

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345288	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/25/2014
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NAME OF PROVIDER OR SUPPLIER MAGNOLIA ESTATES SKILLED CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1404 S SALISBURY AVENUE SPENCER, NC 28159
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F 000	INITIAL COMMENTS	F 000		
F 250 SS=D	<p>IDR conducted 6/23/14. The IDR panel lowered F 280 K and F 323 K both to D.</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to obtain a psychiatric consult according to a physician order for 1 of 4 residents (Resident #9) who had an increased anxiety and aggression towards others.</p> <p>The findings included:</p> <p>Resident #9 was admitted to the facility on 5/8/13 with diagnoses that included depression, anxiety disorder, bipolar disorder and Alzheimer's disease. The most recent quarterly Minimum Data Set (MDS) Assessment dated 11/22/13 indicated Resident #9 required extensive assistance to complete activities of daily living (ADLs). The MDS further indicated Resident #9s physical behavioral symptoms toward others occurred 1 to 3 days. Verbal behavioral symptoms directed at others occurred daily. Resident #9 coded as severely cognitively impaired for daily decision making. The facility could not provide any further quarterly assessment beyond 11/22/13.</p>	F 250	<p>F250</p> <p>STANDARD DISCLAIMER:</p> <p>This Plan of Correction is prepared as a necessary requirements for the continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged practice(s).</p> <p>Resident #9's psychiatric consult was completed on April 17, 2014. As a result of Resident #9's outpatient psychiatric consult on April 17, 2014, the consulting psychiatrist noted the following findings: the resident as having a history of dementia with Bi-Polar and the resident's mood is now very unstable and the resident is both paranoid and delusional.</p> <p>Based on the psychiatrist's consult of April 17, 2014 Resident #9's medication was</p>	5/23/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 06/17/2014
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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 250	Continued From page 1 Review of Resident #9's care plan updated 6/11/13 revealed a problem of "diagnosis of depression/bipolar disorder with use of anti-depressant; risk of adverse reactions related to use of medications; she is frequently resistive to caregivers, no difficulty with wandering; history of seizures." The goals included the resident would have no signs and symptoms of depression daily, like crying, refusal to eat etc. times 90 days. The approaches included providing 1 on 1 visits as needed, moving the resident to a different area and re-approaching as needed secondary to the resident cursing and other behaviors which were not easily redirected. The facility could not provide any updates or revisions to Resident #9's care plan beyond 6/11/13. Physician progress note dated 8/16/13 indicated, " The patient is being evaluated in regards to her behaviors. The nursing staff states that she has for the last month been more agitated and aggressive. She is noted at this time to be moderately agitated and she is upset about her parents who are not living. She is cursing and somewhat aggressive towards other residents however has not physically touched anyone. The note continued with, " the patient is on multiple medications for seizure disorders. She is on Lexapro (anti-anxiety) 15mg daily and is also on Remeron (appetite stimulate) 15mg nightly and did increase this to 30mg daily. She is written for Ativan (anti-anxiety) 0.25 mg every 12 hours PRN (as needed) anxiety and agitation. She is already on Klonopin (anti-anxiety) 1mg three times a day. Will otherwise follow as needed. " Review of Resident #9's physician progress note	F 250	changed as follows: increased Lexapro, an antidepressant, from 30 milligrams per day to 40 milligrams per day; added 25 milligrams of Seroquel, an antipsychotic, to be administered at bedtime for four consecutive nights, then increasing the Seroquel dosing on day five to 50 milligrams at bedtime. The Seroquel was added based on the psychiatrist's assessment of Resident #9's having both psychosis and mood disorders. For those residents having the potential to be affected by the same alleged deficient practice, on April 25, 2014, the facility executed a contract with a consulting psychiatrist to provide in-facility, outpatient psychiatric consults to those residents having an assessed need for psychiatric consultations. The Social Worker shall facilitate and coordinate the facility's referral(s) to the consulting psychiatrist using staff reports, which may be inclusive of, but not limited to, any of the following: 24 hour report, verbal reports made by staff to the Social Worker, Nurse, Director of Nursing, MDS Coordinator, et.al., reports obtained from record review, etc., direct resident observation(s), completed record of complaint form(s), completed investigation of Unwitnessed Resident Incident form, a resident's social and/or medical history, if applicable, and Incident/Accident reports. The facility Social Worker shall ensure the in-house, consulting psychiatrist conducts a consult with any resident(s) identified as having a need for a psychiatric referral.		

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F 250	<p>Continued From page 2</p> <p>dated 10/8/13 indicated, " Resident #9 is having a little bit of issue with increased agitation, irritability, and mood and she is having quite a bit of weight gain and due to this, we are going to make some adjustment to her medications and see if we can improve things a little bit for her from that standpoint. " The physician note continued with due to increase mood disorder and weight gain; will decrease Remeron (appetite Stimulant) from 30mg to 15mg nightly, and increase Lexapro (anti-anxiety) from 15mg to 20mg daily. Reassess and make other adjustments as needed. "</p> <p>Review of Resident #9's physician progress note dated 11/19/14 indicated the patient was being seen for routine re-evaluation. She had a history of seizure disorder that was difficult to control and had a couple of small seizures over the weekend. She had seen neurology recently who really did not feel that there were any other adjustments that can be made for her. The note continued with, " due to mood issues and weight gain, we adjusted her mirtazapine (Remron) down and Lexapro up and she seems to be doing well with that. "</p> <p>Review of Resident #9's physician progress note dated 12/11/13 said, " The patient with a past medical history of significant for seizure disorder, depression, bipolar disorder, and history of frequent urinary tract infections. The nursing staff states that recently she has had an increase in her behaviors with inappropriate language. It was request to repeat a BMP (basic metabolic profile/lab work) in four weeks, these results are not readily available for review at this time however we will have nursing staff obtain the results and if these are not obtained as of yet, will</p>	F 250	<p>The Social Worker shall ensure any relevant consult notes and any relevant interventions, including both pharmacological and non-pharmacological interventions are documented in the resident's medical record and the resident's care plans are updated appropriately, pursuant to any applicable standards of practice related to care planning.</p> <p>The Social Worker has assessed all current residents in the facility to determine if any residents have any unmet psych-social needs, specific to the resident's assessed psycho-social state. Such assessments were completed based on interviews with the resident, staff, and or responsible person(s). Such assessments shall be documented in the resident's medical records. The Social Worker shall assess the psycho-social needs monthly for three months and quarterly thereafter. The Social Worker shall assess the psycho-social needs of newly admitted residents weekly for 4 weeks, monthly for 3 months and quarterly thereafter. Such assessments shall be documented in the resident's medical record.</p>		

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

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F 250	<p>Continued From page 3</p> <p>make sure that is done. " The note continued with, " the patient's overall condition relatively stable except for increase in behaviors and recent hypernatremia found on labs. "</p> <p>Review of Resident #9 's medical record revealed a physician order dated 12/20/13 indicated, " Increase Lexapro (anti-depressant) to 30mg po (by mouth) daily due to worsening behaviors. "</p> <p>Review of Resident #9's medical record revealed a physician order dated 1/10/14 that said, " 1) increase Klonopin (anti-anxiety) to 2mg po tid (by mouth, three times a day), routinely due to worsening behaviors, and 2) refer to psych due to worsening anxiety/agitation. " Further review of Resident #9 ' s medical record revealed no consultation in regards to psychiatry.</p> <p>Physician progress note dated 1/21/14 said, " depression - has been worse lately with acting out. Lexapro was just adjusted within the last 2 to 3 weeks so therefore will hold steady with that. Continue with redirection and make other adjustments as needed. Need to be careful with adjustments on psychiatric medications due to her seizure medications. "</p> <p>Review of appointment record revealed an appointment was booked for resident #9 on 1/29/14 for an appointment date of 2/13/14 at 3:20pm. The appointment scheduled revealed the appointment for 2/13/14 was cancelled. Further review of resident #9's appointment schedule revealed an appointment was booked on 2/27/14 for an appointment for 4/17/14 at 2:00 pm.</p> <p>Review of incident report dated 3/16/14 indicated</p>	F 250			

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F 250	<p>Continued From page 4</p> <p>Resident #67 was kicked by Resident #9 during an altercation in the hallway. The description of occurrence indicated Resident #67 was involved in altercation with another resident in the hall-way. One resident (Resident #9) started to kick the other resident (Resident #67), resulting in an injury to resident #67 ' s left lower leg. The measures to prevent further occurrence indicated, Resident #67 will be separated from the resident in question (Resident #9) at all times.</p> <p>Interview with Transportation Aide #1 on 4/24/14 at 2:40pm revealed she had originally scheduled Resident #9's psychiatric appointment on 1/29/14 for 2/13/14 at 3:20 pm. The outside agency contacted the facility on 1/29/14 and indicated that the appointment was cancelled due to snow and would need to be rescheduled. It was communicated by the outside psychiatric center that the nursing facility would have to call back and reschedule the appointment. Transportation Aide #1 indicated that she had rescheduled the appointment on 2/27/14 for 4/17/14 at 3:40 pm after she realized that the appointment was never rescheduled following the cancellation. The Transportation aide continued with the appointment should have been rescheduled sooner and was an oversight on her behalf that the appointment was not rescheduled sooner.</p> <p>Interview with Nurse #6 on 4/24/14 at 3:41 pm revealed a transportation form is provided by nursing to the transportation aide. Nurse #6 indicated she was responsible for ensuring resident ' s physician orders for outside care were carried out. Nursing provides a transportation slip that were provided to the transportation staff. Transportation were to schedule appointments and ensure a consultation report is brought back</p>	F 250			

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F 250	<p>Continued From page 5 following the appointment. Nurse #6 revealed she was unsure why there was a laps in the scheduling of Resident #9's psych appointment.</p> <p>Interview with the facility Physicians Assistant (PA) on 4/3/14 at 3:43 pm indicated that it was communicated to her by facility staff that Resident #9 was exhibiting behaviors such as physical and verbal aggression towards others. The PA further indicated that she had witnessed Resident #9 reach out in an attempt to hit residents in her way. Psych services was recommended due to Resident #9 ' s use of seizure mediations and adjustments to current medications had been attempted. It was the expectation of the PA that Resident #9 be seen as soon as an appointment could be made. The PA was unaware that Resident #9 had not received a consultation from a psychiatrist. The PA was unaware of the incident that occurred on 3/16/14 and further indicated she was not aware of an increase in Resident #9's behaviors.</p> <p>Interview with the Director of Nursing (DON) on 4/3/14 at 1:18 pm revealed physician request for outside services are scheduled by transportation staff. The DON revealed she was unaware that Resident #9 had a consult to seek psychiatric services. Resident #9 displayed behaviors such as kicking, hitting and cursing that was directed at staff and residents. It was the expectation of the DON that Resident #9's physician order for psychiatry consultation received prompt attention. It was further an expectation that Resident #9 be seen as possible due to the increase in episodes of aggression.</p> <p>Interview with the Administrator on 4/3/14 at 8:38 am revealed it was her expectation that Resident</p>	F 250			

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F 250	Continued From page 6 #9's physician order to receive psychiatric consult be scheduled the day in which it was written (1/10/14). The Administrator further indicated that due to the increase in Resident #9 's verbal and physical outburst, an appointment should have been made a priority. The Administrator was unaware of the increase in aggressive behaviors Resident #9 exhibited to other residents within the facility.	F 250			
F 276 SS=B	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on staff interview and record reviews the facility failed to complete a quarterly assessment every three months for 7 of 19 residents reviewed for quarterly assessments (Resident #2, #9, #13, #29 37, #44 and #46). The findings included: 1. Resident #2 was admitted to the facility on 11/27/13 with a diagnoses that included, renal failure, peripheral vascular disease, depression and anxiety disorder. The most recent MDS assessment dated 12/06/13 indicated Resident #2 required no assistance with locomotion on and off the unit. Resident #2 coded as cognitively intact as evidenced by a BIM ' s score of 13. 2. Resident #9 was admitted to the facility on	F 276	F276 STANDARD DISCLAIMER: This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). Resident #2 has had a Significant Change completed, Resident #13 and Resident #44 has had an Annual Assessment completed, Resident #29, Resident #9, Resident #29, Resident #37 and Resident #46 has had a completed quarterly assessment. MDS Coordinator and the members of the interdisciplinary care planning team (Social Worker, Therapy (if	5/23/14	

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F 276	<p>Continued From page 7</p> <p>5/8/13 with diagnoses that included depression, anxiety disorder, bipolar disorder and Alzheimer ' s disease. The most recent quarterly Minimum Data Set (MDS) Assessment dated 11/22/13 indicated Resident #9 required extensive assistance to complete activities of daily living (ADLs). The MDS further indicated Resident #9 ' s physical behavioral symptoms toward others occurred 1 to 3 days. Verbal behavioral symptoms directed at others occurred daily. Resident #9 was coded as severely cognitively impaired for daily decision making. There were no further MDS assessments at the time of the survey on 3/31/14.</p> <p>3. Resident #13 was admitted to the facility on 7/29/08 with diagnoses that included; Alzheimer ' s disease, dementia, and recurrent depression and anxiety. Review of the most recent MDS assessment dated 10/31/13 indicated Resident #13 was coded as moderately impaired as evidence of a BIM ' s score of 7. There were no further MDS assessments at the time of the survey on 3/31/14.</p> <p>4. Resident #29 was admitted to the facility on 7/3/13 with diagnoses that included anemia, hypertension, peripheral vascular disease, and chronic kidney disease state IV. The most recent MDS assessment dated 11/05/13 indicated Resident #29 was independent with locomotion off and off the unit. Resident #2 coded as cognitively intact as evidenced by as BIM ' s score of 15. There were no further MDS assessments at the time of the survey on 3/31/14.</p> <p>5. Resident #37 was admitted to the facility on 11/1/12 with diagnosis which included alzheimer '</p>	F 276	<p>applicable), Activities, Dining Services, et.al.)have reviewed and updated their care plans.</p> <p>For those residents having the potential to be affected by the same alleged deficient practice, the Director of Nursing and/or Medical Record Coordinator shall monitor the MDS calendar and ensure that the needed assessments are completed timely. All MDS assessments and Care Plans have been audited by the recently hired MDS Coordinator to ensure they all have been completed, and any care plans needing revision(s) have been appropriately revised. Any assessments identified as being untimely shall be corrected upon identification. The Director of Nursing and/or appropriately trained licensed nurse shall monitor accuracy by auditing 25% of all completed MDS assessments weekly for 3 weeks; 15% for 1 week; and 10% monthly thereafter. As of May 22, 2014 all audits for quarterly assessment are 100% in compliance.</p> <p>The Director and/or Medical Records Coordinator shall report any identified untimely assessments to the QA committee monthly for three months and quarterly thereafter. The Director of Nursing shall report any inconsistencies in accuracy to the QA committee monthly for three months and quarterly thereafter.</p>		

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F 276	Continued From page 8 s dementia, rheumatoid arthritis and hypertension. The most recent Minimum Data Set (MDS) assessment was a quarterly assessment dated 10/23/13. There were no further MDS assessment at the time of the survey on 3/31/14. 6. Resident #44 was admitted to the facility on 9/18/10 with diagnosis which included renal insufficiency, dementia and gastroesophageal reflux disease. The most recent MDS assessment was a quarterly assessment dated 10/24/13. There were no further MDS assessment at the time of the survey on 3/31/14. 7. Resident #46 was admitted to the facility on 5/14/12 with diagnosis which included parkinson disease, gastroesophageal reflux disease and hyperlipidemia. The most recent MDS assessment was a quarterly assessment dated 11/13/13. There were no further MDS assessment at the time of the survey on 3/31/14. An interview with the administrator on 4/3/14 at 2:20 PM revealed that she has not had a MDS nurse on staff and MDS ' s were not current. The administrator indicated that an action plan was in place to get the MDS ' s current.	F 276			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed	F 280		5/20/14	

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F 280	<p>Continued From page 9</p> <p>within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to update the care plan for effective interventions for 2 (Resident #9 and Resident #50) of 4 sampled residents with behaviors to prevent continued resident to resident physical altercations. (Resident #9 had physical altercations with Residents #2, #13, #29 and #67) over a period of 3 months. (Resident #50 had physical altercations with Resident #37 on two consecutive days resulting in injury.</p> <p>The findings included:</p> <p>1. Resident #9 was admitted to the facility on 5/8/13 with diagnoses that included depression, anxiety disorder, bipolar disorder and Alzheimer 's disease. The most recent quarterly Minimum Data Set (MDS) Assessment dated 11/22/13 indicated Resident #9 required extensive assistance to complete activities of daily living (ADLs). The MDS further indicated Resident #9s physical behavioral symptoms toward others</p>	F 280	<p>F280 STANDARD DISCLAIMER: This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s):</p> <p>For resident #9, incident occurring 03/16/14 at 2:30 p.m., resident #9 caused a skin tear to resident #67. Resident #9 was removed from the hallway, assessed by nurse and no injuries noted. Resident #67 was assessed by the nurse and skin tear noted to left lower leg. Wound cleansed and dry dressing applied. Responsible party and physician notified of the incident at 2:30 p.m. A scheduled Psychiatric appointment made by the transportation provider was rescheduled for February 13, 2014. The Psychiatric</p>		

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F 280	<p>Continued From page 10</p> <p>occurred 1 to 3 days. Verbal behavioral symptoms directed at others occurred daily. Resident #9 coded as severely cognitively impaired for daily decision making. The facility could not provide any further quarterly assessment beyond 11/22/13.</p> <p>Review of Resident #9 ' s care plan dated 6/11/13 revealed a problem of " diagnosis of depression/bipolar disorder with use of anti-depressant; risk of adverse reactions related to use of medications; she is frequently resistive to caregivers, no difficulty with wandering; history of seizures. " The goals included the resident would have no signs and symptoms of depression daily, like crying, refusal to eat etc. times 90 days. The approaches included providing 1 on 1 visits as needed, moving the resident to a different area and re-approaching as needed secondary to the resident cursing and other behaviors which were not easily redirected. Further review of Resident #9 ' s care plan updated 6/11/13 revealed a problem of, " cognition/communication: resident has memory deficits, alert and is able to comprehend simple information, may miss some facts, able to make her needs known to others: unable to make safe appropriate decisions; safety awareness and history of seizures. " The goals included accept judgment of staff/significant other as appropriate related to clothing and activities x 90 days and resident will be free of injury related to cognitive deficit x 90 days. The approaches included medications as ordered by physician, re-approach as needed, resident frequently resistive and combative to care, use different caregivers as indicated and needed, approach resident warmly and positively and in calm manner, calmly talk with resident and offer</p>	F 280	<p>physician cancelled the appointment due to inclement weather. Resident #9 was seen by the Psychiatric physician on April 17, 2014. Resident #9 was accompanied by the Social Worker and Activity Director. At that time, adjustments were made to her medications (Lexapro increased from 40 milligrams to 50 milligrams by mouth daily and Seroquel 25 milligrams by mouth daily for 4 nights then 50 milligrams by mouth every bedtime Psychosis and mood). Resident #9 remains on 24 hour acute charting for changes in mood and behavior and effectiveness of medications.</p> <p>Social Worker interviewed resident #29 on April 25, 2014 concerning resident to resident physical altercations. Resident #29 stated he has no physical altercations with resident #9. Resident #29 states resident #9 curses loudly in hallway. Resident #29 states she seems a little better. I still hear her cuss at times but not like she used to. Resident #29 states resident #9 does not directly curse at him, he hears her sometimes. Resident #29 states he has no other issues or problems with incidents.</p> <p>Interview by Social Worker with resident #2 on April 25, 2014 concerning resident to resident physical altercations. Resident #2 stated Whatever chair that lady is in ya ll need to keep her in it (resident #9) . Resident #2 stated he noticed improvement with resident #9 behaviors towards him. Resident #2 states resident #9 cusses at him but states I guess she can t help it . Resident #9 states she is quieter than she used to be . Resident #2</p>		

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F 280	<p>Continued From page 11</p> <p>reassurance prior to initiating care, provide instruction to resident using clear voice, simple sentences, repeat as needed, monitor and document resident behavior and status, report any change in cognitive status to physician. The facility could not provide any updates or revisions to Resident #9 ' s care plan beyond 6/11/13.</p> <p>Physician progress note dated 8/16/13 indicated, " The patient is being evaluated in regards to her behaviors. The nursing staff states that she has for the last month been more agitated and aggressive. She is noted at this time to be moderately agitated and she is upset about her parents who are not living. She is cursing and somewhat aggressive towards other residents however has not physically touched anyone. The note continued with, " the patient is on multiple medications for seizure disorders. She is on Lexapro (anti-anxiety) 15mg daily and is also on Remeron (appetite stimulate) 15mg nightly and did increase this to 30mg daily. She is written for Ativan (anti-anxiety) 0.25 mg every 12 hours PRN (as needed) anxiety and agitation. She is already on Klonopin (anti-anxiety) 1mg three times a day. Will otherwise follow as needed. "</p> <p>Review of Resident #9 ' s physician progress note dated 10/8/13 indicated, " Resident #9 is having a little bit of issue with increased agitation, irritability, and mood and she is having quite a bit of weight gain and due to this, we are going to make some adjustment to her medications and see if we can improve things a little bit for her from that standpoint. " The physician note continued with due to increase mood disorder and weight gain; will decrease Remeron (appetite Stimulant) from 30mg to 15mg nightly, and increase Lexapro (anti-anxiety) from 15mg to</p>	F 280	<p>states no incidents or other behaviors noted.</p> <p>Resident #13 interviewed by Social Worker on April 25, 2014 for resident to resident altercations with resident #9. Resident #13 stated I don t know anything about her. But then stated oh, do you mean that stocky lady that sits in the chair? . Resident #13 proceeded to say she does not see resident #9 much. They are on different sides of the hall. Resident #13 states I just don t see her to get close to her. She must stay near her room . Resident #13 stated she has not had any incidents at this time.</p> <p>For resident #50, incident occurring on January 30, 2014 at 6:30 p.m., resident #50 was separated from resident #37. Resident #50 assessed by nurse, no injuries noted. Resident #37 received a skin tear to right side of jaw and fingernails marks on her left forearm, light purple color under left eye. Resident #37 wound cleansed with normal saline, triple antibiotic ointment applied with band aid. Responsible party, physician notified at 7: 30 p.m. Social Worker made aware at 7:30 p.m. and plans to move roommate. Nursing staff increased frequency of rounds and added resident #50 to the 24 hour acute charting to monitor for changes in behaviors. Family and physician notified of the incident by nurse. Social Worker notified family of behaviors and room change. Resident #50 removed to another room.</p> <p>For those residents having the potential to be affected by the same alleged deficient</p>		

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F 280	<p>Continued From page 12 20mg daily. Reassess and make other adjustments as needed. "</p> <p>Review of Resident #9 ' s physician progress note dated 11/19/14 indicated the patient was being seen for routine re-evaluation. She had a history of seizure disorder that was difficult to control and had a couple of small seizures over the weekend. She had seen neurology recently who really did not feel that there were any other adjustments that can be made for her. The note continued with, " due to mood issues and weight gain, we adjusted her mirtazapine down and Lexapro up and she seems to be doing well with that. "</p> <p>Review of physician progress note dated 12/11/13 said, " The nursing staff states that recently she has had an increase in her behaviors with inappropriate language. " The note continued with, " The patient ' s overall condition is relatively stable except for increased behaviors and recent hypernatremia found on labs. "</p> <p>Review of Resident #9 ' s physician progress note dated 12/11/13 said, " The patient with a past medical history of significant for seizure disorder, hypothyroidism, depression, bipolar disorder, and history of frequent urinary tract infections. The nursing staff states that recently she has had an increase in her behaviors with inappropriate language. It was request to repeat a BMP in four weeks, these results are not readily available for review at this time however we will have nursing staff obtain the results and if these are not obtained as of yet, will make sure that is done. " The note continued with, " the patient ' s overall condition relatively stable except for increase in behaviors and recent hypernatremia found on labs. "</p>	F 280	<p>practice, facility shall use 24 hour Report to monitor residents experiencing acute episode(s), including behaviors, until the acute episode(s), including behaviors, have resolved. Social Worker and Administrator shall be notified of any behaviors. In addition Social Worker shall interview 10% of interviewable residents weekly x 4, then monthly thereafter. Social Worker shall interview 10 % of family members/responsible parties for non interviewable residents weekly x 4 then monthly thereafter to identify any changes in behaviors.</p> <p>Resident #9 was reassessed by the MDS Coordinator and the members of the interdisciplinary care planning team (i.e. Social Worker, Therapy (if applicable), Activities, Dining Services, et.al) on May 1st, 2014.</p> <p>Resident #50 was reassessed by the MDS Coordinator and the members of the interdisciplinary care planning team (i.e. Social Worker, Therapy (if applicable), Activities, Dining Services, et. al) on May 1st, 2014.</p> <p>Careplan for resident #9 has been updated on May 1st to reflect specific interventions to behaviors. The interventions include staff to change environment (goes outside accompanied by staff, assist to activities, 1:1 interaction (specific staff members that resident recognizes and enjoys), provide snacks as appropriate, private duty sitters as needed, group activity (assist participation with WEE games, crafts, food activities, etc.), listen to music, redirect with table top activities (coloring book, puzzles), rest</p>		

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F 280	<p>Continued From page 13</p> <p>Review of Resident #9 ' s medical record revealed a physician order dated 12/20/13 indicated, " Increase Lexapro (anti-depressant) to 30mg po (by mouth) daily due to worsening behaviors. "</p> <p>Review of Resident #9 ' s medical record revealed a physician order dated 1/10/14 that said, " 1) increase Klonopin (anti-anxiety) to 2mg pot id (by mouth, three times a day), routinely due to worsening behaviors, and 2) refer to psych due to worsening anxiety/agitation. " Further review of Resident #9 ' s medical record revealed no consultation in regards to psychiatry.</p> <p>Physician progress note dated 1/21/14 said, " depression - has been worse lately with acting out. Lexapro was just adjusted within the last 2 to 3 weeks so therefore will hold steady with that. Continue with redirection and make other adjustments as needed. Need to be careful with adjustments on psychiatric medications due to her seizure medications. "</p> <p>Review of Resident #9 ' s medication administration record (MAR) for the month of January 2014 revealed Resident #9 had received 12 Ativan for increased anxiety.</p> <p>Review of Resident #9 ' s MAR for the month of February 2014 revealed Resident #9 had received 9 Ativan for increased anxiety.</p> <p>Further review of Resident #9 ' s medical record revealed a physician progress note dated 3/4/14 said, " The patient is being seen for routine evaluation. She has a history of difficult to control seizure disorder and is seeing neurology for that.</p>	F 280	<p>periods, stand and reposition, Broda chair positioning, Psychiatric evaluation as needed.</p> <p>Careplans for resident #50 has been updated on May 1st to reflect specific interventions to behaviors. The interventions include 1:1 interaction, baby doll (engages in play, interaction with baby doll, other interaction with residents about baby doll), change environments (activities, goes outside with family and staff), ambulates with restorative nursing, +2-3 assist with bathing, dressing, grooming), group activities (religious singing, bible studies), sensory book, food activities, conversations with 1:1 interaction, Psychiatric eval as needed.</p> <p>For residents having the potential to be affected by the same alleged deficient practice, the facility' s newly hired MDS Coordinator has completed an audit of each resident's MDS assessment and careplans to determine those residents whose care plans and/or MDS assessments fall outside the constricts of the regulatory requirements. As of May 20, 2014, careplans are 100% in compliance. MDS Coordinator shall audit 25% of completed MDS and careplans weekly x 4, then then 25^% weekly x 3, then 10% monthly thereafter.</p>		

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F 280	<p>Continued From page 14</p> <p>Other issues have been stable. Her depression has been worse and Lexapro was adjusted and she seems to be doing better. "</p> <p>Record review for Resident #9 ' s nursing notes documented episodes of combative behaviors with staff and physical aggressive behaviors directed towards other residents for the dates of 1/13, 1/16, 1/23, 2/17, 2/18, 2/20, 2/21, 2/22, 2/23, 3/4, 3/11, 3/16 and 3/24/14.</p> <p>Review of Incident report dated 3/16/14 indicated Resident #67 was kicked by Resident #9 during an altercation in the hallway. The description of occurrence indicated Resident #67 was involved in altercation with another resident in the hall-way. One resident started to kick the other resident, resulting in an injury to resident #67 ' s left lower leg.</p> <p>Review of Resident #9 ' s MAR for the month of March 2014 revealed Resident #9 received Ativan 12 times for increased anxiety.</p> <p>Interview with the Social Worker on 4/3/14 at 11:10 am revealed she did not update care plans in regards to behaviors or specific interventions to behaviors. The Social Worker further indicated that she was not aware that Resident #9 was involved in a physical altercation with Resident #67.</p> <p>Interview with the Director of Nursing (DON) on 4/3/14 at 1:18 PM revealed the care plan was updated by a submitted pink slip. The DON further indicated that Resident #9 ' s care plan should have been updated quarterly and should have further indicated specific interventions associated with Resident #9 ' s episodes of</p>	F 280			

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F 280	<p>Continued From page 15</p> <p>aggression toward other residents. The DON indicated she and nursing were responsible for care plan updates. The MDS nurse position was vacant, and the DON was updating the care plans until one was hired.</p> <p>Interview with the Administrator on 4/3/14 at 8:38 am revealed she was unaware of the increase in aggressive behaviors Resident #9 exhibited to other residents within the facility and indicated it was her expectation that new interventions be included to Resident #9 ' s care plan.</p> <p>2. Resident #50 was admitted to the facility on 4/18/13 with diagnoses of hip fracture, mental disorder and Alzheimer's disease.</p> <p>Review of the initial Minimum Data Set (MDS) dated 10/8/13, indicated Resident #50 was not ambulatory, had no behaviors, and experienced difficulty concentrating some of the time. This MDS indicated she had problems with long and short term memory and was unable to make decisions. The medication used during this assessment period was an antidepressant.</p> <p>The care plan for Resident #50, dated 10/8/13 addressed a problem of " Alteration in cognitive status due to Dementia. " The stated goal included staff would assist in meeting the resident ' s needs related to cognitive status. The approaches for staff to use included redirection when behaviors were exhibited due to confusion and dementia, administer medications as ordered and notify MD of any progressive changes in dementia. There were no updates to this care plan after October for review.</p> <p>Review of a physician ' s progress note for Resident #50, dated 10/16/13 revealed Resident</p>	F 280			

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F 280	<p>Continued From page 16</p> <p>#50 had some "problems with aggression and behaviors mostly in the mornings more so recently. She otherwise was pleasant at times. Ativan .5mg (milligrams) was ordered to be given every morning." Ativan was an antianxiety medication.</p> <p>The next MDS available for review for Resident #50, dated 1/7/14 and was a significant change (SC) MDS. Changes were assessed in the areas of behavior that included physical behavioral symptoms directed toward others that occurred one to three days a week. This MDS assessment of the Impact on Resident " indicated the " identified symptom put the resident at significant risk for physical illness or injury, significantly interfered with the resident ' s care, and put others at significant risk for physical injury " was answered as " Yes. " The SC MDS indicated Resident #50 ' s behaviors were " worse " than the prior MDS assessment. Resident #50 required limited assistance by staff for transfers, extensive assistance with walking in the hallway, locomotion off the unit and bed mobility. She was able to move about the unit with limited assistance by staff. Medications used during the assessment period were an antianxiety and an antidepressant.</p> <p>Review of the Care Area Assessments (CAAS) dated 4/4/14 for cognition included Resident #50 had severe cognitive deficits with a diagnosis of Alzheimer's disease and mental disorder. The resident had short and long term memory impairment with severe impairment with daily decision making abilities. Resident #50 had to be redirected by staff, needed supervision and reminders from staff and had a prior level of care in a secured memory care unit. No wandering</p>	F 280			

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F 280	<p>Continued From page 17</p> <p>episodes were present during that assessment. Review of the CAAS for psychosocial well being included a history of depression and a SC in mood. The family was supportive and visited on regular basis. The resident propelled herself in facility but did not have a self destination. The medications were for depression and anxiety.</p> <p>The care plan for Resident #50 did not address the changes in moods and behaviors after the Significant Change MDS was completed.</p> <p>The nurse ' s note dated 1/30/14 at 10:00 PM indicated Resident #50 had " Some combative (combativeness) this evening. Redirected. "</p> <p>Review of the " Incident/Accident Report for Resident #50 dated 1/31/14 at 1:20 PM revealed an altercation occurred between Residents #50 and #37. The nurse heard noises from the residents ' room and observed the two residents " swatting " at each other. The nurse removed the residents from the situation, Resident (#50) removed from room and gave activity to help. The measures to prevent reoccurrence included " redirected resident to an activity (baby doll). The additional comments included staff to continue frequent rounds and redirect resident to activity such as baby doll. Resident #50 had no injuries noted.</p> <p>The nurse ' s note for dated 2/1/14 at 11:00 AM revealed Resident #50 was up in her wheelchair, saying to her roommate, " You be quiet. " Resident #50 was " agitated at roommate for talking. " (At that time, Resident #50 had been in a new room, on a different hallway from Resident #37 and was yelling at her new roommate.) According to the staff assignment sheet, this</p>	F 280			

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F 280	<p>Continued From page 18</p> <p>nurse ' s note was signed by the nurse on the 100 hall (new location of Resident #50).</p> <p>Interview with the Social Worker on 4/25/14 at 10:21 AM revealed she was not aware of changes in Resident #50 ' s mood and behaviors at the time the significant change MDS was completed. Chart review by the Social Worker revealed she had resisted care, was physically aggressive with staff. Continued interview revealed nothing would be changed on the care plan for moods and behaviors. Further interview revealed the Social Worker completes the mood and behavior section of the MDS, but she does not know there is a significant change MDS until the MDS nurse informs her. The MDS nurse completes a care plan for moods and behaviors. During the interview, the social worker explained her (Resident #50) moods and behaviors have been the same, she is very confused. Resident #50 was moved from memory care unit due to a fall and was admitted to the nursing home after a total hip repair was performed. The Social Worker was not aware what the diagnosis " mental disorder " included. Resident #50 had Alzheimer ' s disease and dementia according to the social worker.</p> <p>Interview with the Director of Nursing (DON) on 4/25/14 at 3:30 PM revealed she was completing the MDS and care plans prior to becoming the DON. In the absence of an MDS nurse, she continued to complete the MDS assessments and do care plan updates. She thought she had included the behaviors of physical aggression of Resident #50 in her note. The explanation provided by the DON was she " missed those behaviors when she went through and tried to update the care plans. "</p>	F 280			

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F 323 SS=D	<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 medical record review, resident interviews, physician assistant and staff interviews the facility failed to manage inappropriate behaviors and implement effective interventions for 2 (Resident #9 and Resident #50) of 4 sampled residents with behaviors to prevent continued resident to resident physical altercations. (Resident #9 had physical altercations with Residents #2, 13, #29 and #67) over a period of 3 months. (Resident #50 had physical altercations with Resident #37 on two consecutive days resulting in injury.</p> <p>The findings included:</p> <p>1. Review of the facilities policy for psychiatric episodes indicated residents who exhibit acute psychiatric symptoms that threatens the well-being of that resident or others, will be evaluated for discharge to a psychiatric crisis center for evaluation. The procedures included 1) the attending physician will be notified once a resident has exhibited behavior that threatens the well-being of himself or others. 3) less severe outbursts may be handled by a psychiatrist on either an in or outpatient basis 4) until a resident</p>	F 323	<p>F323 STANDARD DISCLAIMER: This Plan of Correction is prepared as a necessary requirements for continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s).</p> <p>At 6:30pm on January 30, 2014, staff overheard yelling from Resident #37 s room. Upon entering the room, the second shift Charge Nurse observed Resident # s 37 and 50, who were one another s roommate, yelling at each other. The second shift Charge Nurse calmed both residents down and separated the two residents by removing Resident #50 from the room, temporarily. At that time, the Charge Nurse assessed Resident #37 for any injuries. The Charge Nurse noted Resident #37 to have a skin tear under the right side of the resident s jaw; observed the resident as having scratches on the resident s left forearm, consistent with markings made by fingernails; and</p>	5/26/14	

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F 323	<p>Continued From page 20</p> <p>who needs immediate discharge can be moved out, move the resident to an area where he is not able to injure himself or others and 8) document the episode.</p> <p>Resident #9 was admitted to the facility on 5/8/13 with diagnoses that included depression, anxiety disorder, bipolar disorder and Alzheimer ' s disease. The most recent quarterly Minimum Data Set (MDS) Assessment dated 11/22/13 indicated Resident #9 required extensive assistance to complete activities of daily living (ADLs). The MDS further indicated Resident #9 ' s physical behavioral symptoms toward others occurred 1 to 3 days. Verbal behavioral symptoms directed at others occurred daily. Resident #9 coded as severely cognitively impaired for daily decision making. The facility could not provide any further quarterly assessment beyond 11/22/13.</p> <p>Review of Resident #9 ' s care plan dated 6/11/13 revealed a problem of " diagnosis of depression/bipolar disorder with use of anti-depressant; risk of adverse reactions related to use of medications; she is frequently resistive to caregivers, no difficulty with wandering; history of seizures. " The goals included the resident would have no signs and symptoms of depression daily, like crying, refusal to eat etc. times 90 days. The approaches included providing 1 on 1 visits as needed, moving the resident to a different area and re-approaching as needed secondary to the resident cursing and other behaviors which were not easily redirected. Further review of Resident #9 ' s care plan updated 6/11/13 revealed a problem of, " cognition/communication: resident has memory deficits, alert and is able to comprehend simple</p>	F 323	<p>observed the resident as having a pale, purple area under the resident s left eye. The Charge Nurse asked Resident #37 about the assessed injuries, and Resident #37 stated to the Charge Nurse that Resident #50 had hit and scratched [Resident #37]. Resident #37 s scratches were cleaned with normal saline, triple antibiotic ointment, and covered with a Band-Aid. Resident #50 was also assessed by the second shift Charge Nurse. Based on the Charge Nurse s assessment, Resident #50 had no injuries as a result of the resident-to-resident altercation. After having assessed both residents as not being agitated and/or physically aggressive towards each other, the Charge Nurse returned Resident #50 to the room. The residents attending physicians were notified at 7:00pm and each resident s responsible party was notified at 7:30. The Charge Nurse notified the facility Social Worker during the evening of January 30, 2014. No further incidents were reported on January 30, 2014.</p> <p>During the morning of January 31, 2014, the Social Worker discussed the previous night s incident involving Resident # s 37 and 50 with the facility Administrator. During their morning conversation on January 31, 2014, the Administrator and the Social Worker agreed that Resident #50 should be moved to a different room. Before the room change could be facilitated, a staff nurse observed Resident # s 37 and 50, in their room,</p>		

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F 323	<p>Continued From page 21</p> <p>information, may miss some facts, able to make her needs known to others: unable to make safe appropriate decisions; safety awareness and history of seizures. " The goals included accept judgment of staff/significant other as appropriate related to clothing and activities x 90 days and resident will be free of injury related to cognitive deficit x 90 days. The approaches included medications as ordered by physician, re-approach as needed, resident frequently resistive and combative to care, use different caregivers as indicated and needed, approach resident warmly and positively and in calm manner, calmly talk with resident and offer reassurance prior to initiating care, provide instruction to resident using clear voice, simple sentences, repeat as needed, monitor and document resident behavior and status, report any change in cognitive status to physician. The facility could not provide any updates or revisions to Resident #9 ' s care plan beyond 6/11/13.</p> <p>Physician progress note dated 8/16/13 indicated, " The patient is being evaluated in regards to her behaviors. The nursing staff states that she has for the last month been more agitated and aggressive. She is noted at this time to be moderately agitated and she is upset about her parents who are not living. She is cursing and somewhat aggressive towards other residents however has not physically touched anyone. The note continued with, " the patient is on multiple medications for seizure disorders. She is on Lexapro (anti-anxiety) 15mg daily and is also on Remeron (appetite stimulate) 15mg nightly and did increase this to 30mg daily. She is written for Ativan (anti-anxiety) 0.25 mg every 12 hours PRN (as needed) anxiety and agitation. She is already on Klonopin (anti-anxiety) 1mg three times a day.</p>	F 323	<p>swatting at each other. The nurse observed Resident #37 has having received an abrasion to the resident s right knee, a reddened area to the left side of the resident s neck, as well as, reddened areas to the right side of the resident s face, the resident s right wrist, and resident s left arm. Resident #37 s injuries were treated with normal saline, Neosporin, and a dry dressing was applied to the affected areas. Resident #50 was moved to another room on the afternoon of January 31, 2014. Resident #50 s responsible party was notified of the room change on January 31, 2014. Each resident s attending physician was notified of the incident at 4:30pm on January 31, 2014. After notifying Resident #37 s attending physician of the incident, Resident #37 s responsible party was notified at 4:30pm of both the 1:20pm incident and the change of room assignment for Resident #50. Following the change in rooming assignments, Resident #50 has had no other resident-to-resident altercations.</p> <p>Resident #50 has diagnoses remarkable for mental disorder and Alzheimer s disease, and moved into the room with Resident #37 on Resident #50 s April 18, 2013 admission date. Both residents had lived with one another for approximately ten (10) months without exhibiting any signs of discord or attempts to engage one another in physical, resident-to-resident altercation(s). Given the amount of time Resident # s 37 and 50 had lived in the same room, the facility</p>		

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F 323	<p>Continued From page 22 Will otherwise follow as needed. "</p> <p>Review of Resident #9 ' s physician progress note dated 10/8/13 indicated, " Resident #9 is having a little bit of issue with increased agitation, irritability, and mood and she is having quite a bit of weight gain and due to this, we are going to make some adjustment to her medications and see if we can improve things a little bit for her from that standpoint. " The physician note continued with due to increase mood disorder and weight gain; will decrease Remeron (appetite Stimulant) from 30mg to 15mg nightly, and increase Lexapro (anti-anxiety) from 15mg to 20mg daily. Reassess and make other adjustments as needed. "</p> <p>Review of Resident #9 ' s physician progress note dated 11/19/13 indicated the patient was being seen for routine re-evaluation. She had a history of seizure disorder that was difficult to control and had a couple of small seizures over the weekend. She had seen neurology recently who really did not feel that there were any other adjustments that can be made for her. The note continued with, " due to mood issues and weight gain, we adjusted her Remeron down and Lexapro up and she seems to be doing well with that. "</p> <p>Review of Resident #9 ' s physician progress note dated 12/11/13 said, " The patient with a past medical history of significant for seizure disorder, hypothyroidism, depression, bipolar disorder, and history of frequent urinary tract infections. The nursing staff states that recently she has had an increase in her behaviors with inappropriate language. It was request to repeat a BMP (basic metabolic panel/lab) in four weeks, these results are not readily available for review at this time</p>	F 323	<p>can only speculate that Resident #50 s advancing dementia was a potential causal factor related to the incidents of January 30 and 31, 2014. The facility cannot forecast or adequately prognosticate the potential effects of advancing Alzheimer s disease, or other progressively degenerative diseases affecting cognition, on residents in the facility. The facility can only use resident-specific diagnoses, history, observation, and on-going clinical and psycho-social assessment, as prescribed by the Resident Assessment Instrument (RAI) and Minimum Data Set (MDS) processes, to adequately determine a resident s pre-disposition to engage in resident-to-resident altercations.</p> <p>Following the incident of January 30, 2014, Resident #50 was placed on the 24-Hour Report, a reporting tool used by the facility nurses for those residents identified as experiencing acute episodes, including behaviors. Pursuant to the facility s practice, facility nursing staff continued to monitor Resident #50 s behaviors using the 24-Hour Report, a reporting tool used by the facility nurses for those residents identified as experiencing acute episodes, including behaviors, until February 25, 2014 when no other physically abusive behaviors were observed or reported. Resident #50 has had no other resident-to-resident altercations following the incidents of January 30 and 31, 2014. The facility s initiative to change the rooming assignment of Resident #50 is in concert</p>		

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F 323	<p>Continued From page 23</p> <p>however we will have nursing staff obtain the results and if these are not obtained as of yet, will make sure that is done. " The note continued with, " the patient ' s overall condition relatively stable except for increase in behaviors and recent hypernatremia found on labs. "</p> <p>Review of Resident #9 ' s medical record revealed a physician order dated 12/20/13 indicated, " Increase Lexapro (anti-depressant) to 30mg po (by mouth) daily due to worsening behaviors. "</p> <p>Review of Resident #9 ' s medical record revealed a physician order dated 1/10/14 that said, " 1) increase Klonopin (anti-anxiety) to 2mg po tid (by mouth, three times a day), routinely due to worsening behaviors, and 2) refer to psych due to worsening anxiety/agitation. " Further review of Resident #9 ' s medical record revealed no consultation in regards to psychiatry.</p> <p>A review of Resident #9 ' s nurse ' s note revealed Resident #9 had episodes of aggression towards other residents in the facility. Nursing note dated 1/13/14 said, " Continues to curse when anyone walks by her in hallway. Starting to kick, PRN (as needed) anxiety med given. Still talking to people not there. " Nursing note dated 1/16/14 said, " Remains out in hallway cursing, has continued to try to kick at other residents when they get close to her. "</p> <p>Physician progress note dated 1/21/14 said, " depression - has been worse lately with acting out. Lexapro was just adjusted within the last 2 to 3 weeks so therefore will hold steady with that. Continue with redirection and make other adjustments as needed. Need to be careful with</p>	F 323	<p>with the facility s practice when roommates are determined to be incompatible for any variety of reasons, including having resident-to-resident altercation(s).</p> <p>On January 10, 2014, the physician s assistant (PA) for Resident #9 s attending physician ordered a psychiatric consult due to the resident s worsening anxiety and agitation. According to facility medical staff (e.g. Attending Physicians, Medical Director, et. al), the average lead-time (waiting time) to receive an outpatient psychiatric consult in the community is 4 -6+ weeks. The lead time in scheduling outpatient psychiatric consults is related to the psychiatrist s caseload and patient volume, both factors that are beyond the facility s immediate control. Pursuant to the January 10, 2014 order for a psychiatric consult, the facility s Transportation Scheduler obtained an appointment for an outpatient psychiatric consult for Resident #9 on February 13, 2014. The February 13, 2014 appointment was cancelled due to inclement weather and was subsequently rescheduled for April 17, 2014.</p> <p>Beginning on January 10, 2014, Resident #9 was included on the facility s 24-Hour Report, a reporting tool used by the facility nurses for those residents identified as experiencing acute episodes, including behaviors. Between January 10, 2014 and April 17, 2014, the facility implemented interventions in an attempt to minimize, eliminate, and/or modify Resident #9 s</p>		

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F 323	<p>Continued From page 24</p> <p>adjustments on psychiatric medications due to her seizure medications. "</p> <p>Nursing note dated 1/23/14 indicated, " Resident currently resting quietly in bed with eyes closed. Earlier in shift attempted to kick another resident stating, " Move out of the way s a..." Redirected to another area. "</p> <p>Review of Resident #9 ' s medication administration record (MAR) for the month of January 2014 revealed Resident #9 had received 12 Ativan for increased anxiety.</p> <p>-Nursing note dated 2/17/14 at 8:00 PM said, " Continues with behaviors of cursing and kicking in halls, redirected and environment changes, Unsuccessful. "</p> <p>-Nursing note 2/18/14 at 8:00 PM said, " was cursing in hallway and was going to come in contact with another resident. Environment changed and was redirected. "</p> <p>-Nursing note dated 2/20/14 at 7:00 PM revealed, " One episode of kicking and cursing in hallway. Taken to room to change environment. "</p> <p>-Nursing note dated 2/21/14 at 4:00 PM revealed Resident #9 was cursing and kicking in hallway and had to be brought back to her room.</p> <p>-Nursing note dated 2/22/14 at 6:50 AM said, " resident quiet all shift until arising. After toileting she become abusive to other staff and residents yelling, " you s a.., you s ... a.. " over and over attempting to kick another resident rolling by with wheelchair. " Returned to room when she continued to be verbally abusive until taken to dining room for breakfast. "</p> <p>-Nursing note dated 2/23/14 at 1:15 PM indicated, " able to propel self up and down halls. Tries to kick staff and residents. "</p>	F 323	<p>behaviors, specifically the resident s tendency to attempt to engage in physical altercations with other residents. From January 10, 2014 April 17, 2014, the facility documented the following non-pharmacological interventions specific to Resident #9 s behaviors of agitation:</p> <p>" Diversionary interventions including the following:</p> <ul style="list-style-type: none"> o Use of table top activities (i.e. activities, in which, the resident can engage in self-directed activities with or without supervision) (Successfully Initiated: 01/01/2014, 01/08/2014, 01/15/2014, 01/22/2014, 01/29/2014, 01/20/2014, 1/23/2014, 02/05/2014, 02/12/2014) o Redirecting and/or assisting resident to other, less stimulating areas in the facility (e.g. Day Room with TV, Lobby, Dining Room, et. al.) (Successfully Initiated: 01/23/2014, 03/04/2014, 04/15/2014) o 1:1 interactions between resident and staff (Successfully Initiated: 01/08/2014, 01/11/2014, 01/21/2014, 01/22/2014, 01/23/2014, 01/24/2014, 01/25/2014, 01/28/2014, 02/01/2014, 02/02/2014, 02/04/2014, 02/13/2014, 02/11/2014, 02/13/2014, 03/29/2014, 04/03/2014, 04/06/2014, 04/07/2014, 04/08/2014 04/09/2014) o Assisting resident to interface with resident s family (nephew) via telephone (Successfully Initiated: 04/13/2014) o Diverting the resident s attention with snacks or resident s favorite foods (Successfully Initiated: 01/04/2014, 		

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F 323	<p>Continued From page 25</p> <p>Review of Resident #9 ' s MAR for the month of February 2014 revealed Resident #9 had received 9 Ativan for increased anxiety.</p> <p>Further review of Resident #9 ' s medical record revealed a physician progress note dated 3/4/14 said, " The patient is being seen for routine evaluation. She has a history of difficult to control seizure disorder and is seeing neurology for that. Other issues have been stable. Her depression has been worse and Lexapro was adjusted and she seems to be doing better. "</p> <p>-Nursing note (Resident #9) dated 3/4/14 at 1:15 PM at said, " patient up in wheelchair in hallway. Has been cursing and hollering all day. Kicked at other patients and staff. Slid down in wheelchair and had to be pulled up several times. "</p> <p>-Nursing note (Resident #9) dated 3/11/14 at 2:40 PM revealed, " Resident #9 very combative this pm, was given prn ativan at pm. She was hitting, kicking and trying to bite other resident and staff. She was redirected to her room where she finally calmed down and took a nap. "</p> <p>-Nursing note (Resident #9) dated 3/16/14 at 2:40 PM said, " Resident #9 involved in a physical altercation of kicking another resident (Resident #67) in hallway. Resident redirect to another activity. "</p> <p>-Nursing note (Resident #9) dated 3/24/14 at 3:00 PM dictated, " alert, confused, place and time and events. Continue to curse at staff at intervals will kick at staff and residents. "</p> <p>Review of incident report dated 3/16/14 indicated</p>	F 323	<p>01/10/2014, 01/11/2014, 01/19/2014, 01/24/2014, 01/27/2014, 02/01/2014, 02/13/2014, 02/22/2014, 03/10/2014, 03/11/2014, 03/13/2014, 03/16/2014, 03/19/2014, 03/27/2014, 04/01/2014, 04/08/2014)</p> <p>o Assist resident to interactive group activities enjoyed by the resident (e.g. singing groups, movies, music therapy, garden club, et. al.) (Successfully Initiated: 01/03/2014, 01/04/2014, 01/05/2014, 01/06/2014, 01/13/2014, 01/17/2014, 01/18/2014, 01/20/2014, 01/21/2014, 01/23/2014, 01/24/2014, 02/01/2014, 02/03/2014, 02/10/2014, 02/24/2014, 03/17/2014, 03/24/2014, 04/18/2014)</p> <p>" Using visual assessment and resident interview, assess resident s level of fatigue and assist resident to bed for a period of rest (nap) (Successfully Initiated: 03/11/2014)</p> <p>In such cases where the facility s non-pharmacological interventions were not effective, facility nurses assessed Resident #9 for any unmet physiological needs, including an assessment of pain and/or the clinical appropriateness of administering as-needed (PRN) pain and/or anxiolytic medication(s) pursuant to the orders given by the resident s attending physician. According to review of the resident s medical record, the facility nurses assessed Resident #9 for any potentially unmet physiological needs, when the identified non-pharmacological interventions were not effective. Based on the facility nurses assessment of</p>		

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F 323	<p>Continued From page 26</p> <p>Resident #67 was kicked by Resident #9 during an altercation in the hallway. The description of occurrence indicated Resident #67 was involved in altercation with another resident in the hallway. One resident started to kick the other resident, resulting in an injury to resident #67 ' s left lower leg. The measures to prevent further occurrence indicated, Resident #67 will be separated from the resident in question (Resident #9) at all times.</p> <p>Review of Resident #9 ' s MAR for the month of March 2014 revealed Resident #9 received Ativan 12 times for increased anxiety.</p> <p>Resident #2 was admitted to the facility on 11/27/13 with diagnoses that included depression and anxiety disorder. The most recent MDS assessment dated 12/06/13 indicated Resident #2 required no assistance with locomotion on and off the unit. Resident #2 coded as cognitively intact as evidenced by a (Brief Interview Mental Score) BIM ' s score of 13.</p> <p>Interview with Resident #2 on 4/3/14 at 3:08pm revealed Resident #9 would kick other residents when she was in the hallway. Resident #2 indicated that Resident #9 had been kicked by Resident #9 a couple of times since his admission to include as early as last week. Resident#2 revealed staff (name unknown) did observe Resident #9 kick him. Resident #2 continued that following Resident #9 kicking him, staff moved Resident #9 further down the hall and talked to her for a little bit. Resident #2 stated that he was not hurt as a result of Resident #9 kicking him. Resident #2 indicated that Resident #9 kicked and hit staff as well as other residents that are on the hall without warning. Resident #2 further stated that he was able to propel his own</p>	F 323	<p>Resident #9, facility nurses administered as-needed pain and/or anxiolytic medication(s) appropriately. Similarly, Resident #9 s medical record indicates the pharmacological interventions were effective in reducing the resident s agitation specific to the resident s attempts to engage in physical altercations with other residents. Additionally, in the interim period of time between the receipt of the order for a psychiatry consult on January 10, 2014 and the consult on April 17, 2014, Resident #9 s attending physician was aware of the increases in Resident #9 s agitation and attempts to engage in physical altercations with other residents. Consequently, Resident #9 s attending physician and/or the attending s physician extender (i.e. Nurse Practitioner and/or Physician s Assistant) ordered the following:</p> <p>" A urine analysis (U/A) on 01/09/2014. The results were negative.</p> <p>" On 01/10/2014 the scheduled dosing of Klonopin, an anxiolytic, was increased from 1.5 milligrams by mouth (PO) routinely three (3) times per day to 2 milligrams by mouth (PO) routinely three (3) times per day.</p> <p>" On 01/15/2014, the as-needed (PRN) pain medication, Lortab? (5 milligrams hydrocodone barbiturate and 500 milligrams acetaminophen) 1 tablet by mouth every 6 hours as-needed for pain was changed to Lortab? (5 milligrams hydrocodone and 325 acetaminophen) 1 tablet by mouth every 6 hours as-needed for pain.</p>		

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F 323	<p>Continued From page 27</p> <p>wheelchair and could avoid encounter with Resident #9 by moving out of her way. The facility could not provide any documentation in regards to Resident #9 kicking resident #2.</p> <p>Resident #29 was admitted to the facility on 7/3/13 with diagnoses that included anemia, hypertension, peripheral vascular disease, and chronic kidney disease state IV. The most recent MDS assessment dated 11/05/13 indicated Resident #29 was independent with locomotion off and off the unit. Resident #2 coded as cognitively intact as evidenced by as BIM ' s score of 15.</p> <p>Interview with Resident #29 on 4/3/14 at 3:33 pm revealed Resident #9 would hit and kick residents in the hallway. The resident indicated that the resident #9 had kicked him once before although he could not remember the date. Resident #29 stated staff were aware that the resident kicked and hit at other residents. Resident #9 would become aggressive without warning and it occurred several times weekly. Staff would sometimes observe Resident #9 kick residents and sometimes they did not observe Resident #9 kicking other residents. Resident #29 continued that staff would take Resident #9 to her room when she began kicking and cursing or would move her to another end of the hall away from other residents. Resident #9 would eventually return and continue the same behavior. Resident #29 stated he moves out of Resident #9 ' s way when she passes him in the hallway to prevent Resident #9 from kicking him. Resident #29 stated, " you have to just stay out of kicking distance. "</p> <p>Interview with NA #1 on 4/2/14 at 5:00 pm</p>	F 323	<p>" On 01/28/2014, a Comprehensive Metabolic Panel (CMP) and Complete Blood Count (CBC) was ordered by the attending physician. The results were within normal limits except for a slightly elevated glucose level at 102 (Normal Laboratory Reference Range: 65-99), and a slightly low hemoglobin at 11.1 (Normal Laboratory Reference Range: 12.5 14)</p> <p>" On 02/10/2014, a Basic Metabolic Panel (BMP) was ordered by the attending physician. The results were within normal limits except for a slightly elevated glucose level at 107 (Normal Laboratory Reference Range: 65-99).</p> <p>On March 16, 2014, a CNA observed both Resident # s 9 and 67 seated in their wheelchairs in the hallway. At approximately 2:30pm on March 16, 2014, the same CNA observed Resident #9 kick Resident #67. The CNA immediately separated the two residents and both residents were assessed for injuries. As a result of Resident #9 s having kicked Resident #67, Resident #67 was observed to have sustained a skin tear on the resident s left lower leg. Resident #67 s skin tear was cleaned with normal saline and a dry dressing was applied. Following the immediate separation of the two identified residents, Resident #9 was assessed as not having sustained any injuries as a result of the resident-to-resident altercation with Resident #67. The attending physician and responsible party for both Resident # s 9 and 67 were notified of the incident at</p>		

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F 323	<p>Continued From page 28</p> <p>indicated Resident #9 would become aggressive with other residents in the facility. NA#1 continued that Resident #9 would attempt to kick or hit residents when they passed her by in the hallway. Resident #9 would display aggressive behaviors without warning and not expected. Nursing staff indicated that when resident #9 would become aggressive, staff would attempt to talk to the resident, provide redirection, and remove other residents out of Resident #9 ' s reach. Resident #9 ' s behaviors occurred from 4 to 5 times a week. Resident #9 would occasionally enter other residents ' rooms. NA#1 recalled she had observed Resident #9 having an altercation with Resident # 13 in the doorway of Resident #13 ' s room. Resident #9 was observed to kick Resident #13 about 2 months ago (actual date unknown). NA#1 indicated she recalled separating Resident #9 and Resident #13. NA#1 could not recall if she communicating the incident to nursing. Following the incident NA#1 stated, " I think I took her to her room to calm down. " NA #1 continued with Resident #9 was usually provided an Ativan when attempts to relocating or redirect were unsuccessful.</p> <p>Resident #13 was admitted to the facility on 7/29/08 with diagnoses that included Alzheimer ' s disease, dementia, and recurrent depression and anxiety. Review of the most recent MDS assessment dated 10/31/13 indicated Resident #13 was coded as moderately impaired as evidence of a BIM ' s score of 7.</p> <p>Interview with the Social Worker on 4/3/14 at 11:10 am revealed if an incident was witnessed on the hall the NAs were to report the findings to nursing. The Social Worker indicated that patients at risk are discussed weekly in meetings</p>	F 323	<p>2:30pm on March 16, 2014.</p> <p>As a result of the March 16, 2014 incident involving Resident #67, Resident #9 remained on the 24-Hour Report, a reporting tool used by the facility nurses for those residents identified as experiencing acute episodes, including behaviors for each subsequent 24-hour period. Resident #9 remained on the 24-Hour Report specific to the resident s history of attempting to engage in resident-to-resident altercations. The facility continued with both the non-pharmacological and pharmacological interventions previously identified, pending any potential changes to Resident #9 s care regimen specific to the psychiatric consultation scheduled for April 17, 2014.</p> <p>As a result of Resident #9 s outpatient psychiatric consult on April 17, 2014, the consulting psychiatrist noted the following findings:</p> <p>" The resident as having a history of dementia with bi-polar disorder, and;</p> <p>" The resident s mood is now very unstable and the resident is both paranoid and delusional.</p> <p>Based on the psychiatrist s consult of April 17, 2014, Resident #9 s medication regimen was changed as follows:</p> <p>" Increased Lexapro, an antidepressant, from 30 milligrams per day to 40 milligrams per day;</p> <p>" Added 25 milligrams of Seroquel, an antipsychotic, to be administered at bedtime for four consecutive nights, then increasing the Seroquel dosing on day</p>		

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F 323	<p>Continued From page 29</p> <p>that include medication changes and behaviors. The social worker indicated that she would only get involved with the resident ' s behavior concerns in the instance it was an emergency situation involving another resident or in the instance there was an injury. She would also get involved with a resident in the instance the behavior was not improving and inpatient services would be sought. Resident #9 would occasionally kick her feet at anyone who walks by. The social worker revealed she was unaware that Resident #9 had an order for a psychiatric consult. Had she known resident #9 had an order for a psychiatric consult she would have followed up with transportation to gain clarification about the appointment date. The social worker further indicated that she was unaware Resident #9 was involved in a physical altercation with Resident #67. In the instance she was aware of the altercation she would have followed up the resident and documented her actions. The Social Worker continued with incident reports were not provided to her for review involving resident to resident aggression.</p> <p>Interview with Nurse #3 on 4/3/14 at 11:19 am indicated Resident #9 had exhibited behaviors that included hitting, kicking, and cursing at staff and residents in the facility. Nurse #3 indicated that in the instance Resident #9 became aggressive with other residents staff would remove the resident to a different activity. Nurse #3 stated that resident #9 could be very aggressive and at times she was difficult to calm. Nurse #3 indicated that Resident #9 ' s triggers for the exhibited behaviors were unknown. Nurse #3 revealed when attempts to calm Resident #9 failed Resident #9 was provide with a PRN (as needed) ativan.</p>	F 323	<p>five to 50 milligrams at bedtime. The Seroquel was added based on the psychiatrist s assessment of Resident #9 s having both psychosis and mood disorders.</p> <p>Following the April 17, 2014 psychiatry evaluation and subsequent medication adjustments, a review of Resident #9 s nursing notes indicate a noticeable improvement in Resident #9 s attempts to engage in physically aggressive behaviors with or towards other residents. Resident #9 is still noted to use profane language and has been noted to be resistive to care provided by direct care staff only twice since medication changes made on April 17, 2014. In spite of Resident #9 s having been resistive to care two times since April 17, Resident #9 is not noted as having physically aggressive behaviors, including kicking and/or spitting, to other residents. Resident #9 remains on the 24-Hour Report, a reporting tool used by the facility nurses for those residents identified as experiencing acute episodes, including behaviors. Resident #9 shall remain on the 24-Hour Report until the resident no longer exhibits physically aggressive behaviors towards other residents. The facility cannot attribute any potential causal factors that may have precipitated Resident #9 s behaviors towards other residents. Resident #9 has diagnoses including bi-polar disorder with mixed to moderate mood, depressive disorder, anxiety, impulse control disorder, and dementia. Consequently, the facility cannot forecast or adequately prognosticate the potential effects of</p>		

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F 323	<p>Continued From page 30</p> <p>Interview with Nurse #4 on 4/3/14 at 1:27 pm revealed she completed an incident report for Resident #67 on 3/16/14. Nurse #4 revealed the incident was communicated by a member of the physical therapy (name unknown). Nurse #4 stated that the PT staff stated Resident #9 had kicked Resident #67. Nurse #4 indicated she completed an incident report on Resident #67 due to resident #67 receiving a skin tear. Nurse #67 indicated the incident occurred after lunch when Resident #9 and Resident #67 were coming back from the dining room after lunch. Nurse #4 described Resident #9 's behaviors as verbal and physical. Nurse #4 revealed staff was to retrieve a nurse when Resident #9 was exhibiting behaviors. Nursing staff would normally redirect Resident #9 to another activity or take Resident #9 to another area to talk.</p> <p>Interview with Physical Therapist (PT) #1 on 4/24/14 at 4:02 pm revealed she did communicate Resident #9 and Resident #67 were arguing with each other. PT #1 revealed she heard the two residents when she was headed to the nursing station from the PT department. Resident #9 was observed to be kicking her legs in the direction of Resident #67. It was not known whether the resident was attempting to turn her chair around or if Resident #9 was actually kicking Resident #67. The PT continued that a nurse (name unknown) was coming toward the commotion. At that time the PT#1 indicated that she communicated to the nurse passing her in the hall that it there Resident #9 and Resident #67 were arguing. PT #1 indicated that she was unaware that an injury occurred with Resident #67. PT#1 indicated she does not typically separate residents; she would</p>	F 323	<p>advancing Alzheimer s disease, or other progressively degenerative diseases affecting cognition, on residents in the facility. The facility can only use resident-specific diagnoses, history, observation, and on-going clinical and psycho-social assessments, as prescribed by the Resident Assessment Instrument (RAI) and Minimum Data Set (MDS) processes, to adequately determine a resident s pre-disposition to engage in resident-to-resident altercations.</p> <p>For those residents having the potential to be affected by the same alleged deficient practice, facility nurses shall continue to use the 24-Hour Report to monitor residents experiencing acute episode(s), including behaviors, until the acute episode(s), including behaviors, have resolved or the acute episode(s), including behaviors, are no longer observed. Similarly, the facility shall continue to use both non-pharmacological (as identified above) and pharmacological interventions, pursuant to the attending physician s orders, in attempts to minimize, eliminate, and/or modify physically aggressive behaviors exhibited with and/or between residents. Such interventions shall continue to be documented in the resident s medical record.</p> <p>Additionally, the Administrator and Social Worker have reviewed all Incident/Accident reports from January 1, 2014 to April 25, 2014 in order to identify other residents who may have exhibited</p>		

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F 323	<p>Continued From page 31</p> <p>retrieve nursing staff to deal with behavioral concern.</p> <p>Interview with Nurse #5 on 4/3/14 at 2:53 pm revealed she was made aware of the incident that occurred on 3/16/14 by Nurse #4. Nurse #5 indicated Resident #9 exhibited behaviors such as kicking and cursing at staff and other residents. Nurse #5 revealed staff would move Resident #9 when she would become agitated and attempted to aggress towards other residents. Nurse #5 indicated Resident #9 independently propel her wheelchair and did occasional enter other resident ' s rooms. Nurse #5 revealed Resident #9 had become aggressive with Resident #13 a couple of times as evidenced by trying to kick her. Nurse #5 indicated that she only does incident reports that result in harm not attempt to harm.</p> <p>Interview with Nurse #6 on 4/24/14 at 3:41 pm revealed a transportation form is provided by nursing to the transportation aide. Nurse #6 indicated she was responsible for ensuring resident ' s physician orders for outside care were carried out. Nursing staff would provide a transportation slip to transportation staff and transportation would schedule appointments. Transportation staff would then ensure a consultation report is brought back following the appointment. Nurse #6 revealed she was unsure why there was a laps in the scheduling of Resident #9 ' s psych appointment. Nurse #6 indicated Resident #9 did aggress toward other residents in the facility. Nurse #6 indicated that redirection was not always successful. Nurse #6 further indicated that Resident #9 was moved from the situation, resident #9 would return to the hall and continue the aggressive behaviors.</p>	F 323	<p>physically abusive behaviors towards other residents. This review was completed on 4/25/2014. Only those residents identified by this alleged deficient practice (Resident # s 50 and 9) were determined to have exhibited physically abusive behaviors towards other residents.</p> <p>On April 25, 2014, the facility executed a contract with a consulting psychiatrist to provide in-facility, outpatient psychiatric consults to those residents having an assessed need for psychiatric consultations. The Social Worker shall facilitate the facility s referral(s) to the consulting psychiatrist using staff reports, which may be inclusive of, but not limited to, any of the following:</p> <ul style="list-style-type: none"> " 24-Hour Report, " Verbal reports made by staff to the Social Worker, Nurse, Director of Nursing, MDS Coordinator, et. al. " Reports obtained from record review, etc., " Direct resident observation(s), " Completed Record of Complaint form(s), " Completed Investigation of Unwitnessed Resident Incident form, " A resident s social and/or medical history, if applicable, and " Incident/Accident Reports. <p>On April 25 26, 2014, the facility in-serviced 130 out of 139 staff specific to the staff s responsibility(ies) of reporting resident-to-resident altercations. Similarly, on April 25 26, 2014, the facility in-serviced 130 out of 139 staff specific to</p>		

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F 323	<p>Continued From page 32</p> <p>Resident #9 typically " showed out " in the hallways but did occasionally propel her wheelchair in other resident ' s rooms.</p> <p>Interview with the Director of Nursing (DON) on 4/3/14 at 1:18pm revealed Resident #9 ' s behaviors varied at different times of the day. The DON recalled attempting to redirect Resident #9 herself which resulted in Resident #9 attempting to hit the DON. The DON indicated that occasionally Resident #9 could be redirected or diverted. The DON further indicated that she was not aware of the incident dated 3/16/14 in which Resident #9 aggressed towards Resident #67.</p> <p>Interview with the facility Physician Assistant (PA) on 4/3/14 at 3:43 pm indicated that it was communicated to her by facility staff that Resident #9 was exhibiting behaviors such as physical and verbal aggression towards others. The PA further indicated that she had witnessed Resident #9 reach out in an attempt to hit residents in her way. Psychiatric services were recommended due to Resident #9 ' s use of seizure mediations and adjustments to current medications had been attempted. It was the expectation of the PA that Resident #9 be seen as soon as an appointment could be made. The PA was unaware that Resident #9 had not received a consultation from a psychiatrist. The PA was unaware of the incident that occurred on 3/16/14 and further indicated she was not aware of an increase in Resident #9 ' s behaviors.</p> <p>Interview with the administrator on 4/3/14 at 8:38 am revealed it was her expectation that Resident #9 ' s physician order written on 1/10/14 to receive psychiatric consult should have been</p>	F 323	<p>the staff s responsibility(ies) of reporting all instances of abuse, neglect, misappropriation, and/or injuries of unknown source, pursuant to the facility s Abuse Policy(ies) (Revised: 09/2011). Additionally, on April 25 26, 2014, the facility in-serviced 130 out of 139 staff specific to the types of and effective implementation of interventions specifically related to how to deal with resident to resident altercations, how to deal with residents with aggressive behaviors, including interventions such as immediate separation of residents involved, assessing both residents for any injuries, notifying the attending physician and responsible party of each affected resident, facilitate a room change for the resident who initiated the abuse, attempt to discern any causal factors related to the resident-to-resident altercation(s) and/or aggression. Diversionary interventions including, but not limited to the use of table top activities, (i.e. activities in which the resident can engage in self-directed activities with or without supervision) redirecting or assisting resident to less stimulating areas of the facility (e.g. Day Room with TV, Lobby, Dining Room, et.al.), 1:1 interactions between resident and staff, diverting the residents attention with snacks or residents favorite food (where appropriate or not contra-indicated). Also assist resident to interactive group activities enjoyed by resident (e.g. singing groups, movies, music therapy, garden club, et.al.). For any staff members that were on vacation, sick leave, or new hires and</p>		

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F 323	<p>Continued From page 33</p> <p>scheduled the day in which it was written. Due to the increase in Resident #9 's verbal and physical outburst, an appointment should have been followed up with. The Administrator was unaware of the increase in aggressive behaviors Resident #9 exhibited to other residents within the facility and indicated it was her expectation that new interventions be included to Resident #9 ' s care plan.</p> <p>2. Review of the policy : " Psychiatric Episodes " with a revised date of 10/2006 revealed " Residents who exhibit acute psychiatric symptoms that threatens the well-being of that resident or others, will be evaluated for discharge to a psychiatric crisis center for evaluation. The " Procedure " included ... " 3. Less severe outbursts may be handled by a psychiatrist on either an in or outpatient basis. 4. Until a resident who needs immediate discharge can be moved out, move the resident to an area where he is not able to injure himself or others 8. Document episode. "</p> <p>Resident #50 was admitted to the facility on 4/18/13 with diagnoses of hip fracture, mental disorder and Alzheimer's disease.</p> <p>Review of the initial Minimum Data Set (MDS) dated 10/8/13, indicated Resident #50 was not ambulatory, had no behaviors, and experienced difficulty concentrating some of the time. This MDS indicated she had problems with long and short term memory and was unable to make decisions. The medication used during this assessment period was an antidepressant.</p> <p>The care plan for Resident #50, dated 10/8/13 addressed a problem of " Alteration in cognitive</p>	F 323	<p>have not been educated on instances of abuse, neglect, misappropriation, and/or injuries of unknown source, how to deal with resident to resident altercations, how to deal with residents with aggressive behaviors, shall not be allowed to work until such education outlined herein has been completed.</p> <p>In attempts to determine if a resident has the potential to engage in physically abusive behaviors with other residents, the facility shall use the following information, which may be inclusive of, but shall not be limited to:</p> <ul style="list-style-type: none"> " 24-Hour Report, " Verbal reports made by staff to the Social Worker, Nurse, Director of Nursing, MDS Coordinator, et. al. " Reports obtained from record review, etc., " Direct resident observation(s), " Completed Record of Complaint form(s), " Completed Investigation of Unwitnessed Resident Incident form, " A resident s social and/or medical history, if applicable, and " Incident/Accident Reports. <p>The Director of Nursing/MDS Coordinator/Social Worker shall discuss resident behaviors, to include but not limited to complaints, altercations, changes in mood during clinical meeting daily.</p> <p>The Social Worker shall audit 10% of interviewable and 10% noninterviewable residents responsible parties weekly x 4,</p>		

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F 323	<p>Continued From page 34</p> <p>status due to Dementia. " The stated goal included staff would assist in meeting the resident ' s needs related to cognitive status. The approaches for staff to use included redirection when behaviors were exhibited due to confusion and dementia, administer medications as ordered and notify MD of any progressive changes in dementia. There were no updates to this care plan after October for review.</p> <p>Review of a physician ' s progress note for Resident #50, dated 10/16/13 revealed Resident #50 had some "problems with aggression and behaviors mostly in the mornings more so recently. She otherwise was pleasant at times. Ativan .5mg (milligrams) was ordered to be given every morning. " Ativan was an antianxiety medication.</p> <p>The next MDS available for review for Resident #50, dated 1/7/14 and was a significant change (SC) MDS. Changes were assessed in the areas of behavior that included physical behavioral symptoms directed toward others that occurred one to three days a week. This MDS assessment of the Impact on Resident " indicated the " identified symptom put the resident at significant risk for physical illness or injury, significantly interfered with the resident ' s care, and put others at significant risk for physical injury " was answered as " Yes. " The SC MDS indicated Resident #50 ' s behaviors were " worse " than the prior MDS assessment. Resident #50 required limited assistance by staff for transfers, extensive assistance with walking in the hallway, locomotion off the unit and bed mobility. She was able to move about the unit with limited assistance by staff. Medications used during the assessment period were an antianxiety and an</p>	F 323	<p>10% monthly x 3, then 10% quarterly thereafter.</p> <p>The Director of Nursing/MDS Coordinator/Social Worker shall complete 100% audit of all residents' medical records to ensure appropriate interventions are in place for those residents who may be affected.</p> <p>To ensure continued compliance, the Director of Nursing/MDS Coordinator/Social Worker shall audit 10% weekly x 4, 10% monthly x 3, then quarterly thereafter.</p> <p>The Director of Nursing shall report the findings of such audits to the Quality Assurance Committee monthly x 3, then quarterly thereafter.</p>		

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F 323	<p>Continued From page 35 antidepressant.</p> <p>Review of the Care Area Assessments (CAAS) dated 4/4/14 for cognition included Resident #50 had severe cognitive deficits with a diagnosis of Alzheimer's disease and mental disorder. The resident had short and long term memory impairment with severe impairment with daily decision making abilities. Resident #50 had to be redirected by staff, needed supervision and reminders from staff and had a prior level of care in a secured memory care unit. No wandering episodes were present during that assessment. Review of the CAAS for psychosocial well being included a history of depression and a SC in mood. The family was supportive and visited on regular basis. The resident propelled herself in facility but did not have a self destination. The medications were for depression and anxiety.</p> <p>The care plan for Resident #50 did not address the changes in moods and behaviors after the Significant Change MDS was completed.</p> <p>Review of a physician ' s note for Resident #50, dated 1/7/14 revealed no mention of problems with behaviors or combativeness.</p> <p>The 1/30/14 incident for Resident #50 was not available for review.</p> <p>The nurse ' s note dated 1/30/14 at 10:00 PM indicated Resident #50 had " Some combative (combativeness) this evening. Redirected. "</p> <p>Resident #37 ' s initial admission to the facility was on 6/19/13 with diagnoses of senile dementia, anxiety, depressive disorder.</p>	F 323			

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F 323	<p>Continued From page 36</p> <p>Record review revealed Resident #37 was hospitalized on 8/12/13- 9/11/13 secondary to agitation and aggressive behaviors. Her behaviors were described as being aggressive and fighting with nurses. Resident #37 received psychiatric care at the hospital and was discharged back to the facility on 9/11/13.</p> <p>Review of the admission MDS dated 9/18/13 for Resident #37 indicated she had short and long term memory impairment and moderate impairment with daily decision making abilities. Her moods were identified as being short tempered which occurred several days and behaviors were hallucinations, delusions and verbal. This MDS indicated the verbal behaviors did not impact the resident or others. Resident #37 was independent with bed mobility, transfers and eating. She required limited assistance for ambulating and supervision with moving about on and off the unit. Medications used during this assessment period included antipsychotics for the past 7 days and an antidepressant for the past 7 days.</p> <p>The care plan for Resident #37 dated 9/18/13 indicated a problems of dementia and behaviors listed as episodes of becoming combative, hitting staff, threw water on staff, chased staff out of room and frequently cursing at caregivers. Problems of anxiety and depression were also listed. The approaches included staff was to approach warmly, redirect resident when first onset of behavioral problems, consult Paradigm mental Health Services, provide activities, and monitor behavior.</p> <p>The quarterly MDS dated 10/23/13 for Resident #37 when compared to the admission MDS,</p>	F 323			

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F 323	<p>Continued From page 37</p> <p>indicated no changes in memory, cognition or daily decision making abilities. Behaviors were assessed as hallucinations and delusions. There were no verbal behaviors and no short tempered moods. Resident #37 remained the same with her physical functioning abilities. The medications remained unchanged from the admission MDS with antipsychotic and antidepressant medications received for 7 days during the assessment period.</p> <p>Review of the " Incident/Accident Report for Resident #37 dated 1/30/14 at 6:00 PM revealed an incident had occurred in the room between Residents #37 and #50. The nurse responding heard yelling from the room, entered the room and both residents were yelling at each other. Resident #37 had a skin tear under the right side of the jaw, fingernail marks on the left forearm and a " very pale light purple color under left eye. " Resident #37 was quoted by the nurse as saying " See where she (resident #50) scratched and hit me? " The report indicated the measures to prevent reoccurrence included " spoke c (with) Social worker Roommate moving to different room. " Additional comments were, the social worker was notified and evaluating for a room change. The staff were to continue frequent rounds and redirect to table top activity such as folding laundry.</p> <p>The next nurse ' s note for Resident #50 was documented on 1/31/14 at 4:20 PM. This note indicated the nurse heard noises from the resident ' s room and she observed Resident #50 and #37 " swatting at each other. " The nurse removed residents from the room and gave an activity to help.</p>	F 323			

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F 323	<p>Continued From page 38</p> <p>Review of the " Incident/Accident Report for Resident #50 dated 1/31/14 at 1:20 PM revealed an altercation occurred between Residents #50 and #37. The nurse heard noises from the residents ' room and observed the two residents " swatting " at each other. The nurse removed the residents from the situation, Resident (#50) removed from room and gave activity to help. The measures to prevent reoccurrence included " redirected resident to an activity (baby doll). The additional comments included staff to continue frequent rounds and redirect resident to activity such as baby doll. Resident #50 had no injuries noted.</p> <p>Review of the " Incident/Accident Report for Resident #37 dated 1/31/14 at 1:20 PM revealed the same description and preventative measures that were recorded for Resident #50. Type of injury noted for Resident #37 included the left side of the neck was " red," the right side of the face was " red," the right lower arm had " red areas/wrist red/scrapes," the left lower arm had a " purple area," and the right knee was " red with abrasion." Resident #37 received treatment to the knee and right lower arm with Neosporin ointment and a dry dressing.</p> <p>A nurse ' s note was made for Resident #50, dated 1/31/14 at 4:30 PM that the family member was in the facility and was made aware of the altercation. The resident would be moved out and in another room.</p> <p>A nurse ' s note for Resident #50 on 1/31/14 at 10:00 PM indicated Resident #50 was up in wheelchair and refused to go to bed. She was propelling herself about " at will." The note did not indicate if Resident #50 had been moved to a</p>	F 323			

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

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F 323	<p>Continued From page 39 different room.</p> <p>The nurse ' s note for dated 2/1/14 at 11:00 AM revealed Resident #50 was up in her wheelchair, saying to her roommate, " You be quiet. " Resident #50 was " agitated at roommate for talking. " (At that time, Resident #50 had been in a new room, on a different hallway from Resident #37 and was yelling at her new roommate.) According to the staff assignment sheet, this nurse ' s note was signed by the nurse on the 100 hall (new location of Resident #50).</p> <p>Medication Administration Record for January 2014 indicated Resident #50 received Ativan (antianxiety) each morning at 6:30 AM and the PRN Ativan had not been administered during January.</p> <p>Review of Resident #50 ' s behavior sheet for January 2014 revealed there were no documented episodes of agitation.</p> <p>Review of the 200 hall " 24-Hour Change of Status Report " for the dates of 1/30/14 and 1/31/14 indicated Resident #50 remained in room 201. Review of the 100 hall " 24 Hour Change of Status Report indicated Resident #50 was moved to the new room on the evening shift. No time was provided for the room change. Resident #50 was moved from room 201 to 103 on 1/31/14 during the evening shift. The time was not available for review on the 24 hour report.</p> <p>Review of Resident #50 ' s physician ' s progress note dated 2/12/14 had no mention of behaviors, combativeness or an altercation with infliction of injury to another resident that occurred 1/30/14 and 1/31/14.</p>	F 323			

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F 323	<p>Continued From page 40</p> <p>Medication Administration Record for Resident #40, for the month of February 2014, indicated the morning Ativan had been administered as ordered. The PRN Ativan had been administered one time on 2/19/14 for anxiety and was effective.</p> <p>Review of the February behavior sheet for Resident #50 revealed there were three episodes of agitation that occurred on 2/18, 2/19 and 2/21/14. Other interventions were provided and she was given Ativan one time. Interventions were not effective per the documentation on the behavior sheet as indicated with a "U" for the behaviors were "unchanged."</p> <p>An interview was conducted on 4/2/14 at 4:05 PM with the Social Worker. The incident occurred at the end of January 2014. The Social Worker went to the room after supper, altercation was not witnessed and the residents were separated to another room and moved the next morning. The next day staff noted the room mates were swinging at each other and a room change was initiated.</p> <p>Interview with Nurse #6 on 4/24/14 at 4:30 PM revealed both residents would curse each other and not understand why they were cursing at each other. This nurse completed the incident report for 3/30/14 of the resident to resident altercation. Nurse #6 " heard them yelling. " This nurse explained the incident was at supper, and they cursing each other. When she went to the room, Resident #37 was " swinging on " Resident #50. Nurse #6 did not witness the beginning of the altercation. Resident #37 had fingernail scratches on her arm, and a pale purple discoloration under her eye. The very pale color</p>	F 323			

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F 323	<p>Continued From page 41</p> <p>under the eye was "new." This nurse stated Resident #50 was moved to a different room on 1/30/14. The nurse who completed the incident report for 1/31/14 no longer worked at the facility. Continued interview revealed if the Social Worker was in the facility, she would be notified of an altercation between residents, the floor nurse can make the determination on her own to move a resident. The administration would be made aware the next morning.</p> <p>An interview was conducted with the business office staff member on 4/24/14 at 4:50 PM. The census report was reviewed for the dates of 1/30/14, 1/31/14 and 2/1/14. Resident #50 and #37 were located in the same room (201 A and B) for the dates of 1/30/14 and 1/31/14. Resident #50 was moved to room 103 sometime on 1/31/14. The census report did not have a time of the room change.</p> <p>Interview on 4/25/14 at 9:00 AM with Nurse #7, who worked on 1/30/14, revealed she could not remember the incident between Residents #50 and #37. This nurse stated she remembers Resident#50 hits or kicks. A room change was made for Resident #50, but this nurse could not remember the date it occurred or why she was moved.</p> <p>Interview with Administrator on 4/25/14 at 9:25 AM revealed the administration discussed the incident from 1/30/14 on the next morning during their meeting. The Social Worker was told to separate the two residents and notify the families. She would expect staff to handle a resident to resident altercation by separating the residents, contact the social worker and if the residents were roommates, notify the families. The</p>	F 323			

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F 323	<p>Continued From page 42</p> <p>administrator was not aware of the altercation that occurred on 1/31/14 until the morning of 2/1/14 during the AM meeting. By the time of the meeting, Resident #50 had been moved to a different room. Further interview revealed she did not review accident/incident reports after completion. Those would be discussed in the morning meetings. The Director of Nursing during the time of these altercations no longer worked for the facility.</p> <p>Interview with floor Nurse #1 on 4/25/14 at 10:15 AM revealed Resident #50 had not had any behaviors on 7-3 other than refusing care at times. She had behaviors late afternoon, and the evening supervisor would be able to speak to that.</p> <p>Interview with the Social Worker on 4/25/14 at 10:21 AM revealed Resident #50 has been the same with her moods and behaviors and she was very confused. Resident #50 was moved from the memory care unit due to a fall, and a total hip repair. Continued interview revealed the Social Worker was aware of an altercation between Residents #50 and #37. The incident occurred when a nurse called me down there after supper. The incident happened back in January 2014. During that time, some of the residents had a stomach virus and were eating in their rooms. Resident #50 usually ate out of her room. The altercation started over tray/food. Continued explanation from the Social Worker included, she went in to see Resident #37 and talked to her. She was told by Resident #37, she had a scratch. The Social Worker thought Resident #50 was being moved out of the room on 1/30/14. She explained, it happened the evening her family member was visiting, and she might have the</p>	F 323			

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F 323	<p>Continued From page 43</p> <p>date wrong. When the Social Worker was asked if she had checked on Residents #37 and 50 the next day, she stated she " could not remember. " The method of informing the Social Worker of changes in a resident ' s condition included receiving the " pink slips " each morning. These were copies of any orders that had been written. Further interview revealed if no orders were written, she would not be aware of condition changes. The method of informing the physician ' s of resident behavior changes included making a list for the doctor. After an altercation that is repetitive, it would be put on physician ' s list for review medically. If a resident needed to be seen by anyone, the physician would write the consult order. The nurses will put them on the list. Or the Social Worker could put a resident on the physician ' s list. The Social Worker did not personally put Resident #50 on the physician ' s list to be seen. The explanation provided was she didn ' t know what caused the altercation. Both residents have hallucinations and that could have caused it.</p> <p>An interview was conducted on 4/25/14 at 1:00 PM with Nurse #5. This nurse had knowledge of Resident #50 and made the nurse ' s note entry for 2/1/14 at 11:00 AM. She explained Resident #50 was upset with the new roommate because she kept talking and it upset her (Resident #50). She would tell her to be quiet. Nurse #5 did not remember any physical contact between the two residents. During the interview, this nurse explained she was informed of changes in resident's condition/behaviors, etc verbally and reviewing the 24 hr report. During the interview, this nurse was asked what she would do if she witnessed resident to resident altercations. Nurse #5 explained she would separate them,</p>	F 323			

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F 323	<p>Continued From page 44</p> <p>redirect them and if it did not stop, she would administer medication, such as Ativan.</p> <p>An interview was conducted on 4/25/14 at 2:55 PM with Aide #2 who worked 3-11 on 1/30/14 and 1/31/14. Interview revealed Resident #50 was "on and off" and " sometimes could be redirected, sometimes not. " The aide continued with Resident #50 was " Not in her right mind. " Examples provided by Aide #2 of behaviors exhibited by Resident #50 included strips naked, sometimes resists care, she was fussing and physical with people. Aide #2 continued with " that's why she was moved. " Further interview revealed Aide #2 was working on 1/31/14 on the evening shift and helped move her (Resident #50) into the new room. The new room was on a different hall. After being moved, Resident #50 rolled into her old room. Aide #2 explained Resident #50 kept saying it was her room, wanted to stay in the room, and was aggressive if she got near Resident #37. Aide #2 stated Resident #50 would hit her #37 if allowed to get to her. When aide #2 came on duty, the supervisor (Nurse #6) told her she had to be moved. She wanted to hit/kick Resident #37. During the interview, Aide #2 explained Resident #50 " is not compromising, " but Resident #37 " was compromising. " At the beginning of her shift, she moved Resident #50 on 1/31/14. On that evening, Resident #50 came back to her old room and Resident #37 was in the room. Resident #50 was asking why Resident #37 was in "her room." Aide #2 explained she rolled Resident #50 her out of the room. Then she "turned on me" tried to "kick me." Later that evening, Resident #50 came on the hall, but did not enter anymore into the room.</p>	F 323			

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F 323	Continued From page 45 Interview on 4/25/14 at 3:30 PM with the Director of Nursing explained she would expect staff to separate residents, notify the doctor, look at what the cause, for example, infection, some testing needed, or a recent event that was significant happened with the resident. If the situation can not be de-escalated she would expect staff to take the resident to another part of building, talk them down, try redirection, use a baby doll, but it depends on the resident. Further explanation provided included for staff to maintain safety and do what would be in the resident's best interest. Most of the time redirection and removal from the situation helps. Some times it may not, could be sporadic. Staff would be expected to monitor the residents involved which would include the need one staff to resident, could be keep the resident with the nurse at desk, or take with them down the hall. The nurse would make the decision based on the needs of the residents. Resident #50 ' s primary physician was not available for interview. The medical director was not available for interview during the extended survey.	F 323			
F 329 SS=D	483.25(I) 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.	F 329		5/26/14	

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F 329	<p>Continued From page 46</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to monitor behaviors and identify target behaviors for one of five sampled residents on psychotropic medications. (Resident #72)</p> <p>The findings included:</p> <p>Review of the " Procedure for Using Monthly Behavior Monitoring Record " that was not dated, indicated the following procedures would be used: " ... 2. Monthly Behavior Monitoring Records will be initiated after prescriber ' s order is received to begin one of the indicated agents. 3. Upon initiation of the Monthly Behavior Record, the nurse will determine behaviors to be controlled from the list. If behavior is not there, it can be added as ' other ' behavior. The number of the behavior should be placed in the block(s) labeled Target Behaviors. 4. After Target Behaviors are determined, the Monthly Behavior Monitoring Record should be</p>	F 329	<p>F329 STANDARD DISCLAIMER: The Plan of Correction for this alleged deficient practice is provided as a necessary requirement of continued participation in the Medicare and Medicaid program(s) and does not, in any manner constitute an admission to the validity of the alleged deficient practice(s).</p> <p>Resident #72 expired on 04/14/14 from the facility and is no longer a resident of the facility.</p> <p>For those residents having the potential to be affected by the same alleged deficient practice, residents charts have been audited to ensure accuracy for Monthly Behavior Monitoring Sheets for residents receiving psychotropic medications with targeted behaviors such as, but not</p>		

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F 329	<p>Continued From page 47</p> <p>placed in the Medication Administration Record (MAR) book ... "</p> <p>Resident #72 was admitted to the facility on 3/12/14 with diagnosis including delusions and hallucinations. A Minimum Data Set and care plan had not been formulated due to Resident #72 was a new admission.</p> <p>The admission orders, dated 3/12/14, included Risperdal (antipsychotic drug) 1.5 milligrams one tab twice a day. The medication was started on 3/13/14 at 8:00 AM. Record review revealed no behavior monitoring for the months of March and April and no target behaviors were identified for the use of the drug.</p> <p>Interview with nurse #1 on 4/3/14 at 1:30 PM revealed behaviors are monitored by behavior sheets and the target behaviors would be added by the nurse. The process for obtaining the behavior monitoring sheets included each month, the nurse does an end of month Medication Administration Record (MAR) review. That nurse would get the behavior monitoring sheets ready for the next month. Review of the meds for resident #72 with nurse #1 revealed she identified the Risperdal as a med that would need a behavior sheet due to "for agitation." She did not know where to find the behavior monitoring forms, but would inform the charge nurse. Nurse #1 was not aware who would do the behavior monitoring sheet for a new admission.</p> <p>Interview with the Director of Nursing (DON) on 4/4/14 at 8:52 AM revealed a policy and procedure was in place for the monthly behavior monitoring records. The nurse should have initiated the sheet on admission when the</p>	F 329	<p>limited to, hitting, kicking, combativeness, anxiety, restlessness, increased agitation, aggressive behaviors, etc. by the Director of Nursing.</p> <p>Initially, the Behavior Monitoring Sheets shall be included with the admission packet for each resident upon admission by Medical Records Coordinator. All licensed nurses shall implement use of the Behavior Monitoring Sheet according to the individual resident's medication by ordering physician and behaviors. All licensed nurses have been in-serviced related to identifying targeted behaviors and related medications ordered by physician for behaviors. All licensed nurses and certified Medication Aides have been in-serviced on the importance of use of the Behavior Monitoring Sheet as it relates to medications monitoring specific behaviors of the residents.</p> <p>The Director of Nursing and/or Medical Record Coordinator shall audit medical records for 100% accuracy monthly thereafter.</p>		

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F 329	Continued From page 48 medication was ordered. It had not been done due to human error.	F 329			
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to ensure the medication error rate was less than 5% as evidenced by 2 medication errors being made during 26 opportunities for error, which resulted in an error rate of 7.69%. (Resident #13) The findings included: Resident #13 was admitted to the facility on 10/17/13 with diagnosis including constipation. Observations during medication pass on 5/2/14 at 8:34 AM revealed nurse #1 poured Colace (stool softener) 100 milligram (mg) one capsule and Calcium 500 mg plus vitamin D one tablet for Resident #13. The resident was observed taking all of her medications from the nurse. The March monthly orders for Resident #13 included Senna S (laxative and stool softener) two tablets by mouth every day for constipation. Senna S was to be given at 9:00 AM. Also included in the March monthly orders, was Calcium 500 mg tabs Oyster Shell 1 tablet by mouth twice daily with food at 9 AM and 5 PM.	F 332	F332 STANDARD DISCLAIMER: The Plan of Correction is prepared as necessary requirement for continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). Resident #13 currently receives Oscar 500 milligrams as ordered by the resident's attending physician. For those resident's having the potential to be affected by the same alleged practice, all licensed nurses have received in-service education specific to the importance of verifying and following the attending physician's orders specific to the administration of medications in efforts to avoid medication errors. Such education was conducted by the facility's consulting pharmacist on May 5, 2014. Similarly, the Consultant Pharmacist	5/20/14	

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F 332	Continued From page 49 Interview with nurse #1 on 4/3/14 at 7:26 AM revealed the only Calcium supplement of 500mg available in the medication cart was with Vitamin D. She further explained that was the medication she had been giving Resident #1. After Looking thru the medication cart stock meds, she did not find plain Calcium supplement 500mg. Nurse #1 explained she had given one tablet of Colace instead of two. Further interview revealed the medication should have been Senna S instead of Colace. Interview on 4/3/14 at 9:02 AM with a pharmacist at the contracted pharmacy revealed there were different strengths of Calcium supplements. The nurse could have given TUMS which is plain Calcium 500 mg. The Calcium 500 with Vitamin D was not interchangeable with plain Calcium 500 mg. Interview with the Director of Nursing (DON) and administrator on 4/3/14 at 3:00 PM revealed the medications were not given as ordered. The Calcium should have been plain Calcium 500 mg. Both staff members checked the stock med room and there were no bottles of plain calcium 500mg. Interview with the DON on 4/4/14 at 7:44 AM revealed the plain Calcium supplement had been ordered the calcium and was available in the facility.	F 332	and/or a licensed or registered Nurse has completed medication pass observations on each nurse and/or personnel credentialed to administer medications (e.g. Med Aide). All medication pass observations shall be completed by May 20, 2014. To ensure compliance, the Consulting Pharmacist, Director of Nursing and/or another licensed and/or Registered Nurse shall complete 5 medication pass observations weekly for 4 weeks, 10 medication pass observations monthly for three months, and 15 medication pass observation passes quarterly. The findings of such observations shall be presented to the facility's Quality Assurance Committee monthly for three months and quarterly thereafter.		
F 497 SS=E	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service	F 497		5/26/14	

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F 497	<p>Continued From page 50</p> <p>education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to ensure that 5 of 32 (NA) nurse aide's acquired 12 hours of in-service annually (NA #1, #3, #4, #5 and #6).</p> <p>The findings included:</p> <p>On 4/25/14 staff individual in-service records were reviewed for 32 NA ' s.</p> <p>NA #1 was hired on 1/21/13 and from 1/22/13 to 1/22/14 had 7.5 hours of course time recorded on the individual in-service record. NA #3 was hired on 4/12/13 and from 4/12/13 to 4/12/14 had 4.5 hours of course time recorded on the individual in-service record. NA #4 was hired on 3/10/13 and from 3/10/13 to 3/10/14 had 10.5 hours of course time recorded on the individual in-service record. NA #5 was hired on 4/3/13 and from 4/3/13 to 4/3/14 had 9.5 hours of course time recorded on the individual in-service record. NA#6 was hired on 2/5/13 and from 2/5/13 to 2/5/14 had 11 hours of course time recorded on</p>	F 497	<p>F497</p> <p>STANDARD DISCLAIMER:</p> <p>This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s).</p> <p>NA #1, NA #3, NA #4 are no longer employed with this facility. NA #5 and NA #6 currently have the required 12 in-service hours and recorded.</p> <p>For those residents having the potential to be affected by the alleged deficient practice, all certified nursing assistants 'individual in-service records have been audited. For those certified nursing assistants within their annual review, the required 12 in-service hours are 100% in compliance.</p>		

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F 497	Continued From page 51 the individual in-service record. On 4/25/14 at 3:30 PM an interview with the DON revealed that she was new and did not know how the in-service records were monitored. She has now developed a tool to monitor in-service records for nurses and NA ' s to ensure that in-services are recorded and NA ' s have the required 12 hours of in-services annually.	F 497	The Director of Nursing and/or Administrative Assistant shall review all certified nursing assistants' individual in-service records monthly ongoing. The Director of Nursing shall post and provide in-services monthly to ensure certified nursing assistants receive required in-service education to maintain compliance.		
F 514 SS=B	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to ensure medical records were accurate in monthly orders, treatment records and restorative documentation for three of 26 sampled residents. (Residents #24, #1 and #28) The findings included:	F 514	F514 STANDARD DISCLAIMER: The Plan of Correction for this alleged deficient practice is provided as a necessary requirement of continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of	6/9/14	

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F 514	<p>Continued From page 52</p> <p>1. Resident #24 was admitted to the facility on 9/11/06 with diagnoses including stroke with hemiplegia on the nondominant side (left).</p> <p>Review of the monthly orders dated 3/1/14 revealed orders for a left and right knee orthotic to be worn. The left orthotic was to be worn during the first shift. The right orthotic was to be applied in the morning and removed at night. The original telephone order dated 9/16/13 for the right knee orthotic was written by the therapist.</p> <p>Review of the Treatment Administration Record (TAR) for March had both orders, one for the left knee and a separate order for the right knee orthotic. Documentation was present for application of both orthotics by nurses.</p> <p>Interview with Administrator on 4/2/14 at 11:38 am revealed the nurses documented on TAR that knee splint applied and removed.</p> <p>Interview with nurse #2 on 4/2/14 at 12:05 revealed the splint was on the left leg. She further explained she did not recognize it was documented as the right knee splint. Continued interview revealed she checked the new monthly TARs by previous TAR. Another nurse checked the new monthly orders against the previous orders before she checked the TARs.</p> <p>Interview with the administrator on 4/2/14 at 12:06 PM revealed the monthly orders were checked by a charge nurse that would only do the chart reviews. A second check would be completed by the nurse on 3rd shift.</p> <p>Interview with the restorative nursing assistant</p>	F 514	<p>the alleged deficient practice(s).</p> <p>Resident #24 deceased on May 6, 2014 and is no longer a resident of the facility. Resident #1 currently has a physician's order stating Resident has a Blue Chip Supreme Mattress with Protective Covering (due to heavy urine). Resident #28 currently has a physician order stating Admit resident to Magnolia Gardens Skilled Unit dated 2-15-13.</p> <p>For those residents having the potential to be affected by the same alleged deficient practice, all licensed nurses have been in-serviced on the importance of 1st and 2nd MAR and TAR checks for resident's physician's orders. Furthermore, all licensed nurses/licensed therapist have received in-service education on the importance of verifying a resident's physician order. To ensure compliance, all physicians' orders shall be reviewed by the Director of Nursing/Charge Nurse/Unit Supervisor/MDS Coordinator daily to ensure accuracy for following physician's orders.</p> <p>Additionally, the Director of Nursing shall audit all residents medical records for accuracy of physician's orders transcribed on MARs and TARs.</p> <p>The Director of Nursing shall audit 25% of resident's medical records weekly x 4, then monthly thereafter.</p> <p>The Director of Nursing shall present the findings of the alleged deficient practice to the facility's Quality Assurance Committee.</p>		

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F 514	<p>Continued From page 53</p> <p>(RNA) on 4/2/14 at 2:18 PM revealed she had provided the exercises and splint for Resident #24. She explained the care was provided to the resident ' s left lower extremity. After reviewing the documentation from October 2013 to March 2014, the RNA explained she had documented incorrectly. The restorative documentation flow sheet should have indicated left lower extremity and not right lower extremity.</p> <p>Interview on 4/3/14 at 3:00 PM with the therapist who had written the initial orders for the right knee orthotic revealed it should have been " left " knee orthotic. The symbol " R " for right was supposed to be " L " for left.</p> <p>Interview with the Director of Nursing (DON) on 4/4/14 at 7:56 AM revealed double checks were completed at the end of the month when the MARs (Medication Administration Record) would be changed out.</p> <p>Interview with the DON on 4/4/14 at 8:51 AM revealed there were double checks for the orders by nurses. It was human error in not correcting the inaccurate orders and documentation.</p> <p>2. Resident #1 was admitted to the facility on 4/5/1001. Review of the monthly orders for February and March revealed physician orders for three different types of mattresses. The orders were for special mattresses called a geo mattress, air overlay and a body wrap. Review of the Treatment Administration Records (TAR) for February and March 2014 revealed all three mattresses were on the TAR.</p> <p>Observations on 4/2/14 at 11:45 AM revealed Resident #1 did not have the geo mattress or</p>	F 514			

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F 514	<p>Continued From page 54 body wrap mattress on the bed.</p> <p>Interview on 4/2/14 at 12:05 PM with nurse #2 revealed she did the checks at the end of the month on the TARs. The floor nurse did the order checks, and she checked the orders with the treatments. Nurse #2 was asked what type of mattress was on Resident #1 ' s bed. Nurse #2 went to the room, and returned explaining it was a blue chip mattress. A body wrap mattress had built up sides and the geo mattress was an overlay.</p> <p>Interview with nurse #2 on 4/4/14 at 9:17 AM revealed the geo and body wrap mattress were FYI (for your information) on the TAR. Resident #1 did not have any pressure ulcers. The TAR was signed by her for the air mattress on the blue chip mattress.</p> <p>3. Resident #28 was admitted to the facility on 2/15/13 to the skilled nursing facility. Review of the January, February and March monthly orders revealed the resident required rest home level of care for the next 90 days.</p> <p>Interview with the administrator on 4/2/14 at 12:06 PM revealed the monthly orders were checked by a charge nurse that would only do the chart reviews. A second check would be completed by the nurse on 3rd shift.</p> <p>Interview with the Director of Nursing (DON) on 4/4/14 at 7:56 AM revealed double checks were completed at the end of the month when the MARs (Medication Administration Record) would be changed out. The monthly orders should not have been for rest home level of care, but for skilled nursing care.</p>	F 514			

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F 514	Continued From page 55 Interview with the DON on 4/4/14 at 8:51 AM revealed there were double checks for the orders by nurses. It was human error in not correcting the inaccurate orders and documentation.	F 514			