA Committee will review findings and determine the need for further monitoring and/or education per the QAA process.</p>	

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, interview and record review, the facility failed to develop care plans to address target behaviors being treated by psychoactive medications for 2 of 5 residents reviewed for psychoactive medication use (Residents #169 and #28).</p> <p>Findings include: 1. Resident #169's record was reviewed on 12/18/13 at 2:00 p.m. Resident #169's current diagnoses included, but were not limited to,</p>	F000279	<p>INFORMAL DISPUTE RESOLUTION F279 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. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetable to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The facility respectfully denies and disputes the allegation that it was</p>	01/22/2014	

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	<p>dementia with behavioral disturbances, anxiety and Alzheimer's disease.</p> <p>Resident #169 had current December 2013 orders for the following psychoactive medications:</p> <p>a.) Buspar 5 mg (an anti-anxiety medication) take 1 tablet two times daily. This order originated 1/25/13.</p> <p>b.) Geodon 20 mg (an anti-psychoactive medication) take 1 tablet daily at bedtime. This order originated 5/14/13.</p> <p>c.) Ativan 0.5 mg (an ant-anxiety medication) ½ tablet (equal .25 mg) every morning. This order originated 9/04/13.</p> <p>An untitled document, provided by Social Service Director #2 on 12/23/13 at 8:20 a.m., indicated Resident #169 received psychoactive medications for specific targeted behaviors as follows: Geodon-Target behavior-Paranoia related to food being poisoned and refusing medication,</p> <p>A second untitled document provided by Social Service Director #3 indicated Resident #169 received the anti-anxiety medications Buspar and</p>		<p>deficient with regard to F279 and requests that the deficiency identified as F279 be deleted from the public record for reasons set forth herein. The statement of deficiency cites that the facility failed to develop care plans to address target behaviors being treated by psychoactive medications.</p> <p>Each behavior had a care plan, which is the behavior management plan, present and each care plan had individualized approaches. The level of specificity requested by the surveyor is beyond standard practice. Exhibit 1 demonstrates Resident 169 behavior management plan for use of Buspar and Ativan. This information was part of the electronic Medical Record which the surveyor had access to during the survey process. Exhibit 2 demonstrates Resident 169 behavior management plan for use of Geodon. This information was part of the electronic Medical Record which the surveyor had access to during the survey process. Exhibit 3 demonstrates Resident 169 behavior management plan for use of Nortriptyline. This information was part of the electronic Medical Record which the surveyor had access to during the survey process. Exhibit 4 demonstrates Resident 28 behavior management plan for use of Cymbalta, Xanax and</p>		

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	<p>Ativan for increased agitation, aggression and paranoia when she becomes restless or anxious. "Res (resident) has had noted episodes of going up and down halls laying on floor and exit seeking when more restless or anxious. Resident also has noted episodes of blocking doorways so residents can ' t go into rooms." The form also indicated these behaviors were displayed in August and early September. Resident #169 lacked a care plan to specifically address paranoia related to the belief food was being poisoned, which was the specific target behavior for the use of Geodon. Resident #169 lacked a care plan to specifically address lying on the floor and/or blocking doorways which was the target behavior for the use of Buspar and Ativan.</p> <p>2. Resident #28's record was reviewed on 12/20/13, 9:19 a.m. Resident #28's current diagnoses included, but were not limited to, Alzheimer's disease, hypertension and anxiety. Resident #28 had current December 2013 orders for the following</p>		<p>Depakote. This information was part of the electronic Medical Record which the surveyor had access to during the survey process. Exhibit 5 demonstrates Resident 28 behavior management plan for use of Haldol. This information was part of the electronic Medical Record which the surveyor had access to during the survey process. Surveyor notes that both Residents no noted maladaptive behaviors during a three month period and that her observation was that the Residents did not have behavior symptoms. The lack of behavioral symptoms demonstrates that the behavior management plans were effective and did not require additional specificity in the behavior management plan. The facility provided ongoing behavior monitoring through several areas. Behavior Monitoring occurs for all Residents through the Eagle Room process and tracking is completed by exception. Exhibit 25 is a copy of the process tool. Behavior Monitoring occurs through pharmacy review. For Resident 169 and 28, Exhibit 26 is the Medication Regime Review demonstrating monthly review of all medications. For Residents 169 and 28, Exhibit 27 is the Consultation Reports demonstrating specific monitoring of psychotropic medications.</p>				

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	<p>psychoactive medications:</p> <p>a.) Xanax 0.5 mg (an anti-anxiety medication) take 1 tablet two times daily. This order originated 9/25/13.</p> <p>c.) Haldol 0.5 mg (an anti-psychotic medication) three times daily. This order originated 9/13/13.</p> <p>An untitled document, provided by Social Service Director #2 on 12/23/13 at 8:20 a.m., indicated Resident #169 received psychoactive medications the following target behaviors were identified for the use of each medication:</p> <p>a.) Xanax -she was easily upset with change in treatment schedule. Resident also became anxious with transition from one activity to another such as dinner ending.</p> <p>b.) Haldol- delusions-Resident was frequently delusional as to her environment, thinking she was at home and needed to get up at dinner and it was time to leave. This contributed to falls and placed her in danger. She had also been paranoid with staff.</p> <p>Resident #28 lacked care plans to address upset with changes in treatment and transitions which were</p>		<p>ForResidents 169 and 28, Exhibit 14-20 and Exhibit 28-34 demonstrate behaviormonitoring through psychological and psychiatric assessments.o ForResidents 169 and 28, Exhibits 6-13 demonstrate ongoing monitoring throughSocial Serviceso ForResident 28 Exhibit 35 demonstrates ongoing behavior monitoring through Hospice . States that there was not an individualizedevaluation for behavior symptoms. Each Resident has behavior Care AreaAssessment (CAA) present which is the CMS approved assessment for behavioral symptoms, in the EMR and she was provided with a copied example as well. The Residents also have initial assessment completed by Social Services and Activitiesas well as assessments completed by psychiatric and psychological providers asnecessary.o Exhibit6-12 demonstrates individual evaluation via behavioral CAA for Resident 169.This information was part of the electronic Medical Record which the surveyorhad access to during the survey processo Exhibit13 demonstrates individual evaluation via behavioral CAA for Resident 28o Exhibit14-20 and Exhibit 28-34 demonstrates individual evaluation via psychiatric andpsychological services on Resident 169 and 28.</p>		

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	<p>target behaviors associated with the use of Xanax.</p> <p>Resident #28 lacked a care plan regarding delusions as to her environment which was a target behavior in relation to the use of Haldol.</p> <p>3. During a 12/23/13, 8:30 a.m. interview, Social Services Director #2 indicated she could not provide care plans specific to the identified targeted behavior or individualized resident approaches for said behaviors. The facility did not complete an individual evaluation or use the information to formulate individualized approaches to behavior management.</p> <p>3.1-35(a)</p>		<p>A copy of this information was provided to the surveyor from the Medical Chart. Exhibit 21-24 demonstrates individual evaluation completed by Social Services and Activities upon admission on Resident 169 and 28. This information was part of the electronic Medical Record which the surveyor had access to during the survey process. The surveyor cites a policy, but in fact it was information given from Omniview in relation to pharmacist guidance for dose reductions. This is not facility policy. Omniview has tools intended for pharmacists and it is not a part of facility policy and procedure. Omniview uses it as a tool/guide to direct pharmacists. This is not intended to guide the facility. This was provided secondary to surveyor request for information on how a pharmacist recommends a dose reduction. It was never intended to reflect facility policy. In Summary resident #169 and #28 had care plans to address target behaviors being treated by psychoactive medications. We respectfully requested that F257 be deleted from the public record. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The behavior management care plan for resident #169 has been reviewed and updated to include targeted</p>				

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			behaviors and interventions. The behavior management care plan for resident #28 has been reviewed and updated to include targeted behaviors and interventions. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken; Patients receiving psychotropic medications to manage behavior have the potential to be affected. They have had their care plans reviewed to ensure behavior management interventions are in place and available for staff to visualize prior to providing care to the residents. What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur; Initial audit of 100% of residents receiving psychoactive drugs completed to ensure the presence of behavior monitoring and management plans including specifically identified targeted behaviors being managed by each psychoactive medication with individualized approaches to each behavior/mood. Please see Attachment A. Each new admission will be reviewed by the Interdisciplinary team during morning QAA meeting to validate that target behaviors are identified and care plans are in place to identify individualized approaches for behavior/mood.	

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			Care plans will be reviewed and revised as needed based on patient's individual needs. Social Service staff have been educated in regards to specificity with behavior management. Please see Attachment B. 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 Social Service Director or designee will conduct a weekly review for four weeks of Care Plans for a minimum sample of nine residents with behavioral symptoms to ensure the presence of behavior monitoring and management plans that include specifically identified targeted behaviors being managed by each psychoactive medication with individualized approaches to each behavior/mood. Any concerns that are discovered during these reviews will be addressed immediately. Please see Attachment C. Audit findings will be presented to the QAA Committee weekly for 4 weeks and monthly thereafter for a minimum of 6 months. The QAA Committee will review findings and determine the need for further monitoring and/or education per the QAA process.	

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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review, and interview, the facility failed to ensure wheel chairs brakes were locked during resident care and gait belts were used during ambulation for 2 of 4 residents reviewed for resident care safety. (Resident #A and #B)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #A was reviewed on 12/19/13 at 9:00 a.m.</p> <p>Diagnoses included but were not limited to hypertension, seizure disorder, depression, gastric esophageal reflux, dementia, Alzheimer's, congestive heart failure, right ankle fracture, atrial fibrillation.</p> <p>An Incident Report, dated 11/15/13, indicated "Resident was walking back from DR (sic) with CNA and rolling walker when his legs 'just gave out'. VSS(vital signs stable), resident denies injury or pain. VS and resident assessed for injury, assisted into</p>	F000323	<p>What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice? Resident A no longer resides at the facility. Clinical record for resident B has been reviewed and updatedto reflect current ambulation needs and fall risk interventions. How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective actions will be taken; Patients who require assistance with transfers/mobility havethe potential to be affected. Clinicalrecord review was completed to ensure appropriate interventions are in placeand available for staff to review prior to providing care to the residents. Please see Attachment E. What measures will beput into place or what systemic changes will be made to ensure that the samedeficient practice does not recur; Clinical staff will be educated by the AdministrativeDirector of Nursing or Director of Care Delivery/Administrative Nurses on theuse of mobility devices, transfers and safety with mobility.</p>	01/22/2014	

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	<p>wheelchair and into recliner in room." Statement from a witness of the fall, dated 11/15/13, indicated "After dinner I was walking [Resident #A] down the hall and right before we got to his room his legs gave out and I held him as long as I could before I sat him down on the floor." CNA #1.</p> <p>Care Plan, dated 9/28/13, and revised 11/18/13, indicated a focus of "At risk for falls due to history of falls with interventions of: "Bed in low position, Encourage rest periods when ambulating. Have commonly used articles within easy reach. Provide assist to transfer and ambulate as needed. Staff assists during ambulation. Therapy screen change for change in rolling walker to a walker with a seat.</p> <p>Nurses notes, dated 11/15/13 at 2037 (8:37 p.m.), indicated the resident was ambulating back to his room from the dining room and was assisted to the floor by a CNA. The physician and daughter were notified.</p> <p>Electronic Medical Record Task Sheet indicated "Fall risk assist when ambulation/ encourage use of rest periods when ambulating use gaitbelt (sic), use walker during ambulation."</p>		<p>Please see Attachment F. Each new admission or patients with a change in mobility status will be reviewed during daily QAA meetings to validate that care plans and Kardex reflect the patient's individual needs and/or assistive devices to maintain their safety. Review and revision will occur as needed based on patient's individual needs. The Director of Care Delivery or designee will conduct a minimum of eight observations daily five times per week to include all shifts and weekends to ensure staff are following interventions for transfer and ambulation of residents that require supervision, assistance and/or use of devices for mobility. Any concerns that are discovered during these reviews will be addressed immediately. Please see attachment G. 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; Audit findings will be presented to the QAA Committee weekly for 4 weeks and monthly thereafter for a minimum of 6 months. The QAA Committee will review findings and determine the need for further monitoring and/or education per the QAA process.</p>				

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	<p>During an interview, on 12/23/13 at 9:50 a.m., with the Director of Nursing (DoN), the DoN indicated the term physical assist included the use of gait belts with ambulation.</p> <p>During an interview with CNA #1, the CNA stated she did not offer the resident a gait belt, while assisting the resident to ambulate him from the dining room, prior to his fall. She further indicated she should have used a gait belt to assist with ambulation.</p> <p>2. The clinical record for Resident #B was reviewed on 12/18/13 at 1:04 p.m.</p> <p>Diagnoses for the resident included, but were not limited to, Alzheimer's dementia, depression, hypertension, and congestive heart failure.</p> <p>A quarterly Minimum Data Set assessment, dated 10/7/13, indicated the resident was moderately cognitively impaired and required extensive assistance with 1 member of the staff for dressing, personal hygiene and toileting.</p> <p>Review of the incident report for the 10/30/13 fall indicated the resident had been assisted from the bathroom</p>			

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	<p>to a wheelchair using a walker by CNA #5. The brakes on the wheelchair were not locked. The wheelchair moved as the resident sat down resulting in the resident being lowered to the floor. The incident report lacked any documentation of CNA #5 having used a gait belt while assisting the resident.</p> <p>Review of the incident report for the 11/23/13 fall indicated the resident had been assisted to the bathroom. The resident lost her balance as CNA #4 was assisting the resident with her brief. The incident report lacked any documentation of CNA #4 having used a gait belt while assisting the resident.</p> <p>During an interview with the Director of Nursing on 12/23/13 at 9:00 a.m., she indicated the brakes on the wheelchair should have been locked before having the Resident #B sit down. She further indicated a gait belt should have been used while assisting the Resident #B.</p> <p>During an interview with CNA #6 on 12/23/13 at 9:55 a.m., she indicated during resident transfers the brakes on a wheelchair need to be locked. She further indicated a gait belt is to be used on all the residents which</p>			

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	<p>need assistance with their activities of daily living.</p> <p>During an interview with CNA #7 on 12/23/13 at 10:03 a.m., she indicated the brakes on a wheelchair need to be locked before assisting the resident to or from the wheelchair. She also indicated she uses a gait belt on all residents.</p> <p>During an interview with CNA #5 on 12/23/13 at 12:41 p.m., she indicated she had been assisting Resident #B on 10/30/13 without a gait belt. CNA #5 indicated she should have been using a gait belt while providing care for Resident #B. CNA #5 indicated she assisted the resident while she walked to her wheelchair using her walker. The wheelchair brakes were not locked and the wheelchair slid out from under the resident as the resident sat down. CNA #5 indicated Resident #B slid down the side of the bed but did not touch the floor.</p> <p>3. Review of the current facility procedure, dated 1/2011, titled "TRANSFER: BED-CHAIR/WHEELCHAIR," provided by the Director of Nursing on 12/23/13 at 10:57 a.m., included, but was not limited to, the following:</p>						

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	<p>"PURPOSE: To move safely from bed to chair or wheelchair and back again ...</p> <p>...ONE PERSON-STAND PIVOT: ...</p> <p>...2Lock wheels of wheelchair ...</p> <p>...5Apply gait belt to patient ... "</p> <p>4. Review of the current facility policy, dated 12/2009, titled "GAIT (TRANSFER BELT) POLICY," provided by the Director of Nursing on 12/23/13 at 10:57 a.m., included, but was not limited to, the following:</p> <p>" PURPOSE: To safely and effectively transfer or ambulate a patient ...</p> <p>...6Place gait belt around waist</p> <p>...15. When transferring to a wheelchair, prepare chair by locking both wheel brakes ... "</p> <p>3.1-45(a)(2)</p>				