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	155687	A. BUILDING 00 B. WING	10/26/2016

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GOLDEN LIVING CENTER-MUNCIE	2701 LYN-MAR DR MUNCIE, IN 47304

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00212504. Complaint IN00212504 - Substantiated. Federal/State deficiencies related to the allegations are cited at F250, F279, F309, F329 and F520. Survey dates: October 24, 25 and 26, 2016 Facility number: 000097 Provider number: 155687 AIM number: 100290970 Census bed type: SNF/NF: 93 Total: 93 Census payor type: Medicare: 6 Medicaid: 83 Other: 4 Total: 93 Sample: 6 These deficiencies reflects State findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	This plan of correction constitutes the facility's written allegation of compliance; however, the plan is not an admission that a deficiency existed or that one was cited correctly. The plan of correction is being submitted to meet the requirements of state and federal law.	

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

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	Quality Review completed by 09674 on 11/1/2016.			
F 0250 SS=D Bldg. 00	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, interview and record review, the facility failed to ensure residents receiving psychopharmacological medications for maladaptive behaviors had a monitoring and management program with specific target behaviors and interventions in place for 3 of 6 residents reviewed for unnecessary medications. (Resident B, D and E) Findings Include: 1. The clinical record for Resident B was reviewed on 10/24/16 at 11:03 a.m.	F 0250	1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? A behavior monitoring log was implemented for Res B, D, and F to track behavioral occurrences, effectiveness of interventions, and ensure proper usage of psychoactive medications. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? A behavior log was implemented for Res B and D to track	11/25/2016

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	Diagnoses included, but were not limited to, Alzheimer's disease, dementia, anxiety, depression and hypertension. The most recent quarterly Minimum Data Set (MDS) dated 10/13/16, indicated Resident B was severely cognitively impaired. Review of a nursing note, dated 10/11/16 at 3:10 p.m., indicated "resident after taking his shower jimmied the linen closet door and came out with an armful of linen." No documentation of any redirection was charted. During an observation on 10/26/16 at 3:10 p.m., Resident B was observed to exit the small resident lounge bathroom with a full roll of toilet paper. He was then observed to go into his room and shut the door. No staff followed or redirected the resident. A nursing note, dated 10/7/16 at 7:40 p.m., indicated "Resident took all snacks from refrigerator and hid them under his shirt, became angry when staff asked him about it, very difficult to redirect this pm." No additional information was charted. A nursing note, dated 10/6/16 at 2:17 p.m., indicated "Resident was in art room putting sand paper, glue, and other items		behavioral occurrences, effectiveness of interventions, and ensure proper usage of psychoactive medications. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? A behavior monitoring program has been established to monitor all residents for behaviors and to track appropriate use of psychoactive medications. Specific interventions will be developed for each behavior identified and if need GDR of the psychoactive medication. CNA assignment sheets will be updated to correspond with changes reported. All staff in-serviced on the new behavior monitoring program. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? DNS/SSD/designee to review in clinical start any behaviors from previous day for any follow up needed. These audits to be completed 5 times weekly. Results will be forwarded to the Behavior Committee monthly for trending of behaiors and effectiveness of interventions, and appropriate use of psychoactive medication. Results of these audits will be taken to QAPI x 6 months to track for any trends. If any trends are	

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	in pockets. Resident was redirected after resident pushes himself against staff." No type of redirection was charted. A nursing note, dated 10/4/16 at 11:04 p.m., indicated "resident observed in courtyard had gloves on and a rake attempting to dig a hole under the fence. Re-directed back in facility with difficulty." A nursing note, dated 10/3/16 at 1:44 p.m., indicated "Resident was seen trying to put the code in the doors leading out of the ACU [Alzheimer's Care Unit] unit. Resident was redirected from the doors." A nursing note, dated 10/1/16 at 11:09 a.m., indicated "Resident has been using objects to open the clean linen closet up. Resident is redirected but goes back when no one is around." A general note, dated 9/29/16 at 3:10 p.m., indicated "MD aware with new orders to decrease Depakote (a medication to treat manic depression) 500 mgs [sic] to Depakote 250 mgs [sic] daily." Review of a Behavior Detail Report from 8/24/16 through 10/24/26, indicated no behaviors were noted from 10/1/16 through 10/11/16.		identified the audits will be completed based on QAPI recommendations. If no trends identified then will review on PRN basis. 5. By what the systemic changes will be completed. November 25, 2016	

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Review of the current care plans for Resident B, he had to following care plans in place:
"At times I feel sad and lonely due to my dx [diagnosis] of depression...hoarding items from the art room and the kitchen, I sometimes become physically aggressive with staff...diagnosis of Alzheimer's...Mood Stabilizer medication...."

Resident B did not have a care plan related to exit seeking behaviors.

2. The clinical record for Resident D was reviewed on 10/25/16 at 9:44 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia with behaviors, anxiety, depression, chronic pain and hypertension. The most recent quarterly Minimum Data Set (MDS) dated 10/13/16, indicated Resident C was severely cognitively impaired.

Review of a nursing note, dated 10/26/16 at 2:13 a.m., indicated "stated he needs to get to the guys for work. Unable to redirect."

A nursing note, dated 10/18/16 at 6:33 p.m., indicated "Did wander into another res. room at one point et [and] was resistant to redirection out of the room,

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	requiring 2 staff members to redirect." No type of redirection was charted. A nursing note, dated 10/18/16 at 1:58 p.m., indicated "he did swing and hit cna 1 2nd cna intervene so he eat [sic] her. Nurse intervene...Res attempted to elbow nurse. Then he made this thumb and index finger look like a gun and pretended to shoot at staff...." A nursing note, dated 9/25/16 at 3:27 a.m., indicated "Res became anxious/agitated several times....Wandering in female rooms, became upset about each not being his." Review of a Behavior Detail Report from 8/24/16 through 10/24/26, no behaviors were noted on 9/25/16. Review of the current care plans for Resident D, he had to following care plans in place: "At times I feel sad and distressed, angry and irritable. I have dx of depression...Becoming confused with agitation and combativeness r/t [related to] diagnosis of Dementia...nervous and anxious...." Resident D did not have a care plan related to being physically abusive towards staff.3. Resident E's record was			

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	reviewed on 10/25/2016 at 11:16 a.m. and indicated the following diagnoses: Alzheimer's disease, insomnia, psychosis, major depressive disorder and vascular dementia. Review of the nursing note, dated 9/25/2016 at 3:32 a.m., indicated "...Res [Resident] anxious et crying out, yelling/cursing multi times this shift. Redirected for short periods of time before new bx [sic] episode began. Toileted, foods/fluids provided, denies pain." Review of the "Behavior Detail Report" dated 9/25/2016, lacked any documentation of this occurrence. Review of the nursing note, dated 9/27/2016 at 10:25 a.m., indicated "...She continues to pace up and down the halls. She will wonder [sic] in and out of others rooms. ..." The note lacked any indication of interventions used to address this behavior. Review of the "Behavior Detail Report" dated 9/27/2016, lacked any documentation of this occurrence. Review of the nursing note, dated 10/20/2016 at 3:49 a.m. indicated "resting [sic] in bed. resident [sic] yelling out tonight, roommate keeps talking to her and messing with her bedding. skin [sic] warm and dry			

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	respirations even and unlabored. incontinent [sic] of urine peri care given as needed. v/s [vital signs] 142/84-88-20-97.6." The note lacked any indication of interventions used to address behavior. Review of the "Behavior Detail Report" dated 7/25/2016 to 10/25/2016, lacked any documentation of this occurrence. During an interview on 10/25/16 at 1:55 p.m., Social Service Director indicated the progress notes were read daily in morning meeting. She indicated if it was not charted in "Care Tracker" it should be documented in the progress notes. She indicated she did not have a book or system to keep track of the number of incidents per month for residents. During an interview on 10/26/16 at 9:50 a.m., the Director of ACU indicated she did not have a Gradual Dose Reduction (GDR) tracking book or program, but followed the pharmacist recommendations related to a GDR for a resident. She could not indicate how the physician, pharmacist or psych nurse practitioner knew if a resident had an increase or a decrease in the number of behaviors per month. During an interview on 10/26/16 at 10:18 a.m., the Director of the ACU indicated			

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	the care plans for depression and/or anxiety did not have specific target behaviors. She indicated the progress notes were printed for her and she was to read them in morning clinical meeting related to behaviors. She was unable to indicate how the behaviors listed in the progress notes did not reflect the number of behaviors on the Behavior Detail Report for each resident. During an interview on 10/26/16 at 12:00 p.m., the Director of Nursing indicated no staff person had a copy of the August Behavior Management meeting. Review of a current facility policy, dated 3/31/16 and titled "Mood / Behavior Management" provided by the SSD on 10/25/16 at 2:19 p.m., indicated the following: "POLICY STATEMENT: The LivingCenter behavior management system addresses residents with behavior patterns that interfere with their functional capacity. Assessing Resident's Behavior The social services staff will assess resident's behavior(s) that are potentially harmful to self or others through observation, interview, and record review, including Care Tracker Data and			

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	other Behavior Monitoring tools, and inquiry. Monitoring Residents The social services coordinator, as facilitator, will ensure that the Behavior Committee utilized he existing systems of monitoring the frequency and circumstances surrounding the behaviors.... Care Tracker for Section E ...6. SSD reviews monthly the Mood/Behavior log (medical record document) and writes an IPN summarizing each resident's mood and behavior trends and the effectiveness of interventions and medications. Evaluating for Effectiveness The behavior management plan will be evaluated for effectiveness at least monthly by social services with the interdisciplinary team." This Federal tag relates to complaint IN00212504. 3.1-34(a)			
F 0279	483.20(d), 483.20(k)(1)			

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SS=E Bldg. 00	DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. 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). Based on interview and record review, the facility failed to develop care plans to address targeted behaviors for residents who used psychoactive medications for 4 of 6 residents reviewed for care plan development related to psychoactive medication use. (Resident B, D, E and F) Findings include: 1. The clinical record for Resident B was reviewed on 10/24/16 at 11:03 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia, anxiety, depression and hypertension.	F 0279	1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Care plans for Res B, D, E, and F reviewed and updated to address any targeted behaviors identified for these residents. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? Care plans of all residents who receive psychoactive medications reviewed and updated if needed to ensure any targeted behaviors have been addressed. .	11/25/2016

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	The most recent quarterly Minimum Data Set (MDS) dated 10/13/16, indicated Resident B was severely cognitively impaired. Review of the signed physician orders dated 9/1/16, Resident B had the following psychopharmacological medications ordered: a. sertraline (anti-depressant medication) 25 mg daily for major depressive disorder. b. trazadone (anti-depressant medication) 25 mg at night for dementia with behaviors. A current health care plan problem, dated 5/6/16, indicated a problem with feeling sad and lonely due to a history of depression. The interventions for the problem included, but were not limited to, encourage to get involved with activities, keep contact with family and friends and give medication to help with depression. 2. The clinical record for Resident D was reviewed on 10/25/16 at 9:44 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia with behaviors, anxiety, depression, chronic pain and hypertension. The most recent quarterly Minimum Data Set (MDS) dated 10/13/16, indicated Resident D was		3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? A behavior monitoring program has been established to monitor all residents for behaviors. Specific interventions will be developed for each behavior identified and implemented on the care plan. All staff have been in-serviced on the new behavior monitoring program and the usage of the interventions listed on the care plan. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? DNS/SSD/designee to review in clinical start any behaviors from previous day and update care plans as needed based on any behaviors identified. Results will be forwarded to the Behavior Committee monthly for trending of behaviors and effectiveness of interventions listed on care plan. These audits to be completed 5 times weekly. Results of these audits will be taken to QAPI x 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends identified then will review on PRN basis. 5. By what the systemic changes will be completed. November 25, 2016	

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	severely cognitively impaired. Review of the physician orders, dated 9/1/16, indicated Resident D had the following psychopharmacological medications ordered: a. trazadone (anti-depressant medication) 25 mg at night for major depression. b. venlafaxine (a medication used to treat depression 50 mg twice daily for depression. A current health care plan problem, dated 4/13/16, indicated a problem with feeling sad and distressed due to a history of depression. The interventions for the problem included, but were not limited to, encourage to get involved with activities, keep contact with family and friends and give medication to help with depression.3. Resident E's record was reviewed on 10/25/2016 at 11:16 a.m. Alzheimer's disease, insomnia, psychosis, major depressive disorder and vascular dementia. Resident E's current physician's orders include, but were not limited to, Depakote (anticonvulsant mediation) 125 mg: give 1000 mg by mouth two times a day related to unspecified psychosis not due to a substance or known physiological condition, dated 9/1/2016. Lexapro (antidepressant medication) 5			

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	mg :give 5 mg by mouth one time a day related to major depressive disorder, dated 9/1/2016. Review of Resident E's clinical record indicated a lack of a care plan regarding the targeted behaviors being treated by the use of the antidepressant medication Lexapro. Review of Resident E's care plan for psychosis lacked any description of the type of hallucinations and/or delusions the resident may experience. During an interview on 10/25/2016 at 2:59 p.m., LPN #1 indicated not all interventions for behaviors are on the care plan. " I always chart on them, notify the psych MD. It really depends on who it is. What they are doing - interventions I don't know. We know the residents pretty well and we know what works. I'm sure not all the interventions are on the care plan. Some of them are there some aren't. I don't always look at the care plan." During an interview on 10/26/2016 at 12:16 p.m., LPN #2 indicated Resident E's care plan for depression was missing behavior indicators. LPN #2 indicated, "She was re-admitted recently. There was a new admission at the same time.			

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	The nurse that admitted her omitted the care plan for depression. It was missed." LPN #2 indicated the psychosis care plan lacked information related to the type of hallucinations and/or delusions the resident might experience. 4. Resident F's record was reviewed on 10/25/2016 at 1:26 p.m. Current diagnoses included, but were not limited to, Alzheimer's disease, major depressive disorder, dementia with behaviors and disruptive mood dysregulation disorder. Resident F's current physician's orders include, but were not limited to, Fluoxetine (antidepressant medication) 20 mg: give by mouth one time a day related to major depressive disorder, dated 6/21/16. Remeron (antidepressant medication) 15 mg: give by mouth at bedtime for depression, dated 6/22/2016. Review of Resident F's care plans lacked targeted behavior indicators for the diagnoses of depression. The care plan for depression read as follows "Focus: At times I feel sad and Distressed [sic], Hopeless [sic]. I have a diagnosis of depression, dated 10/5/2016. Goals: I will talk about positive topics and happy memories during conversations through next review, dated 10/5/2016. Interventions: Help me to keep in contact with family and friends. Please			

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	155687	A. BUILDING 00 B. WING	10/26/2016

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	give me my medications that help me with my depression and manage any side effects. Please tell my doctor if my symptoms are not improving to see if I need a change in my mediation. Take the time to discuss my feelings when I'm feeling sad." All interventions were dated 10/5/2016. During an interview on 10/26/2016 at 12:16 p.m., LPN #2 indicated Resident F's care plan for depression lacked specific resident behavior indicators. LPN #2 indicated "She should have had behavior indicators for her diagnosis of depression." This Federal tag relates to complaint IN00212504. 3.1-35(a)			
F 0309 SS=D Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.			

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	Based on interview and record review, the facility failed to develop and implement a behavior management and monitoring program for residents who had dementia and received psychoactive medication for symptoms related to dementia with behavioral disturbances for 2 of 6 residents reviewed for behavior monitoring and management associated with dementia (Resident B and D). Findings include: 1. The clinical record for Resident B was reviewed on 10/24/16 at 11:03 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia, anxiety, depression and hypertension. The most recent quarterly Minimum Data Set (MDS) dated 10/13/16, indicated Resident B was severely cognitively impaired. Resident B had current physician's order for the following psychoactive medication: a) 5/5/16-trazadone (anti-depressant medication) 25 mg at night for dementia with behaviors. A current health care plan problem, dated 5/6/16, indicated a problem with dementia related to Alzheimer's disease.	F 0309	1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? A behavior log was implemented for Res B and D to track behavioral occurrences, effectiveness of interventions, and ensure proper usage of psychoactive medications. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All other residents receiving psychoactive medications had a behavior log implemented to track behavioral occurrences and effectiveness of interventions. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? A behavior monitoring program has been established to monitor all residents for behaviors and to track appropriate use of psychoactive medications. Specific interventions will be developed for each behavior identified and if need GDR of the psychoactive medication. CNA assignment sheets will be updated to correspond with changes reported. All staff in-serviced on the new behavior monitoring program 4. How the corrective actions will be monitored to ensure the deficient practice will not recur,	11/25/2016

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	The interventions for the problem included, but were not limited to, meds per order, allow resident to walk throughout the ACU (Alzheimer's Care Unit) at will and provide environmental cues. Another health care plan problem, dated 5/6/16, indicated a problem with behaviors that included hoarding items and being physically aggressive with staff. Interventions included, but were no limited to, attempt interventions before my behavior, make sure I am not in pain and offer me a diversion. 2. The clinical record for Resident D was reviewed on 10/25/16 at 9:44 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia with behaviors, anxiety, depression, chronic pain and hypertension. The most recent quarterly Minimum Data Set (MDS) dated 10/13/16, indicated Resident D was severely cognitively impaired. Resident D had current physician's order for the following medications: a. 8/16/16-Benadryl (anti-histamine) 25 mg every 6 hours as needed for behaviors. b. 8/16/16-Depakote (a medication used		i.e., what quality assurance program will be put into place? DNS/SSD/designee to review in clinical start any behaviors from previous day for any follow up needed. These audits to be completed 5 times weekly. Results will be forwarded to the Behavior Committee monthly for trending of behaiors and effectiveness of interventions, and appropriate use of psychoactive medication. Results of these audits will be taken to QAPI x 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends identified then will review on PRN basis. 5. By what date will the systemic changes will be completed. November 25, 2016	

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	for manic depression) sprinkles 125 mg, two capsules daily for dementia with behaviors. c. 8/19/16-Depakote sprinkles 125 mg, four capsules daily for dementia with behaviors. A current health care plan problem, dated 1/8/16, indicated an problem with becoming confused , agitated and combative related to a diagnosis of dementia. The interventions for the problem included, but were not limited to, administer medication as ordered, attempt interventions before behavior escalates, offer a quieter setting. During an interview on 10/26/16 at 10:18 a.m., the Director of the ACU indicated the care plans did not have specific target behaviors. She indicated the progress notes were printed for her and she was to read them in morning clinical meeting related to behaviors. She was unable to indicate how the behaviors listed in the progress notes did not reflect the number of behaviors on the Behavior Detail Report for each resident. She was unable to determine if an intervention was effective or not effective. This Federal tag relates to complaint IN00212504.			

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	3.1-37(a)			
F 0329 SS=D Bldg. 00	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on observation, interview and record review, the facility failed to ensure residents were free from psychotropic medications without indication for 2 of 6	F 0329	1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Psychotropic medications reviewed for Res B and Res D to	11/25/2016

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	residents reviewed for unnecessary medications. (Resident B and D) Findings include: 1. The clinical record for Resident B was reviewed on 10/24/16 at 11:03 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia, anxiety, depression and hypertension. The most recent quarterly Minimum Data Set (MDS) dated 10/13/16, indicated Resident B was severely cognitively impaired. During an observation on 10/26/16 at 9:15 a.m., Resident B was seated in the small resident lounge watching television. During an observation on 10/26/16 at 10:26 a.m., Resident B was in the large lounge looking through magazines. Review of a nursing note, dated 10/11/16 at 3:10 p.m., indicated "resident after taking his shower jimmied the linen closet door and came out with an armful of linen." During an observation on 10/26/16 at 3:10 p.m., Resident B was observed to exit the small resident lounge's bathroom with a full roll of toilet paper. He was		ensure indication for use present. Changes were made based on review. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All other residents with psychotropic medications had medications reviewed for proper diagnosis and use. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Licensed staff in-serviced that psychotropic medications must have an appropriate diagnosis to indicate use. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? DNS/designee to review new orders from previous day during clinical start up to ensure that any new psychotropic medication orders have proper diagnosis and indication for use. These audits to be completed 5 times weekly. Results of these audits will be taken to QAPI x 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends identified then will review on PRN basis. 5. By what the systemic changes	

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	then observed to go into his room and shut the door. No staff followed or redirected the resident. A nursing note dated 10/7/16 at 7:40 p.m., indicated "Resident took all snacks from refrigerator and hid then under his shirt, became angry when staff asked him about it, very difficult to redirect this pm." A nursing note, dated 10/6/16 at 2:17 p.m., indicated "Resident was in art room putting sand paper, glue, and other items in pockets. Resident was redirected after resident pushes himself against staff." A nursing note, dated 10/4/16 at 11:04 p.m., indicated "resident observed in courtyard had gloves on and a rake attempting to dig a hole under the fence." Re-directed back in facility with difficulty." A nursing note, dated 10/3/16 at 1:44 p.m., indicated "Resident was seen trying to put the code in the doors leading out of the ACU [Alzheimer's Care Unit] unit. Resident was redirected from the doors." A nursing note dated 10/1/16 at 11:09 a.m., indicated "Resident has been using objects to open the clean linen closet up. Resident is redirected but goes back		will be completed. November 25, 2016	

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	when no one is around." Review of the signed physician orders dated 9/1/16, Resident B had the following psychopharmacological medications ordered: a. sertraline (anti-depressant medication) 25 mg daily for major depressive disorder. b. trazadone (anti-depressant medication) 25 mg at night for dementia with behaviors. A current health care plan problem, dated 5/6/16, indicated a problem with feeling sad and lonely due to a history of depression. The interventions for the problem included, but were not limited to, encourage to get involved with activities, keep contact with family and friends and give medication to help with depression. 2. The clinical record for Resident D was reviewed on 10/25/16 at 9:44 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia with behaviors, anxiety, depression, chronic pain and hypertension. The most recent quarterly Minimum Data Set (MDS) dated 10/13/16, indicated Resident C was severely cognitively impaired.			

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	On 10/26/16 at 8:40 a.m., Resident D was in the dining room seated at a table. He had just finished breakfast. Review of a nursing note, dated 10/26/16 at 2:13 a.m., indicated "stated he needs to get to the guys for work. Unable to redirect." A nursing note, dated 10/25/16 at 11:46 p.m., indicated "resident up pacing hallways trying to get to his truck to go to work. Unable to redirect, getting agitated with staff. prn [as needed] Benadryl given per order for behaviors." A nursing note, dated 10/18/16 at 6:33 p.m., indicated "Did wander into another res. room at one point et [and] was resistant to redirection out of the room, requiring 2 staff members to redirect." No type of redirection was charted. A nursing note, dated 10/18/16 at 1:58 p.m., indicated "he did swing and hit cna 1 2nd cna intervene so he eat [sic] her. Nurse intervene...Res attempted to elbow nurse. Then he made this thumb and index finger look like a gun and pretended to shoot at staff...." A nursing note, dated 9/25/16 at 3:27 a.m., indicated "Res became anxious/agitated several			

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	times....Wandering in female rooms, became upset about each not being his." Review of the current care plans for Resident D, he had the following care plans in place: "At times I feel sad and distressed, angry and irritable. I have dx of depression...Becoming confused with agitation and combativeness r/t [related to] diagnosis of Dementia...nervous and anxious...." Review of the physician orders, dated 9/1/16, indicated Resident D had the following psychopharmacological medications ordered: a. trazadone (anti-depressant medication) 25 mg at night for major depression. b. venlafaxine (a medication used to treat depression) 50 mg twice daily for depression. During an interview on 10/26/16 at 10:18 a.m., the Director of the ACU indicated the progress notes were printed for her and she was to read them in morning clinical meeting related to behaviors. She indicated she saw the Benadryl but was not sure why it was being used. During an interview on 10/26/16 at 10:49 a.m., the Minimum Data Set (MDS) Coordinator indicated Benadryl would			

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	not be able to be coded on the MDS with a diagnosis of behaviors. During an interview on 10/26/16 at 1:47 p.m., the Administrator indicated the Quality Assessment and Assurance (QAA) committee met monthly and someone should have caught the Benadryl being given for behaviors and trazadone was being given for dementia. This Federal tag relates to complaint IN00212504. 3.1-48(a)(4)			
F 0520 SS=E Bldg. 00	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.			

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	A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on observation, interview and record review, the facility failed to identify concerns and successfully implement a plan of action to address the lack of documentation related to behavior management, monitoring and tracking of behaviors. This deficient practice had the potential to impact 19 of 19 residents who resided in the facility and had behavioral healthcare needs. Findings include: 1. The clinical record for Resident B was reviewed on 10/24/16 at 11:03 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia, anxiety, depression and hypertension. The most recent quarterly Minimum Data Set (MDS) dated 10/13/16, indicated Resident B was severely cognitively impaired. Review of a nursing note, dated 10/11/16 at 3:10 p.m., indicated "resident after taking his shower jimmied the linen	F 0520	1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Residents B/C/D/E were found to be affected. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All recommendations from Behavior Committee and Clinical Start Up Committee will be forwarded to QAPI Committee monthly for 3 months, if trends identified will continue, if no trends will do prn for review of trends and if trends are identified based on QAPI recommendations an audit will be completed and trends addressed. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Based on information received from Behavior Committee and Clinical Start Up Committee, trends will be forwarded to QAPI for recommendations monthly for	11/25/2016

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	closet door and came out with an armful of linen." No documentation of any redirection was charted. During an observation on 10/26/16 at 3:10 p.m., Resident B was observed to exit the small resident lounge's bathroom with a full roll of toilet paper. He was then observed to go into his room and shut the door. No staff followed or redirected the resident. A nursing note, dated 10/7/16 at 7:40 p.m., indicated "Resident took all snacks from refrigerator and hid them under his shirt, became angry when staff asked him about it, very difficult to redirect this pm." No additional information was charted. A nursing note, dated 10/6/16 at 2:17 p.m., indicated "Resident was in art room putting sand paper, glue, and other items in pockets. Resident was redirected after resident pushes himself against staff." No type of redirection was charted. A nursing note, dated 10/4/16 at 11:04 p.m., indicated "resident observed in courtyard had gloves on and a rake attempting to dig a hole under the fence." Re-directed back in facility with difficulty."		3 months, if trends identified will continue, if no trends will do prn. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Results identified by the new Behavior Monitoring Program will be reviewed by the Clinical Start Up Committee daily with results forwarded to the Behavior Committee Monthly for trending of behaviors and effectiveness of interventions. Committee Minutes and Audit results will be forwarded to the QAPI Committee monthly for 3 months if the program is effective, if trends identified will continue, if no trends will do prn. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends are identified then will review on PRN basis. 5. By what the systemic changes will be completed. November 25, 2016	

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	A nursing note, dated 10/3/16 at 1:44 p.m., indicated "Resident was seen trying to put the code in the doors leading out of the ACU [Alzheimer's Care Unit] unit. Resident was redirected from the doors." A nursing note dated 10/1/16 at 11:09 a.m., indicated "Resident has been using objects to open the clean linen closet up. Resident is redirected but goes back when no one is around." Review of a Behavior Detail Report from 8/24/16 through 10/24/26, no behaviors were noted from 10/1/16 through 10/11/16. 2. The clinical record for Resident D was reviewed on 10/25/16 at 9:44 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia with behaviors, anxiety, depression, chronic pain and hypertension. The most recent quarterly Minimum Data Set (MDS) dated 10/13/16, indicated Resident C was severely cognitively impaired. Review of a nursing note dated 10/26/16 at 2:13 a.m., indicated "stated he needs to get to the guys for work. Unable to redirect." A nursing note, dated 10/25/16 at 11:46 p.m., indicated "resident up pacing			

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	155687	A. BUILDING 00 B. WING	10/26/2016

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	hallways trying to get to his truck to go to work. Unable to redirect, getting agitated with staff. prn [as needed] Benadryl given per order for behaviors." A nursing note, dated 10/18/16 at 6:33 p.m., indicated "Did wander into another res. room at one point et [and] was resistant to redirection out of the room, requiring 2 staff members to redirect." No type of redirection was charted. A nursing note, dated 10/18/16 at 1:58 p.m., indicated "he did swing and hit cna 1 2nd cna intervene so he eat [sic] her. Nurse intervene...Res attempted to elbow nurse. Then he made this thumb and index finger look like a gun and pretended to shoot at staff...." A nursing note, dated 9/25/16 at 3:27 a.m., indicated, "Res became anxious/agitated several times....Wandering in female rooms, became upset about each not being his." Review of a Behavior Detail Report from 8/24/16 through 10/24/26, no behaviors were noted on 9/25/16. 3. Resident E's record was reviewed on 10/25/2016 at 11:16 a.m. Diagnoses included, Alzheimer's disease, insomnia, psychosis, major depressive disorder and			

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	vascular dementia. Review of the nursing note, dated 9/25/2016 at 3:32 a.m., indicated "...Res [Resident] anxious et crying out, yelling/cursing multi times this shift. Redirected for short periods of time before new bx [sic] episode began. Toileted, foods/fluids provided, denies pain." Review of the "Behavior Detail Report" dated 9/25/2016, lacked any documentation of this occurrence. Review of the nursing note, dated 9/27/2016 at 10:25 a.m., indicated "...She continues to pace up and down the halls. She will wonder [sic] in and out of others rooms. ..." The note lacked any indication of interventions used to address this behavior. Review of the "Behavior Detail Report" dated 9/27/2016, lacked any documentation of this occurrence. Review of the nursing note, dated 10/20/2016 at 3:49 a.m., indicated "resting [sic] in bed. resident [sic] yelling out tonight, roommate keeps talking to her and messing with her bedding. skin [sic] warm and dry respirations even and unlabored. incontinent [sic] of urine peri care given as needed. v/s [vital signs] 142/84-88-20-97.6." The note lacked any			

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	indication of interventions used to address behavior. Review of the "Behavior Detail Report" dated 7/25/2016 to 10/25/2016, lacked any documentation of this occurrence. During an interview on 10/25/16 at 1:55 p.m., Social Service Director indicated the progress notes were read daily in the morning meeting. She indicated if it was not charted in "care tracker" it should be documented in the progress noted. She indicated she did not have a book or system to keep track of the number of incidents per month for residents. During an interview on 10/26/16 at 9:50 a.m., the Director of ACU indicated she did not have a Gradual Dose Reduction (GDR) tracking book or program, but followed the pharmacist recommendations related to a GDR for a resident. She could not indicate how the physician, pharmacist or psych nurse practitioner knew if a resident had an increase or a decrease in the number of behaviors per month. During an interview on 10/26/16 at 10:18 a.m., the Director of the ACU indicated the care plans for depression and/or anxiety did not have specific target behaviors. She indicated the progress notes were printed for her and she was to			

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	read them in morning clinical meeting related to behaviors. She was unable to indicate how the behaviors listed in the progress notes did not reflect the number of behaviors on the Behavior Detail Report for each resident. During an interview on 10/26/16 at 12:00 p.m., the Director of Nursing indicated no staff person had a copy of the August Behavior Management meeting. During an interview on 10/26/16 at 1:47 p.m., the Administrator indicated the facility had not identified poor documentation related to medication indication, behaviors, tracking and trending. She indicated the Quality Assessment and Assurance (QAA) committee met monthly and someone should have caught Benadryl being given for behaviors and trazadone being given for dementia. She indicated behaviors had triggered last week in the QAA meeting, but was not sure why behaviors had not triggered before. This Federal tag relates to complaint IN00212504. 3.1-52(b)(2)			

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