

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

PRINTED: 03/30/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345180</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/02/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>WESLEY PINES RETIREMENT COMM</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1000 WESLEY PINES ROAD</b> <b>LUMBERTON, NC 28358</b>		
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F 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff and physician interviews and record review, the facility failed to notify the physician and the responsible party (RP)</p>	F 157	F157 Corrective Action for Identified Resident: Resident #2's attending physician and	3/30/16	

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

TITLE

(X6) DATE

Electronically Signed

03/24/2016

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

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F 157	Continued From page 1 regarding a cognitively impaired resident ' s (a) repeated refusals of her medications and (b) wandering into other resident rooms and kitchen, disturbing other resident at night and outward expressions of combative behaviors toward other residents for 1 of 2 (Resident # 2) reviewed for notification. Findings included: a. Resident #2 was admitted 4/16/14 with cumulative diagnoses of psychosis, wandering, dementia with behaviors, anxiety and depression. The quarterly Minimum Data Set dated 1/18/16 indicated Resident had severe cognitive impairment, rejection of care, no wandering behaviors and limited assistance with her activities of daily living (ADLs). Resident #2 was care planned for wandering, refusal of her medications, moving another resident ' s head forward twice and yelling out at times. Interventions included notification of the physician and responsible party if Resident #2 refused her medications or care. She was care planned to receive her medications as ordered and psychiatric services for medications checks. A review of Resident #2 ' s physician orders dated 2/29/16 indicated she was to receive Risperdal (antipsychotic) 0.25 milligrams every night at bedtime. A pharmacy recommendation dated 10/20/15 was approved by the physician on 11/3/15 to reduce Resident #2 ' s night time dose of Risperdal from 0.5 milligram to 0.25 mg. A review of the psychiatric note dated 12/18/15 indicated an increase in anxiety and irritability after and Risperdal dose reduction done in November 2015. There was no recommend changes accept to utilize the as needed Ativan. Another note dated 1/26/16 indicated staff stated Resident #2 was more difficult to redirect since the gradual dose reduction. The recommendation	F 157	responsible party were notified of Rdt #2's medication refusals and resulting aggressive behavior. Identification of Residents at Risk Due To Deficient Practice:All Residents who refuse their meds are at risk for negative outcomes. All Rdt. MARs have been audited to determine if any other Rdts. have a pattern of refusing their medications. No other pattern of refusals was identified. Corrective Action /Systemic Change Plan: All RNs and LPNs will be in-serviced by DON and /or ADON regarding facility policy, i.e. that attending physicians and responsible parties are to be notified of any significant changes in any Rdt's physical, mental, or psychosocial status as it occurs. 1. Floor nurses will be responsible for calling the RP after each refusal of a medication. Floor nurses will be responsible for calling the attending physician after three consecutive refusals of medication. 2. The floor nurse is responsible for notifying the RP and MD of any behaviours, especially those impacting other residents, and also of any significant changes in Rdt's physical, mental, or psychosocial status. 3. The Charge Nurse will provide the attending physician with copies of the last two MARs for each Rdt. seen during weekly rounds. 4. Social worker will initiate a family meeting with Rdt. #2's RP to discuss appropriate facility placement if behaviours continue to violate other Rdt's		

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F 157	<p>Continued From page 2</p> <p>was to continue to monitor Resident #2 ' s for behaviors and the Risperdal may need to be increased back to original dose in November 2015. The last psychiatric note dated 2/8/16 indicated her Risperdal was approved to be decreased further to 0.125mg at bedtime but the staff voiced concerns with being able to redirect using snacks, activities and socialization due to her obsession with certain residents. This was not implemented by the physician and the Risperdal dose remained at 0.25mg at night.</p> <p>A review of the medication administration records (MAR) indicated 5 refusals of her Risperdal in October, 6 refusals in November, 4 refusals in December, 13 refusals in January and 11 refusal in February. A review of the monthly MAR ' s and the nursing notes did not indicate any reattempts or notification regarding the ongoing medication refusals.</p> <p>A review of Resident #2 ' s physician orders dated 2/01/16 indicated she was to receive Risperdal (antipsychotic) 0.25 milligrams every night at bedtime.</p> <p>A physician order dated 2/17//16 indicated the Risperdal was increased to 0.5mg at night and another order stated 2/18/16 indicated a one-time intramuscular dose of Risperdal of 25mg and hold her oral Risperdal at night for 14 days. The physician was not notified of the multiple medication until 2/18/16.</p> <p>b. A review of the social services notes indicated in June 2015, alternate placement was discussed because Resident #2 was wandering into other resident rooms and they were afraid of Resident #2. Alternate placement was again addressed with the family in September 2015 but the family refused to place Resident #2 in the accepting facility. Another social note was dated 12/3/15</p>	F 157	<p>rights.</p> <p>Monitoring: The DON or her designee will audit all MARs for refusals weekly for four weeks and then monthly to ensure facility policy is being followed. These audits will be an ongoing part of the facility QAPI program. Any deficient practice by nursing staff will be addressed thru training/retraining of staff members, with discipline applied as appropriate for repeat offenders.</p>		

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F 157	<p>Continued From page 3</p> <p>when Resident #2 ' s wandering behaviors were being tracked because of reports for Resident #2 wandering into other resident rooms but no other residents had been harmed as a result. There was no new interventions put in place and the wandering care plan was not updated since 8/17/15. The SW confirmed the physician and the RP had not been notified of the ongoing wandering issues.</p> <p>A review of the nursing notes indicated the following incidents:</p> <p>On 12/3/16 at 10:00 PM, Resident #2 was up ambulating and noted with increased agitation. She refused her medications and was wandering into other resident rooms, waking the other residents. She became combative with the aide attempting to redirect her and struck the aide in the face. There was no evidence the physician or the RP were notified.</p> <p>On 12/14/15 at 11:30 AM, Resident #2 was in the dining area and confronted another resident. The staff were unable to redirect her and the aide got another staff member who was able to obtain a pepper shaker from Resident #2 who was attempting to throw at the other resident. The RP was notified of this incident and stated she felt Resident #2 must have been provoked by the other resident. There was no evidence the physician was notified.</p> <p>On 12/30/15 at 3:00 PM during the resident birthday party, staff observed Resident #2 was observed grabbing the head other another resident with both hands. The note stated Resident #2 did not shake the other resident ' s head and she was able to be redirected and continued to wander about the facility. There was no evidence the physician or RP were notified.</p> <p>On 1/6/16 at 5:30 PM, the physician assessed Resident #2 and staff reported difficulty</p>	F 157			

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F 157	<p>Continued From page 4</p> <p>re-directing Resident #2. The physician reviewed Resident #2 ' s medications and recent labs and stated Resident #2 may benefit from a new environment for her safety. There was no new orders and no evidence Resident #2 ' s MAR ' s were reviewed for refusals.</p> <p>On 1/24/16 at 7:30 PM, staff observed Resident #2 in the kitchen area urinating in a trash can. Staff was not able to redirect Resident #2 to the bathroom but she refused. After she finished urinating, she continued to ambulate in the halls. There was no evidence the physician or the RP were notified.</p> <p>On 1/26/16 at 2:00 PM, Resident #2 entered into room ### and began arguing with the resident. Resident #2 was noted to be very agitated and was redirected to the nursing station for observation. There was no evidence the physician or the RP were notified.</p> <p>On 2/1/16 at 11:00 PM a weekly note indicated Resident #2 often wandered in the kitchen in the dining area and went into the refrigerator and took resident snacks and placed open items back in the refrigerator. Redirection was unsuccessful. There was no evidence the physician or the RP were notified.</p> <p>On 2/6/16 at 7:30 PM, staff observed Resident #2 in room ### removing the pillow and blankets off the resident ' s bed. Resident #2 was saying, " get out, get on " to the resident sitting in her wheelchair. The nursing note indicated the other resident did not engage Resident #2 and staff were able to redirect Resident #2.</p> <p>On 2/16/16 at 2:30 PM, staff observed Resident #2 enter room ### while the other resident receiving ADL assistance from another staff member. Resident #2 picked a water pitcher and attempted to throw the water pitcher at the resident lying in bed when the staff was able to</p>	F 157			

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F 157	<p>Continued From page 5</p> <p>get the water pitcher from Resident #2 who was very uncooperative, agitated and placed at the nurses ' station for observation. There was no evidence a new of a different intervention and no evidence the physician or the RP were notified. On 2/17/16 at 5:30 PM the physician assessed Resident #2. Staff reported to the physician increased difficult in redirecting Resident #2 and increased agitation with efforts to redirect. The physician review Resident #2 ' s medications and recent psychiatric notes. He increased the Risperdal (antipsychotic) to 0.5 mg every night at the time. There was no evidence the physician was made aware of the ongoing medication refusals at this time.</p> <p>On 2/18/16 at 3:50 PM, staff contacted the physician and informed him of the multiple medication refusals. New orders were given for a one time dose of Risperdal 25mg intramuscular, hold the every oral Risperdal for 14 days then resume.</p> <p>On 3/1/16 at 9:00 PM, Resident #2 was observed standing in hall outside room ###. After repeated attempts to redirect Resident #2, she continued to go back and stand in the resident ' s doorway. Eventually staff was able to redirect Resident#2 with a snack.</p> <p>In an observation on 3/1/16 at 8:10 PM, Resident #2 was observed sitting at the nurses ' station rummaging through a drawer. Nurse #1 stated Resident #2 often wandered into other resident rooms, especially the resident in room ### and it upsets the resident and her family. Nurse #1 stated she had not observed any change in Resident #2 ' s behaviors since receiving the Risperdal injection and Resident #2 was often difficult to redirect. Nurse #1 stated her behaviors were not new but she had noted an increase for " quite some time. "</p>	F 157			

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F 157	<p>Continued From page 6</p> <p>In an interview on 3/1/16 at 8:30 PM, nursing assistant (NA) # 1 stated Resident #2 wandered freely about the facility, into other resident ' s rooms and NA #1 did not attempt to lie her down until toward the end of her shift because of her combativeness. She stated Resident #2 frequently went into the kitchen to open the refrigerator, cleaned and rearranged items. In another observation on 3/1/16 at 8:45 PM, Resident #2 was still observed at the nurses ' station. She was clean and well groomed. She looked bewildered and her speech was unintelligible. NA #1 was sitting with her while she continued to rummage through the drawer at the nurses ' station. NA #1 stated she had to take Resident #2 into the shower room to prepare for bedtime because Resident #2 screamed and disturbed the other residents.</p> <p>In an interview on 3/2/16 at 12:30 PM, NA #2 stated she worked 2/16/16 and was summoned to room ### to remove a water pitcher from Resident #2 who was attempting to throw it at the other resident. NA #2 stated Resident #2 was very agitated and kept going back down to that resident ' s room after the incident. She required constant observation when she was agitated. NA #2 stated the resident in room ### was not cognitively intact but her roommate was. The roommate was at dialysis at the time of the incident. NA #2 stated she worried because it was her belief Resident #2 could become violent with another resident. She stated she frequently was observed wandering into room ###, other residents rooms and in the kitchen area rummaging through the resident snacks and silverware.</p> <p>In an interview on 3/2/16 at 1:50 PM, the facility resident council president stated Resident #2 was well known by management to be a problem with</p>	F 157			

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F 157	<p>Continued From page 7</p> <p>her wandering into other resident rooms and acting out toward other residents. She often wandered into the kitchen was known to go through items stored in the refrigerator reserved for the residents.</p> <p>In an observation on 3/2/16 at 2:15 PM, the resident in room ### she was noted to be pleasantly confused. The roommate stated she recalled a recent incident when Resident #2 entered into the room and removed the pillow and blanket from off the resident lying in bed. She stated Resident #2 often wandering into their room and sometimes stood in the doorway yelling at her roommate and called her the " N-word. "</p> <p>In an interview on 3/2/16 at 2:29 PM, the assistant director of nursing (ADON) stated management was aware of her wandering behaviors and noted it had been a concern soon after her admission. She stated Resident #2 had a history of refusing her medication and care. The social worker was working with the family to find alternate placement.</p> <p>In an observation on 3/2/16 at 2:35 PM, Resident #2 was observed in the dining room picking up salt and pepper shakers and moving them from one table to another. There was no other resident ' s observed in the dining area at the time.</p> <p>In an interview on 3/2/16 at 2:40 PM, the social worker stated they facility had been looking for alternate placement for Resident #2 since last Year in June. The social worker stated there was some improvement in Resident #2 behaviors in September and October but her behaviors have increased again over the last few months. She stated the facility had planned to meet with the responsible party (RP) soon but had not yet. She stated the facility had started logging her behaviors in December to present to the family but stated no other interventions had been</p>	F 157			



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F 157	<p>Continued From page 8 attempted.</p> <p>In an observation and attempted interview on 3/2/16 at 3:00 PM, the resident involved in the incident dated 12/20/15 was determined cognitively unable to answer questions or recall the incident.</p> <p>In an interview on 3/2/16 at 3:10 PM, Nurse #2 stated Resident #2 was hard to redirect some days and she was fixated on certain residents. Nurse #2 recalled the incident involving the water pitcher and stated it was difficult to redirect her that day and she keep returning to the room and yelling at the resident in room ###. Nurse #2 stated she did not notify the physician and the RP for every incident but she did call the physician about the incident involving the water pitcher.</p> <p>In another interview with Nurse #1 on 3/2/216 at 3:20 PM, she stated she did not contact the physician regarding the incident involving Resident #2 when she pulled the pillow and blanket off the resident in room ### bed nor did she contact the RP. Nurse #2 stated when Resident #2 sat at the nurses ' station, staff had to be careful about what they left there because she would bother it. Nurse #2 stated Resident #2 often went into the refrigerator and took out snacks and returned them. She stated the facility put up a retractable rope to block the kitchen entrance but Resident #2 goes underneath the rope without difficulty.</p> <p>In an interview on 3/2/16 at 4:00 PM, the physician stated he was not aware of all the medication refusals until recently and he felt Resident #2 ' s gradual dose reduction (GDR) in November could have caused her behaviors to escalated so badly.</p> <p>In an interview on 3/2/16 at 4:00 PM, the administrator stated his expectation staff communicate Resident #2 ' s medication refusals</p>	F 157			

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F 278 SS=D	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to accurately code the Minimum</p>	F 278		3/30/16	
			F278 Corrective Action for Identified Resident:		

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F 278	Continued From page 10 Data Set (MDS) to reflect a resident wandering behaviors for 1 of 2 (Resident # 2) reviewed for wandering. Findings included: Resident #2 was admitted 4/16/14 with cumulative diagnoses of psychosis, wandering, dementia with behaviors, anxiety and depression. The quarterly Minimum Data Set dated 1/18/16 indicated Resident had severe cognitive impairment, rejection of care, no wandering behaviors. Resident #2 was care planned for wandering, refusal of her medications, moving another resident ' s head forward twice and yelling out at times. Interventions included notification of the physician and responsible party if Resident #2 refused her medications or care. She was care planned to receive her medications as ordered and psychiatric services for medications checks. A review of the social services notes indicated in June 2015, alternate placement was discussed because Resident #2 was wandering into other resident rooms and they were afraid of Resident #2. Alternate placement was again addressed with the family in September 2015 but the family refused to place Resident #2 in the accepting facility. Another social note was dated 12/3/15 when Resident #2 ' s wandering behaviors were being tracked because of reports for Resident #2 wandering into other resident rooms but no other residents had been harmed as a result. In an interview on 3/2/16 at 2:40 PM, the social worker stated the facility had been looking for alternate placement for Resident #2 since last Year in June. She stated the facility had started logging her behaviors in December to present to the family but stated no other interventions had been attempted. The social worker verified that wandering was not coded on the MDS and the care plan was not updated since 8/17/15.	F 278	Resident's past MDS cannot be modified. Identification of Residents at Risk Due to Deficient Practice: All Residents have the potential to be adversely affected by an inaccurate or incomplete assessment. Corrective Action/Systemic Change Plan: Facility will ensure that each Rdt. receives an accurate assessment by staff that are qualified to assess relevant care areas and knowledgeable about the Rdt's status, needs, strengths, and areas of decline. The MDS/Care Plan nurses will review the assessments submitted by each discipline to ensure that each Rdt's MDS accurately reflects the Rdt's current status. In the event that something is not coded because there is not documentation to support the coding, yet the person doing the assessment or the MDS/Care Plan nurses feel that the item/issue should be coded, the nursing administrative staff will designate someone to perform employee interviews in an attempt to establish documentation to support proper coding. If behaviors occur during an activity, the Activity Assistant will provide interventions as appropriate, either those listed in the Rdt's care plan or in the case of a new behavior issue, interventions from a list to be devised by the Activity and Nursing staff. The Activity Assistant will be responsible to report the inappropriate behavior to the MDS nurse so that the care plan can be updated. The nursing floor staff will be given the list of possible interventions for different problem behaviors and instructed to use		

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F 278	Continued From page 11 In an interview on 3/2/16 at 4:00 PM, the administrator stated his expectation that Resident #2 's status be reflected accurately on the MDS to address behavioral concerns.	F 278	as necessary and report any problem behaviors to the Resident's nurse or the MDS/Care Plan Nurses. Nurses will be reeducated re: the importance of documenting problem behaviors in each Rdt's chart so the MDS assessment can be coded correctly. Nurse Aides will be reeducated on the importance of reporting problem behaviors to a nurse so the proper documentation can be inserted into the Rdt's chart. Monitoring: The MDS/Care Plan nurses will review the assessments submitted by each discipline to ensure that each Rdt's MDS accurately reflects the Rdt's current status.		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Based on observations, staff, resident and physician interviews and record review, the facility failed to prevent a cognitively impaired resident from wandering into other resident rooms and kitchen, disturbing other resident at night and outward expressions of combative behaviors toward other residents for 1 of 2 (Resident # 2)	F 309	F 309 Corrective Action for Identified Resident: The DON or her designee will review Resident #2's care plan with all floor staff that have the chance to interact with Rdt 2. Identification of Residents at Risk Due to	3/30/16	

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F 309	Continued From page 12 reviewed for wandering. Findings included: Resident #2 was admitted 4/16/14 with cumulative diagnoses of psychosis, wandering, dementia with behaviors, anxiety and depression. The quarterly Minimum Data Set dated 1/18/16 indicated Resident had severe cognitive impairment, rejection of care, no wandering behaviors and limited assistance with her activities of daily living (ADLs). Resident #2 was care planned for wandering, refusal of her medications, moving another resident ' s head forward twice and yelling out at times. Interventions included notification of the physician and responsible party if Resident #2 refused her medications or care. She was care planned to receive her medications as ordered and psychiatric services for medications checks. A review of Resident #2 ' s physician orders dated 2/29/16 indicated she was to receive Risperdal (antipsychotic) 0.25 milligrams every night at bedtime. A pharmacy recommendation dated 10/20/15 was approved by the physician on 11/3/15 to reduce Resident #2 ' s night time dose of Risperdal from 0.5 milligram to 0.25 mg. A review of the psychiatric note dated 12/18/15 indicated an increase in anxiety and irritability after and Risperdal dose reduction done in November 2015. There was no recommend changes accept to utilize the as needed Ativan . Another note dated 1/26/16 indicated staff stated Resident #2 was more difficult to redirect since the gradual dose reduction. The recommendation was to continue to monitor Resident #2 ' s for behaviors and the Risperdal may need to be increased back to original dose in November 2015. The last psychiatric note dated 2/8/16 indicated her Risperdal was approved to be decreased further to 0.125mg at bedtime but the	F 309	Deficient Practice: All Rdts are at risk of not having their needs met if their care plans are not properly implemented by the staff. Corrective Action/Systemic Change Plan: Floor staff will be reeducated regarding the importance of reading and implementing each Rdt's specifically tailored plan of care. Floor nurses will be reeducated to the fact that they are responsible for notifying the RP and MD of any inappropriate resident behaviors and/or significant changes in Rdt's physical, mental or psychosocial status as they occur. All floor staff will be reeducated re: the importance of appropriate use of diversional activities/interventions for problem behaviors. Staff will also be reeducated to the fact that the Rdt's care plan is the first thing to consult when a Rdt begins to display inappropriate behavior. In the event that a Rdt is displaying behaviors that are not addressed in their care plan, the staff will be given a list of possible behavior problems along with a list of possible interventions. The staff will be told that the list is not all inclusive, but rather some suggestions that may be appropriate or may trigger them to think of other possible interventions to try in the moment. Nurses will be reeducated to the fact that medications are to be given as ordered. One refusal of medication is to be reported to the responsible party, three refusals to the MD. The facility will be implementing Electronic Medical Records in mid-April. The EMR		

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F 309	<p>Continued From page 13</p> <p>staff voiced concerns with being able to redirect using snacks, activities and socialization due to her obsession with certain residents. This was not implemented by the physician and the Risperdal dose remained at 0.25mg at night.</p> <p>A review of the medication administration records (MAR) indicated 5 refusals of her Risperdal in October, 6 refusals in November, 4 refusals in December, 13 refusals in January and 11 refusal in February. A review of the monthly MAR 's and the nursing notes did not indicate any reattempts or notification regarding the ongoing medication refusals.</p> <p>A review of Resident #2 ' s physician orders dated 2/01/16 indicated she was to receive Risperdal (antipsychotic) 0.25 milligrams every night at bedtime.</p> <p>A physician order dated 2/17//16 indicated the Risperdal was increased to 0.5mg at night and another order stated 2/18/16 indicated a one-time intramuscular dose of Risperdal of 25mg and hold her oral Risperdal at night for 14 days.</p> <p>A review of the social services notes indicated in June 2015, alternate placement was discussed because Resident #2 was wandering into other resident rooms and they were afraid of Resident #2. Alternate placement was again addressed with the family in September 2015 but the family refused to place Resident #2 in the accepting facility. Another social note was dated 12/3/15 when Resident #2 ' s wandering behaviors were being tracked because of reports for Resident #2 wandering into other resident rooms but no other residents had been harmed as a result. There was no new interventions put in place and the wandering care plan was not updated since 8/17/15.</p> <p>A review of the nursing notes indicated the</p>	F 309	<p>will display each Rdt's care plan interventions to the staff each time the Rdt's record is accessed. There will also be a hyperlink for nurses and aides to use in accessing each Rdt's care plan. There will also be a care guide for each Rdt. While all these things are currently available to all nurses and aides, the EMR will make it much easier and quicker to for all staff members to access the information.</p> <p>Monitor:</p> <p>In order to ensure that Rdt care plans are being properly implemented, the DON or her designee will audit one Rdt chart each week for five weeks and then one chart each month as part of the facility's ongoing QAPI program. For the initial 5 charts to be audited, the facility QMs will be printed and the 5 Rdts with the highest number of QMs that are outside the acceptable parameters will be chosen for audit. The same process will be used to choose the chart to be audited each month henceforth.</p> <p>In the event that Rdts are identified whose care plans are not being followed, the staff members involved will be reeducated/retrained as needed and disciplined as appropriate for repeat offenders up to and including termination.</p>		

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

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F 309	Continued From page 14 following incidents: On 12/3/16 at 10:00 PM, Resident #2 was up ambulating and noted with increased agitation. She refused her medications and was wandering into other resident rooms, waking the other residents. She became combative with the aide attempting to redirect her and struck the aide in the face. There was no evidence of a new or different intervention attempted at this time. On 12/14/15 at 11:30 AM, Resident #2 was in the dining area and confronted another resident. The staff were unable to redirect her and the aide got another staff member who was able to obtain a pepper shaker from Resident #2 who was attempting to throw at the other resident. The RP was notified of this incident and stated she felt Resident #2 must have been provoked by the other resident. There was no evidence of a new or different intervention attempted at this time On 12/30/15 at 3:00 PM during the resident birthday party, staff observed Resident #2 was observed grabbing the head other another resident with both hands. The note stated Resident #2 did not shake the other resident ' s head and she was able to be redirected and continued to wander about the facility. There was no evidence a new or different intervention was attempted. On 1/6/16 at 5:30 PM, the physician assessed Resident #2 and staff reported difficulty re-directing Resident #2. The physician reviewed Resident #2 ' s medications and recent labs and stated Resident #2 may benefit from a new environment for her safety. There was no new orders and no evidence Resident #2 ' s MAR ' s were reviewed for refusals. On 1/24/16 at 7:30 PM, staff observed Resident #2 in the kitchen area urinating in a trash can. Staff was not able to redirect Resident #2 to the	F 309			

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

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F 309	<p>Continued From page 15</p> <p>bathroom but she refused. After she finished urinating, she continued to ambulate in the halls. There was no evidence a new or different intervention was attempted.</p> <p>On 1/26/16 at 2:00 PM, Resident #2 entered into room ### and began arguing with the resident. Resident #2 was noted to be very agitated and was redirected to the nursing station for observation. There was no evidence of a new or different intervention.</p> <p>On 2/1/16 at 11:00 PM a weekly note indicated Resident #2 often wandered in the kitchen in the dining area and went into the refrigerator and took resident snacks and placed open items back in the refrigerator. Redirection was unsuccessful. There was no evidence of a new or different intervention attempted.</p> <p>On 2/6/16 at 7:30 PM, staff observed Resident #2 in room ### removing the pillow and blankets off the resident ' s bed. Resident #2 was saying, " get out, get on " to the resident sitting in her wheelchair. The nursing note indicated the other resident did not engage Resident #2 and staff were able to redirect Resident #2.</p> <p>On 2/16/16 at 2:30 PM, staff observed Resident #2 enter room ### while the other resident receiving ADL assistance from another staff member. Resident #2 picked a water pitcher and attempted to throw the water pitcher at the resident lying in bed when the staff was able to get the water pitcher from Resident #2 who was very uncooperative, agitated and placed at the nurses ' station for observation. There was no evidence a new of a different intervention and no evidence the physician or the RP were notified.</p> <p>On 2/17/16 at 5:30 PM the physician assessed Resident #2. Staff reported to the physician increased difficult in redirecting Resident #2 and increased agitation with efforts to redirect. The</p>	F 309			



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

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F 309	<p>Continued From page 16</p> <p>physician review Resident #2 ' s medications and recent psychiatric notes. He increased the Risperdal (antipsychotic) to 0.5 mg every night at the time. There was no evidence the physician was made aware of the ongoing medication refusals at this time.</p> <p>On 2/18/16 at 3:50 PM, staff contacted the physician and informed him of the multiple medication refusals. New orders were given for a one time dose of Risperdal 25mg intramuscular, hold the every oral Risperdal for 14 days then resume.</p> <p>On 3/1/16 at 9:00 PM, Resident #2 was observed standing in hall outside room ###. After repeated attempts to redirect Resident #2, she continued to go back and stand in the resident ' s doorway. Eventually staff was able to redirect Resident#2 with a snack.</p> <p>In an observation on 3/1/16 at 8:10 PM, Resident #2 was observed sitting at the nurses ' station rummaging through a drawer. Nurse #1 stated Resident #2 often wandered into other resident rooms, especially the resident in room ### and it upsets the resident and her family. Nurse #1 stated she had not observed any change in Resident #2 ' s behaviors since receiving the Risperdal injection and Resident #2 was often difficult to redirect. Nurse #1 stated her behaviors were not new but she had noted an increase for " quite some time. "</p> <p>In an interview on 3/1/16 at 8:30 PM, nursing assistant (NA) # 1 stated Resident #2 wandered freely about the facility, into other resident ' s rooms and NA #1 did not attempt to lie her down until toward the end of her shift because of her combativeness. She stated Resident #2 frequently went into the kitchen to open the refrigerator, cleaned and rearranged items.</p> <p>In another observation on 3/1/16 at 8:45 PM,</p>	F 309			

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

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F 309	<p>Continued From page 17</p> <p>Resident #2 was still observed at the nurses ' station. She was clean and well groomed. She looked bewildered and her speech was unintelligible. NA #1 was sitting with her while she continued to rummage through the drawer at the nurses ' station. NA #1 stated she had to take Resident #2 into the shower room to prepare for bedtime because Resident #2 screamed and disturbed the other residents.</p> <p>In an interview on 3/2/16 at 12:30 PM, NA #2 stated she worked 2/16/16 and was summoned to room ### to remove a water pitcher from Resident #2 who was attempting to throw it at the other resident. NA #2 stated Resident #2 was very agitated and kept going back down to that resident ' s room after the incident. She required constant observation when she was agitated. NA #2 stated the resident in room ### was not cognitively intact but her roommate was. The roommate was at dialysis at the time of the incident. NA #2 stated she worried because it was her belief Resident #2 could become violent with another resident. She stated she frequently was observed wandering into room ###, other residents rooms and in the kitchen area rummaging through the resident snacks and silverware.</p> <p>In an interview on 3/2/16 at 1:50 PM, the facility resident council president stated Resident #2 was well known by management to be a problem with her wandering into other resident rooms and acting out toward other residents. She often wandered into the kitchen was known to go through items stored in the refrigerator reserved for the residents.</p> <p>In an observation on 3/2/16 at 2:15 PM, the resident in room ### she was noted to be pleasantly confused. The roommate stated she recalled a recent incident when Resident #2</p>	F 309			

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

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FORM APPROVED  
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F 309	<p>Continued From page 18</p> <p>entered into the room and removed the pillow and blanket from off the resident lying in bed. She stated Resident #2 often wandering into their room and sometimes stood in the doorway yelling at her roommate and called her the " N-word. "</p> <p>In an interview on 3/2/16 at 2:29 PM, the assistant director of nursing (ADON) stated management was aware of her wandering behaviors and noted it had been a concern soon after her admission. She stated Resident #2 had a history of refusing her medication and care. The social worker was working with the family to find alternate placement.</p> <p>In an observation on 3/2/16 at 2:35 PM, Resident #2 was observed in the dining room picking up salt and pepper shakers and moving them from one table to another. There was no other resident ' s observed in the dining area at the time.</p> <p>In an interview on 3/2/16 at 2:40 PM, the social worker stated they facility had been looking for alternate placement for Resident #2 since last Year in June. The social worker stated there was some improvement in Resident #2 behaviors in September and October but her behaviors have increased again over the last few months. She stated the facility had planned to meet with the responsible party (RP) soon but had not yet. She stated the facility had started logging her behaviors in December to present to the family but stated no other interventions had been attempted.</p> <p>In an observation and attempted interview on 3/2/16 at 3:00 PM, the resident involved in the incident dated 12/20/15 was determined cognitively unable to answer questions or recall the incident.</p> <p>In an interview on 3/2/6 at 3:10 PM, Nurse #2 stated Resident #2 was hard to redirect some days and she was fixated on certain residents.</p>	F 309			

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

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F 309	<p>Continued From page 19</p> <p>Nurse #2 recalled the incident involving the water pitcher and stated it was difficult to redirect her that day and she keep returning to the room and yelling at the resident in room ###. Nurse #2 stated she was not aware of any interventions put in place to keep Resident #2 from attempting to enter room ###.</p> <p>In another interview with Nurse #1 on 3/2/216 at 3:20 PM, she stated she did not contact the physician regarding the incident involving Resident #2 when she pulled the pillow and blanket off the resident in room ### bed nor did she contact the RP. Nurse #2 stated when Resident #2 sat at the nurses ' station, staff had to be careful about what they left there because she would bother it. Nurse #2 stated Resident #2 often went into the refrigerator and took out snacks and returned them. She stated the facility put up a retractable rope to block the kitchen entrance but Resident #2 goes underneath the rope without difficulty.</p> <p>In an interview on 3/2/16 at 4:00 PM, the physician stated he was not aware of all the medication refusals until recently and he felt Resident #2 ' s gradual dose reduction (GDR) in November could have caused her behaviors to escalated so badly.</p> <p>In an interview on 3/2/16 at 4:00 PM, the administrator stated his expectation that Resident #2 ' s cognitive impairment and associated wandering should not negatively impact the other residents in the facility and alternate interventions be attempted to address the behaviors.</p>	F 309			