STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155374		06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOOGOOTEE HEALTHCARE & REHABILITATION CENTER	313 POPLAR ST LOOGOOTEE, IN 47553

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: June 20, 21, 22, 23, 2016 Facility number: 000571 Provider number: 155374 AIM number: 100266920 Census bed type: SNF/NF: 33 SNF: 2 Total: 35 Census payor type: Medicare: 4 Medicaid: 24 Total: 35 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by #02748 on June 27, 2016.	F 0000	By submitting the following material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuantto our regulatory obligations. The facility requests the plan of correction be considered our allegation ofcompliance effective 07/20/2016 to the state findings of the Recertificationand State Licensure Survey. We are requesting paper compliance.	
F 0250 SS=D Bldg. 00	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, interview, and record review, the facility failed to ensure Social Services were provided after a resident expressed a suicidal ideation and a statement of intent to self-harm (Resident 33) and effective behavior management was provided to a resident who experienced anxiety (Resident #16) for 2 of 2 residents who met the criteria for review of Social Services. Findings include: 1. On 6/20/16 at 12:40 P.M., Resident #33 was observed sitting in a wheelchair in the hallway of the ICF unit, in no apparent distress. The clinical record of Resident #33 was reviewed on 6/21/16 at 3:20 P.M. The record indicated Resident #33 was originally admitted to the facility on 2/5/15 and re-admitted to the facility from a behavior unit on 7/22/15 with diagnoses including, but not limited to, vascular dementia and depression. The most recent Annual MDS (Minimum Data Set) assessment dated 1/14/16 indicated Resident #33 experienced moderate cognitive impairment, did not	F 0250	It is the practice of this facility to provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. 1. Corrective actions accomplished for those residents found to be affected by the alleged deficient practice. a. Resident #33 did not make any actual physical attempts to harm himself. b. Resident #33 was allegedly affected needing Social Service intervention. Social Service, DON, or Administrator were not notified timely of the behavior. Plan of care has been completed to address suicidal ideation. Resident #33 has not expressed any further suicidal ideations or self-harm. c. Resident #16 was allegedly affected needing a behavior management plan. A behavior management has been put in place which include interventions. 2. To identify other residents who have the potential to be affected by the same alleged deficient practice. a. All resident behavior plans and nurse's notes were reviewed for effectiveness of care plans and behavior plans. No other issues were identified. 3. Measures and systemic changes put into place to ensure that the deficient practice does not	07/20/2016

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	experience suicidal ideation or have thoughts of self-harm, and had no behaviors. The Quarterly MDS assessment dated 2/5/16 indicated Resident #33 experienced moderate cognitive impairment, did not experience suicidal ideation or have thoughts of self-harm, and had no behaviors. The most recent Quarterly MDS assessment dated 5/24/16 indicated Resident #33 experienced moderate cognitive impairment, did not experience suicidal ideation or have thoughts of self-harm, and had no behaviors A Care Plan dated 5/6/16 for Depression indicated interventions of, "Monitor for s/s [signs/symptoms] depression...voicing suicidal thoughts, Administer anti-depressant as ordered, Psychiatric services as needed, Encourage family to continue frequent visits, Notify Social Service of decline in mood as noticed, Notify MD of decline in mood as indicated, Encourage...to express feelings of anger, frustration, sadness...and provided support and reassurance." The plan of care lacked any interventions related to		reoccur. a. Staff members in-serviced 07/08/2016 to re-educate on the Behavior Management policy/procedure. Behavior Management Program includes thefollowing: Identification of a new or worsening behavior, Assessment of new behaviors as well as increased or decreased behaviors, Monitoring to determine frequency and impact of challenging behaviors, Initiation of Behavior Management intervention/plan, Behavior plan in effect, Education of staff members, Objective: Each resident of the facility identified as exhibiting problematic behavior will be reported on MARS to identify the casual factor, if possible, of the behavior as well as seek approaches/interventions appropriate for these said behaviors. b. All behaviors are reviewed and discussed daily during stand up meeting to ensure appropriate interventions are in place. 4. The corrective action will be monitored to ensure deficient practice does not recur and quality assurance measures put into place are: a. Social Services will be responsible to monitor the MAR's and meet with the IDT weeklyto monitor and discuss any and all behaviors and interventions. b. QA audit tool will be completed by the Director of Social Services and/or designee weekly for 4 weeks, then monthly for 3 months, and then quarterly	

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	suicide precautions. The Care Plans from 3/30/16 through 5/5/16 were reviewed and lacked any documentation to indicate an intervention of Suicide Precautions had been implemented. During an interview on 6/22/16 at 3:30 P.M., the SSD indicated Resident #33 had a history of suicidal ideation and intent to self-harm. The SSD further indicated, she believed Resident #33 initially made a statement of wanting to die or intent to self-harm on or about 7/14/15 at an unknown time, but the event was not documented in the Nursing notes or the Social Service Progress notes because everything happened quickly and the documentation was missed. The SSD further indicated, she had faxed a Psychotropic Drug Committee Recommendation to the attending physician on 7/14/15 and Resident #33 had been on 15 minute checks from 7/10/15 through 7/15/15 due to an unrelated incident. The SSD then indicated no documentation could be provided to indicate suicide precautions were implemented after the statement of suicidal ideation and self-harm were expressed. A Psychotropic Drug Committee		for 3quarters. c. The outcome of this tool will be reviewed at the facility's quarterly Quality Assurance meeting to determine if any additional action is warranted.	

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	Recommendation dated 7/14/15 at 9:00 A.M., indicated, "Resident is saying he is going to kill himself and end it all...has made this threat several times. He doesn't seem depressed...is very short tempered and easily annoyed..." The Nursing notes from 7/11/15 at 3:00 P.M., through 7/15/15 at 2:00 P.M., lacked any documentation to indicate Resident #33 expressed suicidal ideation, intent to self-harm, or suicide precautions were initiated. A Nursing note dated 7/15/15 at 2:00 P.M., indicated, "Order received may send to [name of] behavior unit due to suicidal remarks..." A Physician's Telephone Order dated 7/22/15 at 2:00 P.M., indicated, "Re-admit to [room number]" A Nursing note dated 3/30/16 at 5:00 P.M., indicated, "Crying today. States want to die. Feels like...has been dumped and no one cares about...anymore..." The note lacked any documentation to indicate suicide precautions were implemented. The next consecutive Nursing note dated 3/31/16 at 10:30 A.M., indicated, "Placed on 15 minute checks for personal safety."			

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	(17.5 hours elapsed before any suicide precautions were implemented) The next consecutive Nursing note dated 3/31/16 at 6:15 P.M., indicated, "Taken to [name of hospital]..." An untimed Social Service Progress note dated 3/30/16 indicated, "Social was notified about resident being tearful...Social spoke with [Resident #33]...said...just missed...family already...Social will follow up with [Resident #33] tomorrow [sic] and see...has gotten better emotionally." An untimed Social Service Progress note dated 3/31/16 indicated, "...informed the (AM) that in [sic] the eveing [sic] of the 30th Resident stated he, "wanted to die." Nsg [nursing] asked why, resident explianed [sic]...felt like...has been dumped here and that no one cares about him anymore...is also upset about his weight gain and stated...was fat and no one would love him, why should they? Social went to talk to resident about stating...wants to die. Social asked resident if...had a plan. Resident told this writer...just wishes...could drink something and never wake up. Social then asked resident why...would want to do something like that. Social then re-assured...of how may people do love			

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	and care about...Social then pulled residents [sic] call light for an aid to come in the room and remove everything out of...room that was drinkable and could possibly harm the resident...stated...didn't feel like...depression meds [medicines] were working anymore and...had lost all ambition in life. Social and resident spoke for about 20 more mins [minutes] and asked resident if...would sit in the lounge until we could take...to a behavior unit to get...the help...asked for b/c [because] we all cared about...and were worried. Resident agreed to sit in lounge and social placed resident on 15 min. checks until [name of psychiatrist] could see...since he was coming to the facility today. [name of psychiatrist] saw resident and agreed...needed inpatient treatment as well due to...depression appearing to get worse. Resident was transferred to [name of behavioral unit]..." During an interview on 6/22/16 at 3:45 P.M., the SSD indicated she had notified the attending physician on 3/31/16, at an unknown time, of Resident #33's expression of suicidal ideation and intent to self-harm and was advised just to monitor Resident #33. The SSD further indicated, [name of psychiatrist] was already scheduled to visit the facility on 3/31/16, so she waited until [name of			

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	psychiatrist] had time to see Resident #33. The SSD further indicated, no documentation could be provided to indicate the time Resident #33 was seen by the psychiatrist but, Resident #33 was transferred to behavior unit on 3/31/16 at 6:00 P.M. During an interview on 6/23/16 at 11:00 A.M., the SSD indicated she was not aware of Resident #33 expression of suicidal ideation and intent to self-harm until the morning of 3/31/16. The SSD further indicated, no documentation could be provided to indicate suicide precautions were implemented between 3/30/16 at 5:00 P.M. and 3/31/16 at 10:30 A.M. During an interview on 6/23/16 at 11:30 A.M., the DON [Director of Nursing) indicated she was not aware of Resident #33 expression of suicidal ideation and intent to self-harm until the morning of 3/31/16. The DON further indicated no documentation could be provided to indicate suicide precautions were implemented between 3/30/16 at 5:00 P.M. and 3/31/16 at 10:15 A.M. During an interview on 6/23/16 at 2:00 P.M., the HFA [Health Facilities Administrator] indicated she was not aware of Resident #33 expression of			

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	suicidal ideation and intent to self-harm until the morning of 3/31/16. The HFA further indicated no documentation could be provided to indicate suicide precautions were implemented between 3/30/16 at 5:00 P.M., and 3/31/16 at 10:15 A.M. The Policy and Procedure for Suicide Precautions provided by the SSD [Social Service Designee] on 6/22/16 at 3:50 P.M., indicated, "...Should a Resident verbally state...the intent to harm themselves...will have implemented, per physician order, precautionary measure to attempt to prevent such harm...Inform the Administrator, Director of Nursing, and the Social Service Director of behavior observed...Document the said behavior in the medical record. Obtain physician order to initiate precautions. Add needed precaution to Resident Careplan [sic]...Obtain order from physician, if appropriate, for a psychiatric consultation...Remove any potentially dangerous items and sharp objects from Resident's room/possession...Resident will be checked at frequent, but irregular intervals to ascertain the Resident's safety and whereabouts..." 2. During an observation on 6/20/16 at 11:12 A.M., Resident #16 was observed sitting in a wheelchair with closed eyes,			

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	in no apparent distress. During an interview on 6/20/16 at 12:40 P.M., LPN #10 indicated Resident #16 received anti-anxiety medication and experienced behaviors of agitation, anxiety, and restlessness. LPN #10 further indicated, Resident #16 did not have an active behavior management plan. The clinical record of Resident #16 was reviewed on 6/21/16 12:30 P.M. The record indicated the diagnoses included, but were not limited to, dementia with behaviors and anxiety. The Admission MDS (Minimum Data Set) assessment dated 6/8/16 indicated Resident #16 experienced severe cognitive impairment, daily symptoms of mood disorder, no behaviors, and received anti-anxiety medications 7 of 7 days during the assessment period. The Admission Physician Orders dated 6/2/16 included, but were not limited to, orders for, "...Xanax [an anti-anxiety medication] 0.25 mg [milligrams] PO [by mouth] BID [twice daily] PRN [as needed] anxiety..." A Care Plan dated 6/2/16 for, "...Dx [diagnosis] of Anxiety..." indicated			

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	interventions of, "Administer meds [medications] as ordered, Assess Residents [sic] needs; [sic] food, thirst, toileting, comfort, positioning, pain, Allow discussion of feelings and emotions, Assist to identify triggers, measures that relieve anxiety, Psych consults as ordered/scheduled, Notify physician PRN, Monitor residents [sic] side effects of medication on side effect log." The Nursing notes from 6/2/16 at 3:45 P.M. through 6/18/16 at 10:30 P.M., were reviewed and the following was noted: 6/3/316 at 9:15 P.M., "...Res. [resident] awake trying to get out of bed..." 6/4/16 at 10:00 P.M., "...spit out all HS [hour of sleep] medication. Res [resident] restless 1:1 [one to one] until res fell asleep in w/c [wheelchair]..." 6/5/16 at 10:00 A.M., "...has been spitting out meds..." 6/5/16 at 6:00 P.M., "Res [resident] agitated and fidgetty [sic] this PM [evening]. Res told daughter he needed to use restroom. this [sic] nurse + [and]			

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	other CNA attempted to use stand aid [sic] to assist to BR [bathroom]. Res kicked at bottom plate of stand aide, would not hold on to [sic] bar. grabbed [sic] CNA thumb + would not let go. was able to losen [sic] grasp. Res batting at staff. had [sic] to do 2 person transferr [sic] DT [due to] refusal to use stand aid [sic]. tolieted [sic] + assisted back to WC [wheelchair]. in [sic] room with daughter. Cont [continue] to fidget with blanket + pillow..." 6/6/16 at 6:30 P.M., "...Res restless. Res 1:1 most of the day. Family was with Res most of the day..." 6/7/16 at 10 A.M., "...Resident confused..." 6/7/16 at 1:30 P.M., "...trying to get out of chair, refuses care. Verbally abusive to staff. Sitting 1:1...continues with behavior..." 6/8/16 at 10:40 A.M., "...very confused..." 6/8/16 at 10:45 P.M., "Res removing clothes and covers. Trying to get up out of bed per self. Resistive to care until 9 pm [P.M.]. Family at bedside until Res. went to sleep. Res. continues to remove cover and moving hands..."			

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	6/9/16 at 7:50 A.M., "At 3 am...Res awake and moving all ext [extremities] repeatedly. Trying to stand up. Staff nurse did 1 on 1 with res until 5 am..." 6/11/16 at 9:45 P.M., "...7 pm-Resident awake et [and] restless-staff 1:1 with res..." 6/12/16 at 3:00 P.M., "...[name of family member] came and fed lunch to resident. All the rest of the day...has been 1:1 on [sic] care. very restless tried taking him to see things up the hall...nothing calmed...Kept trying to get up unassisted out of WC [wheelchair]" 6/12/16 at 3:30 P.M., "...was resisting ADL [Activities of Daily Living] care this morning putting resistance against stand aid [sic]..." 6/13/16 at [no time indicated], "...res pushing against staff. Yelled out in shower room after getting shower..." 6/13/16 at 8:30 P.M., "...cont to be a bit restless moving feet and scooting to edge of chair..." 6/13/16 at 9:00 P.M., "Res cont. to be restless..."			

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	6/14/16 at 9:00 P.M., "...restless scooting feet..." 6/16/16 at 2:05 A.M., "...Res restless X [times] 1 hour..." 6/16/16 at 2:30 P.M., "...Slightly restless this afternoon, fidgettg [sic] with blankets and takg [sic] geri-sleeves off..." 6/16/16 at 10:30 P.M.,"...Res resless (sic) @ [at] 9p..." 6/17/16 at 10:50 A.M., "...becomes restless with need to void..." 6/17/16 at 4:00 P.M., "gave Zanox [sic], extremely irritable, yelling combative. Suppository also given earlier..." 6/17/16 at 7:00 P.M., "Res 1:1 with family-Res attempting to get [arrow up] unassisted. [arrow up] restless at this X..." 6/17/16 at 8:00 P.M., "Continues to be [arrow up] restless...sitting 1:1 with resident...spitting out med...[arrow up] restless et [and] fidgety..." 6/17/16 at 9:00 P.M., "...combative et yelling-resisting care..." 6/17/16 at 9:45 P.M., "Res starting to			

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	fridget [sic]... 6/18/16 at 6:20 A.M., "Resident combative with care et screaming et cursing at staff..." 6/18/16 at 11:45 A.M., "...Has episodes where he tries to get up unassisted. Gets belligerent with staff at time..." 6/18/16 at 9:00 P.M., "Res laying in bed restless talking to self pulling @ blanket et pillow..." 6/18/16 at 10:30 P.M., "Res cont to be restless yelling out et shaking bedrail..." The Nursing notes indicated Resident #16 experienced 30 episodes of anxiety or agitation between 6/3/316 at 9:15 P.M. and 6/18/16 at 10:30 P.M. and received 22 doses of Xanax 0.25 mg. The Skilled Unit Behavior Management Log Book lacked any documentation to indicate Resident #16 had a behavior management plan. The Social History and Psychosocial Assessment dated 6/2/16 indicated Resident #16 experienced, "...no mood issues and only behavior exhibited is trying to get up unassisted..."			

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	155374		06/23/2016

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	The Social Service Supporting Documentation dated 6/2/16 through 6/8/16 indicated Resident #16 experienced no behaviors during the reference period. The Social Service Supporting Documentation dated 6/8/16 through 6/15/16 indicated Resident #16 experienced no behaviors during the reference period. The Social Service Progress notes from 6/2/16 through 6/21/16 lacked any documentation to indicate Resident #16 had a behavior management plan. During an interview on 6/22/16 at 2:30 P.M. the SSD (Social Service Designee) indicated a behavior management plan was not implemented for Resident #16 until 6/21/16 because she was not aware the resident was experiencing behaviors that required medication intervention. The Policy and Procedure for Behavior Management Program provided by the SSD on 2/23/16 at 10:30 A.M., indicated, "...Objective is to identify the causal factor, if possible, of the behavior as well as seek approaches/interventions appropriate for these said behaviors..." 3.1-34(a)			

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	3.1-34(a)(1)			
F 0280 SS=D Bldg. 00	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. 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. Based on interview and record review, the facility failed to ensure a plan of care that addressed the nutritional needs of a resident had been revised to address an unplanned weight loss for 1 of 3 residents reviewed for nutritional status. (Resident #49) Findings include: On 6/21/16 at 3:48 P.M., Resident #49's	F 0280	It is the practice of this facility to ensure the planof care has addressed the nutritional needs of a resident. 1. Corrective actions accomplished for thoseresidents found to be affected by the alleged deficient practice. a. Resident #49 no longer resides at facility. 2. To identify other residents who have the potential to be affected by the same alleged deficient practice. a. All residents will be reviewed for significant weight loss to ensure	07/20/2016

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	clinical record was reviewed. Resident #49's admission physician orders indicated she had been admitted to the facility on 3/8/16. Resident #49's diagnoses included but were not limited to, post op (operation) right hip fracture and dementia. Resident #49's physician's orders included, but were not limited to, a regular diet with thin liquids. An admission nursing assessment dated 3/8/16, indicated, an admission weight of 137 pounds and a height of 5 foot 2 inches. The admission nursing assessment included but was not limited to, "... Has small reddened area between upper most inner buttocks 0.5 x 0.5 [centimeters]. 0 [zero] broken area noted. Area blanchable..." A Dietary Care Plan initiated 3/9/16 addressed the problem of, "...Alteration in nutrition as evidenced by need for normal bone healing R/T [related to] R [right] hip fx [fracture]." The care plan included two short term goals with a target date of 6/9/16. The goals were: "1.) Will maintain Wt. [weight] 137 +_ [plus or minus] 5 # [pounds] thru next review. 2.) Will have no S/S [signs or symptoms] of dehydration thru next review." Approaches included, "... 1.) Serve diet A/O [as ordered]		appropriate interventions are in place. Any resident identified during this review will be placed on the SWAT program and plan of care updated accordingly. 3. Measures and systemic changes put into place to ensure that the deficient practice does not reoccur. a. The members of the SWAT program will be in-serviced 07/08/2016 regarding the SWAT policy/procedure and the care plan policy/procedure. b. The RD for the facility will review upon their visit any significant weight change and make recommendations accordingly. 4. The corrective action will be monitored to ensure deficient practice does not recur and quality assurance measures put into place are: a. The Food Service Manager and/or Designee will review weekly the residents weighed weekly or monthly for significant weight change and update care plan accordingly. This practice will be ongoing. b. Data will be presented at the quarterly Quality Assurance meeting to determine trends, patterns, and effectiveness of facility plan. The process will be updated as needed.	

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	2.) Honor food pref. [preference] as much as possible 3.) Swat [Skin and Weight Assessment Team] Protocol per facility policy 4.) Enc. [encourage] good food & fluid intakes 5.) RD [Registered Dietician] referral prn [when needed] 6.) Monitor intakes & tolerances 7.) Monitor Wts. [weights] 8.) Monitor skin cond. [condition] 9.) Monitor lab data..." A facility weight sheet initiated on admission (3/8/16) listed the following weights, 3/8/16 =137 lbs, 3/11/16=137 lbs, 3/18/16 =138 lbs, 3/25/16 =134 lbs, 4/1/16= 135 lbs, 4/8/16=132 lbs, 4/15/16=130, 4/22/16=131 lbs, 4/29/16=129 lbs, 5/6/16= 130 lbs. On 6/23/16 at 9:54 A.M., the Food Service Manager (FSM) was interviewed regarding the nutritional needs and unplanned weight loss of Resident #49 who had been admitted on 3/8/16 and discharged on 5/11/16. The FSM was made aware that documentation was lacking of the care plan being revised with new interventions to address a greater than 5 pound weight loss on 4/15/16, 4/22/16, 4/29/16, and 5/6/16. The FSM was also made aware that Resident #49 had been treated with			

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	antibiotics in regard to C.Diff. (Clostridium Difficile) bacteria on 3/21/16, 4/13/16 and in regard to urinary tract infections. During the interview an ongoing wound monitoring sheet dated 5/2/16 was reviewed with the FSM. The wound documentation indicated, on 4/29/16, "... staff noted finding open area to R [right] gluteal fold when toileting. Area assessed et found to have stage II pressure area to R gluteal fold..." During the interview on 6/23/16 at 9:54 A.M., the FSM agreed documentation was lacking of a new intervention being initiated to address the unplanned weight loss of Resident #49. On 6/23/16 at 12:20 P.M., a facility policy entitled, "POLICY REGARDING NURSING CARE PLANS [undated]" was reviewed. The policy included but was not limited to, "... The care plan will be referred to as the nursing care plan/physician plan or treatment and will address interventions and exceed standard protocols...the nursing care plan will be updated monthly..." During interview with the Director of Nursing (DON) on 6/23/16 at 12:23 P.M., regarding the above policy, the DON indicated the care plan should be updated monthly and prn (when needed).			

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	3.1-35(d)(2)(B)			
F 0309 SS=D Bldg. 00	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 practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, interview, and record review, the facility failed to ensure suicide precautions were implemented for a resident who made a statement of wanting to die or intent to self-harm on two separate occasions for 1 of 1 resident who met the criteria for review of suicide precautions. (Resident #33) Findings include: On 6/20/16 at 12:40 P.M., Resident #33 was observed sitting in a wheelchair in the hallway of the ICF unit, in no apparent distress. The clinical record of Resident #33 was reviewed on 6/21/16 at 3:20 P.M. The record indicated Resident #33 was originally admitted to the facility on 2/5/15 and re-admitted to the facility	F 0309	It is the practice of this facility to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. 1. Corrective actions accomplished for those residents found to be affected by the alleged deficient practice. a. Review of Resident #33 Behavioral Management Plan including care plans was completed. Interventions have been included for suicide precautions. 2. To identify other residents who have the potential to be affected by the same alleged deficient practice. a. All resident behavior plans and nurse's notes were reviewed for effectiveness of care plans and behavior plans. No other issues were identified. 3. Measures and systemic changes	07/20/2016

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	from a behavior unit on 7/22/15 with diagnoses including, but not limited to, vascular dementia and depression. The most recent Annual MDS (Minimum Data Set) assessment dated 1/14/16 indicated Resident #33 experienced moderate cognitive impairment, did not experience suicidal ideation or have thoughts of self-harm, and had no behaviors. The Quarterly MDS assessment dated 2/5/16 indicated Resident #33 experienced moderate cognitive impairment, did not experience suicidal ideation or have thoughts of self-harm, and had no behaviors. The most recent Quarterly MDS assessment dated 5/24/16 indicated Resident #33 experienced moderate cognitive impairment, did not experience suicidal ideation or have thoughts of self-harm, and had no behaviors The July 2015 through June 2016 Physician's Order Recaps lacked any documentation to indicate suicide precautions were ordered. The May 2016 Physician's Order Recap included, but was not limited to, an order of, "...Zoloft [an anti-depressant		put into place to ensure that the deficient practice does not reoccur. a. A mandatory in-service will be completed on07/08/2016 for Nursing staff on the revised policy/procedure for Suicide Precautions which includes notification to Administrator, DON, and Social Services along with precautions to be taken. 4. The corrective action will be monitored to ensure deficient practice does not recur and quality assurance measures put into place are: a. Quality Assurance tool has been developed and implemented to monitor for statements of wanting to die or intent to self-harm. This tool will be completed by Social Service and/or Designee weekly for4 weeks, then monthly for 3 months, and then quarterly for 3 quarters. b. Data will be presented at the quarterly Quality Assurance meeting to determine trends, patterns, and effectiveness of facility plan. The process will be updated as needed.	

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	medication] 100 mg...Give 2 tablets by mouth once a day for depression..." A Care Plan dated 5/6/16 for Depression indicated interventions of, "Monitor for s/s [signs/symptoms] depression...voicing suicidal thoughts, Administer ant-depressant as ordered, Psychiatric services as needed, Encourage family to continue frequent visits, Notify Social Service of decline in mood as noticed, Notify MD of decline in mood as indicated, Encourage...to express feelings of anger, frustration, sadness...and provided support and reassurance" The plan of care lacked any interventions related to suicide precautions. During an interview on 6/22/16 at 3:30 P.M. the SSD indicated Resident #33 had a history of making statements of wanting to die or self-harm. The SSD further indicated, she believed Resident #33 initially made a statement of wanting to die or intent to self-harm on or about 7/14/15 at an unknown time, but the event was not documented in the Nursing notes or the Social Service Progress notes because everything happened quickly and the documentation was missed. The SSD further indicated she had faxed a Psychotropic Drug Committee Recommendation to the attending			

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	physician on 7/14/15 and Resident #33 had been on 15 minute checks from 7/10/15 through 7/15/15 due to an unrelated incident. The SSD then indicated no documentation could be provided to indicate Resident #33 was on continuous observation after the statement of wanting to die or intent to self-harm was made. A Psychotropic Drug Committee Recommendation dated 7/14/15 at 9:00 A.M. indicated, "Resident is saying he is going to kill himself and end it all...has made this threat several times. He doesn't seem depressed...is very short tempered and easily annoyed..." The Nursing notes from 7/11/15 at 3:00 P.M. through 7/15/15 at 2:00 P.M. lacked any documentation to indicate Resident #33 made statements of wanting to die, intent to self-harm, or suicide precautions were initiated. A Nursing note dated 7/15/15 at 2:00 P.M. indicated, "Order received may send to transitions behavior unit due to suicidal remarks..." A Physician's Telephone Order dated 7/22/15 at 2:00 P.M. indicated, "Re-admit to [room number]			

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	A Nursing note dated 3/30/16 at 5:00 P.M. indicated, "Crying today. States want to die. Feels like he has been dumped and no one cares about him anymore..." The note lacked any documentation to indicate suicide precautions were implemented. The next consecutive Nursing note dated 3/31/16 at 10:30 A.M. indicated, "Placed on 15 minute checks for personal safety." (17.5 hours elapsed until precautions implemented) The next consecutive Nursing note dated 3/31/16 at 6:15 P.M. indicated, "Taken to [name of hospital]..." An untimed Social Service Progress note dated 3/30/16 indicated, "Social was notified about resident being tearful, but one Social spoke with [Resident #33]...said...just missed...family already...Social will follow up with [Resident #33] tomorrow [sic] and see...has gotten better emotionally." An untimed Social Service Progress note dated 3/31/16 indicated, "...informed the (AM) that in [sic] the eveing [sic] of the 30th Resident stated he, "wanted to die." Nsg [nursing] asked why, resident explianed [sic]...felt like...has been dumped here and that no one cares about			

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	him anymore...is also upset about his weight gain and stated...was fat and no one would love him, why should they? Social went to talk to resident about stating...wants to die. Social asked resident if...had a plan. Resident told this writer he just wishes he could drink something and never wake up. Social then asked resident why he would want to do something like that. Social then re-assured him of how may people do love and care about him. Social then pulled residents [sic] call light for an aid to come in the room and remove everything out of ...room that was drinkable and could possibly harm the resident. ...stated...didn't feel like...depression meds [medicines] were working anymore and...had lost all ambition in life. Social and resident spoke for about 20 more mins [minutes] and asked resident if...would sit in the lounge until we could take...to a behavior unit to get...the help...asked for b/c [because] we all cared about...and were worried. Resident agreed to sit in lounge and social placed resident on 15 min. checks until [name of psychiatrist] could see...since he was coming to the facility today. [name of psychiatrist] saw resident and agreed...needed inpatient treatment as well due to...depression appearing to get worse. Resident was transferred to [name of behavioral unit]..."			

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	During an interview on 6/22/16 at 3:45 P.M., the SSD indicated she had notified the attending physician on 3/31/16, at an unknown time, of Resident #33's statement of wanting to die or intent to self-harm and was advised just to monitor Resident #33. The SSD further indicated, [name of psychiatrist] was already scheduled to visit the facility on 3/31/16 so she waited until [name of psychiatrist] had time to see Resident #33. The SSD further indicated no documentation could be provided to indicate what time Resident #33 was seen by the psychiatrist but, Resident #33 was transferred to behavior unit on 3/31/16 at 6:00 P.M. During an interview on 6/23/16 at 11:00 A.M., the SSD indicated she was not aware of Resident #33 statement of wanting to die or intent to self-harm until the morning of 3/31/16. The SSD further indicated no documentation could be provided to indicate suicide precautions were implemented between 3/30/16 at 5:00 P.M. and 3/31/16 at 10:15 A.M. During an interview on 6/23/16 at 11:30 A.M., the DON [Director of Nursing]indicated she was not aware of Resident #33 statement of wanting to die or intent to self-harm until the morning of			

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	3/31/16. The DON further indicated no documentation could be provided to indicate suicide precautions were implemented between 3/30/16 at 5:00 P.M. and 3/31/16 at 10:15 A.M. During an interview on 6/23/16 at 2:00 P.M., the HFA [Health Facilities Administrator] indicated she was not aware of Resident #33 statement of wanting to die or intent to self-harm until the morning of 3/31/16. The HFA further indicated no documentation could be provided to indicate suicide precautions were implemented between 3/30/16 at 5:00 P.M. and 3/31/16 at 10:15 A.M. The Policy and Procedure for Suicide Precautions provided by the SSD [Social Service Designee] on 6/22/16 at 3:50 P.M. indicated, "...Should a Resident verbally state...the intent to harm themselves...will have implemented, per physician order, precautionary measure to attempt to prevent such harm...Inform the Administrator, Director of Nursing, and the Social Service Director of behavior observed...Document the said behavior in the medical record. Obtain physician order to initiate precautions. Add need precaution to Resident Careplan [sic]...Obtain order from physician, if appropriate, for a psychiatric consultation...Remove any potentially			

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	dangerous items and sharp objects from Resident's room/possession...Resident will be checked at frequent, but irregular intervals to ascertain the Resident's safety and whereabouts..." 3.1-37(a)			
F 0319 SS=D Bldg. 00	483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. Based on observation, interview, and record review, the facility failed to ensure behavior management services were correctly provided to a newly admitted resident for 1 of 1 resident who met the criteria for review of psychosocial adjustment needs. (Resident #16) Findings include: During an observation on 6/20/16 at 11:12 A.M., Resident #16 was observed sitting in a wheelchair with closed eyes, in no apparent distress. The clinical record of Resident #16 was reviewed on 6/21/16 12:30 P.M. The record indicated Resident #16 was	F 0319	It is the practice of this facility to ensure that aresident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. 1. Corrective actions accomplished for those residents found to be affected by the alleged deficient practice. a. Resident #16 was allegedly affected needing a behavior management plan. A behavior management has been put in place which include interventions. b. Resident#16 has an order for PRN anti-anxiety medication and there is now documentationto support that non-chemical interventions were attempted in accordance withthe behavior management plan prior to the administration of any	07/20/2016

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	admitted from a behavioral health unit to the facility on 6/2/16 with diagnoses including, but not limited to, dementia with behaviors, insomnia, depression, and anxiety. The Admission MDS (Minimum Data Set) assessment dated 6/8/16 indicated Resident #16 experienced severe cognitive impairment, daily symptoms of mood disorder, no behaviors, and received anti-anxiety, anti-depressant, and hypnotic medications 7 of 7 days during the assessment period. The Admission Physician Orders dated 6/2/16 included, but were not limited to, orders for, "...Ambien [a hypnotic medication] 10 mg [milligrams] PO [by mouth] at HS [hour of sleep] dx [diagnosis] insomnia...Xanax [an anti-anxiety medication] 0.25 mg PO daily at 8 [8:00] pm [P.M.] dx [diagnosis] anxiety...Xanax 0.25 mg 1 PO BID [twice daily] PRN [as needed] anxiety..." A Care Plan dated 6/2/16 for, "...Dx of Anxiety..." indicated interventions of, "Administer meds [medications] as ordered, Assess Residents [sic] needs; [sic] food, thirst, toileting, comfort, positioning, pain,		prnanti-anxiety medication. 2. To identify other residents who have the potential to be affected by the same alleged deficient practice. a. All resident behavior plans and nurse's notes were reviewed for effectiveness of care plans and behavior plans. No other issues were identified. 3. Measures and systemic changes put into place to ensure that the deficient practice does not reoccur. a. Staff members in-serviced 07/08/2016 to re-educate on the Behavior Management policy/procedure. Behavior Management Program includes the following: Identification of a new or worsening behavior, Assessment of new behaviors as well as increased or decreased behaviors, Monitoring to determine frequency and impact of challenging behaviors, Initiation of Behavior Management intervention/plan, Behavior plan in effect, Education of staff members,Objective: Each resident of the facility identified as exhibiting problematic behavior will be reported on MARS to identify the casual factor, if possible,of the behavior as well as seek approaches/interventions appropriate for these said behaviors. b. All behaviors are reviewed and discussed daily during stand up meeting to ensure appropriate interventions arein place. 4. The corrective action will be monitored to ensure	

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	Allow discussion of feelings and emotions, Assist to identify triggers, measures that relieve anxiety, Psych consults as ordered/scheduled, Notify physician PRN, Monitor residents [sic] side effects of medication on side effect log." A Care Plan dated 6/2/16 for "Insomnia" indicated interventions of, "Attempt to limit naps and provide activities, Medicate as ordered, Notify Physician PRN" A Physician's Telephone Order dated 6/3/16 at 8:00 A.M. indicated, "...[arrow down] [decrease] Ambien to 5 mg PO q [every] HS + [and] may repeat X 1 in one hour PRN..." A review of the June 2016 MAR compared to the Controlled Substance record from 6/3/16 through 6/11/16 indicated Resident #16 received Ambien] 10 mg on 6/3/16, 6/4/16, 6/6/16, 6/10/16, and 6/11/16 for insomnia. A Nursing note dated 6/7/16 at 6:25 A.M. indicated, "At 4:45 A.M. found res with feet towards wall (HOB) [head of bed] sitting in floor hold on to [sic] bed rail..." The Nursing 2014 Drug Handbook 34th		deficient practice does not recur and quality assurance measures put into place are: a. Social Services will be responsible to monitor the MAR's and meet with the IDT weekly to monitor and discuss any and all behaviors and interventions. b. QA audit tool will be completed by the Director of Social Services and/or designee weekly for 4 weeks, then monthly for 3 months, and then quarterly for 3 quarters. c. The outcome of this tool will bereviewed at the facility's quarterly Quality Assurance meeting to determine ifany additional action is warranted.	

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	Edition page 1459 indicated, "...Zolpidem Tartrate...Ambien...For elderly or debilitated patients...5 mg P.O. immediately before bedtime...Adverse Reactions: complex sleep-related behaviors, dizziness...nervousness...use drug only for short-term management of insomnia, usually 7 to 10 days..." The June 2016 MAR (Medication Administration Record) indicated Resident #16 was administered Xanax 0.25 mg 10 times as needed between 6/3/16 and 6/18/16. The MAR lacked any documentation to indicate clinical indications for the use of the anti-anxiety medication. A Controlled Substance record dated 6/2/16 indicated, "Alprazolam [Xanax] 0.25 mg Give 1 tablet by mouth q8h [every 8 hours] PRN". The record further indicated Resident #16 was administered 6 additional doses of Xanax 0.25 mg. The record lacked any documentation to indicate clinical indications for use of the anti-anxiety medication. An additional Controlled Substance record dated 6/2/16 indicated, "Alprazolam [Xanax] 0.25 mg Give 1 tablet by mouth q8h as needed for anxiety" The record further indicated			

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	Resident #16 was administered 5 additional doses of Xanax 0.25 mg. The record lacked any documentation to indicate clinical indications for use of the anti-anxiety medication. The Nursing notes from 6/3/16 at 6:00 P.M. through 6/5/16 at 5:30 P.M. lacked any documentation to indicate Resident #16 experienced anxiety, had been administered Xanax prn, or non-pharmacological interventions were attempted prior to the administration. A Nursing note dated 6/5/16 at 6:00 P.M. indicated, "Res [resident] agitated and fidgetty [sic] this PM [evening]. Res told daughter he needed to use restroom. this [sic] nurse + [and] other CNA attempted to use stand aid [sic] to assist to BR [bathroom]. Res kicked at bottom plate of stand aide, would not hold on to [sic] bar. grabbed [sic] CNA thumb + would not let go. was able to losen [sic] grasp. Res batting at staff. had [sic] to do 2 person transferr [sic] DT [sue to] refusal to use stand aid [sic]. tolieted [sic] + assisted back to WC [wheelchair]. in [sic] room with daughter. Cont [continue] to fidget with blanket + pillow. Xanax given will monitor for effective [sic]" The note lacked any documentation to indicate non-pharmacological interventions were attempted prior to the administration of			

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	Xanax. The Nursing notes from 6/6/16 at 10:00 P.M. through 6/6/16 at 11:30 P.M. lacked any documentation to indicate Resident #16 experienced anxiety, had been administered Xanax, or non-pharmacologic interventions were attempted prior to the administration. The Nursing notes from 6/7/16 at 10:10 P.M. through 6/11/16 at 9:45 P.M. lacked any documentation to indicate Resident #16 experienced anxiety, had been administered Xanax, or non-pharmacologic interventions were attempted prior to the administration. A Nursing note dated 6/12/16 at 3:00 P.M. indicated, "...has been 1:1 [one on one] on [sic] care very restless tried taking him to see things up the halls...gave Xanax @ [at] 2pm [2:00 P.M.]..." The Nursing notes from 6/12/16 at 3:30 P.M. through 6/13/16 at 8:30 P.M. lacked any documentation to indicate Resident #16 experienced anxiety, had been administered Xanax, or non-pharmacologic interventions were attempted prior to the administration.			

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	The Nursing notes from 6/14/16 at 10:00 P.M. through 6/16/16 at 2:05 A.M. lacked any documentation to indicate Resident #16 experienced anxiety, had been administered Xanax, or non-pharmacologic interventions were attempted prior to the administration. The Nursing notes from 6/16/16 at 2:30 P.M. through 6/16/16 at 10:30 P.M. lacked any documentation to indicate Resident #16 experienced anxiety, had been administered Xanax, or non-pharmacologic interventions were attempted prior to the administration. The Nursing notes dated 6/18/16 at 11:45 A.M. through 6/18/16 at 9:00 P.M. lacked any documentation to indicate Resident #16 experienced anxiety, had been administered Xanax, or non-pharmacologic interventions were attempted prior to the administration. (The record indicated Resident #16 received 22 doses of Xanax 0.25 mg between 6/3/16 and 6/18/16 without clinical indications for use.) During an interview on 6/22/16 at 3:00 P.M., the DON (Director of Nursing) indicated an accurate accounting of Ambien and PRN Xanax administration			

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	for Resident #16 could not be provided. The DON further indicated, at that time, the Ambien 10 mg supply should have been destroyed when the order was revised and a new supply of Ambien 5 mg should have been obtained and the PRN anti-anxiety medication should not be administered without a clinical indication and non-pharmacological interventions should be attempted before administration. The Policy and Procedure for Psychoactive Medications provided by the SSD on 6/23/16 at 1:40 P.M. indicated, "...Psychoactive medications shall only be used when there is adequate indication for their use...Use of antianxiety [sic] medications...Before antianxiety [sic] therapy is instituted, the resident will be assessed to determine other possible underlying causes for the resident's distress...All resident for whom antianxiety [sic] agents are considered necessary must have documented in the clinical record the disorder...and the specific target behaviors for which the medication is prescribed...There must be a specific plan for staff to monitor, quantitatively document and assess the identified target behaviors...the use of...hypnotic medications must be in accord with the policy governing the use			

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	of psychoactive medications..." During an interview on 6/20/16 at 12:40 P.M., LPN #10 indicated Resident #16 received anti-anxiety medication and experienced behaviors of agitation, anxiety, and restlessness. LPN #10 further indicated, Resident #16 did not have an active behavior management plan. The Skilled Unit Behavior Management Log Book lacked any documentation to indicate Resident #16 had a behavior management plan. The Social History and Psychosocial Assessment dated 6/2/16 indicated Resident #16 experienced, "...no mood issues and only behavior exhibited is trying to get up unassisted..." The Social Service Supporting Documentation dated 6/2/16 through 6/8/16 indicated Resident #16 experienced no behaviors during the reference period. The Social Service Supporting Documentation dated 6/8/16 through 6/15/16 indicated Resident #16 experienced no behaviors during the reference period.			

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	The Social Service Progress notes from 6/2/16 through 6/21/16 lacked any documentation to indicate Resident #16 had a behavior management plan. During an interview on 6/22/16 at 2:30 P.M. the SSD (Social Service Designee) indicated a behavior management plan was not implemented for Resident #16 until 6/21/16 because she was not aware the resident was experiencing behaviors that required medication intervention. 3.1-43(a)(1)			
F 0329 SS=D Bldg. 00	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. 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			

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	receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on observation, interview, and record review, the facility failed to ensure an anti-anxiety medication was clinically indicated for 1 of 5 residents who met the criteria for review of unnecessary medications. (Resident #16) Findings include: During an observation on 6/20/16 at 11:12 A.M., Resident #16 was observed sitting in a wheelchair with closed eyes, in no apparent distress. The clinical record of Resident #16 was reviewed on 6/21/16 12:30 P.M. The record indicated the diagnoses included, but were not limited to, dementia with behaviors and anxiety. The Admission MDS (Minimum Data Set) assessment dated 6/8/16 indicated Resident #16 experienced severe cognitive impairment, daily symptoms of mood disorder, no behaviors, and received anti-anxiety medications 7 of 7 days during the assessment period. The Admission Physician Orders dated 6/2/16 included, but were not limited to, orders for, "...Xanax [an anti-anxiety	F 0329	It is the practice of this facility to ensure each resident's drug regimen must be free from unnecessary drugs. 1. Corrective actions accomplished for those residents found to be affected by the alleged deficient practice. a. The Interdisciplinary Team/Behavioral Management Team will complete a review ofResident #16 medical record and be placed on a behavior management program. b. Resident#16 has an order for PRN anti-anxiety medication and there is now documentationto support that non-chemical interventions were attempted in accordance with the behavior management plan prior to the administration of any prn anti-anxiety medication. 2. To identify other residents who have the potential to be affected by the same alleged deficient practice. a. The Interdisciplinary Team will complete a review of residents currently receiving anti-anxiety drugs. Any resident identified during this review will be placed on a behavior management program if warranted along with the plan of care updated. b. On admission, quarterly, significant change, and as needed, a review of MAR's will be reviewed to determine if specific behavioral management	07/20/2016

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	medication] 0.25 mg [milligrams] PO [by mouth] BID [twice daily] PRN [as needed] anxiety..." A Care Plan dated 6/2/16 for, "...Dx [diagnosis] of Anxiety..." indicated interventions of, "Administer meds [medications] as ordered, Assess Residents [sic] needs; [sic] food, thirst, toileting, comfort, positioning, pain, Allow discussion of feelings and emotions, Assist to identify triggers, measures that relieve anxiety, Psych consults as ordered/scheduled, Notify physician PRN, Monitor residents [sic] side effects of medication on side effect log." The June 2016 MAR (Medication Administration Record) indicated Resident #16 was administered Xanax 0.25 mg 10 times as needed between 6/3/16 and 6/18/16. The MAR lacked any documentation to indicate clinical indications for use and lacked any documentation to indicate non-pharmacological interventions were attempted prior to the administration as follows: "...6/3/16...6p [6:00 P.M.],		program will be warranted along with interventions for specific behaviors. If identified as needing behavior management, then the plan of care will be updated to reflect changes. c. Residents identified by the Interdisciplinary Team will be reviewed on a monthly basis or more often as indicated by individual needs. d. The care plans, behavior flow sheets, and assignment sheets will be updated to reflect changes. 3. Measures and systemic changes put into place to ensure that the deficient practice does not reoccur. a. The nursing staff and Interdisciplinary care planning team will be in-serviced 07/08/2016 to re-educate in the Behavior Management Program by the DNS and/or Designee. This in-service is mandatory for all members of the interdisciplinary team. b. Nursing staff will document any behaviors and report unusual behavior on the daily 24hour report sheets along with documentation in the nurse's notes. 4. The corrective action will be monitored to ensure deficient practice does not recur and quality assurance measures put into place are: a. The DNS and/or Designee and Social ServiceDirector will review daily 24 hour report sheets, behavior flow sheets, and nurse's notes to ensure proper usage of psychotropic medication. This process will be ongoing. b. Data	

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	6/4/16...415a [4:15 A.M.], 6/5/16...1215 [12:15 P.M.], 6/7/16...230 [2:30 P.M.], 6/8/16...340a [3:40 A.M.], 6/9/16...7p [7:00 P.M.], 6/11/16...5p [5:00 P.M.], 6/12/16...530p [5:30 P.M.], 6/18/16...230p, and 6/18/16...5p..." A Controlled Substance record dated 6/2/16 indicated, "Alprazolam [Xanax] 0.25 mg Give 1 tablet by mouth q8h [every 8 hours] PRN". The record further indicated Resident #16 was administered 6 additional doses of Xanax 0.25 mg. The record lacked any documentation to indicate clinical indications for use of the anti-anxiety medication and lacked any documentation to indicate non-pharmacological interventions were attempted prior to the administration as follows: "6/5/16...6p [6:00 P.M.]" "6/6/16...10p [10:00 P.M.]" "6/8/16...6p [6:00 P.M.]" "6/9/16...340a [3:40 A.M.]" "6/11/16...2p [2:00 P.M.]" "6/16/16...6p [6:00 P.M.]" An additional Controlled Substance record dated 6/2/16 indicated, "Alprazolam [Xanax] 0.25 mg Give 1 tablet by mouth q8h as needed for		will presented at the quarterly Quality Assurance meeting to determine trends, patterns, and effectiveness of facility plan. The process will be updated as needed.	

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	anxiety" The record further indicated Resident #16 was administered 5 additional doses of Xanax 0.25 mg. The record lacked any documentation to indicate clinical indications for use of the anti-anxiety medication and lacked any documentation to indicate non-pharmacological interventions were attempted prior to the administration as follows: "6/4/26...1215 [12:15 P.M.]" "6/10/16...6p [6:00 P.M.]" "6/11/16...6p [6:00 P.M.]" "6/13/16...6p [6:00 P.M.]" "6/15/16...6p [6:00 P.M.]" A Nursing note dated 6/12/16 at 3:00 P.M. indicated, "...has been 1:1 [one on one] on [sic] care very restless tried taking him to see things up the halls...gave Xanax @ [at] 2pm [2:00 P.M.]..." (The records indicated Resident #16 received 22 doses of Xanax 0.25 mg between 6/3/16 and 6/18/16 without clinical indications for use or non-pharmacological interventions being attempted.) During an interview on 6/22/16 at 3:00 P.M., the DON (Director of Nursing indicated an accurate accounting of PRN Xanax administration for Resident #16 could not be provided. The DON further indicated, PRN anti-anxiety medication			

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	should not be administered without clinical indication and non-pharmacological interventions should be attempted before administration. The Nursing notes from 6/3/16 at 6:00 P.M. through 6/5/16 at 5:30 P.M. lacked any documentation to indicate Resident #16 experienced anxiety, had been administered Xanax prn, or non-pharmacological interventions were attempted prior to the administration A Nursing note dated 6/5/16 at 6:00 P.M. indicated, "Res [resident] agitated and fidgetty [sic] this PM [evening]. Res told daughter he needed to use restroom. this [sic] nurse + [and] other CNA attempted to use stand aid [sic] to assist to BR [bathroom]. Res kicked at bottom plate of stand aide, would not hold on to [sic] bar. grabbed [sic] CNA thumb + would not let go. was able to losen [sic] grasp. Res batting at staff. had [sic] to do 2 person transferr [sic] DT [due to] refusal to use stand aid [sic]. tolieted [sic] + assisted back to WC [wheelchair]. in [sic] room with daughter. Cont [continue] to fidget with blanket + pillow. Xanax given will monitor for effective [sic]" The note lacked any documentation to indicate non-pharmacological interventions were attempted prior to the administration of			

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	Xanax. The Nursing notes from 6/6/16 at 10:00 P.M. through 6/6/16 at 11:30 P.M. lacked any documentation to indicate Resident #16 experienced anxiety, had been administered Xanax, or non-pharmacologic interventions were attempted prior to the administration. The Nursing notes from 6/7/16 at 10:10 P.M. through 6/11/16 at 9:45 P.M. lacked any documentation to indicate Resident #16 experienced anxiety, had been administered Xanax, or non-pharmacologic interventions were attempted prior to the administration. The Nursing notes from 6/12/16 at 3:30 P.M. through 6/13/16 at 8:30 P.M. lacked any documentation to indicate Resident #16 experienced anxiety, had been administered Xanax, or non-pharmacologic interventions were attempted prior to the administration. The Nursing notes from 6/14/16 at 10:00 P.M. through 6/16/16 at 2:05 A.M. lacked any documentation to indicate Resident #16 experienced anxiety, had been administered Xanax, or non-pharmacologic interventions were attempted prior to the administration.			

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	The Nursing notes from 6/16/16 at 2:30 P.M. through 6/16/16 at 10:30 P.M. lacked any documentation to indicate Resident #16 experienced anxiety, had been administered Xanax, or non-pharmacologic interventions were attempted prior to the administration. The Nursing notes dated 6/18/16 at 11:45 A.M. through 6/18/16 at 9:00 P.M. lacked any documentation to indicate Resident #16 experienced anxiety, had been administered Xanax, or non-pharmacologic interventions were attempted prior to the administration. The June 2016 PRN Pain Indication Log indicated Resident #16 received Xanax as follows: "6/9/16 at 3:40 A.M...continuous body movement and yelling...6/16/16 at 6:00 P.M. for, "fidget with blanket, tearful..." The log lacked any documentation to indicate non-pharmacologic interventions were attempted prior to the administrations. The Policy and Procedure for Psychoactive Medications provided by the SSD on 6/23/16 at 1:40 P.M. indicated, "...Psychoactive medications shall only be used when there is adequate indication for their use...Use of antianxiety [sic] medications...Before			

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	antianxiety [sic] therapy is instituted, the resident will be assessed to determine other possible underlying causes for the resident's distress...All resident for whom antianxiety [sic] agents are considered necessary must have documented in the clinical record the disorder...and the specific target behaviors for which the medication is prescribed...There must be a specific plan for staff to monitor, quantitatively document and assess the identified target behaviors..." 3.1-48(a)(4) 3.1-48(a)(2)			
F 0431 SS=E Bldg. 00	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and			

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	biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 0431	It is the practice of this facility to ensure its policies are followed in regards to disposal of controlled medications, securing medication carts when not in view of a nurse, issuing medication room keys to unauthorized personnel, monitoring medication refrigerator temperatures, and disposal of discontinued medications for discharged residents in a timely manner. 1. Corrective actions accomplished for those residents found to be affected by the alleged deficient practice. a. New refrigerator purchased for Hall 1. All meds affected in refrigerator during survey were replaced. b. A review of Resident #16 was completed and the discontinued medication of Amiben10mg was destroyed per facility policy. c. The meds of discharged/expired residents have been completed. d. Housekeeping/LaundrySupervisor has been instructed that she	07/20/2016

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			cannot be unattended in med room during stocking of supplies. e. The License Nurse that left med cart unlocked was disciplined. 2. To identify other residents who have the potential to be affected by the same alleged deficient practice. a. A complete review of resident's receiving new orders for dosage changes of a controlled substance have been completed. No issues were identified. b. No further incidents have occurred of Housekeeping/Laundry Supervisor being in med room unattended. c. Med carts have been locked which have been observed during random daily rounds. d. All other med room refrigerators were checked for proper temperature and no problems identified. 3. Measures and systemic changes put into place to ensure that the deficient practice does not reoccur. a. The review of daily orders will be completed by DON and/or Designee during stand up meeting and if a controlled substance has an order change then a review of the count sheet record will be completed to ensure appropriate destruction was completed. b. An in-service will be completed 07/08/2016 to License Nurses regarding leaving med cart unlocked, allowing unauthorized personnel in med room unattended, and the importance of the appropriate	

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			refrigerator temperature for storage of medications that require refrigeration. c. A mandatory in-service will be completed07/08/2016 for all License Nurses on the revised policy/procedure for Disposal/Destruction of Expired or Discontinued Medications. d. Temperatures will be recorded daily on all refrigerators to maintain appropriate temperatures. If discrepancy is noted,then immediate action will be taken to correct. 4. The corrective action will be monitored to ensure deficient practice does not recur and quality assurance measures put into place are: a. The DON and/or Designee will monitor temperature log at a minimum of 3 times weekly. This process will be ongoing. b. Controlled Substance audit will be completed 3 times weekly at random for 30 days, then 2times weekly at random for 30 days, then 1 time weekly at random for 30 days. The DON and/or Designee will complete this audit. c. The Administrator, DON, and/or Designee will check during daily rounds to ensure unauthorized personnel are not unattended in med room and Med carts are locked when unattended. Any discrepancies noted will have immediate action taken. d. Data will be presented at the facility's quarterly Quality Assurance meeting to determine trends, patterns, and	

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			effectiveness of facility plan. The process will be updated as needed.	
F 0514 SS=D Bldg. 00	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on observation, interview, and record review, the facility failed to ensure documentation was complete and accurate for 1 of 5 residents who met the criteria for review of unnecessary medications (Resident #16) and for 1 of 1 resident who met the criteria for review of suicide precautions. (Resident #33) Findings include: 1. During an observation on 6/20/16 at 11:12 A.M., Resident #16 was observed sitting in a wheelchair with closed eyes, in no apparent distress. The clinical record of Resident #16 was	F 0514	It is the practice of this facility to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. 1. Corrective action accomplished for those residents found to be affected by the alleged deficient practice. a. Resident #16 has an order for PRN anti-anxiety medication and there is now documentation to support that non-chemical interventions were attempted in accordance with the behavior management plan prior to the administration of any prn anti-anxiety medication. b. A review of Resident #16 was	07/20/2016

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	reviewed on 6/21/16 12:30 P.M. The record indicated the diagnoses included, but were not limited to, dementia with behaviors and anxiety. The Admission MDS (Minimum Data Set) assessment dated 6/8/16 indicated Resident #16 experienced severe cognitive impairment, daily symptoms of mood disorder, and received anti-anxiety medications 7 of 7 days during the assessment period. The Admission Physician Orders dated 6/2/16 included, but were not limited to, orders for, "...Xanax [an anti-anxiety medication] 0.25 mg [milligrams] PO [by mouth] BID [twice daily] PRN [as needed] anxiety..." The June 2016 MAR (Medication Administration Record) indicated Resident #16 was administered Xanax 0.25 mg 10 times as needed between 6/3/16 and 6/18/16 as follows: "...6/3/16...6p [6:00 P.M.], 6/4/16...415a [4:15 A.M.], 6/5/16...1215 [12:15 P.M.], 6/7/16...230 [2:30 P.M.], 6/8/16...340a [3:40 A.M.], 6/9/16...7p [7:00 P.M.], 6/11/16...5p [5:00 P.M.], 6/12/16...530p [5:30 P.M.],		completed and the discontinued medication of Ambien 10mg was destroyed per facility policy. c. Review of Resident #33 Behavioral Management Plan including care plans was completed. Interventions have been included for suicide precautions. 2. To identify other residents who have the potential to be affected by the same alleged deficient practice. a. A complete review of resident's receiving new orders for dosage changes of a controlled substance have been completed. No issues were identified. b. All resident behavior plans and nurse's notes were reviewed for effectiveness of care plans and behavior plans. No other issues were identified. 3. Measures and systemic changes put into placeto ensure that the deficient practice does not reoccur. a. The nursing staff and interdisciplinary care planning team will be in-serviced 07/08/2016 to re-educate in the BehaviorManagement Program by the DNS and/or Designee. This in-service is mandatory for all members of the interdisciplinaryteam b. Nursing staff will document any behaviors and report unusual behavior on the daily 24 hour report sheets along with documentation in the nurse's notes. c. A mandatory in-service will be completed on 07/08/2016 for all License Nurses on the revised policy/procedure	

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	6/18/16...230p, and 6/18/16...5p..." A Controlled Substance record dated 6/2/16 indicated, "Alprazolam [Xanax] 0.25 mg Give 1 tablet by mouth q8h [every 8 hours] PRN". The record further indicated Resident #16 was administered 6 additional doses of Xanax 0.25 mg as follows: "6/5/16...6p [6:00 P.M.]" "6/6/16...10p [10:00 P.M.]" "6/8/16...6p [6:00 P.M.]" "6/9/16...340a [3:40 A.M.]" "6/11/16...2p [2:00 P.M.]" "6/16/16...6p [6:00 P.M.]" An additional Controlled Substance record dated 6/2/16 indicated, "Alprazolam [Xanax] 0.25 mg Give 1 tablet by mouth q8h as needed for anxiety" The record further indicated Resident #16 was administered 5 additional doses of Xanax 0.25 mg as follows: "6/4/26...1215 [12:15 P.M.]" "6/10/16...6p [6:00 P.M.]" "6/11/16...6p [6:00 P.M.]" "6/13/16...6p [6:00 P.M.]" "6/15/16...6p [6:00 P.M.]" A Nursing note dated 6/12/16 at 3:00		for Disposal/Destruction of Expired or Discontinued Medications. d. The review of daily orders will be completed by theDON and/or Designee during stand up meeting and if a controlled substance has an order change then review of the count sheet record will be completed to ensure appropriate destruction was completed. e. Social Service will be in-serviced on 07/08/2016 on the requirement of documentation of any event that requires Social Service intervention. 4. The corrective action will be monitored to ensure deficient practice does not recur and quality assurance measures put into place are: a. Controlled Substance audit will be completed 3 times weekly at random for 30 days, then 2 times weekly at random for 30 days,then 1 time weekly at random for 30 days. The DON and/or Designee will complete this audit. b. Quality Assurance tool has been developed and implemented to monitor for statements of wanting to die or intent to self-harm. This tool will be completedby Social Service and/or Designee weekly for 4 weeks, then monthly for 3months, and then quarterly for 3 quarters. This tool will be reviewed by the Administrator for completeness. c. Data will be presented at the quarterly Quality Assurance Meeting to determine trends,patterns, and effectiveness	

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	P.M. indicated, "...has been 1:1 [one on one] on [sic] care very restless tried taking him to see things up the halls...gave Xanax @ [at] 2pm [2:00 P.M.]..." 2. On 6/20/16 at 12:40 P.M., Resident #33 was observed sitting in a wheelchair in the hallway of the ICF unit, in no apparent distress. The clinical record of Resident #33 was reviewed on 6/21/16 at 3:20 P.M. The record indicated Resident #33 was originally admitted to the facility on 2/5/15 and re-admitted to the facility from a behavior unit on 7/22/15 with diagnoses including, but not limited to, vascular dementia and depression. During an interview on 6/22/16 at 3:30 P.M. the SSD indicated, she believed Resident #33 initially made a statement of wanting to die or intent to self-harm on or about 7/14/15 at an unknown time, but the event was not documented in the Nursing notes or the Social Service Progress notes because everything happened quickly and the documentation was missed. The SSD further indicated she had faxed a Psychotropic Drug Committee Recommendation to the attending physician on 7/14/15.		of facility plan. The process will be updated as needed.	

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	A Psychotropic Drug Committee Recommendation dated 7/14/15 at 9:00 A.M. indicated, "Resident is saying he is going to kill himself and end it all...has made this threat several times. He doesn't seem depressed...is very short tempered and easily annoyed..." The Nursing notes from 7/11/15 at 3:00 P.M. through 7/15/15 at 2:00 P.M. lacked any documentation to indicate Resident #33 made statements of wanting to die, intent to self-harm, or suicide precautions were initiated. During an interview on 6/22/16 at 3:00 P.M. the DON (Director of Nursing indicated an accurate accounting of Xanax administration between 6/3/16 and 6/18/16 could not be provided because the documentation was not complete and accurate. The DON further indicated, at that time, it was the usual practice of the facility to have complete and accurate documentation. 3.1-45(a)(2)			