

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/12/2011
NAME OF PROVIDER OR SUPPLIER CYPRESS GROVE REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DRIVE NEWBURGH, IN47630		
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: April 5, 6, 7, 8, 11, 12, 2011</p> <p>Facility number: 000173 Provider number: 155273 AIM number: 100290920</p> <p>Survey team: Martha Saull, RN TC Carole McDaniel, RN 4/5, 4/6, 4/7, 4/8/2011 Terri Walters, RN 4/5, 4/6, 4/7, 4/11, 4/12, 2011 Liz Harper, RN</p> <p>Census bed type: SNF/NF: 76 SNF: 14 Total: 90</p> <p>Census payor type: Medicare: 12 Medicaid: 58 Other: 20 Total: 90</p> <p>Sample: 18 Supplemental Sample: 1</p>	F0000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law. Cypress Grove Nursing and Rehabilitation Center desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective May 10, 2011.		

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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F0157	<p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 4-18-11 Cathy Emswiller RN</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically</p>				

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SS=D	<p>update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on observation, interview and record review, the facility failed to ensure physician notification of a low blood sugar as outlined in the facility protocol for 1 of 2 residents in a sample of 18. (Resident # 74)</p> <p>Findings include:</p> <p>On 4/5/11 at 9:30 A.M., the record for resident # 74 was reviewed. The Minimum Data Set (MDS) Assessment indicated the resident needed extensive assist with transfers, dressing, eating, hygiene, and bathing. Incontinent of bowel and bladder. The diagnoses include, but not limited to, diabetes, hypertension, dementia, congested heart failure and chronic obstructive pulmonary disease.</p> <p>The physicians diabetic orders for February 2011 included:</p> <ol style="list-style-type: none"> 1. Accucheck AC (before meals) and HS (bedtime) with sliding scale coverage. 2. Lantus 100 units per milliliters vial: inject 22 units subcutaneous at bedtime. 3. Novolog 100 units per milliliters vial: inject 6 units subcutaneous three times a day before meals. 4. Novolog 100 units per milliliters vial: 	F0157	<p>It is the policy of Cypress Grove Rehabilitation Center to ensure resident physician notification of blood sugars below 60. The medical record of resident #74 has been reviewed. Review included blood sugars below 60, physician as well as physician and responsible party notification. Notification was completed as needed. A 100% record review of current in-house residents has been completed on residents with physician orders for in-house blood sugars (accu-checks). Review included but was not limited to BS <60, physician and responsible party notification. Notification was completed on any identified residents. Licensed nurses will be re-educated on policy and procedure for physician and family notification of residents experiencing a blood sugar below 60. Licensed Nurses will document any resident with a blood sugar below 60 on the 24 hour Report Sheet. Nursing Administration will review the 24 hour Report Sheet daily x 2 weeks and 5 x weekly thereafter. The medical record of any resident identified with a blood sugar below 60 will be reviewed by the Interdisciplinary Team (IDT) to ensure appropriate physician and responsible party notification. Identified</p>	05/10/2011	

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	<p>inject subcutaneous per sliding scale: Blood sugar (accucheck reading): 110-150 = 2 units, 151-200 = 3 units, 201-250 = 6 units, 251-300 = 9 units, 201-350 = 12 units, 351-400 = 15 units, blood sugar > 400 = 20 units and call MD (Medical Doctor). If [less than] < 60 follow with protein / carb snack unless meal is within 30 minutes. If able to swallow give orange juice 120 cc (cubic centimeters) and recheck blood sugar in 30 minutes, if still < 60 repeat orange juice x (times) 1, if continues < 60 notify MD again. If blood sugar < 60 start protocol immediately and contact MD. If blood sugar < 60 or > [greater than] 400 notify MD. If unable to swallow give 1 mg (milligram) glucagon IM/SQ (intramuscularly/subcutaneous). Recheck blood sugar in 30 minutes, if blood sugar < 100 and still unable to swallow call MD. I responding give protein/carb snack unless meal is within 30 minutes.</p> <p>On 2/2/11 the insulin was held at bedtime for a blood sugar of 59. The documentation on the front of the MAR was initialed with "cookies" written for the snack and the protocol section initialed to indicate the diabetic protocol was being started. The reverse side of the</p>				<p>non-compliance will result in 1:1 re-education with progressive discipline up to and including termination for failure to follow policy. The DON/Designee will complete an audit on 100% of residents with orders for accu-checks to ensure appropriate notification daily X 2 weeks, 5 X weekly X 2 weeks, weekly X 4 weeks and monthly thereafter. Results of above audits will be forwarded to the Quality Assurance Committee (QA) for review and for further recommendations as deemed appropriate.</p>		

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F0225	<p>MAR indicated "4/2, 2100 [9:00 p.m.], blood sugar rechecked 127, MD aware, No N. O (no new order) and the nurses signature.</p> <p>The nurses notes was lacking documentation for physician notification and/or interventions. Review of the notes indicated an entry on 1/21/11 at 03:00 [3:00 a.m.] and then again 2/14/11 at 11:15 a.m.</p> <p>An interview with the Director of Nursing on 4/12/11 at 8:10 A.M. indicated the blood sugar of 59 on 2/2/11 was rechecked at 2100 to read 127 and a snack was given per protocol. The MD was notified and no new orders received. The Director of Nursing indicated, "the physician would be notified today to see if the insulin orders needed to be changed."</p> <p>3.1-5(a)(2)</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report</p>				

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SS=A	<p>any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to report to the State Agency (SA) 1 of 1 resident to resident aggressive verbal behavior incident. Resident #76 and Resident #77.</p> <p>Findings included:</p> <p>The facility abuse policy with a revised date of 1/2011, included, but was not</p>	F0225	It is the policy of Cypress Grove Rehabilitation Center to report to the State Agency resident to resident aggressive/verbal behavior incidents. Immediately after being informed that the described incident with Resident #76 and Resident #77, the appropriate document was completed and emailed to the State Agency. The Administrator will monitor all unusual incidents for the potential need to report to	05/10/2011	

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	<p>limited to: "...Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property. 3. Report all alleged violations and all substantiated incidents to the state agency and to all other agencies as required, and take all necessary corrective actions depending on the results of the investigation..."</p> <p>Resident #77's clinical record was reviewed on 4/11/11 at 9:30 A.M. His current Minimum Data Set Assessment dated 2/28/11, indicated a severe cognitive impairment and supervision and staff assistance of 1 needed for transfers and ambulation in resident room. Diagnoses included, but were not limited to: Anxiety and Depression.</p> <p>A social service note dated 4/6/11 of Resident #77, indicated, "Resident # 77 bumped his roommate (Resident #76) with his wheelchair. Apologized to roommate but roommate (Resident #76) became loud, cursing at resident. Roommate (Resident #76) drew back his fist at resident (Resident #77) and threatened to hit him. Resident (Resident #77) came out to common area. Roommate (Resident #76) placed on increased monitoring and moved to another room."</p>		the State Agency via morning meetings, when a review of the previous 24-hour period of time is discussed with the Interdisciplinary Team (IDT). The Administrator will monitor to ensure any future like incident is reported as deemed appropriate.		

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F0246	On 4/11/11 at 1:45 P.M., during interview with the Administrator and the Director of Nursing (DON), the Administrator indicated the facility had not reported any resident to resident aggressive behavior to the state agency since survey began on 4/5/11. 3.1-28(c)				
SS=E	A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on observation, record review and interview, the facility failed to provide adequate numbers of Geri chairs, mechanical lifts and lift slings to meet the needs of 2 of 3 residents requiring that equipment for transfers from a sample of 18 with potential to impact 3 resident who require a geri chair 15 residents who require use of a hoyer lift in a total census of 90 and in a sample of 18 utilizing that equipment in the facility. Resident # 27 Resident #28 Findings include: 1. The clinical record of Resident #27	F0246	It is the policy of Cypress Grove Rehabilitation Center to provide an environment where a resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Residents #27 and #28 have been re-assessed to determine their individual needs and personal preferences. Residents #27 and #28 medical records have been updated to reflect their current needs and personal preferences. In addition, Residents #27 & #28 have been assessed by Social Services for any negative	05/10/2011	

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	<p>was reviewed on 4/7/11 at 12:30 P.M. Diagnoses included, but were not limited to, cerebrovascular accident [Stroke, CVA] with Right Hemiplegia and Vascular Dementia. The Minimum Data Set Assessments (MDS) of 12/13/10 and 3/10/11 both indicated the resident was totally dependent for transfers by mechanical lift, and was non ambulatory. Documentation was lacking of any contraindication to the resident being up.</p> <p>The Nurse Assistant assignment sheet last reviewed for consistency with the resident's POC (Plan of Care) on 4/5/2011 called for the resident to utilize a Geri chair when up.</p> <p>During hourly observation of Resident #27 on 4/5/11 from 9:15 A.M. to 3:15 P.M. and from 4:15 to 6:30 P.M. the resident remained in his bed, usually looking out into the hall and often calling passers by and initiating interaction with staff attending his roommate. He was not out of bed. On 4/6/11 from 8:30 A.M. to 3:15 P.M. the same occurred. On 4/6/11 at 9:20 A.M. CNA #10 and #11 were interviewed regarding the resident being up. They indicated he was gotten "up for sure on Tuesdays and Fridays for baths but would get him up today (Thursday)" as directed "they said we better do it." The resident was observed to be gotten up by</p>		<p>psychosocial effects as evidenced by increased behaviors, crying or withdrawal with none noted. A 100% medical record review of current in-house residents has been completed to determine residents requiring the use of a mechanical lift with sling for transfer or the use of a geri-chair when out of bed. Record review included but was not limited to Physician orders for the past 30 days, Minimum Data Set (MDS), Nursing Comprehensive Admission Data Collection and Assessment, Quarterly Nursing Data Collection and Assessment, Activities of Daily Living (ADL) Plan of Care and Resident Lifting, Transferring and Repositioning Data Collection. Facility has obtained an additional mechanical lift for the Willows Unit and has an appropriate amount of lift slings to meet identified residents needs. Residents identified as requiring a geri-chair when out of bed have been provided with one. Nursing staff will be re-educated to facility policy & procedure on providing care and services per residents assessed needs and personal preferences. This education has been added to the facility's general orientation. A Daily Compliance Round sheet has been implemented to ensure residents preferences for being out of bed are met. Licensed Nurses will complete compliance</p>		

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	<p>mechanical lift into a Geri chair. The resident remained up from 9:30 A.M. to 12:15 P.M. in the TV lounge, facing the TV. The resident tolerated being up well.</p> <p>2. The clinical record of Resident #28 was reviewed on 4/6/11 at 10:30 A.M. Diagnoses included, but were not limited to, cerebrovascular accident [Stroke. CVA] with right sided hemiparesis, Coronary Artery disease and Chronic Obstructive Pulmonary disease. The MDS assessments of 7/27/10 and 2/18/11 both indicated the resident was dependent for transfers with a mechanical lift. The resident had a 3/11/11 physician order "may be up in w/c (wheel chair) for at least 1 hour twice daily every day as tolerated and may use Geri chair while up for positioning and comfort."</p> <p>The Nurse Assistant assignment sheet last reviewed for consistency with the resident's POC (Plan of Care) on 4/5/2011 called for the resident to utilize a Geri chair when up.</p> <p>During hourly observation of Resident #28 on 4/5/11 from 9:15 A.M. to 3:15 P.M. and from 4:15 to 6:30 P.M. the resident remained in his bed. On 4/6/11 from 8:30 A.M. to 3:15 P.M. the same occurred with observations of direct care</p>		<p>rounds each shift. Results of compliance rounds will be forwarded to the Administrator for review at the Morning Stand-up Meeting 5 x weekly x 4 weeks, 3 x weekly x 4 weeks and weekly thereafter. Residents identified as not being out of bed per their preference will receive follow-up by Director of Nursing/Designee (DON). Identified non-compliance will result in 1:1 re-education with progressive discipline up to and including termination for failure to follow policy. Results of Compliance Rounds will be forwarded to the facility Quality Assurance Committee (QA) monthly for review and recommendations as deemed appropriate.</p>		

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	<p>every 2 -2 1/2 hours. On 4/6/11 at 9:20 A.M. CNA #10 and #11 were interviewed regarding the resident being up. They indicated he was gotten "up for sure on Tuesdays and Fridays evenings for baths but they would get him up today (Thursday)" as directed" they said "we better do it." The resident was observed to be gotten up by mechanical lift into a Geri chair. The resident remained up from 9:50 A.M. to 12:30 P.M. in the TV lounge, facing the TV. The resident tolerated being up well.</p> <p>Eight Confidential interviews were conducted on 4/6, 7, 8, 2011 with direct care staff from the nursing and therapy departments regarding Resident #27 and Resident #28 being out of bed and the equipment required to transfer current residents. There were 7 of 8 staff members interviewed attributed the problem to an inadequate number of Geri chairs, mechanical lifts with scales, and slings. Staff members #18, #19, #20, #21 all indicated there were a shortage of Geri chairs causing them to alternate between residents getting up so each would get a "turn." They indicated this had been happening for at least 3 months. They indicated there were 2 mechanical lifts in the building, one on each half of the building but only one had a scale. The slings for the lifts were often in short</p>						

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	<p>supply depending on the frequency of them getting soiled and speed of laundry processing them. Some of their comments included:</p> <p>Staff #17 indicated "...it's an unfair problem that residents have to take turns. People need to be up but many times it's not their turn. The slings, we can get by if everything goes perfect but one accident can spoil the whole thing, we know laundry gets them back as quickly as they can..."</p> <p>Staff #19 indicated "... always running and sharing...have to search for the equipment...2 lifts one on each side, but only one scale so if you a scale you have to go find that lift and trade them yours when the get done with it...we burn up a lot of time going back and forth.</p> <p>Staff #18 indicated "Our (name Resident #27)loves to get up and he tries to talk to us as we pass by but we can't get him up every day."</p> <p>Staff #16 and #15 indicated at times a Geri chair would have to be borrowed from another building but locating and getting one could take some time.</p> <p>Staff #20 indicated "our girls want to do the best by the residents but they have to</p>				

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F0248	<p>deal with too many heavy care residents for what we have in equipment."</p> <p>Staff #21 indicated "Our nurses understand but there is a limit to what they can do, we really just need more chairs, and another lift or at least a scale on both but why ask...they are too expensive."</p> <p>On 4/12/11 at 2:15 P.M., the DON (Director of Nursing) was interviewed. She indicated there were 20 slings in the facility for use and that 3 residents in the facility use geri chairs. She indicated only 15 residents in the facility use slings. The DON indicated the facility had 5 geri chairs and not all the residents using the hoyer lift get up daily.</p> <p>3.1-19(v)</p> <p>The facility must provide for an ongoing</p>				

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SS=E	<p>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, record review and interview, the facility failed to provide a program of activities to meet the needs of 2 of 3 residents with severe cognitive impairment from a sample of 18 involving 2 of 2 nonspecific dementia units with a potential to impact 20 residents. Resident # 27 Resident #28</p> <p>Findings include:</p> <ol style="list-style-type: none"> The clinical record of Resident #27 was reviewed on 4/7/11 at 12:30 P.M. Diagnoses included but were not limited to cerebrovascular accident [Stroke, CVA] with Right Hemiplegia and Vascular Dementia. The Minimum Data Set Assessments (MDS) of 12/13/10 and 3/10/11 both indicated the resident had severe cognitive impairment, was totally dependent for transfers by mechanical lift, was non ambulatory, received all nourishment by tube feeding and had an activity preference for listening to music. Documentation was lacking to indicate any contraindication to attempting to help the resident being out of bed and up in a Geri chair, as tolerated. <p>The current interests of the resident were</p>	F0248	<p>It is the policy of Cypress Grove Rehabilitation Center to provide 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. Residents #27 and #28 have been assessed by SSD for signs and symptoms of negative psychosocial effects as evidenced by increased behaviors, crying or withdrawal with none noted. The clinical records have been reviewed by the IDT and updated as needed to reflect their current status. A one time clinical record review of current in-house residents will be completed to identify cognitively impaired residents requiring 1:1 in room activities or requiring staff assistance to attend group activities scheduled for cognitively impaired residents. Record review to include but not be limited to the past 30 days 24 Hour Status Report, social service, activity and nurses notes as well as the MDS. Residents identified as being cognitively impaired and requiring 1:1 in room activities will be reviewed by the IDT to ensure the plan of care includes appropriate activities. 1:1 in room activities for each</p>	05/10/2011			

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	<p>identified on the 11/30/10 Recreational Assessment to be music (specifically jazz), watching TV, talking and conversing.</p> <p>During hourly observation of Resident #27 on 4/5/11 from 9:15 A.M. to 3:15 P.M. and from 4:15 to 6:30 P.M. the resident remained in his bed, usually looking out into the hall and often calling passers by and initiating interaction with staff attending his roommate. He was not out of bed. On 4/6/11 from 8:30 A.M. to 3:15 P.M. the same occurred. It was noted during those observations the TV was unplugged and there was no music provided. On 4/6/11 at 9:20 A.M. CNA #10 and #11 were interviewed regarding the resident being up. They indicated he was gotten "up for sure on Tuesdays and Fridays for baths but would get him up today (Thursday)" as directed "they said we better do it." The resident was observed to be gotten up by mechanical lift into a Geri chair. The resident remained up from 9:30 A.M. to 12:15 P.M. in the TV lounge, facing the TV. The resident tolerated being up well.</p> <p>The 3/8/11 Activity Pursuit Patterns Plan of Care indicate the resident "doesn't speak often". It set a goal of independent activity to be "music" and specified as an intervention "jazz." It failed to provide a</p>		<p>resident will be added to the activity calendar. A copy of the activity calendar will be forwarded to the Administrator for review. Residents identified as being cognitively impaired and requiring staff assistance to attend activities will be noted on the Nursing Assistant Assignment Sheet. The Activity Director will be re-educated to facility policy on providing appropriate group and 1:1 in room activities to cognitively impaired residents based on comprehensive assessment. Nursing staff will be re-educated to facility policy on providing care and services per residents assessed needs and personal preferences to include activity attendance. This education will be added to the facility's general orientation. The Activity Director will provide each units Licensed Nurse with a list of residents scheduled to attend that days group activity for cognitively impaired residents. It is the responsibility of the Licensed Nurse to ensure that residents are assisted to the scheduled activity. Any resident failing to attend the scheduled activity will have follow-up by the Activity Director. Utilizing the provided calendar the facility Administrator will observe that days 1:1 in room activities being provided. An Activity Observation audit including resident, staff and activity being provided will be completed by the Administrator.</p>		

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	<p>plan for therapeutic activity interventions on a 1:1 basis and/or smaller group basis for sensory stimulation.</p> <p>The 3/8/11 Activity Progress note included 4 written comments under various categories "enjoys jazz music, stays in bed mostly, may or may not have conversation and TV on (regarding independent activity)."</p> <p>The activity attendance calendars were reviewed for February, March and the first 7 days of April 2011. The calendars contained group opportunities which were potentially appropriate for the resident. On Tuesdays and Fridays every week each month Group Sensations were held. There were music oriented programs 10 times each month, 2 in the first 7 days of April. The attendance calendars for Resident #27 indicated he attended no programs in that time frame.</p> <p>2. The clinical record of Resident #28 was reviewed on 4/6/11 at 10:30 A.M. Diagnoses included, but were not limited to, cerebrovascular accident [Stroke, CVA] with right sided hemiparesis, Coronary Artery disease and Chronic Obstructive Pulmonary disease. The MDS assessments of 7/27/10 and 2/18/11 both indicated the resident had severely impaired cognition, was dependent for</p>				<p>Observations will be completed 5 x weekly x 4weeks, 3 x weekly x 4 weeks and weekly thereafter. Identified non-compliance will result in 1:1 re-education with progressive discipline up to and including termination for failure to follow policy. Results of above audits will be forwarded to the facility Quality Assurance Committee (QA) monthly for review and recommendations as deemed appropriate</p>		

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	<p>transfers with a mechanical lift, and received primary nutrition through a feeding tube. It also indicated resident preferences for activities included but were not limited to music, watching TV and talking/ conversing. The resident had a 3/11/11 physician order "may be up in w/c (wheel chair) for at least 1 hour twice daily every day as tolerated and may use Geri chair while up for positioning and comfort."</p> <p>The 2/14/11 Activity Pursuit Patterns Plan of Care indicated the resident had cognition problems related to the CVA and set a goal of entertainment men's groups 2 times weekly. It provided interventions of "enjoys exercise, country music, may read, TV news and weather, talking or conversing (talks softly)."</p> <p>The Activity Progress note of 2/15/11 included comments "listens to music and sings too" and "Spends most time in his room. May yell out."</p> <p>During hourly observation of Resident #28 on 4/5/11 from 9:15 A.M. to 3:15 P.M. and from 4:15 to 6:30 P.M. the resident remained in his bed. On 4/6/11 from 8:30 A.M. to 3:15 P.M. the same occurred with observations of direct care every 2 -2 1/2 hours. The resident initiated interaction with staff during</p>				

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	<p>direct care by singing the first verse of a country western song and verbally responding to staff with a word or two It was noted during all observations the TV nor music was not provided.</p> <p>On 4/6 at 9:20 A.M. CNA #10 and #11 were interviewed regarding the resident being up. They indicated he was gotten "up for sure on Tuesdays and Fridays evenings for baths but they would get him up today (Thursday)" as directed "they said we better do it." The resident was observed to be gotten up by mechanical lift into a Geri chair. The resident remained up from 9:50 A.M. to 12:30 P.M. in the TV lounge, facing the TV. The resident tolerated being up well.</p> <p>The activity attendance calendars were reviewed for January, February, March and the first 7 days of April 2011. The calendars contained group opportunities which were potentially appropriate for the resident. Twice weekly, every week each month, Group Sensations (gender not specified) were held. There were music oriented programs 10 times each month (2 in the first 7 days of April. There were exercise programs offered 1 or 2 times weekly each week. The attendance calendars for Resident#28 indicated he attended no programs in January. He attended 1 program in the month of</p>				

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	<p>February, identified as "Just Visiting". He attended no programs in the month of March. He was "visited" twice in the first 7 days of April.</p> <p>The Acting Activity Director (AAD) was interviewed regarding programming on 4/7/11 at 2:45 P.M. She indicated she was normally assigned to the Alzheimer Dementia unit and the Activity Director (on Leave of absence) managed the other 2 units. She indicated she had a CNA assisting her with visits but that person was on scheduled as a CNA full time now and had not provided any activity documentation since February. She indicated she did therapeutic 1:1 visits on 4 residents (not involving Resident #27 or #28) but other "visits" consisted of spontaneous greetings with brief interaction which were not of therapeutic content, or duration to allow a seated visiting.</p> <p>She indicated there were 6 additional residents residents appropriate for 1:1 visits and 12 residents who needed small group activities, who did not routinely receive them. She indicated the residents resided on the facility's 2 nondementia specific units. She indicated the small groups she did hold were attended by whomever was up out of bed and accessible. She characterized the small</p>						

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	<p>group session attendance as unstructured without specific residents routinely designated to attend on specific schedules. The facility lacked a system of communication for identifying small group attendance goals between the Activity department and the Nursing department in order to ensure the choreography of each resident's day was synchronized between departments. The AAD indicated Resident #27 and Resident # 28 were "never up, I hardly ever see them up" and "there never has been a system for that (making sure residents were up and ready for small group) ."</p> <p>3.1-33(a)</p>				

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F0250 SS=D	<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.</p> <p>Based on interview and record review, the facility failed to ensure a behavior of wandering into other resident's rooms and/or aggressive behaviors toward other residents were identified and interventions initiated for 1 of 4 residents reviewed for wandering behaviors in a sample of 18, and 1 of 1 resident in a supplemental sample for wandering behavior. Resident #76 and Resident # 77</p> <p>Findings include:</p> <p>Resident #76 's clinical record was reviewed on 4/5/11 at 10:08 A.M. His current Minimum Data Set Assessment (MDS) dated 3/9/11 indicated a severe cognitive impairment, supervision and assistance of 1 staff for ambulation , verbal behavior symptoms and wandering behavior toward others occurred 4 to 6 days but less than daily, and physical aggressive behavior symptoms directed toward others occurred in 1-3 days. One of his diagnoses included but was not limited to: senile dementia with behaviors. Resident # 76 had been admitted to the secured unit of the facility on 2/5/11.</p>	F0250	<p>It is the policy of Cypress Grove Rehabilitation Center to ensure that medically related social services are provided to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Residents #76 and #77 have been re-assessed for wandering or aggressive behaviors by the Social Services Designee. The clinical record has been reviewed by the Interdisciplinary Team (IDT) and updated to reflect current behavior status as well as appropriate preventive interventions based on assessment. A onetime clinical review including but not limited to, past 30 days of nurses notes, social services notes, Behavior Monitoring report, 24Hour Status report and physician orders on current in-house residents will be completed to identify residents exhibiting wandering or aggressive behavior. Staff interviews across all shifts will be conducted to identify residents exhibiting wandering or aggressive behaviors. Any resident identified through record review or staff interview will be re-assessed with plan of care revision and/or update as needed by the SSD and reviewed by the Interdisciplinary Team (IDT) to</p>	05/10/2011	

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	<p>A care plan initiated 2/12/11, updated 2/15/11, with a target date of 5/11, addressed the problems of may be harmful to self and others. These problems were physical abusive ("yelling/cursing at staff during care") and verbal abusive behaviors ("strikes out/kicks at during care)." Interventions included but were not limited to: call resident by preferred name, explain care, leave resident in safe situation and return later or with an alternate staff member. Another problem addressed was "Wanders about unit likes 'practical jokes.' the goal for this problem was "will wander safely over the assessment period." Interventions included: "1) Wander guard to allow for safe wandering. 2) Redirect as needed."</p> <p>A care plan entitled elopement plan of care had been initiated on the date of 3/3/11. The assessment section of this care plan included risk factors of: expressed desire to leave, senile dementia, independently mobile, desire to go home, and exit seeking behavior. Interventions included : initiate 'wander alert system,' photograph the resident and document a description, place on a list for at risk residents, allow safe wandering, encourage exercise, redirect, utilize signs to assist in managing unsafe wandering, offer conversation, utilize gesture, and</p>		<p>ensure the plan of care includes appropriate preventive interventions based on assessment. SSD/designee will be re-educated to facility Behavior Management Program policy including but not limited to preventive interventions for wandering and aggressive behaviors. Facility staff will be re-educated to policy for behavior management including but not limited to wandering, aggressive and/or combative behaviors, and verbally or physically abusive behaviors as well as implementation of appropriate interventions. SSD/designee will review Behavior Monitoring report, 24 Hour Status report and physician orders to identify residents with an increase in or newly reported behaviors included but not limited to wandering and aggressive behaviors. Identified residents will be taken to the next scheduled Daily Clinical Review (DCR) and re-viewed by the IDT to determine possible causes of behaviors as well as appropriate behavior interventions. The clinical record including plan of care will be updated to reflect residents current status. A Behavior Management Systems Review audit will be completed on above residents daily x 2 weeks, 5 x weekly x 4 weeks and weekly thereafter. Results of audit will be forwarded to the Administrator for review. Identified</p>		

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	<p>encourage family participation and support." Social service notes dated 2/8/11 (no time documented), indicated, "Resident noted to be wandering about facility. Wanders in and out of rooms on unit. Usually easily directed."</p> <p>Nursing note dated 2/28/11 at 11:00 A.M., indicated, "...Alert and mostly wandering the halls and opening front door a couple of times. Easily redirected. Refuses to sleep..."</p> <p>Nursing note dated 3/2/11 at 7:30 A.M., indicated, "Rested in room all noc, was up x 3 to look out door of his room. Up this AM wandering on unit, exit seeking, set off door alarms x 3 since 0700. Easily redirected."</p> <p>Nursing note dated 3/2/11 at 1:30 P.M., indicated, "... alert but pleasantly confused. Constantly going through exit door, despite repeatedly telling him not to. Goes into other resident room, and tries to start conversations with them..."</p> <p>Nursing note dated 3/2/11 at 9:05 P.M., indicated, "... Res. (resident) has been exit seeking several times this shift et also wandering into other res. rooms (females). Redirected numerous times..."</p>		<p>non-compliance of documentation will result in 1:1 re-education with progressive discipline for failure to follow policy. Staff have been re-educated to the facility policies on Behavior Management, and this education will be added to facility's general orientation. Results of Compliance Rounds will be forwarded to the facility Quality Assurance Committee (QA) monthly for review and recommendations as deemed appropriate.</p>		

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	<p>Nursing note dated 3/3/11 at 12:30 A.M., indicated, "Res. sitting in res. lounge @ 2300 (11:00 P.M.), enc to go bed. Res stated had to get home et exit seeking setting off door alarms x 3. Is easily redirected away door, then goes to different door..."</p> <p>Nursing note dated 3/3/11 at 2:00 A.M., indicated, " Res. went to bed with encouragement et reassurance @ 0130 (1:30 A.M.), he stayed in bed for 10 min. then up wandering et exit seeking. Enc. to stay in his room or lounge area et not enter res. rooms..."</p> <p>Nursing note dated 3/5/11 at 10:45 A.M., indicated, "...Still continues to wander into other resident rooms and pushes exit</p>				

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	<p>doors open..."</p> <p>Nursing notes dated 3/6/11 at 7:30 P.M., indicated, "Has been non compliant c (with) redirection from staff going in et out of residents rooms, have offered snacks, liquids, assisted to bed. Keeps getting up et down hallways yelling @ staff when redirected."</p> <p>Nursing note dated 3/7/11 at 8:00 P.M., indicated, "...has behaviors c (with) staff when trying to redirect from going to other residents rm (room). Non compliant c (with) redirection yells out @ staff..."</p> <p>A physician's telephone order dated 3/7/11, indicated, "May have wanderguard on at all times d/t (due to) exit seeking behavior."</p> <p>Nursing note dated 3/9/11 at 10:00 A.M., indicated, "... Ambulates in hallway and roams into people's rooms..."</p> <p>Nursing note dated 3/10/11 at 2:45 A.M., indicated, "... Will wander in other resident rooms have to redirect resident..."</p>			

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	<p>Nursing note dated 3/11/11 at 7:00 P.M., indicated, "alert c (with) confusion. Resident in habit of bothering other female resident. He blocks the way when he sees certain resident walking the halls and laughs about it. He was told to not do such thing, anymore. He keeps speaking to other female resident even when they tell him to stop..."</p> <p>Nursing note dated 3/17/11 at 9:00 P.M., indicated, "continues to in et out of other rms (rooms) on unit when redirected gets angry @ staff. Offered to take resident to his rm. et giving him an activity. Continues thru out the shift until bedtime."</p> <p>Nursing note dated 3/18/11 at 9:30 P.M., indicated, "... Res has behavior involving agitation other residents. Res will jump in front of other res while they ambulate acting as though going to hit them. Redirection usually works..."</p> <p>Social Service note dated 3/24/11, (no time) indicated, "resident noted to wander about unit. He will go in and out of his room. Has been reported to step out in front of other residents..."</p> <p>Nursing note dated 3/25/11 at 10:00 P.M., indicated, "Res. standing in his</p>						

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	<p>doorway-nude as female res walked by, he was redirected into his room et door shut while CNA assisted res."</p> <p>Nursing note 3/27/11 at 9:20 P.M., indicated, " this writer informed that earlier in shift res was attempting to undress in dining room. Res would also make periodic threatening gestures to staff, able to be easily redirected. 0 (zero) behaviors at this time."</p> <p>A physician's telephone order dated 3/30/11, indicated,"D/C (discontinue) Risipardal (sic) (antipathetic medication) 0.5 mg tab (tablet) p.o. (by mouth) Bid (twice a day). Start Risipardal (sic) 1 mg tab by mouth two times a day."</p> <p>Nursing note dated 4/1/11 at 9:21 P.M., indicated, "Res has 0 (zero) behaviors. Aggravates other residents on unit. Raising hand to them et stepping in front of them. 0(zero) harm to others noted. Will monitor."</p> <p>An accident /incident report dated 4/2/11 at 1:00 P.M., indicated, : Resident #76 was talking to (room number given) Resident #81. Soon after he came out of his own room. (Room # given) Resident #81 started to yell 'don't, don't and was pointing her finger at resident.' Nursing separated both of them. (Room # given)</p>				

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	<p>Resident #81 began to say ' Everyday Everyday the same thing.' Moments later (room #number given) walked up to resident as he sat on the couch and hit him on the arm. Resident asked 'Did you see her hit me?' They were separated from each other."</p> <p>Facility documentation of 15 minute checks of Resident #76 after resident to resident altercation began on 4/2/11 at 1:15 P.M., and continued thru 4/4/11 at 9:30 A.M.</p> <p>Nursing note dated 4/3/11 at 2:10 P.M., indicated, "Resident was brought into nursing station twice during shift because he was beginning to bother other residents;standing in their way in the hallway. He was raising his fist at a resident as though he was going to hit, and then laughed about it. Trying to talk him out of this behavior is of no use because he turned right back and does the same thing again. He went through alarmed door into the courtyard. The aide on floor tried to get him to not get through the alarmed door, but he stated he was 'going to hit you in the face.' Aide telephoned nurse in the gardens unit (another unit of the facility) to come help get resident out of the courtyard back into the unit. Resident was twice removed from rooms (room #s</p>						

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	<p>given) (Resident #90 and Resident #80), while he was in those beds lying down. Right now res. is at the nurses station talking c staff. Will continue to monitor."</p> <p>Nursing note dated 4/4/11 at 3:45 A.M., indicated, "Res. asleep in bed in his room@ present. Cont q (every) 15 min (minute) checks..."</p> <p>A physician's telephone order dated 4/4/11 at 11:00 A.M., indicated, "Increase Risperdal 1 mg to TID (three times a day). D/C Risperdal 1 mg BID. Aricept (Alzheimer's medication) increase 23 mg p.o."</p> <p>Nursing note dated 4/4/11 at 11:30 A.M., indicated, " Mostly pacing in halls and going back in his room for short periods of time. Couple of times attempted to talk c (Resident room number) (Resident #80 and #81) but was redirected by staff c no problems. Will monitor."</p> <p>Nursing note dated 4/4/11 at 8:00 P.M., indicated, " Has been coming out of rm (room) s (without) clothes on just pull-up comes out of rm pacing up et down hallway redirected to go back to room several times has been pacing up and down hallways, this afternoon, attempts to talk c (with) female resident redirected 0 (zero) problems noted."</p>				

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	<p>On 4/6/11 at 8:16 A.M., the Social Service Director (SSD) was interviewed regarding the 4/3/11 nursing note regarding Resident #76 raising his hand at another resident and going through the alarmed door and threatening a CNA. The SSD indicated she was not aware of this 4/3/11 behavior incident (Resident #76 raising hand against another resident and going through alarmed door exiting the secured unit) or behaviors of Resident #76 raising hand or fist against residents. She indicated she was only aware of him stepping in front of other residents.</p> <p>On 4/6/11 at 8:25 A. M., during interview the SSD, indicated Resident #76's care plan did not address him going into other resident rooms. She indicated the care plan was "too generic" and addressed just generic wandering.</p> <p>Resident #76's care plans were reviewed on 4/6/11 at 9:40 A.M. Documentation was lacking of any changes regarding the elopement care plan and the behavior symptom care plan since care plans had been initiated. Resident #76's care plans did not address the problem of wandering into other resident rooms or aggressive behavior toward other residents.</p>				

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	<p>Social service note dated 4/6/11 (no time), indicated, "Resident went into his room to get in his closet. Roommate rolled chair and bumped resident. Resident yelled out to 'watch where the h---- you are going.' Roommate apologized and resident pulled back his fist and said 'watch out, the next time I'll knock the F--- out of you.' Staff intervened and redirected resident. Physician is aware and gave order for inpatient psych (psychological) eval. (evaluation). (Hospital name) (hospital phone number) has no available bed. (Another hospital) (hospital phone number) pos. (possible) bed on Friday. (Third hospital name) (phone number) no bed for possibly (sic) another week another week. Physician is aware that placement is not available. Resident is moving to room (room #) (room off secured unit) with one on one monitoring. Wife is aware."</p> <p>Social service note dated 4/7/11 (no date), indicated, "Spoke with (third hospital). They will have a better idea of when a bed will be available this afternoon. Resident continues on one to one monitoring. No noted behaviors. Currently asleep in bed."</p> <p>On 4/8/11 at 7:50 A.M., during interview with the Assistant Director of Nursing (ADON) #1, indicated Resident #76 had</p>				

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F0272	<p>been transferred to a hospital behavior unit.</p> <p>3.1-34(a)</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment</p>				

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SS=D	<p>performed through the resident assessment protocols; and Documentation of participation in assessment.</p> <p>A. Based on observation, interview, and record review, the facility failed to ensure pressure sores were accurately and promptly assessed for 1 of 4 residents reviewed for pressure sores in a sample of 18. Resident #63</p> <p>B. Based on interview and record review, the facility failed to ensure an accurate and thorough assessment was completed in regard to a hip fracture for 1 of 2 resident's reviewed with a hip fracture in a sample of 18. Resident #92</p> <p>Findings include:</p> <p>A. Resident #63's clinical record was reviewed on 4/7/11 at 9:25 A.M. His current Minimum Data Set assessment (MDS) dated 3/22/11, indicated the resident was at risk for pressure sores, had a pressure sore stage 1 or higher, had a pressure ulcer on a prior assessment. Pressure sore had necrotic tissue (eschar) which was unstageable and had been unstageable on admission. Resident #63 was admitted to the facility on 3/4/11. Diagnoses included but were not limited to : fractured femur, esophageal cancer,</p>	F0272	<p>It is the policy of Cypress Grove to conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. Resident #63 has been re-assessed and care plan updated to reflect current status. Resident #92 no longer resides in facility. A one time 100% audit of current in-house residents' clinical records has been conducted to identify residents with changes in condition including but not limited to areas of swelling and pressure areas. No other residents we found to be affected. Licensed Nurses have been re-educated on policy/procedure regarding assessment and or re-assessment of condition changes including but not limited to areas of swelling and pressure areas. This education has been added to the facility's general orientation. Assistant Directors of Nursing will review each days' physician orders and 24 hour report sheets to identify residents with a possible change in condition. Names of identified residents will be placed on an audit tool. The medical record of identified residents will be reviewed to ensure assessment has taken place. Assessment/Re-assessment</p>	05/10/2011	

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	<p>and left kidney mass.</p> <p>A facility admission skin assessment dated 3/3/11(On interview 4/11/11 at 7:50 A.M.,with the Director of Nursing (DON) she indicated the date 3/3/11 should be 3/4/11) included but was not limited to documentation of a suspected deep tissue injury (SDTI). A facility form entitled "Skin Grid -Pressure/Venous Insufficiency Ulcer/Other" was dated 3/3/11, and documented a unstageable SDTI of the right heel. Measurements documented were 3 cm (length) x 1.3 cm (width) with 0 depth. Documentation indicated the area was present on admission. This record included a staging description of an unstageable area as : "full thickness tissue in which the base of the ulcer is covered by slough (yellow, tan, gray, green, or brown) and or/ eschar (tan, brown, or black) in the wound bed."</p> <p>The skin grid-pressure ulcer form indicated the resident had declined the skin assessment of the right heel on 3/10/11. The 3/17/11 and 3/22/11 assessments indicated the right heel measurements remained the same. This record indicated on 3/29/11, the assessment was not completed due to the resident had been hospitalized.</p> <p>A nursing noted dated 4/1/11, indicated</p>		<p>audit tool will be completed 5 X weekly X 4 weeks, 3 X weekly X 4 weeks and weekly thereafter. Identified non-compliance will result in 1:1 re-education with progressive discipline for failure to follow policy up to and including termination. Results of audits will be reported to the the Quality Assurance (QA) Committee monthly for review and recommendations as deemed appropriate.</p>		

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	<p>Resident #63 had returned to the facility.</p> <p>An admission skin assessment was initiated on 4/1/11. Documentation was lacking of a right heel area SDTI that had been present before transfer to the hospital on 3/24/11.</p> <p>The facility skin Grid- Pressure/Venous insufficiency/Ulcer record which had an initiation date of 3/3/11, documented the right heel unstageable SDTI was healed on 4/5/11.</p> <p>On 4/7/11 at 12:25 P.M., the Assistant director of Nursing (ADON) 31, assisted the resident to position his right leg to observe the right heel. A dry dark scab/eschar area of the right outer heel was observed. This area was oblong and approximately as large as an 1 cm.</p> <p>A nursing note dated 4/7/11 at 1:00 P.M., indicated, " ... R (right) foot @ this time healing SDTI to outer aspect of R heel. Dr. (physician's name) made aware okay to observe area @ this time...."</p> <p>A skin grid-pressure/venous insufficiency ulcer/other record was initiated on 4/7/11 regarding the right outer heel. Documentation indicated the wound was a SDTI present on admission with measurements of 1.7 cm x 2.3 cm. The</p>				

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SS=D	<p>stage section of this documentation was left blank.</p> <p>On 4/12/11 at 1:02 P.M., ADON #1 was interviewed regarding the skid grid assessment dated 4/7/11. She indicated the stage section which was left blank should be documented unstageable due to the area had a scab. She also indicated this was the same area identified on the admission skin assessment dated 3/3/11 when the resident was admitted to the facility.</p> <p>B. The clinical record of Resident #92 was reviewed on 4/6/11 at 8:25 A.M. Diagnoses included, but were no limited to, the following: History of falls, Dementia, Arthritis and Cardiac Arrhythmias, congestive heart failure, pneumonia. The most recent MDS (minimum data set assessment), dated 1/27/11, indicated the following: total summary score for cognitive patterns was a 5, indicating severe impairment; transfer and bed mobility required extensive assistance; range of motion had impairment on both sides; mobility device was a wheelchair.</p> <p>A physician order was obtained on 11/18/10 to "admit to hospice d/t (due to) failure to thrive (FTT)..."</p>		<p>It is the policy of Cypress Grove to conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. Resident #63 has been re-assessed and care plan updated to reflect current status. Resident #92 no longer resides in facility. A one time 100% audit of current in-house residents' clinical records has been conducted to identify residents with changes in condition including but not limited to areas of swelling and pressure areas. No other residents we found to be affected. Licensed Nurses have been re-educated on policy/procedure regarding assessment and or re-assessment of condition changes including but not limited to areas of swelling and pressure</p>	05/10/2011	

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	<p>Nurses notes dated 1/20/11 at 1445 (2:45 P.M.) indicated the following: "...Transfers with 2 assist. Total dependence for ADL's (activities of daily living)."</p> <p>Nurses notes, dated 2/18/11 at 1:15 P.M. indicated the following: "N.O. (new order) for oxycodone (narcotic pain medication) TID (three times a day) 10 mg, cont (continue) 5 mg BID (twice a day) PRN (as needed), DC oxycodone 5 mg BID left message for (power of attorney name)."</p> <p>A Pain Data collection and assessment dated 2/18/11 indicated the following: "What is appearance of pain site: D (see nurses notes): Summary: Hospice CNA (certified nursing assistant) visit this day stated "res c/o (complained of) pain bil (bilateral) knee/legs "hurts worse than having a baby." Address issue with Vista Care nurse. with assessment visual observance showed no injuries or abnormalities."</p> <p>A physician notification form, documented by the Hospice nurse and dated 2/23/11, indicated the following: "...swelling L (left) hip..."</p> <p>A hospice nurse note, dated 2/23/11 indicated the following: "...Pt lying in</p>		<p>areas. This education has been added to the facility's general orientation. Assistant Directors of Nursing will review each days' physician orders and 24 hour report sheets to identify residents with a possible change in condition. Names of identified residents will be placed on an audit tool. The medical record of identified residents will be reviewed to ensure assessment has taken place. Assessment/Re-assessment audit tool will be completed 5 X weekly X 4 weeks, 3 X weekly X 4 weeks and weekly thereafter. Identified non-compliance will result in 1:1 re-education with progressive discipline for failure to follow policy up to and including termination. Results of audits will be reported to the the Quality Assurance (QA) Committee monthly for review and recommendations as deemed appropriate.</p>		

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	<p>bed...L leg flexed et (and) drawn...swelling noted L hip..."</p> <p>An accident/incident report, dated 2/23/11, indicated the following: "(name of hospice) nurse in for visit. Stated to 7 - 3 nurse for E (east) hall L (left) hip appears to have swelling. (name of hospice) nurse obtained order for xray to L hip. Results rec'd (received) stating fx (fracture) to L hip...L Hip retracted..."</p> <p>A physician's order was obtained on 2/23/11 at 5:30 P.M. for "Xray L (left) Hip d/t (due to) swelling."</p> <p>The next nurses note was dated 2/24/11 at 1 A.M. indicated the following: "Portable xray here, xray L(left) hip done without difficulty."</p> <p>Nurses notes, dated 2/24/11 at 6:54 A.M., indicated the following: "Received results of L hip X ray with suspicious intertrochanteric Fx (fracture) of the proximal femur with varus (sic) deformity..."</p> <p>Nurses notes, dated 2/24/11 at 9:27 A.M. indicated: "N.O. clarification Dx (diagnosis) senile osteoporosis. No surgery..."</p>				

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	<p>A physician order was obtained on 2/24/11 at 9:50 A.M. "Dx (diagnosis) senile osteoporosis."</p> <p>Nurses notes dated 2/24/11 at 5:50 P.M. indicated the following: "Talked with NS (nursing) from (name of hospice) about pt (patient) increase in pain in L hip. (nurse name) from (name of hospice) talked with Triage et received N.O. to increase pain meds..."</p> <p>A Pain Data collection assessment, dated 2/24/11, indicated the following: "What is appearance of pain site: red/pink; swollen."</p> <p>The left hip xray, dated 2/24/11, indicated the following impression: "Left hip: suspicious intertrochanteric fracture of the proximal femur with varus (sic) deformity."</p> <p>The next documented nurses note was a follows dated 2/25/11 at 9:15 A.M., LE (late entry) 2/21/11: "Admin (administer) PRN (as needed) med (medication)...for s/s (signs and symptoms) of pain d/t (due to) facial grimacing during bed mobility dure noc (night) care. No signs of effectiveness. Admin routine pain med at 0600. Minimal effectiveness will continue to monitor."</p>						

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	<p>The next documented nurses note was dated 2/25/11 10 A.M., LE 2/23/11: "Staff reported facial grimacing resistance to care during ADLS (activities of daily living). Upon assisting to bed staff reported L leg retraction towards chest et res stating that "It hurts." Visual observation res BLE (bilateral lower extremities) no changes et (and) WNL (within normal limits) but unable to flex leg. Hospice nurse visited et approached to stated (sic) going to obtain xray for L hip d/t swelling. Asked reason for xray is for precaution "just to make sure nothing is wrong" stated (name of hospice) nurse..."</p> <p>Nursing notes on 2/25/11 at 9 P.M.: "...Monitored for signs of pain. Admin (administered) pain meds (medications)..."</p> <p>Nurses notes 2/25/11 at 0600 lacked documentation of swelling to left hip.</p> <p>Nurses notes 2/25/11 at 10:45 A.M., indicated: New order for oxycodone (narcotic pain medication). Documentation was lacking of an assessment of the resident's swelling to left hip.</p>				

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	<p>Nurses notes, dated 2/25/11 at 9 A.M. (LE 2/16/11): "Hospice aide reported res c/o pain to BLE after shower..."</p> <p>Next nurses notes, dated 2/25/11 at 9 A.M. (LE for 2/18/11): "Observed hospice aide transferring res by herself. Explained res is 2 assist for transfers. Hospice aide cont with care et completed. After care was informed that res stated pain BLE et "hurts worse than having a baby." Admin (administered) pain med per Dr. order to assist with pain relief...Upon assessment, BLE WNL. Passed in report changes."</p> <p>Nurses notes, dated 2/26/11 at 1:30 A.M. indicated the following: "...no c/o (complaints of pain) except during routine care at times."</p> <p>Nurses notes, dated 2/26/11, at 10 A.M. indicated: "Resident showing s/s severe pain with ADL care given. given (sic) prn Roxanol...will continue to monitor s/s pain."</p> <p>On 4/8/11 at 9:50 A.M., the DON (Director of Nursing) provided a current copy of the facility policy and procedure, dated 10/10, which addressed the subject of "Episodic Documentation." The policy identified the following: "...will document significant resident care issues each shift until stabilized or the situation</p>						

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	<p>is otherwise resolved..." Procedure included, but was not limited to, the following: "...Document the facts regarding the care issue or incident as applicable, including, but not limited to: ...physical assessment..."</p> <p>On 4/8/11 at 9:50 A.M., the DON provided a current copy of the facility policy and procedure, dated January 2004, which addressed "Documentation." The policy indicated "...will provide ongoing documentation of the resident's health status to include observations, assessments, interventions...Nursing documentation includes, but is not limited to, the following types of documentation...assessments. Procedure: Document what can be...touched..or seen without speculation...Continuous Entries: Make all entries into the medical record as soon as possible after an observation, assessment or intervention occurs.</p> <p>On 4/12/11 at 10:15 A.M., the DON (Director of Nursing) was interviewed. She indicated the swelling was first observed on 2/23/11.</p> <p>On 4/24/11 at 11:40 A.M., the DON was interviewed. She indicated the clinical documentation was lacking as to the extent of swelling of the resident's left hip fracture.</p>						

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F0279	<p>3.1-31(a)</p> <p>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>				
SS=D	<p>Based on interview and record review, the facility failed to ensure a behavior of wandering into other resident's rooms and/or aggressive behaviors toward other residents were addressed in the care plan for 1 of 4 residents reviewed for wandering behaviors in a sample of 18, and 1 of 1 resident in a supplemental sample for wandering behavior. Resident #76 and Resident # 77</p> <p>Findings include:</p>	F0279	<p>It is the policy of Cypress Grove to utilize the results of assessments to develop, review and revise the resident's comprehensive plan of care. Social Services has conducted a one time 100% audit of residents MDS's. Care plans for those who triggered for wandering will be reviewed and updated as appropriate. Re-education by Interim Director of Nursing or designee to the Interdisciplinary Team (IDT) regarding comprehensive assessments and</p>	05/10/2011	

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	<p>Resident #76 's clinical record was reviewed on 4/5/11 at 10:08 A.M. His current Minimum Data Set Assessment (MDS) dated 3/9/11 indicated a severe cognitive impairment, supervision and assistance of 1 staff for ambulation , verbal behavior symptoms and wandering behavior toward others occurred 4 to 6 days but less than daily, and physical aggressive behavior symptoms directed toward others occurred in 1-3 days. One of his diagnoses included but was not limited to: senile dementia with behaviors. Resident # 76 had been admitted to the secured unit of the facility on 2/5/11.</p> <p>A care plan initiated 2/12/11, updated 2/15/11, with a target date of 5/11, addressed the problems of may be harmful to self and others. These problems were physical abusive ("yelling/cursing at staff during care") and verbal abusive behaviors ("strikes out/kicks at during care)." Interventions included but were not limited to: call resident by preferred name, explain care, leave resident in safe situation and return later or with an alternate staff member. Another problem addressed was "Wanders about unit likes 'practical jokes.' the goal for this problem was "will wander safely over the assessment period."</p>		<p>development of comprehensive care plans will be completed. This has also been added to the facility's general orientation. Social Services will review the 24 hour report sheet and daily physician's orders to identify residents with wandering behaviors. Any identified resident will be listed on the wandering behavior audit tool. The medical record will be reviewed to ensure appropriate care plans are in place and taken to the next scheduled Daily Clinical Review meeting for review by the IDT. Wandering audit tool will be reviewed 5 x weekly x 4 weeks, then 3 x weekly x 4 weeks, then weekly thereafter during Daily Clinical Review meeting and care plans will be initiated or reviewed and updated as appropriate. Identified non-compliance will result in 1:1 re-education with progressive discipline for failure to follow policy. Results of audits will be reported to the the Quality Assurance Committee monthly for analysis and recommendations as deemed appropriate.</p>		

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	<p>Interventions included: "1) Wander guard to allow for safe wandering. 2) Redirect as needed."</p> <p>A care plan entitled elopement plan of care had been initiated on the date of 3/3/11. The assessment section of this care plan included risk factors of: expressed desire to leave, senile dementia, independently mobile, desire to go home, and exit seeking behavior. Interventions included : initiate 'wander alert system,' photograph the resident and document a description, place on a list for at risk residents, allow safe wandering, encourage exercise, redirect, utilize signs to assist in managing unsafe wandering, offer conversation, utilize gesture, and encourage family participation and support."</p> <p>Social service notes dated 2/8/11 (no time documented), indicated, "Resident noted to be wandering about facility. Wanders in and out of rooms on unit. Usually easily directed."</p> <p>Nursing note dated 2/28/11 at 11:00 A.M., indicated, "...Alert and mostly wandering the halls and opening front door a couple of times. Easily redirected. Refuses to sleep..."</p> <p>Nursing note dated 3/2/11 at 7:30 A.M.,</p>				

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	<p>indicated, "Rested in room all noc, was up x 3 to look out door of his room. Up this AM wandering on unit, exit seeking, set off door alarms x 3 since 0700. Easily redirected."</p> <p>Nursing note dated 3/2/11 at 1:30 P.M., indicated, "... alert but pleasantly confused. Constantly going through exit door, despite repeatedly telling him not to. Goes into other resident room, and tries to start conversations with them..."</p> <p>Nursing note dated 3/2/11 at 9:05 P.M., indicated, "... Res. (resident) has been exit seeking several times this shift et also wandering into other res. rooms (females). Redirected numerous times..."</p> <p>Nursing note dated 3/3/11 at 12:30 A.M., indicated, "Res. sitting in res. lounge @ 2300 (11:00 P.M.), enc to go bed. Res stated had to get home et exit seeking setting off door alarms x 3. Is easily redirected away door, then goes to different door..."</p>				

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	<p>Nursing note dated 3/3/11 at 2:00 A.M., indicated, " Res. went to bed with encouragement et reassurance @ 0130 (1:30 A.M.), he stayed in bed for 10 min. then up wandering et exit seeking. Enc. to stay in his room or lounge area et not enter res. rooms..."</p> <p>Nursing note dated 3/5/11 at 10:45 A.M., indicated, "...Still continues to wander into other resident rooms and pushes exit doors open..."</p> <p>Nursing notes dated 3/6/11 at 7:30 P.M., indicated, "Has been non compliant c (with) redirection from staff going in et out of residents rooms, have offered snacks, liquids, assisted to bed. Keeps getting up et down hallways yelling @</p>				

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	<p>staff when redirected."</p> <p>Nursing note dated 3/7/11 at 8:00 P.M., indicated, "...has behaviors c (with) staff when trying to redirect from going to other residents rm(room). Non compliant c (with) redirection yells out @ staff..."</p> <p>A physician's telephone order dated 3/7/11, indicated, "May have wanderguard on at all times d/t (due to) exit seeking behavior."</p> <p>Nursing note dated 3/9/11 at 10:00 A.M., indicated, "... Ambulates in hallway and roams into people's rooms..."</p> <p>Nursing note dated 3/10/11 at 2:45 A.M., indicated, "... Will wander in other resident rooms have to redirect resident..."</p> <p>Nursing note dated 3/11/11 at 7:00 P.M., indicated, "alert c (with) confusion. Resident in habit of bothering other female resident. He blocks the way when he sees certain resident walking the halls and laughs about it. He was told to not do such thing, anymore. He keeps speaking to other female resident even when they tell him to stop..."</p> <p>Nursing note dated 3/17/11 at 9:00 P.M., indicated, "continues to in et out of other rms (rooms) on unit when redirected gets</p>				

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	<p>angry @ staff. Offered to take resident to his rm. et giving him an activity. Continues thru out the shift until bedtime."</p> <p>Nursing note dated 3/18/11 at 9:30 P.M., indicated, "... Res has behavior involving agitation other residents. Res will jump in front of other res while they ambulate acting as though going to hit them. Redirection usually works..."</p> <p>Social Service note dated 3/24/11, (no time) indicated, "resident noted to wander about unit. He will go in and out of his room. Has been reported to step out in front of other residents..."</p> <p>Nursing note dated 3/25/11 at 10:00 P.M., indicated, "Res. standing in his doorway-nude as female res walked by, he was redirected into his room et door shut while CNA assisted res."</p> <p>Nursing note 3/27/11 at 9:20 P.M., indicated, " this writer informed that earlier in shift res was attempting to undress in dining room. Res would also make periodic threatening gestures to staff, able to be easily redirected. 0 (zero) behaviors at this time."</p> <p>Nursing note dated 4/1/11 at 9:21 P.M., indicated, "Res has 0 (zero) behaviors.</p>				

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	<p>Aggravates other residents on unit. Raising hand to them et stepping in front of them. 0(zero) harm to others noted. Will monitor."</p> <p>Nursing note dated 4/3/11 at 2:10 P.M., indicated, "Resident was brought into nursing station twice during shift because he was beginning to bother other residents;standing in their way in the hallway. He was raising his fist at a resident as though he was going to hit, and then laughed about it. Trying to talk him out of this behavior is of no use because he turned right back and does the same thing again. He went through alarmed door into the courtyard. The aide on floor tried to get him to not get through the alarmed door, but he stated he was 'going to hit you in the face.' Aide telephoned nurse in the gardens unit (another unit of the facility) to come help get resident out of the courtyard back into the unit. Resident was twice removed from rooms (room #s given) (Resident #90 and Resident #80), while he was in those beds lying down. Right now res. is at the nurses station talking c staff. Will continue to monitor."</p> <p>Nursing note dated 4/4/11 at 3:45 A.M., indicated, "Res. asleep in bed in his room@ present. Cont q (every) 15 min (minute) checks..."</p>				

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	<p>Nursing note dated 4/4/11 at 11:30 A.M., indicated, " Mostly pacing in halls and going back in his room for short periods of time. Couple of times attempted to talk c (Resident room number) (Resident #80 and #81) but was redirected by staff c no problems. Will monitor."</p> <p>Nursing note dated 4/4/11 at 8:00 P.M., indicated, " Has been coming out of rm (room) s (without) clothes on just pull-up comes out of rm pacing up et down hallway redirected to go back to room several times has been pacing up and down hallways, this afternoon, attempts to talk c (with) female resident redirected 0 (zero) problems noted."</p> <p>On 4/6/11 at 8:25 A. M., during interview the SSD, indicated Resident #76's care plan did not address the behavior of him going into other resident rooms. She indicated the care plan was "too generic" and addressed just generic wandering.</p> <p>Resident #76's care plans were reviewed on 4/6/11 at 9:40 A.M. Documentation was lacking of any changes regarding the elopement care plan (3/3/11) and the behavior symptom care plan (2/12/11) since care plans had been initiated. Resident #76's care plans did not address the problem of wandering into other</p>			

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F0282 SS=D	<p>resident rooms or aggressive behavior toward other residents.</p> <p>3.1-35(a)</p> <p>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 follow diabetic physician orders for 1 of 2 diabetics reviewed. (Resident # 74)</p> <p>Findings include:</p> <p>On 4/5/11 at 9:30 A.M., the record for resident # 74 was reviewed. The Minimum Data Set (MDS) Assessment indicated the resident needed extensive assist with transfers, dressing, eating, hygiene, and bathing. Incontinent of bowel and bladder. The diagnoses include, but not limited to, diabetes, hypertension, dementia, congested heart failure and chronic obstructive pulmonary disease.</p>	F0282	It is the policy of Cypress Grove Rehabilitation Center that services provided or arranged by the facility be provided by qualified persons in accordance with each resident's written plan of care. Resident #74 has been assessed and has no negative outcomes from this alleged deficit practice. The physician has been notified with no orders received. The clinical record has been reviewed and is reflective of current status. A onetime clinical record review of current in-house residents physician orders, Medication Administration Records (MAR), nurses notes and 24 Hour Status Report for the last 30 days will be completed by the IDT to identify any resident with diabetic physician orders as well as following of diabetic physician orders. Physician and	05/10/2011	

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	<p>The physicians diabetic orders for February 2011 include:</p> <ol style="list-style-type: none"> 1. Accucheck AC (before meals) and HS (bedtime) with sliding scale coverage. 2. Lantus 100 units per milliliters vial: inject 22 units subcutaneous at bedtime. 3. Novolog 100 units per milliliters vial: inject 6 units subcutaneous three times a day before meals. 4. Novolog 100 units per milliliters vial: inject subcutaneous per sliding scale: Blood sugar (accucheck reading): 110-150 = 2 units, 151-200 = 3 units, 201-250 = 6 units, 251-300 = 9 units, 201-350 = 12 units, 351-400 = 15 units, blood sugar > 400 = 20 units and call MD (Medical Doctor). If < 60 follow with protein / carb snack unless meal is within 30 minutes. If able to swallow give orange juice 120 cc (cubic centimeters) and recheck blood sugar in 30 minutes, if still < 60 repeat orange juice x (times) 1, if continues < 60 notify MD again. If blood sugar < 60 start protocol immediately and contact MD. If blood sugar < 60 or > 400 notify MD. If unable to swallow give 1 mg (milligram) glucagon IM/SQ (intramuscularly/subcutaneous). Recheck blood sugar in 30 minutes, if blood sugar < 100 and still unable to swallow call MD. I responding give protein / carb snack unless meal is within 30 minutes. 		<p>responsible party will be notified and assessment completed on identified residents consisting of signs/symptoms of hypoglycemia/hyperglycemia including but not limited to increased confusion, diaphoresis, hunger, light headedness/increased thirst, head ache, increased urination or blurred vision. Licensed Nurses will be re-educated to facility policy on providing services and care per the written physician orders. Training will include but not be limited to following diabetic physician orders. This education has been added to the facility's general orientation. DON/designee will review physician orders and 24 Hour Status Report daily x 2 weeks & 5 x weekly thereafter to identify residents having a change in current diabetic orders or residents receiving new diabetic physician orders. The clinical record, to include but not be limited to, MAR of identified residents will be reviewed to ensure that care and services have been provided per resident's diabetic physician orders. The MAR of residents with no change in diabetic physician orders will be reviewed to ensure that care and services have been provided per residents diabetic physician orders daily x 2 weeks, 5 x weekly x 4 weeks and weekly thereafter. Results of above review will be documented on a Diabetic</p>		

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	<p>The February 2011 Medication Administration Record indicated insulin was held 12 times during the month. The held readings included; 2/1 at 106, 2/7 at 108, both obtained at 1130, and insulin held at bedtime, 2/3 at 132, 2/5 at 92, 2/6 at 117, 2/10 at 139, 2/11 at 106, 2/19 at 115, 2/20 at 90, and 2/23 at 135. Eleven of the 12 held insulin's indicated on the reverse side of the MAR; 2/1, 1130, pt (patient) had eaten, 2/6, 2/7, 2/10, 2,19, 2/23 at 2000 all indicated documentation as "Insulin held d/t (due to) pt request.</p> <p>On 2/2/11 the insulin was held at bedtime for a blood sugar of 59. The documentation on the front of the MAR was initialed with "cookies" written for the snack and the protocol section initialed to indicate the diabetic protocol was being started. The reverse side of the MAR indicated "4/2, 2100, blood sugar rechecked 127, MD aware, No N. O (no new order) and the nurses signature.</p> <p>The nurses notes was lacking documentation for physician notification and/or interventions. Review of the notes indicated an entry on 1/21/11 at 0300 and then again 2/14/11 at 1115.</p> <p>An interview with the Director of Nursing on 4/12/11 at 8:10 A.M. indicated the</p>		System Review and forwarded to the Administrator for review. Identified non-compliance will result in 1:1 re-education with progressive discipline up to and including termination for failure to follow policy. Results of Compliance Rounds will be forwarded to the facility Quality Assurance Committee (QA) monthly for review and recommendations as deemed appropriate.		

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F0323 SS=E	<p>blood sugar of 59 on 2/2/11 was rechecked at 2100 to read 127 and a snack was given per protocol. The MD was notified and no new orders received. The Director of Nursing indicated, "the physician would be notified today to see if the insulin orders needed to be changed".</p> <p>3.1-35(g)(2)</p> <p>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.</p> <p>A. Based on record review and interview, the facility failed to ensure adequate supervision to prevent wandering into other resident rooms, aggressive behavior toward other residents, and attempts to exit the facility for 1 of 4 residents reviewed for wandering behaviors in a sample of 18 and 1 of 1 resident in a supplemental sample for wandering behavior. Resident # 76</p> <p>B. Based on record review and interview, the facility failed to ensure adequate supervision for residents with alarms, decreased safety awareness and/or, history</p>	F0323	<p>It is the policy of Cypress Grove Rehabilitation Center to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistive devices to prevent accidents. Resident #76 has been re-assessed for wandering to include exit seeking or aggressive behaviors by SSD. The clinical record has been reviewed by the IDT and updated to reflect current behavior status as well appropriate preventive interventions based on assessment. Residents #35, #49, and #74 have been reviewed by the IDT. The clinical records</p>	05/10/2011	

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	<p>of falls and/or ensure pressure alarms were functioning properly to prevent falls for 4 of 4 residents reviewed for falls in a sample of 18. Resident #94, Resident #35, Resident #49 and Resident #74</p> <p>C. Based on observation, interview and record review the facility failed to ensure the bed(s) functioned safely (raised and lowered) for individual resident needs for a sample of 1 of 1 residents. (Resident # 35)</p> <p>Findings include:</p> <p>A. Resident #76 's clinical record was reviewed on 4/5/11 at 10:08 A.M. His current Minimum Data Set Assessment (MDS) dated 3/9/11 indicated a severe cognitive impairment, supervision and assistance of 1 staff for ambulation , verbal behavior symptoms and wandering behavior toward others occurred 4 to 6 days but less than daily, and physical aggressive behavior symptoms directed toward others occurred in 1-3 days. One of his diagnoses included but was not limited to: senile dementia with behaviors. Resident # 76 had been admitted to the secured unit of the facility on 2/5/11.</p> <p>A care plan initiated 2/12/11, updated 2/15/11, with a target date of 5/11,</p>				<p>have been updated to reflect current status including but not limited to fall risk prevention and appropriate fall prevention interventions. Sample residents alarms are functioning correctly. The bed of resident #35 is currently functioning correctly. A one time clinical record review including but not limited to, past 30 days of nurses notes, social services notes, Behavior Monitoring report, 24 Hour Status report and physician orders on current in-house residents will be completed to identify residents exhibiting wandering, exit seeking or aggressive behavior as well as residents at risk for falls. Staff interviews across all shifts will be conducted to identify residents exhibiting wandering, exit seeking or aggressive behaviors. Any resident identified through record review or staff interview will be re-assessed with plan of care revision and/or update as needed by the IDT to ensure the plan of care includes appropriate preventive behavior management and fall reduction interventions based on assessment. A one time facility walk through by the facility Administrator and Head of Maintenance has been completed to identify any non-functioning resident beds. Work orders have been completed on any beds identified and beds have been placed on the maintenance schedule for repair. SSD/designee will be re-educated</p>		

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	<p>addressed the problems of may be harmful to self and others. These problems were physical abusive ("yelling/cursing at staff during care") and verbal abusive behaviors ("strikes out/kicks at during care)." Interventions included but were not limited to: call resident by preferred name, explain care, leave resident in safe situation and return later or with an alternate staff member. Another problem addressed was "Wanders about unit likes 'practical jokes.' the goal for this problem was "will wander safely over the assessment period." Interventions included: "1) Wander guard to allow for safe wandering. 2) Redirect as needed."</p> <p>A care plan entitled elopement plan of care had been initiated on the date of 3/3/11. The assessment section of this care plan included risk factors of: expressed desire to leave, senile dementia, independently mobile, desire to go home, and exit seeking behavior. Interventions included : initiate 'wander alert system,' photograph the resident and document a description, place on a list for at risk residents, allow safe wandering, encourage exercise, redirect, utilize signs to assist in managing unsafe wandering, offer conversation, utilize gesture, and encourage family participation and support."</p>		<p>to facility Behavior Management Program policy including but not limited to preventive interventions for wandering and aggressive behaviors. Facility staff will be re-educated to policy for behavior management including but not limited to wandering,aggressive and/or combative behaviors, and verbally or physically abusive behaviors as well as implementation of appropriate interventions. SSD/designee will review Behavior Monitoring report, 24 Hour Status report and physician orders to identify residents with an increase in or newly reported behaviors included but not limited to wandering and aggressive behaviors. Identified residents will be taken to the next scheduled DCR and re-viewed by the IDT to determine possible causes of behaviors as well as appropriate behavior interventions. The clinical record including plan of care will be updated to reflect residents current status. A Behavior Management Systems Review audit will be completed on above residents daily x 2 weeks, 5 x weekly x 4 weeks and weekly x6 weeks. Results of audit will be forwarded to the Administrator for review.Results of Compliance Rounds will also be forwarded to the facility Quality Assurance Committee (QA)monthly for review and recommendations as deemed appropriate.</p>		

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	<p>Social service notes dated 2/8/11 (no time documented), indicated, "Resident noted to be wandering about facility. Wanders in and out of rooms on unit. Usually easily directed."</p> <p>Nursing note dated 2/28/11 at 11:00 A.M., indicated, "...Alert and mostly wandering the halls and opening front door a couple of times. Easily redirected. Refuses to sleep..."</p> <p>Nursing note dated 3/2/11 at 7:30 A.M., indicated, "Rested in room all noc, was up x 3 to look out door of his room. Up this AM wandering on unit, exit seeking, set off door alarms x 3 since 0700. Easily redirected."</p> <p>Nursing note dated 3/2/11 at 1:30 P.M., indicated, "... alert but pleasantly confused. Constantly going through exit door, despite repeatedly telling him not to. Goes into other resident room, and tries to start conversations with them..."</p> <p>Nursing note dated 3/2/11 at 9:05 P.M., indicated, "... Res. (resident) has been exit seeking several times this shift et also wandering into other res. rooms (females). Redirected numerous times..."</p>				

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	<p>Nursing note dated 3/3/11 at 12:30 A.M., indicated, "Res. sitting in res. lounge @ 2300 (11:00 P.M.), enc to go bed. Res stated had to get home et exit seeking setting off door alarms x 3. Is easily redirected away door, then goes to different door..."</p> <p>Nursing note dated 3/3/11 at 2:00 A.M., indicated, " Res. went to bed with encouragement et reassurance @ 0130 (1:30 A.M.), he stayed in bed for 10 min. then up wandering et exit seeking. Enc. to stay in his room or lounge area et not enter res. rooms..."</p> <p>Nursing note dated 3/5/11 at 10:45 A.M., indicated, "...Still continues to wander into other resident rooms and pushes exit</p>				

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	<p>doors open..."</p> <p>Nursing notes dated 3/6/11 at 7:30 P.M., indicated, "Has been non compliant c (with) redirection from staff going in et out of residents rooms, have offered snacks, liquids, assisted to bed. Keeps getting up et down hallways yelling @ staff when redirected."</p> <p>Nursing note dated 3/7/11 at 8:00 P.M., indicated, "...has behaviors c (with) staff when trying to redirect from going to other residents rm(room). Non compliant c (with) redirection yells out @ staff..."</p> <p>A physician's telephone order dated 3/7/11, indicated, "May have wanderguard on at all times d/t (due to) exit seeking behavior."</p> <p>Nursing note dated 3/9/11 at 10:00 A.M., indicated, "... Ambulates in hallway and roams into people's rooms..."</p> <p>Nursing note dated 3/10/11 at 2:45 A.M., indicated, "... Will wander in other resident rooms have to redirect resident..."</p>			

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	<p>Nursing note dated 3/11/11 at 7:00 P.M., indicated, "alert c (with) confusion. Resident in habit of bothering other female resident. He blocks the way when he sees certain resident walking the halls and laughs about it. He was told to not do such thing, anymore. He keeps speaking to other female resident even when they tell him to stop..."</p> <p>Nursing note dated 3/17/11 at 9:00 P.M., indicated, "continues to in et out of other rms (rooms) on unit when redirected gets angry @ staff. Offered to take resident to his rm. et giving him an activity. Continues thru out the shift until bedtime."</p> <p>Nursing note dated 3/18/11 at 9:30 P.M., indicated, "... Res has behavior involving agitation other residents. Res will jump in front of other res while they ambulate acting as though going to hit them. Redirection usually works..."</p> <p>Social Service note dated 3/24/11, (no time) indicated, "resident noted to wander about unit. He will go in and out of his room. Has been reported to step out in front of other residents..."</p> <p>Nursing note dated 3/25/11 at 10:00 P.M., indicated, "Res. standing in his</p>				

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	<p>doorway-nude as female res walked by, he was redirected into his room et door shut while CNA assisted res."</p> <p>Nursing note 3/27/11 at 9:20 P.M., indicated, " this writer informed that earlier in shift res was attempting to undress in dining room. Res would also make periodic threatening gestures to staff, able to be easily redirected. 0 (zero) behaviors at this time."</p> <p>A physician's telephone order dated 3/30/11, indicated,"D/C (discontinue) Rispardal (sic) (antipathetic medication) 0.5 mg tab (tablet) P.O. (by mouth) Bid (twice a day). Start Rispardal (sic) 1 mg tab by mouth two times a day."</p> <p>Nursing note dated 4/1/11 at 9:21 P.M., indicated, "Res has 0 (zero) behaviors. Aggravates other residents on unit. Raising hand to them et stepping in front of them. 0(zero) harm to others noted. Will monitor."</p> <p>An accident /incident report dated 4/2/11 at 1:00 P.M., indicated, : Resident #76 was talking to (room number given) Resident #81. Soon after he came out of his own room. (Room # given) Resident #81 started to yell 'don't, don't and was pointing her finger at resident.' Nursing separated both of them. (Room # given)</p>				

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	<p>Resident #81 began to say ' Everyday Everyday the same thing.' Moments later (room #number given) walked up to resident as he sat on the couch and hit him on the arm. Resident asked 'Did you see her hit me?' They were separated from each other."</p> <p>Facility documentation of 15 minute checks of Resident #76 after resident to resident altercation began on 4/2/11 at 1:15 P.M., and continued thru 4/4/11 at 9:30 A.M.</p> <p>Nursing note dated 4/3/11 at 2:10 P.M., indicated, "Resident was brought into nursing station twice during shift because he was beginning to bother other residents;standing in their way in the hallway. He was raising his fist at a resident as though he was going to hit, and then laughed about it. Trying to talk him out of this behavior is of no use because he turned right back and does the same thing again. He went through alarmed door into the courtyard. The aide on floor tried to get him to not get through the alarmed door, but he stated he was 'going to hit you in the face.' Aide telephoned nurse in the gardens unit (another unit of the facility) to come help get resident out of the courtyard back into the unit. Resident was twice removed from rooms (room #s</p>				

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	<p>given) (Resident #90 and Resident #80), while he was in those beds lying down. Right now res. is at the nurses station talking c staff. Will continue to monitor."</p> <p>Nursing note dated 4/4/11 at 3:45 A.M., indicated, "Res. asleep in bed in his room@ present. Cont q (every) 15 min (minute) checks..."</p> <p>A physician's telephone order dated 4/4/11 at 11:00 A.M., indicated, " Increase Risperdal 1 mg to TID D (three times a day). D/C Risperdal 1 mg BID. Aricept (Alzheimer's medication) increase 23 mg P.O."</p> <p>Nursing note dated 4/4/11 at 11:30 A.M., indicated, " Mostly pacing in halls and going back in his room for short periods of time. Couple of times attempted to talk c (Resident room number) (Resident #80 and #81) but was redirected by staff c no problems. Will monitor."</p> <p>Nursing note dated 4/4/11 at 8:00 P.M., indicated, " Has been coming out of rm (room) s (without) clothes on just pull-up comes out of rm pacing up et down hallway redirected to go back to room several times has been pacing up and down hallways, this afternoon, attempts to talk c (with) female resident redirected 0 (zero) problems noted."</p>				

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	<p>On 4/5/11 at 7:52 A.M., Resident #76 was observed independently ambulating with a steady gait in dining room area of the secured unit dining room.</p> <p>On 4/6/11 at 8:16 A.M., the Social Service Director (SSD) was interviewed regarding the 4/3/11 nursing note regarding Resident #76 raising his hand at another resident and going through the alarmed door and threatening a CNA. The SSD indicated she was not aware of this 4/3/11 behavior incident (Resident #76 raising hand against another resident and going through alarmed door exiting the secured unit) or behaviors of Resident #76 raising hand or fist against residents. She indicated she was only aware of him stepping in front of other residents.</p> <p>On 4/6/11 at 8:25 A. M., during interview the SSD, indicated Resident #76's care plan did not address him going into other resident rooms. She indicated the care plan was "too generic" and addressed just generic wandering.</p> <p>Resident #76's care plans were reviewed on 4/6/11 at 9:40 A.M. Documentation was lacking of any changes regarding the elopement care plan and the behavior symptom care plan since care plans had</p>				

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	<p>been initiated. Resident #76's care plans did not address the problem of wandering into other resident rooms or aggressive behavior toward other residents.</p> <p>Social service note dated 4/6/11 (no time), indicated, "Resident went into his room to get in his closet. Roommate rolled chair and bumped resident. Resident yelled out to 'watch where the h---- you are going.' Roommate apologized and resident pulled back his fist and said 'watch out, the next time I'll knock the F--- out of you.' Staff intervened and redirected resident. Physician is aware and gave order for inpatient psych (psychological) eval. (evaluation). (Hospital name) (hospital phone number) has no available bed. (Another hospital) (hospital phone number) pos. (possible) bed on Friday. (Third hospital name) (phone number) no bed for possibly (sic) another week another week. Physician is aware that placement is not available. Resident is moving to room (room #) (room off secured unit) with one on one monitoring. Wife is aware."</p> <p>Social service note dated 4/7/11 (no date), indicated, "Spoke with (third hospital). They will have a better idea of when a bed will be available this afternoon. Resident continues on one to one monitoring. No noted behaviors. Currently asleep in</p>						

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SS=E	<p>bed."</p> <p>On 4/8/11 at 7:50 A.M., during interview with the Assistant Director of Nursing (ADON) #1, indicated Resident #76 had been transferred to a hospital behavior unit.</p> <p>B.1. The clinical record of Resident # 94 was reviewed on 4/6/11 at 2:10 P.M. Diagnoses included but were not limited to the following: Depression, Psychiatric Disorder, Altered Mental Status and Narcolepsy (sic). The MDS dated 1/18/11, indicated the following for the resident: total cognition score of a 3 which indicated severe cognitive impairment; behaviors of delusions and hallucinations occurred daily; moving from seated to standing position and surface to surface transfer not steady, only able to stabilize with human assistance; falls since admission; 2 falls with no injury; 2 falls with injury. The CAA (Care Assessment) dated January 18, 2011 indicated the following: Falls: Resident has a history of multiple falls. He requires physical assistance with transfers and is very unsteady. Resident has a great deal of confusion. Resident is at risk for further falls r/t (related to) fall history and confusion. Nursing staff must make sure resident is assisted with transfers at all times. Fall precautions must be in place as ordered and as needed." The resident</p>		<p>It is the policy of Cypress Grove Rehabilitation Center to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistive devices to prevent accidents. Resident #76 has been re-assessed for wandering to include exit seeking or aggressive behaviors by SSD. The clinical record has been reviewed by the IDT and updated to reflect current behavior status as well appropriate preventive interventions based on assessment. Residents #35, #49, and #74 have been reviewed by the IDT. The clinical records have been updated to reflect current status including but not limited to fall risk prevention and appropriate fall prevention interventions. Sample residents alarms are functioning correctly. The bed of resident #35 is currently functioning correctly. A one time clinical record review including but not limited to, past 30 days of nurses notes, social services notes, Behavior Monitoring report, 24 Hour Status report and physician orders on</p>	05/10/2011	

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	<p>was admitted to the facility on 1/5/11.</p> <p>On tour of the building on 4/12/11 at 9 A.M., the following was observed: upon entry into the building from the front door, there is a straight hall, with administrative offices off the side at the entrance. At the end of this hall, is a lounge housing the aviary. At this intersection, the main dining room is also located. To the right of this intersection, approximately 34 paces from the aviary, is a nursing station. This hall has a jog in it so the aviary is not in direct view of the nursing station. This hall also houses the therapy department and activity room. The aviary is also not in direct view of the administrative offices. The hall to the left of the aviary, is also jogged and has a nursing station approximately 32 paces from it. This nursing station is also out of view from the aviary.</p> <p>The clinical record indicated falls on the following dates and times: 1/5/11 at 6:30 P.M. and 7:05 P.M.; 1/6/11:20 at 2:40 A.M. and 6:20 P.M.; 1/7/11 at 4:20 P.M.; 1/8/11; 1/10/11 and 1/13/11.</p> <p>A plan of care, which addressed the problem of "Fall/Injury and Assessment: Prevention and management plan of care" had an initial date of 1/6/11. This form indicated the resident was unsteady, had</p>		<p>current in-house residents will be completed to identify residents exhibiting wandering, exit seeking or aggressive behavior as well as residents at risk for falls. Staff interviews across all shifts will be conducted to identify residents exhibiting wandering, exit seeking or aggressive behaviors. Any resident identified through record review or staff interview will be re-assessed with plan of care revision and/or update as needed by the IDT to ensure the plan of care includes appropriate preventive behavior management and fall reduction interventions based on assessment. A one time facility walk through by the facility Administrator and Head of Maintenance has been completed to identify any non-functioning resident beds. Work orders have been completed on any beds identified and beds have been placed on the maintenance schedule for repair. SSD/designee will be re-educated to facility Behavior Management Program policy including but not limited to preventive interventions for wandering and aggressive behaviors. Facility staff will be re-educated to policy for behavior management including but not limited to wandering, aggressive and/or combative behaviors, and verbally or physically abusive behaviors as well as implementation of appropriate interventions. SSD/designee will review Behavior Monitoring</p>				

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	<p>high and low blood sugar, exhaustion, weakness, cardiovascular diagnosis, bowel and bladder incontinence, mental status change and Werneckes Encephalitis. This form indicated the following for</p> <p>A DCR (daily clinical review) note, dated 1/6/11(no time) indicated the following: "Res (resident) sustained fall while leaning forward. He state he was trying to turn the "switch off" on the floor, no switch present. Pressure pad alarm in place and functioning. Replaced with pull tab alarm while up in w/c (wheelchair). Res was put to bed and rolled out. No injury...Mattress placed on floor with mat..."</p> <p>A DCR note, dated 1/7/11 (no time), indicated: "...fall on 1/6/11 Res obtained s/t (skin tear) x 3 et c/o (complained of) back pain after fall...interventions...apply pressure alarm floor mat next to mattress to alert staff of getting out of bed."</p> <p>DCR note, dated 1/10/11, indicated: "r/t fall 1/8/11 at 1:45 P.M. out of w/c in aviary area, no injury. Placed in area of increased supervision and snack given. continues with pull tab alarm in w/c..."</p> <p>On 4/11/11 at 12 P.M., the DON was interviewed. She indicated when the</p>		<p>report, 24 Hour Status report and physician orders to identify residents with an increase in or newly reported behaviors included but not limited to wandering and aggressive behaviors. Identified residents will be taken to the next scheduled DCR and re-viewed by the IDT to determine possible causes of behaviors as well as appropriate behavior interventions. The clinical record including plan of care will be updated to reflect residents current status. A Behavior Management Systems Review audit will be completed on above residents daily x 2 weeks, 5 x weekly x 4 weeks and weekly x6 weeks. Results of audit will be forwarded to the Administrator for review.Results of Compliance Rounds will also be forwarded to the facility Quality Assurance Committee (QA)monthly for review and recommendations as deemed appropriate.</p>		

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SS=E	<p>resident fell on 1/8/11 at 1:45 P.M. the resident's alarm in the wheelchair was sounding to alert staff he was getting up but staff did not get to the resident in time to prevent the fall. She also indicated the resident self propelled himself in a wheelchair in the facility.</p> <p>B.2. On 4/6/11 at 9:00 A.M., Resident # 35 was cued to roll from side to side for his daily bath. The alarm did not sound when the resident turned. The pressure pad was noted to be diagonal on the lower portion of the bed below the resident's buttocks and partially off of the bed.</p> <p>On 4/6/11 at 9:40 A.M., record review on 4/5/11 indicated the alarm sound was tested due to having a low tone sound and could not be heard by surveyor from the residents room to the nurses station. The alarm was heard when the surveyor entered the residents room. (Resident # 35's room was the third door from the end of the hall). C.N.A. # 20 indicated the pad was not working properly when she applied hand pressure to the pad.</p> <p>B.3. On 4/6/11 at 11:15 A.M., Resident # 49 was due to be toileted per his schedule. C.N.A. # 20 informed the resident of time to toilet and Resident # 49 responded and stated he had just took himself because he "s___ himself."</p>		<p>It is the policy of Cypress Grove Rehabilitation Center to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistive devices to prevent accidents. Resident #76 has been re-assessed for wandering to include exit seeking or aggressive behaviors by SSD. The clinical record has been reviewed by the IDT and updated to reflect current behavior status as well appropriate preventive interventions based on assessment. Residents #35, #49, and #74 have been reviewed by the IDT. The clinical records have been updated to reflect current status including but not limited to fall risk prevention and appropriate fall prevention interventions. Sample residents alarms are functioning correctly. The bed of resident #35 is currently functioning correctly. A one time clinical record review including but not limited to, past 30 days of nurses notes, social services notes, Behavior Monitoring report, 24 Hour Status report and physician orders on</p>	05/10/2011	

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	<p>On 4/6/11 at 11:00 A.M., physicians orders included orders for 4 alarms: a pressure alarm to the bed, wheelchair, on top of the mat on the floor beside the bed, and a clip alarm to the bathroom door.</p> <p>On 4/6/11 at 11:00 A.M., the pressure bed alarm for the bed was observed to have a low tone sound when it sounded.</p> <p>B.4. On 4/6/11 at 1:40 P.M., Resident # 74 stood from his wheelchair and the pressure alarm did not sound until he was in full standing position. C.N.A. # 23 stated, "delayed reaction", in response to the pressure alarm sounding after the resident stood up.</p> <p>On 4/7/11 at 2:10 P.M., an interview with the Director of Nursing indicated "pressure alarms will sound immediately when pressure is relieved."</p> <p>C. On 4/5/11 at 10:45 A.M., the Minimum Data Set (MDS) Assessment was reviewed. Resident # 35 requires extensive assist of two staff members using a gait belt for transfers, dressing, hygiene and bathing. Resident # 35 was admitted to the facility on 2/16/11 due to bilateral total knee replacements. Other diagnoses for this resident include, but not</p>				<p>current in-house residents will be completed to identify residents exhibiting wandering, exit seeking or aggressive behavior as well as residents at risk for falls. Staff interviews across all shifts will be conducted to identify residents exhibiting wandering, exit seeking or aggressive behaviors. Any resident identified through record review or staff interview will be re-assessed with plan of care revision and/or update as needed by the IDT to ensure the plan of care includes appropriate preventive behavior management and fall reduction interventions based on assessment. A one time facility walk through by the facility Administrator and Head of Maintenance has been completed to identify any non-functioning resident beds. Work orders have been completed on any beds identified and beds have been placed on the maintenance schedule for repair. SSD/designee will be re-educated to facility Behavior Management Program policy including but not limited to preventive interventions for wandering and aggressive behaviors. Facility staff will be re-educated to policy for behavior management including but not limited to wandering, aggressive and/or combative behaviors, and verbally or physically abusive behaviors as well as implementation of appropriate interventions. SSD/designee will review Behavior Monitoring</p>		

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	<p>limited to, hypertension, diabetes, urinary incontinence, bilateral total knee replacements, diabetic neuropathy, gout, depression, arthritis, mood disorder, and sundowners related to dementia.</p> <p>On 4/6/11 at 9:00 A.M., therapy staff members, # 1 and # 2, entered the room to assist C.N.A. # 20 with a transfer. The gait belt was applied by C.N.A. # 20. Before staff started the transfer, Therapy staff # 1, questioned C.N.A. # 20, "the bed still won't not raise?" Resident # 20 was cued to stand and was transferred to the wheelchair from the bed that was in the lowest position near the floor.</p> <p>On 4/7/11 at 10:00 A.M., an interview with the Maintenance Director indicated he had not received a work order to fix resident # 35's bed.</p> <p>On 4/7/11 at 10:13 A.M., LPN # 22 indicated she was not aware or had not been informed that the bed was not working.</p> <p>On 4/7/11 at 10:15 A.M., C.N.A.'s # 21 and # 22 indicated they were not aware the bed did not raise (or lower).</p> <p>On 4/7/11 at 10:17 A.M., therapy # 1 indicated she was aware the bed was not working properly nor had she told anyone.</p>		<p>report, 24 Hour Status report and physician orders to identify residents with an increase in or newly reported behaviors included but not limited to wandering and aggressive behaviors. Identified residents will be taken to the next scheduled DCR and re-viewed by the IDT to determine possible causes of behaviors as well as appropriate behavior interventions. The clinical record including plan of care will be updated to reflect residents current status. A Behavior Management Systems Review audit will be completed on above residents daily x 2 weeks, 5 x weekly x 4 weeks and weekly x6 weeks. Results of audit will be forwarded to the Administrator for review. Results of Compliance Rounds will also be forwarded to the facility Quality Assurance Committee (QA) monthly for review and recommendations as deemed appropriate.</p>		

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F0363	Therapy # 2 indicated the bed had not functioned properly since resident # 35 had moved into the bed, (3/30/11). 3.1-19(a) 3.1-45(a)(2)				
SS=E	Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. A. Based on observation, interview and record review, the facility failed to ensure menu accuracy for 1 of 3 residents reviewed for menu accuracy in a sample of 18 with the potential to affect a total of 32 residents, (11 with a No added salt diet and 20 with a No added sugar diet). Resident #65	F0363	It is the policy of Cypress Grove that menus meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. Resident #65's care plan and tray ticket have been	05/10/2011	

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	<p>B. Based on observation, interview and record review, the facility failed to ensure recipes were followed for 1 of 1 meal preparations observed.</p> <p>Findings include:</p> <p>A. The clinical record of Resident #65 was reviewed on 4/5/11 at 10:10 A.M. Diagnoses included, but was not limited to, the following: Renal Insufficiency, Chronic cor pulmonae, Pulmonary Edema and Acute Renal Failure.</p> <p>Current physician orders, dated for April 2011, indicated the following for Dietary orders: "Regular, NAS (will define later in the finding)."</p> <p>A Nutrition Services Request/Change order, dated 2/24/11, indicated the following: "Regular No Added Salt."</p> <p>A Dietary progress note, dated 3/29/11, indicated the following: "...Receives regular NAS diet."</p> <p>On 4/5/11 at 12:46 P.M., the resident was observed in his room, eating his meal from a tray. A salt packet was observed on the tray.</p> <p>On 4/6/11 at 7:50 A.M., the resident was observed eating in his room again. A salt</p>		<p>corrected. An audit of no added sugar and no added salt diets will be completed and corrections made as needed. A verification system will be established whereby the nurse is called by dietary upon receipt by dietary of a new diet order, readmission diet or diet change. When diet changes are made and brought to Daily Clinical Review meetings, an audit will be conducted of the diet, care plan and ticket to verify for accuracy. Audit results will be forwarded to the Quality Assurance Committee for 3 months for further review and recommendations as deemed appropriate. Failure to follow policy will result in 1:1 education, followed by progressive disciplinary action up to and including termination. This has been added to the facility's general orientation. In reference to B. page 54 of the 2567, there were no residents identified as being affected by this alleged deficient practice. Potentially affected population are residents on therapeutic and restrictive diets. Education with cooks and culinary assistants on following recipes correctly will be completed. Auditing preparation of menu items will occur 5 meals/week for 4 weeks; then 3 meals/week for 2 weeks; then 2 meals/week thereafter. Recipes will be adjusted under supervision of the Nutrition Services Manager and with permission of Registered</p>				

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	<p>packet was again observed on his tray. The resident's dietary tray card indicated the following: "Regular, No Added Sugar."</p> <p>On 4/6/11 at 12:25 P.M., the resident was observed eating in his room. His tray again included a salt packet and the tray card indicated for diet "Regular, No added Sugar."</p> <p>On 4/12/11 at 8:40 A.M., the FSM was interviewed. She indicated "NAS" means "No added Salt." She indicated the resident should not have had a salt packet on his trays.</p> <p>B. On 4/7/11 at 9:30 A.M., the noon meal preparation was observed. Cook #1 was observed to take 3 7 lb. (pound) cans of baked beans and dump them into a large baking pan. She then opened a 7 lb. 3 ounce can of ketchup and, tipping the can over the baked bean pan, dumped in a portion of unmeasured ketchup. She then opened a large jar of mustard and again, dumped in an unmeasured portion of mustard into the baked bean pan. She then mix the beans, ketchup and mustard. She then took the scoop (with an unmeasured amount of sugar in it) and sprinkled sugar over the bean mixture. She mixed the sugar in the beams, covered them and placed them in the</p>		<p>Dietitian as needed. Audits of staff in the preparation of menu items will be forwarded to the monthly Quality Assurance Committee for further review and recommendations as deemed appropriate. Failure to follow policy will result in one on one re-education, followed by progressive disciplinary action up to and including termination.</p>				

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	<p>oven. No recipe was observed in the kitchen area.</p> <p>On 4/7/11 at 10 A.M. the meal preparation was observed. Dietary Staff #1 was observed preparing the noon dessert, which was menued as "caramel peach parfait." She had bowls of canned peaches, lined up, filling a baking sheet. The peaches were in the bowls, with whipped topping placed on top. Crumb type mixture was observed on the dessert. At 10:05 A.M., Dietary Staff #1 was observed to take a large can of caramel syrup and open it with the can opener. She then started at one end of the baking sheet, tipped the can and in a continuous stream, which resulted in a ribbon of caramel sauce poured over each bowl, moving up and down the baking sheet over each row of bowls.</p> <p>On 4/8/11 at 11 A.M., a copy of the recipe for baked beans and caramel peach parfaits was received from the FSM (food service manager). The recipe for baked beans, portion for 20, included, but was not limited to, the following: Baked beans, 10 and 2/3 cups; onions, yellow fresh chopped, 1 2/3 ounce; ketchup 1/3 cup; white vinegar 4 3/4 tsp (teaspoon); brown sugar 1 2/3 ounce; mustard, prepared 2 1/3 tsp.</p>				

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F0431	<p>The recipe for caramel peach parfaits was received on 4/8/11 at 11 A.M. The recipe included the following for 100 portions: caramel topping 3 cups, whipped topping 1 1/4 gallon, vanilla wafers crumbled fine 1 qt and 25 pints of peaches. The recipe directed the following: "...fold caramel into whipped topping...place peaches into dessert cup followed by crumbled cookies and put caramel whipped topping mixture on top, about 2 tbsp (tablespoons), lightly sprinkle with cinnamon or nutmeg.</p> <p>On 4/12/11 at 10:40 A.M., the FSM was interviewed. She indicated staff should be following the facility recipes and menus for residents. She indicated part of the "confusion" with Resident # 65's diet was that he was a resident here and was on a "no added sugar diet" and went to the hospital and returned on a "no added salt" diet.</p> <p>3.1-20(i)(1)</p> <p>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</p>				

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SS=D	<p>controlled drugs is maintained and periodically reconciled.</p> <p>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.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>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.</p> <p>Based on observation and interview the facility failed to ensure narcotics were locked and refrigerator temperatures are controlled for medications on 1 of 3 units.</p> <p>Findings include:</p> <p>On 4-11-11 at 1:00 P.M., the</p>	F0431	It is the policy of Cypress Grove Rehabilitation Center to store all drugs and biologicals in locked compartments under proper temperature controls and to 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. Drugs and biologicals stored in identified refrigerator on Willows have been	05/10/2011	

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	<p>medication room on Willows was observed with the Director of Nursing. The medication rooms contained 2 small refrigerators. The top refrigerator was noted to have a temperature of 21 degrees Fahrenheit. The lock on the refrigerator was noted to be a combination lock and was not locked. The temperature log on the front of the refrigerator door indicated settings each day in the A.M. column with initials of staff in the P.M. column. The instructions for the log read:</p> <p>" Prior to posting this log, label each column with the appropriate equipment name. Each day, record temperatures for all equipment on the A.M. and the P.M. shifts, and initial. The refrigeration temperature should be 41 degrees or below, the freezer temperature should be zero degrees or below. If any temperature exceeds the critical limits, report discrepancies immediately to the Nutrition Services Manager or Supervisor." The daily temperatures in degrees</p>		<p>returned to pharmacy and replaced at facility expense. A reconciliation of the refrigerator controlled substance lock box located on the Gardens unit has been completed with no missing medications found. Narcotic box has been replaced by pharmacy per policy. These alleged deficit practices have the ability to effect all facility residents. Licensed Nurses will be re-educated to facility policy on appropriate refrigerator temperature to include reporting of abnormal temperatures as well as policy for securing controlled substances. Education will be added to the facility's general orientation for newly hired Licensed Nurses. A Compliance Rounds audit tool has been implemented that will include but not be limited to unit refrigerator temperature checks and securing of controlled substances. Compliance rounds will be completed by the Assistant Directors of Nursing (ADON) daily x 2 weeks, 5 x weekly x 4 weeks and weekly thereafter. Identified non-compliance will result in 1:1 re-education with progressive discipline up to and including termination for failure to follow policy. Results of above audits will be forwarded to the facility Quality Assurance Committee (QA) monthly for review and recommendations as deemed appropriate</p>		

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	<p>Fahrenheit read: 4/1 = 30, 4/2 = 28, 4/3 = 28, 4/4 = 30, 4/5 = 26, 4/6 = 34, 4/7 = 28, 4/8 = 22, 4/9 = 24, 4/10 = 22, 4/11 = 22, 4/12 = 22.</p> <p>The Gardens medication (top) refrigerator lock was unlocked and contained the narcotic box which was not tagged to indicate it had been opened and used.</p> <p>On 4/11/11 at 3:00 P.M., the facility policy was reviewed for medications. On page 4, item # 11 indicated the facility should ensure that medication and biologicals are stored at appropriate temperatures, 11.2 indicated refrigeration temperatures were between 36 - 46 degrees Fahrenheit or 2 - 8 degrees Celsius.</p> <p>On 4/11/11 at 1:10 P.M., an interview with the Director of Nursing indicated, "nothing was frozen", in the refrigerator with the temperature at 21 degrees Fahrenheit.</p> <p>3.1-25(m)</p>				

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