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	155740	A. BUILDING 00 B. WING	05/17/2013

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TIMBERCREST CHURCH OF BRETHREN	2201 EAST ST NORTH MANCHESTER, IN 46962

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F000000	This visit was for the Recertification and State Licensure Survey. Survey dates: May 13, 14, 15, 16 and 17, 2013 Facility number: 000448 Provider number: 155740 AIM number: 100275140 Survey team: Toni Maley, BSW- TC Linn Mackey, RN Karen Koeberlein, RN Tina Smith-Staats, RN Census bed type: SNF/NF: 60 Residential: 144 Total: 204 Census payor type: Medicare: 2 Medicaid: 24 Other: 178 Total: 204 Residential Sample: 9 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F000000		

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

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	Quality Review completed by Debora Barth, RN.			

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F000172 SS=B	483.10(j)(1)&(2) RIGHT TO/FACILITY PROVISION OF VISITOR ACCESS The resident has the right and the facility must provide immediate access to any resident by the following: Any representative of the Secretary; Any representative of the State; The resident's individual physician; The State long term care ombudsman (established under section 307 (a)(12) of the Older Americans Act of 1965); The agency responsible for the protection and advocacy system for developmentally disabled individuals (established under part C of the Developmental Disabilities Assistance and Bill of Rights Act); The agency responsible for the protection and advocacy system for mentally ill individuals (established under the Protection and Advocacy for Mentally Ill Individuals Act); Subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident; and Subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, others who are visiting with the consent of the resident. The facility must provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the			

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	resident's right to deny or withdraw consent at any time. Based on observation, record review and interview, the facility failed to ensure a resident who would desire to contact the Ombudsman had access to the information for 1 of 1 Resident Council President. Findings include: During an interview on 5/16/13 at 9:00 a.m., the Resident Council President indicated she has never heard the word "Ombudsman." The Resident Council President did not know who this was, or how to contact them. The Resident Council President also did not recognize the name of the local Ombudsman when given the information. During record review on 5/16/13 at 9:25 a.m., the Quarterly Minimum Data Set (MDS), dated 12/7/2013, indicated the resident had no cognitive impairment, and was reliable and interviewable. During an observation on 5/16/13, 9:35 a.m., the information posted in the commons area, near the nurses station, mentioned only the state Ombudsman's number, and not the local Ombudsman name and number.	F000172	F-172 It is, and always has been, the intent of Timbercrest to ensure residents have reasonable access to any entity or individual that provides health, social, legal, or other services. In the cited non-compliance, for 1 of 1 resident, this requirement was not met because the resident, who serves as the representative for Health Care on the Resident Council, was not aware of the Ombudsman program and didn't know how to contact the area Ombudsman. Further the posted information was not easily accessible and the contact information for the area Ombudsman was not included with all the other required information. (The survey report listed the resident as the President of the Resident Council. The resident is not the President. She is the Representative from Health Care on the Council.) 1) Regarding affected residents: a. Obstructions were removed from in front of the display to ensure accessibility and visibility on May 16, 2013 b. The name and contact information of the Area Five Ombudsman was posted on the display in a larger font effective June 3, 2013. c. Timbercrest's Director of Resident Care met with the resident in question, the	06/16/2013

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	The print was very small, and access was partially blocked by a recliner chair sitting in front of the posting. 3.1-4(j)(3)		Representative for Health Care on the Resident Council, on June 3, 2013 and explained the Ombudsman program; shared who the Ombudsman for Area Five is; and shared how to contact the area and state Ombudsman. The resident was given the most recent program brochure and a business card of the Area Five Ombudsman. Resident was also notified that the Ombudsman will be attending the Resident Council Meeting on July 9, 2013. 2) Regarding potentially affected residents: Management determined all residents are potentially affected by this deficient practice. Management then reviewed how the information in question has been made available to residents and has developed the following corrective actions: a. The posted contact information about the Area Five Ombudsman will be moved to another location which prevents any obstructions from being placed in front of it. This will be done by June 16, 2013. b. The name and contact information of the Area Five Ombudsman was added to the "Notice to Residents, Staff, and Families of Residents" document which is given to all new residents. The notice was revised on June 3, 2013, and is available for immediate distribution. A copy is included as Exhibit #1.	

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			c. A copy of the most recent "Indiana Long-Term Care Ombudsman Program" brochure will be given to each Health Care resident with an accompanying note about the Area Ombudsman. This will be done by June 16, 2013. A copy of the letter is attached as Exhibit #2. d. A copy of the most recent "Indiana Long-Term Care Ombudsman Program" brochure will be mailed to the primary contact person for each Health Care resident as well. This will be done by June 16, 2013. 3) Regarding systemic changes: a. The Unit Secretary will regularly monitor the information racks and restock brochures as necessary. Additional supplies will be ordered or copies made as necessary. This is effective June 4, 2013. b. The Ombudsman Program brochure will be included in the Social Service packet which is given to all new residents. This will be reviewed with the resident and/or family member and this review documented on the "Signature Form" which is used for each admission. This is effective June 4, 2013. A copy of the form is attached as Exhibit #3. c. Social Service staff will mail a copy of the Ombudsman program brochure to all primary contacts of residents of Health Care on an annual basis. This will be done in conjunction with the invitation to a	

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			care planning meeting. This will begin June 16, 2013. d. Information about the state agencies that may be contacted for assistance; such as ISDH and the Ombudsman program, will be highlighted as part of every Quarterly Health Care Resident meeting beginning with the next regularly scheduled meeting in August of 2013. e. Care plan meetings with each resident and/or their representative will be used to remind them about the Ombudsman program and Resident Rights beginning June 5, 2013. 4) Regarding monitoring to assure ongoing compliance, performance and effectiveness: a. The Quality Assurance Committee will monitor yearly that the state required information given to residents is up to date. b. The Social Service Consultant will check the charts of new residents for the presence of the signature form documenting that required information has been given to the resident upon admission. This check will be part of the consultant's regularly scheduled bi-monthly visits starting August, 2013. c. The Social Service Consultant will randomly ask three reliable and interviewable Health Care residents if they know about the Ombudsman program and how to contact the area Ombudsman. This check will be part of the	

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			consultant's regularly scheduled bi-monthly visits starting August, 2013. 5) All corrective actions will be completed by June 16, 2013.	

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F000250 SS=D	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 with identified behavioral concerns and/or who received psychoactive medication had medically based social services in the area of behavior management and behavior monitoring for 2 of 2 residents reviewed for behavior management. (Resident #59 and #72). Findings include: 1.) Resident #59's record was reviewed on 5/16/13 at 10:00 a.m. Resident #59's current diagnoses included, but were not limited to, diabetes mellitus, panic disorder and dementia. Resident #59 had a current, 3/29/13, physician's order for Zyprexa 2.5 mg (an anti-psychotic medication) one tablet one time daily. Resident #59 had a current, 3/15/13, quarterly, Minimum Data Set (MDS)	F000250	F-250 It is, and always has been, the intent of Timbercrest to ensure residents receive medically-related social services to help them attain and/or maintain the highest practicable physical, mental, and psychosocial well-being. In the cited non-compliance, for 2 of the 2 residents reviewed for behavior management, Timbercrest failed to provide medically-related social services in the area of behavior management and monitoring. Specifically, resident-specific approaches and acceptable care plans associated with the targeted behaviors of two residents receiving psychoactive medications were not completed. 1) Regarding affected residents: For the specified residents (#59 and #72) receiving psychoactive medications: Their care plans have been revised to provide resident specific approaches and interventions related to each resident's specific behavioral symptoms. This was completed June 7, 2013. This was done in collaboration with residents as appropriate. The revised care plans are being communicated to nursing staff. The revised care plans are provided as Exhibits #4	06/21/2013

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	assessment which indicated the resident had cognitive impairment and required assistance for decision making. She had felt down, tired and/or lacked energy 7 to 11 days of the assessment period. She had trouble concentrating 2 to 6 days of the assessment period. She did not display any maladaptive behaviors during the assessment period. The clinical record had a,1/18/12, pharmacy note which indicated the nurse stated the resident used Zyprexa for "panic attacks." Resident #59 had "Behavior Management Team Meeting" notes for a period from 2/18/13 to 4/25/13 indicated the resident's "Monitored Behaviors" were anxiety, panic disorder, and agoraphobia. The meeting notes did not describe how the resident displayed the symptoms of these conditions. The notes indicated the resident had displayed no maladaptive behaviors during this period. Review of Resident #59's "Behavior Detail Report" for 2/15/13 through 5/16/13 indicated the resident had displayed no maladaptive behaviors during this period.		and #5. 2) Regarding potentially affected residents: All residents receiving psychoactive medications were identified as potentially affected by this deficient practice and the following corrective practices will be taken: a. The care plans for every resident on psychoactive medications and/or with behaviors requiring management will be reviewed. This will be completed by June 21, 2013. b. As necessary the care plans will be revised to provide resident-specific approaches and interventions related to each resident's specific behavioral symptoms. This will be completed by June 21, 2013. c. The revised care plan will be communicated to nursing staff via verbal meetings at shift change and through use of the Resident Care Binder. This will be completed by June 21, 2013. 3) Regarding systemic changes: a. A regular stand-up meeting will be created to provide a venue for sharing current information about residents' behaviors and for assisting in the management of the same. This meeting will include (as often as feasible) the DON, the MDS Coordinator, the Social Service Designee, and a Nurse. This will be initiated by June 16, 2013. b. Based upon the findings of the stand-up meeting the care plan for the affected residents will be	

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	Resident #59's record lacked a care plan regarding the resident's specific targeted behavioral symptoms which were being treated by the use of the anti-psychotic medication Zyprexa. Resident #59's clinical record lacked resident specific approaches to address any behavioral concerns. During a 5/16/13, 10:02 a.m., interview, LPN #2, who was the charge nurse, indicated resident's targeted behaviors for the use of psychoactive medications should be on the resident's care plan. She indicated Resident #59 displayed panic by avoiding group activities and sticking to staff and following them around. She indicated resident specific approaches to behaviors should also be on the care plan. She indicated there was no other location to find resident specific approaches to behavioral concerns. At this time, LPN #2 reviewed Resident #59's record and indicated the resident did not have a care plan to identify the resident's specific behaviors or resident specific approaches to address the behavior. During a 5/16/13, 10:30 a.m., interview, CNA #1 indicated Resident #59 never displayed maladaptive behaviors during her shifts. The CNA		revised and updated with specific approaches and interventions. This will be initiated by June 16, 2013. c. The Social Service Designee will more closely monitor the care of those residents involved in behavior management to identify changing behaviors in order to revise/update care plan and to implement specific interventions as necessary. This will be initiated by June 16, 2013. d. Nursing staff will be inserviced regarding the specific signs and symptoms of anxiety and behaviors in order to better develop specific approaches and interventions. Inservices will be completed by June 16, 2013. Related documents are included as Exhibits #6 and #7. e. CNAs will be inserviced on the expanded use of Resident Care Binder which allows them to stay current on behavior management approaches. This inservice will be completed by June 16, 2013. 4) Regarding monitoring to assure ongoing compliance, performance and effectiveness: a. Timbercrest's Social Service consultant will review at least five randomly selected resident charts of residents identified with behavioral concerns and/or who receive psychoactive drugs as part of her regularly scheduled bi-monthly meetings. The consultant will advise staff on whether or not resident-specific approaches are being used and	

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	indicated she was unaware of any documented resident specific approaches to address behaviors. She indicated she knew the residents from her past experiences working with them and would use this experience as her guide. During a 5/13/13, 11:28 a.m., observation, Resident #59 was seated calmly in the dining area eating her meal. During a 5/13/13, 2:00 p.m., observation, Resident #59 was attending an activity and participating in a calm manner. During a a 5/15/13, 11:28 a.m. thorough 11:50 a.m., observation, Resident #59 was seated calmly in the dining room eating her meal. During a 5/16/13, 12:15 p.m. interview, the Social Services Designee indicated a resident's targeted behavior for the use of psychoactive medication should be listed on the resident's care plan. She additionally indicated the resident specific approaches to address behaviors should also be listed on the resident's care plan. She indicated she was unaware of Resident #59's lack of a care plan for targeted		an acceptable plan of care developed. This review will begin with the next scheduled visit in August of 2013. b. The interdisciplinary care planning and behavior management teams will analyze the appropriateness of the approaches being used as part of their regular process. This will be initiated as of June 12, 2013. c. The Quality Assurance Committee will review for ongoing compliance as part of its quarterly responsibilities. This will be initiated as of June 16, 2013. 5) All corrective actions will be completed by or initiated by June 21, 2013 as detailed above.	

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	behaviors or the lack of resident specific approaches. 2.) Resident #72's record was reviewed on 5/15/13 at 10:10 a.m. Resident #72's current diagnoses included, hypertension, depressive disorder and dementia. Resident #72 had a current 4/2/13, physician's order for Celexa 40 mg (an antidepressant medication) 1 tablet daily. Resident #72 had a ,12/20/12, psychiatric progress note which indicated the resident had anxiety, wandering, mild depression, tearfulness and was withdrawn from activities following her admission to the facility. Resident #72 had a, 4/20/13, communication form which indicated the resident had been non-compliant with care and combativeness at times and Celexa was increased. Resident #72 had a,4/24/13, physician's progress note which indicated the resident had an increase in agitation and antidepressant medication would be adjusted.			

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Resident #72 had a current, 3/29/13, quarterly Minimum Data Set (MDS) assessment, which indicated the resident felt down, depressed or hopeless 1 day of the assessment period; had felt tired or had low energy 2 to 6 days of the assessment period; displayed physically aggressive behaviors such as hitting, kicking or scratching 4 to 6 days of the assessment period; displayed verbal aggression such as screaming, cursing and threatening others 4 to 6 days of the assessment period and rejected care 4 to 6 days of the assessment period.

Resident #72's record lacked a care plan which described the resident's symptoms of depression or a care plan for resisting care. Resident #72's record and plan of care lacked resident specific approaches to behavior.

Resident #72 had a "Behavior Management Team Meeting" note for 3/1/13 through 4/23/13 which indicated the resident was physically aggressive toward staff, yelled at and cursed at staff, refused care and personal hygiene, wandered and refused to use alarms as behavioral symptoms to depression. The note

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	indicated the resident had displayed 46 maladaptive behaviors during this time period. During a 5/16/13, 10:30 a.m., interview CNA #1 indicated Resident #72 had ordered her out of the room and the nurse did not want her to provide care to Resident #72 because the resident appeared to be agitated by her presence. She indicated historically Resident #72 had refused care. She indicated there was not a specific location to find resident specific approaches to manage resident behaviors. During a 5/15/13, 11:15 a.m., interview, CNA #3 indicated Resident #72 often resisted care. She additionally indicated there was no place to look for resident specific approaches to behavior. During a 5/15/13, 2:29 p.m., interview, LPN #2, who was the charge nurse, indicated Resident #72 frequently resisted care and became agitated and angry as a symptom of her depression. LPN #2 reviewed Resident#72's record and indicated she could not find a care plan regarding resistance to care or agitation. She indicated there was no place to look for resident specific			

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	approaches to behavior if they were not in the resident's care plan. During a 5/13/13, 11:28 a.m., observation, Resident #72 was seated calmly in the dining area eating her meal. During a 5/15/13, 11:28 a.m. to 12:30 p.m. observation of lunch, Resident #72 refused to leave her room and come have lunch. She did not want to get dressed for the day or leave her room. During a 5/16/13, 12:15 p.m. interview, the Social Services Designee indicated a resident's targeted behavior for the use of psychoactive medication should be listed on the resident's care plan. She additionally indicated the resident specific approaches to address behaviors should also be listed on the resident's care plan. She indicated she was unaware of Resident #72's lack of a care plan for targeted behaviors or the lack of resident specific approaches. Review of a current, facility policy titled " Behavior Management Program Policy and procedure (sic.)," which was provided by the Director of Nursing on 5/17/13 at 8:00 a.m., indicated the following:			

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	" Policy: This program is designed to accommodate individual needs, manage behavioral symptoms and ensure regulatory compliance.... 1. Exhibit behavior symptoms which constitute a source of distress for the resident or represent a threat of danger to the resident or others, regardless of the resident's diagnoses, and whether or not a psychoactive medication is received." 3.1-34 (a)			

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F000279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 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 observation and interview, the facility failed to develop care plans for residents who had behavioral symptoms and/or used psychoactive medications for 3 of 23 residents reviewed for care plan development. (Resident #59, #72 and #11) Findings include: 1.) Resident #59's record was reviewed on 5/16/13 at 10:00 a.m. Resident #59's current diagnoses	F000279	F-279 It is, and always has been, the intent of Timbercrest to ensure residents benefit from a comprehensive care plan that addresses their medical, nursing, mental and psychosocial needs that are identified through a comprehensive assessment. In the cited non-compliance, for 3 of the 23 residents reviewed for care plan development, Timbercrest failed to adjust the residents' care plans according to the changing needs of each resident. 1) Regarding affected residents: For the specified residents (#59, #72 and #11) with behavioral symptoms and/or receiving	06/21/2013

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	included, but were not limited to, diabetes mellitus, panic disorder and dementia. Resident #59 had a current, 3/15/13, quarterly, Minimum Data Set (MDS) assessment which indicated the resident had cognitive impairment and required assistance for decision making. She had felt down, tired and/or lacked energy 7 to 11 days of the assessment period. She had trouble concentrating 2 to 6 days of the assessment period. She did not display any maladaptive behaviors during the assessment period. Resident #59 had "Behavior Management Team Meeting" notes for a period from 2/18/13 to 4/25/13 indicated the resident's "Monitored Behaviors" were anxiety, panic disorder, and agoraphobia. The meeting notes did not describe how the resident displayed the symptoms of these conditions. The notes indicted the resident had displayed no maladaptive behaviors during this period. Review of Resident #59's "Behavior Detail Report" for 2/15/13 through 5/16/13 indicated the resident had displayed no maladaptive behaviors during this period.		psychoactive medications: Their care plans have been revised to provide resident specific approaches and interventions related to each resident's specific behavioral symptoms. This was completed June 7, 2013. This was done in collaboration with residents as appropriate. The revised care plans are being communicated to nursing staff. The revised care plans are provided as Exhibits #4, #5, and #8 2) Regarding potentially affected residents: All residents with behavioral symptoms and/or receiving psychoactive medications were identified as potentially affected by this deficient practice and the following corrective practices will be taken: a. The care plans for every resident on psychoactive medications and/or with behaviors requiring management will be reviewed. This will be completed by June 21, 2013. b. As necessary the care plans will be revised to provide resident-specific approaches and interventions related to each resident's specific behavioral symptoms. These symptoms will be accurately and specifically described to assist in the development of the specific approaches and interventions. This will be completed by June 21, 2013. c. The revised care plan will be	

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	Resident #59 record lacked a care plan regarding the resident's specific targeted behavioral symptoms that were being treated by the use of the anti-psychotic medication Zyprexa. Resident #59's clinical record lacked resident specific approaches to address any behavioral concerns. During a 5/16/13, 10:02 a.m., interview, LPN #2, who was the charge nurse, indicated resident's targeted behaviors for the use of psychoactive medications should be on the resident's care plan. She indicated Resident #59 displayed panic by avoiding group activities and sticking to staff and following them around. She indicated resident specific approaches to behaviors should also be on the care plan. She indicated there was no other location to find resident specific approaches to behavioral concerns. At this time, LPN #2 reviewed Resident #59's record and indicated the resident did not have a care plan to identify the resident's specific behaviors or resident specific approaches to address the behavior. During a 5/16/13, 10:30 p.m., interview, CNA #1 indicated Resident #59 never displayed maladaptive		communicated to nursing staff via verbal meetings at shift change and through use of the Resident Care Binder. This will be completed by June 21, 2013. 3) Regarding systemic changes: a. A regular stand-up meeting will be created to provide a venue for sharing current information about residents' behaviors and for assisting in the management of the same. This meeting will include (as often as feasible) the DON, the MDS Coordinator, the Social Service Designee, and a Nurse. This will be initiated by June 16, 2013. b. Based upon the findings of the stand-up meeting the care plan for the affected residents will be revised and updated with specific approaches and interventions. This will be initiated by June 16, 2013. c. The Social Service Designee will more closely monitor the care of those residents involved in behavior management to identify changing behaviors in order to revise/update care plan and to implement specific interventions as necessary. This will be initiated by June 16, 2013. d. Nursing staff will be inserviced regarding the specific signs and symptoms of anxiety and behaviors in order to better develop specific approaches and interventions. Inservices will be completed by June 16, 2013. e. CNAs will be inserviced on the expanded use of Resident Care	

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	behaviors during her shifts. The CNA indicated she was unaware of any documented resident specific approaches to address behaviors. She indicated she knew the residents from her past experiences working with them and would use this experience as her guide. During a 5/16/13, 12:15 p.m. interview, the Social Services Designee indicated a residents targeted behavior for the use of psychoactive medication should be listed on the resident's care plan. She additionally indicated the resident specific approaches to address behaviors should also be listed on the resident's care plan. She indicated she was unaware of Resident #59's lack of a care plan for targeted behaviors or the lack of resident specific approaches. 2.) Resident #72's record was reviewed on 5/15/13 at 10:10 a.m. Resident #72's current diagnoses included, hypertension, depressive disorder and dementia. Resident #72 had a current, 3/29/13, quarterly Minimum Data Set (MDS) assessment, which indicated the resident felt down, depressed or		Binder which allows them to stay current on behavior management approaches. This inservice will be completed by June 16, 2013. 4) Regarding monitoring to assure ongoing compliance, performance and effectiveness: a. Timbercrest's Social Service consultant will review at least five randomly selected resident charts of residents identified with behavioral concerns and/or who receive psychoactive drugs as part of her regularly scheduled bi-monthly meetings. The consultant will advise staff on whether or not resident-specific approaches are being used and an acceptable plan of care developed. This review will begin with the next scheduled visit in August of 2013. b. The interdisciplinary care planning and behavior management teams will analyze the appropriateness of the approaches being used as part of their regular process. This will be initiated as of June 12, 2013. c. The Quality Assurance Committee will review for ongoing compliance as part of its quarterly responsibilities. This will be initiated as of June 16, 2013. 5) All corrective actions will be completed by or initiated by June 21, 2013 as detailed above.	

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	hopeless 1 day of the assessment period; had felt tired or had low energy 2 to 6 days of the assessment period; displayed physically aggressive behaviors such as hitting, kicking or scratching 4 to 6 days of the assessment period; displayed verbal aggression such as screaming, cursing and threatening others 4 to 6 days of the assessment period and rejected care 4 to 6 days of the assessment period. Resident #72's record lacked a care plan which described the resident's symptoms of depression or a care plan for resisting care. Resident #72's record and plan of care lacked resident specific approaches to behavior. Resident #72 had a "Behavior Management Team Meeting" note for 3/1/13 through 4/23/13 which indicated the resident was physically aggressive toward staff, yelled at and cursed at staff, refused care and personal hygiene, wandered and refused to use alarms as behavioral symptoms to depression. The note indicated the resident had displayed 46 maladaptive behaviors during this time period. During a 5/16/13, 10:30 p.m.,			

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	interview, CNA #1 indicated Resident #72 had ordered her out of the room and the nurse did not want her to provide care to Resident #72 because the resident appeared to be agitated by her presence. She indicated historically Resident #72 had refused care. She indicated there was not a specific location to find resident specific approaches to manage resident behaviors. During a 5/15/13, 11:15 a.m., interview, CNA #3 indicated Resident #72 often resisted care. She additionally indicated there was no place to look for resident specific approaches to behavior. During a 5/15/13, 2:29 p.m., interview, LPN #2, who was the charge nurse, indicated Resident #72 frequently resisted care and became agitated and angry as a symptom of her depression. LPN #2 reviewed Resident#72's record and indicated she could not find a care plan regarding resistance to care or agitation. She indicated there was no place to look for resident specific approaches to behavior if they were not in the resident's care plan. During a 5/16/13, 12:15 p.m. interview, the Social Services			

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	Designee indicated a residents targeted behavior for the use of psychoactive medication should be listed on the resident's care plan. She additionally indicated the resident specific approaches to address behaviors should also be listed on the resident's care plan. She indicated she was unaware of Resident #72's lack of a care plan for targeted behaviors or the lack of resident specific approaches. 3.)The clinical record for Resident #11 was reviewed on 5/15/13 at 9:00 a.m. Diagnoses for the resident included, but were not limited to, congestive heart failure, atrial fibrillation, hypertension, and anxiety. The current care plan, dated 2/18/13, was reviewed. The care plan did not address anxiety as a problem or with any resident specific interventions. Interview with the Director of Nursing on 5/15/13 at 10:00 a.m. indicated there was not a care plan that addressed resident anxiety. 4.) Review of a current, facility policy titled "Minimum Data Set (MDS) and Comprehensive Care Plan," which was provided by the Director of			

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	Nursing on 5/17/13 at 8:00 a.m., indicated: "Comprehensive care plan, based on MD'S information and residents needs/ preferences will be complete by the 21st day after admission or within 7 days after the completion of the MDS. Care plans will be updated as needed between reviews if any new strengths or weakness are noted and are not self limiting." 3.1-35 (d)(2)B			

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F000280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on record review and interview, the facility failed to revise care plans when previous approaches did not successfully manage behaviors for 1 of 23 residents reviewed for revision of care plans. (Resident #82) Findings include: Resident #82 closed record was reviewed on 05/15/2013 at 1:30 p.m. Resident #82's current diagnoses included, but were not limited to, Acute Right Frontal Parietal Cerebral Stroke with Left Sided Weakness.	F000280	F-280 It is, and always has been, the intent of Timbercrest to ensure residents benefit from a comprehensive care plan that addresses their medical, nursing, and mental and psychosocial needs that are identified through a comprehensive assessment. In the cited non-compliance, for 1 of 23 residents reviewed for revision of care plans, Timbercrest failed to revise this resident's care plan according to the change in approaches to address his changing mood state and behavior problems. 1) Regarding affected residents: For the specified resident (#82) nothing can be corrected since the resident is deceased and was	06/21/2013

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	Resident #82 had a, 04/05/13, care plan problem/need regarding "Mood State/Behavior Problems related to acute right frontal parietal cerebral stroke with left sided weakness/refusing care." Approaches to this problem included, but were not limited to, "Monitor behaviors don't rush him with care. Allow time for thought to process. Praise positive efforts. When he becomes resistive and unable to redirect, ensure he is safe and leave room. Give him time to calm down. Re-approach at a later time and with a different caregiver if needed." Care plan notes indicated the resident continued to be resistive towards care i.e. hitting, yelling, punching staff during care. Care plan notes also indicated staff interventions were not effective. No new approaches were added since the last review. Resident #82 had a, 04/05/2013, care plan problem/need regarding "Mood State/Behavior Problems" related to anxiety. Approaches to this problem included, but were not limited to, "Ask resident if he is comfortable i.e. does he need repositioned, want a snack, drink, in pain." No new approaches were added since the last review.		deceased at the time of the survey. This finding resulted from a review of a closed record. 2) Regarding potentially affected residents: All residents with behavioral symptoms and/or receiving psychoactive medications were identified as potentially affected by this deficient practice and the following corrective practices will be taken: a. The care plans for every resident on psychoactive medications and/or with behaviors requiring management will be reviewed. This will be completed by June 21, 2013. b. As necessary the care plans will be revised to provide resident-specific approaches and interventions related to each resident's specific behavioral symptoms. These symptoms will be accurately and specifically described to assist in the development of the specific approaches and interventions. This will be completed by June 21, 2013. c. The revised care plan will be communicated to nursing staff via verbal meetings at shift change and through use of the Resident Care Binder. This will be completed by June 21, 2013. 3) Regarding systemic changes: a. A regular stand-up meeting will be created to provide a venue for sharing current information about residents' behaviors and for assisting in the management of	

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	Resident #82 had a, 04/05/2013, care plan problem/need related to behavior problems regarding resistant to care due to "CVA (hitting, biting,kicking, slapping, refusing)." Approaches to this problem included, but were not limited to, "approach calmly. Explain what you are going to do. Give time to complete task or for thought processes to work. If resistant or combative, give few minutes-then re-approach. Monitor and chart behavior. Med if needed." Resident #82 had a current, 03/28/2013, "Behavior Management Team Meeting" note which indicated the resident had exhibited resistive to care behaviors 2 days and 1 evening since last review. "Anxiety: asking to use bathroom multiple times in a short period of time, asking to be repositioned multiple times in a short time period 4 days and 3 evenings" had been exhibited since the last review. Suggestions included pharmacy to recommend a routine pain medication and a mood stabilizer, but no staff to resident intervention changes. Resident #82 had a current, 04/05/2013, "Social Service Update Assessment and Plan." The note indicated "Per care tracker dated		the same. This meeting will include (as often as feasible) the DON, the MDS Coordinator, the Social Service Designee, and a Nurse. This will be initiated by June 16, 2013. b. Based upon the findings of the stand-up meeting the care plan for the affected residents will be revised and updated with specific approaches and interventions. This will be initiated by June 16, 2013. c. The Social Service Designee will more closely monitor the care of those residents involved in behavior management to identify changing behaviors in order to revise/update care plan and to implement specific interventions as necessary. This will be initiated by June 16, 2013. d. Nursing staff will be inserviced regarding the specific signs and symptoms of anxiety and behaviors in order to better develop specific approaches and interventions. Inservices will be completed by June 16, 2013. e. CNAs will be inserviced on the expanded use of Resident Care Binder which allows them to stay current on behavior management approaches. This inservice will be completed by June 16, 2013. 4) Regarding monitoring to assure ongoing compliance, performance and effectiveness: a. Timbercrest's Social Service consultant will review at least five randomly selected resident charts of residents identified with	

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	3/30/13, 3/31, 4/2,4/4 and 4/5/2013 he exhibited verbally and physically aggressive towards staff resistive towards care and inappropriate behavior i.e. pinching, punching, shoving, yelling towards staff during care. He was very difficult to redirect." Resident #82 had a current, 04/05/2013, "Social Service Update Assessment and Plan." The note indicated "per care tracker dated 04/2/2013 and 04/04/2013 he became physically abusive and exhibited socially inappropriate behavior i.e. starting undressing staff asked if they could get him redressed and he stated "yes" but then started yelling and punching CNA. CNA dressed resident and turned on TV and he then calmed down." During an 05/16/2013 at 2:20 p.m., interview, the Director of Nursing (DoN) indicated Behavior Management Care Plans were updated by MDS Coordinator and Social Services. DoN and MDS Coordinator were present at the afternoon nursing shift change meetings and discussed behaviors and intervention effectiveness. Nurses also copied their notes related to behaviors and gave them to Social		behavioral concerns and/or who receive psychoactive drugs as part of her regularly scheduled bi-monthly meetings. The consultant will advise staff on whether or not resident-specific approaches are being used and an acceptable plan of care developed. This review will begin with the next scheduled visit in August of 2013. b. The interdisciplinary care planning and behavior management teams will analyze the appropriateness of the approaches being used as part of their regular process. This will be initiated as of June 12, 2013. c. The Quality Assurance Committee will review for ongoing compliance as part of its quarterly responsibilities. This will be initiated as of June 16, 2013. 5) All corrective actions will be completed by or initiated by June 21, 2013 as detailed above.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREST CHURCH OF BRETHREN	2201 EAST ST NORTH MANCHESTER, IN 46962

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	Services. The DoN indicated the following interventions were discussed, including but not limited to, during the shift change meetings for Resident #82: "keep out of room as much as possible and bring to nurses station, have the Chaplin come to see him, repositioning, rearranging room to have sitting chair facing the window." No documentation of implementation and evaluation of interventions were available. The DoN indicated the facility had no additional information to provide. During an 05/16/2013 at 10:16 a.m.,interview, the Social Service Designee indicated the Behavior management is reassessed every three months unless the resident is having increased behaviors. Increased behaviors were to be reviewed every month and/or weekly. Social Service indicated the facility had no additional information to provide. Review of a current, facility policy titled "Minimum Data Set (MDS) and Comprehensive Care Plan," which was provided by the Director of Nursing on 5/17/13 at 8:00 a.m., indicated: "Comprehensive care plan, based on MD'S information and residents needs/ preferences will be complete			

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	by the 21st day after admission or within 7 days after the completion of the MDS. Care plans will be updated as needed between reviews if any new strengths or weakness are noted and are not self limiting." 3.1-35 (d)(2)B			

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F000309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview and record review, the facility failed to ensure sliding scale insulin was administered for 1 of 3 residents reviewed for sliding scale insulin. (Resident #22) Findings include: 1.) Resident #22's record was reviewed on 5/15/13 at 9:00 a.m. Resident #22's current diagnoses included, but were not limited to, diabetes mellitus and anxiety. Resident #22 had a current, 4/18/13, physician's order for Humalog 100 u/ml, inject subcutaneous per sliding scale three times daily as follows: 0-150=0 units 151-180=2 units 181-220=4 units 221-250=6 units 251-300=8 units 301-350=10 units 351-400=12 units greater than 401= 14 units.	F000309	F-309 It is, and always has been, Timbercrest's intent to provide each resident with the care necessary to allow the resident to attain and maintain the highest practicable physical, mental, and psychosocial well-being. In the cited non-compliance, Timbercrest failed to meet this requirement by failing to ensure sliding scale insulin was administered for 1 of 3 residents reviewed. 1) Regarding affected residents: For the specified resident (#22) the physician's order has been corrected. The corrected order calls for sliding scale insulin with daily, alternating accuchecks. A copy of the new order and a copy of the residents Medication Administration forms are included as Exhibits #9 and #10. This was completed June 3, 2013. 2) Regarding potentially affected residents: All residents with insulin orders were identified as potentially affected. a. Nurses were inserviced on the "Administration of Insulin" policy on June 6, 2013. Nurses not in attendance will receive a paper	06/16/2013

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	Review of Resident #22's Medication Administration Record (MAR) for May 2013 (5/1/13 through 5/15/13) indicated blood sugar testing was only being completed one time each day. The record also indicated insulin was not administered in accordance with the sliding scale orders on the following dates and times: a.) 5/2/13-6:00 a.m.-188-no insulin given-4 units required per order. b.) 5/5/13-4:00 p.m.-186-no insulin given-4 units required per order. c.) 5/7/13- 12:00 p.m.-158-no insulin given-2 units required per order. d.) 5/9/13-bedtime-181-no insulin given-4 units required per order. e.) 5/11/13-12:00 p.m.-199-no insulin given-4 units required per order. f.) 5/12/13-4:00 p.m.-229-no insulin given-6 units required per order. g.) 5/13/13-bedtime-225-no insulin given-6 units required per order. h.) 5/15/13-12:00 p.m.-181-no insulin given-4 units required per order. Resident #22 had a current, 2/22/13, care plan problem/need regarding a risk for blood sugar fluctuations due to insulin dependent diabetes mellitus. An approach to this problem was "administer medication per MD order."		inservice. This will be completed by June 16, 2013. A copy of the policy is included as Exhibit #11. b. The inservice included a focus on Sliding Scale Insulin. c. The inservice also emphasized the importance of clarifying all resident insulin orders upon admission. d. The medical records for all residents with an order for Sliding Scale Insulin and Accucheck monitoring were reviewed to assure compliance with these orders. This was completed June 7, 2013. 3) Regarding systemic changes: a. All medication orders will be reviewed by two nurses upon admission to assure accuracy. This is effective June 7, 2013, and is ongoing. b. If a resident has an order for Sliding Scale Insulin it will be recorded on the Blood Glucose Record form to call attention to this specific order. This was completed June 7, 2013. A copy of the form is included as Exhibit #12. 4) Regarding monitoring to assure ongoing compliance, performance and effectiveness: a. Staff will audit 100% of the charts of residents receiving Sliding Scale Insulin once every two weeks for the next six weeks. After that the audit will occur once a month for six months. This is effective June 7, 2013. b. The Quality Assurance Committee will review ongoing	

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	During a 5/16/13, 1:14 p.m. interview, LPN #5 indicated Resident #22 should be given insulin in accordance with her sliding scale order for any blood sugar test results greater than 150. She indicated the 8 incidents in May when no insulin was administered was an error on the part of the individual nurses. She indicated there was no other location for the medications administration to be documented. 2. Review of a current, facility policy titled "Administration of Insulin," which was provided by the Director of Nursing on 5/17/13 at 8:00 a.m., indicated the following: "Purpose: To administer insulin safely and accurately." "Procedure: 1. Check physician order. a. Sliding Scale Insulin will only be administered on physician order. Accuchecks will be done prior to sliding Scale Insulin. Doses will be based on specific scale provided by physician." 3.1-37(a)		compliance as a part of its regular, quarterly meeting. This will be effective with the committee's next meeting on June 20, 2013. 5) All corrective actions will be completed by or initiated by June 16, 2013, as detailed above.	

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F000323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation and interview, the facility failed to provide an environment that was free from accident hazards over which the facility had control. Facility failed to ensure hazardous materials were locked in secured areas. This deficiency has the potential to affect 10 of 26 residents who live on the two halls where the chemicals were stored. Findings include: 1. Observation on 05/13/2013 at 9:45 a.m., Micro Kill wipes found in unlocked cabinet in 100 and 200 hall clean utility rooms. 2. Observation on 5/14/2013 at 9:33 a.m., Micro Kill wipes and hairspray were found in unlocked cabinet in the 100 hall clean utility room. LPN #5 made aware. 3. Observation on 5/15/13 at 8:30 a.m., Micro Kill wipes were found in unlocked cabinet in the 100 hall clean	F000323	F-323 It is, and always has been, the intent of Timbercrest to ensure that the environment we provide for residents remains as free of accident hazards as possible. In the cited non-compliance Timbercrest failed to keep certain hazardous materials locked in a secure area which can not be accessed by residents with dementia. 1) Regarding affected residents: The affected residents were those residents with some level of dementia who live in the 100 and 200 wings. All the hazardous materials located on these two wings were identified and locked in a secure area on May 17, 2013. 2) Regarding potentially affected residents: All residents with some level of dementia were identified as potentially affected. a. All areas, resident accommodations and resident accessible areas, were checked for the presence of any unsecured hazardous materials. b. Any hazardous materials found were immediately locked in a secure area. c. This was completed on May 20, 2013.	06/16/2013

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	utility room. The DoN made aware. 4. Observation on 5/17/2013 at 8:55 a.m., storage room unlocked with alcohol, peroxide, and Micro Kill wipes unsecured. LPN #6 made aware. The Material Safety Data Sheet of Micro Kill wipes indicated: "Eye contact: Causes mild to severe irritation...blurred vision...corneal injury may occur...Skin Absorption: May be harmful if absorbed through skin...Inhalation: May cause moderate irritation...." Interview, 05/17/2013 at 2:47 p.m. The DoN indicated the utility rooms were not locked but had locked cabinets where hazardous materials were stored and the supply room was to remain locked. The DoN indicated the facility had no additional information. 3.1-45(a)(1)		3) Regarding systemic changes: a. A policy and procedures will be developed covering the safe handling and storage of hazardous materials. This will be completed by June 16, 2013. b. Nursing staff will be educated regarding the identification of hazardous materials and the safe and proper storage of the same. This will be completed by June 16, 2013. 4) Regarding monitoring to assure ongoing compliance, performance and effectiveness: a. A staff person(s) will be assigned to make a visual inspection of all areas which may be accessed by residents with dementia. The inspection will look for unsecured hazardous materials. This inspection will occur once a week for six months. This will begin effective June 10, 2013. b. The Quality Assurance Committee will review ongoing compliance as a part of its regular, quarterly meeting. This will be effective with the committee's next meeting on June 20, 2013. 5) All corrective actions will be completed by or initiated by June 16, 2013, as detailed above.	

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F000325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on observation, interview and record review, the facility failed to implement a resident's care plan and/or follow physician's order regarding nutrition for 2 of 4 people who met the criteria for nutritional risk (Resident #72 and #54). Findings include: 1.) Resident #72's record was reviewed on 5/15/13 at 10:10 a.m. Resident #72's current diagnoses included, hypertension, depressive disorder and dementia. Resident #72 had a current, 3/28/13, care plan problem/need regarding a risk for weight loss due to dementia, decreased appetite and requiring assistance to eat. Approaches to this problem included, but were not limited to, "encourage 75-100% meal	F000325	F-325 It is, and always has been, Timbercrest's intent to ensure that residents maintain acceptable parameters of nutritional status. In the cited non-compliance, although the residents reviewed were maintaining these parameters, Timbercrest failed to adequately implement a resident's care plan and/or follow the physician's order regarding nutrition. 1) Regarding affected residents: a. The nutritional status of the two specific residents (#54 and #72) was analyzed and it was determined that they were maintaining acceptable nutritional parameters. Both had appropriate and stable weights. Both were receiving supplements as needed. This was completed by June 7, 2013. b. The care plans for these two residents were modified to provide more realistic intake expectations consistent with their nutritional wants, needs, and patterns. This was completed by	06/21/2013

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	consumption-offer substitute if not eating." Review of Resident #72's consumption records for 4/16/13 through 5/16/13 indicated the resident ate less than 50% during 42 meals. During a 5/15/13, 11:28 a.m. to 12:30 p.m. observation of lunch, Resident #72 refused to leave her room and come have lunch. She did not want to get dressed for the day or leave her room. During a 5/15/13, 1:30 p.m. interview, LPN #2 indicated resident #72 had eaten about 18% of her lunch and had not been offered a substitute or a replacement. LPN #2 indicated the resident enjoyed sweet drinks like a milkshake. During a 5/15/13, 4:00 p.m. interview, CNA #1 indicated she had worked in the dining room when resident #72 finally came down for lunch. CNA #1 indicated Resident #72 had consumed less than 25% of her meal. She indicated she had not offered Resident #72 a substitute or meal replacement. She indicated she did not know where to get such items because the resident had a specialized diet (pureed).		June 7, 2013. The revised care plans are included as Exhibits #13 and #14. c. Nursing staff will be educated to offer substitutions when a resident's meal intake has been assessed as inadequate. This will be completed by June 13, 2013. d. Nursing staff will be educated regarding how and where to acquire additional food and/or substitutions when necessary. This will be completed by June 13, 2013. 2) Regarding potentially affected residents: All residents were identified as potentially affected. a. Every resident's care plan will be reviewed and revised to reflect individualized, resident-specific goals and approaches with realistic intake expectations consistent with each resident's nutritional wants, needs and patterns. This will be completed by June 21, 2013. b. Nursing staff will be educated to offer substitutions when a resident's meal intake has been assessed as inadequate. This will be completed by June 13, 2013. c. Nursing staff will be educated regarding how and where to acquire additional food and/or substitutions when necessary. This will be completed by June 13, 2013. 3) Regarding systemic changes: a. From this time forward every resident's care plan will reflect individualized, resident-specific goals and approaches with	

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	During a 5/16/13, 2:00 p.m. interview the Director of Nursing indicated if a resident consumed poorly they should be offered a substitute. 2.) Resident #54's record was reviewed on 5/15/13 at 10:37 a.m. Resident #54's current diagnoses		realistic intake expectations consistent with each resident's nutritional wants, needs and patterns. This will be effective by June 16, 2013. b. Staff will be taught to offer substitution foods to any resident demonstrating non-typical intake. This will be completed by June 13, 2013. 4) Regarding monitoring to assure ongoing compliance, performance and effectiveness: a. A nurse and/or Food Service supervisory staff will observe residents' eating and monitor the process to assure residents are offered additional food and/or substitutions as needed. This will be effective June 16, 2013. b. The interdisciplinary care planning team will analyze the appropriateness of the care plan goals and approaches as part of their regular, quarterly care plan process. This will be initiated as of June 12, 2013. c. The Quality Assurance Committee will review ongoing compliance as a part of its regular, quarterly meeting. This will be effective with the committee's next meeting on June 20, 2013. 5) All corrective actions will be completed by or initiated by June 21, 2013, as detailed above.	

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	included, but were not limited to, diabetes mellitus, hypertension, and dementia. Current, 5/16/13, diet orders were regular diet with NCS (no concentrated sweets). A second, 5/16/13, order indicated, to offer a replacement meal if less then 75% of the meal consumed, encourage meal consumption of 75%-100%, provide a bedtime snack, and provide one sugar-free healthshake daily. During a 5/15/13 at 11:32 a.m.,observation, Resident #54 ate the lunch meal with CNA #4 assisting with the feeding. Resident #54's meal was set up on the bedside table, with Resident #54 lying in bed with the head of bed elevated 65-70 degrees. Resident #54 began to eat, eventually consuming 25% of the meal. CNA #4 did not offer Resident #54 a replacement meal as was indicated in the nutrition orders and care plan. 3.1-46(a)(1)			

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F000329 SS=E	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 who received psychoactive medications had identified behavioral symptoms for the use of the psychoactive medications and residents, who used as needed psychoactive medications, had documented non-chemical interventions attempted prior to the use of the as needed medications for 3 of 10 residents reviewed for unnecessary mediation use	F000329	F-329 It is, and always has been, Timbercrest's intent to assure resident's drug regimen is free from unnecessary drugs. In the cited non-compliance, for 3 of the 10 residents reviewed for use of psychoactive drugs and with identified behavioral symptoms, Timbercrest failed to provide a care plan which described the residents' symptoms and include resident specific approaches to those behaviors. 1) Regarding affected residents: For the specified residents (#54, #59 and #72) receiving	06/21/2013

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	(Residents #59, #72 and #54). Findings include: 1.) Resident #59's record was reviewed on 5/16/13 at 10:00 a.m. Resident #59's current diagnoses included, but were not limited to, diabetes mellitus, panic disorder and dementia. Resident #59 had a current, 3/29/13, physician's order for Zyprexa 2.5 mg (an anti-psychotic medication) one tablet one time daily. Resident #59 had a,1/18/12, pharmacy note which indicated the nurse stated the resident used Zyprexa for "panic attacks." Resident #59 had "Behavior Management Team Meeting" notes for a period from 2/18/13 to 4/25/13 which indicated the resident's "Monitored Behaviors" were anxiety, panic disorder, and agoraphobia. The meeting notes did not describe how the resident displayed the symptoms of these conditions. The notes indicated the resident had displayed no maladaptive behaviors during this period.		psychoactive medications: Their care plans have been revised to provide resident specific approaches and interventions related to each resident's specific behavioral symptoms. This was completed June 7, 2013. This was done in collaboration with residents as appropriate. The revised care plans are being communicated to nursing staff. The revised care plans are provided as Exhibits #15, #6, and #7. 2) Regarding potentially affected residents: All residents receiving psychoactive medications were identified as potentially affected by this deficient practice and the following corrective practices will be taken: a. The care plans for every resident on psychoactive medications and/or with behaviors requiring management will be reviewed. This will be completed by June 21, 2013. b. As necessary the care plans will be revised to provide resident-specific approaches and interventions related to each resident's specific behavioral symptoms. This will be completed by June 21, 2013. c. The revised care plan will be communicated to nursing staff via verbal meetings at shift change and through use of the Resident Care Binder. This will be completed by June 21, 2013. 3) Regarding systemic changes: a. A regular stand-up meeting will	

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	Review of Resident #59's "Behavior Detail Report" for 2/15/13 through 5/16/13 indicated the resident had displayed no maladaptive behaviors during this period. Resident #59's record lacked a care plan regarding the resident's specific targeted behavioral symptoms that were being treated by the use of the anti-psychotic medication Zyprexa. During a 5/16/13, 10:02 a.m., interview, LPN #2, who was the charge nurse, indicated resident's targeted behaviors for the use of psychoactive medications should be on the resident's care plan. She indicated Resident #59 displayed panic by avoiding group activities and sticking to staff and following them around. At this time, LPN #2 reviewed Resident #59's record and indicated the resident did not have a care plan to identify the resident's targeted behaviors or resident specific approaches to address the behavior. During a 5/16/13, 10:30 p.m., interview, CNA #1 indicated Resident #59 never displayed maladaptive behaviors during her shifts. The CNA indicated she was unaware of any documented resident specific		be created to provide a venue for sharing current information about residents' behaviors and for assisting in the management of the same. This meeting will include (as often as feasible) the DON, the MDS Coordinator, the Social Service Designee, and a Nurse. This will be initiated by June 16, 2013. b. Based upon the findings of the stand-up meeting the care plan for the affected residents will be revised and updated with specific approaches and interventions. This will be initiated by June 16, 2013. c. The Social Service Designee will more closely monitor the care of those residents involved in behavior management to identify changing behaviors in order to revise/update care plan and to implement specific interventions as necessary. This will be initiated by June 16, 2013. d. Nursing staff will be inserviced regarding the specific signs and symptoms of anxiety and behaviors in order to better develop specific approaches and interventions. Inservices will be completed by June 16, 2013. e. CNAs will be inserviced on the expanded use of Resident Care Binder which allows them to stay current on behavior management approaches. This inservice will be completed by June 16, 2013. 4) Regarding monitoring to assure ongoing compliance, performance and effectiveness:	

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	approaches to address behaviors. She indicated she knew the residents from her past experiences working with them and would use this experience as her guide. During a 5/13/13, 11:28 a.m., observation, Resident #59 was seated calmly in the dining area eating her meal. During a 5/13/13, 2:00 p.m.,observation, Resident #59 was attending an activity and participating in a calm manner. During a a 5/15/13, 11:28 a.m. thorough 11:50 a.m., observation, Resident #59 was seated calmly in the dining room eating her meal. During a 5/16/13, 12:15 p.m. interview, the Social Services Designee indicated a resident's targeted behavior for the use of psychoactive medication should be listed on the resident's care plan. She additionally indicated the resident specific approaches to address behaviors should also be listed on the resident's care plan. She indicated she was unaware of Resident #59's lack of a care plan for targeted behaviors or the lack of resident specific approaches.		a. Timbercrest's Social Service consultant will review at least five randomly selected resident charts of residents identified with behavioral concerns and/or who receive psychoactive drugs as part of her regularly scheduled bi-monthly meetings. The consultant will advise staff on whether or not resident-specific approaches are being used and an acceptable plan of care developed. This review will begin with the next scheduled visit in August of 2013. b. The interdisciplinary care planning and behavior management teams will analyze the appropriateness of the approaches being used as part of their regular process. This will be initiated as of June 12, 2013. c. The Quality Assurance Committee will review for ongoing compliance as part of its quarterly responsibilities. This will be initiated as of June 16, 2013. 5) All corrective actions will be completed by or initiated by June 21, 2013 as detailed above.	

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	2.) Resident #72's record was reviewed on 5/15/13 at 10:10 a.m. Resident #72's current diagnoses included, hypertension, depressive disorder and dementia. Resident #72 had a current 4/2/13, physician's order for Celexa 40 mg (an antidepressant medication) 1 tablet daily. Resident #72 had a,12/20/12, psychiatric progress note which indicated the resident had anxiety, wandering, mild depression, tearfulness and was withdrawn from activities following her admission to the facility. Resident #72 had a, 4/20/13, communication form which indicated the resident had been non-compliant with care and combative at times and Celexa was increased. Resident #72 had a,4/24/13, physician's progress note which indicated the resident had an increase in agitation and antidepressant medication would be adjusted. Resident #72 had a current, 3/29/13,			

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	quarterly Minimum Data Set (MDS) assessment, which indicated the resident felt down, depressed or hopeless 1 day of the assessment period; had felt tired or had low energy 2 to 6 days of the assessment period; displayed physically aggressive behaviors such as hitting, kicking or scratching 4 to 6 days of the assessment period; displayed verbal aggression such as screaming, cursing and threatening others 4 to 6 days of the assessment period and rejected care 4 to 6 days of the assessment period. Resident #72's record lacked a care plan which described the resident's symptoms of depression or a care plan for resisting care. Resident #72's record and plan of care lacked resident specific approaches to behavior. Resident #72 had a "Behavior Management Team Meeting" note for 3/1/13 through 4/23/13 which indicated the resident was physically aggressive toward staff, yelled at and cursed at staff, refused care and personal hygiene, wandered and refused to use alarms as behavioral symptoms to depression. The note indicated the resident had displayed 46 maladaptive behaviors during this			

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	time period. During a 5/16/13, 10:30 p.m., interview CNA #1 indicated Resident #72 had ordered her out of the room and the nurse did not want her to provide care to Resident #72 because the resident appeared to be agitated by her presence. She indicated historically Resident #72 had refused care. She indicated there was not a specific location to find resident specific approaches to manage resident behaviors. During a 5/15/13, 11:15 a.m., interview, CNA #3 indicated Resident #72 often resisted care. She additionally indicated there was no place to look for resident specific approaches to behavior. During a 5/15/13, 2:29 p.m., interview, LPN #2, who was the charge nurse, indicated Resident #72 frequently resisted care and became agitated and angry as a symptom of her depression. LPN #2 reviewed Resident #72's record and indicated she could not find a care plan regarding resistance to care or agitation. She indicated there was no place to look for resident specific approaches to behavior if they were not in the resident's care plan.			

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During a 5/13/13, 11:28 a.m., observation, Resident #72 was seated calmly in the dining area eating her meal.

During a 5/15/13, 11:28 a.m. to 12:30 p.m. observation of lunch, Resident #72 refused to leave her room and come have lunch. She did not want to get dressed for the day or leave her room.

During a 5/16/13, 12:15 p.m. interview, the Social Services Designee indicated a residents targeted behavior for the use of psychoactive medication should be listed on the resident's care plan. She additionally indicated the resident specific approaches to address behaviors should also be listed on the resident's care plan. She indicated she was unaware of Resident #72's lack of a care plan for targeted behaviors or the lack of resident specific approaches.

3.) Resident #54's record was reviewed on 5/16/13 at 1:21 p.m. Resident #54 had an order for Lorazepam 0.5 mg (an anti-anxiety medication) as needed every 6 hours for anxiety.

Diagnoses for Resident #54 included

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	but were not limited to: hypertension, diabetes mellitus, and dementia. Resident #54's MAR (medication administration record) indicated the resident had received Lorazepam 0.5 mg once in the previous 30 days. On 5/16/13 at 5:30 a.m., a nurses note indicated the resident had increased anxiety at that time, was toileted, and Lorazepam 0.5 mg was given. No other interventions prior to receiving the medication were recorded. Record review on 5/16/13 at 1:45 p.m. of behavior tracking sheet for previous 90 days, indicated resident had no behaviors during this period of time. No other descriptions of what anxiety behaviors were had been included for the resident. During a 5/16/13, 11:00 a.m., observation, Resident #54 was transferred from a broda chair to the bed. The resident appeared calm as staff completed the transfer. No inappropriate behaviors were noted. During a 5/16/13, 11:00 a.m. observation, Resident #54 was lying in bed, and indicated she was in great pain. Resident #54 was asked if the nurse should be notified to receive pain medication, and Resident #54			

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	indicated "Please". Although Resident #54 was grimacing with pain, her behavior was appropriate and Resident #54 remained calm. The nurse was notified of Resident #54's request for pain medication. Review of a current facility policy titled "Antipsychotic drugs," which was provided by the Director of Nursing on 5/17/13 at 8:00 a.m., indicated the following: "Policy: Antipsychotic drug therapy shall be used only when it is necessary to treat a specific condition.... Procedure: 1. Residents who have not used antipsychotic drugs shall not be given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition... 3. The use of an antipsychotic must meet the criteria and applicable, additional requirements listed below.... b. the behavioral symptoms present a danger to the resident or others: OR c. the symptoms are significant enough that the resident is experiencing one or more of the following: inconsolable or persistent distress (fear, continuously yelling, screaming, distress associated with end of life, or crying); a significant decline in function: and/or substantial			

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	difficultly. refusing needed care(not eating resulting in weight loss, fear and not bathing leading to Skin breakdown or infection)." 3.1-48 (a)(2) 3.1-48 (a)(4)			

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F000520 SS=E	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. 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 and implement a plan of action related to behavior monitoring and behavior management; care plan development; revision of care plans; securing potentially hazardous materials; nutritional intervention for weight loss; monitoring behavioral symptoms with psychoactive medication use; administering medication per sliding scale; and	F000520	F-520 It is, and always has been, Timbercrest's intent to maintain a quality assessment and assurance committee to identify quality-related issues and develop appropriate plans of action. Timbercrest does in fact have such a committee. However, according to the survey the committee failed to identify the deficient practices identified by the survey team. 1) Regarding affected residents: Corrective actions have been instituted for each of the affected	06/16/2013

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	demand billing process. This deficient practice had the potential to impact 2 of 2 residents reviewed for behavior management and monitoring (Residents #59 and #72), 1 of 24 residents reviewed for revisions of care plans (Resident #82), 1 of 3 residents reviewed for administration of sliding scale insulin (Resident #22), 2 of 3 residents reviewed for nutritional needs (Residents #72 and #54), 3 of 10 residents reviewed for unnecessary medication (Residents #59, #72 and #54) and 1 of 1 resident reviewed for the Medicare demand billing process (Resident #74). Findings include: During the survey process concerns were identified regarding: a.) Residents with identified behavioral concerns and/or who received psychoactive medication lacked medically based social services in the area of behavior management and behavior monitoring. This concern impacted Resident #59 and #72. b.) Care plans were not revised when previous approaches did not successfully manage behaviors. This concern impacted Resident #82. c.) Sliding scale insulin was not administered per order. This concern		residents as detailed in the plan of correction for each finding as outlined above. The findings and the plans of correction will be shared with the Quality Assurance Committee for their review and oversight. 2) Regarding potentially affected residents: All residents were identified as potentially affected by this deficient practice and the following corrective practices will be taken: Corrective actions have been instituted for all residents as detailed in the plan of correction for each finding as outlined above. The findings and the plans of correction will be shared with the Quality Assurance Committee for their review and oversight. 3) Regarding systemic changes: a. An interdisciplinary Quality Assessment Committee, a sub-committee of the Quality Assurance Committee, will be developed for the purpose of assessing current practices, identifying deficient practices, determining causes, and drafting plans for corrective actions. This sub-committee will operate under the direction and oversight of the existing Quality Assurance Committee. This will be initiated June 16. 4) Regarding monitoring to assure ongoing compliance, performance and effectiveness: a. The Executive Administrator has the responsibility for regular monitoring of the activities of both the Quality Assessment	

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	impacted Resident #22. d.) The environment was not free from potential accident hazards. This deficiency had the potential to impact 10 mobile cognitively impaired residents. e.) Resident's care plan and/or physician's order regarding nutrition were not followed. This concern impacted Residents #72 and #54. f.) Residents who received psychoactive medications did not have an identified behavioral symptoms for the use of the psychoactive medications and residents who used as needed psychoactive medications had no documented non-chemical interventions attempted prior to the use of the as needed medications. This concern impacted Residents #59, #72 and #54. g.) A resident who requested a demand bill was billed for the services while awaiting a response from Medicare. This concern impacted Resident # 74. During an interview with the DoN (Director of Nursing) on 5/17/13 at 9:00 a.m. the concerns were reviewed. The facility did not effectively identify quality deficiencies (quality problems) that had been discovered and had not put into place		Committee and the Quality Assurance Committee. The Executive Committee will assure these committees are effective and performing well with the goal of improving the care and services provided to Timbercrest's residents. 5) All corrective actions were completed or will be initiated by June 16, 2013 as detailed above.	

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	an action plan which addressed the findings. At the time of the exit conference on 5/17/13 at 4:00 p.m., the facility had not provided any additional information regarding quality assurance for behavior monitoring and behavior management, care plan development, revision of care plans, securing potentially hazardous materials, nutritional intervention for weight loss, monitoring behavioral symptoms with psychoactive medication use and administering medication per sliding scale and demand billing process. 3.1-52(b)(2)			