

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

MAY 03 2013

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PRINTED: 04/24/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345293	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/11/2013
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NAME OF PROVIDER OR SUPPLIER  RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>The Division of Health Service Regulation, Nursing Home Licensure and Certification Section, conducted a complaint investigation from 3/25/13 through 3/28/13. An extended survey was done on 4/10/13 and 4/11/13. Immediate Jeopardy was identified at CFR 483.10, 483.20, 483.25, and 483.75. The Immediate Jeopardy began on 3/9/13 and was removed on 4/11/13 at 5:55 PM when the facility provided a credible allegation of compliance. The facility will remain out of compliance at a scope and severity level D (with potential for more than minimal harm that is not immediate jeopardy) until all of the nursing staff can be inserviced. The facility will then implement monitoring of its corrective action.</p>	F 000	<p>Richmond Pines Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.</p>	
F 157 SS=J	<p><b>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</b></p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a):</p> <p>The facility must also promptly notify the resident</p>	F 157	<p>Richmond Pines Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Richmond Pines Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*Sharon Reynolds, Administrator*

04-5-1-13

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	<p>Continued From page 1</p> <p>and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician interviews the facility failed to notify the physician that 1 of 1 sampled resident with aggressive behaviors (Resident #5) hit 2 of 3 (Resident #4 and Resident #5) sampled residents reviewed for accidents in the locked dementia unit. The facility also failed to notify the physician on 3/9/13 that Resident #4 had been hit in the eye and failed to notify the physician on 3/10/13 that Resident #2 had been hit in the face and nose. The Immediate Jeopardy began on 3/9/13 at 8:00 PM and was identified on 04/10/13 at 2:10 PM. The Immediate Jeopardy was removed on 04/11/13 at 5:55 PM when the facility provided a credible allegation of compliance. The facility will remain out of compliance at a scope and severity level D (with potential for more than minimal harm that is not immediate jeopardy) until all of the nursing staff can be in-serviced. The facility will then implement monitoring of its corrective action.</p> <p>The findings included:</p>	F 157	<p>F157</p> <p><u>What measures the facility put in place for the resident affected:</u> On 3-9-2013 resident #4 was assessed by nurse and attempt made to notify MD. XRay of eye area was completed on 3-9-13 10:30 pm with results of no fractures identified. On 3-11-13 MD gave order for resident to see eye physician and resident #4 was seen by eye physician on 3-11-13, with additional eye physician visits on 3-12-13 with order to start antibiotic therapy and a return visit scheduled for 3-13-2013. On 3-14-13 resident had procedure to remove right eye and returned to the facility from procedure on 3-15-13.</p> <p>On 3-10-13 resident #2 was assessed by nurse and attempt made to notify MD. Family notified on 3-10-13. On 3-10-13 resident #2 was moved to another room. On 3-11-13 MD gave order for resident to see eye physician and resident was seen by eye physician on 3-11-13 with orders for cold compress and antibiotic ointment to be applied. On 3-12-13 facility obtained X-Ray of resident nasal bones and received X-Ray results on 3-12-13 for resident #2 showing non-displaced fracture of nose.</p>	5-20-13	

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F 157	<p>Continued From page 2</p> <p>1. Resident #4 was admitted to the facility on 6/7/11 and had diagnoses including Anxiety, Dementia with Behavioral Disturbances and Bi-Polar Disorder.</p> <p>The Quarterly Minimum Data Set (MDS) Assessment dated 2/17/13 revealed that the resident had short and long term memory problems and was moderately cognitively impaired requiring cues and supervision. The MDS revealed that the resident was ambulatory and had behavior symptoms not directed towards others.</p> <p>A facility incident report prepared by Nurse #3 on 3/9/13 at 11:19 PM revealed that the nurse was notified on 3/9/13 at 8:00 PM that 2 residents were fighting. The report revealed that the nurse observed Resident #5 standing over Resident #4 with a clenched fist and Resident #4 's eye was swollen and blood shot. The report read: ADON (Assistant Director of Nursing) notified via phone at 8:10 PM. (Name of physician) beeped via phone @ 8:20 PM x (times) 2. Have not gotten ret. (returned) call. Mobile X-ray called via phone @ 8:45 PM for X-ray of rt. (right) eye r/o (rule out) fracture. X-ray of rt. Eye done. " The report did not reveal that the physician returned the call or that the physician was notified of the incident. There was no documentation in the progress notes for Resident #4 of the incident or that the physician was notified.</p> <p>The nursing progress notes for Resident #4 revealed that Resident #4 was seen by an eye doctor on 3/11/13, 3/12/13 and 3/14/13. An Eye Consult dated 3/14/13 at 4:10 PM revealed the resident had trauma to right eye, had no light</p>	F 157	<p>RP was notified by nurse on 3-9-13 and 3-10-13 of resident #5's behaviors. MD was attempted to be notified by nurse of behavior on 3-9-13 and 3-10-13. On 3-10-13 at 7:00 am resident #5 was placed on 15 minutes checks. On 3-11-13 first shift resident #5 was placed on one to one staff monitoring. DON contacted psychiatric nurse practitioner on 3-11-13 and psychiatric nurse practitioner arrived same day at 3:45 pm to see resident with recommendation to resume previous dosage of antipsychotic medications. Social Worker contacted outside psychiatric center on 3-11-2013 for potential placement due to resident #5's behavior. On 3-11-2013 at 7:00 pm the outside psychiatric center contacted social worker and verified they would admit resident #5 on the morning of 3-12-13. One to One staff monitoring continued with resident #5 until he was discharged from facility. On 3-12-13, resident #5 was transported to outside psychiatric center for admission and no longer resides at this facility.</p> <p><b><u>What measures were put in place for residents having the potential to be affected:</u></b></p> <p>The Corporate Nurse Consultants completed a 100 percent audit of resident nurses notes starting on 3-11-13 and completed on 3-12-13 for the time period of documentation from 12-1-2012 to present 3-11-2013, to assure there were no nursing documentation of resident to resident episodes that may not have been previously identified in incident reporting to include notification of MD with no negative outcomes identified.</p>		

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F 157	<p>Continued From page 3</p> <p>perception and a ruptured globe and that the treatment plan was enucleation (removal of) of the right eye. A Discharge Summary dated 3/15/13 revealed that Resident #4 had the right eye removed on 3/14/13.</p> <p>The Assistant Director of Nursing (ADON) stated in an interview on 3/26/13 at 10:30 AM that she was the nurse on call on the weekend of 3/9-10/13 and that she received a phone call from Nurse #3 on Saturday evening (3/9/13) that Resident #5 had hit Resident #4. The ADON stated that she told the nurse to keep the two residents separated and to go ahead and get a facial X-ray for Resident #4. The ADON stated that Nurse #3 was trying to reach the physician at that time and that she told the nurse to call her back if any further changes.</p> <p>Nurse #3 stated in an interview on 3/26/13 at 10:55 AM that she worked on the dementia unit on the 3PM-11PM shift on 3/9/13 (Saturday). The Nurse stated that she paged the physician on his beeper and called the Assistant Director of Nursing (ADON) who was on call for the weekend regarding the incident where Resident #5 hit Resident #4. The Nurse stated that she did not receive a response from the physician so she beeped the physician again. The Nurse stated that when she did not receive a response from the physician the second time she called the ADON and told her that she had not been able to reach the physician. The Nurse stated that the ADON told her to go ahead and get an X-ray of Resident 4 ' s eye.</p> <p>An interview was conducted with the Administrator, the Director of Nursing (DON) and</p>	F 157	<p>On 3-12-13, the Corporate Nurse Consultant (PG) completed a review of resident to resident altercations from 9-1-12 to 3-11-12 to assure interventions for resident to resident incidents were in place and/or still appropriate to include notification of MD with no new concerns identified.</p> <p><u>What systems were put in place to prevent the deficient practice from reoccurring:</u> On 3-12-2013 the Administrator initiated a Quality Improvement Incident/Accidents Committee starting on 3-12-13 consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Improvement Nurse, Minimum Data Set Nurses, Social Workers, and Therapy staff that will meet five times per week to review all incidents and accidents to assure nurse assessment of situation, intervention put in place, MD notified, RP notified, and Care Plan updated for changes and interventions. This review will be documented on a Quality Improvement Incident/Accident Review Committee QI Audit Tool.</p> <p>On 3-12-2013 the Staff Development Coordinator initiated in-servicing for all Licensed Nurses on Notification of Physician for Changes in Resident's Condition that emphasized when to notify the MD and that if a nurse is unable to reach the Attending MD, to notify the On-Call MD. The in-service continues that if a nurse is unable to reach the attending or on-call MD to notify the facility Medical Director.</p>		

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F 157	<p>Continued From page 4</p> <p>Facility Consultant #1 on 3/26/13 at 12:45 PM. The DON stated that this was the first incident she was aware of that the staff was unable to get (name of physician). The DON stated that she tried to tell all the nurses to call the physician 's cell phone and to call the hospital if they had trouble reaching him. The ADON was asked by the Facility Consultant to join the interview. The ADON stated that on 3/9/13 while on the phone with Nurse #3 she heard the telephone ringing in the background and Nurse #3 commented that the physician was probably calling back. The Facility Consultant stated that they had identified a problem with the nurses not documenting the response of calls made to physicians and had inserviced all the staff regarding this issue.</p> <p>The ADON stated in an interview on 3/26/13 at 1:07 PM that she called the physician on Monday (3/11/13) for an eye appointment for Resident #4 and the physician stated that he was aware of the situation and would see him on Wednesday (3/13/13)</p> <p>The Physician stated in an interview on 3/26/13 at 1:30 PM that he did not think that the staff called him over the weekend of 3/9-10/13 but really could not remember. The Physician stated that he did not remember when he was notified of the incident between Resident #5 and Resident #4 but he thought that he found out on Monday (3/11/13). The Physician stated that he was at home on the weekend and was available by cell phone and his home phone.</p> <p>On 4/10/13 at 1:25 PM an interview was conducted with the Optometrist that first saw Resident #4 on 3/11/13. The Physician stated that</p>	F 157	<p>On 4-11-2013 the Corporate Nurse Consultant and Staff Development Coordinator initiated an additional in-service for all Licensed Nurses on MD Notification that included when contacting the MD for notification of a situation and the MD does not respond, contact the physician who has been designated to take on-call for this physician. If there is a question as to who is taking on-call for an attending MD, then contact the hospital and request the on-call physician for the MD you are attempting to contact. Nurses can also notify the Medical Director. Anytime a nurse feels that a resident needs physician medical evaluation and the physician has not returned call or on-call status of the MD cannot be verified, then send resident to the Emergency Room as a precautionary measure for their needs.</p> <p>On 4-10-13, the Staff Development Coordinator and DON initiated in-servicing at 6:15 pm for all nursing assistants and nurses that anytime a resident has a change in antipsychotic medications, the change will be noted on the Resident Care Guide located in each resident's closet and prompt nursing staff to observe for any changes in behaviors or medical condition. If a Nursing Assistant notices a change in resident behavior or condition they are to notify their nurse immediately. Anytime a Nurse is notified that there is a change in behavior or condition they are to immediately assess the resident, assure resident is safe and other residents are safe related to the behavior, and notify the QI Nurse and/or DON and/or the Nurse On-</p>		

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F 157	<p>Continued From page 5</p> <p>the resident 's eye looked very bad so he sent him to the eye clinic. The Physician stated that he could not say that the eye could have been saved had the resident received treatment on the day that the trauma occurred.</p> <p>On 4/10/13 at 1:40 PM an interview was conducted with the Opthamologist that saw Resident #4 at the eye clinic on 3/11/13. The Physician stated that on the initial examination, the resident had a large laceration of the globe of the eye. The Physician stated that when this happens, the person did not regain their eyesight in the injured eye. The Physician stated that he could not say that resident #4 's eye could have been saved had the resident received emergency care on the night of the injury.</p> <p>Nurse #3 stated in an interview on 4/10/13 at 2:15 PM that on 3/9/13 (Saturday) she never did get the physician during her shift. The Nurse stated that she beeped the physician and that this was the only way she knew to reach the physician. The Nurse stated that she called the hospital to make sure that he was on call and was told that he was on call for himself that night. The Nurse stated that her shift was over at 11:00 PM and she told Nurse #4 in report that she had not been able to reach the physician.</p> <p>Nurse #4 stated in an interview on 4/11/13 at 11:45 AM that on 3/9/13 she worked the 11PM-7AM shift. The Nurse stated that she thought that the physician had been notified because there was an order for an X-ray. The Nurse stated that she did not attempt to call the physician on 3/9/13 during her shift. The Nurse stated that she worked 7PM-7AM on 3/10/13</p>	F 157	<p>Call. If situation warrants, notify the MD and RP. The in-service included the reminder that the QI Nurse will also be routinely observing these residents while on an antipsychotic medication change as well and will also be asking Nursing Assistants and Nurses who work with resident if any observed changes in condition or behavior.</p> <p>Directed In-Service Training on antipsychotic medication and behavioral management will be conducted for all nurses on 5-16-2013 by the North Carolina Elderly Psychiatric Services utilizing a curriculum approved by Arizona State.</p> <p><u>How the facility will monitor systems put in place:</u> The Administrator and/or DON will review the Quality Improvement Incident/Accident Committee QI Audit Tool five times per week to assure all areas are reviewed with appropriate intervention and notifications to MD.</p>		

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F 157	<p>Continued From page 6</p> <p>(Sunday) and attempted to notify the physician that night when Resident #5 hit Resident #2 but was unable to reach him. The Nurse stated that she sent a fax to the physician ' s office on Monday morning about the incident.</p> <p>The Administrator stated in an interview on 4/11/13 at 12:43 PM that she would have expected the nurse to call the physician and that if the physician did not respond in a timely manner to call the on-call nurse or the DON for further instructions. The Administrator stated that it was her expectation that the staff notify her when they were unable to reach the physician; let her know that the DON had been notified and what the end result was.</p> <p>On 4/11/13 at 6:00 PM, Facility Consultant #2 stated that they were not able to determine when the physician was notified of the incident.</p> <p>2. Resident #2 was admitted to the facility on 1/21/11 and had diagnoses including Senile Dementia and Alzheimer ' s Disease.</p> <p>A Quarterly Minimum Data Set (MDS) Assessment dated 2/8/13 revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 4 indicating that the resident was severely cognitively impaired. The MDS revealed that the resident had no behaviors and was ambulatory.</p> <p>A facility incident report prepared by Nurse #4 on 3/10/13 (Sunday) at 10:02 PM revealed that Resident #2 was observed to have a laceration on the nose and under the left eye with redness of the left eye. The report revealed that Resident</p>	F 157	<p>The Regional Director and/or Corporate Nurse Consultant will review the Incident/Accident Committee QI Audits tools monthly for six months starting April 2013 then quarterly thereafter to assure the facility is completing and that MD notifications are made for all facility incidents/accidents.</p> <p>The Quality Improvement Executive Committee which consists of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Quality Improvement Nurse, Minimum Data Set Nurse, Social Workers, Bookkeeper, Activity Director, Dietary Director, Medical Records Director, and Maintenance Director will review the quality improvement audit tools to include the Incident/Accident Committee Reviews for monitoring, assessment and recommendation of needs to further monitor these systems, and to assure continued compliance in these areas.</p>		

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F 157	<p>Continued From page 7</p> <p>#5 was standing at the foot of the bed and said that he hit Resident #2 for being in his bed. The report revealed that the physician was paged but there was no documentation that the physician was notified of the incident.</p> <p>There was a Physician ' s Order dated 3/11/13 for an eye consult due to trauma. The Consultation report for Resident #2 revealed that the resident had a subconjunctival hemorrhage of the left eye with recommendations for cool compresses and an antibiotic ointment twice a day for 7 days.</p> <p>There was a Physician ' s Order dated 3/12/13 to X-ray nasal bones to rule out a fracture. The X-ray report dated 3/12/13 for Resident #2 revealed a non-displaced fracture of the right nasal bone.</p> <p>Nurse #4 stated in an interview on 3/26/13 at 12:25 PM that she worked 7PM to 7AM on 3/10/13 (Sunday). The Nurse stated that Resident #5 hit Resident #2 and that she paged the physician but did not receive a response from the physician.</p> <p>An interview was conducted with the Administrator, the Director of Nursing (DON) and Facility Consultant #1 on 3/26/13 at 12:45 PM. The DON stated that this was the first incident she was aware of that the staff was unable to get (name of physician). The DON stated that she tried to tell all the nurses to call the physician ' s cell phone and to call the hospital if they had trouble reaching him. The Facility Consultant stated that they had identified a problem with the nurses not documenting the response of calls made to physicians and had inserviced all the</p>	F 157			



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F 157	<p>Continued From page 8 staff regarding this issue.</p> <p>The Physician stated in an interview on 3/26/13 at 1:30 PM that he did not think that the staff called him over the weekend of 3/9-10/13 but really could not remember. The Physician stated that he did not remember when he was notified of the incident between Resident #5 and Resident #2 but he thought that he found out on Monday (3/11/13). The Physician stated that he was at home on the weekend and was available by cell phone and his home phone.</p> <p>Nurse #3 stated in an interview on 4/11/13 at 11:45 AM that she worked 7PM-7AM on 3/10/13 (Sunday) and attempted to notify the physician that night when Resident #5 hit Resident #2 but was unable to reach him. The Nurse stated that she called the Administrator about the incident but did not notify the Administrator that she could not reach the physician. The Nurse stated that she sent a fax to the doctor 's office on Monday morning to let him know of the incident.</p> <p>The Administrator stated in an interview on 4/11/13 at 12:43 PM that she would have expected the nurse to call the physician and that if the physician did not respond in a timely manner to call the on-call nurse or the DON for further instructions. The Administrator stated that it was her expectation that the staff notify her when they were unable to reach the physician; let her know that the DON had been notified and what the end result was.</p> <p>On 4/11/13 at 6:00 PM, Facility Consultant #2 stated that they were not able to determine when the physician was notified of the incident.</p>	F 157			

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F 157	<p>Continued From page 9</p> <p>3. Resident #5 was admitted to the facility on 11/17/03 and had diagnoses that included Anxiety, Depression, Dementia and Paranoid Schizophrenia. Resident #5 resided on the locked dementia unit in the facility.</p> <p>A review of the most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 1/11/13 revealed that the Resident #5 had a Brief Interview for Mental Status (BIMS) score of 3 indicating that the resident was severely cognitively impaired. The MDS revealed that the resident had behaviors directed towards others such as threatening others, screaming and cursing at others 1-3 days during the 7 day assessment period. The MDS revealed that the Resident was on anti-anxiety and antipsychotic medications 7 of the 7 days of the assessment period.</p> <p>The resident ' s current Care Plan updated on 1/4/13 revealed that the resident had verbal and physical aggression related to anger, cognitive impairment and depression. Among the interventions were to monitor mental status/mood state changes when new medications were added and notify physician of any significant changes and to Observe and report any changes in behaviors and notify physician of significant changes as necessary.</p> <p>A review of the Resident ' s medical record revealed that on 2/7/13 there had been a gradual dose reduction of the Resident ' s psychoactive medications.</p> <p>a. A facility incident report dated 3/9/13 revealed</p>	F 157			

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F 157	<p>Continued From page 10</p> <p>that Nurse #3 was notified at 8:00 PM that two residents were fighting. The report revealed that upon entering the room the nurse observed Resident #5 standing over Resident #4 with a clenched fist and stated that he hit Resident #4 because the resident was in his bed. The report revealed that Resident #4 had swelling and redness of the eye. The report read: " (Name of physician) beeped via phone @ (at) 8:20PM x (times) 2. Have not gotten ret. (returned) call.</p> <p>The progress notes for Resident #5 revealed no documentation that Resident #5 had hit another resident or that the physician had been notified of the incident.</p> <p>The Assistant Director of Nursing (ADON) stated in an interview on 3/26/13 at 10:30 AM that she was the nurse on call on the weekend of 3/9-10/13 and that she received a phone call from Nurse #3 on Saturday evening (3/9/13) that Resident #5 had hit Resident #4. The ADON stated that she told the nurse to keep the two residents separated and to go ahead and get a facial X-ray for Resident #4. The ADON stated that Nurse #3 was trying to reach the physician at the time and she told the nurse to call her back for further changes.</p> <p>Nurse #3 stated in an interview on 3/26/13 at 10:55 AM that she worked on the dementia unit on the 3PM-11PM shift on 3/9/13 (Saturday). The Nurse stated that she paged the physician on his beeper and called the Assistant Director of Nursing (ADON) who was on call for the weekend regarding the incident where Resident #5 hit Resident #4. The Nurse stated that she did not receive a response from the physician so she</p>	F 157			

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F 157	<p>Continued From page 11</p> <p>beeped the physician again. The Nurse stated that when she did not receive a response from the physician the second time she called the ADON and told her that she had not been able to reach the physician. The Nurse stated that the ADON told her to go ahead and get an X-ray of Resident 4 ' s eye.</p> <p>An interview was conducted with the Administrator, the Director of Nursing (DON) and Facility Consultant #1 on 3/26/13 at 12:45 PM. The DON stated that this was the first incident she was aware of that the staff was unable to get (name of physician). The DON stated that she tried to tell all the nurses to call the physician ' s cell phone and to call the hospital if they have trouble reaching him. The ADON was asked by the Facility Consultant to join the interview. The ADON stated that on 3/9/13 while on the phone with Nurse #3 she heard the telephone ringing in the background and Nurse #3 commented that the physician was probably calling back. The ADON stated that she spoke with the physician on Wednesday (3/13/13) when he made rounds and the physician was aware of the incident. The Facility Consultant stated that they had identified a problem with the nurses not documenting the response of calls made to physicians and had inserviced all the staff regarding this issue.</p> <p>The Physician stated in an interview on 3/26/13 at 1:30 PM that he did not think that the staff called him over the weekend of 3/9-10/13 but really could not remember. The Physician stated that he did not remember when he was notified of the incident between Resident #5 and Resident #4 but he thought that he found out on Monday (3/11/13). The Physician stated that he was at</p>	F 157			

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F 157	<p>Continued From page 12</p> <p>home on the weekend and was available by cell phone and his home phone.</p> <p>Nurse #3 stated in an interview on 4/10/13 at 2:15 PM that on 3/9/13 (Saturday) she never did get the physician during her shift. The Nurse stated that she beeped the physician and that this was the only way she knew to reach the physician. The Nurse stated that she called the hospital to make sure that he was on call and was told that he was on call for himself that night. The Nurse stated that her shift was over at 11:00 PM and she told Nurse #4 in report that she had not been able to reach the physician.</p> <p>Nurse #4 stated in an interview on 4/11/13 at 11:45 AM that on 3/9/13 she worked the 11PM-7AM shift. The Nurse stated that she thought that the physician had been notified because there was an order for an X-ray. The Nurse stated that she did not attempt to call the physician on 3/9/13 during her shift. The Nurse stated that she worked 7PM-7AM on 3/10/13 (Sunday) and attempted to notify the physician that night when Resident #5 hit Resident #2 but was unable to reach him. The Nurse stated that she sent a fax to the physician 's office on Monday morning about the incident.</p> <p>The Administrator stated in an interview on 4/11/13 at 12:43 PM that she would have expected the nurse to call the physician and that if the physician did not respond in a timely manner to call the on-call nurse or the DON for further instructions. The Administrator stated that it was her expectation that the staff notify her when they were unable to reach the physician; let her know that the DON had been notified and</p>	F 157			

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F 157	<p>Continued From page 13 what the end result was.</p> <p>On 4/11/13 at 6:00 PM, Facility Consultant #2 stated that they were not able to determine when the physician was notified of the incident.</p> <p>b. A facility incident report for Resident #2 was prepared by Nurse #4 on 3/10/13 at 10:02 PM. The report revealed that Resident #5 had hit Resident #2 because the resident was in his bed and that Resident #2 had a laceration on the nose and under the left eye. The report revealed that the physician was paged but there was no documentation on the report that the physician was notified of the incident.</p> <p>The progress notes for Resident #5 revealed no documentation of the incident or that the physician was notified that Resident #5 had hit another resident.</p> <p>Nurse #4 stated in an interview on 3/26/13 at 12:25 PM that she worked 7PM to 7AM on 3/10/13 (Sunday). The Nurse stated that Resident #5 hit Resident #2 and that she paged the physician but did not receive a response from the physician.</p> <p>An interview was conducted with the Administrator, the Director of Nursing (DON) and Facility Consultant #1 on 3/26/13 at 12:45 PM. The DON stated that this was the first incident she was aware of that the staff was unable to get (name of physician). The DON stated that she tried to tell all the nurses to call the physician 's cell phone and to call the hospital if they have trouble reaching him. The Facility Consultant stated that they had identified a problem with the</p>	F 157			

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F 157	<p>Continued From page 14</p> <p>nurses not documenting the response of calls made to physicians and had inserviced all the staff regarding this issue.</p> <p>The Physician stated in an interview on 3/26/13 at 1:30 PM that he did not think that the staff called him over the weekend of 3/9-10/13 but really could not remember. The Physician stated that he did not remember when he was notified of the incident between Resident #5 and Resident #2 but he thought that he found out on Monday (3/11/13). The Physician stated that he was at home on the weekend and was available by cell phone and his home phone.</p> <p>Nurse #4 stated in an interview on 4/11/13 at 11:45 AM that on Sunday night (3/10/13) she called the Administrator about the incident and tried to contact the physician but was unable to reach him. The Nurse stated that she did not notify the Administrator that she could not reach the physician and that she sent a fax to the doctor 's office on Monday morning.</p> <p>The Administrator stated in an interview on 4/11/13 at 12:43 PM that she would have expected the nurse to call the physician and that if the physician did not respond in a timely manner to call the on-call nurse or the DON for further instructions. The Administrator stated that it was her expectation that the staff notify her when they were unable to reach the physician; let her know that the DON had been notified and what the end result was.</p> <p>On 4/11/13 at 6:00 PM, Facility Consultant #2 stated that they were not able to determine when the physician was notified of the incident.</p>	F 157			

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F 157	<p>Continued From page 15</p> <p>The Administrator was notified of the Immediate Jeopardy on 4/10/13 at 2:10 PM. The facility provided a credible allegation of compliance on 04/11/13 at 5:55 PM. The allegation of compliance indicated:</p> <p>What measures the facility put in place for the resident affected: On 3-9-2013 resident (JD) was assessed by nurse (LD) and attempt made to notify MD. XRay of eye area was completed on 3-9-13 10:30 pm with results of no fractures identified. On 3-11-13 MD gave order for resident to see eye physician and resident (JD) was seen by eye physician on 3-11-13, with additional eye physician visits on 3-12-13 with order to start antibiotic therapy and a return visit scheduled for 3-13-2013. On 3-14-13 resident had procedure to remove right eye and returned to the facility from procedure on 3-15-13.</p> <p>On 3-10-13 resident (RH) was assessed by nurse (RG) and attempt made to notify MD. Family notified on 3-10-13. On 3-10-13 resident (RH) was moved to another room. On 3-11-13 MD gave order for resident to see eye physician and resident was seen by eye physician on 3-11-13 with orders for cold compress and antibiotic ointment to be applied. On 3-12-13 facility obtained X-Ray of resident nasal bones and received X-Ray results on 3-12-13 for resident (RH) showing non-displaced fracture of nose.</p> <p>RP was notified by nurse on 3-9-13 and 3-10-13 of resident 's behaviors. MD was attempted to be notified by nurse of behavior on 3-9-13 and 3-10-13. On 3-10-13 at 7:00 am resident was placed on 15 minutes checks. On 3-11-13 first</p>	F 157			



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F 157	<p>Continued From page 16</p> <p>shift resident was placed on one to one staff monitoring. DON contacted psychiatric nurse practitioner on 3-11-13 and psychiatric nurse practitioner arrived same day at 3:45 pm to see resident with recommendation to resume previous dosage of antipsychotic medications. Social Worker contacted outside psychiatric center on 3-11-2013 for potential placement due to resident behavior. On 3-11-2013 at 7:00 pm the outside psychiatric center contacted social worker and verified they would admit resident (WM) on the morning of 3-12-13. One to One staff monitoring continued with resident until he was discharged from facility. On 3-12-13, resident (WM) was transported to outside psychiatric center for admission and no longer resides at this facility.</p> <p>What measures were put in place for residents having the potential to be affected: The Corporate Nurse Consultants completed a 100 percent audit of resident nurses notes starting on 3-11-13 and completed on 3-12-13 for the time period of documentation from 12-1-2012 to present 3-11-2013, to assure there were no nursing documentation of resident to resident episodes that may not have been previously identified in incident reporting to include notification of MD with no negative outcomes identified.</p> <p>On 3-12-13, the Corporate Nurse Consultant (PG) completed a review of resident to resident altercations from 9-1-12 to 3-11-12 to assure interventions for resident to resident incidents were in place and/or still appropriate to include notification of MD with no new concerns identified.</p>	F 157			

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F 157	Continued From page 17  What systems were put in place to prevent the deficient practice from reoccurring: On 3-12-2013 the Administrator initiated a Quality Improvement Incident/Accidents Committee starting on 3-12-13 consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Improvement Nurse, Minimum Data Set Nurses, Social Workers, and Therapy staff that will meet five times per week to review all incidents and accidents to assure nurse assessment of situation, intervention put in place, MD notified, RP notified, and Care Plan updated for changes and interventions. This review will be documented on a Quality Improvement Incident/Accident Review Committee QI Audit Tool.  On 3-12-2013 the Staff Development Coordinator initiated in-servicing for all Licensed Nurses on Notification of Physician for Changes in Resident 's Condition that emphasized when to notify the MD and that if a nurse is unable to reach the Attending MD, to notify the On-Call MD. The in-service continues that if a nurse is unable to reach the attending or on-call MD to notify the facility Medical Director.  On 4-11-2013 the Corporate Nurse Consultant and Staff Development Coordinator initiated an additional in-service for all Licensed Nurses on MD Notification that included when contacting the MD for notification of a situation and the MD does not respond, contact the physician who has been designated to take on-call for this physician. If there is a question as to who is taking on-call for	F 157			

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F 157	<p>Continued From page 18</p> <p>an attending MD, then contact the hospital and request the on-call physician for the MD you are attempting to contact. Nurses can also notify the Medical Director. Anytime a nurse feels that a resident needs physician medical evaluation and the physician has not returned call or on-call status of the MD cannot be verified, then send resident to the Emergency Room as a precautionary measure for their needs.</p> <p>On 4-10-13, the Staff Development Coordinator and DON initiated in-servicing at 6:15 pm for all nursing assistants and nurses that anytime a resident has a change in antipsychotic medications, the change will be noted on the Resident Care Guide located in each resident 's closet and prompt nursing staff to observe for any changes in behaviors or medical condition. If a Nursing Assistant notices a change in resident behavior or condition they are to notify their nurse immediately. Anytime a Nurse is notified that there is a change in behavior or condition they are to immediately assess the resident, assure resident is safe and other residents are safe related to the behavior, and notify the QI Nurse and/or DON and/or the Nurse On-Call. If situation warrants, notify the MD and RP. The in-service included the reminder that the QI Nurse will also be routinely observing these residents while on an antipsychotic medication change as well and will also be asking Nursing Assistants and Nurses who work with resident if any observed changes in condition or behavior.</p> <p>How the facility will monitor systems put in place: The Administrator and/or DON will review the Quality Improvement Incident/Accident Committee QI Audit Tool five times per week to</p>	F 157			

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F 157	<p>Continued From page 19</p> <p>assure all areas are reviewed with appropriate intervention and notifications to MD.</p> <p>The Regional Director and/or Corporate Nurse Consultant will review the Incident/Accident Committee QI Audits tools monthly for six months starting April 2013 then quarterly thereafter to assure the facility is completing and that MD notifications are made for all facility incidents/accidents.</p> <p>The Quality Improvement Executive Committee which consists of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Quality Improvement Nurse, Minimum Data Set Nurse, Social Workers, Bookkeeper, Activity Director, Dietary Director, Medical Records Director, and Maintenance Director will review the quality improvement audit tools to include the Incident/Accident Committee Reviews for monitoring, assessment and recommendation of needs to further monitor these systems, and to assure continued compliance in these areas.</p> <p>On 4/11/13 at 5:00 PM the credible allegation was validated by reviewing the audits conducted on the dementia unit and the general floors for signs of injury or other signs of resident to resident abuse. Interviews were conducted with the administrative staff and the managers that are on call after business hours and on weekends to assure that interventions are immediately put in place with resident to resident incidents. An " On-call Incident Management " form had been developed for the administrative and on-call staff to take home to document calls regarding incidents and accidents in the facility after</p>	F 157			

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F 157	Continued From page 20 business hours and on weekends. This form included the notification of the physician. The staff was knowledgeable of the form and its use. A QI Worksheet had been developed for the staff that rotate nurse on-call duties to document interventions for incidents/accidents that occur after business hours. Interviews were conducted with the nurses and the nursing assistants on the locked dementia unit and on the general floors. It was confirmed that staff had received inservices regarding the new systems put in place.	F 157			
F 279 SS=J	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).  This REQUIREMENT is not met as evidenced by:	F 279	F279  <u>What measures the facility put in place for the resident affected:</u> On 3-9-2013 resident #4 was assessed by nurse and attempt made to notify MD. XRay of eye area was completed on 3-9-13 10:30 pm with results of no fractures identified. On 3-11-13 MD gave order for resident to see eye physician and resident #4 was seen by eye physician on 3-11-13, with additional eye physician visits on 3-12-13 with order to start antibiotic therapy and a return visit scheduled for 3-13-2013. On 3-14-13 resident had procedure to remove right eye and returned to the facility from procedure on 3-15-13.  On 3-10-13 resident #2 was assessed by nurse and attempt made to notify MD. Family notified on 3-10-13. On 3-10-13 resident #2 was moved to another room. On 3-11-13 MD gave order for resident to see eye physician and resident was seen by eye physician on 3-11-13 with orders for cold compress and antibiotic ointment to be applied. On 3-12-13 facility obtained X-Ray of resident nasal bones and received X-Ray results on 3-12-13 for resident #2 showing non-displaced fracture of nose.	5-20-13	

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F 279	<p>Continued From page 21</p> <p>Based on record review and staff interviews, the facility failed to develop a comprehensive care plan to address 1 of 1 resident (Resident #5) protective of his personal space and failed to address behaviors of 2 of 2 sampled residents (Resident #4 and Resident #2) who wandered and would lie down in other resident 's beds resulting in injury to Resident #4 and Resident #2. The Immediate Jeopardy began on 3/9/13 at 8:00 PM and was identified on 04/10/13 at 2:10 PM. The Immediate Jeopardy was removed on 04/11/13 at 5:55 PM when the facility provided a credible allegation of compliance. The facility will remain out of compliance at a scope and severity level D (with potential for more than minimal harm that is not immediate jeopardy) until all of the nursing staff can be in-serviced. The facility will then implement monitoring of its corrective action.</p> <p>The findings include:</p> <p>1. Resident #5 was admitted to the facility on 11/17/03 and had diagnoses that included Anxiety, Dementia and Paranoid Schizophrenia and resided on the locked dementia unit in the facility.</p> <p>The Resident 's Annual Minimum Data Set (MDS) Assessment dated 07/18/12 revealed no behavioral symptoms or mood issues therefore a Care Area Assessment was not done. The assessment revealed that the Resident received psychotropic medications 7 out of 7 days during the assessment period and would be care planned.</p> <p>The Resident 's current Care Plan dated 1/4/13 revealed that the Resident had verbal and</p>	F 279	<p>RP was notified by nurse on 3-9-13 and 3-10-13 of resident #5's behaviors. MD was attempted to be notified by nurse of behavior on 3-9-13 and 3-10-13. On 3-10-13 at 7:00 am resident #5 was placed on 15 minutes checks. On 3-11-13 first shift resident #5 was placed on one to one staff monitoring. DON contacted psychiatric nurse practitioner on 3-11-13 and psychiatric nurse practitioner arrived same day at 3:45 pm to see resident with recommendation to resume previous dosage of antipsychotic medications. Social Worker contacted outside psychiatric center on 3-11-2013 for potential placement due to resident #5's behavior. On 3-11-2013 at 7:00 pm the outside psychiatric center contacted social worker and verified they would admit resident #5 on the morning of 3-12-13. One to One staff monitoring continued with resident #5 until he was discharged from facility. On 3-12-13, resident #5 was transported to outside psychiatric center for admission and no longer resides at this facility.</p> <p><u>What measures were put in place for residents having the potential to be affected:</u></p> <p>On 3-11-13 at 5:45 pm the Regional Director in-serviced the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Improvement Nurse, Minimum Data Set Nurses and Administrative Nurses who take Nurse On Call responsibilities on assuring that interventions are immediately put in place with resident to resident incidents to</p>		

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F 279	Continued From page 22 physical aggression related to anger, cognitive impairment and depression. The interventions included the following: Do not argue or condemn Resident. Document summary of each episode. Note cause and successful interventions, include frequency and duration. Medication/Treatment as prescribed by physician in a timely manner. Monitor and document behavior per facility protocol. Remove Resident from public area when behavior is disruptive and unacceptable. Talk with resident in a low pitch, calm voice to decrease/eliminate undesired behavior and provide diversional activity. Remove to a quiet area; reassure Resident of personal safety and stay with Resident during periods of anger if appropriate or if resident wishes. Try not to reason with Resident, as Resident no longer has the ability to think logically. The care plan did not include information regarding the Resident ' s aggression when other resident ' s got in his personal space. The Care Plan for Psychoactive Medications showed that the Resident received drugs that had the potential of having an altering effect of the mind. The Care Plan showed that the Resident was taking the medications due to anxiety, depression and a decline in mood and behaviors. The interventions included monitoring of the Resident ' s mood and behaviors with documentation per facility policy and to notify the physician of any significant changes. The Care Plan revealed no new interventions until 3/13/13.  The most recent MDS (Quarterly) dated 1/11/13 revealed that the Resident was severely cognitively impaired and had behaviors of threatening others, screaming and cursing at others during 1 to 3 days of the 7 day assessment period. The MDS showed that the	F 279	include one to one staff monitoring when a resident strikes another resident until the situation is assessed further and appropriate interventions are decided to meet the resident's individualized needs to include care planning. When unsure about a situation, the Administrator and/or Director of Nursing should contact the Regional Director or Corporate Nurse Consultant for additional advisement. No Administrative Nurses worked until they received this in-servicing.  On 4-11-2013 the Administrator in-serviced the MDS Nurses and Interdisciplinary Care Plan Team on using the results of the interdisciplinary assessments to develop, review, and revise the resident's comprehensive plan of care during new assessments, assessed changes, and routine comprehensive plan of care updates.  On 4-3-13 the MDS Nurses started a 100 percent review and comprehensive assessment of all Care Plans to assure individualization of the comprehensive plan of care was completed for each resident to include behaviors of residents  On 4-10-2013 the MDS nurses completed a 100 percent audit and comprehensive assessment of all residents on antipsychotic medications to assure that the comprehensive plan of care addresses the use of antipsychotic medication and any current dose reduction or changes. Any areas identified were corrected by updating of the residents' comprehensive care plan.	5-20-13	

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F 279	<p>Continued From page 23</p> <p>Resident was ambulatory with the supervision of 1 person and received antianxiety and antipsychotic medications.</p> <p>A nursing progress note dated 12/4/12 at 11:10 PM revealed that Resident #5 was standing in the doorway of the dining room and Resident #4 started to go in and Resident #5 balled up his fist and started yelling at Resident #4 stating that he would hit him. It was noted that this happened x (times) 2.</p> <p>A nursing progress note dated 12/20/12 at 11:34 PM revealed that Resident #5 knocked down Resident #4 after Resident #4 pulled his chair from behind him. No injuries were noted.</p> <p>A nursing progress note dated 2/20/13 at 9:42 PM revealed that the Resident yelled out x 3 at other residents. When asked why he was yelling at them he stated: "I don't want them to touch me." The Resident yelled at another resident that was in his room.</p> <p>A facility incident report dated 3/9/13 revealed that at 8:00 PM Resident #5 hit Resident #4 because the Resident was in his bed. Resident #4 had to have his eye removed due to trauma to the eye.</p> <p>A facility incident report dated 3/10/13 at 10:02 PM revealed that Resident #5 hit Resident #2 because the Resident was in his bed resulting in a fracture of the Resident's nose.</p> <p>Nurse #1 stated in an interview on 3/25/13 at 2:52 PM that Resident #5 did not like to be touched and if anyone was in his room he would holler out</p>	F 279	<p>On 3-13-2013 to 3-15-2013 the pharmacy consultant completed a drug regimen review of all residents to include residents on psychoactive medications. Any recommendations made regarding possible antipsychotic medications will be reviewed by the Quality Improvement Antipsychotic Medication Committee. The Committee will review each resident medication(s) to include current dosage, whether there are documented behaviors since last review, verification that MD orders are correct, PRN Medications used are properly documented for the need and frequency, diagnosis to support present medications, and recommendations for changes in medications that will be submitted to the Medical Doctor for review as appropriate.</p> <p><u>What systems were put in place to prevent the deficient practice from reoccurring:</u> On 3-12-2013 the Administrator initiated a Quality Improvement Incident/Accidents Committee starting on 3-12-13 consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Improvement Nurse, Minimum Data Set Nurses, Social Workers, and Therapy staff that will meet five times per week to review all incidents and accidents to assure nurse assessment of situation, intervention put in place, MD notified, RP notified, and Comprehensive Care Plan updated for</p>		



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F 279	<p>Continued From page 24 and the staff would go to the room to see what was going on.</p> <p>An interview was conducted with NA #1 and NA #2 on 3/25/13 at 3:13 PM. NA #1 stated that Resident #4 and Resident #2 would wander around the unit and might get into any resident 's bed. The NA stated that when this happened the staff would get them up and show them their bed.</p> <p>The Director of Nursing (DON) stated in an interview on 3/26/13 at 9:54 AM that the girls in the unit know Resident #5 and if someone bothers him, he will yell and the staff go see what is going on and redirects the resident.</p> <p>The Quality Improvement Nurse stated in an interview on 3/26/13 at 10:04 AM that Resident #5 had always been aggressive but did not hit people on a regular basis. The Nurse stated that it was a known fact that Resident #5 did not like anyone in his personal space and if the person did not move, the Resident would become aggressive.</p> <p>On 3/26/13 at 12:45 PM an interview was conducted with the Administrator, Director of Nursing and a Facility Consultant. The Facility Consultant stated that they had completed a Plan of Correction (POC) after the altercations on the weekend of 3/9-10/13.</p> <p>A review of the POC revealed no information regarding the care plan for Resident #5.</p> <p>The MDS Nurse stated in an interview on 3/28/13 at 3:30 PM that when updating care plans and coding the MDS she looked at the nurse 's notes</p>	F 279	<p>changes and interventions. This review will be documented on a Quality Improvement Incident/Accident Review Committee QI Audit Tool.</p> <p>The facility Quality Improvement Antipsychotic Committee will meet monthly to review all residents that are on antipsychotic medications. The Committee will consist of the Administrator, Director of Nursing, Assistant Director of Nursing, Minimum Data Set Nurses, Quality Improvement Nurses, Social Workers, and Pharmacy Consultant. The Committee will review each resident medication(s) to include current dosage, whether there are documented behaviors since last review, verification that MD orders are correct, PRN Medications used are properly documented for the need and frequency, diagnosis to support present medications, and recommendations for changes in medications that will be submitted to the Medical Doctor. Any recommendations made during the Committee Meeting will be referred to the Attending Physician for acceptance or decline of recommendation. If the physician agrees with the recommendation of change in medication, then the resident's Comprehensive Care Plan will be changed to reflect antipsychotic medication adjustments with goal and approaches listed and the QI Nurse and/or DON will note the change in antipsychotic medication on the Resident Care Guide to prompt staff to watch for any changes in behavior or condition.</p>		

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F 279	<p>Continued From page 25</p> <p>and behaviors documented by the staff. The Nurse stated that she was not aware that Resident #5 was protective of his personal space until the incidents on the weekend of 3/9-10/13. The Nurse stated that she was not aware of residents getting into other resident 's beds on the Alzheimer 's Unit.</p> <p>2. Resident #4 was admitted to the facility on 6/7/11 and had diagnoses that included Anxiety, Depression and Dementia with Behavioral Disturbances.</p> <p>A review of the nursing progress notes for Resident #4 showed a note dated 2/5/13 at 7:32 PM that the Resident was lying in another resident 's bed.</p> <p>A nursing progress note dated 2/13/13 at 12:05 AM that the Resident was in and out of other resident 's beds.</p> <p>The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 2/17/13 showed that the Resident had short and long term memory loss and had poor decision making skills and required cues and supervision. The MDS showed that the Resident had behavior symptoms not directed toward others and was ambulatory with the supervision of one person.</p> <p>The Resident 's current Care Plan last updated on 2/18/13 showed problematic manner in which Resident acts characterized by ineffective coping and repetitive actions related to cognitive impairment, shaking doors in the unit almost daily, wandering into other resident 's rooms and getting into other resident 's beds. The care plan</p>	F 279	<p>On 4-10-13, the Staff Development Coordinator and DON initiated in-serviceing at 6:15 pm for all nursing assistants and nurses that anytime a resident has a change in antipsychotic medications, the change will be noted on the Resident Care Guide located in each resident's closet and prompt nursing staff to observe for any changes in behaviors or medical condition. If a Nursing Assistant notices a change in resident behavior or condition they are to notify their nurse immediately. Anytime a Nurse is notified that there is a change in behavior or condition they are to immediately assess the resident, assure resident is safe and other residents are safe related to the behavior, and notify the QI Nurse and/or DON and/or the Nurse On-Call. If situation warrants, notify the MD and RP. The in-service included the reminder that the QI Nurse will also be routinely observing these residents while on an antipsychotic medication change as well and will also be asking Nursing Assistants and Nurses who work with resident if any observed changes in condition or behavior.</p> <p>Directed In-Service Training on antipsychotic medication and behavioral management will be conducted for all nurses on 5-16-2013 by the North Carolina Elderly Psychiatric Services utilizing a curriculum approved by Arizona State.</p>		

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F 279	<p>Continued From page 26</p> <p>was initiated by MDS Nurse #1 on 8/22/12. The interventions were as follows: Give Resident item or task in attempt to distract or break repetitive cycle. Monitor episodes of repetitive behavior and report to MD as indicated. Note frequency, duration, interventions and results. Pharmacy review of medications monthly and/or as needed. Praise/reward resident for demonstrating consistent desired/acceptable behavior. Redirect behavior (shaking doors). The care plan showed no interventions to prevent Resident #4 from getting into Resident #5's bed.</p> <p>A nursing progress note dated 2/18/13 at 11:16 PM showed that the Resident continued to get into roommates bed to rest.</p> <p>The Quality Improvement Nurse stated in an interview on 3/26/13 at 10:04 AM that Resident #5 had always been aggressive but did not hit people on a regular basis. The Nurse stated that it was a known fact that Resident #5 did not like anyone in his personal space and if the person did not move, the Resident would become aggressive.</p> <p>The MDS Nurse stated in an interview on 03/28/13 at 3:30 PM that when updating care plans and coding the MDS she looked at the nurse 's notes and behaviors documented by the staff. The Nurse stated that she was not aware of residents getting in other resident 's beds on the Alzheimer 's Unit.</p> <p>3. Resident #2 was admitted to the facility on 1/21/11 and had diagnoses that included Depression, Senile Dementia and Alzheimer 's Disease.</p>	F 279	<p><u>How the facility will monitor systems put in place:</u></p> <p>The Administrator and/or DON will review the Quality Improvement Incident/Accident Committee QI Audit Tool five times per week to assure all areas are reviewed with appropriate intervention and notifications. Any changes in interventions from this review will be updated on the Comprehensive Care Plan for the resident.</p> <p>The Administrator will review the QI Review of Nurses Notes three times a week for eight weeks starting 3-11-2013 the once per week ongoing thereafter to assure all notes were reviewed and that any areas with identified concerns were handled to meet the individual needs of the resident and situation. Any changes in interventions from this review will be updated on the Comprehensive Care Plan for the resident.</p> <p>The Regional Director and/or Corporate Nurse Consultant will review the "Incident Notification Worksheet QI Audit tools, the Incident/Accident Committee QI Audits tools, and the QI Review of Nurses Notes monthly for six months starting April 2013 then quarterly thereafter to assure the facility is completing and interventions are in place and working to meet residents' needs.</p>		

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F 279	Continued From page 27  A nursing progress note dated 1/22/13 at 10:54 AM revealed that Resident #2 wandered into the wrong rooms and beds and was found in a female 's room in bed fast asleep.  A nursing progress note dated 1/31/13 at 3:31 PM revealed that the Resident was in and out of other resident 's rooms and beds.  The Annual Minimum Data Set (MDS) Summary sheet for the Minimum Data Set (MDS) Assessment dated 12/25/13 revealed that Behaviors triggered. There was not a Care Area Assessment for behaviors.  The most recent MDS(Quarterly) dated 2/8/13 revealed that the Resident had no behaviors during the assessment period.  The Resident 's current Care Plan last updated on 1/8/13 showed no care plan for behaviors. There was a care plan that read: " Trauma Potential for Wandering. The Interventions were to check for whereabouts frequently. Insure (sic) that alarmed exits are functional. Preventive Intervention: (wanderguard). " There were no interventions to prevent the Resident #2 from getting into Resident #5's bed.  A nursing progress note dated 3/10/13 at 10:20 PM showed that the Resident was observed with lacerations on his nose and left eye with reddened sclera. The note showed that Resident #5 stated that Resident #2 was in his bed so he hit him and that Resident #2 was placed in another room.	F 279	The Quality Improvement Executive Committee which consists of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Quality Improvement Nurse, Minimum Data Set Nurse, Social Workers, Bookkeeper, Activity Director, Dietary Director, Medical Records Director, and Maintenance Director will review the quality improvement audit tools to include the Incident Notification Worksheets, the Reviews of Nurses Notes for unreported incidents, the Incident/Accident Committee Reviews, and the Antipsychotic Medication Committee Meeting Minutes for monitoring, assessment and recommendation of needs to further monitor these systems, and to assure continued compliance in these areas.		

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F 279	<p>Continued From page 28</p> <p>An Eye Consultation report dated 3/11/13 showed subconjunctival hemorrhage left eye.</p> <p>An interview was conducted with NA #1 and NA #2 on 3/25/13 at 3:13 PM. NA #1 stated that Resident #4 was confused and wandered around the unit and might get into any resident 's bed. NA #1 stated that the staff would get them up and show them their bed.</p> <p>The Quality Improvement Nurse stated in an interview on 3/26/13 at 10:04 AM that Resident #5 had always been aggressive but did not hit people on a regular basis. The Nurse stated that it was a known fact that Resident #5 did not like anyone in his personal space and if the person did not move, the Resident would become aggressive.</p> <p>On 3/26/13 at 12:45 PM an interview was conducted with the Administrator, Director of Nursing and Facility Consultant #1. The Facility Consultant stated that they had completed a Plan of Correction (POC) after the altercation on the weekend of 3/9-10/13.</p> <p>A review of the POC revealed no information regarding the care plan for Resident #2.</p> <p>The MDS Nurse stated in an interview on 3/28/13 at 3:30 PM that when updating the care plans and coding the MDS she looked at the nurse 's notes and behaviors documented by the staff. The Nurse stated that she was not aware of residents getting in other resident 's beds on the Alzheimer 's Unit.</p> <p>The MDS Nurse stated in an interview on 4/2/13</p>	F 279			

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F 279	<p>Continued From page 29</p> <p>that the only behavior for the 12/25/12 MDS assessment period was pacing and that this was not new behavior for Resident #2 therefore a Care Area Assessment was not done.</p> <p>The Administrator was notified of the Immediate Jeopardy on 4/10/13 at 2:10 PM. The facility provided a credible allegation of compliance on 04/11/13 at 5:55 PM. The allegation of compliance indicated:</p> <p>What measures the facility put in place for the resident affected:</p> <p>On 3-9-13 Resident #4 was assessed by Nurse #3 and attempt made to notify MD. XRay of eye area was completed on 3/9/13 at 10:30 pm with results of no fractures identified. On 3/11/13 the physician gave an order for the resident to see an eye physician. Resident #4 was seen by an eye physician on 3/11/13, with additional eye physician visits on 3/12/13 with order to start antibiotic therapy and a return visit scheduled for 3/13/13. On 3/14/13 Resident #4 had a procedure to remove the right eye and returned to the facility on 3/15/13.</p> <p>On 3-10-13 Resident #2 was assessed by Nurse #4 and an attempt made to notify the physician. The family was notified on 3-10-13. On 3-10-13 Resident #2 was moved to another room. On 3-11-13 the physician gave an order for Resident #2 to see the eye physician and the resident was seen by eye physician on 3-11-13 with orders for cold compress and antibiotic ointment to be applied. On 3-12-13 the facility obtained X-Ray of resident nasal bones and received X-Ray results on 3-12-13 for Resident #2 showing a</p>	F 279			

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F 279	<p>Continued From page 30 non-displaced fracture of nose.</p> <p>The Responsible party was notified by the nurse on 3-9-13 and 3-10-13 or resident ' s behaviors. The MD was attempted to be notified by nurse of behavior on 3/9/13 and 3/10/13. On 3-10-13 at 7:00 am Resident #5 was placed on 15 minutes checks. On 3-11-13 first shift Resident #5 was placed on one to one staff monitoring. The Director of Nursing (DON) contacted the psychiatric nurse practitioner on 3-11-13 and psychiatric nurse practitioner arrived same day at 3:45 pm to see resident with recommendation to resume previous dosage of antipsychotic medications. Social Worker contacted outside psychiatric center on 3-11-2013 for potential placement due to resident behavior. On 3-11-2013 at 7:00 pm the outside psychiatric center contacted social worker and verified they would admit Resident #5 on the morning of 3-12-13. One to One staff monitoring continued with Resident #5 until he was discharged from facility. On 3-12-13, Resident #5 was transported to outside psychiatric center for admission and no longer resides at this facility.</p> <p>What measures were put in place for residents having the potential to be affected:</p> <p>On 3-11-13 at 5:45 pm the Regional Director in-serviced the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Improvement Nurse, Minimum Data Set Nurses and Administrative Nurses who take Nurse On Call responsibilities on assuring that interventions are immediately put in place with resident to resident incidents to include one to one staff monitoring when a resident strikes another</p>	F 279			

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F 279	<p>Continued From page 31</p> <p>resident until the situation is assessed further and appropriate interventions are decided to meet the resident ' s individualized needs to include care planning. When unsure about a situation, the Administrator and/or Director of Nursing should contact the Regional Director or Corporate Nurse Consultant for additional advisement. No Administrative Nurses worked until they received this in-servicing.</p> <p>On 4-3-13 the MDS Nurses started a 100 percent review of all Care Plans to assure individualization of the plan of care was completed for each resident to include behaviors of residents.</p> <p>On 4-10-2013 the MDS nurses completed a 100 percent audit of all residents on antipsychotic medications to assure that the plan of care addresses the use of antipsychotic medication and any current dose reduction or changes. Any areas identified were corrected by updating of the residents ' care plan.</p> <p>On 3-13-2013 to 3-15-2013 the pharmacy consultant completed a drug regimen review of all residents to include residents on psychoactive medications. Any recommendations made regarding possible antipsychotic medications will be reviewed by the Quality Improvement Antipsychotic Medication Committee. The Committee will review each resident medication(s) to include current dosage, whether there are documented behaviors since last review, verification that MD orders are correct, PRN Medications used are properly documented for the need and frequency, diagnosis to support present medications, and recommendations for</p>	F 279			



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F 279	<p>Continued From page 32</p> <p>changes in medications that will be submitted to the Medical Doctor for review as appropriate.</p> <p>What systems were put in place to prevent the deficient practice from reoccurring: On 3-12-2013 the Administrator initiated a Quality Improvement Incident/Accidents Committee starting on 3-12-13 consisting of the Administrator, Director of Nursing (DON), Assistant Director of Nursing, Quality Improvement Nurse, Minimum Data Set Nurses, Social Workers, and Therapy staff that will meet five times per week to review all incidents and accidents to assure nurse assessment of situation, intervention put in place, MD notified, RP notified, and Care Plan updated for changes and interventions. This review will be documented on a Quality Improvement Incident/Accident Review Committee QI Audit Tool.</p> <p>The facility Quality Improvement Antipsychotic Committee will meet monthly to review all residents that are on antipsychotic medications. The Committee will consist of the Administrator, Director of Nursing, Assistant Director of Nursing, Minimum Data Set Nurses, Quality Improvement (QI) Nurses, Social Workers, and Pharmacy Consultant. The Committee will review each resident medication(s) to include current dosage, whether there are documented behaviors since last review, verification that MD orders are correct, PRN Medications used are properly documented for the need and frequency, diagnosis to support present medications, and recommendations for changes in medications that will be submitted to the Medical Doctor. Any</p>	F 279		

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F 279	<p>Continued From page 33</p> <p>recommendations made during the Committee Meeting will be referred to the Attending Physician for acceptance or decline of recommendation. If the physician agrees with the recommendation of change in medication, then the resident will be Care Planned for changes in antipsychotic medications with goal and approaches listed and the QI Nurse and/or DON will note the change in antipsychotic medication on the Resident Care Guide to prompt staff to watch for any changes in behavior or condition.</p> <p>On 4-10-13, the Staff Development Coordinator and DON initiated in-servicing at 6:15 pm for all nursing assistants and nurses that anytime a resident has a change in antipsychotic medications, the change will be noted on the Resident Care Guide located in each resident 's closet and prompt nursing staff to observe for any changes in behaviors or medical condition. If a Nursing Assistant notices a change in resident behavior or condition they are to notify their nurse immediately. Anytime a Nurse is notified that there is a change in behavior or condition they are to immediately assess the resident, assure resident is safe and other residents are safe related to the behavior, and notify the QI Nurse and/or DON and/or the Nurse On-Call. If situation warrants, notify the physician and responsible party. The in-service included the reminder that the QI Nurse will also be routinely observing these residents while on an antipsychotic medication change as well and will also be asking Nursing Assistants and Nurses who work with resident if any observed changes in condition or behavior.</p>	F 279			

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F 279	<p>Continued From page 34</p> <p>How the facility will monitor systems put in place:</p> <p>The Administrator and/or DON will review the Quality Improvement Incident/Accident Committee QI Audit Tool five times per week to assure all areas are reviewed with appropriate intervention and notifications.</p> <p>The Administrator will review the QI Review of Nurses Notes three times a week for eight weeks starting 3-11-2013 the once per week ongoing thereafter to assure all notes were reviewed and that any areas with identified concerns were handled to meet the individual needs of the resident and situation.</p> <p>The Regional Director and/or Corporate Nurse Consultant will review the " Incident Notification Worksheet QI Audit tools, the Incident/Accident Committee QI Audits tools, and the QI Review of Nurses Notes monthly for six months starting April 2013 then quarterly thereafter to assure the facility is completing and interventions are in place and working to meet residents ' needs.</p> <p>The Quality Improvement Executive Committee which consists of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Quality Improvement Nurse, Minimum Data Set Nurse, Social Workers, Bookkeeper, Activity Director, Dietary Director, Medical Records Director, and Maintenance Director will review the quality improvement audit tools to include the Incident Notification Worksheets, the Reviews of Nurses Notes for unreported incidents, the Incident/Accident Committee Reviews, and the Antipsychotic Medication Committee Meeting Minutes for</p>	F 279			

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F 279	Continued From page 35 monitoring, assessment and recommendation of needs to further monitor these systems, and to assure continued compliance in these areas.  On 4/11/13 at 5:00 PM, the credible allegation was validated by reviewing the audits of resident ' s care plans and inservices conducted with the staff. Interviews were conducted with the MDS Nurses who were knowledgeable of the changes and updates to be made to the resident care plans and care guides. The Incident/Accident Committee QI Audit Tool was in place to be used to ensure that care plans address changes in a resident ' s psychoactive medications.	F 279			
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to address a physician ' s recommendation to remove the foot board of the bed to prevent pressure to a resident ' s toes for 1 (Resident #1) of 3 sampled residents reviewed for pressure ulcers.  The findings included:	F 314	F314 On 4-10-13 the treatment nurse contacted the wound physician to clarify his recommendation for Resident #1 related to risk benefits and physician agreed to pad the resident footboard rather than remove footboard.  A 100 percent audit of all residents who receive wound physician services progress notes were reviewed on 4-12-13 by the treatment nurse to assure any recommendations had follow through by nursing. Any areas identified will be handled as appropriate for each resident individual needs.  The treatment nurse and the DON was inserviced on 4-10-13 by the Corporate Nurse Consultant on assuring when all wound physician visits are completed, that there is a thorough review of their written notes to assure any orders or recommendations are identified and followed through as appropriate.	S20-13	

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F 314	<p>Continued From page 36</p> <p>Resident #1 was admitted to the facility on 6/30/09, re-admitted to the facility on 3/20/13 and had diagnoses that included Multiple Cerebrovascular Accidents (CVAs), Diabetes Mellitus, End Stage Renal Disease on Dialysis, Anemia, Protein/Calorie Malnutrition, Peripheral Artery Disease and Stage IV Pressure Ulcer of the Right Heel.</p> <p>The Annual Minimum Data Set (MDS) Assessment dated 2/23/13 revealed that the Resident had short and long term memory loss and was severely cognitively impaired. The MDS revealed that the Resident required extensive assistance with bed mobility and was dependent on staff for transfers. The MDS revealed that the Resident was at risk for pressure ulcers and had a Stage IV pressure ulcer that was present upon admission. The MDS revealed that a pressure reducing device was used for the bed and chair and that the Resident received pressure ulcer care.</p> <p>The Care Area Assessment for Pressure Ulcers dated 2/23/13 revealed that the Resident had a Stage IV pressure ulcer on the right heel and was at risk for further skin breakdown.</p> <p>The Resident ' s current Care Plan last updated on 2/6/13 revealed that the Resident was at risk for skin breakdown and development of further pressure ulcers. The interventions were as follows: Staff to turn and reposition Resident routinely. Bunny boots to feet/heels as ordered. Monitor skin daily for any changes and report to nurse.</p>	F 314	<p>The treatment nurse will complete a "Wound Physician Order or Recommendation" QI audit Tool weekly for four weeks then monthly for 3 months to assure all wound physician orders or recommendations have follow through as appropriate.</p> <p>The Director of Nursing will review the Wound Physician Order or Recommendation QI Audit Tool weekly for four weeks then monthly for three months to assure completion and that areas are addressed as appropriate.</p> <p>The Quality Improvement Executive Committee which consists of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Quality Improvement Nurse, Minimum Data Set Nurse, Social Workers, Bookkeeper, Activity Director, Dietary Director, Medical Records Director, and Maintenance Director will review the quality improvement audit tools to include the Wound Physician Order and Recommendation Audits, for monitoring, assessment and recommendation of needs to further monitor these systems, and to assure continued compliance in this area.</p>		

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F 314	<p>Continued From page 37</p> <p>A Nursing Admission Assessment dated 3/21/13 revealed that the Resident had a Stage III pressure ulcer to the right foot and a Stage IV pressure ulcer to the heel of the right foot.</p> <p>A pressure ulcer assessment dated 3/21/13 revealed that the Resident was at high risk for pressure ulcers.</p> <p>A Wound Consult dated 3/21/13 revealed that the Resident had diagnoses of End Stage Renal Disease, Insulin Dependent Diabetes with Brittle Poor Glycemic Control, Diabetic Neuropathy, Acquired Hemolytic Anemia, Iron Deficiency, Chronic Obstructive Pulmonary Disease, Multiple CVA ' s (strokes) and Aphasia. The wound specialist ' s exam revealed absent pedal pulses on the left and right and absent posterior tibial pulses on the left and right with a capillary refill of &lt; 3 seconds. The assessment revealed that debridement of the pressure ulcer was not indicated secondary to severe peripheral arterial disease.</p> <p>On 3/28/13 at 12:50 PM Nurse #6 stated that the wound specialist made rounds at the facility on Thursdays. The Nurse stated that the treatment nurse was on medical leave and that she did the treatments on the weekends. On 3/28/13 at 1:00 PM the wound specialist was observed to examine and measure the wounds on the Resident ' s right foot while the Director of Nursing (DON) was holding the resident ' s right leg up off of the bed. During the examination, Nurse #6 was observed to point out a small purple area on the end of the Resident ' s left great toe and stated that the area was new. The Resident ' s left toes were observed to be resting</p>	F 314			

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F 314	<p>Continued From page 38</p> <p>against the foot board of the bed. The Wound Doctor instructed the nurses to have the foot board of the bed removed to keep pressure off of the resident ' s toes.</p> <p>A Wound Care Specialist Evaluation dated 3/28/13 under Assessment &amp; Plan for arterial wound of the left, distal first toe - initial evaluation read: " Recommendation: Remove foot board to reduce pressure on distal foot. "</p> <p>On 3/28/13 at 2:42 PM and 4:00 PM the foot board was observed to be on the resident ' s bed.</p> <p>A Wound Care Specialist Evaluation dated 4/4/13 revealed in the Assessment &amp; Plan that the arterial wound of the left distal first toe had improved evidenced by decreased surface area.</p> <p>On 4/10/13 at 10:30 AM the Resident ' s bed was observed to have a foot board in place.</p> <p>On 4/10/13 at 10:58 AM the Treatment Nurse stated that she was not aware that the wound doctor had told the staff to remove the foot board from Resident 1 ' s bed. The Treatment Nurse stated that she was on medical leave when the wound doctor saw the Resident on 3/28/13. The Treatment Nurse stated that the wound doctor saw the Resident last Thursday and did not say anything about the foot board. The Treatment Nurse stated that she had not had a discussion with the interdisciplinary team regarding the removal of the foot board of Resident 1 ' s bed.</p> <p>On 4/10/13 at 11:30 AM an interview was conducted with the Administrator, the DON and the Quality Improvement Nurse. The DON stated</p>	F 314			

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F 314	<p>Continued From page 39</p> <p>that the wound doctor made a statement about removing the foot board but the wound doctor did not write an order for the foot board to be removed. The DON stated that she did not follow-up on it. The DON stated that maybe she should have taken the statement as a verbal order but she did not. The DON stated that there was not a discussion with the interdisciplinary team about the resident ' s foot board.</p> <p>On 4/10/13 at 12:48 PM an interview was conducted with the Treatment Nurse and the DON. The Treatment Nurse stated that she called the wound doctor today to clarify what he wanted regarding the foot board. The Treatment Nurse stated that the wound doctor told her that it was a recommendation to remove the foot board to keep the Resident ' s foot off of the foot board. The DON stated that she was not used to taking verbal orders from the wound doctor and she had rolled up the foot of the bed to keep the Resident from sliding down and that is the way she left it. The DON stated that the Resident had recently had a fall from the bed and that the wound doctor stated that it could be more of a risk than a benefit to remove the foot board so they had decided to pad the foot board instead of removing it.</p> <p>On 4/10/13 at 1:05 PM an interview was conducted with Facility Consultant #1 and the DON. The Facility Consultant stated that today she stressed to the treatment nurse to pull the wound consult sheets on Fridays or Mondays to review and follow-up on the recommendations. The Facility Consultant stated that since it was brought to their attention today, they were addressing it and the foot board was being</p>	F 314			



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F 314	Continued From page 40 currently being padded.	F 314			
F 323 SS=J	<p>On 4/10/13 at 2:30 PM, Nurse #6 stated in an interview that she remembered the wound doctor saying that the foot board needed to be removed but she did not follow-up on it. The Nurse stated that she was not used to working with the wound doctor when he made his rounds.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to supervise 2 of 2 sampled residents (Resident #4 and #2) in the locked dementia unit who wandered into other resident 's rooms resulting in physical injury to 2 of 2 sampled Residents (#4 and #2). The facility failed to implement interventions for 1 of 1 sampled resident (Resident #5) who was protective of his personal space resulting in physical aggression toward two other residents (Resident #4 and #2). The Immediate Jeopardy began on 3/9/13 at 8:00 PM and was identified on 04/10/13 at 2:10 PM. The Immediate Jeopardy was removed on 04/11/13 at 5:55 PM when the facility provided a credible allegation of compliance. The facility will remain out of compliance at a scope and severity</p>	F 323	<p>F323</p> <p><u>What measures the facility put in place for the resident affected:</u> On 3-9-2013 resident #4 was assessed by nurse and attempt made to notify MD. XRay of eye area was completed on 3-9-13 10:30 pm with results of no fractures identified. On 3-11-13 MD gave order for resident to see eye physician and resident #4 was seen by eye physician on 3-11-13, with additional eye physician visits on 3-12-13 with order to start antibiotic therapy and a return visit scheduled for 3-13-2013. On 3-14-13 resident had procedure to remove right eye and returned to the facility from procedure on 3-15-13.</p> <p>On 3-10-13 resident #2 was assessed by nurse and attempt made to notify MD. Family notified on 3-10-13. On 3-10-13 resident #2 was moved to another room. On 3-11-13 MD gave order for resident to see eye physician and resident was seen by eye physician on 3-11-13 with orders for cold compress and antibiotic ointment to be applied. On 3-12-13 facility obtained X-Ray of resident nasal bones and received X-Ray results on 3-12-13 for resident #2 showing non-displaced fracture of nose.</p>	5-20-13	

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F 323	<p>Continued From page 41</p> <p>level D (with potential for more than minimal harm that is not immediate jeopardy) until all of the nursing staff can be inserviced. The facility will then implement monitoring of its corrective action.</p> <p>The findings included:</p> <p>1. Resident #5 was admitted to the facility on 11/17/03 and had diagnoses of Dementia, Anxiety and Paranoid Schizophrenia.</p> <p>The Annual Minimum Data Set (MDS) Assessment dated 7/18/13 revealed that the Resident had no mood issues or behavioral symptoms during the 7 day assessment period. The MDS revealed that the resident was on an antipsychotic medication and an antidepressant medication and would be addressed in the care plan.</p> <p>A nursing progress note dated 11/14/12 at 6:47 PM revealed that Resident #5 yelled out when another resident got too close or was in his way.</p> <p>A nursing progress note dated 12/4/12 at 11:10 PM revealed that Resident #5 was standing in the doorway of the dining room and Resident #4 started to go in and Resident #5 balled up his fist and started yelling at the Resident that he would hit him. The note revealed that both Residents were redirected.</p> <p>A progress note by the Quality Improvement (QI) Nurse dated 12/27/12 revealed that Resident #5 was aggressive at times with multiple behavioral issues and that staff continued to redirect the Resident when having behaviors and being aggressive with other residents.</p>	F 323	<p>RP was notified by nurse on 3-9-13 and 3-10-13 of resident #5's behaviors. MD was attempted to be notified by nurse of behavior on 3-9-13 and 3-10-13. On 3-10-13 at 7:00 am resident #5 was placed on 15 minutes checks. On 3-11-13 first shift resident #5 was placed on one to one staff monitoring. DON contacted psychiatric nurse practitioner on 3-11-13 and psychiatric nurse practitioner arrived same day at 3:45 pm to see resident with recommendation to resume previous dosage of antipsychotic medications. Social Worker contacted outside psychiatric center on 3-11-2013 for potential placement due to resident #5's behavior. On 3-11-2013 at 7:00 pm the outside psychiatric center contacted social worker and verified they would admit resident #5 on the morning of 3-12-13. One to One staff monitoring continued with resident #5 until he was discharged from facility. On 3-12-13, resident #5 was transported to outside psychiatric center for admission and no longer resides at this facility.</p> <p><u>What measures were put in place for residents having the potential to be affected:</u></p> <p>On 3-11-13 at 7:00 pm a 100 percent audit was completed by the ADON on all residents residing in the locked dementia unit to check for any signs of injury or suspicious signs of resident to resident abuse. No negative outcomes were identified in this audit.</p>		

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F 323	Continued From page 42  A physician ' s progress note dated 1/4/12 revealed that Resident #5 had a problem with anger management and that the Resident had severe dementia. The note revealed that the Resident was not combative as long as he was left alone.  The Resident ' s Care Plan initiated on 7/18/13 and updated on 1/4/13 revealed that the Resident had verbal and physical aggression related to anger, cognitive impairment and depression. The interventions included the following: Do not argue or condemn Resident. Document summary of each episode. Note cause and successful interventions, include frequency and duration. Medication/Treatment as prescribed by physician in a timely manner. Monitor and document behavior per facility protocol. Remove Resident from public area when behavior is disruptive and unacceptable. Talk with Resident in a low pitch, calm voice to decrease/eliminate undesired behavior and provide diversional activity. Remove to a quiet area; reassure Resident of personal safety and stay with Resident during periods of anger if appropriate or if Resident wishes. Try not to reason with Resident, as Resident no longer has the ability to think logically. The Care Plan revealed that the Resident received drugs that had the potential to have an altering effect on the mind and had problems that included anxiety, depression and decline in mood and behaviors. Among the interventions were to monitor the Resident ' s mood and behaviors with documentation per facility policy and to notify the physician of any significant changes. The Care Plan revealed no new interventions since 7/18/12.	F 323	On 3-12-13 the audit was expanded by the floor nurses to the remaining residents residing in the nursing facility as an additional precautionary intervention to check for any signs of injury or resident to resident abuse. No negative outcomes were identified from this audit.  The Corporate Nurse Consultants completed a 100 percent audit of resident nurses notes starting on 3-11-13 and completed on 3-12-13 for the time period of documentation from 12-1-2012 to present 3-11-2013, to assure there were no nursing documentation of resident to resident episodes that may not have been previously identified in incident reporting with no negative outcomes identified.  On 3-12-13, the Corporate Nurse Consultant (PG) completed a review of resident to resident altercations from 9-1-12 to 3-11-12 to assure interventions for resident to resident incidents were in place and/or still appropriate with no new concerns identified.  On 3-11-13 at 5:45 pm the Regional Director in-serviced the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Improvement Nurse, Minimum Data Set Nurses and Administrative Nurses who take Nurse On Call responsibilities on assuring that interventions are immediately put in place with resident to resident incidents to include one to one staff monitoring when a resident strikes another resident until the		

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F 323	<p>Continued From page 43</p> <p>The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 01/11/13 revealed that Resident #5 was severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 3. The MDS revealed that the Resident had behaviors directed towards others that included threatening others, screaming at others and cursing at others that occurred 1-3 days during the 7 day assessment period.</p> <p>A review of the Physician 's Orders dated 2/7/13 revealed a gradual dose reduction of Resident #5 's psychoactive medications as follows: Reduce Buspar from 300mg (milligrams) to 200mg daily. Reduce Ativan from 1mg to 0.5mg every morning, Reduce Remeron from 15mg to 7.5mg at bedtime and reduce Zyprexa from 5mg to 2.5mg at bedtime.</p> <p>A nursing progress note dated 2/17/13 at 11:31 PM revealed that Resident #5 was standing at the sink in the dining room and Resident #7 was in the dining room in a wheelchair and was fussing at Resident #5 about leaving her stove alone and that this was her house and he needed to leave. The note revealed that Resident #5 hit Resident #7 on the side of the face after yelling at her. The note revealed that no injury had occurred and both Residents were redirected and separated. The note revealed that Resident #5 was asked if he hit Resident #7 and he said " Yes, she told me to get out of her house and this is not her house. " The note revealed that the physician and the administrator were made aware.</p> <p>A nursing progress note dated 2/18/13 at 11:35 PM revealed that Resident #5 yelled out several times at residents if they came into his room while</p>	F 323	<p>situation is assessed further and appropriate interventions are decided to meet the resident's individualized needs to include care planning. When unsure about a situation, the Administrator and/or Director of Nursing should contact the Regional Director or Corporate Nurse Consultant for additional advisement. No Administrative Nurses worked until they received this in-servicing.</p> <p>On 3-12-13, the Regional Director in-serviced the Administrator and all Administrative Nurses who take Nurse On Call to include the Director of Nursing, Assistant Director of Nursing, Quality Improvement Nurse, and Minimum Data Set Nurses on "On-Call Incident Management; steps to look at when called about an incident that outlined data to collect about situation including answers to WHO, WHAT, WHEN, WHERE, HOW, and INTERVENTION to be put in place. On 3-15-13 the Administrator expanded the "On-Call Incident Management" in-service to all staff members who rotate weekend Administrative Call Rounds including the Housekeeping Director, Medical Records Director, Social Workers, Business Office staff, Dietary Manager, Activity Director, and Maintenance Director.</p> <p>On 3-11-13 at 7:10 pm the Staff Development Coordinator initiated in-servicing for all facility staff to include nurses, nursing assistant, nursing support staff, dietary staff, housekeeping staff, maintenance staff, activities staff, office</p>	5-20-13	

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F 323	<p>Continued From page 44</p> <p>he was resting in bed and stated that these residents did not belong in his room.</p> <p>A nursing progress note dated 2/20/13 revealed that Resident #5 yelled out three times at other residents and when asked why he was yelling stated: " I don ' t want them to touch me. " The note revealed that he yelled at another resident for entering into his room and the resident was removed from the room and reminded that it was not her room.</p> <p>A facility Incident Report revealed that on 3/9/13 at 8:00 PM Nurse #3 was called to Resident #5 ' s room due to two residents fighting. The report showed that Resident #5 was standing over Resident #4 with a clenched fist and stated: " I told him to leave me alone and get out of my bed. " The report revealed that Resident #4 ' s eye was swollen and blood shot. The report revealed that the Responsible Party for Resident #4 was notified.</p> <p>A review of the clinical record for Resident #4 revealed a nursing progress note dated 3/10/13 at 11:03 AM that Resident #4 had peri-orbital swelling and ecchymosis of the right eye. A nursing progress note dated 3/11/13 at 3:10 PM revealed that Resident #4 was transported to the doctor ' s office for a right eye consult. A nursing progress note dated 3/12/13 at 12:22 PM revealed that Resident #4 was taken to an eye specialist.</p> <p>An eye consultation report dated 3/14/13 revealed the following: Trauma to right eye. No light perception. Ruptured globe. Impression: Blind painful eye. Plan of treatment: Enucleation</p>	F 323	<p>staff, and therapy staff on Resident to Resident Abuse to include when episodes are observed that safety is provided immediately, charge nurses are notified immediately for appropriate interventions. No staff was allowed to work until they received this in-service.</p> <p>On 4-10-2013 the MDS nurses completed a 100 percent audit of all residents on antipsychotic medications to assure that the plan of care addresses the use of antipsychotic medication and any current dose reduction or changes. Any areas identified were corrected by updating of the residents' care plan.</p> <p>On 3-13-2013 to 3-15-2013 the pharmacy consultant completed a drug regimen review of all residents to include residents on psychoactive medications. Any recommendations made regarding possible antipsychotic medications will be reviewed by the Quality Improvement Antipsychotic Medication Committee. The Committee will review each resident medication(s) to include current dosage, whether there are documented behaviors since last review, verification that MD orders are correct, PRN Medications used are properly documented for the need and frequency, diagnosis to support present medications, and recommendations for changes in medications that will be submitted to the Medical Doctor for review as appropriate.</p>		

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F 323	<p>Continued From page 45 (removal of) right eye.</p> <p>A Discharge Summary dated 3/15/13 showed that Resident #4 had surgery to remove the right eye on 3/14/13.</p> <p>Record review revealed that Resident #4 was admitted to the facility on 6/7/11 with a diagnosis of Dementia with Behavioral Disturbance. The Quarterly MDS Assessment dated 2/17/13 revealed that Resident #4 had short and long term memory loss and was moderately cognitively impaired with poor decision making skills and required cues and supervision. A review of Resident #4 's Care Plan updated on 2/18/13 revealed that the resident wandered into other resident 's rooms and would get into other resident 's beds. The nursing progress notes revealed that Resident #4 was lying in another resident 's bed on 2/5/13, was in and out of other resident 's beds on 2/13/13 and continued to get into roommate 's bed to rest on 2/18/13.</p> <p>On 3/25/13 at 2:52 PM an interview was conducted with Nurse #1 (7AM-3PM) and Nurse #2 (3PM-11PM). The Nurses stated that they were not working on the weekend of the altercation between Resident #5 and Resident #4. Nurse #1 stated that during the evening, Resident #5 would keep to himself and did not like to be touched. The Nurse stated that if anyone was in his room he would holler out for the nurse and they would go down to see what was going on. Nurse #1 stated that there were altercations with 2 different residents the same weekend and Resident #4 had his eye taken out.</p> <p>On 3/25/13 at 3:13 PM an interview was</p>	F 323	<p><u>What systems were put in place to prevent the deficient practice from reoccurring:</u></p> <p>On 3-12-2013 a QI worksheet guide was implemented to be used by the Administrator, Director of Nursing, and all Administrative Nurses that rotate Nurse On-Call duties for non-business hours, weekends, and nights to assist in gathering information to make decisions about interventions for incidents to include resident to resident incidents utilizing a "On-Call Incident Management" Worksheet QI Audit Tool. This audit tool will be utilized when calls are received and forwarded to the Administrator for review.</p> <p>On 3-12-2013 the Administrator initiated a Quality Improvement Incident/Accidents Committee starting on 3-12-13 consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Improvement Nurse, Minimum Data Set Nurses, Social Workers, and Therapy staff that will meet five times per week to review all incidents and accidents to assure nurse assessment of situation, intervention put in place, MD notified, RP notified, and Care Plan updated for changes and interventions. This review will be documented on a Quality Improvement Incident/Accident Review Committee QI Audit Tool.</p> <p>Administrative Nurses will review all resident nurses notes three times per week for eight weeks starting week of 3-11-2013 and then once per week ongoing thereafter to assure there are no resident to resident</p>		

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F 323	<p>Continued From page 46</p> <p>conducted with the 2 nursing assistants (NAs) working on 3/9/13 when the altercation occurred between Resident #5 and Resident #4. NA #1 stated that on Saturday night (3/9/13) they were doing patient care and heard a resident yell that they were fighting. NA #1 stated she went to the room and observed Resident #4 lying in Resident #5 's bed bleeding. The NA stated that she asked Resident #5 if he hit Resident #4 and he said that he did. The NA stated that she took Resident #4 to the bench in the hallway and Resident #5 stayed in his room. NA #1 stated that on Sunday when starting her shift at 3:00 PM, Resident #5 was on 15 minute checks which meant that they had to check on the resident and document his location every 15 minutes. The NAs stated that Resident #4 would wander around the unit and might get in any resident ' s bed and staff would get him up and show him his bed.</p> <p>An interview was conducted with the Administrator and the Director of Nursing on 3/25/13 at 4:50 PM. The Administrator stated that the Assistant Director of Nursing (ADON) was the on duty manager on Saturday (3/9/13) when the incident with Resident #5 and Resident #4 occurred and had already left for the day but was the nurse on-call for the weekend. The Administrator stated that the Medical Records Manager was the manager on duty on Sunday (3/10/13). The Administrator stated that on Sunday AM she received a call from the Medical Records Manager who told her of the incident with Resident #5 and Resident #4. The Administrator stated that the Manager had put into place every 15 minute checks on Resident #5 meaning the staff was to check his whereabouts every 15 minutes. The Administrator stated that</p>	F 323	<p>episodes that may have occurred that were not identified by incident reporting.</p> <p>On 4-10-2013 the Staff Development Coordinator initiated in-servicing at 1:17 pm for nurses and nursing assistants regarding monitoring of residents that in the daily monitoring of our residents staff should routinely monitor their whereabouts. If a dementia resident is identified as being in another resident's space or bed to redirect the resident to the common care areas of the unit and that if the resident is resistive to the redirection to stay with the resident to assure no resident to resident conflicts occur until the resident is able to be redirected.</p> <p>The facility Quality Improvement Antipsychotic Committee will meet monthly to review all residents that are on antipsychotic medications. The Committee will consist of the Administrator, Director of Nursing, Assistant Director of Nursing, Minimum Data Set Nurses, Quality Improvement Nurses, Social Workers, and Pharmacy Consultant. The Committee will review each resident medication(s) to include current dosage, whether there are documented behaviors since last review, verification that MD orders are correct, PRN Medications used are properly documented for the need and frequency, diagnosis to support present medications, and recommendations for changes in medications that will be submitted to the Medical Doctor. Any recommendations made during the Committee Meeting will</p>		

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F 323	<p>Continued From page 47</p> <p>after a second altercation between Resident #5 and another resident on Sunday night, Resident #5 was put on 1 to 1 observation until he was transferred out of the facility on 3/12/13.</p> <p>The Medical Records Manager stated in an interview on 3/25/13 at 5:02 PM that she was the in-house manager on 3/9/13 but was not in the facility at the time of the altercation between Resident #5 and Resident #4. The Manager stated that when she came in on Sunday morning (3/10/13) she was making her rounds and a nursing assistant told her that Resident #5 had hit Resident #4 and that she needed to go and look at his eye. The Manager stated that the nurse had already called the physician and the Responsible Party, an X-ray had been done and the nurse was doing neurochecks on Resident #4. The Manager stated that she instructed the nurse on the Alzheimer 's Unit to start 15 minute checks on Resident #5 and she called the Administrator to let her know what had been done.</p> <p>On 3/26/13 The DON stated in an interview that the girls in the back know Resident #5 and usually know where he is and that if someone bothers the Resident, he will yell and the staff go to see what is going on and re-directs the Resident.</p> <p>The Quality Improvement Nurse stated in an interview on 3/26/13 at 10:04 AM that Resident #5 had always been aggressive but did not hit people on a regular basis. The Nurse stated that it was a known fact that Resident #5 did not like anyone in his personal space and if the person did not move Resident #5 would become</p>	F 323	<p>be referred to the Attending Physician for acceptance or decline of recommendation. If the physician agrees with the recommendation of change in medication, then the resident will be Care Planned for changes in antipsychotic medications with goal and approaches listed and the QI Nurse and/or DON will note the change in antipsychotic medication on the Resident Care Guide to prompt staff to watch for any changes in behavior or condition.</p> <p>On 4-10-13, the Staff Development Coordinator and DON initiated in-servicing at 6:15 pm for all nursing assistants and nurses that anytime a resident has a change in antipsychotic medications, the change will be noted on the Resident Care Guide located in each resident's closet and prompt nursing staff to observe for any changes in behaviors or medical condition. If a Nursing Assistant notices a change in resident behavior or condition they are to notify their nurse immediately. Anytime a Nurse is notified that there is a change in behavior or condition they are to immediately assess the resident, assure resident is safe and other residents are safe related to the behavior, and notify the QI Nurse and/or DON and/or the Nurse On-Call. If situation warrants, notify the MD and RP. The in-service included the reminder that the QI Nurse will also be routinely observing these residents while on an antipsychotic medication change as well and will also be asking Nursing Assistants and Nurses who work with resident if any observed changes in condition or behavior.</p>	



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F 323	<p>Continued From page 48 aggressive.</p> <p>The ADON stated in an interview on 3/26/13 at 10:30 AM that she was the nurse on-call on 3/9/13 and that she received a phone call from the nurse on the Alzheimer ' s Unit on Saturday evening (3/9/13) saying that Resident #5 had hit Resident #4. The ADON stated that she told the nurse to keep them separated and to call back if any further changes. The ADON stated that up to that point she was not aware of Resident #5 ever hitting another resident.</p> <p>On 3/26/13 at 10:55 AM an interview was conducted with Nurse #3 who was working on the Alzheimer ' s Unit on 3/9/13 on the 3PM-11PM shift. The Nurse stated that she was at the nurse ' s station and the NAs were making their rounds. The Nurse stated that a resident came to the nurse ' s station and said that two residents were fighting. The Nurse stated that she went to Resident #5 ' s room and the 2 NAs arrived about the same time. The Nurse stated that Resident #4 was in Resident 5 ' s bed and Resident #5 was standing over Resident #4. The Nurse stated that she noticed that Resident #4 ' s eye was bloodshot and swollen. The Nurse stated that Resident #4 was put in a wheelchair and taken to the nurse ' s station. The Nurse stated that an X-ray was done of Resident #4 ' s eye and the report was faxed back to her around 11:00 PM that there was no fracture.</p> <p>On 3/26/13 at 12:25 PM an interview was conducted with Nurse #4 who worked 11PM-7AM on Saturday night 3/9/13. The Nurse stated that Resident #5 stayed in his room and had no further problems.</p>	F 323	<p>Starting the week of 4-8-13, the QI Nurse will two times a week observe residents who are currently under a antipsychotic medication change and question staff who work with the resident to assess if there are any changes in behaviors or condition related to the change in the medication that have not already been reported by other staff observations utilizing a QI Audit Tool. Any changes in behavior or condition will be assessed and referred to the MD for any further changes needed in medications for the resident. Any changes identified and actions taken by nursing and/or MD will be reported to the Antipsychotic Medication QI Committee on their next review.</p> <p>Directed In-Service Training on antipsychotic medication and behavioral management will be conducted for all nurses on 5-16-2013 by the North Carolina Elderly Psychiatric Services utilizing a curriculum approved by Arizona State.</p>	

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F 323	<p>Continued From page 49</p> <p>On 3/26/13 at 12:45 PM an interview was conducted with the Administrator, Director of Nursing and Facility Consultant #1. The Facility Consultant stated that they had completed a Plan of Correction (POC) after the altercations on the weekend of 3/9-10/13.</p> <p>A review of the POC showed that all administrative staff was inserviced on assuring that interventions were immediately put in place with resident to resident incidents to include one on one when a resident strikes another resident until the appropriate intervention can be determined. The POC did not address interventions to prevent Resident #4 from getting in other resident 's beds and personal space.</p> <p>NA #3 stated in an interview on 4/10/13 at 10:34 AM that Resident #5 was the one you had to supervise. The NA stated Resident #5 would sit in the dining room until staff would tell him to go to the bathroom. The NA stated that when Resident #5 would start getting loud, staff would go to see what was going on. The NA stated that Resident #4 was easily directed.</p> <p>The ADON stated in an interview on 4/10/13 at 10:43 AM that Resident #4 was up and about the facility and Resident #5 stayed in one spot. The ADON stated that on 3/9/13 when the incident occurred between Resident #5 and Resident #4 she told the staff to keep the 2 Residents separated. The ADON stated that this meant for the staff to keep a constant eye on Resident #5 and keep him away from Resident #4. When asked how she intended to protect the other residents the ADON stated that she put an</p>	F 323	<p><u>How the facility will monitor systems put in place:</u></p> <p>The Administrator will review the "Incident Notification Worksheet QI Audit Tools" daily as they are completed to include nights and weekends as incidents occur.</p> <p>The Administrator and/or DON will review the Quality Improvement Incident/Accident Committee QI Audit Tool five times per week to assure all areas are reviewed with appropriate intervention and notifications.</p> <p>The Administrator will review the QI Review of Nurses Notes three times a week for eight weeks starting 3-11-2013 the once per week ongoing thereafter to assure all notes were reviewed and that any areas with identified concerns were handled to meet the individual needs of the resident and situation.</p> <p>The Regional Director and/or Corporate Nurse Consultant will review the "Incident Notification Worksheet QI Audit tools, the Incident/Accident Committee QI Audits tools, and the QI Review of Nurses Notes monthly for six months starting April 2013 then quarterly thereafter to assure the facility is completing and interventions are in place and working to meet residents' needs.</p>	
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F 323	<p>Continued From page 50</p> <p>intervention in place to protect Resident #4 from Resident #5 and at the time was concerned about the situation with these 2 residents.</p> <p>Nurse #3 stated in an interview on 4/10/13 at 2:15 PM that she worked 3PM-11PM on 3/9/13 (Saturday). The Nurse stated that they kept an eye on Resident #5 as much as possible. The Nurse stated that the resident 's tend to gather in the hall near the nurse 's station and one NA sits on the bench and talks with the residents and can observe the hall. The Nurse stated that there were windows around the TV room and the dining room and that the residents in those areas could be observed from the hall. The Nurse stated that Resident #5 had a routine and after eating supper would go outside to smoke and then go to his room. The Nurse stated that she was getting ready to do a medication pass when Resident #5 hit Resident #4. The Nurse stated that Resident #4 was taken to the nurse 's station where he stayed the rest of the night. The Nurse stated that they checked on Resident #5 and Resident #2 who were roommates periodically during the evening and they both stayed in their beds the rest of her shift. The Nurse stated that most of the residents knew to stay out of Resident #5 's way.</p> <p>2. Resident #5 was admitted to the facility on 11/17/03 and had diagnoses of Dementia, Anxiety and Paranoid Schizophrenia.</p> <p>The Annual Minimum Data Set (MDS) Assessment dated 7/18/13 revealed that the Resident had no mood issues or behavioral symptoms during the 7 day assessment period. The MDS revealed that the Resident was on</p>	F 323	<p>The Administrative Nurses and/or Corporate Nurse Consultant will randomly administer written quiz forms with the employees to verify knowledge from the in-service given on resident to resident/abuse and On-Call Incident Management. The quizzes will be completed with staff on all shifts and at varying times of the day to verify continued knowledge of this information. Quizzes on Resident to Resident abuse were started on 3-13-2013 and will continue for six months, and then quarterly ongoing. New employees hired will receive this in-servicing and quiz as a part of their general orientation to the facility.</p> <p>The Quality Improvement Executive Committee which consists of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Quality Improvement Nurse, Minimum Data Set Nurse, Social Workers, Bookkeeper, Activity Director, Dietary Director, Medical Records Director, and Maintenance Director will review the quality improvement audit tools to include the Incident Notification Worksheets, the Reviews of Nurses Notes for unreported incidents, the Incident/Accident Committee Reviews, and the Antipsychotic Medication Committee Meeting Minutes for monitoring, assessment and recommendation of needs to further monitor these systems, and to assure continued compliance in these areas.</p>		

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F 323	<p>Continued From page 51</p> <p>antipsychotic and antidepressant medications and would be addressed in the care plan.</p> <p>A Progress note by the QI (Quality Improvement) Nurse dated 12/27/12 revealed that the Resident was aggressive at times with multiple behavioral issues and that staff continued to redirect the Resident when having behaviors and being aggressive with other residents.</p> <p>A physician 's progress note dated 1/4/12 revealed that Resident #5 had a problem with anger management and that the resident had severe dementia. The note revealed that the resident was not combative as long as he was left alone.</p> <p>A nursing progress note dated 1/3/13 revealed that Resident #5 continued to yell out at residents if they get too close to him.</p> <p>The Resident 's Care Plan updated on 1/4/13 revealed that the Resident had verbal and physical aggression related to anger, cognitive impairment and depression. The interventions included the following: Do not argue or condemn Resident. Document summary of each episode. Note cause and successful interventions, include frequency and duration. Medication/Treatment as prescribed by physician in a timely manner. Monitor and document behavior per facility protocol. Remove Resident from public area when behavior is disruptive and unacceptable. Talk with Resident in a low pitch, calm voice to decrease/eliminate undesired behavior and provide diversional activity. Remove to a quiet area; reassure Resident of personal safety and stay with Resident during periods of anger if</p>	F 323			

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F 323	<p>Continued From page 52</p> <p>appropriate or if Resident wishes. Try not to reason with Resident, as Resident no longer has the ability to think logically. The Care Plan revealed that the Resident received drugs that had the potential to have an altering effect on the mind and had problems that included anxiety, depression and decline in mood and behaviors. Among the interventions were to monitor the Resident ' s mood and behaviors with documentation per facility policy and to notify the physician of any significant changes. The Care Plan revealed no new interventions since the 7/18/12 assessment.</p> <p>A nursing progress note dated 1/9/13 at 10:06 PM revealed that Resident #5 yelled out at other residents at intervals if they were getting too close to him or touching him.</p> <p>A nursing progress note dated 1/10/13 at 3:26 PM revealed that Resident #5 was yelling at another resident for him being in his space and touching him.</p> <p>The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 01/11/13 revealed that Resident #5 was severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 3. The MDS revealed that the Resident had behaviors directed towards others that included threatening others, screaming at others and cursing at others that occurred 1-3 days during the 7 day assessment period.</p> <p>A nursing progress note dated 2/17/13 at 11:31 PM revealed that Resident #5 was standing at the sink in the dining room and Resident #7 was in the dining room in a wheelchair and was fussing</p>	F 323			

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F 323	<p>Continued From page 53</p> <p>at Resident #5 about leaving her stove alone and that this was her house and he needed to leave. The note revealed that Resident #5 it Resident #7 on the side of the face after yelling at her and both residents were redirected and separated. The note revealed that Resident #5 was asked if he hit Resident #7 he said " Yes, that she told me to get out of her house and this is not her house. " The note revealed that the physician and the administrator were made aware.</p> <p>A nursing progress note dated 2/18/13 at 11:35 PM revealed that Resident #5 yelled out several times at residents if they came into his room while he was resting in bed and stated that these residents did not belong in his room.</p> <p>A nursing progress note dated 2/19/13 at 9:46 PM revealed that Resident #5 yelled a few times at other residents being too close to him and that there had been no physical altercations between him with other residents.</p> <p>A nursing progress note dated 2/20/13 revealed that Resident #5 yelled out three times at other residents and when asked why he was yelling stated: " I don ' t want them to touch me. " The note revealed that he yelled at another resident for entering into his room and the resident was removed from the room and reminded that it was not her room.</p> <p>A nursing progress note dated 3/5/13 revealed that the Resident had been very vocal and cussing at other residents and staff.</p> <p>A facility Incident Report dated 03/10/13 at 10:02 PM revealed that Resident #2 was observed to</p>	F 323		

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F 323	<p>Continued From page 54</p> <p>have a laceration on the nose and under the left eye with redness in the left eye. The report revealed that Resident #5 was standing at the foot of the bed who stated that he hit Resident #2 because he was in his bed. The report revealed that Resident #2 was moved to another room.</p> <p>There was a physician ' s order dated 3/11/13 for an eye consultation for Resident #2. A Consultation Report dated 3/11/13 showed subconjunctival hemorrhage of the left eye. The recommendations were cool compresses to the left eye and an antibiotic ointment to the left eye twice a day for 7 days. An X-ray report of the nasal bones for Resident #2 revealed a nondisplaced fracture of the right nasal bone and that the orbital rims were intact.</p> <p>A physician ' s progress note dated 3/13/13 revealed that Resident #2 had a nondisplaced fracture of the nose and ecchymosis of the left eye. The note revealed that the Resident was hit by another resident in the unit and his vision was okay in his left eye even though he did have some conjunctivitis from the trauma.</p> <p>Record review revealed that Resident #2 was admitted to the facility on 1/21/11 with a diagnosis of Senile Dementia and Alzheimer ' s disease. A Quarterly MDS dated 02/08/13 revealed that the Resident ' s Care Plan updated on 12/26/12 showed a potential for trauma due to wandering but did not address the issue of the resident getting in other resident ' s beds. The nursing progress notes for Resident #2 revealed that the Resident was found in a female ' s room in bed fast asleep on 1/22/13, was in and out of other ' s rooms and beds on 1/31/13 and in and out of</p>	F 323			

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F 323	<p>Continued From page 55</p> <p>resident ' s rooms and in and out of resident ' s beds on 2/15/13.</p> <p>On 3/25/13 at 2:52 PM an interview was conducted with Nurse #1 (7AM-3PM) and Nurse #2 (3PM-11PM). The Nurses stated that they were not working on the weekend of the altercation between Resident #5 and Resident #2. Nurse #1 stated that during the evening, Resident #5 would keep to himself and did not like to be touched. The Nurse stated that if anyone was in his room he would holler out for the nurse and they would go to see what was going on. Nurse #1 stated that there were altercations with 2 different residents on the same weekend and Resident #4 had his eye taken out and Resident #2 had a broken nose. The Nurse stated that Resident #2 was likely to get into any resident ' s bed. The Nurse stated that Resident #5 and Resident #2 were roommates.</p> <p>On 3/25/13 at 3:13 PM an interview was conducted with the 2 nursing assistants (NAs) working on 3/9/13 when the altercation occurred between Resident #5 and Resident #2. NA #1 stated that when she came to work on Sunday (3/10/13) at 3:00 PM, Resident #5 was on q (every) 15 minute documentation checks meaning that they had to write down every 15 minutes where he was. NA #1 stated that NA #2 had just checked on him and was leaving the unit to go to the main nurse ' s station to get snacks for the residents. NA #2 stated that as she was leaving to go get the snacks she heard the alarm go off and entered the room and Resident #2 was out of bed and she asked him where he was going but he did not say anything. NA #2 stated that when she left the room, Resident #2 was</p>	F 323			



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F 323	<p>Continued From page 56</p> <p>behind her and she left to go get the snacks. NA #1 stated that she heard yelling and ran to the room and saw Resident #2 in Resident #5 ' s bed bleeding. NA #1 stated that she took Resident #2 to the bench near the nurse ' s station and then put him in the room with Resident #4. NA #1 stated that Resident #2 was confused and wandered around the unit and might get in any resident ' s bed. The NA stated that the staff would get him up and show him his bed.</p> <p>An interview was conducted with the Administrator and the Director of Nursing on 3/25/13 at 4:50 PM. The Administrator stated that on Sunday 3/10/13 the NA heard yelling and when she went into the room she found Resident #2 in Resident #5 ' s bed. The Administrator stated that Resident #5 had hit Resident #2. The Administrator stated that Resident #2 was moved to another room and assessed by the nurse. The Administrator stated that Resident #5 was put on 1 to 1 observation and was seen by the psychiatric nurse on 3/11/13. The Administrator stated that the psychiatric hospital could not take the resident on 3/11/13 but was moved to the psychiatric hospital on 3/12/13. The Administrator stated that Resident #5 remained on 1 on 1 observation until discharged from the facility. The Administrator stated that they got the X-ray report for Resident #2 on 3/12/13 showing a nondisplaced fracture of the nose.</p> <p>The Director of Nursing (DON) stated in an interview on 3/26/13 at 9:54 AM that the girls in the unit know Resident #5 and usually know where he is and that if someone bothers the Resident he would yell and staff would go to see what was going on and re-direct the Resident.</p>	F 323			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345293	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/11/2013
NAME OF PROVIDER OR SUPPLIER  RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		
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F 323	<p>Continued From page 57</p> <p>The QI Nurse stated in an interview on 3/26/13 at 10:04 AM that Resident #5 had always been aggressive but did not hit people on a regular basis. The Nurse stated that it was a known fact that Resident #5 did not like anyone in his personal space and if the person did not move, Resident #5 would become aggressive.</p> <p>On 3/26/13 at 12:25 PM an interview was conducted with Nurse #4 that worked 7PM to 7AM on 03/10/13 when the altercation occurred between Resident #5 and Resident #2. The Nurse stated that Resident #5 was on q15 minute checks. The Nurse stated that Resident #5 yelled at female resident 's that were at his door and she re-directed the resident 's so Resident #5 could go in his room and went back to the nurse 's station. The Nurse stated that she heard yelling and the NA called her to the room. The Nurse stated that she observed Resident #2 in Resident #5 's bed and Resident #5 told her that Resident #2 was in his bed so he hit him. The Nurse stated that Resident #2 was taken down to the bench near the nurse 's station and put him in another room.</p> <p>On 3/26/13 at 12:45 PM an interview was conducted with the Administrator, Director of Nursing and Facility consultant #1. The Facility Consultant stated that they had completed a Plan of Correction (POC) after the altercations on the weekend of 3/9-10/13.</p> <p>A review of the POC showed that all administrative staff was inserviced on assuring that interventions were immediately put in place with resident to resident incidents to include one</p>	F 323			

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F 323	<p>Continued From page 58</p> <p>on one when a resident strikes another resident until the appropriate intervention can be determined. The POC did not address interventions to prevent Resident #2 from getting in other resident ' s beds and personal space.</p> <p>NA #3 stated in an interview on 4/10/13 at 10:34 AM that Resident #5 was the one you had to supervise. The NA stated Resident #5 would sit in the dining room until staff would tell him to go to the bathroom. The NA stated that when Resident #5 would start getting loud, staff would go to see what was going on.</p> <p>The ADON stated in an interview on 4/10/13 at 10:43 AM that Resident #4 was up and about the facility and Resident #5 stayed in one spot. Stated that on 3/9/13 when the incident occurred between Resident #5 and Resident #4 she told the staff to keep the 2 residents separated. The ADON stated that this meant for the staff to keep a constant eye on Resident #5 and keep him away from Resident #4. When asked how she intended to protect the other residents the ADON stated that she put an intervention in place to protect Resident #4 from Resident #5 and at the time was concerned about the situation with these 2 Residents.</p> <p>Nurse #4 stated in an interview on 4/10/13 at 12:13 PM that she worked 7PM-7AM on 3/10/13 (Sunday night). The Nurse stated that at the time of the altercation between Resident #5 and Resident #2 she was at the nurse ' s station. The Nurse stated that one NA was at the desk charting and the other NA had left the unit to go to the main nurse ' s station to get snacks for the residents.</p>	F 323			

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F 323	<p>Continued From page 59</p> <p>NA #2 stated in an interview on 4/10/13 at 1:45 PM that she had to leave the unit to go to the main nurse ' s station to pick up the snacks. The NA stated that on the way she heard an alarm and went into the room and Resident #2 was getting out of his bed that was closest to the door of the room. The NA stated that Resident #5 ' s bed was next to the window and the curtain was pulled and she could not see Resident #5 ' s bed. The NA stated that she did not know where Resident #5 was at that time. The NA stated that she turned off the alarm because Resident #2 was out of bed and he followed her out of the room.</p> <p>The Administrator was notified of the Immediate Jeopardy on 4/10/13 at 2:10 PM. The facility provided a credible allegation of compliance on 04/11/13 at 5:55 PM. The allegation of compliance indicated:</p> <p>What measures the facility put in place for the resident affected:</p> <p>On 3-9-13 Resident #4 was assessed by Nurse #3 and attempt made to notify MD. XRay of eye area was completed on 3/9/13 at 10:30 pm with results of no fractures identified. On 3/11/13 the physician gave an order for the resident to see an eye physician. Resident #4 was seen by an eye physician on 3/11/13, with additional eye physician visits on 3/12/13 with order to start antibiotic therapy and a return visit scheduled for 3/13/13. On 3/14/13 Resident #4 had a procedure to remove the right eye and returned to the facility on 3/15/13.</p>	F 323			

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F 323	<p>Continued From page 60</p> <p>On 3-10-13 Resident #2 was assessed by Nurse #4 and an attempt made to notify the physician. The family was notified on 3-10-13. On 3-10-13 Resident #2 was moved to another room. On 3-11-13 the physician gave an order for Resident #2 to see the eye physician and the resident was seen by eye physician on 3-11-13 with orders for cold compress and antibiotic ointment to be applied. On 3-12-13 the facility obtained X-Ray of resident nasal bones and received X-Ray results on 3-12-13 for Resident #2 showing a non-displaced fracture of nose.</p> <p>The Responsible party was notified by the nurse on 3-9-13 and 3-10-13 of resident 's behaviors. The MD was attempted to be notified by nurse of behavior on 3/9/13 and 3/10/13. On 3-10-13 at 7:00 am Resident #5 was placed on 15 minutes checks. On 3-11-13 first shift Resident #5 was placed on one to one staff monitoring. The Director of Nursing (DON) contacted the psychiatric nurse practitioner on 3-11-13 and psychiatric nurse practitioner arrived same day at 3:45 pm to see resident with recommendation to resume previous dosage of antipsychotic medications. Social Worker contacted outside psychiatric center on 3-11-2013 for potential placement due to resident behavior. On 3-11-2013 at 7:00 pm the outside psychiatric center contacted social worker and verified they would admit Resident #5 on the morning of 3-12-13. One to One staff monitoring continued with Resident #5 until he was discharged from facility. On 3-12-13, Resident #5 was transported to outside psychiatric center for admission and no longer resides at this facility.</p> <p>What measures were put in place for residents</p>	F 323			

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F 323	<p>Continued From page 61</p> <p>having the potential to be affected: On 3-11-13 at 7:00 pm a 100 percent audit was completed by the ADON on all residents residing in the locked dementia unit to check for any signs of injury or suspicious signs of resident to resident abuse. No negative outcomes were identified in this audit.</p> <p>On 3-12-13 the audit was expanded by the floor nurses to the remaining residents residing in the nursing facility as an additional precautionary intervention to check for any signs of injury or resident to resident abuse. No negative outcomes were identified from this audit.</p> <p>The Corporate Nurse Consultants completed a 100 percent audit of resident nurses notes starting on 3-11-13 and completed on 3-12-13 for the time period of documentation from 12-1-2012 to present 3-11-2013, to assure there were no nursing documentation of resident to resident episodes that may not have been previously identified in incident reporting with no negative outcomes identified.</p> <p>On 3-12-13 Corporate Nurse Consultant #1 completed a review of resident to resident altercations from 9-1-12 to 3-11-12 to assure interventions for resident to resident incidents were in place and/or still appropriate with no new concerns identified.</p> <p>On 3-11-13 at 5:45 pm the Regional Director in-serviced the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Improvement Nurse, Minimum Data Set Nurses and Administrative Nurses who take Nurse On Call responsibilities on assuring that interventions</p>	F 323			

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F 323	<p>Continued From page 62</p> <p>are immediately put in place with resident to resident incidents to include one to one staff monitoring when a resident strikes another resident until the situation is assessed further and appropriate interventions are decided to meet the resident ' s individualized needs to include care planning. When unsure about a situation, the Administrator and/or Director of Nursing should contact the Regional Director or Corporate Nurse Consultant for additional advisement. No Administrative Nurses worked until they received this in-servicing.</p> <p>On 3-12-13, the Regional Director in-serviced the Administrator and all Administrative Nurses who take Nurse On Call to include the Director of Nursing, Assistant Director of Nursing, Quality Improvement Nurse, and Minimum Data Set Nurses on " On-Call Incident Management; steps to look at when called about an incident that outlined data to collect about situation including answers to WHO, WHAT, WHEN, WHERE, HOW, and INTERVENTION to be put in place. On 3-15-13 the Administrator expanded the " On-Call Incident Management " in-service to all staff members who rotate weekend Administrative Call Rounds including the Housekeeping Director, Medical Records Director, Social Workers, Business Office staff, Dietary Manager, Activity Director, and Maintenance Director.</p> <p>On 3-11-13 at 7:10 pm the Staff Development Coordinator initiated in-servicing for all facility staff to include nurses, nursing assistant, nursing support staff, dietary staff, housekeeping staff, maintenance staff, activities staff, office staff, and therapy staff on Resident to Resident Abuse to</p>	F 323		

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F 323	<p>Continued From page 63</p> <p>include when episodes are observed that safety is provided immediately, charge nurses are notified immediately for appropriate interventions. No staff was allowed to work until they received this in-service.</p> <p>On 4-10-2013 the MDS nurses completed a 100 percent audit of all residents on antipsychotic medications to assure that the plan of care addresses the use of antipsychotic medication and any current dose reduction or changes. Any areas identified were corrected by updating of the residents ' care plan.</p> <p>On 3-13-2013 to 3-15-2013 the pharmacy consultant completed a drug regimen review of all residents to include residents on psychoactive medications. Any recommendations made regarding possible antipsychotic medications will be reviewed by the Quality Improvement Antipsychotic Medication Committee. The Committee will review each resident medication(s) to include current dosage, whether there are documented behaviors since last review, verification that MD orders are correct, PRN Medications used are properly documented for the need and frequency, diagnosis to support present medications, and recommendations for changes in medications that will be submitted to the Medical Doctor for review as appropriate.</p> <p>What systems were put in place to prevent the deficient practice from reoccurring: On 3-12-2013 a Quality Improvement (QI) worksheet guide was implemented to be used by the Administrator, Director of Nursing, and all Administrative Nurses that rotate Nurse On-Call</p>	F 323			



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F 323	<p>Continued From page 64</p> <p>duties for non-business hours, weekends, and nights to assist in gathering information to make decisions about interventions for incidents to include resident to resident incidents utilizing a " On-Call Incident Management " Worksheet QI Audit Tool. This audit tool will be utilized when calls are received and forwarded to the Administrator for review.</p> <p>On 3-12-2013 the Administrator initiated a Quality Improvement Incident/Accidents Committee starting on 3-12-13 consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Improvement Nurse, Minimum Data Set Nurses, Social Workers, and Therapy staff that will meet five times per week to review all incidents and accidents to assure nurse assessment of situation, intervention put in place, MD notified, RP notified, and Care Plan updated for changes and interventions. This review will be documented on a Quality Improvement Incident/Accident Review Committee QI Audit Tool.</p> <p>Administrative Nurses will review all resident nurse ' s notes three times per week for eight weeks starting week of 3-11-2013 and then once per week ongoing thereafter to assure there are no resident to resident episodes that may have occurred that were not identified by incident reporting.</p> <p>On 4-10-2013 the Staff Development Coordinator initiated in-servicing at 1:17 pm for nurses and nursing assistants regarding monitoring of residents that in the daily monitoring of our residents staff should routinely monitor their whereabouts. If a dementia resident is identified</p>	F 323			

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F 323	<p>Continued From page 65</p> <p>as being in another resident ' s space or bed to redirect the resident to the common care areas of the unit and that if the resident is resistive to the redirection to stay with the resident to assure no resident to resident conflicts occur until the resident is able to be redirected.</p> <p>The facility Quality Improvement Antipsychotic Committee will meet monthly to review all residents that are on antipsychotic medications. The Committee will consist of the Administrator, Director of Nursing, Assistant Director of Nursing, Minimum Data Set Nurses, Quality Improvement Nurses, Social Workers, and Pharmacy Consultant. The Committee will review each resident medication(s) to include current dosage, whether there are documented behaviors since last review, verification that MD orders are correct, PRN Medications used are properly documented for the need and frequency, diagnosis to support present medications, and recommendations for changes in medications that will be submitted to the Medical Doctor. Any recommendations made during the Committee Meeting will be referred to the Attending Physician for acceptance or decline of recommendation. If the physician agrees with the recommendation of change in medication, then the resident will be Care Planned for changes in antipsychotic medications with goal and approaches listed and the QI Nurse and/or the Director of Nursing (DON) will note the change in antipsychotic medication on the Resident Care Guide to prompt staff to watch for any changes in behavior or condition.</p> <p>On 4-10-13, the Staff Development Coordinator and DON initiated in-servicing at 6:15 pm for all</p>	F 323			

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F 323	<p>Continued From page 66</p> <p>nursing assistants and nurses that anytime a resident has a change in antipsychotic medications, the change will be noted on the Resident Care Guide located in each resident 's closet and prompt nursing staff to observe for any changes in behaviors or medical condition. If a Nursing Assistant notices a change in resident behavior or condition they are to notify their nurse immediately. Anytime a Nurse is notified that there is a change in behavior or condition they are to immediately assess the resident, assure resident is safe and other residents are safe related to the behavior, and notify the QI Nurse and/or DON and/or the Nurse On-Call. If situation warrants, notify the MD and RP. The in-service included the reminder that the QI Nurse will also be routinely observing these residents while on an antipsychotic medication change as well and will also be asking Nursing Assistants and Nurses who work with resident if any observed changes in condition or behavior.</p> <p>Starting the week of 4-8-13, the QI Nurse will two times a week observe residents who are currently under a antipsychotic medication change and question staff who work with the resident to assess if there are any changes in behaviors or condition related to the change in the medication that have not already been reported by other staff observations utilizing a QI Audit Tool. Any changes in behavior or condition will be assessed and referred to the MD for any further changes needed in medications for the resident. Any changes identified and actions taken by nursing and/or MD will be reported to the Antipsychotic Medication QI Committee on their next review.</p>	F 323			

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F 323	<p>Continued From page 67</p> <p>How the facility will monitor systems put in place:</p> <p>The Administrator will review the " Incident Notification Worksheet QI Audit Tools " daily as they are completed to include nights and weekends as incidents occur.</p> <p>The Administrator and/or DON will review the Quality Improvement Incident/Accident Committee QI Audit Tool five times per week to assure all areas are reviewed with appropriate intervention and notifications.</p> <p>The Administrator will review the QI Review of Nurses Notes three times a week for eight weeks starting 3-11-2013 the once per week ongoing thereafter to assure all notes were reviewed and that any areas with identified concerns were handled to meet the individual needs of the resident and situation.</p> <p>The Regional Director and/or Corporate Nurse Consultant will review the " Incident Notification Worksheet QI Audit tools, the Incident/Accident Committee QI Audits tools, and the QI Review of Nurses Notes monthly for six months starting April 2013 then quarterly thereafter to assure the facility is completing and interventions are in place and working to meet residents ' needs.</p> <p>The Administrative Nurses and/or Corporate Nurse Consultant will randomly administer written quiz forms with the employees to verify knowledge from the in-service given on resident to resident abuse and On-Call Incident Management. The quizzes will be completed with staff on all shifts and at varying times of the day to verify continued knowledge of this information.</p>	F 323			

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F 323	<p>Continued From page 68</p> <p>Quizzes on Resident to Resident abuse were started on 3-13-2013 and will continue for six months, and then quarterly ongoing. New employees hired will receive this in-servicing and quiz as a part of their general orientation to the facility.</p> <p>The Quality Improvement Executive Committee which consists of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Quality Improvement Nurse, Minimum Data Set Nurse, Social Workers, Bookkeeper, Activity Director, Dietary Director, Medical Records Director, and Maintenance Director will review the quality improvement audit tools to include the Incident Notification Worksheets, the Reviews of Nurses Notes for unreported incidents, the Incident/Accident Committee Reviews, and the Antipsychotic Medication Committee Meeting Minutes for monitoring, assessment and recommendation of needs to further monitor these systems, and to assure continued compliance in these areas.</p> <p>On 4/11/13 at 5:00 PM, the credible allegation was validated after reviewing the audits completed for the locked dementia unit and the rest of the facility and the audits completed by the pharmacy consultant for residents on psychoactive medications. The " On-call Incident Management " form that included the steps to look at when called about an incident that outlined the data to collect about the incident was in place and interviews with the administrative staff and management staff that take call after business hours and on weekends revealed that they had knowledge of the form and how to respond to incidents of resident to resident altercations. A QI</p>	F 323		

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F 323	Continued From page 69 tool to audit incidents and accidents was in place to document each incident and accident to ensure nurse assessment of the situation, interventions put in place, MD and RP notification and updating of the resident ' s care plan. Interviews with nurses and nursing assistants on the locked dementia unit and the general floors revealed that staff had been inserviced on response to resident to resident altercations and were knowledgeable of how to respond to resident to resident altercations. The staff was aware of the changes that would be made to the resident care guides when psychoactive medications were being adjusted and aware that these resident ' s behaviors should be closely monitored and changes in behaviors should be reported immediately.	F 323			
F 329 SS=J	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	F 329	F329  <u>What measures the facility put in place for the resident affected:</u> On 3-9-2013 resident #4 was assessed by nurse and attempt made to notify MD. XRay of eye area was completed on 3-9-13 10:30 pm with results of no fractures identified. On 3-11-13 MD gave order for resident to see eye physician and resident #4 was seen by eye physician on 3-11-13, with additional eye physician visits on 3-12-13 with order to start antibiotic therapy and a return visit scheduled for 3-13-2013. On 3-14-13 resident had procedure to remove right eye and returned to the facility from procedure on 3-15-13.	S-20-13	

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F 329	<p>Continued From page 70</p> <p>behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to identify an increase in behaviors for 1 of 1 sampled resident (Resident #5) after a reduction of the resident 's psychoactive medications resulting in injury to 2 of 2 sampled residents (Resident #4 and Resident #2) that were known to get into other resident 's beds. The Immediate Jeopardy began on 3/9/13 at 8:00 PM and was identified on 04/10/13 at 2:10 PM. The Immediate Jeopardy was removed on 04/11/13 at 5:55 PM when the facility provided a credible allegation of compliance. The facility will remain out of compliance at a scope and severity level D (with potential for more than minimal harm that is not immediate jeopardy) until all of the nursing staff can be in-serviced. The facility will then implement monitoring of its corrective action.</p> <p>The findings include:</p> <p>Resident #5 was admitted to the facility on 11/17/03 and had diagnoses that included Dementia, Anxiety, Depression and Paranoid Schizophrenia.</p> <p>The Annual Minimum Data Set (MDS) Assessment dated 7/18/13 revealed that the Resident had no mood issues or behavioral</p>	F 329	<p>On 3-10-13 resident #2 was assessed by nurse and attempt made to notify MD. Family notified on 3-10-13. On 3-10-13 resident #2 was moved to another room. On 3-11-13 MD gave order for resident to see eye physician and resident was seen by eye physician on 3-11-13 with orders for cold compress and antibiotic ointment to be applied. On 3-12-13 facility obtained X-Ray of resident nasal bones and received X-Ray results on 3-12-13 for resident #2 showing non-displaced fracture of nose.</p> <p>RP was notified by nurse on 3-9-13 and 3-10-13 of resident #5's behaviors. MD was attempted to be notified by nurse of behavior on 3-9-13 and 3-10-13. On 3-10-13 at 7:00 am resident #5 was placed on 15 minutes checks. On 3-11-13 first shift resident #5 was placed on one to one staff monitoring. DON contacted psychiatric nurse practitioner on 3-11-13 and psychiatric nurse practitioner arrived same day at 3:45 pm to see resident with recommendation to resume previous dosage of antipsychotic medications. Social Worker contacted outside psychiatric center on 3-11-2013 for potential placement due to resident #5's behavior. On 3-11-2013 at 7:00 pm the outside psychiatric center contacted social worker and verified they would admit resident #5 on the morning of 3-12-13. One to One staff monitoring continued with resident #5 until he was discharged from facility. On 3-12-13, resident #5 was transported to outside psychiatric center for admission and no longer resides at this facility.</p>		

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F 329	Continued From page 71 symptoms during the 7 day assessment period. The MDS revealed that the Resident was on antipsychotic and antidepressant medications and would be addressed in the care plan.  A progress note by the Quality Improvement (QI) Nurse dated 12/27/12 revealed that Resident #5 was aggressive at times with multiple behavioral issues and that staff continued to redirect the resident when having behaviors and was aggressive with other residents.  The resident ' s Care Plan updated on 1/4/13 revealed that the resident had verbal and physical aggression related to anger, cognitive impairment and depression. The interventions included the following: Do not argue or condemn Resident. Document summary of each episode. Note cause and successful interventions, include frequency and duration. Medication/Treatment as prescribed by physician in a timely manner. Monitor and document behavior per facility protocol. Remove Resident from public area when behavior is disruptive and unacceptable. Talk with Resident in a low pitch, calm voice to decrease/eliminate undesired behavior and provide diversional activity. Remove to a quiet area; reassure Resident of personal safety and stay with Resident during periods of anger if appropriate or if Resident wishes. Try not to reason with Resident, as Resident no longer has the ability to think logically. The Resident ' s Care Plan showed that the Resident had feelings of sadness, emptiness, anxiety, uneasiness and depression characterized by ineffective copying, low self esteem, tearfulness, motor agitation, withdrawal from care/activities related to brain deterioration. Among the interventions were as	F 329	<u>What measures were put in place for residents having the potential to be affected:</u> On 3-11-13 at 7:00 pm a 100 percent audit was completed by the ADON on all residents residing in the locked dementia unit to check for any signs of injury or suspicious signs of resident to resident abuse. No negative outcomes were identified in this audit.  On 3-12-13 the audit was expanded by the floor nurses to the remaining residents residing in the nursing facility as an additional precautionary intervention to check for any signs of injury or resident to resident abuse. No negative outcomes were identified from this audit.  The Corporate Nurse Consultants completed a 100 percent audit of resident nurses notes starting on 3-11-13 and completed on 3-12-13 for the time period of documentation from 12-1-2012 to present 3-11-2013, to assure there were no nursing documentation of resident to resident episodes that may not have been previously identified in incident reporting with no negative outcomes identified.  On 3-12-13, the Corporate Nurse Consultant (PG) completed a review of resident to resident altercations from 9-1-12 to 3-11-12 to assure interventions for resident to resident incidents were in place and/or still appropriate with no new concerns identified.	S:20-13	



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F 329	<p>Continued From page 72</p> <p>follows: Monitor mental status/mood state changes when new medication is added and notify physician of any significant changes. Observe and report any changes in mental status, mood or behaviors and notify physician of significant changes as necessary. The Care Plan revealed that the Resident was using drugs that had an altering effect of the mind with the potential for side effects including a decline in mood and behaviors. The interventions included to monitor the Resident ' s mood and behaviors with documentation per facility policy and to notify the physician of any significant changes.</p> <p>A physician ' s progress note dated 1/2/13 revealed that Resident #5 was okay as long as everybody left him alone. The note revealed that the resident was very protective of his space and did not like anyone to crowd his space.</p> <p>A nursing progress note dated 1/9/13 at 10:06 PM revealed that Resident #5 yelled out at other residents at intervals if they were getting too close to him or touching him.</p> <p>A nursing progress note dated 1/10/13 at 3:26 PM revealed that Resident #5 was yelling at another resident for being in his space and touching him.</p> <p>A nursing progress note dated 1/10/13 at 11:39 PM revealed that Resident #5 was yelling out at other residents walking close to him.</p> <p>The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 01/11/13 revealed that Resident #5 was severely cognitively impaired with a Brief Interview for Mental Status</p>	F 329	<p>On 3-11-13 at 5:45 pm the Regional Director in-serviced the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Improvement Nurse, Minimum Data Set Nurses and Administrative Nurses who take Nurse On Call responsibilities on assuring that interventions are immediately put in place with resident to resident incidents to include one to one staff monitoring when a resident strikes another resident until the situation is assessed further and appropriate interventions are decided to meet the resident's individualized needs to include care planning. When unsure about a situation, the Administrator and/or Director of Nursing should contact the Regional Director or Corporate Nurse Consultant for additional advisement. No Administrative Nurses worked until they received this in-servicing.</p> <p>On 3-12-13, the Regional Director in-serviced the Administrator and all Administrative Nurses who take Nurse On Call to include the Director of Nursing, Assistant Director of Nursing, Quality Improvement Nurse, and Minimum Data Set Nurses on "On-Call Incident Management; steps to look at when called about an incident that outlined data to collect about situation including answers to WHO, WHAT, WHEN, WHERE, HOW, and INTERVENTION to be put in place. On 3-15-13 the Administrator expanded the "On-Call Incident Management" in-service to all staff members who rotate weekend Administrative Call Rounds including the</p>		

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F 329	<p>Continued From page 73</p> <p>(BIMS) score of 3. The MDS revealed that the Resident had behaviors directed towards others that included threatening others, screaming at others and cursing at others that occurred 1-3 days during the 7 day assessment period.</p> <p>A review of the Medication Administration Record (MAR) for February 2013 revealed that the Resident received Buspar 300 milligrams (mg) daily, Ativan 1mg every morning, Remeron 15mg every night at bedtime and Zyprexa 5mg every night at bedtime. Buspar is a non-benzodiazepine medication used to treat generalized anxiety. Ativan is a benzodiazepine medication used to treat anxiety. Remeron is a medication used to treat depression and Zyprexa is an antipsychotic medication used in the treatment of Schizophrenia.</p> <p>A review of the physician ' s orders revealed an order dated 2/7/13 for the following: Decrease Buspar to 200mg every day. Decrease Ativan to 0.5mg every day. Decrease Remeron to 7.5mg every day and decrease Zyprexa to 2.5mg every night at bedtime. A review of the MAR showed that Buspar 300mg was given on the morning of 2/7/13 and the dose reduced on 2/8/13. The other medications were given at the reduced dosage beginning 2/7/13.</p> <p>An incident report dated 2/17/13 at 4:20 PM revealed that Resident #5 and Resident #7 were in the dining room. The report revealed that Nurse #2 responded when she heard yelling and Resident #7 stated that Resident #5 had hit her on the left side of her face. The report revealed that no visible injuries were noted. A nursing progress note dated 2/17/13 at 11:31PM (late</p>	F 329	<p>Housekeeping Director, Medical Records Director, Social Workers, Business Office staff, Dietary Manager, Activity Director, and Maintenance Director.</p> <p>On 3-11-13 at 7:10 pm the Staff Development Coordinator initiated in-servicing for all facility staff to include nurses, nursing assistant, nursing support staff, dietary staff, housekeeping staff, maintenance staff, activities staff, office staff, and therapy staff on Resident to Resident Abuse to include when episodes are observed that safety is provided immediately, charge nurses are notified immediately for appropriate interventions. No staff was allowed to work until they received this in-service.</p> <p>On 4-3-13 the MDS Nurses started a 100 percent review of all Care Plans to assure individualization of the plan of care was completed for each resident to include behaviors of residents.</p> <p>On 4-10-2013 the MDS nurses completed a 100 percent audit of all residents on antipsychotic medications to assure that the plan of care addresses the use of antipsychotic medication and any current dose reduction or changes. Any areas identified were corrected by updating of the residents' care plan.</p> <p>On 3-13-2013 to 3-15-2013 the pharmacy consultant completed a drug regimen review of all residents to include residents on psychoactive medications. Any recommendations made regarding possible antipsychotic medications will be reviewed</p>		

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F 329	<p>Continued From page 74</p> <p>entry) revealed that Resident #5 was standing at the sink in the dining room and Resident #7 was in the dining room in a wheelchair. The note revealed that Resident #5 hit Resident #7 on the right side of the face. The note revealed that Resident #5 was asked if he hit Resident #7 and Resident #5 stated that he did because Resident #7 was fussing at him about standing at the sink and that it belonged to her and he hit her. Under " Other info " revealed that Resident #5 had a history of yelling at other residents, did not want anyone around him and did not want to be told what to do by another resident. A nursing progress note for Resident #7 revealed that a nursing assessment revealed no visible injuries and that the Administrator was made aware and that the physician and responsible parties for both residents was notified.</p> <p>A nursing progress note dated 2/18/13 at 11:35 PM revealed that Resident #5 yelled out several times during the evening at residents if they came into his room while he was resting in bed. The note revealed that when asked why he was yelling so loud he replied that they did not belong in his room.</p> <p>A nursing progress note dated 2/19/13 at 9:46 PM revealed that Resident #5 yelled a few times at other resident ' s being too close to him.</p> <p>A nursing progress note dated 2/20/13 at 9:42 PM revealed that Resident #5 yelled out three times this evening at other residents. When asked why he was yelling he stated: " I don ' t want them to touch me. " The note revealed that Resident #5 yelled at Resident #7 for entering his room.</p>	F 329	<p>by the Quality Improvement Antipsychotic Medication Committee. The Committee will review each resident medication(s) to include current dosage, whether there are documented behaviors since last review, verification that MD orders are correct, PRN Medications used are properly documented for the need and frequency, diagnosis to support present medications, and recommendations for changes in medications that will be submitted to the Medical Doctor for review as appropriate.</p> <p><u>What systems were put in place to prevent the deficient practice from reoccurring:</u> On 3-12-2013 a QI worksheet guide was implemented to be used by the Administrator, Director of Nursing, and all Administrative Nurses that rotate Nurse On-Call duties for non-business hours, weekends, and nights to assist in gathering information to make decisions about interventions for incidents to include resident to resident incidents utilizing a "On-Call Incident Management" Worksheet QI Audit Tool. This audit tool will be utilized when calls are received and forwarded to the Administrator for review.</p> <p>On 3-12-2013 the Administrator initiated a Quality Improvement Incident/Accidents Committee starting on 3-12-13 consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Improvement Nurse, Minimum Data Set Nurses, Social Workers, and Therapy staff</p>		

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F 329	Continued From page 75  A nursing progress note dated 3/3/13 at 7:59 AM revealed that Resident #5 was yelling and trying to hit at the nursing assistants when they went in the room to provide care for his roommate.  A nursing progress note dated 3/5/13 at 9:34 PM revealed that Resident #5 had been very vocal and cursing at other residents and staff.  A review of the behavior monitoring documentation for Resident #5 revealed that from 1/1/13 to 2/8/13 (psychoactive medications reduced on 2/7/13), 20 episodes of yelling/screaming were documented. There were no other behaviors documented on the behavior monitoring sheets during that time. The monitoring sheets revealed that from 2/9/13 to 3/8/13 there were 22 episodes of yelling/screaming, one episode of agitation without harm to self or others, one clear threat of violence towards others, three episodes of hitting (the incident on 2/27/13 when Resident #5 hit Resident #7 was not documented on the behavior monitoring sheet), and one episode of swinging at others.  An incident report for Resident #4 revealed that on 3/9/13 Nurse #3 was called to Resident 5's room at 8:00 PM due to two residents fighting. The report revealed that Resident #5 was standing over Resident #4 with a clenched fist and stated: " I told him to leave me alone and get out of my bed. " The report revealed that Resident #4 had swelling and redness of the right eye and that an X-ray was done that showed no fracture.	F 329	that will meet five times per week to review all incidents and accidents to assure nurse assessment of situation, intervention put in place, MD notified, RP notified, and Care Plan updated for changes and interventions. This review will be documented on a Quality Improvement Incident/Accident Review Committee QI Audit Tool.  Administrative Nurses will review all resident nurses notes three times per week for eight weeks starting week of 3-11-2013 and then once per week ongoing thereafter to assure there are no resident to resident episodes that may have occurred that were not identified by incident reporting.  On 4-10-2013 the Staff Development Coordinator initiated in-servicing at 1:17 pm for nurses and nursing assistants regarding monitoring of residents that in the daily monitoring of our residents staff should routinely monitor their whereabouts. If a dementia resident is identified as being in another resident's space or bed to redirect the resident to the common care areas of the unit and that if the resident is resistive to the redirection to stay with the resident to assure no resident to resident conflicts occur until the resident is able to be redirected.		

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F 329	<p>Continued From page 76</p> <p>A review of the nursing progress notes for Resident #4 revealed that the resident was seen by an eye doctor on 3/11/13 and a consultation report dated 3/14/13 revealed that Resident #4 had a ruptured globe, had a blind, painful eye and the right eye was removed on 3/14/13.</p> <p>An incident report for Resident #2 dated 3/10/13 at 11:02 PM revealed that Nurse #4 observed Resident #2 to have a laceration on his nose and under the left eye with redness of the left eye. The report revealed that Resident #5 said he hit Resident #2 for being in his bed. An eye consult dated 3/11/13 revealed that Resident #2 had subconjunctival hemorrhage of the left eye related to trauma and an antibiotic ointment for the eye was ordered.</p> <p>There was a physician ' s order for Resident #2 dated 3/12/13 for X-rays of the nasal bones to rule out a fracture. The X-ray report for Resident #2 dated 3/12/13 revealed a nondisplaced fracture of the right nasal bone.</p> <p>A physician ' s progress note for Resident #2 dated 3/12/13 revealed that the resident had a nondisplaced fracture of the nose and ecchymosis of the left eye. The note revealed that Resident #2 was hit by another resident on the unit and had some conjunctivitis from the injury.</p> <p>Nurse #1 stated in an interview on 3/25/13 at 2:52 PM that after Resident #5 ' s medications were reduced the resident would say that he stayed up all night cleaning. The Nurse stated that Resident #5 was easier to redirect prior to the reduction in his medications and that his aggressive behaviors were worse after reducing his meds. The Nurse</p>	F 329	<p>The facility Quality Improvement Antipsychotic Committee will meet monthly to review all residents that are on antipsychotic medications. The Committee will consist of the Administrator, Director of Nursing, Assistant Director of Nursing, Minimum Data Set Nurses, Quality Improvement Nurses, Social Workers, and Pharmacy Consultant. The Committee will review each resident medication(s) to include current dosage, whether there are documented behaviors since last review, verification that MD orders are correct, PRN Medications used are properly documented for the need and frequency, diagnosis to support present medications, and recommendations for changes in medications that will be submitted to the Medical Doctor. Any recommendations made during the Committee Meeting will be referred to the Attending Physician for acceptance or decline of recommendation. If the physician agrees with the recommendation of change in medication, then the resident will be Care Planned for changes in antipsychotic medications with goal and approaches listed and the QI Nurse and/or DON will note the change in antipsychotic medication on the Resident Care Guide to prompt staff to watch for any changes in behavior or condition.</p> <p>On 4-10-13, the Staff Development Coordinator and DON initiated in-servicing at 6:15 pm for all nursing assistants and nurses that anytime a resident has a change</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345293	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/11/2013
NAME OF PROVIDER OR SUPPLIER  RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28346		
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F 329	<p>Continued From page 77</p> <p>stated that Resident #5 would usually call the nurse if someone was in his space but it was not like him to just hit someone.</p> <p>Nurse #1 stated in an interview on 3/26/13 at 9:40 AM that the nurses document behaviors in the progress notes and the nursing assistants address behaviors in their documentation in the computer. The Nurse stated that the nurses can also document behaviors in the computer. The Nurse stated that she did not monitor the behavior documentation because the information was reviewed by administration.</p> <p>The Director of Nursing (DON) stated in an interview on 3/26/13 at 9:54 AM that after a dose reduction of a resident ' s psychoactive medications, the Antipsychotic Medication Committee monitored the resident ' s behaviors by talking with the nurses.</p> <p>The Quality Improvement (QI) Nurse stated in an interview on 3/26/13 at 10:04 AM that the nurses document any resident behaviors in the nurse ' s notes and the nursing assistants document behaviors in the computer. The QI Nurse stated that the system will flag a change in condition that had occurred in the past 24 hours. The Nurse stated that nothing unusual happened with Resident #5 after his medications were changed. The Nurse stated that Resident #5 had always been aggressive but did not hit people on a regular basis. The QI Nurse stated that Resident #7 had delusions and Resident #5 admitted that he hit Resident #7. The QI Nurse stated that it was a known fact that Resident #5 did not like anyone in his personal space and if the person did not move, Resident #5 would become</p>	F 329	<p>in antipsychotic medications, the change will be noted on the Resident Care Guide located in each resident's closet and prompt nursing staff to observe for any changes in behaviors or medical condition. If a Nursing Assistant notices a change in resident behavior or condition they are to notify their nurse immediately. Anytime a Nurse is notified that there is a change in behavior or condition they are to immediately assess the resident, assure resident is safe and other residents are safe related to the behavior, and notify the QI Nurse and/or DON and/or the Nurse On-Call. If situation warrants, notify the MD and RP. The in-service included the reminder that the QI Nurse will also be routinely observing these residents while on an antipsychotic medication change as well and will also be asking Nursing Assistants and Nurses who work with resident if any observed changes in condition or behavior.</p> <p>Starting the week of 4-8-13, the QI Nurse will two times a week observe residents who are currently under a antipsychotic medication change and question staff who work with the resident to assess if there are any changes in behaviors or condition related to the change in the medication that have not already been reported by other staff observations utilizing a QI Audit Tool. Any changes in behavior or condition will be assessed and referred to the MD for any further changes needed in medications for the resident. Any changes identified and actions taken by nursing and/or MD will be reported to the Antipsychotic Medication QI Committee on their next review.</p>		

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F 329	<p>Continued From page 78</p> <p>aggressive. The QI Nurse stated that Resident #5 ' s behaviors did not change after his dose reduction. The QI Nurse stated that the staff was being educated regarding the documentation of behaviors during this time and that all residents with behaviors showed an increase in documentation of behaviors.</p> <p>The DON stated in an interview on 3/26/13 at 1:03 PM that in the morning meetings on Monday through Friday they review the 24 hour reports for any changes in a resident ' s behaviors. The DON stated that the administrative staff reviewed the nurse ' s notes for changes in behaviors and the QI Nurse and the Assistant Director of Nursing reviewed the documentation by the nursing assistants for behavior monitoring in the computer system. The DON was observed to review the behavior monitoring sheets for January 1, 2013 through March 8, 2013 and stated that there was a slight change in Resident #5 ' s behaviors after his psychoactive medications were reduced.</p> <p>On 4/10/13 at 10:00 AM Nurse #1 stated in an interview that Resident #5 and Resident #2 were roommates. The Nurse stated that prior to the reduction in his psychoactive medications, Resident #5 would yell for Resident #2 to get out of his bed and staff would go down and get Resident #2 out of Resident #5 ' s bed. The Nurse stated Resident #5 never hit anyone for being in his bed until after his medications were reduced.</p> <p>An interview was conducted with the Administrator, DON and the QI Nurse on 4/10/13 at 11:15 AM. The QI Nurse stated that he did not</p>	F 329	<p>Directed In-Service Training on antipsychotic medication and behavioral management will be conducted for all nurses on 5-16-2013 by the North Carolina Elderly Psychiatric Services utilizing a curriculum approved by Arizona State.</p> <p><u>How the facility will monitor systems put in place:</u></p> <p>The Administrator will review the "Incident Notification Worksheet QI Audit Tools" daily as they are completed to include nights and weekends as incidents occur.</p> <p>The Administrator and/or DON will review the Quality Improvement Incident/Accident Committee QI Audit Tool five times per week to assure all areas are reviewed with appropriate intervention and notifications.</p> <p>The Administrator will review the QI Review of Nurses Notes three times a week for eight weeks starting 3-11-2013 the once per week ongoing thereafter to assure all notes were reviewed and that any areas with identified concerns were handled to meet the individual needs of the resident and situation.</p>		

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F 329	<p>Continued From page 79</p> <p>see any documented changes in Resident #5 ' s behaviors. The Nurse stated that the computer system flags if there is a behavior change in a 24 hour period. Stated that he would be looking for extreme behaviors that had not occurred before; something that would indicate a change in condition that he would need to follow up on. The Nurse stated that he did not usually print out the behavior monitoring sheets to look at the behaviors. The Nurse was observed to review a print out of the behaviors for Resident #5 from January 1, 2013 to March 8, 2013. The Nurse stated that there was a slight increase in the resident ' s behaviors but did not see any difference in his behaviors that were alarming or that would indicate that the resident would do what he did on March 9 and 10, 2013 (hit Resident #4 and Resident #2). The Nurse stated that if anything needed to be done about Resident #5 ' s behaviors the staff would have come to them and told them and it would have been addressed.</p> <p>The Administrator was notified of the Immediate Jeopardy on 4/10/13 at 2:10 PM. The facility provided a credible allegation of compliance on 04/11/13 at 5:55 PM. The allegation of compliance indicated:</p> <p>What measures the facility put in place for the resident affected:</p> <p>On 3-9-13 Resident #4 was assessed by Nurse #3 and attempt made to notify MD. XRay of eye area was completed on 3/9/13 at 10:30 pm with results of no fractures identified. On 3/11/13 the physician gave an order for the resident to see an eye physician. Resident #4 was seen by an eye</p>	F 329	<p>The Regional Director and/or Corporate Nurse Consultant will review the "Incident Notification Worksheet QI Audit tools, the Incident/Accident Committee QI Audits tools, and the QI Review of Nurses Notes monthly for six months starting April 2013 then quarterly thereafter to assure the facility is completing and interventions are in place and working to meet residents' needs.</p> <p>The Administrative Nurses and/or Corporate Nurse Consultant will randomly administer written quiz forms with the employees to verify knowledge from the in-service given on resident to resident abuse and On-Call Incident Management. The quizzes will be completed with staff on all shifts and at varying times of the day to verify continued knowledge of this information. Quizzes on Resident to Resident abuse were started on 3-13-2013 and will continue for six months, and then quarterly ongoing. New employees hired will receive this in-servicing and quiz as a part of their general orientation to the facility.</p>		



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F 329	<p>Continued From page 80</p> <p>physician on 3/11/13, with additional eye physician visits on 3/12/13 with order to start antibiotic therapy and a return visit scheduled for 3/13/13. On 3/14/13 Resident #4 had a procedure to remove the right eye and returned to the facility on 3/15/13.</p> <p>On 3-10-13 Resident #2 was assessed by Nurse #4 and an attempt made to notify the physician. The family was notified on 3-10-13. On 3-10-13 Resident #2 was moved to another room. On 3-11-13 the physician gave an order for Resident #2 to see the eye physician and the resident was seen by eye physician on 3-11-13 with orders for cold compress and antibiotic ointment to be applied. On 3-12-13 the facility obtained X-Ray of resident nasal bones and received X-Ray results on 3-12-13 for Resident #2 showing a non-displaced fracture of nose.</p> <p>The Responsible party was notified by the nurse on 3-9-13 and 3-10-13 of resident 's behaviors. The MD was attempted to be notified by nurse of behavior on 3/9/13 and 3/10/13. On 3-10-13 at 7:00 am Resident #5 was placed on 15 minutes checks. On 3-11-13 first shift Resident #5 was placed on one to one staff monitoring. The Director of Nursing (DON) contacted the psychiatric nurse practitioner on 3-11-13 and psychiatric nurse practitioner arrived same day at 3:45 pm to see resident with recommendation to resume previous dosage of antipsychotic medications. Social Worker contacted outside psychiatric center on 3-11-2013 for potential placement due to resident behavior. On 3-11-2013 at 7:00 pm the outside psychiatric center contacted social worker and verified they would admit Resident #5 on the morning of</p>	F 329	<p>The Quality Improvement Executive Committee which consists of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Quality Improvement Nurse, Minimum Data Set Nurse, Social Workers, Bookkeeper, Activity Director, Dietary Director, Medical Records Director, and Maintenance Director will review the quality improvement audit tools to include the Incident Notification Worksheets, the Reviews of Nurses Notes for unreported incidents, the Incident/Accident Committee Reviews, and the Antipsychotic Medication Committee Meeting Minutes for monitoring, assessment and recommendation of needs to further monitor these systems, and to assure continued compliance in these areas.</p>	
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F 329	<p>Continued From page 81</p> <p>3-12-13. One to One staff monitoring continued with Resident #5 until he was discharged from facility. On 3-12-13, Resident #5 was transported to outside psychiatric center for admission and no longer resides at this facility.</p> <p>What measures were put in place for residents having the potential to be affected: On 3-11-13 at 7:00 pm a 100 percent audit was completed by the ADON on all residents residing in the locked dementia unit to check for any signs of injury or suspicious signs of resident to resident abuse. No negative outcomes were identified in this audit.</p> <p>On 3-12-13 the audit was expanded by the floor nurses to the remaining residents residing in the nursing facility as an additional precautionary intervention to check for any signs of injury or resident to resident abuse. No negative outcomes were identified from this audit.</p> <p>The Corporate Nurse Consultants completed a 100 percent audit of resident nurses notes starting on 3-11-13 and completed on 3-12-13 for the time period of documentation from 12-1-2012 to present 3-11-2013, to assure there were no nursing documentation of resident to resident episodes that may not have been previously identified in incident reporting with no negative outcomes identified.</p> <p>On 3-12-13, the Corporate Nurse Consultant (PG) completed a review of resident to resident altercations from 9-1-12 to 3-11-12 to assure interventions for resident to resident incidents were in place and/or still appropriate with no new concerns identified.</p>	F 329			

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F 329	Continued From page 82  On 3-11-13 at 5:45 pm the Regional Director in-serviced the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Improvement Nurse, Minimum Data Set Nurses and Administrative Nurses who take Nurse On Call responsibilities on assuring that interventions are immediately put in place with resident to resident incidents to include one to one staff monitoring when a resident strikes another resident until the situation is assessed further and appropriate interventions are decided to meet the resident ' s individualized needs to include care planning. When unsure about a situation, the Administrator and/or Director of Nursing should contact the Regional Director or Corporate Nurse Consultant for additional advisement. No Administrative Nurses worked until they received this in-servicing.  On 3-12-13, the Regional Director in-serviced the Administrator and all Administrative Nurses who take Nurse On Call to include the Director of Nursing, Assistant Director of Nursing, Quality Improvement Nurse, and Minimum Data Set Nurses on " On-Call Incident Management; steps to look at when called about an incident that outlined data to collect about situation including answers to WHO, WHAT, WHEN, WHERE, HOW, and INTERVENTION to be put in place. On 3-15-13 the Administrator expanded the " On-Call Incident Management " in-service to all staff members who rotate weekend Administrative Call Rounds including the Housekeeping Director, Medical Records Director, Social Workers, Business Office staff, Dietary Manager, Activity Director, and Maintenance Director.	F 329			

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F 329	<p>Continued From page 83</p> <p>On 3-11-13 at 7:10 pm the Staff Development Coordinator initiated in-servicing for all facility staff to include nurses, nursing assistant, nursing support staff, dietary staff, housekeeping staff, maintenance staff, activities staff, office staff, and therapy staff on Resident to Resident Abuse to include when episodes are observed that safety is provided immediately, charge nurses are notified immediately for appropriate interventions. No staff was allowed to work until they received this in-service.</p> <p>On 4-3-13 the MDS Nurses started a 100 percent review of all Care Plans to assure individualization of the plan of care was completed for each resident to include behaviors of residents.</p> <p>On 4-10-2013 the MDS nurses completed a 100 percent audit of all residents on antipsychotic medications to assure that the plan of care addresses the use of antipsychotic medication and any current dose reduction or changes. Any areas identified were corrected by updating of the residents ' care plan.</p> <p>On 3-13-2013 to 3-15-2013 the pharmacy consultant completed a drug regimen review of all residents to include residents on psychoactive medications. Any recommendations made regarding possible antipsychotic medications will be reviewed by the Quality Improvement Antipsychotic Medication Committee. The Committee will review each resident medication(s) to include current dosage, whether there are documented behaviors since last review, verification that MD orders are correct,</p>	F 329			

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F 329	<p>Continued From page 84</p> <p>PRN Medications used are properly documented for the need and frequency, diagnosis to support present medications, and recommendations for changes in medications that will be submitted to the Medical Doctor for review as appropriate.</p> <p>What systems were put in place to prevent the deficient practice from reoccurring: On 3-12-2013 a QI worksheet guide was implemented to be used by the Administrator, Director of Nursing, and all Administrative Nurses that rotate Nurse On-Call duties for non-business hours, weekends, and nights to assist in gathering information to make decisions about interventions for incidents to include resident to resident incidents utilizing a " On-Call Incident Management " Worksheet QI Audit Tool. This audit tool will be utilized when calls are received and forwarded to the Administrator for review.</p> <p>On 3-12-2013 the Administrator initiated a Quality Improvement Incident/Accidents Committee starting on 3-12-13 consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Improvement Nurse, Minimum Data Set Nurses, Social Workers, and Therapy staff that will meet five times per week to review all incidents and accidents to assure nurse assessment of situation, intervention put in place, MD notified, RP notified, and Care Plan updated for changes and interventions. This review will be documented on a Quality Improvement Incident/Accident Review Committee QI Audit Tool.</p> <p>Administrative Nurses will review all resident nurses notes three times per week for eight</p>	F 329			

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F 329	<p>Continued From page 85</p> <p>weeks starting week of 3-11-2013 and then once per week ongoing thereafter to assure there are no resident to resident episodes that may have occurred that were not identified by incident reporting.</p> <p>On 4-10-2013 the Staff Development Coordinator initiated in-servicing at 1:17 pm for nurses and nursing assistants regarding monitoring of residents that in the daily monitoring of our residents staff should routinely monitor their whereabouts. If a dementia resident is identified as being in another resident ' s space or bed to redirect the resident to the common care areas of the unit and that if the resident is resistive to the redirection to stay with the resident to assure no resident to resident conflicts occur until the resident is able to be redirected.</p> <p>The facility Quality Improvement Antipsychotic Committee will meet monthly to review all residents that are on antipsychotic medications. The Committee will consist of the Administrator, Director of Nursing, Assistant Director of Nursing, Minimum Data Set Nurses, Quality Improvement Nurses, Social Workers, and Pharmacy Consultant. The Committee will review each resident medication(s) to include current dosage, whether there are documented behaviors since last review, verification that MD orders are correct, PRN Medications used are properly documented for the need and frequency, diagnosis to support present medications, and recommendations for changes in medications that will be submitted to the Medical Doctor. Any recommendations made during the Committee Meeting will be referred to the Attending Physician for acceptance or decline of</p>	F 329			

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F 329	<p>Continued From page 86</p> <p>recommendation. If the physician agrees with the recommendation of change in medication, then the resident will be Care Planned for changes in antipsychotic medications with goal and approaches listed and the QI Nurse and/or DON will note the change in antipsychotic medication on the Resident Care Guide to prompt staff to watch for any changes in behavior or condition.</p> <p>On 4-10-13, the Staff Development Coordinator and DON initiated in-servicing at 6:15 pm for all nursing assistants and nurses that anytime a resident has a change in antipsychotic medications, the change will be noted on the Resident Care Guide located in each resident ' s closet and prompt nursing staff to observe for any changes in behaviors or medical condition. If a Nursing Assistant notices a change in resident behavior or condition they are to notify their nurse immediately. Anytime a Nurse is notified that there is a change in behavior or condition they are to immediately assess the resident, assure resident is safe and other residents are safe related to the behavior, and notify the QI Nurse and/or DON and/or the Nurse On-Call. If situation warrants, notify the MD and RP. The in-service included the reminder that the QI Nurse will also be routinely observing these residents while on an antipsychotic medication change as well and will also be asking Nursing Assistants and Nurses who work with resident if any observed changes in condition or behavior.</p> <p>Starting the week of 4-8-13, the QI Nurse will two times a week observe residents who are currently under a antipsychotic medication change and question staff who work with the resident to assess if there are any changes in behaviors or</p>	F 329			

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F 329	<p>Continued From page 87</p> <p>condition related to the change in the medication that have not already been reported by other staff observations utilizing a QI Audit Tool. Any changes in behavior or condition will be assessed and referred to the MD for any further changes needed in medications for the resident. Any changes identified and actions taken by nursing and/or MD will be reported to the Antipsychotic Medication QI Committee on their next review.</p> <p>How the facility will monitor systems put in place:</p> <p>The Administrator will review the " Incident Notification Worksheet QI Audit Tools " daily as they are completed to include nights and weekends as incidents occur.</p> <p>The Administrator and/or DON will review the Quality Improvement Incident/Accident Committee QI Audit Tool five times per week to assure all areas are reviewed with appropriate intervention and notifications.</p> <p>The Administrator will review the QI Review of Nurses Notes three times a week for eight weeks starting 3-11-2013 the once per week ongoing thereafter to assure all notes were reviewed and that any areas with identified concerns were handled to meet the individual needs of the resident and situation.</p> <p>The Regional Director and/or Corporate Nurse Consultant will review the " Incident Notification Worksheet QI Audit tools, the Incident/Accident Committee QI Audits tools, and the QI Review of Nurses Notes monthly for six months starting April 2013 then quarterly thereafter to assure the</p>	F 329			



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F 329	<p>Continued From page 88</p> <p>facility is completing and interventions are in place and working to meet residents ' needs.</p> <p>The Administrative Nurses and/or Corporate Nurse Consultant will randomly administer written quiz forms with the employees to verify knowledge from the in-service given on resident to resident abuse and On-Call Incident Management. The quizzes will be completed with staff on all shifts and at varying times of the day to verify continued knowledge of this information. Quizzes on Resident to Resident abuse were started on 3-13-2013 and will continue for six months, and then quarterly ongoing. New employees hired will receive this in-servicing and quiz as a part of their general orientation to the facility.</p> <p>The Quality Improvement Executive Committee which consists of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Quality Improvement Nurse, Minimum Data Set Nurse, Social Workers, Bookkeeper, Activity Director, Dietary Director, Medical Records Director, and Maintenance Director will review the quality improvement audit tools to include the Incident Notification Worksheets, the Reviews of Nurses Notes for unreported incidents, the Incident/Accident Committee Reviews, and the Antipsychotic Medication Committee Meeting Minutes for monitoring, assessment and recommendation of needs to further monitor these systems, and to assure continued compliance in these areas.</p> <p>On 4/11/13 at 5:00 PM the credible allegation was validated by reviewing the audits conducted on the dementia unit and the general floors for signs</p>	F 329			

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F 329	Continued From page 89 of injury or other signs of resident to resident abuse. Interviews were conducted with the administrative staff and the managers that are on call after business hours and on weekends to assure that interventions are immediately put in place with resident to resident incidents. An " On-call Incident Management " form had been developed for the administrative and on-call staff to take home to document calls regarding incidents and accidents in the facility after business hours and on weekends. The staff was knowledgeable of the form and its use. A QI Worksheet had been developed for the staff that rotate nurse on-call duties to document interventions for incidents/accidents that occur after business hours. Interviews were conducted with the nurses and the nursing assistants on the locked dementia unit and on the general floors. It was confirmed that staff had received inservices on monitoring behaviors and were knowledgeable of the interventions put into place for monitoring residents with behaviors and residents whose medications had been changed.	F 329			
F 520 SS=J	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	F 520	F520 <u>What measures the facility put in place for the resident affected:</u> On 3-9-2013 resident #4 was assessed by nurse and attempt made to notify MD. XRay of eye area was completed on 3-9-13 10:30 pm with results of no fractures identified. On 3-11-13 MD gave order for resident to see eye physician and resident #4 was seen by eye physician on 3-11-13, with additional eye physician visits on 3-12-13 with order to start antibiotic therapy and a return visit scheduled for 3-13-2013. On 3-14-13 resident had procedure to remove right eye and returned to the facility from procedure on 3-15-13.	3-20-13	

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F 520	<p>Continued From page 90</p> <p>develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility 's Quality Improvement Committee failed to develop and implement a plan of action to monitor 1 of 1 sampled resident ' s (Resident #5) behaviors after a reduction of the Resident ' s psychoactive medications. This failure resulted in injury to 2 of 2 sampled residents (Resident #4 and Resident #2) known to get into other resident ' s beds. The facility also failed to develop and implement a plan of action to monitor the behaviors of other residents whose psychoactive medications could potentially be reduced after the 2 residents were injured. The Immediate Jeopardy began on 3/9/13 at 8:00 PM and was identified on 04/10/13 at 2:10 PM. The Immediate Jeopardy was removed on 04/11/13 at 5:55 PM when the facility provided a credible allegation of compliance. The facility will remain out of compliance at a scope and severity level D (with potential for more than minimal harm that is not immediate jeopardy) until all of the nursing staff could be in-serviced. The facility will then</p>	F 520	<p>On 3-10-13 resident #2 was assessed by nurse and attempt made to notify MD. Family notified on 3-10-13. On 3-10-13 resident #2 was moved to another room. On 3-11-13 MD gave order for resident to see eye physician and resident was seen by eye physician on 3-11-13 with orders for cold compress and antibiotic ointment to be applied. On 3-12-13 facility obtained X-Ray of resident nasal bones and received X-Ray results on 3-12-13 for resident #2 showing non-displaced fracture of nose.</p> <p>RP was notified by nurse on 3-9-13 and 3-10-13 of resident #5's behaviors. MD was attempted to be notified by nurse of behavior on 3-9-13 and 3-10-13. On 3-10-13 at 7:00 am resident #5 was placed on 15 minutes checks. On 3-11-13 first shift resident #5 was placed on one to one staff monitoring. DON contacted psychiatric nurse practitioner on 3-11-13 and psychiatric nurse practitioner arrived same day at 3:45 pm to see resident with recommendation to resume previous dosage of antipsychotic medications. Social Worker contacted outside psychiatric center on 3-11-2013 for potential placement due to resident #5's behavior. On 3-11-2013 at 7:00 pm the outside psychiatric center contacted social worker and verified they would admit resident #5 on the morning of 3-12-13. One to One staff monitoring continued with resident #5 until he was discharged from facility. On 3-12-13, resident #5 was transported to outside psychiatric center for admission and no longer resides at this facility.</p>		

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F 520	<p>Continued From page 91 implement monitoring of its corrective action.</p> <p>The findings included:</p> <p>The facility ' s Quality Improvement Policy dated 1/11 read as follows: "The Quality Improvement Executive Committee directs and supervises the Quality Improvement Program in the facility. This committee meets quarterly or as designated by the administrator to review information concerning resident care. The Quality Improvement Program reviews trends noted from Action Team meetings and rounds made by facility staff. The committee should then determine if changes in plans of action are required to improve outcomes. The Quality Improvement Executive Committee should decide if an Action Team needs to be formed or modified, if further staff education is required and if increased monitoring is required in resident care. The Executive Committee should then direct the Quality Improvement Coordinator or responsible department head to initiate any changes or retraining of staff as required."</p> <p>Resident #5 was admitted to the facility on 11/17/03 and had diagnoses that included Depression, Anxiety, Dementia and Paranoid Schizophrenia. The resident resided on the locked dementia unit in the facility.</p> <p>The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 1/11/13 revealed that Resident #5 was severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 3. The MDS revealed that the Resident had behaviors directed towards others such as threatening others, screaming and</p>	F 520	<p><u>What measures were put in place for residents having the potential to be affected:</u></p> <p>On 3-11-13 at 7:00 pm a 100 percent audit was completed by the ADON on all residents residing in the locked dementia unit to check for any signs of injury or suspicious signs of resident to resident abuse. No negative outcomes were identified in this audit.</p> <p>On 3-12-13 the audit was expanded by the floor nurses to the remaining residents residing in the nursing facility as an additional precautionary intervention to check for any signs of injury or resident to resident abuse. No negative outcomes were identified from this audit.</p> <p>The Corporate Nurse Consultants completed a 100 percent audit of resident nurses notes starting on 3-11-13 and completed on 3-12-13 for the time period of documentation from 12-1-2012 to present 3-11-2013, to assure there were no nursing documentation of resident to resident episodes that may not have been previously identified in incident reporting with no negative outcomes identified.</p> <p>On 3-12-13, the Corporate Nurse Consultant (PG) completed a review of resident to resident altercations from 9-1-12 to 3-11-12 to assure interventions for resident to resident incidents were in place and/or still appropriate with no new concerns identified.</p>		

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F 520	<p>Continued From page 92</p> <p>cursing at others for 1-3 days during the 7 day assessment period. The MDS showed that the Resident was ambulatory with the supervision of 1 person and was on anti-anxiety and antipsychotic medications for 7 of 7 days of the assessment period.</p> <p>A Physician ' s Order dated 2/7/13 revealed orders to reduce the Resident ' s psychoactive medications. An entry in the Resident ' s progress notes by the QI Nurse dated 2/12/13 read: " Quality Improvement - Antipsychotic Medication. Data: Resident received Buspar 300 MG, Ativan 1 MG, Remeron 15 MG and Zoloft 50 MG with diagnosis of paranoid schizophrenia, anxiety, mental disorder and depression. Behaviors include yelling, cursing and screaming. No GDR (gradual dose reduction) noted for any meds. Action: Recommend decreasing Buspar 200 mg daily, decreasing Ativan 0.5 mg, decreasing Remeron 7.5mg, decreasing Zyprexa 2.5mg. No changes recommended to Zoloft at this time, continue to monitor for behaviors. Response: MD (medical doctor) and RP (responsible party) aware, MD agrees with recommendations. "</p> <p>There were no QI progress notes on the resident ' s clinical record after the 2/12/13 entry.</p> <p>A facility Incident Report dated 2/17/13 revealed that Resident #5 hit Resident #7 in the face while in the dining room. There were no injuries noted to Resident #7.</p> <p>A facility Incident Report dated 3/9/13 revealed that Resident #5 hit Resident #4 in the face resulting in Resident #4 losing his right eye.</p>	F 520	<p>On 3-11-13 at 5:45 pm the Regional Director in-serviced the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Improvement Nurse, Minimum Data Set Nurses and Administrative Nurses who take Nurse On Call responsibilities on assuring that interventions are immediately put in place with resident to resident incidents to include one to one staff monitoring when a resident strikes another resident until the situation is assessed further and appropriate interventions are decided to meet the resident's individualized needs to include care planning. When unsure about a situation, the Administrator and/or Director of Nursing should contact the Regional Director or Corporate Nurse Consultant for additional advisement. No Administrative Nurses worked until they received this in-servicing.</p> <p>On 3-12-13, the Regional Director in-serviced the Administrator and all Administrative Nurses who take Nurse On Call to include the Director of Nursing, Assistant Director of Nursing, Quality Improvement Nurse, and Minimum Data Set Nurses on "On-Call Incident Management; steps to look at when called about an incident that outlined data to collect about situation including answers to WHO, WHAT, WHEN, WHERE, HOW, and INTERVENTION to be put in place. On 3-15-13 the Administrator expanded the "On-Call Incident Management" in-service to all staff members who rotate weekend</p>	

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F 520	<p>Continued From page 93</p> <p>A facility Incident Report dated 3/10/13 revealed that Resident #5 hit Resident #2 in the face resulting in Resident #2 having a non-displaced fracture of the nose and conjunctivitis of the left eye.</p> <p>Resident #5 was discharged from the facility on 3/12/13.</p> <p>The QI Nurse stated in an interview on 3/25/13 at 1:15 PM that the facility had established a new committee to look at residents on antipsychotic medications with the goal of reducing these medications. The QI Nurse stated that on 2/6/13 the psychiatric nurse saw Resident #5 and reviewed the recommendations of the QI committee regarding the GDR (gradual dose reduction) of the psychoactive medications for Resident #5. The QI Nurse stated that the psychiatric nurse agreed to the recommendations and the physician signed for the recommendations to be initiated.</p> <p>On 3/25/13 at 2:52 PM, Nurse #1 stated in an interview that she noticed a difference in Resident #5 after his medications had been cut. The Nurse stated that prior to the reduction in his medications, Resident #5 was easier to re-direct. The Nurse stated that after his medications were reduced, Resident #5's aggressive behaviors were worse and Resident #5 hit a female resident in the dining room. The Nurse stated that Resident #5 would usually call the nurse if someone was in his space but it was not like him to just hit someone.</p> <p>Nurse #1 stated in an interview on 3/26/13 at 9:40 AM that the nurse's document resident's</p>	F 520	<p>Administrative Call Rounds including the Housekeeping Director, Medical Records Director, Social Workers, Business Office staff, Dietary Manager, Activity Director, and Maintenance Director.</p> <p>On 3-11-13 at 7:10 pm the Staff Development Coordinator initiated in-service for all facility staff to include nurses, nursing assistant, nursing support staff, dietary staff, housekeeping staff, maintenance staff, activities staff, office staff, and therapy staff on Resident to Resident Abuse to include when episodes are observed that safety is provided immediately, charge nurses are notified immediately for appropriate interventions. No staff was allowed to work until they received this in-service.</p> <p>On 4-3-13 the MDS Nurses started a 100 percent review of all Care Plans to assure individualization of the plan of care was completed for each resident to include behaviors of residents.</p> <p>On 4-10-2013 the MDS nurses completed a 100 percent audit of all residents on antipsychotic medications to assure that the plan of care addresses the use of antipsychotic medication and any current dose reduction or changes. Any areas identified were corrected by updating of the residents' care plan.</p> <p>On 3-13-2013 to 3-15-2013 the pharmacy consultant completed a drug regimen</p>		

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F 520	<p>Continued From page 94</p> <p>behaviors in the nurse ' s notes and the nursing assistants address behaviors in their documentation in the Point of Care (POC) computer program. The Nurse stated that she did not monitor the documentation of resident ' s behaviors and that the information went to administration.</p> <p>The Director of Nursing (DON) stated in an interview on 3/26/13 at 9:54 AM that the nurses document resident ' s behaviors in the nurse ' s notes. The DON stated that the Antipsychotic Committee monitors the resident after a medication dose reduction by talking with the nurses.</p> <p>On 4/10/13 at 11:15 AM an interview was conducted with the Administrator, the Director of Nursing (DON) and the QI Nurse. The Administrator stated that during the QI meeting on February 13, 2013 they discussed the need for medication dose reductions for all residents on psychoactive medications. The Administrator stated that resident ' s behaviors were to be monitored on every shift like they normally do for any medication changes. The Administrator stated that during the QI meeting on March 13, 2013 there was no discussion regarding dose reductions for specific residents but there was a general discussion regarding dose reductions for residents on psychoactive medications.</p> <p>The Administrator stated in an interview on 4/11/13 at 10:30 AM that there were various action teams and that the teams met separately and would bring their information to the monthly QI meeting. The Administrator stated that the QI Committee met on February 13, 2013 and there</p>	F 520	<p>review of all residents to include residents on psychoactive medications. Any recommendations made regarding possible antipsychotic medications will be reviewed by the Quality Improvement Antipsychotic Medication Committee. The Committee will review each resident medication(s) to include current dosage, whether there are documented behaviors since last review, verification that MD orders are correct, PRN Medications used are properly documented for the need and frequency, diagnosis to support present medications, and recommendations for changes in medications that will be submitted to the Medical Doctor for review as appropriate.</p> <p><u>What systems were put in place to prevent the deficient practice from reoccurring:</u></p> <p>On 3-12-2013 a QI worksheet guide was implemented to be used by the Administrator, Director of Nursing, and all Administrative Nurses that rotate Nurse On-Call duties for non-business hours, weekends, and nights to assist in gathering information to make decisions about interventions for incidents to include resident to resident incidents utilizing a "On-Call Incident Management" Worksheet QI Audit Tool. This audit tool will be utilized when calls are received and forwarded to the Administrator for review.</p>	

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F 520	<p>Continued From page 95</p> <p>was no specific information in the meeting minutes about the dose reduction of medications for Resident #5 but they did talk in general about reducing psychoactive medications in the facility.</p> <p>The QI Nurse stated in an interview on 4/11/13 at 10:49 AM that during the February 13, 2013 QI meeting they had a brief discussion about the new regulations and guidelines on psychoactive medications. The QI Nurse stated that there was no discussion on the reduction of Resident #5 's psychoactive medications and no change in the plan for monitoring resident ' s behaviors after a reduction of psychoactive medications.</p> <p>The Administrator was notified of the Immediate Jeopardy on 4/10/13 at 2:10 PM. The facility provided a credible allegation of compliance on 04/11/13 at 5:55 PM. The allegation of compliance indicated:</p> <p>What measures the facility put in place for the resident affected:</p> <p>On 3-9-13 Resident #4 was assessed by Nurse #3 and attempt made to notify MD. XRay of eye area was completed on 3/9/13 at 10:30 pm with results of no fractures identified. On 3/11/13 the physician gave an order for the resident to see an eye physician. Resident #4 was seen by an eye physician on 3/11/13, with additional eye physician visits on 3/12/13 with order to start antibiotic therapy and a return visit scheduled for 3/13/13. On 3/14/13 Resident #4 had a procedure to remove the right eye and returned to the facility on 3/15/13.</p> <p>On 3-10-13 Resident #2 was assessed by Nurse</p>	F 520	<p>On 3-12-2013 the Administrator initiated a Quality Improvement Incident/Accidents Committee starting on 3-12-13 consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Improvement Nurse, Minimum Data Set Nurses, Social Workers, and Therapy staff that will meet five times per week to review all incidents and accidents to assure nurse assessment of situation, intervention put in place, MD notified, RP notified, and Care Plan updated for changes and interventions. This review will be documented on a Quality Improvement Incident/Accident Review Committee QI Audit Tool.</p> <p>Administrative Nurses will review all resident nurses notes three times per week for eight weeks starting week of 3-11-2013 and then once per week ongoing thereafter to assure there are no resident to resident episodes that may have occurred that were not identified by incident reporting.</p> <p>On 4-10-2013 the Staff Development Coordinator initiated in-servicing at 1:17 pm for nurses and nursing assistants regarding monitoring of residents that in the daily monitoring of our residents staff should routinely monitor their whereabouts. If a dementia resident is identified as being in another resident's space or bed to redirect the resident to the common care areas of the unit and that if the resident is resistive to the redirection to stay with the resident to assure no resident to resident conflicts occur until the resident is able to be redirected.</p>	5-20-13	



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F 520	<p>Continued From page 96</p> <p>#4 and an attempt made to notify the physician. The family was notified on 3-10-13. On 3-10-13 Resident #2 was moved to another room. On 3-11-13 the physician gave an order for Resident #2 to see the eye physician and the resident was seen by eye physician on 3-11-13 with orders for cold compress and antibiotic ointment to be applied. On 3-12-13 the facility obtained X-Ray of resident nasal bones and received X-Ray results on 3-12-13 for Resident #2 showing a non-displaced fracture of nose.</p> <p>The Responsible party was notified by the nurse on 3-9-13 and 3-10-13 of resident 's behaviors. The MD was attempted to be notified by nurse of behavior on 3/9/13 and 3/10/13. On 3-10-13 at 7:00 am Resident #5 was placed on 15 minutes checks. On 3-11-13 first shift Resident #5 was placed on one to one staff monitoring. The Director of Nursing (DON) contacted the psychiatric nurse practitioner on 3-11-13 and psychiatric nurse practitioner arrived same day at 3:45 pm to see resident with recommendation to resume previous dosage of antipsychotic medications. Social Worker contacted outside psychiatric center on 3-11-2013 for potential placement due to resident behavior. On 3-11-2013 at 7:00 pm the outside psychiatric center contacted social worker and verified they would admit Resident #5 on the morning of 3-12-13. One to One staff monitoring continued with Resident #5 until he was discharged from facility. On 3-12-13, Resident #5 was transported to outside psychiatric center for admission and no longer resides at this facility.</p> <p>What measures were put in place for residents having the potential to be affected:</p>	F 520	<p>The facility Quality Improvement Antipsychotic Committee will meet monthly to review all residents that are on antipsychotic medications. The Committee will consist of the Administrator, Director of Nursing, Assistant Director of Nursing, Minimum Data Set Nurses, Quality Improvement Nurses, Social Workers, and Pharmacy Consultant. The Committee will review each resident medication(s) to include current dosage, whether there are documented behaviors since last review, verification that MD orders are correct, PRN Medications used are properly documented for the need and frequency, diagnosis to support present medications, and recommendations for changes in medications that will be submitted to the Medical Doctor. Any recommendations made during the Committee Meeting will be referred to the Attending Physician for acceptance or decline of recommendation. If the physician agrees with the recommendation of change in medication, then the resident will be Care Planned for changes in antipsychotic medications with goal and approaches listed and the QI Nurse and/or DON will note the change in antipsychotic medication on the Resident Care Guide to prompt staff to watch for any changes in behavior or condition.</p> <p>On 4-10-13, the Staff Development Coordinator and DON initiated in-servicing at 6:15 pm for all nursing assistants and nurses that anytime a resident has a change in antipsychotic medications, the change will be noted on the Resident Care Guide</p>		

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F 520	<p>Continued From page 97</p> <p>On 3-11-13 at 7:00 pm a 100 percent audit was completed by the ADON on all residents residing in the locked dementia unit to check for any signs of injury or suspicious signs of resident to resident abuse. No negative outcomes were identified in this audit.</p> <p>On 3-12-13 the audit was expanded by the floor nurses to the remaining residents residing in the nursing facility as an additional precautionary intervention to check for any signs of injury or resident to resident abuse. No negative outcomes were identified from this audit.</p> <p>The Corporate Nurse Consultants completed a 100 percent audit of resident nurses notes starting on 3-11-13 and completed on 3-12-13 for the time period of documentation from 12-1-2012 to present 3-11-2013, to assure there were no nursing documentation of resident to resident episodes that may not have been previously identified in incident reporting with no negative outcomes identified.</p> <p>On 3-12-13, the Corporate Nurse Consultant (PG) completed a review of resident to resident altercations from 9-1-12 to 3-11-12 to assure interventions for resident to resident incidents were in place and/or still appropriate with no new concerns identified.</p> <p>On 3-11-13 at 5:45 pm the Regional Director in-serviced the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Improvement Nurse, Minimum Data Set Nurses and Administrative Nurses who take Nurse On Call responsibilities on assuring that interventions are immediately put in place with resident to</p>	F 520	<p>located in each resident's closet and prompt nursing staff to observe for any changes in behaviors or medical condition. If a Nursing Assistant notices a change in resident behavior or condition they are to notify their nurse immediately. Anytime a Nurse is notified that there is a change in behavior or condition they are to immediately assess the resident, assure resident is safe and other residents are safe related to the behavior, and notify the QI Nurse and/or DON and/or the Nurse On-Call. If situation warrants, notify the MD and RP. The in-service included the reminder that the QI Nurse will also be routinely observing these residents while on an antipsychotic medication change as well and will also be asking Nursing Assistants and Nurses who work with resident if any observed changes in condition or behavior.</p> <p>Starting the week of 4-8-13, the QI Nurse will two times a week observe residents who are currently under a antipsychotic medication change and question staff who work with the resident to assess if there are any changes in behaviors or condition related to the change in the medication that have not already been reported by other staff observations utilizing a QI Audit Tool. Any changes in behavior or condition will be assessed and referred to the MD for any further changes needed in medications for the resident. Any changes identified and actions taken by nursing and/or MD will be reported to the Antipsychotic Medication QI Committee on their next review.</p>		

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F 520	<p>Continued From page 98</p> <p>resident incidents to include one to one staff monitoring when a resident strikes another resident until the situation is assessed further and appropriate interventions are decided to meet the resident's individualized needs to include care planning. When unsure about a situation, the Administrator and/or Director of Nursing should contact the Regional Director or Corporate Nurse Consultant for additional advisement. No Administrative Nurses worked until they received this in-servicing.</p> <p>On 3-12-13, the Regional Director in-serviced the Administrator and all Administrative Nurses who take Nurse On Call to include the Director of Nursing, Assistant Director of Nursing, Quality Improvement Nurse, and Minimum Data Set Nurses on " On-Call Incident Management; steps to look at when called about an incident that outlined data to collect about situation including answers to WHO, WHAT, WHEN, WHERE, HOW, and INTERVENTION to be put in place. On 3-15-13 the Administrator expanded the " On-Call Incident Management " in-service to all staff members who rotate weekend Administrative Call Rounds including the Housekeeping Director, Medical Records Director, Social Workers, Business Office staff, Dietary Manager, Activity Director, and Maintenance Director.</p> <p>On 3-11-13 at 7:10 pm the Staff Development Coordinator initiated in-servicing for all facility staff to include nurses, nursing assistant, nursing support staff, dietary staff, housekeeping staff, maintenance staff, activities staff, office staff, and therapy staff on Resident to Resident Abuse to include when episodes are observed that safety is</p>	F 520	<p>Directed In-Service Training on antipsychotic medication and behavioral management will be conducted for all nurses on 5-16-2013 by the North Carolina Elderly Psychiatric Services utilizing a curriculum approved by Arizona State.</p> <p><u>How the facility will monitor systems put in place:</u></p> <p>The Administrator will review the "Incident Notification Worksheet QI Audit Tools" daily as they are completed to include nights and weekends as incidents occur.</p> <p>The Administrator and/or DON will review the Quality Improvement Incident/Accident Committee QI Audit Tool five times per week to assure all areas are reviewed with appropriate intervention and notifications.</p> <p>The Administrator will review the QI Review of Nurses Notes three times a week for eight weeks starting 3-11-2013 the once per week ongoing thereafter to assure all notes were reviewed and that any areas with identified concerns were handled to meet the individual needs of the resident and situation.</p> <p>The Regional Director and/or Corporate Nurse Consultant will review the "Incident Notification Worksheet QI Audit tools, the Incident/Accident Committee QI Audits tools, and the QI Review of Nurses Notes monthly for six months starting April 2013 then quarterly thereafter to assure the facility is completing and interventions are in place and working to meet residents' needs.</p>	
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F 520	<p>Continued From page 99</p> <p>provided immediately, charge nurses are notified immediately for appropriate interventions. No staff was allowed to work until they received this in-service.</p> <p>On 4-3-13 the MDS Nurses started a 100 percent review of all Care Plans to assure individualization of the plan of care was completed for each resident to include behaviors of residents.</p> <p>On 4-10-2013 the MDS nurses completed a 100 percent audit of all residents on antipsychotic medications to assure that the plan of care addresses the use of antipsychotic medication and any current dose reduction or changes. Any areas identified were corrected by updating of the residents ' care plan.</p> <p>On 3-13-2013 to 3-15-2013 the pharmacy consultant completed a drug regimen review of all residents to include residents on psychoactive medications. Any recommendations made regarding possible antipsychotic medications will be reviewed by the Quality Improvement Antipsychotic Medication Committee. The Committee will review each resident medication(s) to include current dosage, whether there are documented behaviors since last review, verification that MD orders are correct, PRN Medications used are properly documented for the need and frequency, diagnosis to support present medications, and recommendations for changes in medications that will be submitted to the Medical Doctor for review as appropriate.</p> <p>What systems were put in place to prevent the</p>	F 520	<p>The Administrative Nurses and/or Corporate Nurse Consultant will randomly administer written quiz forms with the employees to verify knowledge from the in-service given on resident to resident abuse and On-Call Incident Management. The quizzes will be completed with staff on all shifts and at varying times of the day to verify continued knowledge of this information. Quizzes on Resident to Resident abuse were started on 3-13-2013 and will continue for six months, and then quarterly ongoing. New employees hired will receive this in-servicing and quiz as a part of their general orientation to the facility.</p> <p>The Quality Improvement Executive Committee which consists of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Quality Improvement Nurse, Minimum Data Set Nurse, Social Workers, Bookkeeper, Activity Director, Dietary Director, Medical Records Director, and Maintenance Director will review the quality improvement audit tools to include the Incident Notification Worksheets, the Reviews of Nurses Notes for unreported incidents, the Incident/Accident Committee Reviews, and the Antipsychotic Medication Committee Meeting Minutes for monitoring, assessment and recommendation of needs to further monitor these systems, and to assure continued compliance in these areas.</p>		

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F 520	<p>Continued From page 100</p> <p>deficient practice from reoccurring: On 3-12-2013 a QI worksheet guide was implemented to be used by the Administrator, Director of Nursing, and all Administrative Nurses that rotate Nurse On-Call duties for non-business hours, weekends, and nights to assist in gathering information to make decisions about interventions for incidents to include resident to resident incidents utilizing a " On-Call Incident Management " Worksheet QI Audit Tool. This audit tool will be utilized when calls are received and forwarded to the Administrator for review.</p> <p>On 3-12-2013 the Administrator initiated a Quality Improvement Incident/Accidents Committee starting on 3-12-13 consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Improvement Nurse, Minimum Data Set Nurses, Social Workers, and Therapy staff that will meet five times per week to review all incidents and accidents to assure nurse assessment of situation, intervention put in place, MD notified, RP notified, and Care Plan updated for changes and interventions. This review will be documented on a Quality Improvement Incident/Accident Review Committee QI Audit Tool.</p> <p>Administrative Nurses will review all resident nurses notes three times per week for eight weeks starting week of 3-11-2013 and then once per week ongoing thereafter to assure there are no resident to resident episodes that may have occurred that were not identified by incident reporting.</p> <p>On 4-10-2013 the Staff Development Coordinator initiated in-servicing at 1:17 pm for nurses and</p>	F 520			

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F 520	<p>Continued From page 101</p> <p>nursing assistants regarding monitoring of residents that in the daily monitoring of our residents staff should routinely monitor their whereabouts. If a dementia resident is identified as being in another resident ' s space or bed to redirect the resident to the common care areas of the unit and that if the resident is resistive to the redirection to stay with the resident to assure no resident to resident conflicts occur until the resident is able to be redirected.</p> <p>The facility Quality Improvement Antipsychotic Committee will meet monthly to review all residents that are on antipsychotic medications. The Committee will consist of the Administrator, Director of Nursing, Assistant Director of Nursing, Minimum Data Set Nurses, Quality Improvement Nurses, Social Workers, and Pharmacy Consultant. The Committee will review each resident medication(s) to include current dosage, whether there are documented behaviors since last review, verification that MD orders are correct, PRN Medications used are properly documented for the need and frequency, diagnosis to support present medications, and recommendations for changes in medications that will be submitted to the Medical Doctor. Any recommendations made during the Committee Meeting will be referred to the Attending Physician for acceptance or decline of recommendation. If the physician agrees with the recommendation of change in medication, then the resident will be Care Planned for changes in antipsychotic medications with goal and approaches listed and the QI Nurse and/or DON will note the change in antipsychotic medication on the Resident Care Guide to prompt staff to watch for any changes in behavior or condition.</p>	F 520			

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F 520	<p>Continued From page 102</p> <p>On 4-10-13, the Staff Development Coordinator and DON initiated in-servicing at 6:15 pm for all nursing assistants and nurses that anytime a resident has a change in antipsychotic medications, the change will be noted on the Resident Care Guide located in each resident 's closet and prompt nursing staff to observe for any changes in behaviors or medical condition. If a Nursing Assistant notices a change in resident behavior or condition they are to notify their nurse immediately. Anytime a Nurse is notified that there is a change in behavior or condition they are to immediately assess the resident, assure resident is safe and other residents are safe related to the behavior, and notify the QI Nurse and/or DON and/or the Nurse On-Call. If situation warrants, notify the MD and RP. The in-service included the reminder that the QI Nurse will also be routinely observing these residents while on an antipsychotic medication change as well and will also be asking Nursing Assistants and Nurses who work with resident if any observed changes in condition or behavior.</p> <p>Starting the week of 4-8-13, the QI Nurse will two times a week observe residents who are currently under a antipsychotic medication change and question staff who work with the resident to assess if there are any changes in behaviors or condition related to the change in the medication that have not already been reported by other staff observations utilizing a QI Audit Tool. Any changes in behavior or condition will be assessed and referred to the MD for any further changes needed in medications for the resident. Any changes identified and actions taken by nursing and/or MD will be reported to the Antipsychotic</p>	F 520			

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F 520	<p>Continued From page 103 Medication QI Committee on their next review.</p> <p>How the facility will monitor systems put in place:</p> <p>The Administrator will review the " Incident Notification Worksheet QI Audit Tools " daily as they are completed to include nights and weekends as incidents occur.</p> <p>The Administrator and/or DON will review the Quality Improvement Incident/Accident Committee QI Audit Tool five times per week to assure all areas are reviewed with appropriate intervention and notifications.</p> <p>The Administrator will review the QI Review of Nurses Notes three times a week for eight weeks starting 3-11-2013 the once per week ongoing thereafter to assure all notes were reviewed and that any areas with identified concerns were handled to meet the individual needs of the resident and situation.</p> <p>The Regional Director and/or Corporate Nurse Consultant will review the " Incident Notification Worksheet QI Audit tools, the Incident/Accident Committee QI Audits tools, and the QI Review of Nurses Notes monthly for six months starting April 2013 then quarterly thereafter to assure the facility is completing and interventions are in place and working to meet residents ' needs.</p> <p>The Administrative Nurses and/or Corporate Nurse Consultant will randomly administer written quiz forms with the employees to verify knowledge from the in-service given on resident to resident abuse and On-Call Incident</p>	F 520			



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F 520	<p>Continued From page 104</p> <p>Management. The quizzes will be completed with staff on all shifts and at varying times of the day to verify continued knowledge of this information. Quizzes on Resident to Resident abuse were started on 3-13-2013 and will continue for six months, and then quarterly ongoing. New employees hired will receive this in-servicing and quiz as a part of their general orientation to the facility.</p> <p>The Quality Improvement Executive Committee which consists of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Quality Improvement Nurse, Minimum Data Set Nurse, Social Workers, Bookkeeper, Activity Director, Dietary Director, Medical Records Director, and Maintenance Director will review the quality improvement audit tools to include the Incident Notification Worksheets, the Reviews of Nurses Notes for unreported incidents, the Incident/Accident Committee Reviews, and the Antipsychotic Medication Committee Meeting Minutes for monitoring, assessment and recommendation of needs to further monitor these systems, and to assure continued compliance in these areas.</p> <p>On 4/11/13 at 5:00 PM the credible allegation was validated by reviewing the audits conducted on the dementia unit and the general floors for signs of injury or other signs of resident to resident abuse. Interviews were conducted with the administrative staff and the managers that are on call after business hours and on weekends to assure that interventions are immediately put in place with resident to resident incidents. An " On-call Incident Management " form had been developed for the administrative and on-call staff</p>	F 520			

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F 520	Continued From page 105 to take home to document calls regarding incidents and accidents in the facility after business hours and on weekends. The staff was knowledgeable of the form and its use. A QI Worksheet had been developed for the staff that rotate nurse on-call duties to document interventions for incidents/accidents that occur after business hours. Interviews were conducted with the nurses and the nursing assistants on the locked dementia unit and on the general floors. It was confirmed that staff had received inservices on monitoring behaviors and were knowledgeable of the interventions put into place for monitoring residents with behaviors and residents whose medications had been changed.	F 520		
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