

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155488	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/22/2014
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-ROLLING HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 3625 ST JOSEPH RD NEW ALBANY, IN 47150
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00153896.</p> <p>Complaint IN00153896 - Substantiated. Federal/State deficiencies related to the allegations are cited at F282 and F323.</p> <p>Survey dates: August 18, 19, 20, 21, and 22, 2014</p> <p>Facility number: 000526 Provider number: 155488 AIM number: 100266970</p> <p>Survey team: Janelyn Kulik, RN-TC Brenda Buroker, RN Deborah Barth, RN Brenda Marshall, RN William C. Greeney, QIDP</p> <p>Census bed type: SNF/NF: 90 Total: 90</p> <p>Census payor type: Medicare: 9 Medicaid: 64 Other: 17 Total: 90</p>	F000000	<p>Submission 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 requirements under state and federal law. Please accept this plan of correction as our credible plan of compliance. Please find enclosed the plan of correction for the survey ending on August 22, 2014. We are alleging compliance on September 19, 2014. Should additional information be necessary to confirm said compliance feel free to contact me at 812-948-0670. Christopher Kellogg Executive Director.</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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F000167 SS=C	<p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed on September 1, 2014, by Brenda Meredith, R.N.</p> <p>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. Based on observation and interview, the facility failed, for 90 of 90 residents currently residing in the facility, to make readily accessible the results of the most recent surveys.</p> <p>Findings include:</p> <p>During an observation on 8/22/2014, 8:55 A.M., a sign was posted in a frame on a table at the entrance that stated, "Annual survey results are available upon request at the receptionist's desk." A subsequent paper sign was posted on a bulletin board in a resident room hallway</p>	F000167	<u>F167 Right to survey results-readily accessible</u> I. All residents have the potential to be affected. II. All residents have the potential to be affected. Survey book was placed on the table in the entryway. III. Residents were made aware of location of the survey result binder in resident council meeting on 9//8/14. SDC or designee to educate staff on location of the survey result binder. IV. ED or designee will validate that the survey results are readily available in the entry way . This will be ongoing. Any issues will be taken to QA for review and any issues corrected	09/21/2014

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F000241 SS=D	<p>that stated "Notice to all residents, visitors and staff. Survey results for the past two years are available for inspection at the receptionist desk."</p> <p>During an interview on 8/22/14 at 9:00 A.M., the Social Services Director (SSD) indicated the survey results were in a binder behind the receptionist's desk. The SSD, along with the receptionist demonstrated where the binder was located and pulled it from a series of binders maintained by the receptionist. The SSD indicated the binder had to be requested and retrieved by the receptionist.</p> <p>3.1-3(b)(1)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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. Based on observation, interview and record review, the facility failed to ensure resident's dignity was maintained during dining for 2 of 11 residents who ate in the 200 hall dining room. (Resident #2 and Resident #49).</p> <p>Findings include:</p>	F000241	<p>immediatelyThe facility would like to request a desk review for this citation.</p> <p>I. Resident # 2 MD to evaluate PICA for further medical intervention, care plan reviewed and revised, staff educated related to interventions, psych to see resident on 9/19/14, and staff to layer clothing, GI appointment scheduled. Resident # 49 MD to evaluate resident for PICA type behaviors, care plan reviewed</p>	09/21/2014			

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	<p>1. During observations on 8/18/14 between 11:35 a.m. and 12:26 p.m., Resident #2 chewed the clothing protector while waiting for the trays to be served and in between bites. Certified Nurse Aide (CNA) #2, CNA #3 and Restorative Aide (RA) #1 were present in the dining room and did not redirect the resident from chewing his clothing protector.</p> <p>During observations on 8/19/14 at 11:55 a.m., Resident #2 was seated at a table with peers in the dining room. The resident was not wearing a shirt and was being fed by CNA #1.</p> <p>During an interview on 8/19/14 at 11:55 a.m., LPN #2 indicated Resident #2 had a history of chewing his clothing. She indicated the resident wore a shirt to the dining room and should have had his shirt replaced with a different shirt when the shirt was removed.</p> <p>2. During observations on 8/18/14 between 11:35 a.m. and 12:26 p.m., Resident #49 chewed the clothing protector while waiting for the trays to be served. CNA #2, CNA #3 and Restorative Aide (RA) #1 were present in the dining room and did not redirect the resident from chewing the clothing</p>		<p>and revised, and psych to see resident on 9/19/14. Care sheets updated.II. All residents who have a history of chewing or eating non edible items have the potential to be affected. 100 percent audit of these residents care plan and interventions to be reviewed and revised to meet current needs. Staff educated on new or ongoing interventions. The meal manager will observe residents at each meal for any dignity issues, and will correct immediatelyIII. The SDC or designee will in-service staff related to dignity, and new interventions of care plan.IV. The facility designated representative will observe resident Monday through Friday ongoing related to dignity issues, and will report findings Monday through Friday in the IDT leadership meeting, plan of care will be updated daily with any issues identified. The DNS/ designee will audit findings 5 days for 30 days, then 3 times a week for 30 days then twice weekly for 30 days discuss issues in the behavior management meeting. Audit results will be reviewed in monthly Quality Assurance meeting to achieve 100% compliance as determined by Quality Assurance committee. The facility would like to request a desk review for this citation.</p>				

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F000247 SS=D	<p>protector.</p> <p>During an interview on 8/18/14 at 12:25 p.m., CNA #3 indicated residents were usually redirected from chewing on clothing protector by taking the protector away from the resident's mouth. The CNA stated, "I can't answer that," when asked why residents were not redirected from chewing clothing during the dining experience.</p> <p>During an interview on 8/22/14 at 8:30 a.m., the SSD (Social Service Director) indicated Residents #2 and #49 "always chewed" their clothing and it would be hard to get them to stop. She indicated staff should have redirected the residents from chewing clothing protectors.</p> <p>An undated policy, titled, "Dining Standards," was provided by the SSD on 8/22/14 at 8:40 a.m. The policy indicated, "...Patients are offered clothing protectors...Specialty Dining Services can have a positive effect on the patient's mental and physical health by increasing socialization, increasing activity mobility and improving meal intake...."</p> <p>3.1-3(t)</p> <p>483.15(e)(2) RIGHT TO NOTICE BEFORE</p>						

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	<p>ROOM/ROOMMATE CHANGE</p> <p>A resident has the right to receive notice before the resident's room or roommate in the facility is changed.</p> <p>Based on interview and record review, the facility failed to ensure a resident was given notice prior to a roommate change for 1 of 3 residents reviewed for notices prior to changing room or roommate. (Resident #32).</p> <p>Findings include:</p> <p>During an interview on 8/19/14 at 10:59 a.m., Resident #32 indicated the facility did not inform the resident in advance of receiving a new roommate.</p> <p>During an interview on 8/21/14 at 1:00 p.m., the Social Service Director (SSD), with the Director of Nursing (DON) present, indicated the facility did not notify the resident prior to moving in a roommate.</p> <p>Resident #32's record was reviewed on 8/21/14 at 2:05 p.m. The Minimum Data Set (MDS) assessment, dated 6/20/14, indicated a Brief Interview for Mental Status (BIMS) score of 13 of 15, indicating the resident was cognitively intact. The record lacked documentation to indicate the resident/family was notified prior to receiving a new roommate on 7/8/14.</p>	F000247	<p>I. Notification was made to resident #32.II. All residents with roommate change and or new roommate in the 12 months have a potential to be affected. 100 percent audit of room change or change in roommate in the past year complete and SSD validated residents had no complaints or issues with roommate. III. The SDC or designee will educate the Social Service staff, licensed nurses and weekend manager of appropriate notifications related to room change and the intrafacility transfer form. IV. The Social Worker or designee will audit charts 5 days a week for 30 days, then 3 times a week for 30 days then twice weekly for 30 days any resident who had a room change or got a roommate for appropriate notification, this will be reviewed in the daily IDT leadership meeting, any findings will be corrected immediately. Audit results will be reviewed in monthly Quality Assurance meeting to achieve 100% compliance as determined by Quality Assurance committee daily. Review as an ongoing process of this facility. Audit results will be reviewed in monthly Quality Assurance meeting to achieve 100% compliance as determined by Quality Assurance committee. The facility would like to ask for a</p>	09/21/2014

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F000248 SS=D	<p>An undated policy, titled "Room-to-Room Transfer," was provided by the SSD on 8/22/14 at 8:40 a.m., and was identified as current. The policy indicated, "...Residents are introduced to the new roommate prior to a room move...."</p> <p>3.1-3(v)(2)</p> <p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview and record review, the facility failed to ensure the individual activity needs to redirect a resident from wandering behaviors for 1 of 3 residents reviewed for maladaptive behaviors in a sample of 28 residents. (Resident # 120)</p> <p>Findings include:</p> <p>Resident #112 expressed concern with a wandering resident (identified by him as Resident #120) during a resident interview on 8/19/14 at 9:30 a.m.</p>	F000248	<p>desk review for this citation</p> <p>I. Resident #120 is being moved to the Reflections unit for more appropriate activity programming, work program D/C'd as resident would not participate, care plan reviewed and revised to meet current activities related to wandering.II. All residents at risk for wandering have the potential to be affected. 100 percent wandering assessments completed. Activity programming and plan of care reviewed and revised for the identified residents. III. SDC or designee to educate activity staff and floor staff on wandering residents and appropriate activity programming, care plans, and interventions.IV.</p>	09/21/2014

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	<p>A search for Resident # 120 was begun on 8/19/14 at 2:45 p.m. Resident # 120 was observed, on 8/19/14 at 3:00 p.m., sleeping in a room that was not his own, in the bed by the window. His bed was located by the door in his room. CNA #20 indicated he did this all the time. Staff assisted him ambulating back into his room. He wandered out of his room again at 3:02 p.m. He wandered into room 409. He was redirected out of that room and directed back to his own room again by the staff. At 3:25 p.m. on 8/19/14, he was observed sitting on the other bed in his room.</p> <p>On 8/20/14 at 8:40 a.m., Resident # 120 was observed wandering down to the aviary lounge and then to the front lounge reception area.</p> <p>On 8/20/14 at 9:26 a.m., Resident #120 was again found in room 411 fiddling with the door. He then wandered back to his room.</p> <p>The resident was observed during the day of 8/21/14. He slept the whole day.</p> <p>The clinical record for Resident # 120 was reviewed on 8/20/14 at 9:00 a.m. His diagnoses included, but were not limited to: Bipolar, anxiety, depression, alcoholic liver disease and liver cancer.</p>		<p>The Activity Director or designee will audit activity log 5 x weekly for 30 days, then 3 x weekly for 30 days, then twice weekly for 30 days any resident that is at risk of wandering to validate appropriate programming is effective, this will be reviewed in the M-F IDT leadership meeting, any findings will be corrected immediately. The facility assigned representative will observe daily Monday through Friday during rounds if any issues are occurring with wandering residents, any issues identified will be corrected immediately. Review as an ongoing process of this facility. Audit results will be reviewed in monthly Quality Assurance meeting to achieve 100% compliance as determined by Quality Assurance committee. The facility would like to ask for a desk review for this citation.</p>	

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	<p>The resident was receiving Risperdal (an antipsychotic), lithium (an antimanic), Ativan (an antianxiety) and Lexapro (an antidepressant) medications on a daily basis. A quarterly Minimum Data Set assessment, dated 7/18/14, indicated the resident had no cognitive impairment.</p> <p>The Medication Administration Record was reviewed for June, July, and August, 2014. There was no indication of the resident being tracked for the wandering behavior. RN # 21 indicated the resident was not being tracked for wandering behaviors during an interview on 8/20/14 at 10:00 a.m.</p> <p>A care plan, dated 7/20/14, indicated the following: problem of elopement risks/ wandering behavior. Interventions included: 15 min (minute) checks prn (as needed); assess resident for therapeutic work - work order - idt (Interdisciplinary Team) to assess & evaluate, other options if not interested in this, tokens for pay; praise, report difficulties; infection control; supervise and train; work with dept heads for jobs; redirect from inappropriate areas; engage in diversional activity; evaluate need for additional supervision and obtain order for procedure; 1:1(one to one) with staff prn; provide structured activities - toileting, walking inside and outside, reorientation</p>			

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	<p>strategies, including signs, pictures, and memory boxes; therapy to evaluate for cognitive therapy; wander alert.</p> <p>A care plan, dated 7/20/14, indicated the problem of activities had the following interventions identified: provide 1:1 intervention during activities as needed; keep instructions easy with one step processes; allow resident simple choices; provide cues and modeling for activities that require complexity as resident was easily confused; explain activity, location and time; assure resident of abilities; assist to activity if needed; monitor resident for signs of anxiety/agitation or physical discomfort during activities; assist to nursing staff or calmer environment as needed if resident wanders or becomes agitated during activities; redirect, reapproach, invite, encourage and assist as needed to activities of choice, interest as tolerated by the resident, monitor resident for behaviors during groups i.e. touching or reaching for other people's food; remind resident of contamination concern; offer personal snacks; gently redirect or assist to calmer environment; offer (Resident's name) food and/or drinks as a diversion or intervention when agitated; offer resident resources and opportunities appropriate for their age, whatever they may be, transportation to stores,</p>			

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	<p>encouraging visits with peers; providing appropriate supplies r/t (related to) young age - movies, music, reading materials; provide activity calendar in room; resident to be offered independent supplies and appropriate relating to their interest; inform of newspaper and daily chronicle availability in activity room; respect wishes to decline invitations when rest/activities leisure type are preferred; visit and monitor resident weekly for need of comfort measures; if needed, offer resident comfort measure pleasant music, sensory stimulation, and verbalization.</p> <p>On 8/20/14 at 10:40 a.m., RN # 21 was asked about the resident's therapeutic work program. She indicated she would have to ask someone.</p> <p>The Director of Nursing (DON) and the Activities Director were interviewed on 8/20/14 at 10:45 a.m. The Activities Director indicated there had not been a therapeutic work program established for the resident. She provided a copy of the resident's activities attendance calendar. The Director of Nursing indicated the resident had been difficult to manage. She indicated he had gone from very active to total bedrest, then up ambulating the next day. She indicated he was difficult to anticipate when it</p>			

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	<p>came to meeting his needs.</p> <p>Resident #120 was discharged on 7/27/14 to an inpatient psychiatric facility. He had been readmitted to the facility on 8/5/14. The attendance calendar indicated the resident had been involved in eight activities during the month of August from 8/5/14 through 8/19/14. On 8/6/14, "wrote work order, he said 'maybe later'." On 8/7/14, "res [resident] sleeping - declined work." On 8/11/14, 20 minutes "1:1 visit: took res soft drink very pleasant." On 8/13/14, 10 minutes "bake sale: res had cake." On 8/14/14, one hour "Res enjoyed music with Steve." On 8/15/14, 10 minutes "social visit invited to Country Sounds res declined." On 8/18/14, one hour "res down for coffee, newspaper, and conversation." On 8/19/14, 20 minutes "res had hotdog and soft drink."</p> <p>Review of the behavior reports indicated the resident had been found outside the building on 7/25/14 and was placed on 1:1 with staff until he had been discharged on 7/27/14 at 4:00 p.m. to an inpatient psychiatric facility for elopement. He had been readmitted to the facility on 8/5/14. There were no behavior notes for the resident wandering into other resident rooms uninvited.</p>			
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F000250 SS=D	<p>CNA # 1 was interviewed on 8/20/14 at 2:10 p.m. She indicated she worked the 2-10 shift. She also indicated Resident # 120 wandered daily into other resident rooms. She indicated the resident was redirected when he wandered. She knew he liked ice cream sandwiches and coke. She also indicated staff may take him outside if they had time.</p> <p>3.1-33(a)</p> <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, record review and interview, the facility failed for 1 of 3 residents reviewed for behavior management, to identify appropriate goals and interventions to manage behaviors related to a diagnosis of PICA (a behavior associated with eating non-food materials). (Resident #2)</p> <p>Findings include:</p> <p>During an observation on 8/19/14 at 2:40 P.M., Resident #2 was laying flat in low bed wearing no shirt. On 8/20/14 at 8:20 A.M., Resident #2 was up in his wheelchair sitting in his room in front of</p>	F000250	<p>I. Resident # 2 contacted MD for medical intervention R/T PICA. CP reviewed and revised to meet residents current needs. Behavior management program put in place for resident. Psych to see resident on 9/19/14. Staff to layer clothing R/T dignity. GI appointment made. II. All residents with PICA diagnosis has a potential to be affected. 100 percent audit of residents with PICA will be reviewed with plan of care revised. III. The SDC or designee will in-service the Social Service staff and licensed nurses on behavior management program and dignity related to residents with the diagnosis of PICA. IV. The Social Worker or designee will audit Behavior</p>	09/21/2014			

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	<p>a television. He was wearing a T-shirt with a large hole in front. At 10:25 A.M., he was still sitting in front of the television, chewing on the same shirt, however the hole had gotten larger.</p> <p>Another observation, on 8/20/14 at 11:00 A.M., found him still sitting in his room in his wheelchair unmonitored. The same shirt now showed his bare chest all the way down. The only part of the t-shirt still attached was the collar around his neck. On 8/20/14 at 11:30 A.M., Resident #2 was transported to the Social Dining room still wearing the same shirt, with his chest exposed. While in the dining area, waiting for his food, Resident #2 was observed to take a string from the shirt and put in his mouth.</p> <p>During observation on 8/21/14 at 8:40 A.M., Resident #2 was sitting in his room in front of the television in his wheelchair. He was wearing another white t-shirt, this t-shirt had a small hole in the chest, about the size of a silver dollar.</p> <p>Resident #2's record was reviewed on 8/20/14 at 8:51 A.M. His diagnoses included, but were not limited to; cerebral palsy, seizure disorder, profound intellectual disability, Paraplegia, PICA (a behavior associated with eating non-food materials), esophageal reflux</p>		<p>Monitoring Flow Sheets 5 x weekly for 30 days, then 3 x weekly for 30 days, then twice weekly for 30 days to validate behaviors related to PICA , and will present findings M-F in leadership IDT meeting, Plan of care will be updated immediately with any issues Identified. The residents designated facility angel will make rounds Monday through Friday to identify any issues with residents with the DX of PICA. IDT will discuss PICA behaviors on going in Behavior management meeting weekly.</p> <p>Review as an ongoing process of this facility. Audit results will be reviewed in monthly Quality Assurance meeting to achieve 100% compliance as determined by Quality Assurance committee. The facility would like to ask for a desk review for this citation.</p>	

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	<p>and convulsions. The resident's 7/1/14 physician's order recap indicated the diet order was regular puree texture with thin liquids. The Social Service related notes in the resident record indicated that back in 2007 family members indicated to the facility, "He has ate through items since the time he got teeth."</p> <p>Resident #2's Care Plan, dated 6/25/14, indicated a number of care areas that identified the behavior, but there was no care plan specific to addressing and reducing the PICA behavior. For example, in the Care area of self care, the plan indicated "self-care performance deficit related to cerebral palsy, Chews, eats any clothing he gets to his mouth." The Goal was "I need my caregiver to be able to assist me/perform grooming/dressing/bathing." The Interventions included: Totally dependent on staff...for all ADL's. Maintain in optimum position for eating and/or digesting food. All meals in social dining room-fed per staff. "Change clothing as necessary as he chews on t-shirts."</p> <p>Another Care Plan area, dated 6/25/14, addressed "potential for constipation r/t [related to] PICA...Goal He will pass soft formed stool. The interventions included: "Monitor for impacted/clothing material</p>						

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	<p>r/t PICA, Follow facility bowel protocol for bowel management, Record bowel movement patterns each day Describe amount color and consistency."</p> <p>Another Care Plan area, dated 6/25/14, addressed "Focus: [Resident #2] has a behavior problem r/t PICA-chews/eats any clothing he can get into his mouth. Goal: He will have no evidence of complications. Interventions. Anticipate and meet needs, Intervene as necessary to protect the rights and safety of others, Try to keep clothing out of his mouth. Change clothing frequently if he chews on them. Provide a program of activities that is of interest."</p> <p>Review of the activities care area, revised 7/15/2014, indicated Resident #2 must be monitored for PICA during involvement in sensory stimulation and social activities two or more times weekly.</p> <p>In the above care plans there no interventions were found that identified the cause of the behavior or any interventions that were designed to prevent and reduce the frequency of the behavior. Additionally, no documentation was found in the record to indicate the behavior was being tracked and monitored for frequency.</p>			

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F000278 SS=D	<p>On 8/2014 at 11:10 A.M., Licensed Practical Nurse (LPN) #30 was interviewed regarding what staff were to be doing when PICA was observed. She stated, "we change his shirt before he comes out of his room. The CNA's monitor for bowel movement and record on flow sheet."</p> <p>There was no documentation located in Resident #2's August 2014 Medication Administration Record and Treatment Administration Record to indicate data was being recorded relative to the behavior.</p> <p>3.1-34(a) 3.1-34(a)(1)</p> <p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p>						

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	<p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on observation, record review and interview, the facility failed for 1 of 28 residents reviewed (Resident #2) to ensure the Minimum Data Set (MDS) assessment accurately identified a maladaptive behavior.</p> <p>Findings include:</p> <p>During an observation on 8/19/14 at 2:40 P.M., Resident #2 was laying flat in a low bed wearing no shirt. On 8/20/14 at 8:20 A.M., Resident #2 was up in his wheelchair sitting in his room in front of a television. He was wearing a T-shirt with a large hole in front. At 10:25 A.M., he was still sitting in front of the television, chewing on the same shirt, however the hole had gotten larger. On 8/20/14 at 11:00 A.M., another observation found him still sitting in his</p>	F000278	I. Resident #2, MDS was modified to meet current needs and reflect current status related to DX of PICA, behaviors and bowel status. II. All residents with behavior or DX of eating or attempting to eat non edible food items are potentially at risk. 100 percent audit of these residents conducted, MDS modified if any issues identified, care plan review and revision complete. Behavior programming validated. Bowel management program implemented.III. SDC or designee to educate MDS, and nursing staff related to appropriate assessment, documentation, care plan and interventions.IV. MDS or designee will audit ADL books, MAR and TAR 5 x weekly for 30 days, then 3 x weekly for 30 days, then twice weekly for 30 days to validate appropriate documentation is available for bowel monitoring. SSD or designee will audit behavior flow	09/21/2014

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	<p>room in his wheelchair unmonitored. The same shirt now showed his bare chest all the way down. The only part of the T-shirt still attached was the collar around his neck. On 8/20/14 at 11:30 A.M., Resident #2 was transported to the Social Dining room still wearing the same shirt, with his chest exposed. While in the dining area, waiting for his food, Resident #2 was observed to take a string from the shirt and put in his mouth.</p> <p>During observation on 8/21/14 at 8:40 A.M., Resident #2 was sitting in his room in front of the television in his wheelchair. He was wearing another white T-shirt, this T-shirt had a small hole in the chest, about the size of a silver dollar.</p> <p>Resident #2's record was reviewed on 8/20/14 at 8:51 A.M. His diagnoses included, but were not limited to; cerebral palsy, seizure disorder, profound intellectual disability, Paraplegia, and PICA (a behavior associated with eating non-food materials). The Social Service related notes in the client record indicated that back in 2007 family members indicated to the facility, "He has ate through items since the time he got teeth."</p> <p>Resident #2's MDS Quarterly assessment,</p>		<p>sheets 5 x weekly for 30 days, then 3 x weekly for 30 days, then twice weekly for 30 days to validate appropriate behavior programming. They will be presented in the Monday –Friday IDT leadership meeting and any issues identified will be corrected. MDS will review any MDS submitted with the DNS and discuss changes, this will occur twice a week for 4 weeks, then weekly for 8 weeks, then as needed . SSD will discuss any further findings in related to the behavior in the behavior management meeting weekly. Review as an ongoing process of this facility. Audit results will be reviewed in monthly Quality Assurance meeting to achieve 100% compliance as determined by Quality Assurance committee.</p>		

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	<p>dated 7/16/2014, indicated "Other Behavioral Symptoms Not Directed Toward Others. NO."</p> <p>Resident #2's Care Plan, dated 6/25/14, indicated a number of care areas that identified the PICA behavior. For example, in the care area of self care, the plan indicated "self-care...Chews, eats any clothing he gets to his mouth...Change clothing as necessary as he chews on T-shirts."</p> <p>Another Care Plan area, dated 6/25/14, addressed "potential for constipation r/t [related to] PICA...Goal He will pass soft formed stool." The interventions included: "Monitor for impacted/clothing material r/t PICA...."</p> <p>Another Care Plan area, dated 6/25/14, addressed "Focus: [Resident #2] has a behavior problem r/t PICA-chews/eats any clothing he can get into his mouth. Goal: He will have no evidence of complications. Interventions...Try to keep clothing out of his mouth. Change clothing frequently if he chews on them...." The activities care area, revised 7/15/2014, indicated resident #2 must be monitored for PICA during involvement in sensory stimulation and social activities two or more times weekly.</p>			

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F000279 SS=D	<p>During an interview on 8/20/14 at 11:10 A.M., Licensed Practical Nurse (LPN) #30 indicated the resident had a behavior of chewing his shirts and ingesting threads from them.</p> <p>3.1-31(d)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>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 interview and record review, the facility failed to develop a plan of care which informed staff of a residents needs as reflected in the Minimum Data Set (MDS) assessment related to toileting (Resident #72) and Range of Motion</p>	F000279	I. Resident # 72 MDS was modified, 3 day Bowel and bladder assessment completed, toileting program implemented, care plan reviewed and revised. Resident # 21 MDS was modified, therapy screened resident and resident was placed on case load.	09/21/2014

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	<p>(Resident #21) for 2 of 28 residents reviewed for care plans.</p> <p>Findings include:</p> <p>1. During an interview on 8/19/14 at 10:50 A.M., a family member of Resident #72 indicated "numerous times I've went to (the facility) and he's been soaked. I believe he needs to be checked more frequently."</p> <p>Resident #72's record was reviewed on 8/20/14 at 2:05 P.M. An 8/12/14 MDS assessment indicated the resident was always incontinent of bowel and bladder. The MDS further indicated Resident #72 had not had a trial of a toileting program.</p> <p>Resident #72's Care Plan, dated 5/22/2014, indicated an "ADL [Activities of Daily Living] Self Care Performance deficit r/t [related to] stroke, limited mobility, impaired balance. Has potential for complications associated with urinary incontinence. Goal: He will not develop any complications associated with incontinence. Offer assistance with urinal/toileting frequently and provide incontinence care PRN [as needed]." The Care Plan further indicated "[Resident #72] will place himself on floor next to bed in praying position to "exercise his bowels. He states it makes it easier for</p>		<p>Care plan reviewed and revised.II. All residents have a potential to be affected. 100 percent bowel and bladder assessment completed on all residents. 100 percent care plan review and revision completed on all residents. Nursing will do a 100 percent head to toe assessment on all residents to identify any new or worsening issues with mobility, self care, or decrease in functioning, and therapy will screen residents if any issues identified per nursing. Care sheets updated to validate current care plan.III. SDC or designee to educate IDT and floor staff related to toileting program, notifications of change in condition, care plans and interventions. IV. DNS/designee will audit toileting program 3 times a week for 4 weeks then 2 times a week for 4 weeks then weekly for 4 weeks to monitor effectiveness or changes. These audits will be discussed in the Monday – Friday IDT leadership meeting. Any issues identified will be corrected. The facility designated representative will observe residents Monday through Friday for any decline in condition, or decrease in functioning. These issues will be relayed to the appropriate team member and corrected immediately. Audit results will be reviewed in monthly Quality Assurance meeting to achieve 100% compliance as determined</p>				

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	<p>him to have a BM [Bowel Movement]." There was no indication of a formal toileting program in Resident #72's care plan.</p> <p>During an interview on 8/20/14 at 3:23 P.M., Registered Nurse (RN) #31 indicated, "We try to take him every two hours if we can."</p> <p>During an interview on 8/20/14 at 3:48 P.M., the MDS Coordinator indicated, "He just returned recently from surgery for an amputation. The doctor stated the incontinence may be due to that (the surgery)"</p> <p>On 8/20/14 at 4:00 P.M., further review of Resident #72's MDS assessment, dated 7/29/14, indicated that prior to the surgery the resident had been assessed as being "always incontinent" of both bowel and bladder prior to the surgery.</p> <p>2. During an observation on 8/20/14 at 9:06 A.M., Resident #21's left hand was contracted in a fist. The resident was interviewed at that time and indicated she did not receive passive range of motion (PROM) by staff. The resident indicated she opened the left hand by pulling the fingers away from the palm with the right hand.</p>		by Quality Assurance committee.				

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	<p>During an interview on 8/20/14 at 10:58 A.M., CNA #50 indicated she did not provide passive range of motion to Resident #21.</p> <p>During an interview on 8/20/14 at 1:51 P.M., with the Director of Nursing (DON) present, the MDS Coordinator indicated the resident did not have a care plan for ROM. The MDS Coordinator indicated the resident was screened by occupational therapy on 7/15/14 to determine if services were needed.</p> <p>During an interview on 8/20/14 at 2:22 P.M., the OTR/L (Occupational Therapist, Registered/Licensed), indicated that all residents were recently screened for mobility. The OTR/L indicated the screening did not address the range of motion for the resident's left side (upper and lower impairment).</p> <p>During an interview on 8/20/14 at 2:24 P.M., the MDS Coordinator indicated the facility had not developed and/or implemented a care plan for range of motion for the resident.</p> <p>Resident #21's record was reviewed on 8/20/14 at 1:35 P.M. Diagnosis included, but was not limited to, osteoarthritis.</p> <p>A Minimum Data Set (MDS) assessment,</p>			

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	<p>dated 6/10/14, indicated a functional limitation in range of motion on one side for upper and lower extremity. The MDS indicated Resident #21 had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact.</p> <p>A care plan, dated 6/11/2014, indicated Resident #21 had potential for pain related to history of cerebrovascular accident (stroke). Interventions, included, but were not limited to, "Observe and report changes in usual routine, sleep patterns, decrease in functional abilities, decrease ROM (range of motion) withdrawal or resistance to care." The care plan did not indicate interventions to prevent decreased range of motion.</p> <p>A policy, dated January 7, 2012 and titled "Care Plans," indicated, "...A comprehensive care plan is developed consistent with the patients' (sic) specific conditions, risks, needs, behaviors, preferences and with standards of practice including measurable objectives, interventions/services, and timetables to meet the patient's needs as identified in the patient's assessment or as identified in relation to the patient's response to the interventions or changes in the patient's condition...."</p>			

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F000280 SS=D	<p>3.1-35(a)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, interview and record review, the facility failed to revise the care plan for 2 of 28 residents whose care plans were reviewed. (Resident #120 & #140)</p> <p>Findings include:</p> <p>1. Resident # 112 expressed concern with a wandering resident (identified by him as Resident # 120) during a resident interview on 8/19/14 at 9:30 a.m.</p>	F000280	<p>I. Resident # 120 care plan was reviewed and revised per the IDT team to reflect current needs. Resident # 140 care plan was reviewed and revised to reflect current needs. An appropriate behavior management program was updated for both residents. II. All residents have a potential to be affected. 100 percent care plan audit conducted on all residents to reflect their current status per the IDT team. 100 percent audit of residents with behaviors was conducted, and appropriate management</p>	09/21/2014

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	<p>A search for Resident # 120 was begun on 8/19/14 at 2:45 p.m. Resident # 120 was observed on 8/19/14 at 3:00 p.m. sleeping in a room that was not his own in the bed by the window. His bed was located by the door in his room. CNA #20 indicated he did this all the time. Staff assisted him ambulating back into his room. He wandered out of his room again at 3:02 p.m. He wandered into room 409. He was redirected out of that room and directed back to his own room again by the staff. At 3:25 p.m. on 8/19/14, he was observed sitting on the other bed in his room.</p> <p>On 8/20/14 at 8:40 a.m., Resident # 120 was observed wandering down to the aviary lounge and then to the front lounge reception area.</p> <p>On 8/20/14 at 9:26 a.m., Resident #120 was again found in room 411 fiddling with the door. He then wandered back to his room.</p> <p>The resident was observed during the day of 8/21/14. He slept the whole day.</p> <p>The clinical record for Resident # 120 was reviewed on 8/20/14 at 9:00 a.m. His diagnoses included, but were not limited to: Bipolar, anxiety, depression, alcoholic liver disease and liver cancer.</p>		<p>implemented. Care sheets updated. New care plans placed in ADL binder for staff accessibility. III. SDC or designee to educate IDT and floor staff on care plans, revision of care plans and interventions. SDC to educate on the behavior management program. Iv. IDT team will audit, update and revise care plans Monday – Friday during the IDT leadership meeting for any new issues. Care plans will be updated quarterly per schedule, or during any care plan meeting as scheduled. SSD or designee will audit the behavior management program 5 x weekly for 30 days, then 3 x weekly for 30 days, then twice weekly for 30 days, any issues identified will be discussed daily during the IDT leadership meeting and will be corrected immediately. Audit results will be reviewed in monthly Quality Assurance meeting to achieve 100% compliance as determined by Quality Assurance committee. The facility is asking for a desk review for this citation.</p>		

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	<p>The resident was receiving Risperdal (an antipsychotic), lithium (an antimanic), Ativan (an antianxiety), and Lexapro (an antidepressant) medications on a daily basis. A quarterly Minimum Data Set assessment, dated 7/18/14, indicated the resident had no cognitive impairment.</p> <p>The Medication Administration Record was reviewed for June, July, and August, 2014. There was no indication of the resident being tracked for the wandering behavior.</p> <p>During an interview on 8/20/14 at 10:00 a.m., RN # 21 indicated the resident was not being tracked for wandering behaviors.</p> <p>A care plan, dated 7/20/14, indicated the following: problem of elopement risks/ wandering behavior. Interventions included: 15 min (minute) checks prn (as needed); assess resident for therapeutic work - work order - idt (Interdisciplinary team) to assess & evaluate, other options if not interested in this, tokens for pay; praise, report difficulties; infection control; supervise and train; work with dept heads for jobs; redirect from inappropriate areas; engage in diversional activity; evaluate need for additional supervision and obtain order for procedure; 1:1 with staff prn; provide</p>			

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	<p>structured activities - toileting, walking inside and outside, reorientation strategies, including signs, pictures, and memory boxes; therapy to evaluate for cognitive therapy; wander alert.</p> <p>A care plan, dated 7/20/14, indicated the problem of activities had the following interventions identified: provide 1:1 intervention during activities as needed; keep instructions easy with one step processes; allow resident simple choices; provide cues and modeling for activities that require complexity as resident was easily confused; explain activity, location and time; assure resident of abilities; assist to activity if needed; monitor resident for signs of anxiety/agitation or physical discomfort during activities; assist to nursing staff or calmer environment as needed if resident wanders or becomes agitated during activities; redirect, reapproach, invite, encourage and assist as needed to activities of choice, interest as tolerated by the resident, monitor resident for behaviors during groups i.e. touching or reaching for other people's food; remind resident of contamination concern; offer personal snacks; gently redirect or assist to calmer environment; offer (Resident's name) food and/or drinks as a diversion or intervention when agitated; offer resident resources and opportunities</p>			

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	<p>appropriate for their age, whatever they may be, transportation to stores, encouraging visits with peers; providing appropriate supplies r/t young age - movies, music, reading materials; provide activity calendar in room; resident to be offered independent supplies and appropriate relating to their interest; inform of newspaper and daily chronicle availability in activity room; respect wishes to decline invitations when rest/activities leisure type are preferred; visit and monitor resident weekly for need of comfort measures; if needed, offer resident comfort measure pleasant music, sensory stimulation, and verbalization.</p> <p>During an interview on 8/20/14 at 10:40 a.m., RN # 21 was asked about the resident's therapeutic work program. She indicated she would have to ask someone.</p> <p>The Director of Nursing and the Activities Director were interviewed on 8/20/14 at 10:45 a.m. The Activities Director indicated there had not been a therapeutic work program established for the resident. She provided a copy of the resident's activities attendance calendar. The Director of Nursing indicated the resident had been difficult to manage. She indicated he had gone from very</p>			

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	<p>active to total bedrest, then up ambulating the next day. She indicated he was difficult to anticipate when it came to meeting his needs.</p> <p>The resident had been readmitted to the facility on 8/5/14 from an inpatient psychiatric facility. The attendance calendar indicated the resident had been involved in eight activities during the month of August from 8/5/14, after the readmission, through 8/19/14. On 8/6/14, "wrote work order, he said 'maybe later'." On 8/7/14, "res sleeping - declined work." On 8/11/14, 20 minutes "1:1 visit: took res soft drink very pleasant." On 8/13/14, 10 minutes "bake sale: res had cake." On 8/14/14, one hour "Res enjoyed music with Steve." On 8/15/14, 10 minutes "social visit invited to Country Sounds res declined." On 8/18/14, one hour "res down for coffee, newspaper, and conversation." On 8/19/14, 20 minutes "res had hotdog and soft drink."</p> <p>Review of the behavior reports indicated the resident had been found outside the building on 7/25/14 and was placed on 1:1 with staff until he had been discharged on 7/27/14 at 4:00 p.m. to an inpatient psychiatric facility for elopement. He had been readmitted to the facility on 8/5/14. There were no</p>			

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	<p>behavior notes for the resident wandering into other resident rooms uninvited.</p> <p>CNA # 1 was interviewed on 8/20/14 at 2:10 p.m. She indicated she worked the 2-10 shift. She also indicated Resident # 120 wandered daily into other resident rooms. She indicated the resident was redirected when he wandered. She knew he liked ice cream sandwiches and coke. She also indicated staff may take him outside if they had time.</p> <p>There was no indication the care plan had been revised to address the wandering behavior as it occurred daily.</p> <p>2. The record for Resident #140 was reviewed on 8/20/14 at 1:50 p.m. The resident's diagnoses included, but were not limited to, osteoarthritis, abnormal mental status, incontinence of urine, Alzheimer's Disease, chronic back pain, and transient ischemic attacks. The resident was admitted to the facility on 7/17/14.</p> <p>Review of the Admission Orders Record, dated, 7/17/14, indicated the resident's medications included, but were not limited to haloperidol (also known as Haldol/antipsychotic medications) 1 mg (milligram) once daily at hs (bed time) for dementia.</p>			

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	<p>A Physician Order, dated 7/31/14, indicated to d/c (discontinue) Haldol 1 mg at hs.</p> <p>A Physician Order, dated 8/2/14, indicated for Haldol 1 mg po (by mouth) at hs and d/c Namenda (medications used for dementia).</p> <p>A Care Plan, dated 7/25/14, indicated a problem of potential for signs /symptoms of tardive dyskinesia (abnormal movement) due to antipsychotic medications. The interventions included, but were not limited to, monitor for signs and symptoms of tardive dyskinesia and observe for interference from abnormal body movements in self performance of activities of daily living. There were no revisions noted to the Care Plan.</p> <p>During an interview on 8/20/14 at 3:34 p.m., LPN #50 indicated she thought the Haldol was discontinued because of it sedating the resident when he was admitted. The Nurse Practitioner had stopped the Haldol due to lethargy. It was restarted due to the family's request.</p> <p>An interview was conducted, on 8/20/14 at 3:52 p.m., with the Social Service Director and the Director of Nursing (DON). The Social Service Director</p>			

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F000282 SS=E	<p>indicated the Haldol was discontinued due to no behaviors. The DON indicated it was restarted because the resident had been taking it forever at night and the resident was not sleeping.</p> <p>During an interview on 8/20/14 at 3:59 p.m., the Social Service Director indicated there were no behavior monitoring logs completed for Resident #140.</p> <p>3.1-35(d)(2)(B)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview and record review, the facility failed to ensure care was provided according to the residents' plan of care regarding fall prevention for Resident's #D, #E, and #F; restorative care for Resident #64; bowel monitoring for Resident #72 and #2; behaviors monitoring for Resident #2; assessing and monitoring non-pressure skin conditions for Resident #140; and, administration of medications for Resident #89. This deficient practice affected 8 of 28 residents reviewed for following care plans and</p>	F000282	<p>I. Resident # D, E, F unidentified. Resident # 64 restorative program was re evaluated and updated, care plan reviewed and revised. Resident # 72 had a three day bowel and bladder assessment completed, with a toileting program implemented, care plan reviewed and revised, care sheets updated. Resident # 2 , MD assessed resident for further medical management, SSD implemented behavior management program to meet residents current needs, psych to see resident on 9/19/14, staff to layer clothing, three day bowel</p>	09/21/2014	

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	<p>Physician orders.</p> <p>Findings include:</p> <p>1. Resident #D's record was reviewed on 8/20/14 at 11:15 a.m. The Minimum Data Set (MDS) assessment, dated 7/31/14, indicated Resident #D had cognitive impairment, and needed the limited assistance of one person for transfers and walking in the room. The resident needed the extensive assistance of one person for walking in the corridor. The resident's balance for all transitions and walking was assessed as not steady and the resident was only able to stabilize with human assistance. These were the same assessments as found on the 5/5/14 quarterly MDS assessment.</p> <p>The care plan indicated the resident was at risk for falls related to unsteady gait, poor balance, poor communication/comprehension, and dementia. The goal for this problem was for the resident to have no significant injuries through the next review. The interventions for the problem of falls was to ensure proper footwear when out of bed and encourage gripper socks when not in shoes, non-skid strips in the residents bathroom for safety, and to place a pressure sensitive alarm on the bed to alert staff of attempts to transfer</p>		<p>and bladder assessment complete with toileting program put into place, care sheets updated. Resident # 89, MD and family aware of error, no new orders. Resident # 140 IR completed on area to hand, skin sheets and treatment completed. Notifications made. II. All residents have a potential to be affected. 100 percent care plan audit conducted on all residents to reflect their current status per the IDT team. 100 percent audit of residents with behaviors was conducted, and appropriate management implemented. 100 percent skin sweep completed, with skin sheets completed if needed and care plans updated, 100 percent fall care plans updated to revise current interventions to match residents needs. 100 percent audit of the restorative program conducted with interventions as needed to fit the residents program. 100 percent audit of the MARS and TARS completed for the past 3 months to ensure no other error has occurred. Care sheets updated. New care plans placed in ADL binder for staff accessibility. III. SDC or designee to educate IDT and floor staff on care plans, revision of care plans and interventions. SDC or designee to educate Floor Staff on appropriate restorative documentation as well as signing out medication appropriately. SDC or designee to educate</p>				

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	<p>without assistance.</p> <p>Physician's orders included: 5/18/14 Check resident for proper footwear while out of bed related to recent fall.</p> <p>5/24/14 Resident to wear gripper socks while in bed.</p> <p>6/30/14 Gripper sock on at bedtime and while in bed.</p> <p>7/18/14 Non skid strips next to bed for safety.</p> <p>8/9/14 Have non skid strips placed in resident bathroom for safety.</p> <p>The record indicated the resident had falls on 4/18/14, 5/24/14, 6/30/14, 7/18/14 and 8/9/14. The 8/9/14 fall resulted in a fractured hip.</p> <p>Observation of the resident in her room in bed, on 8/20/14 at 11:20 a.m., indicated she did not have gripper socks on her feet. The socks were plain white. Interview with CNA #1 at 11:24 a.m., indicated she did not know the resident was to have gripper socks on when in bed. The assignment sheet was provided at that time and did not indicate the resident was to wear gripper socks.</p>		<p>Floor Staff on fall and skin policy. SDC or designee to educate staff on the behavior management program. Iv. IDT team will audit, update and revise care plans Monday - Friday during the IDT leadership meeting for any new issues including any new falls or skin issues. Care plans will be updated quarterly per schedule, or during any care plan meeting as scheduled. SSD will audit the behavior management program 5 x weekly for 30 days, then 3 x weekly for 30 days, then twice weekly for 30 days any issues identified will be discussed Monday – Friday during the IDT leadership meeting. Any issues identified will be corrected immediately. DNS/Designee will audit MARS/ TARS 5 x weekly for 30 days, then 3 x weekly for 30 days, then twice weekly for 30 days to ensure all medications have been given. MDS or designee will audit ADL books, MAR and TAR 5 x weekly for 30 days, then 3 x weekly for 30 days, then twice weekly for 30 days to validate appropriate documentation is available for bowel monitoring. Audit results will be reviewed in monthly Quality Assurance meeting to achieve 100% compliance as determined by Quality Assurance committee. Facility is asking for a desk review for this citation.</p>		

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	<p>Observation with LPN #3 in the resident's bathroom, on 8/20/14 at 11:20 a.m., indicated there were no non-skid strips on the floor in front of the toilet. The LPN indicated she would notify maintenance to apply the strips.</p> <p>2. Resident #E's clinical record was reviewed on 8/20/14 at 3 p.m. The MDS assessment, dated 2/18/14, indicated Resident #E had cognitive impairment, needed the extensive assistance of one for transfer and toileting, and did not walk.</p> <p>The most recent quarterly MDS assessment, dated 6/2/14, indicated the resident needed the extensive assistance of one for bed mobility, transfers, toileting and personal hygiene. The resident required limited assistance of one for ambulation in room, but extensive assistance of one for ambulation in the corridor. The resident was assessed as having difficulty with balance in all areas of transitions and walking, was not steady and only able to stabilize with human assist.</p> <p>The care plan identified the resident's risk for falls and noted impaired vision due to glaucoma. The intervention was to ensure glasses were washed and clean prior to application. The goal for this</p>			

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	<p>problem of falls was for the resident to not sustain serious injury. "[Resident E] is at risk for falls r/t [related to] vision problems, gait/balance problems, incontinence, diminished safety awareness, history of falls, psychoactive drug use. Often walks w/o [without] shoes and walker and will trip over her own feet, refusal to wear shoes or use walker at times."</p> <p>"7/11/2014-transfers independently even when unsteady-refuses to ask for or accept assistance." The interventions included:</p> <p>"Anticipate and meet needs 5/6/14."</p> <p>"Be sure the call light is within reach and encourage to use it for assistance as needed."</p> <p>"bed alarm"</p> <p>"Encourage to use gripper socks when not in shoes."</p> <p>Encourage/remind to use walker when ambulating. If refuses to use walker notify nurse and monitor closely for safety 6/3/14."</p> <p>"Follow facility fall policy."</p> <p>"She needs to be in the falling star program. 5/6/14"</p> <p>"Ensure that she is wearing appropriate footwear or gripper socks. Encourage to wear 1 or the other."</p> <p>Observation of Resident #E, on 8/20/14 at 11:34 a.m., with CNA 3# indicated the</p>			

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	<p>resident was in bed in her room and had no socks on her feet. She was barefooted. The CNA provided the assignment sheet which failed to include the intervention of gripper socks when in bed.</p> <p>Interview with CNA #1, on 8/20/14 at 11:24 a.m., indicated the resident had glasses but did not wear them. Interview with the Social Service Director, on 8/22/14 at 10 a.m., indicated the resident's daughter had taken the glasses home. There was no intervention for the resident's loss of vision besides having her glasses in place.</p> <p>During lunch observation, on 8/19/14 at 11:50 a.m., the right arm of the wheel chair Resident #E sat in had a black arm rest that was unattached at the place where the residents hand rested. The black plastic piece swung sideways on the chair. CNA #4 noted the broken w/c (wheel chair) arm.</p> <p>Observation on 8/21/14 at 3 p.m., indicated the resident sat in the hallway in her w/c. Two CNA's were with the resident. The right arm to the w/c was off to the side and only attached at the back. This appeared the same as it was on 8/19/14. Neither CNA were aware if the broken chair arm had been reported</p>			

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	<p>so it could be fixed.</p> <p>3. Resident #64's clinical record was reviewed on 8/20/14 at 9:40 a.m. The 7/23/14, PT(Physical Therapy)-Therapist Progress & Discharge Summary for Resident #64 included, "The patient requires 2-Wheeled Walker and min [minimal] assist [25% assist]/CGA [Contact Guard Assist] for safe ambulation for 125 feet..." For gait training pt [patient] is able to ambulate with CGA holding hand rail for 50 ft, but using FWW [Front Wheeled Walker] pt is able to ambulate longer distances and quality of gait is better."</p> <p>Interview with the Program Director for Therapy, on 8/20/14 at 10:20 a.m., indicated upon discharge from skilled therapy, a restorative plan was given to the restorative nurse, LPN #8. The nurse provided oversight for the restorative program. LPN #8 provided Resident #64's Restorative Nursing Care Referral. The referral, dated 7/14/14, instructed nursing staff to ambulate Resident #64 for 60 - 80 feet with a front wheeled walker with minimal contact guard assist and a wheel chair pushed behind for safety and active range of motion to the bilateral lower extremities for 15 repetitions. This was to be completed one to two times a day, seven times a</p>						

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	<p>week, for 12 weeks.</p> <p>Observation of Restorative Aide (RA) #2 on 8/21/14 at 2:30 p.m., indicated the only restorative care provided for Resident #64 was ROM (Range of Motion) of the upper extremities. Interview with RA #2 at the time indicated she only completed ROM of the upper extremities and cueing during meals.</p> <p>Review of the Restorative Nursing Program Flow Sheet indicated there were two areas of care to be provided twice daily starting 7/22/14. The two areas were: Verbal/tactile cues to initiate and complete self feeding and Active range of motion to bilateral upper extremities. The documentation indicated neither were completed twice a day seven days a week from 7/25/14 through 8/20/14. Interview with the MDS nurse at the time indicated the other restorative aide had been on vacation and there was no staff to complete her assignment during that time.</p> <p>Interview with LPN #8, on 8/21/14 at 2:50 p.m., indicated he had no answer as to why the resident had not received ambulation or range of motion to the lower extremities as indicated on the referral form.</p>						

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	<p>Interview with CNA #4, on 8/22/14 at 9:45 a.m., indicated she provided care for Resident #64. She was assigned to his care that day and ambulating the resident was not in his plan of care.</p> <p>4. Resident #72's record was reviewed on 8/20/14 at 2:05 p.m. An 8/12/14 MDS assessment indicated the resident was always incontinent of bowel and bladder.</p> <p>Resident #72's Care Plan, dated 5/22/2014, indicated an "ADL [Activities of Daily Living] Self Care Performance deficit r/t [related to] stroke, limited mobility, impaired balance. Has potential for complications associated with urinary incontinence. Goal: He will not develop any complications associated with incontinence. Offer assistance with urinal/toileting frequently and provide incontinence care PRN [as needed]." The Care Plan further indicated "[Resident #72] will place himself on floor next to bed in praying position to "exercise his bowels. He states it makes it easier for him to have a BM [Bowel Movement]." The Care Plan further indicated "Potential for constipation r/t decreased mobility. Goal: He will pass soft formed stool through review date. Record bowel movement pattern each day. Describe</p>			

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	<p>amount, color and consistency."</p> <p>Review of Resident #72's August 2014 Flow Sheet Record indicated they were only recording the frequency of bowel movements and the size, but not the consistency or color.</p> <p>Interview with Registered Nurse (RN) #31, on 8/20/14 at 3:23 p.m., indicated the resident was incontinent and they only charted the frequency and size per shift.</p> <p>5. During observation, on 8/19/14 at 2:40 p.m., Resident #2 was laying flat in low bed wearing no shirt. On 8/20/14 8:20 a.m., Resident #2 was up in his wheelchair sitting in his room in front of a television. He was wearing a T-shirt with a large hole in front. At 10:25 a.m., he was still sitting in front of the television, chewing on the same shirt, however the hole had gotten larger. Another observation, on 8/20/14 at 11:00 a.m., found him still sitting in his room in his wheelchair unmonitored. The same shirt now showed his bare chest all the way down. The only part of the t-shirt still attached was the collar around his neck. At 11:30 a.m. on 8/20/14, Resident #2 was transported to the Social Dining room still wearing the same shirt, with his chest exposed. While in the dining</p>			

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	<p>area, while waiting for his food, Resident #2 was observed to take a string from the shirt and put in his mouth.</p> <p>During observation, on 8/21/14 at 8:40 a.m., Resident #2 was sitting in his room in front of the television in his wheelchair. He was wearing another white T-shirt, this T-shirt had a small hole in the chest, about the size of a silver dollar.</p> <p>Resident #2's record was reviewed on 8/20/14 at 8:51 a.m. His diagnoses included, but were not limited to; cerebral palsy, seizure disorder, profound intellectual disability, Paraplegia, PICA (a behavior associated with eating non-food materials), esophageal reflux and convulsions. The resident's 7/1/14 physician's order recap indicated the diet order was regular puree texture with thin liquids. Review of Social Service related notes in the client record indicated that back in 2007 family members indicated to the facility "He has ate through items since the time he got teeth."</p> <p>Resident #2's Care Plan, dated 6/25/14, indicated "I need my caregiver to be able to assist me/perform grooming/dressing/bathing. Interventions: Totally dependent on staff...for all ADL's...."Change clothing</p>						

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	<p>as necessary as he chews on T-shirts."</p> <p>Another Care Plan area, dated 6/25/14, addressed "potential for constipation r/t (related to) PICA...Goal He will pass soft formed stool. Interventions: "Monitor for impacted/clothing material r/t PICA, Follow facility bowel protocol for bowel management, Record bowel movement patterns each day Describe amount color and consistency."</p> <p>A 6/25/14 Care Plan indicated "Focus: [Resident #2] has a behavior problem r/t PICA-chews/eats any clothing he can get into his mouth. Goal: He will have no evidence of complications. Interventions...."Try to keep clothing out of his mouth." "Change clothing frequently if he chews on them."</p> <p>During interview with Licensed Practical Nurse (LPN) #30, on 8/20/14 at 11:10 a.m., regarding what staff were to be doing when PICA was observed she stated, "we change his shirt before he comes out of his room. The CNA's monitor for bowel movement and record on flow sheet." However, during the 8/20/14 observation at 11:30 a.m., Resident #2 was transported to the social dining room still wearing the same shirt that had been opened exposing his entire chest. While in the dining area, while</p>			

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	<p>waiting for his food, Resident #2 was observed to take a string from the shirt and put in his mouth. There were two CNA's in the room assisting others however no redirection was given.</p> <p>In addition to the above care plan intervention not implemented, review of Resident #2's August 2014 Flow Sheet Record indicating the facility only documented the number of bowel movements and size each shift. There was no record of consistency or color as documented in the care plan.</p> <p>6. The record for Resident #89 was reviewed on 8/20/14 at 9:00 a.m. The resident's diagnoses included, but were not limited to allergic rhinitis, reflux, cardiomegaly, hypothyroidism, congestive heart failure, atrial fibrillation, and pace maker.</p> <p>Review of the Physician Order Statement (POS) for August 2014, indicated the resident was to received Coumadin 3 milligrams (mg) on Tuesdays, Thursdays, and Saturdays. The resident was to receive Coumadin 2.5 mg on Monday, Wednesday, Friday, and Sunday.</p> <p>A Physician's order, dated 7/8/14 at 12:15 p.m., indicated Coumadin 3 mg daily until antibiotics were completed. Hold routine dose of Coumadin and resume on</p>			

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	<p>7/13/14.</p> <p>Review of the Medication Administration Record (MAR) for July 2014, indicated Coumadin 3 mg was held on 7/8, 7/10 and 7/12/14. Coumadin 2.5 mg was held on 7/9 and 7/11/14. Hand written on the MAR was Coumadin 3 mg PO (by mouth) daily until completed antibiotic which was signed out on 7/8/14. There were no other signatures on the MAR from 7/9 thru 7/12/14 to indicate the Coumadin 3 mg had been given to Resident #89.</p> <p>A care plan for a problem of risk for abnormal bleeding due to use of anticoagulants was initiated on 4/19/14. The interventions included, but were not limited to, administer anticoagulants as currently prescribed by the physician, administer medications as ordered, and monitor effectiveness and for side effects.</p> <p>Interview on 8/20/14 at 10:59 a.m. with RN #51, indicated Resident #89's Coumadin was held on 7/9 to 7/12/14 and it was not given. She indicated there was another order for Coumadin 3 mg daily until the antibiotics were complete. She further indicated the Coumadin 3 mg was not given on 7/9 thru 7/12/14.</p> <p>Interview with the ADON (Assistant</p>			

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	<p>Director of Nursing) on 8/20/14 at 4:08 p.m., indicated she had called all of the nurses who took care of Resident #89 on 7/9 to 7/12/14. She indicated all of the nursed had indicated they had given the resident her dose of Coumadin. She further indicated she was having all of the nurses sign a statement they had given the resident the Coumadin dose.</p> <p>7. On 8/18/14 at 10:36 a.m., Resident #140 was observed with a scratch to the top of his left hand that had a dark brown dried scab. At this time the resident's significant other indicated they did not know how it had happened but it was thought that it occurred during the night.</p> <p>On 8/19/14 at 3:11 p.m., the resident was observed in a high back wheelchair with an alarm to the wheelchair. He was visiting with his family. He had a dark dried scab to the top of his left hand.</p> <p>On 8/20/14 at 8:33 a.m., the resident was observed sitting in his recliner in this room. He was rocking in the recliner trying to get up. There was a dark brown scab observed on the top of his left hand.</p> <p>The record for Resident #140 was reviewed on 8/20/14 at 1:50 p.m. The resident's diagnoses included, but were not limited to, osteoarthritis, abnormal</p>			

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	<p>mental status, incontinence of urine, Alzheimer's Disease, chronic back pain, and transient ischemic attacks. The resident was admitted to the facility on 7/17/14.</p> <p>The Patient Nursing Assessment Part 1, dated 7/17/14, indicated, the resident's skin was normal and free from open areas. The skin was warm, dry, and intact.</p> <p>A Skin Impairment Assessment, dated, 7/18/14, indicated the resident was free of any areas of impairment.</p> <p>A Skin Impairment Assessment, dated 7/19/14, indicated the resident had a small bruise to the left wrist which was on old IV (intravenous) site.</p> <p>A Skin Assessment, dated 7/20/14, indicated no areas.</p> <p>A Weekly Skin Assessment, dated 7/24/14, indicated no new concerns.</p> <p>A Weekly Skin Assessment, dated 8/8/14, indicated no new concerns.</p> <p>A Weekly Skin Assessment, dated 8/15/15, indicated no noted skin issues.</p> <p>A Weekly Skin Assessment, dated</p>			

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	<p>8/17/14, indicated no new skin issues. No skin issues noted.</p> <p>Resident #140's progress note, from 7/17/14 to 8/20/14, indicated no assessment or follow up of the area to the resident's left hand.</p> <p>A Care Plan, initiated on 7/18/14, indicated an issue of potential for skin/issues integrity related to incontinence. The interventions included, but were not limited to, apply skin care products as ordered, assess skin weekly and as needed, and check and change frequently for incontinence care.</p> <p>The Treatment Administration Record for July 2014 and August 2014, indicated there were no treatments for the resident's left hand.</p> <p>The Physician's Orders for July 2014 and August 2014, indicated there were no orders for a treatment to the scabbed area on the resident's left hand.</p> <p>Interview with LPN #50, on 8/20/14 at 3:34 p.m., indicated, if she remembered correctly she had received report one night about the area to the resident's left hand and she thought they were to monitor the area.</p>						

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	<p>Interview with LPN #50, on 8/20/14 at 3:57 p.m., indicated if any area was found it should be assess and report called to the Physician to obtain an order. The area should be documented on every shift for 72 hours. At this time the DON indicated there was no incident report or non-pressure skin form for the area to the resident's left hand.</p> <p>8. On 8/21/14 at 10:23 a.m., the Resident #F was observed sitting in the dining room at a table eating a snack. The resident was wearing shoes with thin white socks.</p> <p>On 8/21/14 at 10:50 a.m., the resident was observe up in the dining room sitting at a table for activities. The resident was wearing shoes on her feet with thin white socks.</p> <p>On 8/21/14 at 1:39 p.m., the resident was observed in the dining room sitting at a table, playing with a flower. The resident was wearing shoes and thin white socks.</p> <p>The resident's record was reviewed on 8/21/14 at 8:44 a.m. The resident's diagnoses included, but were not limited to, constipation, anemia, CHF, psychosis, dementia with behaviors, anxiety, Alzheimer's Disease, osteoarthritis, and insomnia.</p>			

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	<p>The Physician Order Statement (POS) for 7/2014 to 8/2014, indicated gripper socks at all times.</p> <p>A Physician order, dated 6/14/14 at 5:45 a.m., indicated remove shoes while in bed and keep gripper socks on at all times. Monitor bruise and hematoma on forehead till healed every shift.</p> <p>A Care Plan, initiated on 4/21/14 and updated on 5/7/14, indicated a problem of risk for falls related to confusion, poor communication/comprehension, gait/balance problems, incontinence, fall risk assessment score, diminished safety awareness, diagnosis of dementia, history of falls, and psychotic drug use. The intervention included, but were not limited to, transfer with one assist, anticipate and meet the resident's needs, be sure call light in reach, bed against the wall, encourage to take off shoes while in bed, ensure resident wearing appropriate footwear and shoes to be tied, evaluate resident's surroundings when ambulating to avoid trip hazards, alarm in place to bed, frequent checks on resident while in bed to make sure resident not tangled up in sheet, gripper socks on at all times and shoes on while ambulating, non skid socks or shoes on at all times.</p>			

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F000309 SS=D	<p>Interview with LPN #51, on 8/21/14 at 1:46 p.m., indicated the resident had on regular socks. She would need to see the bottom of the resident's sock to be sure, however the resident refused to allow the nurse to take off her shoes.</p> <p>Interview with CNA #52, on 8/21/14 at 2:05 p.m., indicated the resident had on regular socks and just gripper socks were used when the resident was in bed. She provided her Care Report Sheet which indicated the resident was to be encouraged to not wear shoes while in bed and to wear non-skid socks. It also indicated non-skid socks.</p> <p>Interview with the SDC (Staff Development Coordinator) on 8/21/14 at 3:59 p.m. indicated in regards to the resident having on gripper socks at all times the intervention needed to be worded better.</p> <p>This Federal tag relates to Complaint IN00153896.</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest</p>						

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	<p>practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure bruising and an abrasion were identified and monitored through healing for 2 of 3 residents reviewed for skin-related issues in a sample of 4. (Residents #D and #140) The facility also failed to ensure maladaptive behavior of wandering was addressed for 1 of 3 residents with maladaptive behaviors with a diagnosis of dementia (Resident # 120)</p> <p>Findings include:</p> <p>1. Observation on 8/19/14 at 10:26 a.m., indicated Resident #D had dark purple bruising to the top of both hands. On 8/20/14 at 8:27 a.m., the resident wore short sleeves and light purple bruising was observed covering the entire right elbow area.</p> <p>Interview with LPN #3, on 8/20/14 at 8:30 a.m., indicated the bruises were from a fall. The bruises were being monitored and documentation would be found in the electronic medical record.</p> <p>Review of the care plan on 8/20/14 at 9 a.m. indicated there was nothing regarding the resident's bruises. Review</p>	F000309	<p>I. Resident # D is unidentified. Resident #120 is being moved to the Reflections unit for more appropriate activity programming, work program D/C'd as resident would not participate, care plan reviewed and revised to meet current activities related to wandering. II. All residents have a potential to be affected. 100 percent care plan audit conducted on all residents to reflect their current status per the IDT team. 100 percent skin sweep conducted. Skin sheets completed and care plans updated. 100 percent wandering assessments completed on all residents, appropriate behavioral management programming implemented and activity programming and plan of care reviewed and revised for the identified residents. Care sheets updated. New care plans placed in ADL binder for staff accessibility. III. SDC or designee to educate IDT and floor staff on care plans, revision of care plans and interventions. SDC or designee to educate floor staff skin policy. SDC or designee to educate staff on the behavior management program. Iv. IDT team will audit, update and revise care plans during the IDT leadership meeting Monday through Friday for any new</p>	09/21/2014

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	<p>of the electronic medical record indicated there was one entry on 8/20/14, "Bruises on arms."</p> <p>Interview with the ADON (Assistant Director of Nursing), on 8/21/14 at 10:26 a.m., indicated she could not find any documentation regarding an assessment of bruises on the hands and elbow. She looked at the admission assessment, dated 8/13/2014, and it had nothing about bruises on hands or elbow.</p> <p>2. Resident #112 expressed concern with a wandering resident (identified by him as Resident #120) during a resident interview on 8/19/14 at 9:30 a.m. Resident #112 was concerned that Resident # 120 wandered into other resident rooms daily and the staff had not addressed the concern. Resident #112 indicated he believed the resident belonged on a dementia unit to protect him and other residents.</p> <p>A search for Resident #120 was begun on 8/19/14 at 2:45 p.m. in his room. The resident was not there. Resident # 120 was observed on 8/19/14 at 3:00 p.m. sleeping in a room that was not his in the bed by the window. His bed was located by the door in his room. CNA #20 indicated he did this all the time. Staff assisted him ambulating back into his</p>		<p>issues. Care plans will be updated quarterly per schedule, or during any care plan meeting as scheduled. SSD or designee will audit the behavior management program 5 x weekly for 30 days, then 3 x weekly for 30 days, then twice weekly for 30 days and any issues identified will be discussed and corrected immediately. Audit results will be reviewed in monthly Quality Assurance meeting to achieve 100% compliance as determined by Quality Assurance committee. Facility is asking for a desk review for this citation.</p>	

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	<p>room. He wandered out of his room again at 3:02 p.m. He wandered into room 409. He was redirected out of that room and directed back to his own room again by the staff. At 3:25 p.m. on 8/19/14, he was observed sitting on the other bed in his room.</p> <p>On 8/20/14 at 8:40 a.m., Resident #120 was observed wandering down to the aviary lounge and then to the front lounge reception area.</p> <p>On 8/20/14 at 9:26 a.m., Resident #120 was again found in room 411 fiddling with the door. He then wandered back to his room.</p> <p>The resident was observed during the day of 8/21/14. He slept the whole day.</p> <p>The clinical record for Resident # 120 was reviewed on 8/20/14 at 9:00 a.m. His diagnoses included, but were not limited to: Bipolar, anxiety, depression, alcoholic liver disease and liver cancer, and dementia. The resident was receiving Risperdal (an antipsychotic), lithium (an antimanic), Ativan (an antianxiety) and Lexapro (an antidepressant) on a daily basis. A quarterly Minimum Data Set assessment, dated 7/18/14, indicated the resident had no cognitive impairment.</p>			

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	<p>The Medication Administration Record was reviewed for June, July, and August, 2014. There was no indication of the resident being tracked for the wandering behavior. RN # 21 indicated the resident was not being tracked for wandering behaviors during an interview on 8/20/14 at 10:00 a.m.</p> <p>The care plan, dated 7/20/14, indicated the following: problem of elopement risks/ wandering behavior. Interventions included: 15 min checks prn; assess resident for therapeutic work - work order - idt (Interdisciplinary Team) to assess & evaluate, other options if not interested in this, tokens for pay; praise, report difficulties; infection control; supervise and train; work with dept heads for jobs; redirect from inappropriate areas; engage in diversion activity; evaluate need for additional supervision and obtain order for procedure; 1:1 (one to one) with staff prn (as needed); provide structured activities - toileting, walking inside and outside, reorientation strategies, including signs, pictures, and memory boxes; therapy to evaluate for cognitive therapy; wander alert.</p> <p>A care plan, dated 7/20/14. indicated the problem of activities had the following interventions identified: provide 1:1</p>			

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	intervention during activities as needed; keep instructions easy with one step processes; allow resident simple choices; provide cues and modeling for activities that require complexity as resident was easily confused; explain activity, location and time; assure resident of abilities; assist to activity if needed; monitor resident for signs of anxiety/agitation or physical discomfort during activities; assist to nursing staff or calmer environment as needed if resident wanders or becomes agitated during activities; redirect, reapproach, invite, encourage and assist as needed to activities of choice, interest as tolerated by the resident, monitor resident for behaviors during groups i.e. touching or reaching for other people's food; remind resident of contamination concern; offer personal snacks; gently redirect or assist to calmer environment; offer (Resident's name) food and/or drinks as a diversion or intervention when agitated; offer resident resources and opportunities appropriate for their age, whatever they may be, transportation to stores, encouraging visits with peers; providing appropriate supplies r/t (related to) young age - movies, music, reading materials; provide activity calendar in room; resident to be offered independent supplies and appropriate relating to their interest; inform of newspaper and daily			

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	<p>chronicle availability in activity room; respect wishes to decline invitations when rest/activities leisure type are preferred; visit and monitor resident weekly for need of comfort measures; if needed, offer resident comfort measure pleasant music, sensory stimulation, and verbalization.</p> <p>On 8/20/14 at 10:40 a.m., RN # 21 was asked about the resident's therapeutic work program. She indicated she would have to ask someone.</p> <p>The Director of Nursing (DON) and the Activities Director were interviewed on 8/20/14 at 10:45 a.m. The Activities Director indicated there had not been a therapeutic work program established for the resident. She provided a copy of the resident's activities attendance calendar. The DON indicated the resident had been difficult to manage. She indicated he had gone from very active to total bedrest, then up ambulating the next day. She indicated he was difficult to anticipate when it came to meeting his needs.</p> <p>The attendance calendar indicated the resident had been involved in eight activities during the month of August from 8/5/14 through 8/19/14. The resident had been readmitted to the facility on 8/5/14 from an inpatient</p>			

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	<p>psychiatric facility. On 8/6/14, "wrote work order, he said 'maybe later'." On 8/7/14, "res sleeping - declined work." On 8/11/14, 20 minutes "1:1 visit: took res soft drink very pleasant." On 8/13/14, 10 minutes "bake sale: res had cake." On 8/14/14, one hour "Res enjoyed music with Steve." On 8/15/14, 10 minutes "social visit invited to Country Sounds res declined." On 8/18/14, one hour "res down for coffee, newspaper, and conversation." On 8/19/14, 20 minutes "res had hotdog and soft drink."</p> <p>The "recreations/leisure patterns summary" form, dated 10/14/13, indicated: "Individual will independently choose events and leisure pursuits of interest."</p> <p>The "Pleasant and meaningful activities" choice form, dated 10/14/13 and updated 12/19/13, indicated: "enjoys now - alone time, animals/pets, church, eating out, family time/visiting with friends, listening to music, outdoor time and watching movies/television."</p> <p>The behavior reports indicated the resident had been found outside the building on 7/25/14 and was placed on 1:1 with staff until he had been discharged on 7/27/14 at 4:00 p.m. to an inpatient psychiatric facility for</p>			

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	<p>elopement. He had been readmitted to the facility on 8/5/14. There were no behavior notes for the resident wandering into other resident rooms uninvited.</p> <p>CNA # 1 was interviewed on 8/20/14 at 2:10 p.m. She indicated she worked the 2-10 shift. She also indicated Resident # 120 wandered daily into other resident rooms. She indicated the resident was redirected when he wandered. She knew he liked ice cream sandwiches and coke. She also indicated staff may take him outside if they had time.</p> <p>There was no indication that staff had tracked the wandering behavior, looked for a cause or precipitating factor, or tracked interventions to determine which ones worked and which were ineffective.</p> <p>3. On 8/18/14 at 10:36 a.m., Resident #140 was observed with a scratch to the top of his left hand that had a dark brown dried scab. At this time the resident's significant other indicated they were not sure how it had happened but it was thought that it occurred during the night.</p> <p>On 8/19/14 at 3:11 p.m., the resident was observed in a high back wheelchair with alarm to the wheelchair. He was visiting with his family. He had a dark dried scab to the top of his left hand.</p>			

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	<p>On 8/20/14 at 8:33 a.m., the resident was observed sitting in his recliner in this room. He was rocking in the recliner trying to get up. There was a dark brown scab observed on the top of his left hand.</p> <p>The record for Resident #140 was reviewed on 8/20/14 at 1:50 p.m. The resident's diagnoses included, but were not limited to, osteoarthritis, abnormal mental status, incontinence of urine, Alzheimer's Disease, chronic back pain, and transient ischemic attacks. The resident was admitted to the facility on 7/17/14.</p> <p>The Patient Nursing Assessment Part 1, dated 7/17/14, indicated, the resident's skin was normal and free from open areas. The skin was warm, dry, and intact.</p> <p>The Skin Impairment Assessment, dated 7/18/14, indicated the resident was free of any areas of impairment.</p> <p>The Skin Impairment Assessment, dated 7/19/14, indicated the resident had a small bruise to the left wrist which was on old IV (intravenous) site.</p> <p>The Skin Assessment, dated 7/20/14, indicated no areas.</p>				

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	<p>The Weekly Skin Assessment, dated 7/24/14, indicated no new concerns.</p> <p>The Weekly Skin Assessment, dated 8/8/14, indicated no new concerns.</p> <p>The Weekly Skin Assessment, dated 8/15/15, indicated no noted skin issues.</p> <p>The Weekly Skin Assessment, dated 8/17/14, indicated no new skin issues. No skin issues noted.</p> <p>Resident #140's progress note, from 7/17/14 to 8/20/14, indicated no assessment or follow up of the area to the resident's left hand.</p> <p>A Care Plan, initiated on 7/18/14, indicated an issue of potential for skin/issues integrity related to incontinence. The interventions included, but were not limited to, apply skin care products as ordered, assess skin weekly and as needed, and check and change frequently for incontinence care.</p> <p>The Treatment Administration Record for July 2014 and August 2014, indicated there were no treatments for the resident's left hand.</p> <p>The Physician's Orders for July 2014 and August 2014, indicated they were no</p>						

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	<p>orders for a treatment for the scabbed area on the resident's left hand.</p> <p>The prevention and treatment of Pressure Ulcers and Non-Pressure Related Wounds was provided by the DON on 8/21/14 at 8:50 a.m. The policy had a date of 2/8/14. The Policy "Pressure ulcer prevention interventions are initiated based on the Braden or Norton risk factors identified initially and ongoing. Pressure ulcers and other wound and skin related interventions are created in collaboration with the interdisciplinary team and implemented in order to identify, prevent or reduce the risk of acquiring pressure and/or non-pressure related wounds or skin issues. Treatment of existing or new wounds shall be initiated according to the principles of wound healing identified in evidenced based practice."</p> <p>Treatment Components: "1. Identification of pressure and non-pressure related wound characteristics initially, at regular intervals, as needed with changes in wound status and on date of discharge; document findings using the Bates-Jensen Wound Assessment Tool. 2. Initiate the Skin Tear Prevention and Treatment guidelines for risk patients or patients with active skin tears." "5.</p>			

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	<p>Identification of deterrents to wound healing and measures to eliminate or manage identified deterrents to healing initially and ongoing at times of designated for. 6. Treatment of of new or existing pressure and non-pressure related wounds will be initiated following the principles of wound healing." "8. Reassessment of patient characteristics if the ulcer/wound does not show signs of healing as expected despite elimination/management of etiology, adequate local wound care, and nutrition." "10. Documentation to included: a. The level of tissue destruction." "b. Wound characteristics to include tissue type, exudates amount/type, undermining/tunneling surrounding tissue appearance, odor initially and with each dressing change. c. Pain related to wound, dressing and/or dressing procedure, d. Communication with patient/family, staff, MD or other licensed providers.</p> <p>Interview with LPN #50, on 8/20/14 at 3:34 p.m., indicated, if she remembered correctly she had received report one night about the area to the resident's left hand and she thought they were to monitor the area.</p> <p>Interview with LPN #50, on 8/20/14 at 3:57 p.m., indicated if any area was</p>			

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F000311 SS=D	<p>found it should be assess and report called to the Physician to obtain an order. The area should be documented on every shift for 72 hours. At this time the DON indicated there was no incident report or non-pressure skin form for the area to the resident's left hand.</p> <p>3.1-37(a)</p> <p>483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.</p> <p>Based on observation, interview and record review, the facility failed to ensure the restorative plan of care was followed post therapy for ambulation and lower extremity range of motion exercises. This affected one of three residents reviewed for rehabilitation services. (Resident #64) The facility also failed to ensure provision of treatment and services for incontinence was provided for 1 of 2 residents (#72) who triggered for Activities of Daily Living.</p> <p>Findings include:</p> <p>1. Resident #64's clinical record was reviewed on 8/20/14 at 9:40 a.m. The 7/23/14, PT (Physical Therapy) -</p>	F000311	<p>I. Resident # 64 restorative program was re evaluated and updated, care plan reviewed and revised. Resident # 72 MDS was modified, 3 day Bowel and bladder assessment completed, toileting program implemented, care plan reviewed and revised II. All residents on a restorative program are at risk. All residents on requiring a toileting program have a potential to be affected. 100 percent audit of the restorative program was conducted, interventions updated, care plan reviewed and revised, care sheets updated. 3 day bowel and bladder assessments conducted on all residents, toileting program updated, care plans reviewed and revised and care sheets updated. III. SDC or designee to educate IDT and floor</p>	09/21/2014

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	<p>Therapist Progress & Discharge Summary for Resident #64 included, "The patient requires 2-Wheeled Walker and min [minimal] assist [25% assist]/CGA [Contact Guard Assist] for safe ambulation for 125 feet...." "For gait training pt [patient] is able to ambulate with CGA holding hand rail for 50 ft, but using FWW {Front Wheeled Walker} pt is able to ambulate longer distances and quality of gait is better. "</p> <p>Interview with the Program Director for Therapy on 8/20/14 at 10:20 a.m., indicated upon discharge from skilled therapy, a restorative plan was given to the restorative nurse, LPN #8. The nurse provided oversight for the restorative program. LPN #8 provided Resident #64's Restorative Nursing Care Referral. The referral, dated 7/14/14, instructed nursing staff to ambulate Resident #64 for 60 - 80 feet with a front wheeled walker with minimal contact guard assist and a wheel chair pushed behind for safety and active range of motion to the bilateral lower extremities for 15 repetitions. This was to be completed one to two times a day, seven times a week, for 12 weeks.</p> <p>Observation of Restorative Aide (RA) #2, on 8/21/14 at 2:30 p.m., indicated the only restorative care provided for</p>		<p>staff on care plans, revision of care plans and interventions. SDC or designee to educate floor staff on restorative program and toileting programming. Iv. IDT team will audit, update and revise care plans daily during the IDT leadership meeting for any new issues, Monday through Friday, Care plans will be updated quarterly per schedule, or during any care plan meeting as scheduled. DNS/designee will audit toileting program 3 times a week for 4 weeks then 2 times a week for 4 weeks then weekly for 4 weeks to monitor effectiveness or changes. These audits will be discussed in the daily IDT leadership meeting; Any issues identified will be corrected immediately. Restorative nurse/ or designee will audit restorative books 5 x weekly for 30 days, then 3 x weekly for 30 days, then twice weekly for 30 days to validate appropriate programs are in place. Restorative nurse or designee to implement new restorative orders and educate restorative aides on the programs as orders are received. Director of Rehab and Restorative nurse to meet monthly to review and validate appropriate programming. Audit results will be reviewed in monthly Quality Assurance meeting to achieve 100% compliance as determined by Quality Assurance committee. Facility is asking for a desk review for this citation.</p>	

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	<p>Resident #64 was ROM (Range of Motion) of the upper extremities. Interview with RA#2 at the time indicated she only completed ROM of the upper extremities and cueing during meals.</p> <p>Review of the Restorative Nursing Program Flow Sheet indicated there were two areas of care to be provided twice daily starting 7/22/14. The two areas were: Verbal/tactile cues to initiate and complete self feeding and Active range of motion to bilateral upper extremities. The documentation indicated neither were completed twice a day seven days a week from 7/25/14 through 8/20/14. Interview with the MDS (Minimum Data Set assessment) nurse at the time indicated the other restorative aide had been on vacation and there was no staff to complete her assignment during that time.</p> <p>Interview with LPN #8 on 8/21/14 at 2:50 p.m. indicated he had no answer as to why the resident had not received ambulation or range of motion to the lower extremities as indicated on the referral form.</p> <p>Interview with CNA #4 on 8/22/14 at 9:45 a.m., indicated she provided care for Resident #64. She was assigned to his</p>			

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	<p>care that day and ambulating the resident was not in his plan of care.</p> <p>2. Resident #72's record was reviewed on 8/20/14 at 2:05 p.m. An 8/12/14 MDS (Minimum Data Set) assessment indicated the resident was always incontinent of bowel and bladder. The MDS further indicated resident #72 had not had a trial of a toileting program.</p> <p>Interview on 8/19/14 at 10:50 a.m., with a family member of resident #72 indicated "numerous times I've went to (the facility) and he's been soaked. I believe he needs to be checked more frequently."</p> <p>Resident #72's Care Plan, dated 5/22/2014, indicated an "ADL [Activities of Daily Living] Self Care Performance deficit r/t [related to] stroke, limited mobility, impaired balance. Has potential for complications associated with urinary incontinence. Goal: He will not develop any complications associated with incontinence. Offer assistance with urinal/toileting frequently and provide incontinence care PRN [as needed]." The Care Plan further indicated "[Resident #72] will place himself on floor next to bed in praying position to "exercise his bowels. He states it makes it easier for him to have a BM [bowel movement]."</p>			
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F000318 SS=D	<p>There was no indication of a formal toileting program in Resident #72's care plan.</p> <p>Interview with Registered Nurse (RN) #31, on 8/20/14 at 3:23 p.m., indicated "We try to take him every every two hours if we can." Review at the time of the interview of Resident #72's August 2014 Flow Sheet Record indicated he had been incontinent multiple times/day each day since his return from surgery on August 6, 2014. Interview with the MDS coordinator at 3:48 p.m., indicated the resident's incontinence may have been attributable to his recent surgery. However, further review of Resident #72's MDS, on 8/20/14 at 4:00 p.m., indicated that prior to the surgery, an assessment dated 7/29/14, indicated the resident as being "always incontinent" of both bowel and bladder prior to the surgery. There was no further evidence in the record that the resident had been provided with a toileting program to address his incontinence.</p> <p>3.1-38(a)(2)(B) 3.1-38(a)(2)(C)</p> <p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of</p>						

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	<p>a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, interview, and record review, the facility failed to ensure a resident with limited range of motion was provided services to prevent further decrease in range of motion for 1 of 1 resident reviewed for contractures without range of motion (Resident #21).</p> <p>Findings include:</p> <p>During an observation on 8/20/14 at 9:06 a.m., Resident #21's left hand was contracted in a fist. The resident was interviewed at that time and indicated she did not receive passive range of motion (PROM) by staff. The resident indicated she opened the left hand by pulling the fingers away from the palm with the right hand.</p> <p>During an interview on 8/20/14 at 10:58 a.m., CNA #50 indicated she did not provide passive range of motion to Resident #21.</p> <p>During an interview on 8/20/14 at 1:51 p.m., with the Director of Nursing (DON) present, the MDS (Minimum Data Set assessment) Coordinator indicated the resident did not have a care plan for</p>	F000318	<p>I. Resident # 21 MDS modified, therapy screened resident now on caseload, care plan reviewed and revised. II. All residents have the potential to be affected. 100 percent head to toe assessment completed on all residents to identify if any resident is exhibiting decreased strength, if a resident is identified, therapy will screen resident. All care plans reviewed and revised. Care sheets updated. III. SDC or designee to educate IDT and floor staff on care plans, revision of care plans and interventions. SDC or designee to educate staff on resident condition change and notification. Iv. IDT team will audit, update and revise care plans daily during the IDT leadership meeting for any new issues, Monday through Friday, Care plans will be updated quarterly per schedule, or during any care plan meeting as scheduled. Restorative nurse/ or designee will audit restorative books to validate appropriate programs are in place 5 x weekly for 30 days, then 3 x weekly for 30 days, then twice weekly for 30 days. Restorative nurse or designee to implement new restorative orders and educate restorative aides on the programs as orders are received. MDS or</p>	09/21/2014

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	<p>ROM. The MDS Coordinator indicated the resident was screened by occupational therapy on 7/15/14 to determine if services were needed.</p> <p>During an interview on 8/20/14 at 2:22 p.m., the OTR/L (Occupational Therapist, Registered/Licensed), indicated that all residents were recently screened for mobility. The OTR/L indicated the screening did not address the range of motion for the resident's left side (upper and lower impairment).</p> <p>During an interview on 8/20/14 at 2:24 p.m., the MDS Coordinator indicated the facility had not developed and/or implemented a care plan for range of motion for the resident.</p> <p>Resident #21's record was reviewed on 8/20/14 at 1:35 p.m. Diagnosis included, but was not limited to, osteoarthritis.</p> <p>A Minimum Data Set (MDS) assessment, dated 6/10/14, indicated a functional limitation in range of motion on one side for upper and lower extremity. The MDS indicated Resident #21 had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact.</p> <p>A care plan, dated 6/11/2014, indicated</p>		<p>designee will audit ADL books daily 5 x weekly for 30 days, then 3 x weekly for 30 days, then twice weekly for 30 days to identify if any residents are having a change in condition, this will be discussed Monday through Friday during IDT leadership meeting and issues corrected. Director of Rehab and Restorative nurse to meet monthly to review and validate appropriate programming. Audit results will be reviewed in monthly Quality Assurance meeting to achieve 100% compliance as determined by Quality Assurance committee. Facility is asking for a desk review for this citation.</p>				

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F000323 SS=G	<p>Resident #21 had potential for pain related to history of cerebrovascular accident (stroke). Interventions, included, but were not limited to, "Observe and report changes in usual routine, sleep patterns, decrease in functional abilities, decrease ROM (range of motion) withdrawal or resistance to care." The care plan did not indicate interventions to prevent decreased range of motion.</p> <p>3.1-42(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 ensure fall risk was evaluated and interventions were in place according to an individualized plan of care for 3 of 5 residents reviewed in a sample of 8 residents who met the criteria for falls. This failure resulted in a fall with hip fracture for Resident #D. (Residents</p>	F000323	I. Resident # D, E, F are anonymousII. All residents deemed to be at risk for falls have a potential to be affected. 100 percent care plan review and revision complete per IDT. Validation and update of the care sheets complete, with the appropriate interventions in place.100 percent room observation audit of residents	09/21/2014

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	<p>#D,# E, and #F)</p> <p>Findings include:</p> <p>1. Interview with LPN #9 on 8/18/14 at 2:40 p.m., indicated Resident #D had fallen the previous week and sustained a fractured right hip.</p> <p>The clinical record was reviewed on 8/20/14 at 11:15 a.m. Diagnosis included, but was not limited to, dementia. The Minimum Data Set (MDS) assessment, dated 7/31/14, indicated the resident had cognitive impairment, and needed the limited assistance of one person for transfers and walking in the room. The resident needed the extensive assistance of one person for walking in the corridor. The resident's balance for all transitions and walking was assessed as not steady and the resident was only able to stabilize with human assistance. These were the same assessments as found on the 5/5/14 quarterly assessment.</p> <p>The care plan indicated the resident was at risk for falls related to unsteady gait, poor balance, poor communication/comprehension, and dementia. The goal for this problem was for the resident to have no significant injuries through the next review. The</p>		<p>complete to ensure fall interventions are available and in place. III. SDC or designee will educate staff policy and procedure in relation to falls, interventions, care sheets, and care plans. IV. All falls will be discussed Monday through Friday in clinical meeting. A root cause analysis will be complete with each fall. IDT will review and revise care plans daily in IDT leadership meeting, Monday through Friday. SDC or designee will educate staff on new interventions immediately, and they will be placed on the care sheet daily per DNS or designee. DNS/ designee will ensure daily that a fall risk assessment is completed with each fall to determine if any changes need to be made. IDT will write progress notes daily Monday through Friday with each fall, after determining the root cause analysis, and appropriate intervention. This will be on going. The residents facility designated representative (angel) will observe resident and rooms daily to ensure appropriate interventions are in place per care plan and care sheet. This will occur daily ongoing Monday through Friday. Audit results will be reviewed in monthly Quality Assurance meeting to achieve 100% compliance as determined by Quality Assurance committee. Facility would like to ask for a desk review for this</p>				

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	<p>interventions for the problem of falls was to ensure proper footwear when out of bed and encourage gripper socks when not in shoes, non-skid strips in the residents bathroom for safety, and to place a pressure sensitive alarm on the bed to alert staff of attempts to transfer without assist.</p> <p>Physician's orders included: 5/18/14 Check resident for proper footwear while out of bed related to recent fall.</p> <p>5/24/14 Resident to wear gripper socks while abed (in bed).</p> <p>6/30/14 Gripper sock on at bedtime and while in bed.</p> <p>7/18/14 Non skid strips next to bed for safety.</p> <p>8/9/14 Have non skid strips placed in resident bathroom for safety.</p> <p>The record indicated the resident had falls on 4/18/14, 5/24/14, 6/30/14, 7/18/14 and 8/9/14. The 8/9/14 fall resulted in a fractured hip.</p> <p>Observation of the resident in her room in bed, on 8/20/14 at 11:20 a.m., indicated she did not have gripper socks</p>		citation	

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	<p>on her feet. The socks were plain white. Interview with CNA #1 at 11:24 a.m., indicated she did not know the resident was to have gripper socks on when in bed. The assignment sheet was provided at that time and did not indicate the resident was to wear gripper socks.</p> <p>Observation with LPN #3 in the resident's bathroom on 8/20/14 at 11:20 a.m. indicated there were no non-skid strips on the floor in front of the toilet.</p> <p>Review of Fall Investigations on 8/21/14 at 8:40 a.m., indicated the facility did not use the Root Cause Analysis to document the evaluation of the fall for the underlying reasons the resident fell. For example, the Root Cause Analysis for the 8/9/14 fall included: What was missing or weak? "CP [care plan] Intervention" was written with no explanation of what care plan intervention was missing. What steps contributed to the event? "CP Intervention." with no explanation.</p> <p>"What do we do now to prevent failure at the step?" "New intervention: Res [resident] sent to ER [emergency room] and admitted, CP will be updated when readmitted to facility."</p> <p>Action Plan: Care Plan Interventions,</p>			

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	<p>"Resident sent to ER [with] later being admitted. Will update CP when resident is readmitted to facility."</p> <p>"What are the details of the event? Resident fell from w/c while attempting to transfer self into bathroom."</p> <p>"Where or when did the event(s) occur? Resident Bathroom 8/9/14 at 9:30 a.m."</p> <p>The resident had been identified as having the inability to sustain balance with transfers on the MDS assessment. The problem of the resident not having adequate supervision to prevent falls was not identified as a potential reason for the fall.</p> <p>On 7/8/14, the resident had an unwitnessed fall without injury. The resident was found in her room on the floor without shoes and attempting to put self to bed at 9:10 p.m.</p> <p>The Root Cause Analysis for this fall included:</p> <p>"What was missing or weak? CP Intervention." There was no explanation of what care plan intervention was missing.</p> <p>"What do we do now to prevent failure at the step? "Non skid strips to be placed</p>			

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	<p>next to bed for safety." "CP intervention added."</p> <p>On 6/30/14, the resident had an unwitnessed fall without injury. The resident was found beside the bed on the floor with regular socks.</p> <p>On 5/24/14, the resident had an unwitnessed fall on the floor of the bedroom when she attempted to self transfer. The invention was to assure proper footwear.</p> <p>Interview with the DON (Director of Nursing) on 8/22/14 at 10:40 a.m. indicated the falls are reviewed by the interdisciplinary team and new interventions are written for the resident. The documentation for these meeting was kept in their Quality Assurance (QA). The QA record for the 8/9/14 fall was provided by the DON and indicated, "Resident assisting self to toilet, non slip socks in place, was able to transfer self, c/o pain, sent to ER, with revision of CP to be updated when resident returns."</p> <p>2. Interview with LPN #9 on 8/18/14 at 2:50 p.m., indicated Resident #E had falls on 7/20/14, 7/28/14 and 8/2/14. Injuries were limited to skin tears and bruising.</p> <p>Clinical record review on 8/20/14 at 3</p>						

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	<p>p.m., the Minimum Data Set (MDS) assessment, dated 2/18/14, indicated the resident had cognitive impairment, needed the extensive assistance of one for transfer and toileting, and did not walk.</p> <p>The most recent quarterly MDS assessment, dated 6/2/14, indicated the resident needed the extensive assistance of one for bed mobility, transfers, toileting and personal hygiene. The resident required limited assistance of one for ambulation in room, but extensive assistance of one for ambulation in the corridor. The resident was assessed as having difficulty with balance in all areas of transitions and walking and was not steady and only able to stabilize with human assist.</p> <p>The care plan identified the resident's risk for falls and noted impaired vision due to glaucoma. The intervention was to ensure glasses were washed and clean prior to application.</p> <p>The goal for this problem of falls was for the resident to not sustain serious injury. "[Resident E] is at risk for falls r/t [related to] vision problems, gait/balance problems, incontinence, diminished safety awareness, history of falls, psychoactive drug use. Often walks w/o (without) shoes and walker and will trip over her own feet, refusal to wear shoes</p>			

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	<p>or use walker at times." "7/11/2014-transfers independently even when unsteady-refuses to ask for or accept assistance." Interventions included: "Anticipate and meet needs 5/6/14." "Be sure the call light is within reach and encourage to use it for assistance as needed." "bed alarm" "Encourage to use gripper socks when not in shoes." Encourage/remind to use walker when ambulating. If refuses to use walker notify nurse and monitor closely for safety 6/3/14." Follow facility fall policy." "She needs to be in the falling star program. 5/6/14" "Ensure that she is wearing appropriate footwear or gripper socks. Encourage to wear 1 or the other."</p> <p>Observation of Resident #E, on 8/20/14 at 11:34 a.m., with CNA 3# indicated the resident was in bed in her room and had no socks on her feet. She was barefooted. The CNA provided the assignment sheet which failed to include this intervention.</p> <p>Review of the Root Cause Analysis forms, the facility failed to look for the underlying cause of the falls. For</p>						

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	<p>example, the 8/1/14 unwitnessed fall when the resident was found between the bathroom and the bed resulted in the new intervention of bed alarms and hipsters while out of bed. The facility failed to identify this resident with problems with balance had not been adequately supervised in order to provide the assistance needed.</p> <p>The 7/28/14 witnessed fall when the resident was standing in the hallway and lost balance and feel to floor resulted in a therapy evaluation and hipsters while out of bed. The facility failed to identify the resident was allowed to be ambulating in the hall without assistance.</p> <p>The 5/25/14 unwitnessed fall when the resident was found prone on the floor at 12:30 a.m., resulted in the intervention of the resident to wear gripper socks while in bed.</p> <p>Interview with CNA #1 on 8/20/14 at 11:24 a.m., indicated the resident had glasses but did not wear them. Interview with the Social Service Director, on 8/22/14 at 10 a.m., indicated the resident's daughter had taken glasses home. There was no intervention for the resident's loss of vision besides having her glasses in place.</p>			

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	<p>During lunch observation, on 8/19/14 at 11:50 a.m., the right arm of the wheel chair (w/c) Resident #E sat in had a black arm rest that was unattached at the place wear the residents hand rested. The black plastic piece swung sidewise on the chair. CNA #4 noted the broken w/c arm.</p> <p>Observation on 8/21/14 at 3 p.m., indicated the resident sat in hallway in her w/c. Two CNA's were with the resident. The right arm to the w/c was off to the side and only attached at the back. This appeared the same as it was on 8/19/14. Neither CNA were aware if the broken chair arm had been reported so it could be fixed.</p> <p>Review of the Fall Response and Management policy provided by the DON on 8/22/14 at 10:40 a.m. indicated, "Patients who have fallen are assessed to determine if there is injury while maintaining the safety of the patient. Post fall, patients are assessed to attempt to determine the cause of the fall and implement individualized patient intervention to reduce the risk of a fall occurrence. Any staff member finding a patient who has fallen is responsible for remaining with the patient and being part of the investigation."</p> <p>3. On 8/21/14 at 10:23 a.m., the Resident</p>			

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	<p>#F was observed sitting in the dining room at a table eating a snack. The resident was wearing shoes with thin white socks.</p> <p>On 8/21/14 at 10:50 a.m., the resident was observe up in the dining room sitting at a table for activities. The resident was wearing shoes on her feet with thin white socks.</p> <p>On 8/21/14 at 1:39 p.m., the resident was observed in the dining room sitting at a table, playing with a flower. The resident was wearing shoes and thin white socks.</p> <p>The resident's record was reviewed on 8/21/14 at 8:44 a.m. The resident's diagnoses included, but were not limited to, constipation, anemia, CHF, psychosis, dementia with behaviors, anxiety, Alzheimer's Disease, osteoarthritis, and insomnia.</p> <p>The Physician Order Statement (POS), for 7/2014 to 8/2014, indicated gripper socks at all times.</p> <p>A Physician order, dated 6/14/14 at 5:45 a.m., indicated remove shoes while in bed an keep gripper socks on at all times. Monitor bruise and hematoma on forehead till healed every shift.</p>						

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	<p>A Quarterly Minimum Data Set (MDS) Assessment, dated 6/3/14, indicated there had been 2 or more falls since the last admission, none since last assessment.</p> <p>A Quarterly MDS Assessment, dated 7/28/14, indicated, there had been falls since the last admission and one fall since the last assessment.</p> <p>The following Fall Risks Assessments were completed: 5/11/14 - a score of 15 which was a low risk for a fall, 5/27/14 - a score of 50 which was high risk for falls, 6/01/14 - a score of 65 which was high risk for falls, 6/14/14 - a score 75 which was high risk for falls, 7/14/14 - a score of 40 which was medium risk for falls, 7/21/14 - a score of 75 which was high risk for falls, 8/01/14 - a score of 65 which was a high risk for falls, 8/05/14 - a score of 75 which was a high risk for falls, 8/14/14 - a score of 75 which was a high risk for falls.</p> <p>A Care Plan, initiated on 4/21/14 and updated on 5/7/14, indicated a problem of risk for falls related to confusion, poor</p>			

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	<p>communication/comprehension, gait/balance problems, incontinence, fall risk assessment score, diminished safety awareness, diagnosis of dementia, history of falls, and psychotic drug use. The intervention included, but were not limited to, transfer with one assist, anticipate and meet the resident's needs, be sure call light is in reach, bed against the wall, encourage to take off shoes while in bed, ensure resident is wearing appropriate footwear and shoes are tied, evaluate resident's surroundings when ambulating to avoid trip hazards, alarm in place to bed, frequent check on resident while in bed to make sure resident is not tangled up in sheet, gripper socks on at all times and shoes on while ambulating, non skid socks or shoes on at all times.</p> <p>Review of a Post Fall Assessment, dated 5/27/14, indicated, the resident fell on 5/27/14 at 5:10 a.m. The fall was unwitnessed and there was no injury. The assessment indicated a loud noise was heard by the CNA and the resident was found sitting on the floor beside her bed with her back against the wall under the window in the resident's room. The resident was confused and unable to tell what happened. The resident's speech was disoriented and non-sensible. Interventions to be put into place were no objects with wheels were to be left in the</p>			

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	<p>residents room by her bedside.</p> <p>Review of a Post Fall Assessment, dated 6/1/14, indicated, the resident fell on 6/1/14 at 1605 (4:05 p.m.) The fall was unwitnessed and there was no injury. The resident was found on the floor in the dining room. The interventions to be put into place were the resident's bed was to be against the wall, staff were to assure her shoe laces were tied, non-skid strips by the bed, and a perimeter mattress to the bed.</p> <p>Review of a Post Fall Assessment, dated 6/14/14, indicated, the resident fell on 6/14/14 at 5:00 a.m. The fall was unwitnessed and there an injury. The resident was found on the floor laying on the right side facing the bed with feet wrapped in in the covers. The resident was fully dressed with socks and shoes on. The resident had a bruise with a hematoma present on the forehead. The interventions to be put into place were to remove the resident's shoes while in bed even if the resident was napping and be sure the resident wore gripper socks were on at all times.</p> <p>A Post Fall Assessment, dated 7/21/14, indicated, the resident fell on 7/14/14 at 0000 (12:00 a.m.) The fall was witnessed and there was no injury. The</p>			

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	<p>resident was grabbed by another falling resident and went to the floor.</p> <p>Review of a Health Service Event Report, dated 7/14/14 at 8:00 p.m., indicated, the interventions put into place were to provide more activities to decrease wandering.</p> <p>A Post Fall Assessment, dated 8/1/14, indicated, a fall occurred on 8/1/4 at 4:35 a.m. that was unwitnessed with an injury. The resident got out of bed and was ambulating gin the room and was found laying on her right side in front of the bathroom door. The interventions were to assess the resident and help get back to bed.</p> <p>A Post Fall Assessment, dated 8/5/14, indicated, a fall occurred on 8/5/14 at 1803 (6:03 p.m.) which was witnessed with no injury. The resident was ambulating through the dining room and tripped over another residents anti-rollback mechanism on the wheelchair. The resident tripped and fell into another resident. The interventions was a review in medications and a decrease in Buspar.</p> <p>A Health Service Reporting Form, dated 8/5/14 at 6:30 p.m., indicated, to decrease the resident's medications and rearrange</p>			

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	<p>the furniture to allow for more free space.</p> <p>A Post Fall Assessment, dated 8/11/4, indicated, the resident fell on 8/11/14 at 7:10 a.m. The fall was unwitnessed with no injury. The resident was transferring from bed. The resident was to be checked on frequently while in bed to make sure she was not tangled in the sheets.</p> <p>A Health Services Event Reporting Form, dated 8/11/14 at 7:10 a.m., indicated, the resident was trying to get out of bed and became tangled up in sheets which caused the fall. She had no non-skid socks, non-skid strips by the bed. The resident was to have her shoes removed when she was in bed.</p> <p>Interview with LPN #51, on 8/21/14 at 1:46 p.m., indicated the resident had on regular socks. She would need to see the bottom of the resident's sock to be sure, however the resident refused to all the nurse to take off her shoes.</p> <p>Interview with CNA #52, on 8/21/14 at 2:05 p.m., indicated the resident had on regular socks and just gripper socks were used when the resident was in bed. She provided her a Care Report Sheet which indicated the resident was to be encouraged to not wear shoes while in</p>			

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F000329 SS=D	<p>bed and to wear non-skid socks. It also indicated non-skid socks.</p> <p>Interview with the SDC (Staff Development Coordinator), on 8/21/14 at 3:59 p.m., indicated in regards to the resident having on gripper socks at all times the intervention needed to be worded better.</p> <p>On 8/22/14 at 8:30 a.m. in an interview with the DON, it was indicated a new Activities staff member was added to the unit. The staff member started on 8/4/14.</p> <p>This Federal tag relates to Complaint IN00153896.</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p>						

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	<p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure residents did not receive unnecessary medications for 2 of 5 residents reviewed for unnecessary medications related to the use of antipsychotics without a medical diagnosis and lack of behavior monitoring for the use of antipsychotics and anti-anxiety medications. (Residents #140 and #94)</p> <p>Findings include:</p> <p>1. The record for Resident #140 was reviewed on 8/20/14 at 1:50 p.m. The resident's diagnoses included, but were not limited to, osteoarthritis, abnormal mental status, incontinence of urine, Alzheimer's Disease, chronic back pain, and transient ischemic attacks. The resident was admitted to the facility on 7/17/14.</p> <p>The Admission Orders Record, dated</p>	F000329	<p>I. Resident # 140 psych medication re evaluated, behavior sheet validated, DX appropriate, care plan updated. Psych to see resident on 9/19/14. Resident # 94 psych medication re evaluated, behavior sheet validated, DX appropriate, care plan updated, psych to see resident on 9/19/14. II. All residents with psychotropic medication orders have potential to be affected. A chart audit was completed on all residents with psychotropic medications to validate monthly behavior flow sheets addressing related behaviors and side effects of medication, associated plan of care, and gradual dose reduction has been attempted or physician has documented patient specific rationale of contraindication is in place. Any discrepancy has been corrected with immediate placement of monthly behavior flow sheets addressing related behaviors and signs and symptoms of medication, updated plan of care, immediate physician</p>	09/21/2014			

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	<p>7/17/14, indicated the resident's medications included, but was not limited to haloperidol (also known as Haldol/antipsychotic medications) 1 mg (milligram) once daily at hs (bed time) for dementia.</p> <p>The Patient Nursing Assessment Part 2, dated 7/18/14, indicated the resident was a fall risk and had a history of falls, gait was impaired, and the resident over estimated or forgets limitations. The nursing delirium screen indicated the resident had moderate to severe disorientation and was not oriented to time or place. and severe impairment by not being able to tell you the date, month, year, season, city, state, or country. The resident had no inappropriate behaviors at this time, communication mildly to moderately inappropriate and was slightly difficult to follow, responses to questions were slightly off target to disorganized, and speech being clearly present. The resident has no delusions, hallucinations, or psychomotor retardations.</p> <p>A Patient Nursing Assessment Part 3, dated 7/18/14, indicated the resident was calm and tired.</p> <p>An Admissions Minimum Data Set (MDS) Assessment, dated 7/24/14, indicated the resident had no behaviors.</p>		<p>and family/responsible party notification, and gradual dose reduction attempt initiated or documented patient specific rationale of contraindication obtained. III. The SDC or designee will educate the Social Service staff and licensed nurses on Psychoactive Medications. The SDC or designee to educate staff Behavior Monitoring Flow Sheets and Monthly Behavior Summary. The SDC or designee to educate the floor staff. Psychoactive Gradual Dose Reduction (GDR) Review. IV. The Social Worker or designee will audit Behavior Monitoring Flow Sheets 5 x weekly for 30 days, then 3 x weekly for 30 days, then twice weekly for 30 days validate any related behaviors and side effects of medication are documented, and will present findings Monday through Friday in leadership IDT meeting. IDT will discuss psychoactive medications, GDR review and BX flow sheets weekly on going in Behavior management meeting. The Director of Nursing or designee will audit Consultant Pharmacist Recommendations for physician affirmative response or patient specific reasoning for contraindication monthly for 3 months; and discuss Behavior Monitoring Flow Sheets, psychoactive medication changes during monthly behavior meeting tracked on Monthly Behavior Summary/Psychoactive Gradual</p>	

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	<p>The resident's diagnoses included, but were not limited to, Alzheimer's Disease, anxiety, and psychosis. The resident received as need pain medications and non-medication interventions and antipsychotic medications for 7 days.</p> <p>A Physician Order, dated 7/31/14, indicated to d/c (discontinue) Haldol 1 mg at hs.</p> <p>A Physician Order, dated 8/2/14, indicated for Haldol 1 mg po (by mouth) at hs and d/c Namenda (medications used for dementia).</p> <p>A progress noted, dated 8/2/14 at 1513 (3:13 p.m.), indicated new order received and noted, family notified, per family request wanted Haldol back due to resident had always taken Haldol at night.</p> <p>An assessment, dated 8/14/14, indicated Haldol 1 mg q (every) hs dementia related psychosis. The resident had no abnormal movements noted. The resident was admitted on 7/18 with orders for Haldol to be d/c on 7/31 and restarted on 8/2 due to family insistent that the Haldol be restated per nursing.</p> <p>Review of the progress note and assessment section of the the residents record from 7/17/14 thru 8/20/14</p>		Dose Reduction (GDR) Review as an ongoing process of this facility. Audit results will be reviewed in monthly Quality Assurance meeting to achieve 100% compliance as determined by Quality Assurance committee. Facility is asking for a desk review for this citation	

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	<p>indicated no issues of insomnia.</p> <p>Interview with LPN #50, on 8/20/14 at 3:34 p.m., indicated she thought the Haldol was discontinued because of it sedating the resident when he was admitted. The Nurse Practitioner had stopped the Haldol due to lethargy. It was restarted due to the family's request.</p> <p>An Interview with the Social Service Director and the DON (Director of Nursing) was conducted on 8/20/14 at 3:52 p.m. The Social Service Director indicated the Haldol was discontinued due to no behaviors. The DON indicated it was restarted because the resident had been taking it forever at night and the resident was no sleeping.</p> <p>Interview with the Social Service Director, on 8/20/14 at 3:59 p.m., indicated there were no behavior monitoring logs completed for Resident #140.</p> <p>2. Resident #94's record was reviewed on 8/19/14 at 3:03 p.m. Diagnoses included, but were not limited to, dementia cce (conditions classified elsewhere) with behavioral disturbances, unspecified psychosis, and generalized anxiety disorder.</p>			

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	<p>A care plan, dated 7/7/14, indicated Resident #94 used anti-anxiety and antipsychotic medications. Interventions included, but were not limited to, "...Develop a behavior monitor [system] to track behavior...Monitor/record occurrence of for (sic) target behavior symptoms and document per facility policy...." The care plan did not indicate specific target behaviors and medications prescribed to reduce the maladaptive behavior.</p> <p>An untimed physician's order, dated 7/19/13, indicated, ".D/C [discontinue] mid-day dose of Klonopin [benzodiazepine used to treat anxiety] [trial reduction]." The record indicated the mid-day dose was 0.5 mg [milligrams].</p> <p>An untimed physician's order, dated 8/15/13, indicated, "D/C a.m. Seroquel [anti-psychotic]/GDR [gradual dose reduction]." The record indicated the a.m. dose was 50 mg.</p> <p>A "Resident Progress Note," date 8/28/13 at 4:30 p.m., indicated, "...Resident is agitated asking to go outside...Attempts to calm res [resident] are unsuccessful...Res resisting this writers [sic] suggestion to go back to her room...."</p>			

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	<p>A physician's order, dated 8/29/13 at 1:00 p.m., indicated, "Seroquel [Quetiapine] 50 mg P.O. [by mouth] daily @ [at] 0600 [6 a.m.]. DX [diagnosis]: Dementia [symbol for with] bx [behavioral] disturbance-Failed Dose Reduction."</p> <p>A "Psychiatric Follow-up Evaluation," date 9/27/13, indicated, "...PSYCHIATRIC MEDICATION(S) - Klonopin 0.5 mg BID [twice daily] (-7/19/2013 per PV [unknown abbreviation])-GDR,...Seroquel 50 mg QD [every day] and 100 mg QHS [every bedtime] (+8/29/13 per PV)- Failed GDR...Recent failed GDR of Seroquel. Staff states patient is still getting agitated with her roommate, thinking she is her mother-law, causing her to become irritable. Staff is discussing possibility of room change due to this...."</p> <p>A SBAR (Situation Background Assessment Record), dated, 10/17/13, indicated, "...This nurse was informed of the altercation between the two resident, witnesses report that [Resident #94] was reading her newspaper and the other resident was tapping his leg repeatedly. [Resident #94] states, "I asked him to stop and he did it more!" When I arrived at the birdcage both residents had already struck each other...Residents were</p>			

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	<p>immediately separated and both residents appear fine...."</p> <p>A psychiatric "Examination" form, dated 10/18/13, indicated, "...Increase Klonopin 0.5 mg tid for agitation and anxiety. continue [sic] to observe for pschosis [sic] and delusions and call if problems continue...."</p> <p>A physician's order, dated 10/18/13 at 5:30 p.m., indicated, "[symbol for increase] Klonopin 0.5 mg tid [three times daily] GDR failure."</p> <p>A "Psychiatric Follow-up Evaluation," dated 7/29/14, indicated, "...A TRIAL DOSE REDUCTION OF THE PSYCHIATRIC MEDICATES LISTED ABOVE, EXCEPT AS OTHERWISE MAY BE INDICATED IN THE TREATMENT PLAN, ARE CONTRAINDICATED SECONDARY TO RISK FOR EXACERBATION OF: Psychotic Features, Mood Dysregulation, Anxiety, Cognitive Impairment...."</p> <p>Behavior tracking sheets were provided for review on 8/22/14 at 8:30 a.m. A tracking sheet was not available for August 2013 to review behavior frequency/intensity/non pharmacological interventions for the 14 day Seroquel GDR trial from 8/15/13-8/29/13.</p>			

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	<p>The "Monthly Behavior Monitoring Flowsheet," dated 9/12013-9/30/2013, indicated 3 episodes of "easily angered" behavior on 9/1/13. The tracking form indicated the resident was redirected and the intervention was successful.</p> <p>A behavior tracking sheet for October 2013 indicated target behavior of "easily angered" occurred twice during the month (10/2/13 and 10/11/13) and the behavior improved with redirection and toileting. The record indicated Klonopin was increased on 10/18/13 due to a failed GDR attempt.</p> <p>A behavior sheet, with month and year not available for viewing on the copy provided by the facility, indicated 3 target behaviors of "easily angered" occurred on the 8th of the month and the 26th of the month. The interventions of "redirection" and "return to room" resulted in improved behavior.</p> <p>A behavior sheet, with month and year not available for viewing on the copy provided by the facility, indicated 1 target behavior of "easily angered" on the 22nd of the month. The intervention of "return to room" resulted in improved behavior. The behavior tracking forms indicated no other target behaviors occurred during the</p>			

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	<p>past year.</p> <p>During an interview on 8/20/14 at 10:25 a.m., the Social Service Director (SSD) was queried regarding criteria used by the facility to determine when a resident was considered for GDR of psychotropic medications. She indicated monthly behavior tracking sheets were stored in her office after data collection by staff. The SSD indicated there was not a system that linked target behaviors to a specific medication and the facility relied on psych services to determine medication adjustments. Monthly behavior tracking sheets were requested for review.</p> <p>During an interview, with the Director of Nursing (DON) present, on 8/21/14 at 1:29 p.m., the SSD indicated she was unable to locate behavior tracking sheets for August 2013. The SSD indicated the facility implemented a new system for reviewing behaviors "approximately 3 months ago." She provided a form, titled, "Meeting Behavior" that listed team members present, residents reviewed, and recommendations. The form did not address behavior data and correlation of target behaviors with specific medications. The SSD indicated there was no documentation to indicate the IDT (Interdisciplinary team)</p>			

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	<p>discussed Resident #94's behaviors prior to determining the GDR for Seroquel and Klonopin failed. The SSD indicated the facility did not have a system that collectively reviewed behavior data for trends, patterns, and non-pharmacological interventions before determining a GDR failure and returning a medication to the pre-GDR dose. Monthly behavior data tracking sheets were requested for the past year.</p> <p>A policy titled, "Antipsychotic Medications," dated 4/9/04, released 9/10/12, indicated, "...Antipsychotics used to control behavior or used off label are considered chemical restraints. Patients have the right to be free of chemical restraints unless treating a medical condition that has been diagnosed and documented in the patient's medical record...4. Within the first year in which a patient is admitted on an antipsychotic medication or after the center has initiated an antipsychotic medication, the center attempts gradual dose reduction (GDR) in two separate quarters (with a least one month between the attempts) unless clinically contraindicated. After the first year, a GDR must be attempted annually, unless contraindicated...6. Patients who use antipsychotic drugs receive gradual dose reductions and behavioral interventions,</p>			

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F000333 SS=D	<p>unless clinically contraindicated, in an effort to discontinue these drugs...."</p> <p>3.1-48(b)(6)</p> <p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors. Based on record review and interview, the facility failed to ensure a significant medication error did not occur for 1 of 5 residents reviewed for unnecessary medications related to not following a Physician's order to administer Coumadin (a medication used to thin the blood). (Resident #89)</p> <p>Finding includes:</p> <p>The record for Resident #89 was reviewed on 8/20/14 at 9:00 a.m. The resident's diagnoses included, but were not limited to allergic rhinitis, reflux, cardiomegaly, hypothyroidism, congestive heart failure, atrial fibrillation, and pace maker.</p> <p>Review of the Physician Order Statement (POS) for August 2014, indicated the resident was to received Coumadin 3 milligrams (mg) on Tuesdays, Thursdays, and Saturdays. The resident was to receive Coumadin 2.5 mg on Monday,</p>	F000333	<p>I. Resident # 89 assessed for adverse reactions, no issues identified, MD and family notification made. Nurses educated. II. All residents have the potential to be affected. 100 percent audit of the MAR/TAR for the past month conducted to validate all medications given. III. SDC or designee to educate licensed nurses on medication errors, and appropriate documentation in the MAR/TAR. IV. DNS/Designee will audit MARS/ TARS daily ongoing 5 x weekly for 30 days, then 3 x weekly for 30 days, then twice weekly for 30 days to ensure all medications have been given. Coumadin medications and changes will be audited Monday through Friday via the Coumadin flow sheet per DNS/Designee 5 x weekly for 30 days, then 3 x weekly for 30 days, then twice weekly for 30 days to make sure appropriate dosage is given, and appropriate changes are made. Two nurses are to initial daily that all the holes in the MAR/TAR are completed validating all</p>	09/21/2014			

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	<p>Wednesday, Friday, and Sunday.</p> <p>A Physician's order, dated 7/8/14 at 12:15 p.m., indicated Coumadin 3 mg daily until antibiotics were completed. Hold routine dose of Coumadin and resume on 7/13/14.</p> <p>Review of the Medication Administration Record (MAR) for July 2014, indicated Coumadin 3 mg was held on 7/8, 7/10, and 7/12/14. Coumadin 2.5 mg was held on 7/9, and 7/11/14. Hand written on the MAR was Coumadin 3 mg PO (by mouth) daily until completed antibiotic which was signed out on 7/8/14. There were no other signatures on the MAR from 7/9 thru 7/12/14 to indicate the Coumadin 3 mg had been given to Resident #89.</p> <p>Review of a lab report dated 7/15/14, indicated the PT/INR (blood test to indicate how thin the blood was/prothrombin/international normalized ratio) indicated the PT was 13.4 (high) and INR was 1.3 (high).</p> <p>A Physician Order, dated 7/14/14, indicated the resident was to be given a double dose of Coumadin today and tomorrow.</p> <p>Interview on 8/20/14 at 10:59 a.m. with</p>		<p>medications are give.</p> <p>DNS/Designee will audit this tool 5 x weekly for 30 days, then 3 x weekly for 30 days, then twice weekly for 30 days. These issues will be discussed in the Monday - Friday IDT leadership meeting and any issues identified will be corrected. Audit results will be reviewed in monthly Quality Assurance meeting to achieve 100% compliance as determined by Quality Assurance committee. Facility is asking for a desk review for this citation</p>				

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F000364 SS=D	<p>RN #51, indicated Resident #89's Coumadin was held on 7/9 to 7/12/14 and it was not given. She indicated there was another order for Coumadin 3 mg daily until the antibiotics were complete. She further indicated the Coumadin 3 mg was not given on 7/9 thru 7/12/14.</p> <p>Interview with the ADON (Assistant Director of Nursing) on 8/20/14 at 4:08 p.m., indicated she had called all of the nurse who took care of Resident #89 on 7/9 to 7/12/14. She indicated all of the nursed had indicated they had given the resident her dose of Coumadin. She further indicated she was having all of the nursed sign a statement they had given the resident the Coumadin does.</p> <p>3.1-48(c)(2)</p> <p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation and interview, the facility failed to present food in a palatable manner for 1 of 3 resident in a sample of 5 who met the criteria for food quality. (Resident # 115)</p> <p>Finding includes:</p>	F000364	<p><u>F364 Nutritive value/appear palatable/ prefer temp l.</u> Resident # 115 has been interviewed per DM R/T food preferences, and dietary is offering resident alternative with every meal when he expresses dislike. Care plan reviewed and</p>	09/21/2014

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	<p>Resident # 115 was interviewed about the food quality on 8/18/14 at 3:40 p.m. He indicated the food "tasted bad."</p> <p>A test tray was done, on 8/21/14 at 12:40 p.m., after the last tray had been served for the lunch meal. The tray had a chicken breast, browned potatoes, peas, and fried apples. All the food was at a palatable temperature, but tasted bland.</p> <p>The resident was again interviewed, on 8/21/14 at 1:30 p.m., in his room. He indicated the food looked appetizing, but tasted like "nothing." He indicated no one had offered him any spices or condiments to make it taste better.</p> <p>The clinical record for Resident # 115 was reviewed on 8/21/14 at 2:00 p.m. The resident had diagnoses which included, but were not limited to: diabetes, high blood pressure and anemia. He was identified as reliably interviewable.</p> <p>3.1-21(a)(1) 3.2-21(a)(2)</p>		<p>revised. Resident is on a special diet, dietary is giving resident seasoning that pertains to diet. II. All residents have a potential to be affected. 100 percent audit of all resident likes and dislikes completed, food tray tickets updated to reflect likes. Appropriate spices are given with each tray. Department managers will do a test tray weekly. Care plans reviewed and revised. III. SDC to educate DM and dietary staff on the P/P of meal service, Dietary manager to educate dietary staff R/T appropriate spices and alternative meal trays. SDC to educate staff related to appropriate spices and alternative meal trays. IV. DM/designee will audit trays for one meal 3 times a week for 4 weeks, then 2 times a week for 4 weeks, then spot check weekly for 8 weeks, any issues will be discussed and corrected In daily IDT meeting. Department managers will do a test tray weekly and complete tray forms. Any issues will be discussed in the daily in IDT leadership meeting. Designated facility representative will ask residents daily Monday through Friday about any food issues and document. Audit results will be reviewed in monthly Quality Assurance meeting to achieve 100% compliance as determined by Quality Assurance committee. The facility is asking for a desk review on this citation</p>				

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F000465 SS=E	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed, for 9 of 28 resident rooms observed, and one main dining room, to timely address environmental issues as they arose.</p> <p>Findings include:</p> <p>Dining observation of the main dining area, on 8/18/14 at 11:30 a.m., residents were coming to the area for lunch. The floor was found to be sticky when walking across the room.</p> <p>During observation, 8/18/2014 at 2:20 p.m., in room 205 the floors in the resident room was found to have scuff marks and sticky residue. The light switch in the bathroom required multiple attempts at turning on and off the switch before the light came on. Interview with the Maintenance Director, 8/21/2014 at 1:10 p.m., indicated there have been issues with light fixtures in the bathrooms and they are being replaced.</p> <p>During observation, on 8/19/2014 at 9:43 a.m., in room 406 the toilet cover was laying on the floor in the bathroom.</p>	F000465	<p>I. Main Dining area floor has been cleaned and is no longer found to be sticky during ED rounds. Room 205 floors have been cleaned and are no longer sticky or showing Scuff marks during ED rounds. Room 205's bathroom light switch and fixture have been replaced and operates correctly. Room 406's toilet cover has been reattached and working properly. Room 409 bathroom has had the broken tile replaced. Room 124 toilet has been replaced and operating correctly. Room 124 over bed table has been replaced and old table taken out of circulation. Room 126 wall has been repainted and no longer has signs of chipped paint. Room 125 wall above headboard has been repaired and repainted. Room 112 wall has been repaired and repainted. Facility has a new room paint schedule which Maintenance Director will follow.</p> <p>II. All residents entering and exiting the main dining room could have found the floor to be sticky. Main Dining room floors are monitored daily by House Keeping Supervisor or designee and issues are addressed immediately. Maintenance Director will do a 100 % initial audit then once bi – weekly of all</p>	09/21/2014

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	<p>During observation, on 8/19/2014 at 9:50 a.m., in room 409B the bathroom had chipped and broken tile in front of the toilet. During observation, on 8/21/14 at 12:50 p.m., the situation still remained.</p> <p>During observation, on 8/19/2014 at 10:40 a.m., in room 124 the toilet cover on top of of tank was found to not fit and just rested on the top of the toilet. Also in room 124 the overbed table had exposed particle board around the edges of the table.</p> <p>During observation, on 8/19/2014 at 10:42 p.m., in room 403 the door jamb around the bathroom door had chipped paint. During observation on 8/21/14 at 12:50 PM the situation still remained.</p> <p>During observation, on 8/19/2014 at 10:51 p.m., in room 126 the wall underneath the soap dispenser in the bathroom was stained and one spot of paint was chipped. During observation, on 8/21/14 at 1:00 p.m., the situation still remained.</p> <p>During observation, on 8/19/2014 at 11:57 a.m., in room 125 there were multiple indentations and chipped or missing paint in the wall above the headboard. During observation, on</p>		<p>resident rooms to ensure all light switches, light fixtures, and toilets are in good working order. Maintenance Director will audit all rooms bi weekly for needed wall repairs, repainting or general up keep and make repairs as soon as possible. III. ED or designee to educate House Keeping Supervisor on the importance of overseeing her cleaning staff to ensure dining room floors, hall way floors and residents rooms are free from sticky substances. ED to educate Maintenance Director on the importance of keeping a painting schedule current and up to date. SDC or designee will educate leadership team on the infection control and the importance of the cleanliness of facility floors and how to address if a deficient practice should occur. IV. The House Keeping Supervisor or designee will audit the cleanliness of dining room floors 3 x daily for 30 days, then once daily for a minimum of 5 days a week for 60 days. House Keeping Supervisor or designee will audit resident rooms 5 times weekly for four weeks and then as needed to verify deficient practice does not reoccur. Maintenance Director will audit all patient rooms and determine a need and schedule for painting. Painting schedules are not limited to painting but will include wall repairs as well. Maintenance Director will submit findings to QA monthly. Review</p>	

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	<p>8/21/14 at 1:00 p.m., the condition of the wall still remained.</p> <p>During observation, on 8/19/2014 at 3:28 p.m., in room 112B the wall next to the closet had broken plaster and metal edging was exposed. During interview, on 8/21/14 at 1:05 p.m., the Maintenance Director indicated he noticed that condition when the surveyor was in the room on 8/19/2014 and had since mudded the wall. The area still required painting.</p> <p>Interview, on 8/21/14 at 12:44 p.m., with the Maintenance Director confirmed all the above issues existed at the time of the observations. The Maintenance Director indicated that there was a facility paint schedule, however they are "3 to 4 months behind" in completing that schedule. He indicated he does rounds at least once a month in each room. The Administrator, who was present during the interview indicated that staff were to complete maintenance requests as they were identify issues.</p> <p>During observation, on 8/21/14 at 1:00 p.m., the toilet tank lid still fit improperly, the table still remained in the room, at which time the maintenance director removed it to the nurse's station.</p>		<p>as an ongoing process of this facility. Audit results will be reviewed in monthly Quality Assurance meeting to achieve 100% compliance as determined by Quality Assurance committee. Facility is asking for a desk review for this citation</p>		

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F000520 SS=E	<p>3.1-19(f)</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on observation, interview and record review, the facility failed to identify non-compliance for range of motion maintenance program, to ensure a behavior monitoring programs was in place and monitoring was completed for gradual dose reductions for psychotropic medications, care plan revision and implementation was completed, non-pressure skin issues were assessed</p>	F000520	<p>1. Resident 120 has been reevaluated and has been moved to the Reflections unit for more appropriate activity programming, work program D/C'd as resident would not participate, care plan reviewed and revised to meet current activities related to wandering, Resident #64's restorative program was re evaluated and updated, care plan reviewed and</p>	09/21/2014			

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	<p>and monitored and environmental issues were corrected through the quality assurance protocol.</p> <p>Findings include:</p> <p>Interview with the Administrator on 8/22/14 at 10:02 a.m., indicated the facility's Quality Assurance Committee meets every month and it consisted of the Administrator, and the leadership teams who included the department heads, the Medical Director, Unit Managers, DON (Director of Nursing), and SDC (Staff Development Coordinator). The Administrator indicated at this time that the restorative program had been mentioned during the Quality Assurance meetings but there had been no plan established. The Administrator further indicated at this time gradual dose reduction, behavioral monitoring, revisions and implementations of care plans, and environmental issues had not been addressed or identified as being a problem in Quality Assurance. He also indicated no action plan or system had been put into place in regards to the maintaining of the restorative program, gradual dose reduction, behavior monitoring, implementation and revision of care plans and environmental maintenance.</p>		<p>revised. Resident #140's care plan was reviewed and revised to reflect current needs. An appropriate behavior management program was updated for residents #120, #64, and #140. Resident D unidentified. Room 205's bathroom light switch and fixture have been replaced and operates correctly. Room 406's toilet cover has been reattached and working properly. Room 409 bathroom has had the broken tile replaced. Room 124 toilet has been replaced and operating correctly. Room 124 over bed table has been replaced and old table taken out of circulation. Room 126 wall has been repainted and no longer has signs of chipped paint. Room 125 wall above headboard has been repaired and repainted. Room 112 wall has been repaired and repainted. Facility has a new room paint schedule which Maintenance Director will follow 2. All Residents have the potential to be affected. All residents have been interviewed, while also having a full chart audit, care plan audit, and full assessment completed as it relates to any identified issues from the current 2567. Any issues or concerns were addressed and necessary changes made. 3. ED will educate leadership team on the QA process and the importance or reporting to QA. SDC or designee will educate staff on the QA Process and the importance</p>				

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	<p>1. On 8/20/14 at 8:40 a.m., Resident # 120 was observed wandering down to the aviary lounge and then to the front lounge reception area.</p> <p>On 8/20/14 at 9:26 a.m., Resident was again found in room 411 fiddling with the door. He then wandered back to his room.</p> <p>The resident was observed during the day of 8/21/14. He slept the whole day.</p> <p>The clinical record for Resident # 120 was reviewed on 8/20/14 at 9:00 a.m. His diagnoses included, but were not limited to: Bipolar, anxiety, depression, alcoholic liver disease and liver cancer. The resident was receiving Risperdal (an antipsychotic), lithium (an antimanic), Ativan (an antianxiety) and Lexapro (an antidepressant) medications on a daily basis. A quarterly Minimum Data Set assessment, dated 7/18/14, indicated the resident had no cognitive impairment.</p> <p>The Medication Administration Record was reviewed for June, July, and August, 2014. There was no indication of the resident being tracked for the wandering behavior. RN # 21 indicated the resident was not being tracked for wandering behaviors during an interview on 8/20/14</p>		<p>of reporting to the QA committee any issues or concerns. 4. QA committee has begun meeting daily at 3:30 and will do so for the next 30 days and then monthly thereafter. ED will submit monthly QA reports to Divisional Vice President for on going reviews of Rolling Hills QA process. QA committee will discuss monthly the facility wide QA process to determine any changes or concerns that need to be addressed. Facility is asking for a desk review for this citation</p>				

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	<p>at 10:00 a.m.</p> <p>The care plan indicated the following: problem of elopement risks/ wandering behavior. Interventions included: 15 min checks prn (as needed); assess resident for therapeutic work - work order - idt (Interdisciplinary Team) to assess & evaluate, other options if not interested in this, tokens for pay; praise, report difficulties; infection control; supervise and train; work with dept heads for jobs; redirect from inappropriate areas; engage in diversional activity; evaluate need for additional supervision and obtain order for procedure; 1:1(one to one) with staff prn; provide structured activities - toileting, walking inside and outside, reorientation strategies, including signs, pictures, and memory boxes; therapy to evaluate for cognitive therapy; wander alert.</p> <p>The problem of activities had the following interventions identified: provide 1:1 intervention during activities as needed; keep instructions easy with one step processes; allow resident simple choices; provide cues and modeling for activities that require complexity as resident was easily confused; explain activity, location and time; assure resident of abilities; assist to activity if needed; monitor resident for signs of</p>						

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	<p>anxiety/agitation or physical discomfort during activities; assist to nursing staff or calmer environment as needed if resident wanders or becomes agitated during activities; redirect, reapproach, invite, encourage and assist as needed to activities of choice, interest as tolerated by the resident, monitor resident for behaviors during groups i.e. touching or reaching for other people's food; remind resident of contamination concern; offer personal snacks; gently redirect or assist to calmer environment; offer [Resident's name] food and/or drinks as a diversion or intervention when agitated; offer resident resources and opportunities appropriate for their age, whatever they may be, transportation to stores, encouraging visits with peers; providing appropriate supplies r/t young age - movies, music, reading materials; provide activity calendar in room; resident to be offered independent supplies and appropriate relating to their interest; inform of newspaper and daily chronicle availability in activity room; respect wishes to decline invitations when rest/activities leisure type are preferred; visit and monitor resident weekly for need of comfort measures; if needed, offer resident comfort measure pleasant music, sensory stimulation, and verbalization.</p>			

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	<p>On 8/20/14 at 10:40 a.m., RN # 21 was asked about the resident's therapeutic work program. She indicated she would have to ask someone.</p> <p>The Director of Nursing and the Activities Director were interviewed on 8/20/14 at 10:45 a.m. The Activities Director indicated there had not been a therapeutic work program established for the resident. She provided a copy of the resident's activities attendance calendar. The Director of Nursing indicated the resident had been difficult to manage. She indicated he had gone from very active to total bedrest, then up ambulating the next day. She indicated he was difficult to anticipate when it came to meeting his needs.</p> <p>Review of the behavior reports indicated the resident had been found outside the building on 7/25/14 and was placed on 1:1 with staff until he had been discharged on 7/27/14 at 4:00 p.m. to an inpatient psychiatric facility for elopement. He had been readmitted to the facility on 8/5/14. There were no behavior notes for the resident wandering into other resident rooms uninvited.</p> <p>CNA # 1 was interviewed on 8/20/14 at 2:10 p.m. She indicated she worked the 2-10 shift. She also indicated Resident # 120 wandered daily into other resident</p>			

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	<p>rooms. She indicated the resident was redirected when he wandered. She knew he liked ice cream sandwiches and coke. She also indicated staff may take him outside if they had time.</p> <p>There was no indication the care plan had been revised to address the wandering</p> <p>2. Resident #64's clinical record was reviewed on 8/20/14 at 9:40 a.m. The 7/23/14, PT (Physical Therapy) - Therapist Progress & Discharge Summary for Resident #64 included, "The patient requires 2-Wheeled Walker and min [minimal] assist [25% assist]/CGA [Contact Guard Assist] for safe ambulation for 125 feet...." "For gait training pt [patient] is able to ambulate with CGA holding hand rail for 50 ft, but using FWW [Front Wheeled Walker] pt is able to ambulate longer distances and quality of gait is better. "</p> <p>Interview with the Program Director for Therapy on 8/20/14 at 10:20 a.m., indicated upon discharge from skilled therapy, a restorative plan was given to the restorative nurse, LPN #8. The nurse provided oversight for the restorative program. LPN #8 provided Resident #64's Restorative Nursing Care Referral. The referral, dated 7/14/14, instructed nursing staff to ambulate Resident #64</p>			

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	<p>for 60 - 80 feet with a front wheeled walker with minimal contact guard assist and a wheel chair pushed behind for safety and active range of motion to the bilateral lower extremities for 15 repetitions. This was to be completed one to two times a day, seven times a week, for 12 weeks.</p> <p>Review of the Restorative Nursing Program Flow Sheet indicated there were two areas of care to be provided twice daily starting 7/22/14. The two areas were: Verbal/tactile cues to initiate and complete self feeding and Active range of motion to bilateral upper extremities. The documentation indicated neither were completed twice a day seven days a week from 7/25/14 through 8/20/14. Interview with the MDS nurse at the time indicated the other restorative aide had been on vacation and there was no staff to complete her assignment during that time.</p> <p>Interview with CNA #4 on 8/22/14 at 9:45 a.m., indicated she provided care for Resident #64. She was assigned to his care that day and ambulating the resident was not in his plan of care.</p> <p>3. The record for Resident #140 was reviewed on 8/20/14 at 1:50 p.m. The resident's diagnoses included, but were</p>						

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	<p>not limited to, osteoarthritis, abnormal mental status, incontinence of urine, Alzheimer's Disease, chronic back pain, and transient ischemic attacks. The resident was admitted to the facility on 7/17/14.</p> <p>A Physician Order dated 7/31/14, indicated to d/c (discontinue) Haldol 1 mg at hs for Resident #140.</p> <p>A Physician Order dated 8/2/14, indicated for Haldol 1 mg po (by mouth) at hs and d/c Namenda (medications used for dementia).</p> <p>An assessment dated 8/14/14, indicated Haldol 1 mg q (every) hs dementia related psychosis. The resident had no abnormal movements noted. The resident was admitted on 7/18 with orders for Haldol to be d/c on 7/31 and restarted on 8/2 due to family insistent that the Haldol be restated per nursing.</p> <p>Review of the progress note and assessment section of the the residents record from 7/17/14 thru 8/20/14 indicated no issues of insomnia.</p> <p>Interview with the Social Service Director and the DON on 8/20/14 at 3:52 p.m. indicated, per the Social Service Director the Haldol was discontinued due</p>			

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	<p>to no behaviors. The DON indicated it was restarted because the resident had been taking it forever at night and the resident was no sleeping.</p> <p>Interview with the Social Service Director on 8/20/14 at 3:59 p.m., indicated there were no behavior monitoring logs completed for Resident #140.</p> <p>4. Observation on 8/19/14 at 10:26 a.m., indicated Resident #D had dark purple bruising to the top of both hands. On 8/20/14 at 8:27 a.m., the resident wore short sleeves and light purple bruising was observed covering the entire right elbow area.</p> <p>Interview with LPN #3 on 8/20/14 at 8:30 a.m. indicated the bruises were from a fall. The bruises were being monitored and documentation would be found in the electronic medical record.</p> <p>Review of the care plan on 8/20/14 at 9 a.m. indicated there was nothing regarding the resident's bruises. Review of the electronic medical record indicated there was one entry on 8/20/14, "Bruises on arms."</p> <p>Interview with the ADON on 8/21/14 at 10:26 a.m., indicated she could not find</p>						

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	<p>any documentation regarding an assessment of bruises on the hands and elbow. She looked at the admission assessment, dated 8/13/2014, and it had nothing about bruises on hands or elbow.</p> <p>5. Interview on 8/21/14 at 12:44 PM with the Maintenance Director confirmed all the above issues existed at the time of the observations. The Maintenance Director indicated that there was a facility paint schedule, however they are "3 to 4 months behind" in completing that schedule. He indicated he does rounds at least once a month in each room. The Administrator, who was present during the interview indicated that staff were to complete maintenance requests as they were identify issues.</p> <p>3.1-52(a)(2)</p>			