

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155159	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/19/2016
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NAME OF PROVIDER OR SUPPLIER  SUMMIT CITY NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 2940 N CLINTON ST FORT WAYNE, IN 46805
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00200372.</p> <p>Complaint IN00200372 Substantiated. Federal/ State deficiencies related to the allegations are cited at F241, F312, and F315.</p> <p>Unrelated deficiency is cited at F323.</p> <p>Survey dates: May 18, and 19, 2016</p> <p>Facility number : 000079 Provider number: 155159 AIM number: 100266160</p> <p>Census bed type: SNF/NF: 79 Total: 79</p> <p>Census payor type: Medicare: 12 Medicaid: 56 Other: 11 Total: 79</p> <p>Sample: 10</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC</p>	F 0000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance.</p>	

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 0241 SS=D Bldg. 00	<p>16.2-3.1.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation and interview, the facility failed to ensure dignity for 2 of 3 residents reviewed for dignity in a sample of 10. (Resident N and T)</p> <p>Findings include:</p> <p>1. Resident #N's record was reviewed 5-19-2016 at 1:31 PM. Resident #N's diagnoses included, but were not limited to, stroke, dementia, and high blood pressure.</p> <p>On 5-18-2016 at 12:10 AM, Resident #N was observed resting in her bed. Resident could be observed from the hall way. Additionally, Resident #N's catheter bag was observed on the floor at the foot of the bed.</p> <p>On 5-18-2016 at 3:15 PM, Resident #N was again observed resting in her bed,</p>	F 0241	<p><b>F241– Dignity and Respect of Individuality</b></p> <p>It is the practice of this provider to promote carefor residents in a manner and in an environment that maintains or enhances eachresident's dignity and respect in full recognition of his or her individuality.</p> <p><b>Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice:</b></p> <p>Resident #N's Catheter will be covered at all times,and will not be visible from the hallway to ensure resident's dignity. Resident #T continues to receive dailyassistance with dressing and personal care including shaving and nail care.</p> <p><b>Howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken:</b></p> <p>·All residents who have</p>	06/17/2016

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	<p>Resident #N could be observed from the hallway. Resident #N's catheter bag was observed on the floor at the foot of the bed in the same position as observed earlier.</p> <p>In an interview on 5-19-2016 at 10:52 AM, LPN #1 indicated Resident #N's catheter should not have been visible, and a privacy bag should have been used.</p> <p>2. On 5/18/16 at 1:15 p.m., Resident T was observed sitting in the dining room on a couch. He was unshaven and had dirty fingernails. He had a frown shaped wound on his chin and an open reddened area on his right kneecap. He was wearing non-skid socks which was partially falling off his left foot.</p> <p>On 5/19/16 from 12:10 p.m. to 3:45 p.m., Resident T was observed in his room lying in bed. He was lying on his right side and was curled up in a fetal position. His hands were clasped together and his eyes closed. Between his eyebrows, was a swollen area surrounded by purple discoloration. There was a wound with stitches located in the middle of the swollen area. He had dried blood around the stitches and several spots of dried blood on the bed sheet and pillow case. He was unshaven with dried dark substances at the corners of his mouth</p>		<p>catheters havethe potential to be affected by this finding</p> <ul style="list-style-type: none"> <li>·All residents who have catheters havebeen identified and will be monitored daily to maintain each resident's dignityrelated to catheter use and care.</li> <li>·All residents have the potential to beaffected by this finding related to dignity.</li> </ul> <p><b>Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur:</b></p> <ul style="list-style-type: none"> <li>·Nurse Managers monitor resident carethrough rounds on their units daily which include monitoring that residentshave catheter bags off the floor, and are in privacy bags. The Nurse Managerswill also monitor catheter bag placement to ensure they cannot be observed fromthe hallway when a resident is in bed.</li> <li>·Rounds are completed each shift by theCharge Nurses daily and by Department Heads Monday through Friday to monitor dignityrelated to catheters, as well as monitoring the residents for overallappearance (clean nails, shaving care provided).</li> <li>·All staff in-services will be conductedon or before 6/17/16. This in-servicewill review the facility policy related to Resident Dignity. This in-service will also review theimportance of honoring catheter care including keeping the catheter bag off thefloor, keeping the catheter covered in a</li> </ul>	

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F 0312 SS=D Bldg. 00	<p>and was wearing the same shirt and sweatpants from 5/18/16. This Federal Tag is related to Complaint IN00200372.</p> <p>3.1-3(t)</p> <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.</p>	F 0312	<p>privacy bag, and ensuring the catheterbag cannot be seen from the hallway when a resident is in bed.</p> <p><b>Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur; i.e., what quality assurance program will be put into place:</b></p> <ul style="list-style-type: none"> <li>·Ongoing compliance with this correctiveaction will be monitored through the facility CQI Program.</li> <li>·Nurses will document their rounds on the“Resident Care Rounds CQI Audit Tool” daily for 4 weeks and monthly for 6months to ensure dignity is maintained in relation to catheters and hygiene.</li> <li>·Department Heads/designee will documenton the “Customer Care Rounds Sheet” for6 months to ensure residents are dressed appropriately.</li> <li>·Ifthreshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQICommittee for review and follow up.</li> </ul> <p><b>Bywhat date the systemic changes will be completed:</b> Compliance Date = 6/17/16</p> <p><b>F312—ADLCare Provided For Dependent Residents</b></p>	06/17/2016	

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	<p>Based on observation, interview, and record review, the facility failed to ensure personal hygiene was completed for 2 of 3 residents reviewed for personal hygiene in a sample of 10. (Resident #L and Resident #Q)</p> <p>Findings include:</p> <p>1. Resident #L's record was reviewed 5-18-2016 at 2:17 PM. Resident #L's diagnoses included, but were not limited to, respiratory failure, diabetes, and high blood pressure.</p> <p>A review of Resident #L's ADL care records on 5-18-2016 indicated AM and PM care had been given on 5-12-2016 in the morning and in the evening. No other documentation was available for review at that time. AM and PM care records provided by the Director of Nursing on 5-19-2016 at 10:10 AM indicated AM and PM care had been given daily since 5-1-2016.</p> <p>In an interview on 5-19-2016 at 10:15 AM, CNA #2 indicated some staff did not always get things done like they were supposed to and she came into work sometimes to find residents had not had care the day prior.</p> <p>A review Resident #L's hospital</p>		<p>It is the practice of this provided to ensure aresident who is unable to carry out activities of daily living receives thenecessary services to maintain good nutrition, grooming and personal and oralhygiene.</p> <p><b>Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice:</b></p> <ul style="list-style-type: none"> <li>Residents # L and #Q are receivingnecessary services to maintain good nutrition, grooming, and personal and oralhygiene. These residents experienced no negative outcome as a result of thisfinding.</li> </ul> <p><b>Howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken:</b></p> <ul style="list-style-type: none"> <li>All residents who are considereddependent residents were reviewed. TheDNS/Nurse Management Team and Customer Care Reps will be responsible forensuring that any resident determined to be dependent are receiving goodnutrition, grooming, and personal and oral hygiene.</li> </ul> <p><b>Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur:</b></p> <ul style="list-style-type: none"> <li>All nursing staff will be</li> </ul>				

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	<p>emergency room record dated 5-13-2016 at 4:23 AM indicated "eyes matted shut, dried drainage around the PEG (feeding) tube site finger and toenails long, unkempt, and dirty."</p> <p>2. 5/18/16 at 12:00 PM, Resident Q observed wearing a white shirt with a brown stain in the middle of his abdomen. He pulled up his shirt to expose dark, crusty debris on his abdomen around a feeding tube insertion site. He stated " the staff won ' t remove it and it ' s dirty " .</p> <p>5/19/16 at 2:10 PM, Resident #Q's clinical record was reviewed and indicated Resident #Q was not cognitively impaired.</p> <p>On 5-18-2016, during initial tour, the Director of Nursing indicated Resident #Q was interviewable. She further indicated Resident #Q had a temporary feeding tube for an acute injury. A physician ' s order dated 4/22/16 indicated " g-tube site care every shift " . His tube feedings were discontinued on 4/26/16.</p> <p>The MAR (Medication Administration Record) indicated he received " g-tube care every shift " from 5/1/16 through 5/19/16.</p> <p>This Federal tag is related to Complaint IN00200372.</p>		<p>in-serviced on or before 6/17/16. This in-service will be conducted by the DNS/designee and will include review of the facility policy related to providing care to dependent residents; including good nutrition, grooming, and personal and oral hygiene.</p> <ul style="list-style-type: none"> <li>The DNS/Nurse Management Team and Customer Care Reps will be responsible for ensuring that any resident who is determined to be dependent upon staff for ADL care is well groomed including having, grooming, nail care, and G-Tube sites are clean.</li> </ul> <p><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:</b></p> <ul style="list-style-type: none"> <li>Ongoing compliance with this corrective action will be monitored through the facility CQI program.</li> <li>The DNS/designee will be responsible for completing the following CQI Audit Tools: "ADL Care" weekly for 4 weeks and then monthly for 6 months.</li> <li>If threshold of 90% is not met, an action plan will be developed.</li> <li>Findings will be submitted to the CQI Committee for review and follow up.</li> </ul> <p><b>By what date the systemic changes will be completed:</b> Compliance Date = 6/17/16</p>	

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F 0315 SS=D Bldg. 00	<p>3.1- 38(a)(3)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, and interview, the facility failed to ensure catheters are cared for in a way to prevent infection for 2 of 3 residents reviewed with catheters in a sample of 10. (Resident #M and Resident #N)</p> <p>Findings include:</p> <p>1. Resident #N's record was reviewed 5-19-2016 at 1:31 PM. Resident #N's diagnoses included, but were not limited to, stroke, dementia, and high blood pressure.</p> <p>On 5-18-2016 at 12:10 AM, Resident #N was observed resting in her bed. Resident</p>	F 0315	<p><b>F315– No Catheter, Prevent UTI, Restore Bladder</b> It is the practice of this provider to ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b> ·Residents # M and #N are receiving necessary treatment and</p>	06/17/2016

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	<p>#N's catheter bag was observed lying on the floor at the foot of the bed.</p> <p>On 5-18-2016 at 3:15 PM, Resident #N was again observed resting in her bed. Resident #N's catheter bag was observed lying on the floor at the foot of the bed in the same position as observed earlier.</p> <p>In an interview on 5-19-2016 at 10:52 AM, LPN #1 indicated Resident #N's catheter should not have been on the floor.</p> <p>2. Resident #M's record was reviewed 5-19-2016 at 1:55 PM. Resident #M's diagnoses included, but were not limited to, diabetes, dementia, and depression.</p> <p>On 5-18-2016 at 11:46 AM, Resident #M was observed in the hallway in his wheelchair. Resident #M's catheter tubing was on the floor as Resident #M wheeled himself down the hall.</p> <p>On 5-18-2016 at 3:42 PM, Resident #M was again observed in his wheelchair in the hall. Resident #M's catheter tubing was still touching the floor.</p> <p>In an interview on 5-18-2016 at 3:46 PM, the Nurse Consultant indicated Resident #M's catheter tubing should not have been on the floor.</p>		<p>services related to proper placement of their cathetertubing, and the bag is off the floor; and not visible from the hallway. This resident experienced no negative outcomeas a result of this finding.</p> <p><b>Howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken:</b></p> <ul style="list-style-type: none"> <li>All residents with indwelling catheterswere reviewed. The DNS/Nurse ManagementTeam and Customer Care Reps will be responsible for ensuring that any residentutilizing an indwelling catheter receives proper care and treatment to preventinfections and to assist with proper placement of catheter tubing and bag toprevent dragging on the floor during daily rounds.</li> </ul> <p><b>Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur:</b></p> <ul style="list-style-type: none"> <li>All nursing staff will be in-serviced onor before 6/17/16. This in-service willbe conducted by the DNS/designee and will include review of the facility policyrelated to care and treatment of residents with indwelling catheters includingproper place of catheter tubing and bag at all times.</li> <li>The DNS/Nurse Management Team andCustomer Care Reps will be responsible for ensuring that any resident utilizingan</li> </ul>		

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F 0323 SS=G Bldg. 00	<p>This Federal Tag is related to Complaint IN00200372.</p> <p>3.1-41(a)(2)</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 comprehensively assess distressed</p>	F 0323	<p>indwelling catheter receives proper care and treatment to prevent infections and to assist with proper placement of catheter tubing and bags to prevent dragging on the floor during daily rounds.</p> <p><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:</b></p> <ul style="list-style-type: none"> <li>· Ongoing compliance with this corrective action will be monitored through the facility CQI program.</li> <li>· The DNS/designee will be responsible for completing the following CQI Audit Tools: "Catheter" weekly for 4 weeks and then monthly for 6 months.</li> <li>· If threshold of 90% is not met, an action plan will be developed.</li> <li>· Findings will be submitted to the CQI Committee for review and follow up.</li> </ul> <p><b>By what date the systemic changes will be completed:</b> Compliance Date = 6/17/16</p> <p><b>F323- Free of Accident Hazards/Supervision/Devices</b> It is the practice of this facility that the resident environment remains</p>	06/17/2016

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	<p>behaviors for 1 of 3 residents reviewed for behaviors (Resident T). The facility further failed to develop and implement effective preventive interventions to prevent an initial fall and subsequent falls for 2 of 3 residents reviewed for falls (Resident T and Resident P). This resulted in a laceration and fracture to Resident T's jaw and head injury with laceration.</p> <p>Findings include:</p> <p>1. On 5/18/16 the following observations were made:</p> <p>At 1:15 p.m., Resident T was observed sitting in the dining room on a couch. He was unshaven and had dirty fingernails. He had a frown shaped wound on his chin and an open reddened area on his right kneecap. He was wearing non-skid socks which were partially falling off his left foot.</p> <p>His meal tray was sitting across the room from the couch. The tray contained several full bowls of pureed food.</p> <p>At 1:20 p.m., he was pacing in the glassed in computer room across from the nurses station.</p> <p>At 1:30 p.m., he was seated back in the dining room on the couch.</p> <p>At 2:50 p.m., Resident T was observed standing in the hallway next to the nurse 's desk. Another resident seated in a</p>		<p>as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b></p> <ul style="list-style-type: none"> <li>·Resident #T's care plan has been reviewed and all current fall interventions are in place and being followed per MD order. This resident experienced nonegative outcome as a result of this finding.</li> <li>·Resident #P's care plan has been reviewed and all current fall interventions are in place and being followed per MD order. This resident experienced nonegative outcome as a result of this finding</li> </ul> <p><b>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:</b></p> <ul style="list-style-type: none"> <li>·All resident fall care plans will be reviewed by the Nurse Management Team. The prevention interventions on each resident's fall care plan will be compared to the physician's orders and Resident Profile to ensure all safety and fall interventions are in place and properly being utilized.</li> <li>·The DNS and/or designee will be responsible for environmental inspections of all resident rooms and equipment.</li> </ul>	

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	<p>wheelchair, was holding on to the resident ' s right arm, cursed and pulled him towards the wheelchair. The DON, transportation manager, and LPN #3 intervened and separated the two residents.</p> <p>On 5/18/16 at 3:45 p.m., during an interview, The Director of Social Services indicated that Resident T ' s behaviors had increased and he was aggressive with staff and residents. He was transferred to an acute hospital for evaluation of behaviors and aggression on 5/6/16 and 5/15/16. She further indicated attempts had been made to transfer him to a behavioral facility and two other nursing facilities that specialized in care of his disease however he was not accepted due to his age and aggression.</p> <p>On 5/19/16 from 12:10 p.m. to 3:45 p.m., Resident T was observed in his room lying in bed. He was lying on his right side and was curled up in a fetal position. His hands were clasped together and his eyes closed. Between his eyebrows, was a swollen area surrounded by purple discoloration. There was a wound with stitches located in the middle of the swollen area. He had dried blood around the stitches and several spots of dried blood on the bed sheet and pillow case.</p>		<p><b>Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur:</b></p> <ul style="list-style-type: none"> <li>·All nursing staff will be in-serviced onor before 6/17/16. This in-service willbe conducted by the DNS/designee and will include review of the facility policyrelated to the fall management program and the importance of following all fallprevention interventions per each resident's individual plan of care.</li> <li>·The DNS and/or designee, Charge Nursesand/or Weekend Nurse Manager will be responsible for environmental inspections of all resident rooms and equipment to ensure fall prevention interventions arein place and being utilized properly during daily rounds.</li> </ul> <p><b>Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur; i.e., what quality assurance program will be put into place:</b></p> <ul style="list-style-type: none"> <li>·Ongoing compliance with this correctiveaction will be monitored through the facility CQI program.</li> <li>·The DNS/designee will be responsible forcompleting the following CQI Audit Tools: "Fall Management" weekly for 4 weeks and then monthly for 6 months.</li> <li>·Ifthreshold of 90% is not met, an action plan will be developed.</li> <li>·Findingswill be submitted to the CQI Committee for review</li> </ul>				

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	<p>He was unshaven with dried dark substances at the corners of his mouth and was wearing the same shirt and sweatpants from 5/18/16.</p> <p>On 5/18/16 at 1:45 p.m., record review for Resident T indicated diagnoses included, but were not limited to, neuromuscular disorder and dementia without behavioral disturbance.</p> <p>A quarterly MDS (Minimum Data Set) assessment dated 4/3/16 indicated a BIMS (Brief Interview Mental Status) score of 3 which indicated the resident had severely impaired cognition.</p> <p>Nurse and IDT (Interdisciplinary Team) notes for Resident T indicated the following:</p> <p>5/3/16 at (unknown time) an order was received to increase Haldol (psychotropic) medication dosage due to increase in aggressive behaviors.</p> <p>5/15/16 at 12:12 p.m., Resident T became aggressive in the dining room with RN #4. He refused lunch and pursued staff when they were carrying his lunch tray. He was re-directed to his room.</p> <p>An incident report dated 5/15/16 at 12:55 p.m., indicated Resident T had struck a female resident in the face. The residents were separated immediately.</p> <p>Preventative measures taken were to place the resident on a 15 minute</p>		<p>and follow up.</p> <p><b>By what date the systemic changes will be completed:</b> Compliance Date = 6/17/16</p>	

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	<p>monitoring schedule and keep residents separated from each other during meal times and activities to ensure safety.</p> <p>On 5/15/16 at 4:45 p.m., Resident T was aggressive, throwing objects in the dining room, grabbed staff, and threatened to hit another resident. An order was received for Haldol per injection. The injection was given but had no effect on his behaviors. Emergency transport was called. The police arrived to the facility at 4:25 p.m. and restrained the resident. EMT ' s arrived at 4:35 p.m. and transferred resident to the hospital. At 10:50 p.m., resident returned from the hospital. Resident T had bruises to his face, arms, and legs. He continued to ambulate.</p> <p>An incident report dated 5/16/16 at 3:50 p.m., indicated Resident T made threatening remarks to a female resident. The residents were separated and Resident T was placed on 15 minute monitoring schedule. Staff directed to keep the residents separated during meal times and activities.</p> <p>On 5/16/16 at 8:19 p.m., Resident T was walking back and forth from his room to the dining room. He was aggressive towards staff and chased staff around the nurse ' s desk with " intent to harm " . He cursed at staff, left the area and</p>			

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	<p>returned to his room.</p> <p>On 5/16/16 at 10:08 p.m., Resident T was given Haldol per injection. He was chasing staff and attempted to hit them.</p> <p>On 5/17/16 at 2:35 a.m., Resident T was jogging and pacing up and down the hall. He was banging on a computer monitor and fax machine. Resident T was given " new dose of Haldol 50 mg IM (long acting) at 1:20 a.m. " The resident continued to pace and jog down the hall but then became " unstable " . He fell asleep in the computer room for approximately 25 minutes.</p> <p>On 5/19/16 at 1:45 p.m., Resident T ' s plan of care and physician orders reviewed and indicated the following: A problem start date of 11/24/15 and update 4/12/16, indicated Resident T had potential for psychosocial distress related to his young age and nursing home placement. Approaches included ...encourage and allow expression of feelings; offer support and validation and observe for any signs of depression, isolation, distress, etc.</p> <p>A Physician order dated 5/9/16, was for Sertraline (anti-depressant). On 5/12/16, Resident T ' s Haldol (psychotropic) medication was discontinued and Zyprexa (psychotropic) medication started.</p>			

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	<p>On 5/15/16, Zyprexa was discontinued and Haldol restarted at 50 mg per injection every two weeks and Haldol 5 mg per injection every 6 hours as needed. On 5/18/16 an order for Ativan 2 mg per injection every 4 hours as needed for agitation and anxiety was obtained.</p> <p>A problem start date of 8/15/14 and update 4/12/16, indicated the resident was at risk for side effects due to psychotropic medication. Interventions included to observe for ...dizziness ...drowsiness ... impaired balance....tremors ...</p> <p>A problem start date of 9/8/14 indicated the resident had verbal and physical aggression toward staff during care and meals. An intervention updated on 5/4/16 indicated the resident should be offered extra food throughout the day related to agitation at meal time due to wanting food.</p> <p>A problem start date of 5/18/16 indicated the resident had episodes of aggression and threatening gestures. The goal was that the resident would cause no harm to self or others. Interventions included " provide assistance when walking as resident will allow, provide extra food and beverages when observed agitated, psych and medication reviews, and re-direct other peers away from resident</p>			

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	<p>when in common areas.</p> <p>An activities plan of care updated on 5/18/16 indicated the resident would benefit from socialization and activities. An intervention was to provide resident with 1:1 activities such as music, readings, looking at magazines, computer tablet to keep him from being agitated. A problem start date of 8/15/14 and updated on 5/18/16, indicated the resident had difficulty making himself understood due to dementia. Interventions included give resident time to complete his thoughts, provide a quiet non-hurried environment free of background noises and distractions and remind resident to speak slowly and clearly.</p> <p>On 5/18/16 at 3:45 p.m., during an interview, the Director of Nursing (DON) indicated the resident was at risk for falls due to unsteady gait, uncontrolled body movements and progression of his disease. She indicated Resident T had multiple falls recently. She further indicated that when the resident was aggressive and pacing in the hallways, staff would provide 1:1 attention to prevent falls and maintain safety of Resident T and other residents around him.</p> <p>During an interview on 5/19/16 at 2:15</p>			

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	<p>p.m., LPN #6 indicated Resident T had fallen on 5/18/16 at 10:40 p.m. He had been sent to the hospital for treatment of a laceration to his forehead. She indicated the resident had been asleep all day. He was difficult to wake up and had not eaten lunch.</p> <p>During an interview on 5/19/16 at 2:20 p.m., RN #4 indicated there was no record of what medications were administered to Resident T while at the hospital on 5/18/16. He further indicated that the facility ' s medical records staff would need to contact the hospital to obtain that information.</p> <p>During an interview on 5/19/16 at 2:25 p.m., CNA #7 indicated the following: Resident T gets agitated and aggressive and won ' t allow staff to care for him. He indicated this has gotten worse the last few weeks. The resident ' s agitation was worse when he was in the dining room. Orderlies " usually " provided the resident ' s care because the resident " doesn ' t t like females " . The resident spits out his food and tries to hit female CNA ' s when they assist him to eat. CNA #7 indicated when Resident T is agitated and aggressive, the staff will try and isolate him to his room. If he won ' t go to his room, staff will try and keep other resident ' s away from him.</p>			

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	<p>CNA #7 further indicated he has had to " grab " Resident T and " hold his arms down by his side " or " hold him down " to separate him from other residents. CNA #7 indicated staff are not always able to provide 1:1 care when the resident is aggressive and pacing because other residents need care.</p> <p>During an interview on 5/19/16 at 2:35 p.m., CNA #5 indicated there are " usually " two staff on the floor in the evenings and they are not able to provide 1:1 care when Resident T is aggressive, pacing, and falling. She further indicated when male CNA ' s are not working, female CNA ' s " try and do his care " . She indicated that female CNA ' s are afraid of the resident.</p> <p>Nurse and IDT (Interdisciplinary Team) notes for Resident T indicated the following:</p> <p>On 5/5/16 at 12:13 p.m., Resident T had a witnessed fall onto his knees in the hallway. There was no new intervention on care plan.</p> <p>On 5/16/16 at 3:15 a.m., resident was walking around a corner, lost his balance, and fell onto his face. He had a cut to his chin. He was transported to the hospital for evaluation and treatment.</p> <p>A fall event report dated 5/16/16 at 3:15 a.m., indicated preventative measures to</p>			

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	<p>prevent another fall was for resident to have someone with him at all times.</p> <p>An incident report dated 5/16/16 at 3:15 a.m., indicated preventative measures taken to prevent further falls was update the plan of care with recommendations from the hospital. There was no update made to the care plan.</p> <p>On 5/16/16 at 10:13 a.m., Resident T returned from the hospital with a diagnosis of fractured jaw. He had stitches to his lower chin and bruising to various areas over his face and body.</p> <p>On 5/16/16 at 6:42 p.m., Resident T was walking towards his room and fell.</p> <p>A fall event reported dated 5/16/16 at 6:48 p.m., indicated intervention to prevent another fall was to feed the resident more often.</p> <p>On 5/18/16 at 10:23 a.m., Resident T had a witnessed fall in the hallway. He was walking when went down on his knees. The intervention to prevent further falls was offer assistance when the resident turns a corner on the hallway, when he allows.</p> <p>5/18/16 at 10:40 p.m., Resident T had a fall resulting in a head injury. He required emergency treatment and stitches to his forehead.</p> <p>A care plan dated 4/12/16 indicated Resident T was at risk for falls due to</p>			

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	<p>[diagnosis] and dementia. The goal was to keep the resident from having a fall related injury. The care plan indicated the resident was at risk for side effects due to psychotropic medication. Interventions included to observe for dizziness ...drowsiness ... impaired balance.... The last fall intervention entered on the care plan was dated 3/7/16 and indicated a chair to be replaced with a bigger more stable one.</p> <p>2. On 5/18/16 at 12:40 p.m., Resident P was observed lying in her bed. There were half side rails on both sides of the bed. She had fading yellow to green colored bruises on both hands. The left side of her chest, near the clavicle bone, had purple, yellow to green colored bruises.</p> <p>During an interview on 5/18/16 at 12:40 p.m., Resident P wanted to know why State " doesn ' t ' t allow side rails " . She indicated she had requested them but " staff kept saying the State won ' t allow " . She had a fall from bed on 4/30/16. She did not have half side rails at the time. She indicated she was being bathed by two CNA ' s. She was lying on her left side with one CNA behind and one CNA in front of her. Both CNA ' s moved away from her at the same time. She rolled out of the bed onto the floor.</p>			

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	<p>The EMS was called and she was transported to the hospital. She returned to the facility later that day. She had no serious injuries.</p> <p>On 5/19/16 at 2:45 p.m., during an interview with CNA #5, she indicated Resident P needed assistance of 3 persons for bed mobility. She further indicated there were usually two CNA 's to assist resident with bed mobility.</p> <p>Resident P ' s record was reviewed on 5/19/16 at 2:30 p.m. The resident ' s diagnoses included, but were not limited to, morbid obesity and depression.</p> <p>An admission MDS (Minimum Data Set) assessment dated 5/9/16 indicated a BIMS (Brief Interview Mental Status) score of 15 which indicated no cognitive impairment. The MDS further indicated she required extensive to dependent assistance of two plus persons with bed mobility and bathing. She was bedbound.</p> <p>A pre-admission Resident Assessment form dated 4/26/16 requested the facility ' s input on their ability to care for the resident due to her weight and need for three person assist with care.</p> <p>Review of nursing notes for Resident P indicated the following: 4/27/16 at 3:30 p.m., resident needed assistance of 5 persons to transfer into</p>			

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	<p>bed.</p> <p>4/28/16 at 10:13 a.m., 3 person assist with ADL ' s (Activities of Daily Living).</p> <p>4/28/16 at 10:03 p.m., 3 plus assist with repositioning resident.</p> <p>4/29/16 at 12:11 p.m., patient is a 3 plus assist with ADL ' s and repositioning in bed.</p> <p>4/30/16 at 10:15 a.m., resident observed rolling out of bed on left side of bed. " Large purple bruising to left side of chest near clavicle, left hand, and left upper arm " .</p> <p>4/30/15 at 10:30 a.m., resident was transported to the hospital per EMS. She returned to the facility on 4/30/16 at 7:42 p.m.</p> <p>5/2/16 at 10:08 a.m., an IDT (Interdisciplinary Team) note indicated that staff had given care with two CNA ' s. The resident rolled out of bed when she turned too far while lying on her side. The immediate intervention was to place side rails to her bed for bed mobility and positioning and care plan updated.</p> <p>5/3/16 at 7:54 p.m., a nursing note indicated the resident is a " three to four assist with bed mobility " .</p> <p>5/4/16 at 12:28 p.m., a nursing note indicated she is a " three to 4 assist with repositioning in the bed " .</p> <p>On 5/19/16 at 3:44 p.m., the DON</p>			

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	<p>(Director of Nursing) provided a copy of Resident P ' s most current care plan. Resident P ' s care plan dated 4/28/16, indicated she required assistance with ADL ' s with goal of having ADL needs met. Interventions did not include the amount of assistance and staff needed to provide care.</p> <p>Resident P ' s care plan dated 4/29/16, indicated she was at risk for falls with goal of reducing fall risk factors and avoid a fall related injury. There was no intervention for use of side rails to prevent further falls.</p> <p>3.1-45(a)(2)</p>			