

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

PRINTED: 08/05/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/25/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-GOLDEN AGE			STREET ADDRESS, CITY, STATE, ZIP CODE 720 E KINGS RD TOMAHAWK, WI 54487		
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F 000	INITIAL COMMENTS A recertification survey, complaint investigation, and extended survey was conducted at Golden Living Center-Golden Age from 6/3/14 through 6/25/14. This survey identified substandard quality of care at F253, F309, F312, and F329 # of federal deficiencies: 21 The most serious deficiency was F309 cited at a cope/severity level of K (immediate jeopardy/pattern). Census: 51 Sample Size: 13 Supplemental Sample Size: 35 Survey Coordinator: #25803	F 000			
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the	F 164			

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

TITLE

(X6) DATE

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 164	<p>Continued From page 1</p> <p>resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility did not ensure the privacy for 2 of 13 sampled residents.</p> <p>Three staff were observed discussing information about Resident #1 in the dining room while 5 residents and a family member were present.</p> <p>LPN-W (Licensed Practical Nurse) was heard discussing Resident #12's toe in a loud voice while 5 residents and the beautician were in the immediate area and other residents were on the hall.</p> <p>This is evidenced by:</p> <p>Example #1:</p> <p>Resident #1 was admitted to the facility in February 2014 and currently resides on the ACU (Alzheimer's Care Unit).</p> <p>On 6/5/14 at 7:40 a.m., Surveyor #16041 was observing the morning meal. Present in the dining room were Residents #24, #23, #12, #2; and a family member. The ACUD (Alzheimer's</p>	F 164			

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F 164	<p>Continued From page 2</p> <p>Care Unit Director), RN-J (Registered Nurse) and CNA-B (Certified Nursing Assistant) were also present in the dining room.</p> <p>The ACUD asked if Resident #1 had received his breakfast. CNA-B confirmed he had and then stated Resident #1 was sitting on the edge of the bed looking like he could fall asleep. RN-J then stated Resident #1 had been up all night. The ACUD asked if Resident #1 received his medications. RN-J stated, "Yep, I got them in him." CNA-B stated, "I got his shower in too."</p> <p>The 5 residents and family member remained in the kitchen throughout this conversation.</p> <p>This observation was shared with the NHA and DON on 6/5/14. The DON indicated this was not acceptable.</p> <p>Example #2:</p> <p>Resident #12 was admitted to the facility on 3/28/11 and currently resides on the ACU.</p> <p>On 6/11/14, Surveyor #16041 observed breakfast in the ACU dining room. The dining room is at the far end of the ACU. Prior to exiting the dining room, Surveyor #16041 noted Resident #12, #24, #22, #20, #23, #21 and #2. In addition, the facility beautician was also in the dining room.</p> <p>Surveyor #16041 walked to the other end of the hall and stood by the unit entrance doors and nurses' station. Very clearly, Surveyor #16041 heard LPN-W state, "Hey Resident #12, it says here you have a sore toe. How is that? We'll take a look at that later."</p>	F 164			

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F 221 F 221 SS=D	Continued From page 3 483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility did not ensure that 2 of 2 sampled residents with a physical restraint had the least restrictive device or were assessed for the medical requirement to treat the medical symptoms. Resident #5 had a seat-belt type restraint that was secured in the back of Resident #5's Broda chair. The restraint was placed after Resident #5 had 4 falls without injury. According to the restraint assessment, the restraint was placed to prevent further falls. Prior to implementing the restraint the facility did not clinically evaluate Resident #5, analyze each fall, or consider alternate devices based on Resident #5's individual needs. Resident #2 had a Velcro seat belt in the Broda chair, which Resident #2 could not release. The restraint was placed after Resident #2 had 10 falls, 7 of which happened in a short period of time. According to the restraint assessment, the restraint was placed to prevent further falls. Prior to implementing the restraint, the facility did not clinically evaluate Resident #2's falls, analyze each fall, or consider alternate devices including supervision based on Resident #2's individual	F 221 F 221			

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F 221	<p>Continued From page 4 needs.</p> <p>This is evidenced by:</p> <p>According to the Centers for Medicare and Medicaid Services memo 07-22, "Clarification of Terms Used in the Definition of Physical Restraints as Allied to the Requirements of Long Term Care Facilities," dated 6/22/07:</p> <p>"...Note: Falls do not constitute self-injurious behavior or a medical symptom that warrants the use of a physical restraint. Although restraints have been traditionally used as a falls prevention approach, they have major, serious drawbacks and can contribute to serious injuries...Additionally, falls that occur while a person is physically restrained often result in more severe injuries."</p> <p>According to the Long-Term Care Facility Resident Assessment Instrument User's Manual Version 3.0, "...A physical restraint is defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily and that restricts freedom of movement of normal access to one's body...Before a resident is restrained, the facility must determine the presence of a specific medical symptom that would require the use of the restraint and how the use of the restraint would treat the medical symptom, protect the resident's safety, and assist the resident in attaining or maintaining his or her highest practicable level of physical and psychosocial well-being...The focus of an individualized care plan based directly on these conclusions should be to address the underlying physical or</p>	F 221			

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F 221	<p>Continued From page 5</p> <p>psychological conditions that led to restraint use. By addressing underlying conditions and causes, the facility may eliminate the medical symptom that led to using restraints..."</p> <p>Example #1:</p> <p>Resident #5's current diagnoses include arthritis, dementia, and anxiety.</p> <p>The most current MDS (Minimum Data Set) dated 5/8/14, indicated Resident #5: ~Had a BIMS (Brief Interview for Mental Status) score of 0, indicating a severe cognitive impairment; ~Had symptoms of delirium including inattention and disorganized thinking; ~Had mood indicators of difficulty concentrating and being abnormally restless and fidgety; ~Required extensive assistance with bathing, dressing, grooming, using the bathroom, and eating; ~Walked only once or twice; ~Was frequently incontinent of bladder and occasionally incontinent of bowels; ~Had a urinary tract infection in the last 30 days; and ~Had 2 non-injury falls.</p> <p>Resident #5's care plan, dated 5/28/14, indicated Resident #5 had a belt restraint "...to prevent falls..."</p> <p>Surveyor #25803 completed a review of a facility form titled "Restraint-Chair Prevent Rising Assessment/Consent." The assessment did not direct the assessor to clinically evaluate a resident's physical and psychosocial status in order to determine the medical symptoms</p>	F 221			

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F 221	<p>Continued From page 6</p> <p>requiring the use of a restraint. The assessment did not direct the assessor to determine the least restrictive device necessary.</p> <p>Surveyor #25803 completed a review of Resident #5's "Restraint-Chair Prevent Rising Assessment/Consent" dated 5/1/14. The assessment did not include a clinical evaluation of Resident #5's physical or psychosocial status. The assessment did not include medical justification for the use of the restraint.</p> <p>Surveyor #25803 completed a review of Resident #5's nursing note. According to the nursing notes, Resident #5 had 4 falls since admission. After the last fall on 5/1/14, the facility placed a restraint. According to the fall investigation, the root cause of all falls was noted as either restlessness, reaching, and/or loss of balance.</p> <p>Surveyor #25803 observed Resident #5 on all days of the survey. On all days, Resident #5 was seated in a Broda chair with a belt restraint secured in the back of the chair. Resident #5 was observed to either be sleeping or in constant motion by either propelling the chair forward or backward with his feet, propelling his chair forward by utilizing the hand rails, leaning over attempting to pick up items off the floor, putting on/taking off socks, or manipulating the variety of positioning devices on the Broda chair.</p> <p>On 6/4/14 at 1:30 p.m. Surveyor #25803 spoke with the ST (Speech Therapist) who is also the director of therapy services. The ST indicated she felt the restraint for Resident #5 was inappropriate. The ST indicated Resident #5 was restless and looking for something to do. The ST indicated OT (Occupational Therapy) had devised</p>	F 221			

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F 221	<p>Continued From page 7</p> <p>a low table with a non-skid mat and items for Resident #5 to manipulate. The ST indicated this was, however, not being used by the nursing staff.</p> <p>On 6/4/14 at 10:32 a.m., Surveyor #25803 spoke with CNA-C (Certified Nursing Assistant). CNA-C indicated she felt there have been more falls because staff has been unable to attend to residents timely. CNA-C also indicated when Resident #5 was fidgety it was an indication Resident #5 needed to use the bathroom. CNA-C also stated Resident #5 loved chocolate and Coke.</p> <p>This information is not identified on Resident #5's care plan to direct all staff on specific approaches on how to manage restlessness leading to falls, which the facility responded to by applying a restraint.</p> <p>Surveyor #25803 spoke with Staff-I (Anonymous). Staff-I stated Resident #5 was not being engaged in a meaningful activity.</p> <p>On 6/11/14 at 3:10 p.m., Surveyor #25803 spoke with the DON (Director of Nursing). The DON indicated Resident #5's restraint was for falls. Surveyor #25803 asked the DON if the facility ever considered the use of other modalities besides the restraint. The DON stated they hadn't.</p> <p>Example #2:</p> <p>Resident #2's admitting diagnoses included, but not limited to, dementia, anxiety, and PTSD (Post Traumatic Stress Disorder).</p>	F 221			

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F 221	<p>Continued From page 8</p> <p>The most current MDS was dated 3/25/14 and indicated Resident #2:</p> <p>~Was usually understood and sometimes understands;</p> <p>~Had a BIMS score of 0 indicating a severe cognitive impairment;</p> <p>~Had symptoms of delirium including inattention and disorganized thinking which did fluctuate;</p> <p>~Had 3 mood indicators;</p> <p>~Rejected care, wandered,</p> <p>~Walked with supervision;</p> <p>~Required limited to extensive assistance for bathing, dressing, grooming, eating, and using the bathroom;</p> <p>~Was frequently incontinent;</p> <p>~Had 3 falls; and</p> <p>~Weighed 120 pounds.</p> <p>Resident #2's physical restraint care plan was dated 6/2/14. The care plan indicated, "...Self release belt - unable to remove..." According to the care plan, the restraint was placed due to "...falls/weakness while up..."</p> <p>Surveyor #25803 completed a review of a facility form titled "Restraint-Chair Prevent Rising Assessment/Consent." This assessment did not direct the assessor to clinically evaluate a resident's physical and psychosocial status in order to determine the medical symptoms requiring the use of a restraint. The assessment does not direct the assessor to determine the least restrictive device necessary.</p> <p>Surveyor #25803 completed a review of Resident #2's "Restraint-Chair Prevent Rising Assessment/Consent" dated 6/2/14. The assessment did not include a clinical evaluation of Resident #5's physical or psychosocial status.</p>	F 221			

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F 221	Continued From page 9 The assessment did not include the medical justification for using the restraint. Surveyor #25803 completed a review of Resident #2's nursing notes. Since admission on 12/16/13, Resident #2 had 10 falls; 7 of the falls occurred between 5/5/14 to 6/2/14. A review of Resident #2's falls indicated the facility was not assessing the root cause of each fall and implementing interventions based on the root cause to prevent further falls. (Refer to F323.) On 6/3/14 at 6:10 p.m., Surveyor #25803 observed Resident #2 seated in a Broda chair with a seat belt on. RN-EE (Registered Nurse) indicated Resident #2 had an over-all decline in functioning, including many recent falls which required the use of the Broda chair and seat belt. On 6/11/14 at 3:10 p.m., Surveyor #25803 spoke with the DON (Director of Nursing). The DON indicated Resident #2 had a dramatic decline in condition. The DON stated Resident #2 was very weak but still restless. The DON stated Resident #2 had multiple falls in one day. The DON stated the belt was applied for safety so Resident #2 didn't have any further falls. Surveyor #25803 asked the DON if the facility attempted 1:1 for Resident #2. The DON stated, "Not for any extended period of time." Surveyor #25803 asked the DON why. The DON stated she didn't know why.	F 221			
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program	F 248			

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F 248	<p>Continued From page 10</p> <p>of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility did not ensure that the activity programs met the individual needs for 13 of 13 residents who reside on the ACU (Alzheimer's Care Unit).</p> <p>Observations found residents not being assisted to participate in activities per their personal preferences or activities that are consistent with their cognitive abilities.</p> <p>This is evidenced by:</p> <p>On 6/4/14, Surveyor #16041 toured and observed the ACU. Surveyor #16041 noted there were no activity items available to residents. There was a corner cabinet in the dining room with some items on the shelf and inside the cabinet. However, the dining room table and chair placed in front of the cabinet would make it difficult for a person to get to the items, and residents with Dementia/Alzheimer's may not recognize the need to open the cabinet doors.</p> <p>Throughout the day, several residents were observed to walk up and down the halls with little to no engagement in any activities. No activity/sensory items were left out to allow the residents to self initiate an activity that would be consistent with their life long interests.</p>	F 248			

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F 248	<p>Continued From page 11</p> <p>On 6/5/14, Surveyor #16041 asked the ACUD (Alzheimer's Care Unit Director) about the availability of activity items. The ACUD first took Surveyor #16041 to the TV Room. There were 2 tall cabinets with a small love seat in front of them. The ACUD moved the loveseat and opened the cabinets. Inside were VHS tapes, DVDs, music, and other activity items.</p> <p>When asked why they were not readily accessible to the residents, the ACUD stated if items are left out, residents will take them and there would be nothing left.</p> <p>The ACUD then led Surveyor #16041 to the "Country Store" across the hall. In the room were 2 tall cabinets identical to those in the TV Room. The ACUD moved a table that was in front of the cabinets and unlocked the cabinet doors. The cabinets were filled with activity items.</p> <p>The ACUD stated yesterday (6/4/14) staff were "nervous" because of the surveyor's presence and activities did not occur like they normally do.</p> <p>Surveyor #16041 observed residents in the dining room after breakfast on 6/5/14. Activity items were out on the tables. Residents were observed to interact with staff and the activity items. Prior to lunch, all of the activity items were put away.</p> <p>On 6/9/14 at 10:00 a.m., Surveyor #16041 entered the ACU. Observations found no activity/sensory items out and accessible to residents.</p> <p>On 6/11/14 at 8:30 a.m., Surveyor #16041 observed activities in the dining room with AA-II (Activities Assistant). AA-II was working with</p>	F 248			

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F 248	<p>Continued From page 12</p> <p>Residents #24 and #11 on a word sorting activity. Resident #23 was sitting at the same table with a pipe cleaner and a large button. AA-II would give Resident #23 an oversized button to thread onto the pipe cleaner and then turn back to Residents #24 and #11. After placing the button on the pipe cleaner, Resident #23 would sit in the chair and start to doze off. AA-II would wake Resident #23 and give her another oversized button to thread on the pipe cleaner. This was repeated another 2 times with Resident #23 dozing during the long intervals between getting another button.</p> <p>AA-II was asked why Resident #23 was only given 1 button at a time. AA-II stated Resident #23 would take the buttons and put them in her pockets if she had more than 1 at a time.</p> <p>During this observation, Resident #1 was also in the dining room and had finished eating breakfast. Resident #1 was not engaged in an activity after eating. Resident #4 was also seated in the dining room. Resident #4 was not engaged in any activity and was not seated in an area where he could observe the activity as his Recreational Assessment indicated he liked to do.</p> <p>At 9:00 a.m., AA-II put all of the activity supplies away. Surveyor #16041 asked AA-II why no activity or sensory items were left out for the residents. AA-II stated residents are confused and they may try to eat the items or they would take them and there would be no supplies left.</p> <p>Resident #1's family had shared information about Resident #1's past, including his career as a contractor, his love for his dog and for the outdoors. The facility did not develop a program of activities to interest and engage Resident #1.</p>	F 248			

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F 248	Continued From page 13 Resident #1's medical record indicated he had an increase in behaviors and altercations with staff and peers. (Refer to F309.) Throughout the survey, Surveyor #16041 observed Resident #1 to walk up and down the halls, and attempt to engage in conversations with others. On 6/9/14, the ACUD showed Surveyor #16041 a board full of several different locks, including some with very small keys, that can be locked and unlocked by the user. This had been given to Resident #1 to engage him when he was looking for something to do. On 6/11/14 at 9:40 a.m., Surveyor #16041 observed Resident #1 seated in the hall with the lock board on a table in front of him. Resident #1 was observed trying to manipulate the locks, but was unable to do so. Resident #1 appeared to get frustrated with the locks, pushed the table away and began to walk in the hall again.	F 248			
F 253 SS=F	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility did not maintain clean and comfortable interior resident living areas. This has the potential to affect all residents. Flooring, walls and wallcoverings, furniture, handrails, doors and door jambs, and windows	F 253			

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F 253	<p>Continued From page 14</p> <p>were in poor condition and/or dirty throughout the entire facility. Mold was observed in the handrails where food/fluids were spilled and not cleaned. Urine odors were noted in the hall and in furniture on the ACU. Odors were evident and air was stagnant on the East and West.</p> <p>This is evidenced by:</p> <p>Alzheimer's Care Unit:</p> <p>Throughout the survey, Surveyor #16041 made the following observations of the resident environment on the ACU:</p> <p>A brown tape was observed across the entire length of the hall between the "Country Store" and the living room. While walking, residents were observed to take an exaggerated step over the tape.</p> <p>The living room had several rubber black mats glued to the floor immediately upon entrance and extending approximately 1/4 the length of the room.</p> <p>The living room had a musty odor in all areas of the room.</p> <p>There is an exterior door in the "Country Store" leading to a secured courtyard. There was no doorknob on the door, only a keyed deadbolt.</p> <p>In the hall between the "Country Store" and the living room, Surveyor #16041 noted an odor of urine.</p> <p>The walls throughout the unit are badly marred, scuffed, and scraped.</p>	F 253			

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F 253	Continued From page 15 All door jambs and doors throughout the unit are badly scraped and scratched. Handrails throughout the unit are worn and without any finish rendering them uncleanable. The tile flooring in all resident rooms was tacky and sticky. Wallpaper in the main hall was also peeling in multiple areas. Resident Room 3 had peeling wallpaper border and a large whitish splatter/spill the entire length of the window. Resident Room 6 had grey residue on the floor; the wallpaper border was peeling, and several dust accumulations were noted on the ceiling. Resident Room 10 had peeling wallpaper. The handrails are constructed in a sideways T shape - behind the handrail is a continuous wooden piece that attaches the handrail to the wall. Juice spills were observed behind the handrail in 2 locations. The spills were covered by small white dots, which had the appearance of mold. The black dehumidifer in the middle of the unit had a white substance spilled on top and down the front. The door at the end of the hall was dirty and appeared as though someone repeatedly put their head/face against the window.	F 253			

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F 253	<p>Continued From page 16</p> <p>There were several spills and splatters noted on the walls of the ACU hall.</p> <p>The flooring transition trim between the hallway and the dining room was broken, cracked, and chipped.</p> <p>There were large gouges in the wall surrounding the dining room entrance. A clear plastic corner protector had been glued onto the corner without repairs being made to the wall. On the other side of the entrance, there were large gouges and the plastic corner protector was not fully adhered to the wall and was sticking out. A resident's clothing could easily catch or snag on the corner protector.</p> <p>The countertops in the ACU kitchen had worn, chipped, cracked, and missing veneer rendering the countertops uncleanable.</p> <p>There were spills down the front of the stove in the ACU and 2 burners were missing.</p> <p>The kitchen cabinets were splattered and dirty, especially around the cabinet handles, which are high touch areas.</p> <p>There were large gouges on the inside of all the table legs, presumably from the chairs. These areas were noted to be rough and splintering to the touch.</p> <p>The dining table closest to the courtyard door is missing the finishing edge. Particle board and glue residue remain on the table edge. Two residents eat their meals and sit on this side of the table. The table is no longer cleanable.</p>	F 253			

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F 253	<p>Continued From page 17</p> <p>There is an exterior door in the dining room/kitchen area that also leads to the secured courtyard. The door had no doorknob, only a keyed deadbolt. The same exterior door has a window that was dirty and also appeared as though someone repeatedly put their head/face against the window.</p> <p>On 6/4/14, Surveyor #16041 spoke with the ACUD (Alzheimer's Care Unit Director) and asked about the carpeting. The ACUD indicated the carpet had been like that since a "flood" occurred prior to the last survey 8 months ago. The ACUD indicated the corporation had just approved replacement the evening before.</p> <p>On 6/4/14, Surveyor #16041 spoke with the INHA (Interim Nursing Home Administrator). The INHA confirmed that he received an email approval to replace the flooring. When asked when the flooring is expected to be replaced, the INHA was unable to say.</p> <p>Main Side:</p> <p>Surveyor #30570 conducted an environmental walk through of the main side facility. The following observations of the resident environments were made:</p> <p>The front lobby of the facility has ceiling tiles that are discolored and stained. There are two love seats and 6 lounge/winged chairs that have wooden legs that are chipped.</p> <p>The walls in front of the nurses' station are</p>	F 253			

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F 253	<p>Continued From page 18</p> <p>covered in wallpaper that is faded, discolored and spotted.</p> <p>The hallway leading to the dining room is covered in wallpaper that is torn and discolored.</p> <p>The main dining room has ceiling tiles that are dirty with visible food particles and several contain holes. The doors entering the dining room and kitchen are chipped. The wallpaper below the windows is torn. There are 16 chairs in the dining room with wooden arms, legs and bases with chips in the wood.</p> <p>West Wing:</p> <p>The wallpaper is discolored and torn away from the wall near rooms 32 and 39.</p> <p>The handrails are wooden and the stain has worn off.</p> <p>The door at the end of the hall that leads to the outside has numerous areas of chipped paint around the door frame.</p> <p>The frames around the windows at the end of the hall also have many areas of chipped paint.</p> <p>The register/vent at the end of the hall has a rusted frame and has no air flow from the unit.</p> <p>The air at the end of the hall is stagnant and musty smelling.</p> <p>The wood doors to rooms 42, 45 and 46 are chipped on the lower portion of the doors.</p> <p>The baseboards that run the length of the hallway</p>	F 253			

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F 253	<p>Continued From page 19 on both sides are marred and discolored.</p> <p>New Wing/Activity Room:</p> <p>The wallpaper is stained in several areas, discolored and pulling away from the walls.</p> <p>There is an area of wallpaper near the men's room that has peeled away and is missing.</p> <p>There are ceiling tiles in the activity room that are chipped, discolored and sagging.</p> <p>The lower portion of the wall has numerous areas of mars and stains that run the length of the hallway.</p> <p>The stain on the wood hand rails that run the length of the hall on both sides has worn off.</p> <p>The baseboards that run the full length of the hall are chipped and discolored.</p> <p>The activity room has 2 lounge type chairs with wooden legs that are chipped.</p> <p>East Wing:</p> <p>The wallpaper is stained in several areas, discolored and pulling away from the walls.</p> <p>The ceiling tiles are mis-matched, chipped, discolored and sagging.</p> <p>The baseboards are marred and stained.</p> <p>The stain on the wood hand rails that run the length of the hall on both sides has worn off.</p>	F 253			

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F 253	<p>Continued From page 20</p> <p>The vent/register on the ceiling at the end of the hall is not functioning. The air is very stagnant with increased odors; a musty smell was noted each day of the survey.</p> <p>On 6/11/14 at 11:10 a.m., Surveyor #30570 spoke with HLD-U (Housekeeping/Laundry Director) regarding the dirty walls in the facility. HLD-U indicated the walls are scrubbed weekly but no longer come clean because of the age and condition of the wallpaper.</p> <p>On 6/11/14 at 11:35 a.m., Surveyor #30570 spoke with M-R (Maintenance) regarding the noted concerns. M-R indicated he goes through several gallons of paint in attempt to touch up the lower portions of the walls and doors in the facility but due to the residents banging the walls with their wheelchairs it is difficult to keep up with the touch ups. M-R further explained the facility purchases a few sheets of Empro (a protective wall covering) each month to cover the walls and doors. M-R explained he has been instructed to spray paint the baseboards in the facility to touch up the scrapes and mars, but the paint is ineffective in covering the material. M-R explained the wallpaper stains are related to the age of the wallpaper and the epoxy glue showing through the wallpaper as it is aged and worn. M-R also explained the handrails in the facility are worn to a point that they will no longer hold stain. Surveyor #30570 asked M-R about the increased odor at the end of East and West halls. M-R indicated the vents are air handlers that circulate internal air. Due to the vents not working, there is little to no airflow at the ends of the hallways. Surveyor #30570 asked M-R if the air handlers not working impacts the air quality and odors. M-R explained the air quality and odors are</p>	F 253			

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F 253	Continued From page 21 affected due to no air motion. On 6/11/14 at 2:45 p.m., Surveyor #30570 met with the Nursing Home Administrator (NHA) regarding the facility's overall disrepair. The NHA indicated paint is purchased on a regular basis for repairs and Empro is purchased routinely to cover lower portions of walls and doors that are chipped. The NHA further expressed there is no plan for a remodel, but recognizes it is time to update. The NHA indicated new hand rails will be requested and the facility is in the process of replacing sinks in resident rooms. Surveyor #30570 asked the NHA if he had plans for the numerous chairs in the dining room, lobby and activity room that have chips in the wood. The NHA indicated the chairs would be repaired or replaced.	F 253			
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being;	F 272			

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F 272	<p>Continued From page 22</p> <p>Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, 3 out of 7 sampled residents reviewed for behaviors had no comprehensive assessments to determine the underlying cause of the behavior.</p> <p>The facility did not use the RAI (Resident Assessment Instrument) Manual to further evaluate triggered areas for Resident #1. Completed CAAs (Care Area Assessment) analysis did not:</p> <ol style="list-style-type: none"> 1. Describe the nature of the condition; 2. Did not identify complication and risk factors that affect the decision to proceed to care planning; 3. Did not identify factors that must be 	F 272			

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F 272	<p>Continued From page 23</p> <p>considered in developing individualized care plan interventions;</p> <p>4. Did not identify the need for referrals or further evaluation by appropriate health professionals.</p> <p>Resident #2 had a diagnosis of dementia. According to the facility, Resident #2 had behaviors of anger, fighting, aggression toward others, pacing, combativeness, yelling, shouting, crying, weeping, agitation, restlessness, delusions, hallucinations, and attempting to elope. While the facility identified the behaviors, there was no indication the facility completed a comprehensive assessment to determine underlying causes of Resident #2's behaviors.</p> <p>Resident #5 had a diagnosis of dementia. According to the facility, Resident #5 had behaviors of restlessness, agitation, insomnia and falls. While the facility identified these behaviors, there was no indication the facility completed a comprehensive assessment of Resident #5's medical, physical, mental nor psychosocial needs to determine underlying causes of Resident #5's behaviors. Consequently, there was no direction to staff on how to manage Resident #5's behaviors.</p> <p>This is evidenced by:</p> <p>Example #1:</p> <p>Resident #1 was admitted to the facility on 2/4/14 with a diagnoses of but not limited to, Dementia, Depression and Chronic Obstructive Pulmonary Disease with Stage IV emphysema.</p> <p>The Initial MDS (Minimum Data Set) assessment, dated 2/12/14, revealed:</p>	F 272			

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F 272	<p>Continued From page 24</p> <p>*Signs and symptoms of delirium such as inattention, which comes and goes. *Resident says he has less energy and feeling tired. Having problems concentrating on things and being so fidgety or restless that he has to be moving around a lot more than usual. *Wandering occurred 4 to 6 days, but less than daily, which puts him at significant risk of getting to a potentially dangerous place and significantly intrudes on the privacy of others. *Activities that are very important is to be around pets, keep up with the news, go outside to get fresh air and participate in religious services. *Sometimes is understood and understands. *Ambulates independently and requires assistance of 1 staff for dressing, hygiene, and toilet use.</p> <p>Review of the Behavior symptom CAA (Care Area Assessment) indicated the following were addressed: *Triggered condition is wandering. Is this problem/need: Actual. Seriousness: Resident is immediate threat to self. *Nature of the behavior disturbance was left blank, nothing was checked/addressed. *Medication side effects that can cause behavioral symptoms was left blank, nothing was checked. *Hospital records indicate he was a smoker and was on a nicotine patch which could have affected his behavior. *Illness or conditions that can cause behavior problems. Constipation was checked. (This problem was not addressed until 5/29/14 when Miralax (laxative) was ordered.) *Factors that can cause or exacerbate the behavior (from observation, interview, record).</p>	F 272			

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F 272	<p>Continued From page 25</p> <p>Sensory impairment, such as hearing or vision problems was the only box checked.</p> <p>*Cognitive status problems. Dementia was checked.</p> <p>*Other considerations such as the actions and responses of family members and caregivers can aggravate or even cause behavioral outbursts was left blank, nothing was checked.</p> <p>*Care Plan Considerations. Avoid complications and Minimize risk boxes were checked.</p> <p>*Describe impact of this problem/need on the resident and your rationale for care plan decision. "Will proceed to plan of care as resident has wandered throughout the facility and attempts to go outside."</p> <p>*Referral to other Disciplines. Nothing was documented.</p> <p>The CAA was completed by the SW (Social Worker) on 2/13/14.</p> <p>There was no comprehensive assessment to determine the underlying cause of Resident #1's behaviors. (Refer to F309 and F329.)</p> <p>Example #2:</p> <p>Resident #2's admitting diagnoses include, but not limited to, dementia, anxiety, and PTSD (Post Traumatic Stress Disorder).</p> <p>Resident #2's most current MDS was dated 3/25/14. The MDS indicated Resident #2: ~ Was usually understood and sometimes understands; ~ Had a BIMS (Breif Interview for Mental Status) score of 0, indicating a severe cognitive impairment;</p>	F 272			

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F 272	<p>Continued From page 26</p> <ul style="list-style-type: none"> ~ Had symptoms of delirium including inattention and disorganized thinking which did fluctuate; ~ Had 3 mood indicators; ~ Rejected care, wandered, ~ Walked with supervision; ~ Required limited to extensive for bathing, dressing, grooming, eating, and using the bathroom; ~ Was frequently incontinent; ~ Had 3 falls; and ~ Weighed 120 pounds. <p>Resident #2's most current CAA (Care Area Assessment) for behavior was dated 12/17/13. Several components of the CAA are incomplete including "Nature of the behavior...Medication side effects...Illness or conditions that can cause behavior...Factors that can cause or exacerbate the behavior..." The CAA indicated, "... resident has verbal symptoms directed at others... Resident is a new admission...displayed verbal aggression towards others with recent placement...new orders for additional anti-anxiety medications, family...comes to facility when aggressive behavior displayed...Staff has discovered watching church videos are calming...bathing appears to calm resident...Will proceed to care plan to minimize risk and continue with interventions to calm resident at times of increased anxiety..."</p> <p>The CAA did not clinically assess nor critically analyze Resident #2's behaviors. (Refer to F309 and F329.)</p> <p>Example #3:</p> <p>Resident #5 had current diagnoses including, but not limited to, arthritis, dementia, and anxiety.</p>	F 272			

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F 272	Continued From page 27 The most current MDS dated 5/8/14 indicated Resident #5: ~ Had a BIMS (Brief Interview for Mental Status) score of 0 indicating a severe cognitive impairment; ~ Had symptoms of delirium including inattention and disorganized thinking; ~ Had mood indicators of difficulty concentrating and being abnormally restless and fidgety; ~ Required extensive assistance with bathing, dressing, grooming, using the bathroom, and eating; ~ Walked only once or twice; ~ Was frequently incontinent of bladder and occasionally incontinent of bowels; ~ Had a urinary tract infection in the last 30 days; and ~ 2 non-injury falls. Resident #5's most current behavior CAA (Care Area Assessment) was dated 2/11/14. The CAA indicated Resident #5 had behaviors. There was no further information. The CAA did not include an assessment, problem identification, cause and effect analysis, goals and objectives of care, and interventions for care planning. (Refer to F309.)	F 272			
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the	F 274			

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F 274	<p>Continued From page 28</p> <p>resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility did not conduct a significant change in status MDS (Minimum Data Set) for 2 of 13 sampled residents.</p> <p>Resident #1 had declines in 3 sections of the MDS between the 2/12/14 and 5/13/14 assessments. A Significant Change in Status assessment was not completed.</p> <p>Resident #2 had declines in 5 sections of the MDS between 12/23/13 and 3/25/14. A Significant Change in Status assessment was initiated.</p> <p>This is evidenced by:</p> <p>In accordance with Appendix R, the RAI (Resident Assessment Instrument) Manual, Chapter 2-20 notes the following: "A significant change is a decline or improvement in a resident that:</p> <ol style="list-style-type: none"> 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not 'self-limiting'. 2. Impacts more than one area of the resident's health status; and 	F 274			

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F 274	Continued From page 29 3. Requires interdisciplinary review and/or revision of the care plan." Example #1: Resident #1 has diagnoses of, but not limited to, Dementia, GERD (gastroesophageal reflux) and COPD (chronic obstructive pulmonary disease). Review of the initial MDS for Resident #1 was completed on 2/14/14 which revealed the following data: *Displaying signs and symptoms of delirium; inattention present but fluctuates. *Independent ambulation in the hallway, limited assist with one staff for dressing, hygiene and toilet use. *No pain assessment to be conducted. *Receiving antidepressant medications. Review of the quarterly assessment for Resident #1 completed on 5/13/14, revealed the following data: *Displaying signs and symptoms of delirium; inattention is now continuous and has fluctuating disorganized thinking. *Requires limited assistance of one staff for ambulation in room and for locomotion in the facility. Requires extensive assistance of 2 staff for dressing, hygiene and toilet use. *Yes to pain assessment should be conducted but the rest of the MDS pain assessment was left blank, which indicates the type of pain scale to use is either the Numeric rating scale (00-10) or the Verbal descriptor scale for Resident #1. *Receiving in addition to the antidepressants are antipsychotic and antianxiety medications 7 days a week.	F 274			

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F 274	<p>Continued From page 30</p> <p>The facility should have recognized the significant change in status upon completion of the quarterly assessment when Resident #1 was having increased signs and symptoms of delirium, placed on antianxiety and antipsychotic medications, which could indicate the decline in functional status and falls.</p> <p>Example #2:</p> <p>Resident #2 has a diagnoses of, but not limited to, Dementia, Anxiety, Depression and PTSD (posttraumatic stress disorder).</p> <p>Review of the initial MDS for Resident #2, completed on 12/23/14, revealed the following data:</p> <ul style="list-style-type: none"> *Displaying signs and symptoms of delirium; inattention and disorganized thinking continuously. Having behavior issues. *Independent with transfers and bed mobility. Requires supervision with ambulation and locomotion. Limited assist of one staff for dressing, hygiene and toilet use. *No balance problems. No falls. *Frequently incontinent of bowel and bladder. No toileting program. *Weight 144# (pounds). Eating is supervision with set up. *Receiving antianxiety medication 7 days a week. <p>Review of the quarterly assessment for Resident #2, completed on 3/25/14, revealed the following data:</p> <ul style="list-style-type: none"> *Delirium for disorganized thinking now fluctuates but continues with inattention. *Supervision with transfers and bed mobility. Extensive assistance of one staff for dressing, hygiene and toilet use. 	F 274			

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F 274	Continued From page 31 *Balance is not steady with moving from seated to standing position, walking, turning around, moving on and off toilet and surface-to-surface transfer. *Always incontinent of bowel and on a bladder toileting program. *Requires limited assistance with assistance of one staff. Wt. loss. Wt. 120 pounds *Has indicators of pain and has had 2 or more falls. *Receiving antianxiety and antidepressant medications 7 days a week. The facility should have recognized the significant change in status upon completion of the quarterly assessment when Resident #2 continued with the signs and symptoms of delirium, decline in functional status, decline in bowel status, increase medications, falls and significant weight loss in 3 months. On 6/5/14 at 12:45 p.m., Surveyor #25989 interviewed RN-A (Registered Nurse) who is the MDS Coordinator on what constitutes a significant change in condition MDS. RN-A stated 2 or more changes would indicate a change in condition MDS. RN-A stated she identifies changes from looking at the interdisciplinary notes, weekly meetings and if the staff tell her. RN-A stated she does feel there is a communication problem. RN-A and Surveyor #25989 reviewed Resident #1's and #2's MDS assessments and stated a significant change assessment should have been completed.	F 274			
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment	F 279			

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F 279	<p>Continued From page 32</p> <p>to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews, the facility did not ensure that 9 out of 9 residents reviewed for dementia care had individualized goals or interventions on the care plan. This had the potential to affect 38 of 51 residents with dementia.</p> <p>Resident #1 had identified targeted behaviors of pacing, restlessness, tearful and agitation. The care plan did not have a description of and how to prevent targeted behaviors. Since there were no individualized approaches or goals, there were no effective monitoring of which approaches are effective or not. Family involvement was not taken to the extent possible.</p>	F 279			

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F 279	<p>Continued From page 33</p> <p>Resident #3 has identified targeted behaviors of agitation and continuous pacing. The care plan does not have a description of and how to prevent targeted behaviors such as activities he likes and to go outside to get fresh air. There was no effective monitoring on approaches to identify if approaches were effective or not to meet a goal.</p> <p>Resident #2 had a diagnosis of dementia. According to the facility, Resident #2 had behaviors of anger, fighting, aggression toward others, pacing, combativeness, yelling, shouting, crying, weeping, agitation, restlessness, delusions, hallucinations, and attempting to elope. While the facility identified the behaviors, there was no individualized care plan developed to direct staff on how to manage Resident #2's behaviors.</p> <p>Resident #5 had a diagnosis of dementia. According to the facility, Resident #5 had behaviors of restlessness, agitation, insomnia and falls. While the facility identified these behaviors, there was no individualized care plan developed to direct staff on how to manage Resident #5's behaviors.</p> <p>Resident #7 had periods of calling out. While the facility identified this behavior, there was no individualized care plan directing staff on how to manage Resident #7's behavior.</p> <p>Resident #6 had facility defined behaviors of calling out, shouting, and cursing. While the facility identified the behaviors, there was no care plan developed with individualized approaches to direct staff on how to manage Resident #6's behaviors.</p>	F 279			

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F 279	<p>Continued From page 34</p> <p>The facility did not use the comprehensive assessments to develop an individualized care plan to meet Resident #4's #11's and #12's needs related to behaviors and/or pain.</p> <p>This is evidenced by:</p> <p>Example #1:</p> <p>Resident #1 was admitted to the facility on 2/4/14 with diagnoses of, but not limited to, Dementia, Depression and Chronic Obstructive Pulmonary Disease.</p> <p>A care plan initiated on 2/11/14 included, "I sometimes have behaviors which include walking out the front door and trying to catch a ride. I walk around the hallways with no real sense of where or what I want to be doing. Goals-My behavior will stop with staff intervention." There are no measurable objectives/goals.</p> <p>Interventions include, "Attempt interventions before my behaviors begin. Give me my medications as my doctor has ordered. Help me to avoid situations or people that are upsetting to me. Let my physician know if my behaviors are interfering with my daily living. Offer me something I like as a diversion. Please tell me what you are going to do before you begin."</p> <p>The care plan did not include specific interventions to use to prevent behaviors from occurring, no description of situations to avoid, and no specific things Resident #1 likes for diversions.</p> <p>Example #2:</p>	F 279			

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F 279	<p>Continued From page 35</p> <p>Resident #3 was admitted on 9/12/13 with diagnoses of, but not limited to, Advance Dementia, Anxiety and Urinary Incontinence.</p> <p>Review of the initial MDS dated 9/19/13, indicated under Section F: Customary routine/activities that it is very important to do favorite activities and to go outside to get fresh air. He also wanders.</p> <p>Behavior monitoring sheets indicated Resident #1 has targeted behaviors of continuous pacing and agitation.</p> <p>The care plan, dated 9/12/13, indicated: "I have little or no awareness of safety, or boundaries related to other's personal space (etiology choice here). Please help me remain in a living environment that meets and supports my need to safely wander such as a secured unit or specialized care unit. Wandering about my living space. Going into other resident's rooms. Not always aware if areas are okay for me to be in."</p> <p>Goals: "I will continue to wander freely as I desire with the safety parameters of a secured, specialized unit." There are no measurable objectives/goals.</p> <p>Interventions: "...Invite me to participate in activities that remind me of things I enjoy doing. 11/1/13." There are no approaches as to what type of activities he likes to do. There are no approaches to indicate what triggers the targeted behaviors of continuous pacing and agitation and/or monitoring of these approaches to evaluate if effective or not.</p>	F 279			

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F 279	Continued From page 36 Example #3: Surveyor #25803 completed a review of Resident #2's clinical record and noted the following. Resident #2's admitting diagnoses include, but not limited to, dementia, anxiety, and PTSD (Post Traumatic Stress Disorder). Resident #2's behavior care plan was dated 12/16/13. The care plan indicated Resident #2 had behaviors of yelling, shouting, crying, agitation, combativeness, aggression, restlessness, and anger. The care plan had the following approaches: ~ 12/16/13, "...Assist me to watch church video...Attempt interventions before my behaviors begin...Do not seat me around others who disturb me...Give me medications my doctor has ordered...Help me maintain my favorite place to sit...Help me avoid situations or people that are upsetting to me...may call family to assist in redirection...Let my physician know...if my behaviors are interfering with my daily living...Make sure I am not in pain...Offer me something I like as a diversion...tell me what you are going to do before you begin...Reduce external stimuli as possible, speak in gentle, calm, soft but firm voice..." ~ 12/18/13, "...may bath to assist with calming..." ~ 1/2/14, "...Administer medications as ordered..." ~ 1/31/13, "...Monitor for s/sx (signs and symptoms) of anxiety towards others and attempt redirection..." None of the above interventions, with the	F 279			

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F 279	<p>Continued From page 37</p> <p>exception of 2, are individualized based on Resident #2's specific needs. (Refer to F309 and F329.)</p> <p>Example #4:</p> <p>Surveyor #25803 completed a review of Resident #5's clinical record and noted the following.</p> <p>Resident #5 had current diagnoses including but not limited to arthritis, dementia, and anxiety.</p> <p>Surveyor #25803 completed a review of Resident #5's care plan dated 5/28/14. Behavior approaches were noted in multiple areas within the care plan and included the following: ~2/1/14, "...if I'm upset, please re-direct... Offer things that are soothing to me..." ~2/10/14, "...Make sure I have my things with me that make me comfortable..." ~2/11/14, "...Attempt interventions before my behaviors begin...Do not seat me around others who disturb me...Help me avoid situations or people that are upsetting to me...Make sure I am not in pain..." ~3/3/14, "...Offer activities at table as he will tolerate..."</p> <p>None of the above interventions are person-centered, individualized approaches.</p> <p>Surveyor #25803 completed a review of Resident #5's CNA (Certified Nursing Assistant) care plan dated 6/3/14. There was no direction to staff on how to manage Resident #5's behaviors. (Refer to F309)</p> <p>Example #5:</p>	F 279			

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F 279	<p>Continued From page 38</p> <p>Surveyor #25803 completed a review of Resident #7's clinical record and noted the following.</p> <p>Resident #7 had current diagnoses that include, but not limited to, congestive heart failure and anxiety.</p> <p>Resident #7's behavior care plan, dated 7/12/10, indicated, "...I have behavior of calling out and can become anxious at times..." The approaches included the following: ~ 7/12/10, "...encourage me to make independent decisions...Encourage...activities which are mentally stimulating..." ~ 4/26/13, "...Reapproach as needed...Approach with calm soothing voice..."</p> <p>None of the above approaches are individualized based on the reasons Resident #7 calls out. (Refer to F309.)</p> <p>Example #6:</p> <p>Surveyor #25803 completed a review of Resident #6's clinical record and noted the following.</p> <p>Resident #6 had current diagnoses which include, but not limited to, dementia with delusions, psychosis, anxiety, and glaucoma resulting in blindness in the right eye and poor vision in the left eye.</p> <p>Resident #6's behavior care plan was dated 4/14/14. The care plan had the following approaches: ~ 4/14/14, "...Attempt interventions before my behaviors begin...Do not seat me around others who disturb me...maintain by favorite place to sit...Help me avoid situations or people that are</p>	F 279			

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F 279	<p>Continued From page 39</p> <p>upsetting to me...Let my physician know if...my behaviors are interfering with my daily living...Make sure I am not in pain... Offer me something I like as a diversion...tell me what you are going to do before you begin....Speak to me unhurriedly and in a calm voice..."</p> <p>None of the above approaches are individualized based on Resident #6's specific needs. Consequently, there was no direction to staff on how to manage Resident #6's behaviors. (Refer to F309.)</p> <p>Example #7:</p> <p>Resident #4 was admitted to the facility on 11/21/13 with diagnoses of Alzheimer's Disease, Dementia with Behaviors, and Depression.</p> <p>Resident #4's current care plan with a print date of 3/14/14 included the following:</p> <p>~Problem of "Sometimes I show behavior symptoms/risks include wandering or resisting cares. Episodes of displaying aggression toward others" dated 11/21/13.</p> <p>Approaches, all dated 11/21/13, include:</p> <p>**15 minute checks.</p> <p>*Administer medications as ordered.</p> <p>*Build on my strengths of (insert personalization here) and invite me to participate in various activities and tasks related to those strengths.</p> <p>*During episodes of inappropriate behaviors, please re-direct me by approaching slowly and speaking to me in a calm and steady voice-trying to redirect me to an alternate activity or topic of discussion.</p> <p>*Encourage me to participate in activities to give</p>	F 279			

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F 279	<p>Continued From page 40</p> <p>me something to focus on.</p> <p>*Help me avoid situations and people that trigger inappropriate behaviors.</p> <p>*Help me maintain a consistent routine.</p> <p>*Honor my life's simple pleasure of (insert personalization here)..."</p> <p>The approaches do not identify Resident #4's specific behaviors, strengths, what activities he prefers, does not define triggers for inappropriate behaviors, does not outline Resident #4's consistent routine, and does not identify simple pleasures.</p> <p>~Problem of "Needs Pain Management..." dated 11/21/13.</p> <p>Approaches all dated 11/21/13 include:</p> <p>"...*Coordinate with patient/family/rp (representative) to identify patient's favorite items/activities that could serve to distract from pain.</p> <p>*Evaluate and establish level of pain on numeric scale/evaluation tool.</p> <p>*Evaluate characteristics and frequency of pain.</p> <p>...*Evaluate what makes patient's pain worse.</p> <p>*Implement the patient's preferred non-pharmacological pain relief strategies..."</p> <p>The approaches are pieces of a comprehensive pain assessment. The care plan should outline specific distraction activities, characteristics of Resident #4's pain, when he has more pain, what makes pain worse, and define non-pharmacological interventions.</p> <p>Example #8:</p>	F 279			

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F 279	<p>Continued From page 41</p> <p>Resident #11 was admitted to the facility on 11/29/10 and has diagnoses that include Dementia with Behavioral Disturbances, Depression, Osteoarthritis and Breast Cancer. Resident #11 was admitted to Hospice on 5/5/14.</p> <p>Resident #11's current care plan with a print date of 5/23/14 includes the following:</p> <p>~Problem of "Needs Pain Management..." dated 9/10/13.</p> <p>Approaches all dated 9/10/13 include:</p> <p>"...*Coordinate with patient/family/rp (representative) to identify patient's favorite items/activities that could serve to distract from pain. *Evaluate and establish level of pain on numeric scale/evaluation tool. ...*Evaluate what makes patient's pain worse. *Implement the patient's preferred non-pharmacological pain relief strategies..."</p> <p>The approaches are pieces of a comprehensive pain assessment. The care plan should outline specific distraction activities, characteristics of Resident #11's pain, what makes pain worse, and define non-pharmacological interventions.</p> <p>~Problem of "I sometimes have behaviors..." dated 9/10/13.</p> <p>Approaches all dated 9/10/13 include:</p> <p>**Attempt interventions before my behaviors begin. ...*Offer me something I like as a diversion..."</p>	F 279			

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F 279	<p>Continued From page 42</p> <p>There is no description of what Resident #11's behaviors are or what triggers certain behaviors. The care plan approaches do not define what interventions are successful in eliminating behaviors or what can be used as a diversion.</p> <p>Example #9:</p> <p>Resident #12 was admitted to the facility on 3/28/11 and has diagnoses of Alzheimer's Disease, Vascular Dementia, History of Stroke, Depression, Anxiety, Osteoarthritis and Degenerative Joint Disease.</p> <p>Resident #12's current care plan with a print date of 8/1/13 included the following:</p> <p>~Problem of "Needs Pain Management..." dated 5/7/11.</p> <p>Approaches all dated 5/7/11 include:</p> <p>"...*Coordinate with patient/family/rp (representative) to identify patient's favorite items/activities that could serve to distract from pain. *Evaluate characteristics and frequency of pain. ...*Evaluate what makes patient's pain worse. *Implement the patient's preferred non-pharmacological pain relief strategies..."</p> <p>The approaches are pieces of a comprehensive pain assessment. The care plan should outline specific distraction activities, characteristics of Resident #12's pain, what makes pain worse, and define non-pharmacological interventions. The care plan does include 1 individualized approach related to headaches, however, Resident #12 has other diagnoses related to pain, which include</p>	F 279			

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F 279	<p>Continued From page 43</p> <p>Osteoarthritis and Degenerative Joint Disease.</p> <p>On 6/10/14 at 8:35 a.m., Surveyor #16041 spoke with the SW (Social Worker) and asked about his involvement in developing individualized care plans, particularly for those residents with behaviors. The SW said his involvement is limited and he is primarily responsible for adjustment difficulties and discharge planning. The SW indicated he is part of the Behavior Committee and some residents are discussed there, but he is not involved in developing individualized approaches for resident on the ACU (Alzheimer's Care Unit).</p> <p>On 6/10/14 at 7:45 a.m., Surveyor #16041 spoke with the ACUD. The ACUD stated the care plans, "Don't have a lot in them. The staff have the knowledge." The ACUD stated residents are placed in one of three groups based on the level of their Dementia and staff are expected to provide appropriate activities.</p> <p>The ACUD showed Surveyor #16041 copies of Dementia Management Training Program definitions of the level of Dementia by colors; Greens are residents with mild cognitive impairments, Yellows have moderate cognitive impairment, and Reds have severely impaired cognition. Each color has specific activities based on the rating.</p> <p>The ACUD was asked how staff who normally don't work on the unit are made aware of the specific psychosocial and physical needs of each resident. The ACUD stated all they need to know is what color the resident is and basic ADL (activities of daily living) cares. "They don't want or need to know anything else." The ACUD</p>	F 279			

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F 279	Continued From page 44 indicated there are 4 or 5 consistent staff on the ACU, the rest are staff from the main side that fill in on the ACU. Surveyor #16041 asked the ACUD how residents receive care consistent with their needs. The ACUD stated if the person is a "regular" fill in, she would expect the previous CNA or the nurse to "take them under their wing;" take them room to room and tell them about each resident and their needs. On 6/11/14 at 7:00 a.m., Surveyor #16041 spoke with CNA-HH (Certified Nursing Assistant). CNA-HH was asked how care needs are communicated to all staff on the ACU. CNA-HH stated if she has a problem, she writes it down for the ACUD. CNA-HH stated they don't use care cards and was not sure how the information she shares is communicated to others.	F 279			
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after	F 280			

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F 280	<p>Continued From page 45 each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility did not periodically update 5 of 13 sampled residents' care plans.</p> <p>Resident #4 had an altercation with a peer. Staff did not comprehensively assess the reasons for the altercation and did not review and revise Resident #4's care plan to include new non-pharmacological interventions to prevent future altercations between the residents.</p> <p>Resident #1 had a change in condition with his quarterly assessment dated 5/13/14 with no revision to the care plan related to needing more assistance with his ADLs, pain, and requiring the need for antipsychotic medications.</p> <p>Resident #3 had episode of urinary retention and required an indwelling catheter, which was to be removed 14 days later. There was no care plan revision to monitor resident intake and outputs after the indwelling catheter was removed, subsequently requiring the indwelling catheter to be reinserted on 6/3/13.</p> <p>Resident #9 sustained a left humerus fracture on 5/14/14, which required needing assistance with all her ADLs (activities of daily living). The care plan under Altered Skin Integrity was not revised to include a seat cushion. On 5/31/14, Resident #9 developed an open area on the buttocks.</p>	F 280			

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F 280	<p>Continued From page 46</p> <p>Resident #2 had displayed several behaviors. After a behavioral episode, the facility did not review and revise the care plan, instead antianxiety and antipsychotic medications were added and doses were increased.</p> <p>This is evidenced by:</p> <p>Example #1:</p> <p>Resident #4's care plan indicated he does wander and will urinate in inappropriate places. According to Resident #4's bladder assessment, he has a diagnosis of Benign Prostatic Hyperplasia, or enlargement of the prostate which can cause the person to have bladder urgency and frequency.</p> <p>During the initial tour on 6/9/14, the ACUD (Alzheimer's Care Unit Director) told Surveyor #16041 that Resident #18 has a diagnosis of schizophrenia, is a private person, and his room door always stays closed.</p> <p>Surveyor #16041 reviewed a Verification of Investigation for an altercation that occurred between Resident #4 and Resident #18.</p> <p>On 3/8/14 at 3:50 p.m., staff heard Resident #18 call for help and found Resident #4 in Resident #18's room. Resident #4 pulled Resident #18's watch off and tore his shirt.</p> <p>According to Resident #4's physician orders, the order for Ativan had been reduced from 2 mg twice a day to 1 mg twice a day on 3/7/14. The lower dose was administered only 3 times before the altercation occurred.</p>	F 280			

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F 280	<p>Continued From page 47</p> <p>The only intervention found was that immediately after the incident, the on-call physician was notified of the altercation and Resident #4's Ativan had ben recently decreased. The on-call physician increased the Ativan dose back to 2 mg twice a day.</p> <p>On 6/11/14 at 11:15 a.m., Surveyor #16041 spoke with the ACUD and asked about interventions following the 3/8/14 altercation between Resident #4 and Resident #18. The ACUD indicated she was not in the facility when the altercation occurred. The ACUD stated she goes with what the nurse on duty at the time decides. Surveyor #16041 asked why the only intervention was the increase in the Ativan. The ACUD stated, "That's not how we do business."</p> <p>Example #2:</p> <p>Resident #1 was admitted on 2/14/14 with a diagnoses of, but not limited to, Dementia, Depression, Anxiety, Gastroesophageal Reflux Disease and Chronic Obstructive Pulmonary Disease.</p> <p>Review of the initial and quarterly MDS (Minimum Data Set) assessment indicated a decline in functional status which requires staff assistance for ADLs. Resident #1 is displaying more pain and has increase behaviors which required police intervention. Resident #1 is now receiving antipsychotic medications.</p> <p>Review of the Resident #1's care plan, dated 2/12/14, indicated no revision in interventions or goals for the decline in ADLs, pain, increase</p>	F 280			

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F 280	<p>Continued From page 48 behaviors, need for antipsychotics. (Refer to F274.)</p> <p>Example #3:</p> <p>Resident #3 was admitted on 9/12/13 with diagnoses of, but not limited to, Advanced Dementia, Anxiety, and Urinary Incontinence.</p> <p>On 5/11/14, family was called to take Resident #3 to the ER (emergency room) to insert an indwelling catheter for abdominal distention. The ER completed a bladder scan which revealed almost 800 cc of urine. A Foley catheter was subsequently placed with good return of urine. Impression: Urinary retention with swollen glans of the penis. New orders to keep Foley catheter in for 14 days, then remove. Push fluids and monitor urine output.</p> <p>Review of the elimination of bowel and bladder care plan, dated 10/21/13, was not reviewed or revised.</p> <p>Review of the Falls care plan had a goal for, "No Falls." Interventions: No date was "urinary retention-to ER. Foley inserted. UA (urinalysis) neg. (negative) Decrease Tramadol to 25 mg TID (three times a day) with Tylenol after behaviors reviewed with NP (nurse practitioner). Chest x-ray. Monitor VS (vital signs) q (every shift) x 2 days, then review with NP."</p> <p>There was no care plan update regarding intake and output monitoring and pushing fluids. There was no output monitoring after the Foley catheter was removed to ensure no further urinary retention was prevalent. On 6/3/14 on the p.m. shift, family notified the nurse that Resident #3</p>	F 280			

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F 280	<p>Continued From page 49</p> <p>had abdominal distention. The nurse straight catheterized him which revealed 1100 cc of urine return. Subsequently, Resident #3 now has a urinary tract infection. (Refer to F315.)</p> <p>Example #4:</p> <p>On 5/4/14, Resident #9 was readmitted on 5/13/14 following a fall with a fracture left humerus. Resident #9 was previously independent with most ADLs including transfers, ambulation and toilet use.</p> <p>On 6/11/14 at 8:05 a.m., Surveyor #25989 asked Resident #9 about the fall and how it has affected her ADLs. Resident #9 stated, "I need help now even to just get up, my life has changed significantly since I fell. I got a sore on my bottom from sitting so much." Surveyor #25989 observed her sitting on a cushion.</p> <p>Review of Resident #9's care plan indicated the care plan related to ADLs was reviewed and revised on 6/4/14 after surveyor was asking questions. The pain care plan was not revised. Resident did develop an open area on her buttocks on 5/31/14, care plan was not updated. The CNA care card does not indicate any cushion on her chair.</p> <p>On 6/10/14 at 4:55 p.m., Surveyor #25989 asked CNA-P why Resident #9 developed a sore on her buttocks. CNA-P stated, "Wasn't getting up enough." CNA-P stated Resident #9 requires assist with standing up and ambulating to the bathroom. CNA-P stated that she sits on a cushion in the recliner, "I noticed it the last 2-3 weeks, not on her chair right after she fractured her arm."</p>	F 280			

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F 280	Continued From page 50 Example #5: Resident #2's admitting diagnoses include, but not limited to, dementia, anxiety, and PTSD (Post Traumatic Stress Disorder). Resident #2's behavior care plan was dated 12/16/13. The care plan indicated Resident #2 had behaviors of yelling, shouting, crying, agitation, combativeness, aggression, restlessness, and anger. The care plan had the following approaches: ~ 12/16/13, "...Assist me to watch church video...Attempt interventions before my behaviors begin...Do not seat me around others who disturb me...Give me medications my doctor has ordered...Help me maintain my favorite place to sit...Help me avoid situations or people that are upsetting to me...may call family to assist in redirection...Let my physician know...if my behaviors are interfering with my daily living...Make sure I am not in pain... Offer me something I like as a diversion...tell me what you are going to do before you begin...Reduce external stimuli as possible, speak in gentle, calm, soft but firm voice..." ~ 12/18/13, "...may bath to assist with calming..." ~ 1/2/14, "...Administer medications as ordered..." ~ 1/31/13, "...Monitor for s/sx (signs and symptoms) of anxiety towards others and attempt redirection..." Resident #2 began displaying behaviors upon admission on 12/16/14. By 12/30/14, Resident #2	F 280			

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F 280	Continued From page 51 began receiving Ativan (an antianxiety medication) first as needed, then scheduled; and Zyprexa (an antipsychotic) with a subsequent dose increase. There was no evidence the facility clinically assessed Resident #2 and then analyzed Resident #2's behaviors to identify causative factors, or what triggered the behaviors, after the noted behaviors and prior to administering medications. There were no changes made to Resident #2's plan of care. During January 2014, another antianxiety, Xanax, was ordered and Zyprexa was increased due to behaviors. There were no updates to Resident #2's care plan prior to the medication additions and increases.	F 280			
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility did not ensure 3 of 7 sampled resident's care plan was followed. According to Resident #5's care plan, Resident #5 was to be transferred with a mechanical lift. Observations revealed staff were not utilizing the mechanical lift.	F 282			

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F 282	<p>Continued From page 52</p> <p>Resident #7 was to be assisted with incontinence cares every 2 to 3 hours. On 6/3/14, Resident #7 was not assisted with incontinence cares for at least 6 hours and 30 minutes.</p> <p>According to Resident #1 care plan, nursing was to administer oxygen as needed, monitor oxygen saturations on room air and/or oxygen and to elevate HOB (head of bed) to alleviate shortness of breath. Record review and observations revealed that oxygen saturations and/or oxygen was not given to alleviate behavior symptoms.</p> <p>This is evidenced by:</p> <p>Example #1:</p> <p>Resident #5 had current diagnoses which include, but not limited to, arthritis, dementia, and anxiety.</p> <p>Resident #5's most current MDS (Minimum Data Set), dated 5/8/14, indicated Resident #5 had a BIMS (Brief Interview for Mental Status) score of 0, indicating a severe cognitive impairment and required extensive assistance of 1 to 2 staff persons for all aspects of care.</p> <p>Resident #5's care plan, dated 5/28/14, and CNA (Certified Nursing Assistant) care plan, dated 6/3/14, indicated staff were to use the Sara lift (a mechanical lift) to transfer Resident #5.</p> <p>On 6/4/14 at 10:20 a.m., Surveyor #25803 observed CNA-C and CNA-K transfer Resident #5 to the bathroom. The mechanical lift was not used.</p> <p>On 6/4/14 at 10:32 a.m., Surveyor #25803 spoke with CNA-C. CNA-C indicated sometimes they</p>	F 282			

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F 282	<p>Continued From page 53</p> <p>use the mechanical lift and sometimes transfer Resident #5 using 2 staff.</p> <p>Example #2:</p> <p>Resident #7 had current diagnoses which include, but not limited to, congestive heart failure and anxiety.</p> <p>Resident #7's most current MDS (Minimum Data Set) was dated 5/15/14 and indicated Resident #7 had a severe cognitive impairment, required the assistance of 1 to 2 staff persons for all aspects of care and was always incontinent of both bowel and bladder.</p> <p>Resident #7's elimination care plan dated 5/6/12 directed staff to "...check and change..." Resident #7 every 2 to 3 hours.</p> <p>On 6/3/14 at 9:00 p.m., Surveyor #25803 observed CNA-GG (Certified Nursing Assistant) assist Resident #7 with incontinent care. Surveyor #25803 noted Resident #7's adult brief was saturated with both urine and stool.</p> <p>Surveyor #25803 spoke with CNA-GG following the observation. CNA-GG indicated she started work at 2:30 p.m. Surveyor #25803 asked CNA-GG when she last assisted Resident #7 with incontinence care. CNA-GG stated she hadn't been able to get to Resident #7 until she put her to bed at 9:00 p.m.</p> <p>Resident #7 was not assisted with incontinence cares for at least 6 hours and 30 minutes.</p> <p>On 6/11/14 at 8:15 a.m., Surveyor #25803 spoke with LPN-AA (Licensed Practical Nurse). LPN-AA</p>	F 282			

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F 282	<p>Continued From page 54</p> <p>indicated she expected the CNAs to follow resident care plans. LPN-AA stated if the CNAs were unable to complete a task including toileting, they were to let the nurse know.</p> <p>Example #3:</p> <p>Resident #1 has current diagnoses including but not limited to dementia, anxiety and stage IV emphysema.</p> <p>Resident #1 MDS (Minimum Data Set) dated 5/13/13 indicated Resident #1 had a BIMS (Brief Interview for Mental Status) score of 0 indicating a severe cognitive impairment and required limited assistance of 1 staff for bed mobility, ambulation, and locomotion. Initial MDS indicated that Resident #1 has shortness of breath with exertion and lying flat.</p> <p>Resident #1 care plan dated 2/4/14 indicated a Problem: " Alteration in Respiratory Status Due to Chronic Obstructive Pulmonary Disease, due to Emphysema, risk for decline due to hx (history) of smoking....Interventions: ...Administer oxygen as needed per Physician order. Monitor oxygen saturations on room air and/or oxygen. Monitor oxygen flow rate and response. Elevate HOB (head of bed) to alleviate shortness of breath. Monitor for hypotension, dizziness, unsteady gait, sweating, nausea and cramping, increased falls risk ...Observe and document vital signs, specifically respiratory pattern rate, rhythm, effort, and use of accessory muscles. Observe for changes in level of consciousness, restlessness, confusion, lethargy, somnolence, apprehension,</p>	F 282			

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F 282	Continued From page 55 and anxiety." On 6/3/14 during PM observation, Surveyor #25989 observed Resident #1 showing signs of anxiety and restlessness and was short of breathe while moving about in his room. At 9:18 p.m., CNA-MM was trying to get Resident #1 to lay flat in bed in which he got right back up. Review of Resident #1 medical record did not reveal any evidence that oxygen saturations were completed or that oxygen was ever given during his behavior (restlessness, anxiety) episodes. (Refer to F309.)	F 282			
F 309 SS=K	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, interviews, and record reviews, the facility did not provide individualized interventions to dementia care resulting in distress and a continuation and/or escalation of behavior patterns. Additionally, the facility relied on medications to control resident behaviors, creating a risk for side effects associated with these medications. This resulted in actual and potential physical declines, agitation, and distress for 7 of 9 residents reviewed for dementia.	F 309			

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F 309	<p>Continued From page 56</p> <p>For 7 of 9 residents reviewed for dementia care:</p> <p>~There was no comprehensive evaluation of each person's daily routines, medical conditions, description of behaviors, and how they communicate needs;</p> <p>~There was no evidence staff identified causal/contributing factors to behaviors such as medical conditions, adverse reactions to medications, or other factors such as boredom, anxiety, personal needs not being met, fatigue, etc; and/or</p> <p>~Staff did not develop care plans that addressed specific behavioral expressions, goals, and individualized approaches for responding to or preventing target behaviors and/or expressions of distress.</p> <p>1. The facility did not comprehensively assess Resident #1's behaviors, identify remediable causes, did not identify some of the behaviors as potential side effects to a medication, and did not develop and implement an individualized plan of care to assist Resident #1 in avoiding the development of behaviors and to assist with de-escalating behaviors that are already occurring. Instead, the facility implemented several medications, with multiple dosage changes in a short period of time.</p> <p>Namenda was the first medication that was ordered on 2/7/14, which has side effects of restlessness, distress, dizziness, somnolence, hypertension, headache, hallucinations, or increased confusion. Resident #1 began to demonstrate several of these symptoms. The facility did not assess these as potential side effects; rather, they were identified as behaviors,</p>	F 309			

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F 309	<p>Continued From page 57</p> <p>and treated with other psychotropic medications of Seroquel, Ativan, and Prozac. Even though the dose of Seroquel and Ativan was increased, the facility did not complete a root cause analysis of the behaviors to determine the causative factors and/or individualized approaches for Resident #1.</p> <p>Resident #1 did not have a complete social history to determine individualized customary routine. The facility did identify that Resident #1 enjoyed pets, news, church and being outdoors. However, none of these interventions were used as approaches to prevent behaviors. The family had shared with the facility a number of approaches to use when Resident #1 appeared to be having difficulties. Although behaviors began in shortly after admission in February 2014, the facility did not actively involve the family and document the approaches until late May 2014. These approaches were never included in the care plan or on the CNA Care Cards.</p> <p>Resident #1 also has a history of chronic pain. Again, the family made the facility aware of this, but pain was not addressed for Resident #1 until May 2014 and was not assessed as being a potential cause for his behaviors.</p> <p>Subsequently, Resident #1's behaviors were not adequately addressed and staff called the police when they were no longer able to control Resident #1. Resident #1 was handcuffed and family took the resident home for the evening.</p> <p>2. Resident #2 had a diagnosis of dementia. According to the facility, Resident #2 had behaviors of anger, fighting, aggression towards others, pacing, combativeness, yelling, shouting,</p>	F 309			

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F 309	<p>Continued From page 58</p> <p>crying, weeping, agitation, restlessness, delusions, hallucinations, and attempting to elope. According to staff, Resident #2's behaviors started after admission to the facility. While the facility identified the behaviors, there was no indication the facility completed a comprehensive assessment of Resident #2's medical, physical, mental nor psychosocial status to determine underlying causes of Resident #2's distressing behaviors.</p> <p>There was no care plan implemented based on Resident #2's specific individual needs directing staff on how to manage Resident #2's behaviors to minimize and/or eliminate the behaviors in order to improve Resident #2's quality of life and well-being.</p> <p>Resident #2 was also placed on multiple psychoactive medications including antipsychotic medications. There was no consideration on the part of the facility the psychoactive medications could be causing and/or making Resident #2's distressing behaviors worse.</p> <p>Lack of completing a comprehensive assessment to determine the root cause of Resident #2's distressing behaviors and implementing an individualized care plan based on Resident #2's specific needs led to a significant decline in Resident #2's overall functioning including physical functioning, psychosocial well-being, anorexia and weight loss, and falls.</p> <p>3. Resident #3 has behaviors of "continuous pacing" and "agitation" for which Resident #3 receives Ativan as needed. There was no definition of what "agitation" is for Resident #3 and when administering the Ativan would be</p>	F 309			

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F 309	<p>Continued From page 59</p> <p>appropriate. There was no assessment of Resident #3's behaviors to determine the root cause for the distress. There was also no evidence that individualized, nonpharmacological interventions were tried prior to administering psychotropic medications.</p> <p>4. Resident #5 had a diagnosis of dementia. According to the facility, Resident #5 had behaviors of restlessness, agitation, insomnia and falls. While the facility identified these behaviors, there was no indication the facility completed a comprehensive assessment of Resident #5's medical, physical, mental or psychosocial status to determine underlying causes of Resident #5's behaviors. There was no care plan implemented based on Resident #5's specific individual needs directing staff on how to manage Resident #5's behaviors to minimize and/or eliminate the behaviors to improve Resident #5's quality of life and well-being.</p> <p>Consequently, Resident #5 was observed on all days of the survey to either be sleeping in the Broda chair or in constant motion by either propelling the Broda chair forward or backward with his feet, propelling his chair forward by utilizing the hand rails, leaning over attempting to pick up items off the floor, putting on/taking off socks, or manipulating the variety of positioning devices on the Broda chair. Staff also indicated Resident #5 would "fight" with them during cares.</p> <p>5. Resident #7 had periods of calling out. While the facility defined the calling out as a behavior, there was no comprehensive assessment completed to determine underlying causes of Resident #7 calling out. There was no</p>	F 309			

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F 309	<p>Continued From page 60</p> <p>individualized care plan directing staff on how to manage Resident #7's calling out.</p> <p>6. Resident #6 had facility defined behaviors of calling out, shouting, and cursing. While the facility identified the behaviors, there was no comprehensive assessment completed to determine underlying causes of Resident #6's behaviors. There were no individualized approaches developed based on the comprehensive assessment to minimize and/or eliminate Resident #6's behaviors to improve Resident #6's quality of life and well-being.</p> <p>7. Resident #4 has diagnoses of Alzheimer's Disease and Dementia with Behaviors. Resident #4 had an altercation with another male resident. There was no evidence that the situation was comprehensively assessed to identify potentially remediable causes. There were no nonpharmacological interventions attempted. Immediately following the incident, the dose of Resident #4's antianxiety medication was increased.</p> <p>The failure to provide person-centered care for residents with dementia aimed at understanding, preventing, relieving, and/or accommodating residents' signs of distress created a finding of immediate jeopardy. The immediate jeopardy began on 6/3/14. The NHA (Nursing Home Administrator) and RN Consultant were notified of the immediate jeopardy on 6/23/14 at 3:45 p.m. The immediate jeopardy was not removed by the exit date of the survey.</p> <p>In addition to the residents in immediate jeopardy, the facility failed to provide appropriate pain management for 2 of 11 residents reviewed for</p>	F 309			

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F 309	<p>Continued From page 61</p> <p>pain, and 1 of 2 residents was not provided with an assessment by a Registered Nurse when a change in condition was reported.</p> <p>For 2 of 11 residents reviewed for pain:</p> <p>~Resident #1 has a diagnosis of Dementia and a history of chronic pain. Resident #1 was displaying behaviors which were treated with antipsychotic medications. Staff did not assess to determine if the behaviors could have been non-verbal indicators of pain.</p> <p>In addition, the facility does not have a systematic process for a comprehensive pain assessment and/or for documentation when administering a prn (as needed) psychotropic medication. The licensed nurse will tag the physician order, which goes into the progress note and will document if effective or ineffective. There is no assessment of the pain or behavior, no descriptors of type of pain, any nonpharmacological approaches used prior to administering any prn medication, any documentation of possible triggers such as pain, constipation, loneliness, boredom, etc., for the behaviors and if the medication was effective or not, as evidenced by.</p> <p>~Resident #11 has diagnoses that are associated with pain for which she receives scheduled and as-needed pain medications. Documentation when the as-needed pain medication is administered does not include a comprehensive assessment of Resident #11's pain prior to administration or after administration to determine effectiveness.</p> <p>For 1 of 2 residents who had a change in condition:</p>	F 309			

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F 309	<p>Continued From page 62</p> <p>~Resident #12 had a change in condition. There was no evidence of an RN (Registered Nurse) assessment after the event and no ongoing monitoring of her condition.</p> <p>This is evidenced by:</p> <p>Example #1 (also cross reference F329):</p> <p>Resident #1 was admitted to the facility on 2/4/14 with diagnoses of, but not limited to, Dementia, Depression, Anxiety, Chronic Back pain, COPD (Chronic Obstructive Pulmonary Disease), Gastroesophageal Reflux Disease (heart burn) and Stage 4 Emphysema.</p> <p>Resident #1 was admitted from home after his wife fell and broke her hip. She was also admitted to the facility for rehab and shared a room with Resident #1.</p> <p>The admission note, documented by the DON (Director of Nursing) states, "...reports resident has been occ (occasionally incontinent of urine...Usual bowel pattern daily..Reports appetite good with no restrictions, has had difficulty maintaining weight...Does have chronic back pain, used Ibuprofen PRN (as needed) at home for same...Likes to watch TV before going to bed...Tends to nap several hours a day. Likes sweets at HS (Hour of Sleep) as well..."</p> <p>The Initial MDS (Minimum Data Set) Assessment dated 2/12/14 revealed:</p> <p>*Signs and symptoms of delirium such as inattention which comes and goes.</p> <p>*Resident says he has less energy and feeling</p>	F 309			

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F 309	<p>Continued From page 63</p> <p>tired. Having problems concentrating on things and being so fidgety or restless that he has to be moving around a lot more than usual.</p> <p>*Wandering occurred 4 to 6 days, but less than daily, which puts him at significant risk of getting to a potentially dangerous place and significantly intrudes on the privacy of others.</p> <p>*Activities that are very important is to be around pets, keep up with the news, go outside to get fresh air and participate in religious services.</p> <p>*Sometimes is understood and understands.</p> <p>*Ambulates independently and requires assistance of 1 staff for dressing, hygiene, and toilet use.</p> <p>Review of the Behavior symptom CAA (Care Area Assessment) indicated the following was addressed:</p> <p>*Triggered condition is wandering. Is this problem/need: Actual. Seriousness: Resident is immediate threat to self.</p> <p>*Nature of the behavior disturbance was left blank, nothing was checked/addressed.</p> <p>*Medication side effects that can cause behavioral symptoms was left blank, nothing was checked.</p> <p>*Hospital records indicate he was a smoker and was on a nicotine patch which could have affected his behavior.</p> <p>*Illness or conditions that can cause behavior problems. Constipation was checked. (This problem was not addressed until 5/29/14 when Miralax [laxative] was ordered.)</p> <p>*Factors that can cause or exacerbate the behavior (from observation, interview, record). Sensory impairment, such as hearing or vision problems was the only box checked.</p> <p>*Cognitive status problems. Dementia was</p>	F 309			

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F 309	<p>Continued From page 64 checked.</p> <p>*Other considerations such as the actions and responses of family members and caregivers can aggravate or even cause behavioral outbursts was left blank, nothing was checked.</p> <p>*Care Plan Considerations. Avoid complications and Minimize risk boxes were checked.</p> <p>*Describe impact of this problem/need on the resident and your rationale for care plan decision. "Will proceed to plan of care as resident has wandered throughout the facility and attempts to go outside."</p> <p>*Referral to other Disciplines. Nothing was documented.</p> <p>The CAA was completed by the SW (Social Worker) on 2/13/14.</p> <p>There was no comprehensive assessment to determine the underlying cause of Resident #1's behaviors identified in the MDS.</p> <p>Care Plan initiated on 2/11/14 includes, "I sometimes have behaviors which include walking out the front door and trying to catch a ride. I walk around the hallways with no real sense of where or what I want to be doing. Goals-My behavior will stop with staff intervention." There are no measurable objectives/goals.</p> <p>Interventions include, "Attempt interventions before my behaviors begin. Give me my medications as my doctor has ordered. Help me to avoid situations or people that are upsetting to me. Let my physician know if my behaviors are interfering with my daily living. Offer me something I like as a diversion. Please tell me what you are going to do before you begin."</p>	F 309			

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F 309	<p>Continued From page 65</p> <p>The care plan did not include specific interventions to use to prevent behaviors from occurring, no description of situations to avoid, and no specific things Resident #1 likes for diversions.</p> <p>On 2/7/14, Physician order to start Namenda 5 mg every day for 7 days, then on 2/14/14 increase Namenda to 5 mg to twice a day.</p> <p>Review of Resident #1's progress notes and care plans revealed no care plan was developed for the Namenda. Therefore, there was no goal for the treatment.</p> <p>Review of Resident #1's Side Effects Monthly Flow Sheets and Progress Notes found that side effects of Namenda were not being monitored.</p> <p>According to Nursing 2013 Drug Handbook side effects of Namenda include, but are not limited to:</p> <ul style="list-style-type: none"> *aggressiveness, agitation, anxiety, ataxia (lack of voluntary coordination of muscles), confusion, depression, dizziness, fatigue, hallucinations, headache, insomnia, pain, somnolence, syncope (fainting), vertigo. *anorexia, constipation, diarrhea, nausea, vomiting. *incontinence, urinary frequency, UTI. *Arthralgia (severe pain in the joint), back pain. *bronchitis, coughing, shortness of breath, flu-like symptoms, pneumonia, upper respiratory tract infection. *rash. *abnormal gait, falls, injury. <p>Resident #1 was also receiving Prozac (an antidepressant) 20 mg every day. According to</p>	F 309			

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F 309	<p>Continued From page 66</p> <p>Nursing 2013 Drug Handbook, side effects of Prozac include:</p> <ul style="list-style-type: none"> *nervousness, anxiety, insomnia, dizziness, suicidal behavior, fatigue; *nausea, anorexia, impaired digestion, constipation, abdominal pain; *respiratory tract infection, cough, respiratory distress. <p>Review of Resident #1's medical record including Progress Notes, Physician Progress Notes, Physician Orders and Care Plans from 2/7/14 through 6/5/14 reveal the following:</p> <p>~2/26/14, Resident #1 fell in his room after sitting on a wheeled walker.</p> <p>~3/2/14, Resident #1 was asking about wife's whereabouts frequently. "Relaxes when he sees her."</p> <p>~3/3/14, Resident #1 was transferred to the ACU (Alzheimer's Care Unit) and an order for Ativan (an antianxiety) 0.5 mg (milligrams) every 6 hours as needed for "agitation" was written by the NP (Nurse Practitioner).</p> <p>According to the Nursing 2013 Drug Handbook, Ativan has side effects that include insomnia, agitation, dizziness, depression, visual disturbances, and abdominal discomfort.</p> <p>There was no care plan developed identifying the definition of what agitation was for Resident #1, and no development of nonpharmacological interventions to attempt prior to administering the Ativan. There was also no care plan developed that addressed adjustment to life in the ACU and also living without his wife, who had been his</p>	F 309			

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F 309	<p>Continued From page 67 primary caregiver.</p> <p>~3/5/14, Resident #1 grabbed the shirt of another resident. Ativan given at 12:32 p.m. for "restless, agitated, becoming aggressive" and 8:02 p.m. for "increased agitation" without evidence of nonpharmacological interventions attempted or attempts at trying to identify what might have triggered Resident #1's behaviors.</p> <p>~3/6/14, Complained of stomach pain, offered toileting with no results.</p> <p>~3/7/14, Ativan given for "increased agitation" that was ineffective. 5 hours after receiving the medication, Resident #1 received a second dose after becoming agitated with signs of increased anxiety. No evidence of nonpharmacological interventions attempted and no evidence of an assessment of the agitation and aggression to determine root cause and to rule out remediable causes.</p> <p>~3/7/14, Physician progress note: "Continue his current medications. He seems to be tolerating the Namenda 5 mg p.o. b.i.d."</p> <p>~3/8/14, Resident #1's wife was discharged to home.</p> <p>~3/9/14, Resident #1's family visited and Resident #1 was calm. That same day at 1:44 p.m. and 7:36 p.m., Resident #1 received Ativan for "agitation" and "restlessness and increased agitation" respectively. According to the Behavior Monitoring Flow Sheet, staff tried "one on one, activities, and redirect" that were "Effective," therefore the reason for administration of the Ativan is not evident. There is no documented</p>	F 309			

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F 309	<p>Continued From page 68</p> <p>assessment to identify what might be triggering the resident's behaviors. There is no indication that staff considered the possibility that his behaviors might be related to anxiety or distress from being without his wife, who had been discharged home the previous day.</p> <p>~3/10/14, "Resident became agitated, appears to be sudden change in mood. He was pacing back and forth at the kitchen area. CNA was in the kitchen with other residents playing trivia game. Resident #1 came up to the table where the CNA and residents were sitting. He was angry and yelled at the CNA making motion to hit her. Nurse did one on one with resident. He walked away and seemed fine. He had no other episodes like this throughout the shift...he does become frustrated when he is unable to find words and speak words properly..." Ativan was given at this time despite the one-on-one supervision being successful. There was no assessment to identify what may have triggered Resident #1's anger.</p> <p>~3/11/14, Resident #1 received Ativan for "increased agitation."</p> <p>~3/12/14, Resident #1 received Ativan for "anxiety, weepiness."</p> <p>~3/13/14, Resident #1 received Ativan for "restless, continuous pacing." Resident #1 is up ad lib and can ambulate independently. There is no assessment demonstrating that Resident #1's actions were more than walking through the unit.</p> <p>~3/14/14, Resident received Ativan at 12:26 a.m. for "restless, continuous pacing."</p>	F 309			

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F 309	<p>Continued From page 69</p> <p>~3/14/14, Resident #1 received Ativan at 11:44 p.m. for "anxiety and restlessness. Was noted to be attempting to enter other resident's rooms."</p> <p>There was no evidence of nonpharmacological interventions being attempted prior to administration of the Ativan and no documented assessment to identify what might be triggering the resident's behaviors. Of note, insomnia is a side effect of Namenda.</p> <p>~3/16/14, Resident #1 received Ativan at 12:44 p.m. for "increased agitation."</p> <p>~3/16/14 at 4:30 p.m., Resident #1 was yelling at another resident and pounding on the dining room table. At 6:07 p.m., effectiveness is documented as "Unknown. Resident continous [sic] to pace, move furniture and is anxious, continue one on one, redirect."</p> <p>~3/16/14 at 11:43 p.m. states, "Resident is pacing all shift. At one point he was attempting to pick imaginary things of [sic] the floor. He began to crawl on the floor saying this needs to get fixed. He kneeled on the floor and became slightly unbalanced and tipped to one side...he continued to attempt to kneel on the floor but staff was able to redirect him..."</p> <p>According to an interview with Resident #1's daughter, Resident #1 worked as a contractor; was always fixing things; staying busy. Even though the note indicates Resident #1 wanted to fix something on the floor, there was no evidence of an activity being offered to allow Resident #1 to continue a life long pattern.</p> <p>~3/17/14, Resident #1 given Ativan for "weepy with increased agitation." No evidence of</p>	F 309			

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F 309	<p>Continued From page 70 nonpharmacological interventions.</p> <p>~3/19/14, Resident #1 was seen by the NP who documented, "...While on the unit he has been somewhat agitated. He is weeping at times...I am concerned about this agitated behavior as well as the weeping that he is exhibiting. I am going to treat him with an antidepressant. I am going to start Citalopram 2.5 once daily for 2 weeks, then increase to 5 mg daily..."</p> <p>Monthly Behavior Flow Sheets did not reflect Resident #1 having difficulties with weeping. Progress Notes indicate weeping two times. Tearfulness or Weeping was not added as a target behavior to the Monthly Behavior Flow Sheets. In addition, Resident #1 was already receiving the antidepressant Fluoxetine (Prozac). This would be considered duplicative therapy. (Refer to F329.)</p> <p>Review of Resident #2's care plan does not indicate the use of Citalopram on the care plan, therefore there is no goal to evaluate if the medication is effective or not and what nonpharmacological interventions should be tried.</p> <p>According to Nursing 2013 Drug Handbook, side effects of Citalopram include: *insomnia, dizziness, anxiety, confusion, delusions, impaired sleep quality, fatigue, syncope; *urinary frequency; *constipation, anorexia, abdominal pain.</p> <p>Under Nursing Considerations, it states, "Many patients experience a period of increased restlessness, including agitation, insomnia, and anxiety especially at start of therapy."</p>	F 309			

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F 309	<p>Continued From page 71</p> <p>The Side Effects monitoring form was not updated to include Citalopram.</p> <p>~3/21/14, Resident #1 received Ativan for "increased agitation." No evidence of nonpharmacological interventions.</p> <p>~3/22/14, Resident #1 was found at 1:30 a.m. sitting on the floor in a puddle of urine. The Fall Assessment form did not address the possibility of side effects of Namenda, Prozac and Citalopram.</p> <p>There was no documentation indicating Resident #1 received any Ativan on 3/22/14, 3/23/14.</p> <p>~3/24/14, Resident #1 was seen by the NP who ordered scheduled Ativan 0.5 mg twice a day in addition to the as-needed Ativan 0.5 mg.</p> <p>~3/25/14, Resident #1 entered another resident's room and was "bumped into the wall."</p> <p>~3/26/14, Resident #1 was sent to the hospital with increased temperature and decreased oxygen saturation levels. Resident #1 was admitted to the hospital, and returned on 3/28/14.</p> <p>~3/28/14, a Behavior Summary note states, "Pacing-restlessness, being agitated and fearful are all being monitored by staff...Not seeing anything consistent in report to warrant a trigger for behavior yet resident is still adjusting to being transferred to this wing. Flow sheet indicates that giving food or fluids or removing resident from environment are interventions that have been successful."</p>	F 309			

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F 309	<p>Continued From page 72</p> <p>Surveyor #25989 reviewed the March Behavior Flow Sheets and noted the following:</p> <ul style="list-style-type: none"> -27 instances of pacing/restlessness. Food and fluids were offered 1 time with improvement. -9 instances of agitation. Food and fluids were offered 2 times with improvement. <p>There was no evidence that the Progress Notes were reviewed in order to provide a comprehensive review of Resident #10's medication use, lack of nonpharmacological interventions, possible side effects of the medications, or to determine a root cause/trigger of the behaviors.</p> <p>~4/3/14, "NP updated re (regarding) resident's increased irritability, restlessness and requesting cigarette yesterday PM (afternoon). Staff reports that he is probably smoking when he goes out with spouse. Direction to continue to monitor and NP will review on...rounds."</p> <p>According to the Behavior Flow Sheets, Resident #1 has only had 1 episode of agitation from 3/22/14 through 4/3/14. On 4/3/14, day shift documented 1 episode of agitation, as-needed Ativan was administered.</p> <p>~4/3/14, per NP order on 3/19/14, Resident #1's Citalopram increased to 5 mg one time a day.</p> <p>Despite the addition and increase in the Citalopram, along with Namenda, and Prozac, staff were only monitoring for a side effect of drowsy/dizzy/falls.</p> <p>~4/4/14, Resident #1 was yelling at other residents in the dining room and was not easily directed with food, fluids, and toileting.</p>	F 309			

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F 309	<p>Continued From page 73</p> <p>~4/5/14 at 8:00 a.m., Resident #1 sat on the edge of the bed yelling at someone only visible to him. He was redirected and laid back down.</p> <p>There was no evidence of an assessment being completed in order to determine if this was a side effect of Resident #1's medications.</p> <p>~4/6/14, Resident #1 went out with spouse.</p> <p>From 4/6/14 through 4/9/14, Resident #1 had 1 documented episode of agitation with redirection providing improvement.</p> <p>~4/9/14, Resident #1 was seen by the NP. The NP Progress Note states, "...He becomes quite agitated in the afternoon and especially agitated after he has been on an outing with his family. Staff do have a hard time calming him down and redirecting him after he has been out, but usually the afternoon is when he becomes the agitated...He wants to move around the unit. He does appear mildly agitated, some anxiety as well...I am going to increase the Lorazepam (Ativan) to 0.5 mg tid (three times a day)..."</p> <p>With the NP order, Resident #1 will be receiving 1.5 mg per day. The standard of practice for Ativan maximum dose for the elderly is 2 mg per day.</p> <p>There was no evidence that the facility assessed Resident #1's agitation/anxiety and/or restlessness to determine possible triggers, identify remediable causes, and review/revise the care plan to include individualized nonpharmacological interventions before increasing the Ativan dose.</p>	F 309			

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F 309	<p>Continued From page 74</p> <p>~4/12/14, "Resident observed having hallucinations this shift. Seen sitting on the edge of his bed talking to and petting his dog. Asked writer 'Isn't she a pretty dog? Also asked for some water and a hot dog for the dog. Staff observed him 'walking' his dog with his arm extended, mimicking a person holding onto a leash. Talking to the dog: 'slow down' and 'that's a good girl.'..."</p> <p>Of note, Resident #1 had been out with family prior to this entry. He would have seen his dog during his outing with family.</p> <p>~4/14/14, Resident #1 was seen by the NP for abdominal pain. The NP ordered labs, but did not review medications to determine if the abdominal pain was related to the Namenda, Prozac, or the increased usage of Ativan. All of these medications have a side effect of stomach upset/abdominal pain.</p> <p>~4/17/14, as-needed Ativan 0.5 mg was given at 6:19 p.m., and was effective. With this administration, Resident #1 was at the top of the daily dosage for older adults.</p> <p>~4/18/14, Resident #1 was seen by the physician. The physician progress note states, "...He is receiving both Prozac and Celexa (Citalopram). The pharmacist questioned the need for both of them...He does use the Lorazepam (Ativan) 0.5 mg tid (three times a day) prn (as needed)...We will plan on discontinuing the Celexa. Continue with the Prozac..."</p> <p>The documentation by the physician is inaccurate. The NP order for Ativan is for 0.5 mg three times a day, and as-needed Ativan 0.5 mg</p>	F 309			

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F 309	<p>Continued From page 75 every 6 hours as needed.</p> <p>~4/18/14, as-needed Ativan was given for "pacing, getting too close to other residents, and pulling on wheelchairs and chairs." Behavior Flow Sheets do not document any behaviors and no nonpharmacological interventions attempted prior to administration of the Ativan.</p> <p>~4/22/14, indicate that Ativan 0.5 mg was given at 12:47 a.m. for pacing and attempting to go into other resident rooms. There were no behaviors documented on the behavior monitoring log and no evidence of nonpharmacological interventions attempted prior to administration of the Ativan.</p> <p>~4/23/14, as-needed Ativan was given at 3:37 p.m. for "anxious, pacing, pounding on window in kitchen. There is no progress note on that day. No behaviors documented on the behavior monitoring log and no evidence of nonpharmacological interventions attempted prior to administration of the Ativan.</p> <p>~4/27/14, "Resident was irritable and easily agitated...threatening towards peers, staff and visitors...redirected to a quiet area and brief one on one was provided and was effective...He has been pleasant, watching TV and walking about the unit..."</p> <p>~4/30/14, as-needed Ativan 0.5 mg was given at 12:44 a.m. for restlessness, inability to settle for sleep, and "wandering about unit." The behavior monitoring log indicates having episodes of restlessness, pacing and agitation. Interventions are 1:1, redirect and return to room which were either the same or ineffective.</p>	F 309			

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F 309	<p>Continued From page 76</p> <p>~4/30/14, as-needed Ativan was given at 3:55 p.m. for agitation. With this administration, Resident #1 received 2.5 mg, which is above the maximum dose for older adults.</p> <p>~5/1/14 as-needed Ativan was given at 12:08 a.m. and 5:44 p.m. Progress note dated 5/1/14 states, "Resident very agitated, swing fists at staff. Resident cursing at staff and other residents. PRN Ativan was not effective."</p> <p>Behavior monitoring sheets indicate having behaviors of pacing, restlessness, tearful and agitation. Intervention was the Ativan.</p> <p>This is a total of 2.5 mg in 24 hrs. which is over the maximum dose for the elderly.</p> <p>On 5/1/14 at 10:45 p.m., Resident had a fall with no injury. The Fall Investigation states Resident #1 reached down and was patting the floor before "seating himself on floor."</p> <p>Since Resident #1's admission on 2/4/14, there has been no assessment of Resident #1's behaviors to determine triggers, causative factors (physical, emotional, environmental, personal needs, mismatch in cognitive skills and activities/routines); develop individualized interventions including nonpharmacological interventions including a program of activities that meet his cognitive abilities and personal preferences/desires. There has also been no monitoring of the specific medications to determine if behaviors are more appropriately identified as side effects.</p> <p>~5/4/14, as-needed Ativan given for increased agitation at 8:33 a.m. The Behavior Monitoring</p>	F 309			

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F 309	<p>Continued From page 77</p> <p>Flow Sheet does not indicate any nonpharmacological interventions were attempted. It is documented as "9" which means "refer to nurse's notes."</p> <p>~Progress Notes on 5/4/14 indicate Resident #1 was in a "foul mood." At 7:15 a.m., Resident #1 was holding a CNA by the arms and would not let go. "Able to redirect to come to dining room for morning coffee and let go of CNA." Resident #1 then started pacing the hall and dining room yelling. Staff stepped in between Resident #1 and other residents. The DON was notified. Resident #1 threw a bowl of cereal on the floor. Staff were able to direct Resident #1 into an empty room and calls were made to family and to police. During this time, Resident #1 continued to grab at the staff. The police arrived and Resident #1 struck out at the police officer and was handcuffed. At the same time, Resident #1's family arrived with his dog. Resident #1 began to calm and sat quietly petting the dog. Family took Resident #1 home for the day. He returned that afternoon and was quiet.</p> <p>Following the incident, there was, again, no assessment of Resident #1's behaviors, no identification of triggers, no identification of remediable causes including pain, and no individualized interventions. Review of Resident #1's care plan found no updates despite the escalation in Resident #1's behaviors.</p> <p>~5/4/14 at 8:55 p.m., Resident #1 was found "tangled up" with another resident. Resident #1 was documented as calm. Despite that, police were called again. Family was also called and told that the facility was unable to provide one on one supervision. (Refer to F353.) Family took</p>	F 309			

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F 309	<p>Continued From page 78</p> <p>Resident #1 home for the night.</p> <p>~5/5/14, Resident #1 was seen by the NP. The progress note states, "Resident #1 had 2 aggressive behaviors yesterday which required the police to be called here to the nursing home...Will start out by treating his pain. I am going to schedule Aleve 220 mg twice a day with breakfast and supper, alternating with Tylenol 1000 mg twice a day at noon and bedtime...I am going to decrease the Prozac to 10 mg daily as the Prozac may be causing some increased aggravation. Will have Ben-Gay topical available to apply to his low back joints if needed for pain. I am going to start Seroquel 12.5 mg daily...He may have 1 dose as needed in 24 hours."</p> <p>This is the first time in the 3 months Resident #1 has lived at the facility that his pain was addressed and treated.</p> <p>~5/6/14, Resident #1 received as-needed Seroquel after grabbing staff's arm and twisting it. Review of the Behavior Flow Chart finds no documentation of any behaviors, and no attempts at nonpharmacological interventions before administration of the Seroquel.</p> <p>~5/7/14, Resident #1's Aleve was changed to Oxycodone 5 mg two times a day.</p> <p>~5/8/14, Resident #1 received as-needed Seroquel at 2:03 a.m. for "agitation and aggression." There was no documentation describing the behaviors. There are no behaviors documented on the Behavior Flow Sheet and no evidence of any nonpharmacological interventions attempted prior to administration of the Seroquel. There was also no evidence an</p>	F 309			

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F 309	<p>Continued From page 79</p> <p>assessment to determine what may have triggered Resident #1's "agitation and aggression."</p> <p>~5/8/14, Resident #1 received a second dose of Seroquel at 1:00 p.m. for "starting to get restless, agitated." There was no documentation describing the behaviors. There are no behaviors documented on the Behavior Flow Sheet and no evidence of any nonpharmacological interventions attempted prior to administration of the Seroquel. There was also no evidence an assessment to determine what may have triggered Resident #1's behavior.</p> <p>The order for the Seroquel reads, "...may have only one dose in 24 hrs (hours)..." Resident #1 received 2 doses in 11 hours.</p> <p>~5/8/14, Progress Note at 1:34 p.m. states, "...Some pacing noted. Did push a resident in her wheelchair against her wishes. With coaxing did let go of wheelchair. Did wandering [sic] into other residents rooms, many redirections given. After lunch resident started to get figity [sic] and agitated..."</p> <p>~5/8/14, Progress Note at 2:49 p.m., states, "Call received from NP, order received to increase Seroquel to 12.5 mg BID (twice a day) at 8 AM and 6 PM, may have additional 12.5 mg (as needed) x 2 (2 doses) in 24 hours, each dose 6 hours apart..."</p> <p>Resident #3 had only been on Seroquel for 2 days. In this short period of time, it is unclear if an increase was warranted. There was no indication as to who may have initiated the conversation/request to increase the dose with</p>	F 309			

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F 309	<p>Continued From page 80 the NP.</p> <p>There was no evidence of nonpharmacological interventions being attempted, no evidence that the behaviors were assessed to determine triggers, no evidence that remediable causes were identified/ruled out/addressed. There was no evidence that the facility involved the family in developing individualized approaches to address Resident #1's behaviors or assist staff in determining what Resident #1 is trying to communicate. There were also no updates/revisions made to Resident #1's care plan.</p> <p>~5/13/14, as-needed Seroquel administered at 3:13 a.m. for "agitation and aggression." There was no documentation describing the agitation and aggression. No evidence of nonpharmacological interventions, and no evidence of an assessment to determine a trigger and new/revised interventions.</p> <p>~5/14/14, Resident #1 was documented as pacing, confused, and talking to a person who wasn't there. He did refuse medications and became "agitated." Staff called family and requested they come in to assist.</p> <p>~5/14/14, as-needed Seroquel given for "agitated and unable to redirect." Behavior Flow Sheet indicates one-on-one, food, and removing from environment were attempted, however, no outcome was documented.</p> <p>~5/17/14, Progress Note states, "...began pounding on the DR (dining room) door screaming 'help.' Pacing about the unit pounding on windows, ripping down curtains, turning over</p>	F 309			

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F 309	<p>Continued From page 81</p> <p>furniture, all the time yelling 'help'...upon assessment resident appeared frightened and angry."</p> <p>~5/17/14, as-needed Seroquel and as-needed Ativan given as Resident #1 remained "easily agitated following angry outburst earlier" that morning.</p> <p>~5/17/14 Progress Note, "...NP also called facility, she had been notified of incident by ACUD, new orders received to increase Seroquel..."</p> <p>Seroquel order was increased to 12.5 mg every morning and 25 mg every evening. This is in addition to 12.5 mg as needed up to 2 doses in 24 hours.</p> <p>There was no evidence that Resident #1's behaviors were assessed, no evidence of a systemic analysis and consideration of possible causes, development/revision of the care plan identifying ongoing details of common behaviors, and specific goals and interventions.</p> <p>~5/18/14, RN-W documented that at 11:15 a.m., Resident #1 was becoming "figity [sic]" and wanting his dog. "PRN Seroquel given at this time." The Behavior Flow Sheet indicates one-on-one, redirection, and "family" were used with improvement. There was no indication that the as-needed medication was warranted.</p> <p>~5/18/14, as-needed Seroquel was given at 8:06 p.m. for increased agitation. No nonpharmacological interventions were attempted prior to administration of the Seroquel.</p> <p>~5/21/14, as-needed Seroquel administered at</p>	F 309			

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F 309	<p>Continued From page 82</p> <p>12:19 p.m. No reason for the administration was documented. Behavior Flow Sheets has no documentation on that day.</p> <p>~5/21/14, as-needed Seroquel administered at 9:33 p.m. for agitation and wandering/grabbing other residents. Behavior Flow Sheets has no documentation on that day.</p> <p>~5/22/14, as-needed Seroquel and Ativan were administered for agitation at 11:20 p.m. There are no behaviors or interventions documented on the Behavior Flow Sheets.</p> <p>~5/26/14, as-needed Ativan was administered at 5:17 p.m. without documented reason. Behavior Flow Sheet had no documentation on that day.</p> <p>~5/26/14 as-needed Ativan and Seroquel were administered at 9:04 p.m. and 9:07 p.m. respectively for anxiety and aggression. The nurse assessed effectiveness within 5 minutes of administration documenting it was effective.</p> <p>Ativan has an onset time of 1 hour, and Seroquel has an unknown onset time. The effects of the medications could not be assessed in such a short period of time.</p> <p>~5/28/14 as-needed Seroquel given for agitation at 12:29 a.m. Behavior Flow Sheet had no documentation for the shift.</p> <p>On 5/28/14, the facility had a care conference with Resident #1's family. At that time, the family provided the facility with several interventions to attempt and some information about Resident #1's routine before coming to the facility. This information was on a sheet of paper in the</p>	F 309			

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F 309	<p>Continued From page 83</p> <p>nurses' station on the ACU and was not incorporated into Resident #1's care plan. Information includes:</p> <ul style="list-style-type: none"> -Offer snack to rule out hunger, enjoys cookies and sandwiches. -Offer back rubs and reassurance. -May try music with head set. -Offer baby doll and stroller. -Remove from noise and too much stimuli. -Always been cold, wore long sleeves all year and long underwear. -Allow to sleep later. -Prompt assist with toileting before napping/sleeping. <p>~5/29/14 at 12:52 a.m. as-needed Seroquel was administered.</p> <p>~5/29/14 at 9:14 p.m., as-needed Seroquel and Ativan were administered for agitation. Behavior Flow Sheet had no documentation on that day. There was no documentation describing the behaviors or what nonpharmacological interventions were attempted prior to administration of the medications.</p> <p>~5/31/14 at 12:45 a.m., as-needed Seroquel was administered for restlessness and agitation. Behavior Flow Sheet had no documentation on that day. There was no documentation describing the behaviors or what nonpharmacological interventions were attempted prior to administration of the medications.</p> <p>6/3/14, Resident #1's care plan was updated to include the information shared with the facility on 5/28/14.</p>	F 309			

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F 309	<p>Continued From page 84</p> <p>~6/4/14 as-needed Seroquel given at 2:21 a.m. for agitation and aggression.</p> <p>~6/5/14 as-needed Seroquel was given at 11:52 a.m. for restlessness and agitation. At 1:00 p.m., effectiveness is documented as "Ineffective." A note at 3:07 p.m. states, "...Was up at beginning of shift. Pacing in the hall, unable to redirect...PRN Seroquel given at 1152...This was not effective. Resident continued to pace. Unable to stay in one spot for more than two min. (minutes). Did finally lay down on bed at 1:30 p.m. and sleep for approx. one hour. Pain rated at a 5 for the day. Would stop and hold onto back occasionally. Received scheduled Oxycodone and Tylenol."</p> <p>Resident #1 has orders for as-needed Tylenol and also an order for as-needed Ben-Gay. Even though the nurse identified Resident #1 had pain, there was no evidence that the as-needed pain medication was administered before administering the antipsychotic medication Seroquel.</p> <p>On 6/6/14, Resident #1 was seen by the physician. The physician ordered to discontinue the Prozac, among other changes.</p> <p>On the same date, the NP ordered several changes to Resident #1's medications including: -Decrease Seroquel to 12.5 mg twice a day. -Start Depakote 250mg a day. -Increase Lorazepam to 1 mg.</p> <p>When making changes to psychotropic medications, a prudent practitioner makes one change at a time. The DON contacted the physician and the physician ordered the NP</p>	F 309			

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F 309	<p>Continued From page 85 changes be held.</p> <p>On 6/4/14, Surveyor #16041 spoke with the ACUD and asked what training is provided to staff before working on the ACU. The ACUD said the corporation uses "Copper Ridge" which is 15 - 18 hours of training. Surveyor #16041 looked up the Copper Ridge training and found that the most recent update was 2004 and may not be current with accepted standards of practice. In 2012, the Centers for Medicare and Medicaid Services provided free training programs for dementia care called Hand-in-Hand to every nursing facility in the United States. The ACUD had heard of the training, but said it was not being used in the facility.</p> <p>Surveyor #16041 asked what interventions had been put into place since the 5/4/14 incident where the police were called to intervene when Resident #1's behaviors escalated. The ACUD stated they had a care conference with the family and pointed to a sheet of paper, dated 5/28/14, Care Conference.</p> <p>On 6/5/14, Surveyor #16041 spoke with the ACUD again and asked what sort of things are staff supposed to try before they call family to assist with cares. The ACUD stated, "If they called me every time something happened, I would never go home. I tell my staff to give the PRN (medication), wait 20 minutes and then call me for ideas."</p> <p>On 6/10/14 at 8:35 a.m., Surveyor #16041 spoke with the SW (Social Worker) and asked about his involvement in developing individualized care plans, particularly for those residents with behaviors. The SW said his involvement is</p>	F 309			

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F 309	<p>Continued From page 86</p> <p>limited and he is primarily responsible for adjustment difficulties and discharge planning. The SW indicated he is part of the Behavior Committee and some residents are discussed there, but he is not involved in developing individualized approaches for resident on the ACU (Alzheimer's Care Unit).</p> <p>On 6/10/14 at 7:45 a.m., Surveyor #16041 spoke with the ACUD. The ACUD stated care plans "don't have a lot in them. The staff have the knowledge." The ACUD stated residents are placed in one of three groups based on the level of their dementia and staff are expected to provide appropriate activities.</p> <p>The ACUD showed Surveyor #16041 copies of Dementia Management Training Program definitions of the level of Dementia by colors; Greens are residents with mild cognitive impairments, Yellows have moderate cognitive impairment, and Reds have severely impaired cognition. Each color has specific activities based on the rating.</p> <p>The ACUD was asked how staff who normally don't work on the unit are made aware of the specific psychosocial and physical needs of each resident. The ACUD stated all they need to know is what color the resident is and basic ADL (activities of daily living) cares. "They don't want or need to know anything else." The ACUD indicated there are 4 or 5 consistent staff on the ACU, the rest are staff from the main side that fill in on the ACU. Surveyor #16041 asked the ACUD how residents receive care consistent with their needs. The ACUD stated if the person is a "regular" fill in, she would expect the previous CNA or the nurse to "take them under their wing"</p>	F 309			

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F 309	<p>Continued From page 87</p> <p>and take them room to room and tell them about each resident and their needs.</p> <p>On 6/11/14 at 6:45 a.m., Surveyor #16041 entered the ACU. Surveyor #16041 introduced herself to the staff on the unit. LPN-W was the nurse on the unit. Surveyor #16041 asked LPN-W if she usually worked the ACU. LPN-W stated she almost never works the ACU. LPN-W stated RN-LL was working as a CNA on the ACU that day. Surveyor #16041 asked RN-LL if she has worked the unit in the past. RN-LL stated she hadn't and had not worked as a CNA since her clinicals in nursing school. Surveyor #16041 asked RN-LL how she learns about the cares each resident needs. RN-LL stated she would ask questions.</p> <p>On 6/11/14 beginning at 7:45 a.m., Surveyor #16041 observed the ACUD in the nurses' station with RN-LL. The ACUD was telling RN-LL about each resident's likes and dislikes.</p> <p>Throughout the survey, Surveyor #16041 observed Resident #1 walk up and down the halls, and attempt to engage in conversations with others. Staff would try to direct Resident #1 away from other residents even if there was no sign of agitation.</p> <p>On 6/11/14 at 8:30 a.m., Surveyor #16041 observed activities in the dining room with AA-II (Activities Assistant). AA-II was engaging Residents #24, #11, and #23 in activities. During this observation, Resident #1 was also in the dining room and had finished eating breakfast. Resident #1 was not engaged in an activity after eating. Resident #1 came over to the table where AA-II, Residents #24, #11, and #23 were engaged</p>	F 309			

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F 309	<p>Continued From page 88</p> <p>in activities and conversation. Resident #1 attempted to join the conversation, but was unable to due to the advancement of the Dementia. Resident #1 began to fidget with Resident #11's wheelchair, appearing as though he was trying to fix it. AA-II took Resident #1's hand and said, "OK, this is Resident #11's chair," and pulled Resident #1's hand away. AA-II then continued the activity with the 3 residents and did not engage Resident #1 in an activity of his preference.</p> <p>On 6/9/14, the ACUD showed Surveyor #6041 a board full of several different locks, including some with very small keys and parts, that can be locked and unlocked by the user. This had been given to Resident #1 to engage him when he was looking for something to do.</p> <p>On 6/11/14 at 9:40 a.m., Surveyor #16041 observed Resident #1 seated in the hall with the lock board on a table in front of him. Resident #1 was observed trying to manipulate the locks, but was unable to do so. Resident #1 appeared to get frustrated with the locks, pushed the table away and began to walk in the hall again.</p> <p>Example #2 (also cross reference F329):</p> <p>Resident #2's admitting diagnoses included, but not limited to, dementia, anxiety, and PTSD (Post Traumatic Stress Disorder).</p> <p>Resident #2's admission MDS (Minimum Data Set), dated 12/23/13, indicated Resident #2:</p> <p>~Was able to make self understood and usually understood verbal content; ~Had a BIMS (Brief Interview for Mental Status)</p>	F 309			

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F 309	<p>Continued From page 89</p> <p>score of 1 indicating a severe cognitive impairment;</p> <p>~Had symptoms of delirium including inattention, and disorganized thinking which did not fluctuate;</p> <p>~Had no mood indicators;</p> <p>~Had verbal behavior symptoms 1 to 3 days;</p> <p>~Walked independently with supervision;</p> <p>~Required limited staff assistance with bathing, dressing, grooming, and using the toilet;</p> <p>~Frequently incontinent (of notation Resident #2's admission 3-day bladder log dated 12/16/13 through 12/18/13 indicated Resident #2 had 1 incontinent episode over the 3-day period);</p> <p>~Had no pain or falls; and</p> <p>~Weighed 144 pounds.</p> <p>Resident #2's most current MDS was dated 3/25/14. The MDS indicated Resident #2:</p> <p>~Was usually understood and sometimes understands;</p> <p>~Had a BIMS score of 0, indicating a severe cognitive impairment;</p> <p>~Had symptoms of delirium including inattention and disorganized thinking which did fluctuate;</p> <p>~Had 3 mood indicators;</p> <p>~Rejected care, wandered;</p> <p>~Walked with supervision;</p> <p>~Required limited to extensive for bathing, dressing, grooming, eating, and using the bathroom;</p> <p>~Was frequently incontinent;</p> <p>~Had 3 falls; and</p> <p>~Weighed 120 pounds.</p> <p>A comparison of the MDS assessments show a marked decline in Resident #2's overall condition in just 3 months.</p>	F 309			

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F 309	<p>Continued From page 90</p> <p>Observations made by Surveyor #25989 and #25803 during the course of the survey indicated Resident #2 had a further decline in overall functioning. Resident #2 was noted to require extensive assistance of 1 to 2 staff persons for all aspects of care including walking, had numerous falls, and continued weight loss. (Refer to F274.)</p> <p>Resident #2's most current CAA (Care Area Assessment) for behavior was dated 12/17/13. Several components of the CAA are incomplete including "Nature of the behavior...Medication side effects...Illness or conditions that can cause behavior...Factors that can cause or exacerbate the behavior..." The CAA indicated, "... resident has verbal symptoms directed at others... Resident is a new admission...displayed verbal aggression towards others with recent placement...new orders for additional anti-anxiety medications, family...comes to facility when aggressive behavior displayed...Staff has discovered watching church videos are calming...bathing appears to calm resident...Will proceed to care plan to minimize risk and continue with interventions to calm resident at times of increased anxiety..."</p> <p>The CAA did not clinically assess nor critically analyze Resident #2's behaviors.</p> <p>Resident #2's behavior care plan was dated 12/16/13. The care plan indicated Resident #2 had behaviors of yelling, shouting, crying, agitation, combativeness, aggression, restlessness, and anger. The care plan had the following approaches:</p> <p>~12/16/13, "...Assist me to watch church video...Attempt interventions before my behaviors</p>	F 309			

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F 309	<p>Continued From page 91</p> <p>begin...Do not seat me around others who disturb me...Give me medications my doctor has ordered...Help me maintain my favorite place to sit...Help me avoid situations or people that are upsetting to me...may call family to assist in redirection...Let my physician know...if my behaviors are interfering with my daily living...Make sure I am not in pain...Offer me something I like as a diversion...tell me what you are going to do before you begin...Reduce external stimuli as possible, speak in gentle, calm, soft but firm voice..."</p> <p>~12/18/13, "...may bathe to assist with calming..."</p> <p>~1/2/14, "...Administer medications as ordered..."</p> <p>~1/31/13, "...Monitor for s/sx (signs and symptoms) of anxiety towards others and attempt redirection..."</p> <p>None of the above interventions, with the exception of 2, are individualized based on Resident #2's specific needs.</p> <p>Surveyor #25803 completed a review of a facility form titled "Social History." Resident #2's "Social History" was not dated. It indicated Resident #2 worked on a farm and worked as a painter, liked watching TV, bingo, gardening, and being out in the sun. The "Social History" did not include Resident #2's prior life patterns, preferences, and customary responses to things such as stress, anxiety, pain, hunger, and fatigue. The "Social History" did not include information obtained by Resident #2's family regarding how they managed Resident #2's responses to stressors while at home. The "Social History" also did not include Resident #2's life's pleasures.</p> <p>Surveyor #25803 completed a review of a hospital record dated 12/16/13 and titled</p>	F 309			

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F 309	<p>Continued From page 92</p> <p>"Discharge Summary." The "Discharge Summary" indicated Resident #2 lived at home. The "Discharge Summary" indicated Resident #2 was taken to the hospital after being found wandering outside in the early morning hours. The "Discharge Summary" stated, "...had several episodes, during this admission, where he seemed to be remembering events from the Korean War. At times, he would get somewhat emotional...On several occasions he did become a little agitated and he did make an attempt to leave the hospital...They found that if they walked him around and kept him busy, that he did better. Additionally, if he would sit with staff members, he did much better...he did have...Lorazepam (antianxiety medication)...Zyprexa (antipsychotic medication) order which he did not require..."</p> <p>The "Nursing Section" of the hospital discharge records indicated, "...enjoys sitting where there are people around. Needs supervision at all times. Continent bowel/bladder...No behaviors or agitation while hospitalized the last few days. Likes to be kept busy..."</p> <p>The facility did not capture the information regarding Resident #2 being a war veteran including flashbacks from the war. There was no care planned direction to staff on how to manage Resident #2's flashbacks.</p> <p>Resident #2 was admitted to the facility with an order for as-needed Ativan 0.5 mg 2 times a day.</p> <p>Surveyor #25803 completed a review of Resident #2's Progress Notes, MARs, Monthly Behavior Flow Sheets, and Physician/NP orders and noted the following:</p>	F 309			

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F 309	<p>Continued From page 93</p> <p>~12/16/13, Resident #2 received as-needed Ativan at 3:53 p.m.</p> <p>~12/17/13, Resident #2 received as-needed Ativan at 12:16 p.m.</p> <p>For the above 2 administrations, there was no documentation of behaviors demonstrated, nonpharmacological interventions attempted, and/or reason medication was used.</p> <p>~12/18/13, Resident #2 received as-needed Ativan at 9:15 a.m. and 4:36 p.m. Monthly Behavior Flow Sheets indicate Resident #2 had "agitation," and "Activity" was attempted with improved behaviors.</p> <p>For the above 2 administrations, there was no documentation of behaviors demonstrated or why Ativan was given if "Activity" improved behaviors.</p> <p>~12/19/13, as-needed Ativan was given at 8:04 a.m. A Progress Note states, "Resident very restless, agitated, angry. Attempting to strike another resident. Yelling out at that resident...pacing shaking fists..." Interventions attempted included redirection, rest, TV, one-on-one, and the as-needed Ativan. "No interventions effective. Ativan showing little effect after one hour..."</p> <p>~12/19/13, physician was contacted by RN-J to review behaviors and request an increase in Ativan. On-call physician increased the order for Ativan to 0.5 mg every 4 hours as needed for agitation.</p> <p>There was no indication that a comprehensive assessment was completed to determine triggers</p>	F 309			

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F 309	<p>Continued From page 94</p> <p>for Resident #2's behaviors, what exactly the behaviors were, that nonpharmacological interventions were tried prior to each administration, and that individualized interventions were developed and implemented.</p> <p>~12/19/13, as-needed Ativan given at 4:30 p.m. for "Resident very agitated, raising voice, entering into other resident's personal space... Would express concern about [sic] the furnace not working [sic]...talking about how he was going to smash and kill the man who was suppose to fix it...one to one, redirection, offered food and drink. PRN Ativan..."</p> <p>There was no evidence that either of Resident #2's individualized approaches (church or bathing) were attempted.</p> <p>~12/20/13 through 12/30/13, Resident #2 received 23 doses of as-needed Ativan.</p> <p>Of the 23 administrations, the Monthly Behavior Flow Chart and Progress notes indicated nonpharmacological interventions were attempted only 4 times.</p> <p>~On 12/23/13, Resident #2's physician ordered scheduled Ativan 0.5 mg three times a day in addition to the as-needed Ativan 0.5 mg every 4 hours.</p> <p>~12/25/13, Resident #2 received a total of 3 mg of Ativan in one day. The maximum dose for older adults is 2 mg in 24 hours.</p> <p>~12/27/13, Resident #2 received a total of 2.5 mg of Ativan, again exceeding the maximum dose of 2 mg for older adults.</p>	F 309			

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F 309	<p>Continued From page 95</p> <p>~12/28/13, RN-J sent a fax to the on-call physician concerning Resident #2's "increasing agitation." At this time, the scheduled Ativan was discontinued and Zyprexa 2.5 mg daily was added.</p> <p>~12/30/13, another on-call physician (the facility's Medical Director) was contacted regarding behaviors. The physician increased the Zyprexa 2.5 mg to twice a day and to discontinue the Ativan. There is also an order for Zyprexa 2.5 mg 1 every 24 hours PRN.</p> <p>In the 15 days since admission, Resident #2 had 5 changes to 2 antipsychotic medications. There was no evidence the facility clinically assessed Resident #2 and then analyzed Resident #2's behaviors to identify causative factors, or what triggered the behaviors, after the noted behaviors and prior to administering medications. There were no changes made to Resident #2's plan of care.</p> <p>~1/1/14 Progress Note, "(Physician) updated on behaviors, medication changes. Order received for referral to Amery Regional Medical Center for evaluation." Amery Regional Medical Center has a behavioral health unit for persons over the age of 55 with severe emotional or behavior issues. Dementia is not a treatable emotional or behavioral disturbance.</p> <p>There was no evaluation completed in order to rule out remediable causes of the behaviors, identify triggers, or develop individualized interventions to meet Resident #2's physical, mental, and/or psychosocial needs.</p>	F 309			

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F 309	<p>Continued From page 96</p> <p>~1/2/14 a nursing note indicated Resident #2 was requesting to fix the hand rails and was looking for parts. The nursing note indicated, "...going into other residents rooms and starting to remove items. Started talking about finishing the job...Redirected resident that...the working day is done. Prn (as needed) Zyprexa given..."</p> <p>Resident #2 was looking to fulfill the desire to be useful and to fix something, to work. Instead of meeting Resident #2's needs, Resident #2 was told no, your day is done and an as-needed dose of Zyprexa was given without just cause.</p> <p>~ 1/3/14, "...Resident seen by Dr...New orders to DC (discontinue) PRN Zyprexa, start PRN ativan 0.5mg tid (three times a day)...POA (Power of Attorney) updated...gave verbal consent for the PRN Xanax."</p> <p>Surveyor #25803 completed a review of the physician's progress note dated 1/3/14. The progress note indicated, "...was recently seen by...Nurse Practitioner, and Zyprexa p.r.n. was ordered to assist with agitation and aggressive behaviors. He is also having some hallucinations...He has had Paparazzo (Xanax) in the past, but that seemed to escalate his behaviors. The staff states he has not tried Ativan previously...discontinue the p.r.n. Zyprexa...Lorazepam (Ativan)...t.i.d. (three times a day) p.r.n..."</p> <p>According to Resident #2's clinical record, Resident #2 had been on Ativan in the past. The physician ordered Ativan, however, the facility obtained Xanax.</p> <p>Monthly Behavior Flow Sheets indicate Resident</p>	F 309			

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F 309	<p>Continued From page 97</p> <p>#2 had 1 behavior of being angry on 1/8/14 with one on one, and temperature adjustment. However, Resident #2 received as-needed Xanax on 1/7/14, 1/8/14, 1/9/14, and 1/10/14 without documentation of the behaviors being demonstrated, assessment to determine triggers/remediable causes, and/or nonpharmacological interventions tried.</p> <p>On 1/10/14 Resident #2 had a fall. A nursing note dated 1/10/14 indicated Resident #2 had been, "...picking things out of the air, picking things off the floor which were not there..." A nursing note dated 1/10/14 also indicated Resident #2 had increased irritability and restlessness.</p> <p>Instead of completing a clinical assessment analyzing Resident #2's behaviors, determining probable cause, and updating Resident #2's care plan, Resident #2's primary physician was contacted and ordered Xanax 0.5 mg at bed time. This was in addition to the as-needed Xanax three times a day, and the 2.5 mg Zyprexa twice a day.</p> <p>According to the 2013 Nursing Drug Handbook, Zyprexa has side effects that include, but are not limited to, dizziness, personality disorder, thirst, joint pain, extremity pain, and back pain.</p> <p>According to the 2013 Nursing Drug Handbook, Xanax has side effects of irritability, dizziness, anxiety, confusion, impaired coordination, memory impairment, depression, ataxia, agitation, and restlessness among others.</p> <p>~1/11/14, "...came out of his room with an angry affect & (and) threatening gestures &</p>	F 309			

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F 309	<p>Continued From page 98</p> <p>verbalizations...unable to ...redirect him...cornered both of us as we attempted to steer him away from other residents, and struck us several times. He went aggressively in & out of residents' rooms making threatening remarks & shaking his fist, overturning mattresses [sic] and cushions. He threw water & eventually got a towel which he used as a whip...contacted Dr (doctor) who ordered him transported to ER (emergency room)...made several papanoid [sic], delusional remarks. Ambulance staff & a police officer arrived shortly afterwards..."</p> <p>Resident #2 was transported to the ER and seen by an on-call physician. A nursing note dated 1/11/14 indicated, "...ER reports all labs were normal with no UTI (Urinary Tract Infection) or pneumonia...Zyprexa increased to 5 mg BID (twice a day)..."</p> <p>Resident #2 has now had significant and distressing behaviors. Despite this, the facility did not complete an assessment analyzing Resident #2's behaviors to determine causative factors in order to make changes to Resident #2's plan of care and give directives to staff on how to manage Resident #2's behavior. Again, Resident #2's Zyprexa was increased.</p> <p>~1/12/14 and 1/13/14, Resident #2 received 5 doses of as-needed Xanax without documentation of the behaviors being demonstrated, assessment to determine triggers/remediable causes, and/or nonpharmacological interventions tried.</p> <p>~1/14/14 at 1:06 p.m., documented that Resident #2 became "agitated" and required as-needed Xanax. No evidence of nonpharmacological</p>	F 309			

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F 309	<p>Continued From page 99</p> <p>interventions tried and no evidence that an assessment was completed in order to attempt to identify the trigger/remediable cause.</p> <p>~1/14/16 at 9:18 p.m., documented that Resident #2 complained of back pain earlier in the shift, was treated with Tylenol, and was resting comfortably in the recliner.</p> <p>Nursing notes continue:</p> <p>~ 1/16/14, Resident #2 received as-needed Xanax at 12:34 p.m. There was no documentation of the behaviors being demonstrated, assessment to determine triggers/remediable causes, and/or nonpharmacological interventions tried, assessment to determine triggers/remediable causes, and/or nonpharmacological interventions tried. A later note at 10:01 p.m. states, "...could not be woken up for HS (Hour of Sleep) meds (medications) after several attempts..."</p> <p>Review of the MAR finds that from 1/17/14 through 1/31/14, Resident #2 received as-needed Xanax 16 times. Of those, there was documentation 4 times describing the behaviors. However, there was no evidence of an assessment to determine triggers/remediable causes, and/or nonpharmacological interventions tried.</p> <p>~1/21/14, "...became agitated when his hearing aids were taken out of his ears..." Removing Resident #2's hearing aids was not identified as a possible trigger for some of Resident #2's behaviors. There were no changes made to Resident #2's plan of care.</p>	F 309			

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F 309	<p>Continued From page 100</p> <p>~From 2/1/14 through 2/6/14, Resident #2 received as-needed Xanax 10 times. There was documentation describing behaviors as agitated, aggressive, restless, and pacing 6 times. Of note, agitation can be a side effect of Xanax.</p> <p>~On 2/3/14, Resident #2 was started on Citalopram, an antidepressant. According to 2013 Nursing Drug Handbook, side effects of Citalopram include, but are not limited to, anxiety, agitation, depression, confusion, fatigue, and abdominal pain.</p> <p>~2/7/14, Resident #2 was seen by his primary physician, who changed Resident #2's Zyprexa from 5 mg twice a day to 10 mg one time a day.</p> <p>~From 2/7/14 to 2/12/14, Resident #2 received as-needed Xanax 5 times. Although reasons for the medication are documented, there was no evidence of an assessment to determine triggers/remediable causes, and/or nonpharmacological interventions tried.</p> <p>~2/13/14, the NP discontinued the scheduled and as-needed Xanax and started Clonazepam 0.5 mg twice daily and Clonazepam 0.5 mg once a day as needed for agitation/aggression. There was no corresponding documentation indicating why the changes were made.</p> <p>According to 2013 Nursing Drug Handbook, side effects of Clonazepam include agitation, behavioral disturbances, confusion, depression, and ataxia (lack of voluntary coordination of muscle movement) among others.</p> <p>~Progress notes through 2/28/14 document almost daily pacing, entering resident rooms,</p>	F 309			

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F 309	<p>Continued From page 101</p> <p>sleeping in others' beds, and/or agitation. However, there was no evidence that the behaviors were assessed to determine triggering factors, remediable causes, and/or development and implementation nonpharmacological interventions.</p> <p>During February 2014, Resident #2 had 6 changes/additions of antipsychotic medications, yet there were no assessments of the ongoing behaviors or changes to the care plan to include nonpharmacological interventions to avoid or address Resident #2's behaviors.</p> <p>~3/1/14, Resident #2's weight is documented as 130 pounds, which is down 14 pounds since admission on 12/16/13</p> <p>~3/10/14, the Clonazepam order was changed to 0.5 mg as needed up to three times a day. Prior, Resident #2 had been receiving 0.5 mg twice a day with the option of an as-needed dose one time a day. Notes indicate that although Resident #2 continued to walk throughout the unit, he was tired, lethargic, unable to be woken, and taking several rest breaks.</p> <p>On 3/14/14 a nursing note indicated, "...Resident was sleeping in his bed all shift. Unable to take his medications, difficult to arouse. Normally wanders...is diabetic and has not had any food or fluid intake throughout the shift...blood glucose 64 (64 milligram per deciliter), B/P (blood pressure) 92/55...O2 sat 98% (oxygen saturation 98 percent)...T (temperature) 96.0...R (respirations) 16..."</p> <p>This was the first assessment completed since Resident #2 was admitted to the facility. This</p>	F 309			

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F 309	<p>Continued From page 102</p> <p>was a significant change in Resident #2's usual behavior. Despite that, the assessment was incomplete and did not include an assessment of all body systems, changes in functional status, appetite and weight changes, changes in behavior, use of medications including assessing for side effects.</p> <p>~3/28/14 Progress Note, "...paces sometimes for an hour straight. Walking with him can be helpful but trying to remove him from the environment only seems to trigger more hostility from him as pacing is his 'work' at the time. He was a hard worker in lift that ran his own painting business and his recall of that time can be very vivid..."</p> <p>~4/3/14 Progress Note, "...will sing when he is feeling very happy...enjoys Music Therapy...participant in Music and Memory with his own iPod...loves pre-meal stories and often watches Bonanza..."</p> <p>None of this information was added to Resident #2's plan of care to assist staff with providing care to Resident #2.</p> <p>~4/9/14, "...has been quite sleepy this shift...did not eat/drink much at supper. Entered another residents room and went to sleep there. Staff was abe [sic] to arouse resident later to take him to his room via w/ch (wheel chair). Resident did not ambulate much this shift..."</p> <p>This was again a significant change in Resident #2's activity level, historical behaviors, level of consciousness, and mobility. There was no comprehensive assessment completed to in attempt to determine cause. There were no changes made to Resident #2's plan of care.</p>	F 309			

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F 309	<p>Continued From page 103</p> <p>On 5/5/14, Resident #2 began to fall. From 5/5/14 to 6/3/14, the date of survey, Resident #2 fell 7 times.</p> <p>Additionally, Resident #2's weight on admission was 144.4 pounds. Resident #2's last recorded weight on 6/5/14 was 116.0 pounds, a 28.4 pound weight loss in approximately 5 1/2 months.</p> <p>To the date of survey, there was no comprehensive assessment completed of Resident #2's overall condition to determine cause and effect of Resident #2's behaviors including the use of medications and medication side effects, there was no individualized care plan implemented to manage Resident #2's behaviors.</p> <p>On 6/3/14 at 6:10 p.m., Surveyor #25803 observed Resident #2 seated in a Broda chair with a seat belt on. RN-EE (Registered Nurse) indicated Resident #2 had an over-all decline in functioning, including many recent falls which required the use of the Broda chair and seat belt.</p> <p>On 6/10/14 at 3:30 p.m., Surveyor #25803 spoke with the ST (Speech Therapist). The ST indicated she was also the Rehab Director. Surveyor #25803 asked the ST about Resident #2. The ST indicated when Resident #2 came into the facility, Resident #2 was functioning at a much higher level than he was currently. The ST indicated Resident #2 had a decline in overall functioning since admission. The ST also indicated she noted Resident #2 had a continued decline over the weekend. The ST indicated she was not aware of Resident #2 having any agitation or striking out during therapy sessions.</p>	F 309			

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F 309	<p>Continued From page 104</p> <p>On 6/10/14 at 4:00 p.m., Surveyor #25803 spoke with Resident #2's guardian, Family-NN. Family-NN indicated she was Resident #2's daughter and came regularly to the facility. Family-NN indicated prior to coming into the facility, Resident #2 was living alone at his home and taking care of himself. Family-NN indicated Resident #2 was still cutting the grass, raking leaves, sitting on a swing outside, loved the sun, liked to play bingo, liked company, loved to tell stories, and became more depressed during the winter as there was nothing to do. Family-NN also described Resident #2 as being a "loner" but once Resident #2 got to know someone he was "loving and friendly." Family-NN indicated she had noted increasing confusion while at home but Resident #2 was on no medications of any kind to treat the confusion.</p> <p>Family-NN also indicated since Resident #2's wife died, Resident #2 had been having flash backs from the Korean war.</p> <p>Family-NN indicated Resident #2 had a "first good week" but then Resident #2 began to exhibit a lot of behaviors. Family-NN stated the facility called them many times to come in and sit with Resident #2. Family-NN stated coming in some times was OK but felt the facility needed to figure out how to manage Resident #2. Family-NN indicated Resident #2's behaviors are better now, however Resident #2 had also had a decline in condition. Family-NN indicated Resident #2 had gotten so weak he couldn't stand up by himself.</p> <p>Family-NN also indicated they thought they were going to "lose him" this afternoon as Resident #2 had an unresponsive episode.</p>	F 309			

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F 309	<p>Continued From page 105</p> <p>Nursing notes this day indicate that clergy was called and administered last rites to Resident #2.</p> <p>To the date of survey, there was no comprehensive assessment completed of Resident #2's overall condition to determine cause and effect of Resident #2's behaviors, declining condition, use of medications, and medication side effects.</p> <p>On 6/11/14 at 8:40 a.m., Surveyor #25803 spoke with the ACUD (Alzheimer's Care Unit Director). The ACUD indicated it was her job to manage the ACU and make sure it was running smoothly. The ACUD stated it was not her job to manage residents clinically from a nursing perspective, including the use of medications. The ACUD indicated she did inform residents' physician or the NP (nurse practitioner) of resident behaviors, but never recommended medications of any kind. The ACUD indicated Resident #2 loved dogs. The ACUD stated they had a toy dog which they have used when Resident #2 was agitated. The ACUD indicated this had not been put on the care plan yet as she was still evaluating its effectiveness.</p> <p>The ACUD indicated when Resident #2 was admitted to the facility, there were initially no behaviors. The ACUD stated when Resident #2 started exhibiting aggressive behaviors she was "flabbergasted" and asked the family, "Where did this come from?" The ACUD stated Resident #2 has had a significant, rapid decline. The ACUD was not sure why Resident #2 had such a decline but questioned if there was something medically going on or if it was just Resident #2's dementia progressing. The ACUD stated if she saw a change in a resident's condition she was</p>	F 309			

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F 309	<p>Continued From page 106</p> <p>responsible to communicate these changes to nursing. The ACUD stated they did need better communication between herself, the CNAs (Certified Nursing Assistants) and nursing.</p> <p>On 6/11/14 at 2:20 p.m., Surveyor #25803 spoke with LPN-AA (Licensed Practical Nurse) about the facility's process when a change in a resident's condition occurred. LPN-AA indicated as an LPN she would only gather information not requiring an assessment. LPN-AA stated she would refer the assessment to a RN (Registered Nurse).</p> <p>On 6/11/14 at 2:30 p.m., Surveyor #25803 spoke with the ADON (Assistant Director of Nursing). The ADON indicated she as well as the DON (Director of Nursing) read each resident's progress notes every day. The ADON stated they would also talk with staff regarding changes in residents' condition. The ADON stated for any change in a resident's condition, she or another RN would make an assessment and then notify the DON. The ADON stated the DON "fields everything." The ADON stated because of the facility's process, she felt follow-up on residents' condition was "splintered." The ADON also stated the ACUD and NP made most of the medication changes in the ACU.</p> <p>On 6/11/14 at 3:10 p.m., Surveyor #25803 spoke with the DON about Resident #2. The DON stated Resident #2 has had a significant decline in condition. The DON stated the ACU was utilizing too many medications to manage behaviors instead of attempting a variety of interventions first. The DON stated medication changes have been based on 1 persons perception, instead of the interdisciplinary team.</p>	F 309			

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F 309	Continued From page 107 Example #3: Resident #3 was admitted to the facility on 9/12/13 with diagnoses of Advanced Dementia, Anxiety, Generalized Osteoarthritis of multiple sites and Functional and Urge urinary incontinence. Review of Resident #3's Social History does indicate that he worked in a motor shop, was in the Army, raised deer at his home, likes to greet people daily with Happy Birthday/Merry Christmas and if he is not acknowledged he gets angry. Stuffs paper products in clothing. Review of the Comprehensive MDS, dated 9/19/13, indicated it is very important to do his favorite activities and it is very important to go outside and get fresh air. There was no mention what his favorite activities are. Review of the most current quarterly MDS assessment indicates a change in condition; needing more assistance with ADLs and receiving antianxiety medications. Resident continues to wander almost daily which does not put him or others in danger. Review of the Resident #3's CAAs dated 9/18/13, completed by the ACUD indicated the following Analysis of Findings: ~Nature of the problem: "walks up and down the corridor many times per day. Does not enter other peoples room and stays quiet." ~Seriousness of the behavioral symptoms is blank. ~Nature of the behavioral disturbances (resident	F 309			

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F 309	<p>Continued From page 108</p> <p>interview, if possible; staff observation) is blank. ~Medication side effects that can cause behavioral symptoms is blank. ~Illness or conditions that can cause behavior problems is blank. ~Factors that can cause or exacerbate the behavior (from observation, interview, record is blank. ~Cognitive status problems; Delirium and Dementia is checked. ~Other considerations is blank. ~Care Plan Considerations: Will behavior symptoms-Functional Status be addressed in the care plan? "yes." If care planning for this problem what is the overall objective? blank. Describe impact of this problem/need on the resident and your rationale for care plan decision. "...exhibits pacing behaviors and has difficulty staying on task. He is pleasant but can get aggressive with cares if he doesn't like your answer. He is constantly searching for his wife. Will care plan to have interventions in place to redirect and monitor."</p> <p>Resident #3's care plan, dated 9/12/13, indicated: "I have little or no awareness of safety, or boundaries related to others personal space (etiology choice here). Please help me remain in a living environment that meets and supports my need to safely wander such as a secured unit or specialized care unit..." There was no mention of continuous pacing and/or agitated (agitation does not describe the specific behavior). There are no triggers identified that increases Resident #3 continuous pacing and/or agitation. There are no individualized nonpharmacological interventions put into place to decrease Resident #3 anxiety prior to administering the prn Ativan. There are no</p>	F 309			

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F 309	<p>Continued From page 109</p> <p>goals written related to his agitation and need for the Ativan. Staff, subsequently, from September 2013 through survey, have treated Resident #3's behaviors by using Ativan without trying to identify what had triggered the behavior and without using nonpharmacological approaches.</p> <p>Review of the monthly activity record does not indicate that he goes outdoors, which the facility had identified as being one of his most important things he liked to do.</p> <p>Review of Resident #3's behavior monthly flow sheet indicated continuous pacing and agitation.</p> <p>An entry of Resident #3's progress notes, dated 9/13/13, "Resident has been wandering the unit aimlessly...does well with redirection."</p> <p>On 9/14/13, progress note indicated: "Resident has been wandering the unit aimlessly going into others rooms and tends to wear others clothing...is no longer trying to leave the unit and is doing well with redirection..."</p> <p>On 9/15/13, progress note documented at 6:45 p.m. indicated: "Resident was trying to leave the ACU via the fire exit door. Writer attempted to stop resident by saying that we can not leave out of this door at this time and holding door shut. Resident became agitated and garbed [sic] by the throat in attempt remove writer form [sic] the area so that he could leave and go for a walk outside which is one of the activities he enjoyed while at home...another staff member who was able to distract the resident and redirect to the TV lounge..."</p> <p>No nursing documentation from 9/17/13 until</p>	F 309			

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F 309	<p>Continued From page 110</p> <p>9/20/13. On 9/20/13 at 4:37 p.m., a progress note indicated, "has a sore throat and a bad cough."</p> <p>No nursing documentation from 9/21/13 until 9/26/13 regarding the sore throat or assessment of the bad cough. A nurse's note indicated the physician was updated at family's request for an antianxiety to promote resident's well-being.</p> <p>On 9/26/13, Resident #3's physician orders included an order for Ativan 0.5 mg every 6 hrs. as needed for anxiety, restlessness, agitation regarding to anxiety state.</p> <p>According to the 2013 Nursing Drug Handbook, Ativan has side effects that include dizziness, weakness, unsteadiness, disorientation, and visual disturbances among others. All of these can increase a person's risk for falls and injuries.</p> <p>Review of the Medication Records (MAR), Monthly Behavior Flow Sheets and Progress notes indicate:</p> <p>~September 2013: Ativan 0.5 mg given 4 times. No documentation of behavior characteristic or reassessment of the need for medication administration. 1 documented behavior of pacing in halls unable to sit 5 minutes. No nonpharmacological interventions tried prior to administration of the psychotropic medication. No behavior flow sheets.</p> <p>On 9/27/13 at 10:32, progress note indicated: "Where can I go to the Bathroom" Taken and he toileted self." Resident #4 brought forward an approach that he was not toileted.</p> <p>~October 2013: Ativan 0.5 mg given 14 times. 4</p>	F 309			

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F 309	<p>Continued From page 111</p> <p>times no documented reason for the medication given. The other 10 times, behaviors of anxiety, agitation, restlessness, pacing, wandering and resistive of cares were documented. No nonpharmacological interventions tried prior to administration of the psychotropic medication. No behavior flow sheets.</p> <p>~November 2013: Ativan 0.5 mg given 14 times. 9 times no documented reason for the medication given. The other 5 times behaviors of restlessness and anxiousness are documented. No nonpharmacological interventions tried prior administration of the psychotropic medication. No behavior flow sheets.</p> <p>On 11/4/13 Resident #3 experienced a fall with no injury.</p> <p>~December 2013: Ativan 0.5 mg given 14 times. 7 times no documented reasons for the medication given. The other 7 times behaviors of restlessness, anxiety, agitated, pacing and increase behaviors are documented. No nonpharmacological interventions tried prior administration of the psychotropic medication. No nonpharmacological interventions were used prior to administration of the psychotropic medications.</p> <p>On 12/3/13, new order to give Tylenol 650 mg for complaints of aching knees and elevated temperature.</p> <p>On 12/11/13, progress note indicated: at 4:00 p.m., lost balance and became dizzy about 10 minutes. Dr. notified. Monitor blood pressure twice a day for 2 days.</p> <p>Tylenol 650 mg given 6 times with the Ativan</p>	F 309			

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F 309	<p>Continued From page 112 dose.</p> <p>~January 2014: Ativan given 9 times. 4 times no documented reason for the medication given. The other 5 times behaviors of agitation, pacing, irritable and in bed with another resident were documented. Nonpharmacological approaches used 5 times; was 1:1, Activity, Food, Fluids and Redirect. These approaches are generic approaches and are not individualized to address Resident #3's behaviors or meet his physical, mental, and psychosocial needs.</p> <p>Tylenol 650 mg given 9 times. 5 of those times were given with Ativan.</p> <p>Since pain has been identified as a precursor to the behaviors, Ativan administration has been decreased. The facility should have known that Resident #3 was having pain according to his history of chronic pain and previous injuries. Therefore, Ativan was an unnecessary medication without proper indication and justification.</p> <p>~February 2014: Ativan 0.5 mg given 14 times. 4 times no documented reason for the medication given. Documented behaviors of restlessness, agitation and pacing. Nonpharmacological approaches used 3 times.</p> <p>Tylenol 650 mg given 10 times. 6 of those times were given with Ativan.</p> <p>~March 2014: Ativan 0.5 mg given 9 times. 5 times documented with no reason. Documented behaviors of restlessness, agitation and pacing. Nonpharmacological approaches used 4 times which are the same as above.</p>	F 309			

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F 309	<p>Continued From page 113</p> <p>Tylenol 650 mg given 6 times. 3 of those times were given with Ativan. Resident #3's pain regimen was reassessed and medications changed to: On 3/10/14, Tylenol 650 mg TID (three times a day) On 3/10/14, Tramadol 50 mg ordered every 4 hours as needed. Received 7 times with no nonpharmacological approaches prior to administering the medication. Tramadol is an Analgesic for moderate to moderately severe chronic pain.</p> <p>~April 2014: Ativan 0.5 mg given 8 times. Documented behaviors of agitation, pacing, swearing at staff, striking out and found in another person's bed. Nonpharmacological interventions were tried and ineffective, however there was no evidence that anyone tried individualized approaches.</p> <p>Tramadol 50 mg was given 4 times. No nonpharmacological approaches were tried prior to administration of the medication.</p> <p>On 4/14/13, Resident #3 had a witnessed fall; lost balance and fell on right side. Received Ativan at 7:29 a.m., scheduled Tylenol 8:00 a.m., Noon, 8:00 p.m. and Tramadol 50 mg at 7:47 p.m.</p> <p>~May 2014: Ativan given 3 times. No documentation 1 time. Documented behaviors of agitation and restlessness. Nonpharmacological approaches were tried 1 time which was ineffective.</p> <p>Medication changes in May include: ~On 5/5/14- Tramadol 50 mg TID (8,12,8).</p>	F 309			

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F 309	<p>Continued From page 114</p> <p>Received 20 doses.</p> <p>~On 5/13 & 5/14, Tramadol 25 mg TID, give with scheduled Tylenol. Received 5 doses then discontinued.</p> <p>~On 5/16/14, Discontinue Tylenol 650 mg TID.</p> <p>~On 5/16/14, Tylenol Extra Strength 1000 mg TID.</p> <p>Resident #3 had a fall on 5/11/14 with a bruise/swelling on the back of his left hand.</p> <p>~June 2014: As of 6/10/14, Received Ativan 0.5 mg 1 time on 6/7/14 at 1:41 p.m. by medication aide. Behaviors documented were very anxious, keeps getting up. No nonpharmacological interventions tried prior Ativan administration. There was no evidence that the nurse was contacted to give permission to the medication aide to administer the medication. The medication aide documented that the medication was effective; "started settling down right away."</p> <p>According to 2013 Nursing Drug Handbook, Ativan has an onset time of 1 hour. Immediate change could not be attributed to the medication administration.</p> <p>On 6/7/14 at 2:48 p.m., Progress note indicated, "Resident had a fall, witnessed by staff..." No assessment documented. At 3:06 documented a SBAR-Change of Condition: "...Staff noted that his gait was unsteady however they were ambulating another resident who needs 1:1 assistance. He turned to go into bedroom door and lost his balance causing him to fall. Did not hit his head." "Assessment...He had c/o (complaints of) pain in the right flank however upon questioning family and staff they stated he had this complaint for at least 3</p>	F 309			

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F 309	<p>Continued From page 115 days...VS=186/75, 82, 20, 96.9 MD...update with NNOs (no new orders)."</p> <p>Review of Resident's MARs since admission reveals the same systematic problem of not documenting the need of the medication. The computer system does not require nursing to do so. They select the medication to be given and may or may not document reason for administration. After administration, the medication is selected again and staff document either effective or ineffective. Occasionally a nurse will describe the behavior but does not identify what triggered the behavior, or describe the individualized nonpharmacological interventions that was in place prior to administering the prn Ativan.</p> <p>Example #4:</p> <p>Resident #5 had current diagnoses including, but not limited to, arthritis, dementia, and anxiety.</p> <p>Resident #5's most current MDS (Minimum Data Set) indicated Resident #5:</p> <ul style="list-style-type: none"> ~ Had a BIMS (Brief Interview for Mental Status) score of 0, indicating a severe cognitive impairment; ~ Had symptoms of delirium including inattention and disorganized thinking; ~ Had mood indicators of difficulty concentrating and being abnormally restless and fidgety; ~ Required extensive assistance with bathing, dressing, grooming, using the bathroom, and eating; ~ Walked only once or twice; ~ Was frequently incontinent of bladder and occasionally incontinent of bowels; 	F 309			

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F 309	<p>Continued From page 116</p> <p>~ Had a urinary tract infection in the last 30 days; and</p> <p>~ 2 non-injury falls.</p> <p>Resident #5's most current behavior CAA (Care Area Assessment) was dated 2/11/14. The CAA indicated Resident #5 had behaviors. There was no further information. The CAA did not include an assessment, problem identification, cause and effect analysis, goals and objectives of care, and interventions for care planning.</p> <p>Consequently, there was no individualized person-centered care plan developed.</p> <p>Surveyor #25803 completed a review of Resident #5's care plan dated 5/28/14. Behavior approaches were noted in multiple areas within the care plan and included the following:</p> <p>~ 2/1/14, "...if I'm upset, please re-direct... Offer things that are soothing to me..."</p> <p>~ 2/10/14, "...Make sure I have my things with me that make me comfortable..."</p> <p>~ 2/11/14, "...Attempt interventions before my behaviors begin...Do not seat me around others who disturb me...Help me avoid situations or people that are upsetting to me...Make sure I am not in pain..."</p> <p>~ 3/3/14, "...Offer activities at table as he will tolerate..."</p> <p>None of the above interventions are person-centered, individualized approaches based on a comprehensive assessment. The interventions do not describe what "things are soothing to me," what "things..make me comfortable," what "situations or people...are upsetting to me," or what activities "he will</p>	F 309			

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F 309	<p>Continued From page 117 tolerate."</p> <p>Surveyor #25803 completed a review of Resident #5's CNA (Certified Nursing Assistant) care plan dated 6/3/14. There was no direction to staff on how to manage Resident #5's behaviors.</p> <p>A review of Resident #5's nursing notes indicated Resident #5 became agitated when incontinent, liked finger foods, usual bedtime was 9:30 p.m., usual time for rising was 6:00 a.m., liked Christian TV and music, and was fearful of the bathroom.</p> <p>There was no indication that the above approaches were analyzed to determine their effect on Resident #5's behavioral symptoms and added to Resident #5's plan of care.</p> <p>Surveyor #25803 completed a review of a facility form titled "Social History." Resident #5's "Social History" was not dated. It indicated Resident #5 enjoyed being by himself, liked hunting, gardening, and being outside. The "Social History" did not include Resident #5's prior life patterns and preferences, and customary responses to things such a stress, anxiety, pain, hunger, and fatigue. The "Social History" did not include information obtained by Resident #5's family regarding how they managed Resident #5's responses to stressors while at home. The "Social History" also did not include Resident #5's life's pleasures.</p> <p>Surveyor #25803 observed Resident #5 on all days of the survey. On all days, Resident #5 was noted seated in a Broda chair with a belt restraint secured in the back of the chair. Resident #5 was observed to either be sleeping in the Broda chair or in constant motion by either propelling the</p>	F 309			

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F 309	<p>Continued From page 118</p> <p>chair forward or backward with his feet, propelling his chair forward with his hand by utilizing the hand rails, leaning over attempting to pick up items off the floor, putting on/taking off socks/shoes, or manipulating the variety of positioning devices on the Broda chair. Resident #5 was also noted to ram into walls, doors, and the nursing station while propelling the Broda chair.</p> <p>On 6/5/14 at 8:20 a.m., Surveyor #25803 observed Resident #5 in the Broda chair next to the nursing station. Surveyor #25803 noted Resident #5 was in constant motion, either propelling his chair forward of backwards with his feet or propelling himself forward with his hand using the hand rail. Surveyor #25803 spoke with Resident #5. Resident #5 indicated he was "nervous" and "this is a big area."</p> <p>On 6/10/14 at 6:50 a.m., Surveyor #25803 observed CNA-K assist Resident #5 with morning cares. On arrival to Resident #5's room, Surveyor #25803 noted Resident #5 to be sitting in bed attached via a harness to the sit-to-stand lift (mechanical lift). CNA-K indicated she was going to take Resident #5 into the bathroom for cares. CNA-K transported Resident #5 into the bathroom via the lift and began cares. CNA-K indicated to Surveyor #25803 that Resident #5 sometimes "fights me" when doing cares.</p> <p>CNA-K assisted Resident #5 with bathing his upper body. CNA-K obtained a shirt and attempted to place it on Resident #5's arms and then over Resident #5's head. Resident #5 became resistive to CNA-K trying to place the shirt. CNA-K became insistent that Resident #5 allow her to put the shirt on despite Resident #5's</p>	F 309			

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F 309	<p>Continued From page 119</p> <p>resistance to have the shirt placed. Resident #5 told CNA-K he was "not taking that now...I will get my rifle..." CNA-K then tussled with Resident #5 to obtain the shirt at which point Resident #5 stated to CNA-K, "No right to do what you are doing." CNA-K then ceased trying to put Resident #5's shirt on.</p> <p>At 7:10 a.m., CNA-N entered Resident #5's room and began to assist CNA-K with Resident #5's cares. CNA-N obtained Resident #5's shirt and attempted to put it on Resident #5 several times at which point Resident #5 became resistive. CNA-N and CNA-K then each took one of Resident #5's arms, placed the shirt on either arm, and pulled the shirt over Resident #5's head.</p> <p>Both CNA-N and CNA-K indicated to Surveyor #25803 that Resident #5's fighting them during cares was "better today."</p> <p>On 6/5/14 at 8:01 a.m., Surveyor #25803 spoke with CNA-N about Resident #5. CNA-N stated Resident #5 would occasionally yell, cry, or be combative, and sometimes uncooperative with using the bathroom. CNA-N indicated their approach to Resident #5 was to re-direct, re-approach, get extra staff to assist when needed, and if Resident #5's behaviors were "real bad" she would get the nurse.</p> <p>Although Progress Notes document Resident #5 was fearful of the bathroom, staff took Resident #5 into the bathroom to provide cares. No individualized alternatives to meet Resident #5's needs were developed and implemented into the care plan.</p> <p>On 6/5/14 at 8:30 a.m., Surveyor #25803 spoke</p>	F 309			

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F 309	<p>Continued From page 120</p> <p>with CNA-C about Resident #5. CNA-C stated Resident #5 would at times swing at staff and Resident #5 didn't like to stay in bed. CNA-C indicated she wasn't sure why Resident #5 had these behaviors. CNA-C indicated she was aware Resident #5 slept in a recliner when at home. CNA-C stated staff would put Resident #5 to bed at night between 9:30 p.m. and 10:00 p.m. CNA-C was uncertain what time Resident #5 got up in the morning as he was on the "night get up list." CNA-C stated she thought the night shift starting getting residents up around 5:00 a.m. CNA-C stated because of Resident #5's restlessness, they always used 2 staff for any cares. CNA-C stated their approach to Resident #5's behaviors was to talk with him and calmly explain things to him. CNA-C also indicated Resident #5 did not like to stay in bed. CNA-C was unsure why.</p> <p>Of note, Progress Notes indicate Resident #5's usual waking time is 6:00 a.m. It is unclear why Resident #5 is on the "night get up list."</p> <p>On 6/4/14 at 1:30 p.m., Surveyor #25803 spoke with the ST (Speech Therapist) who is also the director of therapy services. The ST indicated she felt Resident #5 was restless and looking for something to do. The ST indicated OT (Occupational Therapy) had devised a low table with a non-skid mat and items for Resident #5 to manipulate. The ST indicated this was however not being utilized by the nursing staff.</p> <p>On 6/3/14, Surveyor #25803 spoke with Staff-D (Anonymous) who indicated there was not enough staff to care for the residents who resided in the facility. Staff-D stated staff were rushed and unable to attend to resident behaviors</p>	F 309			

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F 309	<p>Continued From page 121 causing behaviors to escalate.</p> <p>On 6/4/14 at 10:32 a.m., Surveyor #25803 spoke with CNA-C (Certified Nursing Assistant). CNA-C indicated when Resident #5 was fidgety it was an indication Resident #5 needed to use the bathroom. CNA-C also stated Resident #5 loved chocolate and coke.</p> <p>This information is not identified on Resident #5's care plan.</p> <p>Surveyor #25803 spoke with Staff-I (Anonymous). Staff-I stated staff does not have enough time to implement resident specific fall/behavioral interventions. Staff-I stated Resident #5 was not being engaged in a meaningful activity due to lack of staff and follow through.</p> <p>On 6/9/14 at 2:00 p.m., Surveyor #25803 spoke with Resident #5's spouse. Resident #5's spouse indicated when Resident #5 was restless at home he would walk or go outside. Resident #5's spouse also indicated Resident #5 liked it quiet. Resident #5's spouse stated Resident #5 liked to hunt, do yard work including mowing and gardening, liked cake and cookies, would drink at least 2 cans of soda every day, always took an afternoon nap, usually in a recliner, loved music and Christian TV, took a shower in the evening, didn't like water in his face, usually got up 2 times during the night to go to the bathroom, became more restless if needed to go to the bathroom, responded best to sweet, short, simple directions.</p> <p>None of this information was noted on Resident #5's care plan.</p>	F 309			

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F 309	<p>Continued From page 122</p> <p>Resident #5 shared a room with Resident #16. According to the ADON (Assistant Director of Nursing), Resident #16 spent a majority of time in his room in bed. Surveyor #25803 observed Resident #16 in bed with his TV on multiple times during the survey.</p> <p>There was no indication the facility had considered the noise of Resident #16's TV as a trigger to restlessness and inability to settle when in bed.</p> <p>Surveyor #25803 spoke with Staff-T (Anonymous) who indicated resident care was not being managed by the nursing department. Staff-T stated the facility was not being staffed sufficiently enough to allow for staff to respond to resident behaviors. Staff-T stated this caused more resident behaviors which could have been avoided.</p> <p>On 6/11/14 at 9:45 a.m., Surveyor #25803 spoke with the SW (Social Worker). The SW indicated the facility form titled "Social History" was the only history obtained during the admission process. The SW indicated the assessment did not go beyond what was requested on the form.</p> <p>Example #5:</p> <p>Resident #7 had current diagnoses including, but not limited to, congestive heart failure and anxiety.</p> <p>Resident #7's most current MDS (Minimum Data Set), dated 5/15/14, indicated Resident #7 had a BIMS (Brief Interview for Mental Status) score of 0, indicating a severe cognitive impairment, required extensive assistance of 1 to 2 staff</p>	F 309			

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F 309	<p>Continued From page 123</p> <p>persons for all aspects of care, and had no behaviors.</p> <p>Resident #7's behavior care plan dated 7/12/10 indicated, "...I have behavior of calling out and can become anxious at times..." The approaches included the following:</p> <p>~ 7/12/10, "...encourage me to make independent decisions...Encourage...activities which are mentally stimulating..."</p> <p>~ 4/26/13, "...Reapproach as needed...Approach with calm soothing voice..."</p> <p>None of the above approaches are individualized (for example, they do not describe what "activities...are mentally stimulating" for Resident #7) and are not based on the reasons Resident #7 calls out (they do not address what might be done to proactively prevent anxiousness and calling out).</p> <p>On 6/5/14 at 8:30 a.m., Surveyor #25803 spoke with CNA-C (Certified Nursing Assistant). CNA-C. CNA-C indicated she worked full time and worked on the unit in which Resident #7 resided. CNA-C indicated Resident #7 would call out in the lobby, "Help, help," or call out "Aw, aw." CNA-C indicated their approach to Resident #7's calling out was to tell Resident #7, "It's OK."</p> <p>There was no evidence that the facility comprehensively assessed Resident #7's calling out to determine potential triggers, determine if her needs are being met, or to develop and implement approaches to address the calling out. The facility's approach has been to respond to the behavior and to calm the resident rather than to identify what triggers the behavior and to prevent</p>	F 309			

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F 309	<p>Continued From page 124 the distress the resident may be feeling.</p> <p>Example #6:</p> <p>Surveyor #25803 completed a review of Resident #6's clinical record and noted the following.</p> <p>Resident #6 had current diagnoses including, but not limited to, dementia with delusions, psychosis, anxiety, and glaucoma resulting in blindness in the right eye and poor vision in the left eye.</p> <p>Resident #6's most current MDS was dated 4/1/14. The MDS was noted as an annual MDS. The MDS indicated Resident #6:</p> <ul style="list-style-type: none"> ~ Had a BIMS (Brief Interview for Mental Status) of 2, indicating a severe cognitive impairment; ~ Had indicators of delirium including disorganized thinking; ~ Had verbal behavioral symptoms directed towards others and other behavioral symptoms not directed towards others on 1 to 3 days; ~ Behavioral symptoms significantly interfered with Resident #6's participation in activities, and significantly disrupted care or the living environment; and ~ Required the assistance of 1 to 2 staff persons for all aspects of care. <p>Resident #6's behavior care plan was dated 4/14/14. The care plan had the following approaches:</p> <ul style="list-style-type: none"> ~ 4/14/14, "...Attempt interventions before my behaviors begin...Do not seat me around others who disturb me...maintain by favorite place to sit...Help me avoid situations or people that are 	F 309			

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F 309	<p>Continued From page 125</p> <p>upsetting to me...Let my physician know if...my behaviors are interfering with my daily living...Make sure I am not in pain... Offer me something I like as a diversion...tell me what you are going to do before you begin....Speak to me unhurriedly and in a calm voice..."</p> <p>None of the above approaches are individualized based on Resident #6's specific needs. These approaches do not describe the types of residents "who disturb me, " what his "favorite place to sit" is, or what "situations or people are disturbing to me." Consequently, there was no direction to staff on how to manage Resident #6's behaviors.</p> <p>On 6/5/14 at 12:30 p.m., Surveyor #25803 was walking towards the nursing station from the west wing of the facility. Surveyor #25803 heard Resident #6 calling out in the dining room. The dining room was approximately 100 feet from where Surveyor #25803 began to hear Resident #6 calling out. Surveyor #25803 entered the dining room. Surveyor #25803 noted no staff attending to Resident #6. CNA-C was seated at a table assisting a resident to eat. When CNA-C noted Surveyor #25803, CNA-C attended to Resident #6.</p> <p>On 6/10/14 at 6:45 a.m., Surveyor #25803 observed Resident #6 seated in the day room. Resident #6 was hollering out.</p> <p>On 6/5/14 at 8:30 a.m., Surveyor #25803 spoke with CNA-C (Certified Nursing Assistant) about Resident #6. CNA-C indicated Resident #6 "yells a lot, swears, very vocal, talks very loud." CNA-C stated they try one-on-one when able or talk with Resident #6. CNA-C also stated they try and take Resident #6 to the bathroom or give Resident #6</p>	F 309			

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F 309	<p>Continued From page 126</p> <p>something to eat. CNA-C stated sometimes these work and sometimes they don't. CNA-C also stated Resident #6 liked "extra attention" and if staff were not able to spend one-on-one time with Resident #6 the behaviors got worse.</p> <p>Example #7:</p> <p>Upon admission, Resident #4's physician orders included an order for Depakote 250 mg (milligrams) twice a day for Dementia with Behavioral Disturbances and an order for Ativan 2 mg twice a day.</p> <p>An entry in the Progress Notes, dated 3/7/14 states, "...New orders decreasing scheduled Ativan...Gdn (Guardian) updated and very pleased with reduction in antianxiety medication."</p> <p>Resident #4's physician order was updated to include Ativan 1 mg twice a day.</p> <p>Review of Resident #4's MARs (Medication Administration Records) found that Resident #4 received the reduced dose of Ativan 3 times; evening of 3/7/14 and morning and evening on 3/8/14.</p> <p>An entry in Resident #4's Progress Notes, dated 3/8/14 at 7:02 p.m., states, "Resident had altercation with another male resident...no known provocation. No injury noted to either resident. Noted that residents Ativan was decreased from 2 mg BID (twice a day) to 1 mg BID. (On-call physician) informed of incident. Received new order to restart Ativan 2 mg BID..."</p>	F 309			

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F 309	<p>Continued From page 127</p> <p>Surveyor #16041 asked the facility to contact the Registered Nurse who made the entry. Attempts to reach her during the survey were unsuccessful.</p> <p>Review of Resident #4's care plan found that he has a history of wandering. The other male resident, identified as Resident #18, was identified by staff as preferring privacy in his room. The facility's investigation indicated Resident #4 had entered Resident #18's room prior to the altercation. Despite having knowledge of both residents' histories and preferences, there were no non-pharmacological interventions attempted prior to increasing Resident #4's antianxiety medication.</p> <p>Surveyor #16041 reviewed Resident #4's progress notes for 5/1/14 which state, "Resident was seen on rounds...informed that the resident appears to be having increased behaviors during the noc (night) time hrs. (hours). New order received to change Depakote Sprinkles to 250 mg in AM and 375 mg in PM..."</p> <p>Review of Resident #4's physician orders found that on 5/1/14, the order for Depakote was increased to 250 mg in the morning and 375 mg in the evening.</p> <p>The facility also completed Behavior Monthly Flow Sheets. Resident #4 is being observed for "Continuous Pacing" and "Danger to Others." Review of March and April flow sheets found only 1 behavior of kicking and continuously pacing in 61 days. There was no evidence of what the behaviors actually were that the nurse referred to, assessment of the causal factors of the perceived behaviors, and development of a care plan to include nonpharmacological interventions for the</p>	F 309			

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F 309	<p>Continued From page 128 behaviors before increasing medications.</p> <p>Review of previous progress notes (back to February 2014) found entries in March 2014 when he was up at night and urinating in inappropriate places. Review of Resident #4's medical record found one Sleep Hygiene Assessment dated 11/21/13 and one Bladder Assessment dated 11/21/13.</p> <p>Surveyor #16041 reviewed Resident #4's care plan. There was a care plan for bladder and bowel elimination dated 11/21/13. The approaches all dated 11/21/13 do identify that Resident #4 does not always use the toilet for elimination, and that he may walk faster if he needs to use the bathroom, but does not provide direction to staff on how to assist him to urinate in appropriate places.</p> <p>The care plan also included a problem of "Sometimes I show behavior symptoms/risks including wandering or resisting cares. Episode of displaying aggression toward others" dated 11/21/13. The approaches are all dated 11/21/13, with the exception of "Decrease Ativan to 1 mg BID" on 3/7/14, are not individualized and do not provide direction to staff on how to effectively manage Resident #4's environment and cares to avoid triggers and/or behaviors. Approaches state:</p> <p>"~Build on my strengths of (insert personalization here) and invite me to participate in various activities and tasks related to those strengths. ~During episodes of inappropriate behaviors, please re-direct me by approaching slowly and speaking to me in a calm and steady voice-trying to redirect me to an alternate activity or topic of</p>	F 309			

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F 309	<p>Continued From page 129 discussion.</p> <p>~Encourage me to participate in activities to give me something to focus on.</p> <p>~Help me avoid situations and people that trigger inappropriate behaviors.</p> <p>~Help me maintain a consistent daily routine.</p> <p>~Honor my life's simple pleasure of (insert personalization here)..."</p> <p>The care plan does not define the type of activity to use, does not identify situations that trigger a negative response, and does not identify Resident #4's strengths or life's pleasures. Even though cues were made in the care plan, approaches for staff to enter personal information and individualized approaches, they were left blank.</p> <p>On 6/10/14 at 4:10 p.m., Surveyor #16041 spoke with the DON (Director of Nursing). The DON was asked how the determination was made that Resident #4's behavior was related to dose reduction. The DON indicated she was not here at the time of the incident, so she didn't know what was tried. The DON stated, "I read the note too. Not sure how the determination was made."</p> <p>On 6/11/14 at 11:15 a.m., Surveyor #16041 spoke with the ACUD (Alzheimer's Care Unit Director) about Resident #4's altercation on 3/8/14 and the subsequent increase in the Ativan. The ACUD stated she was not in the facility during the altercation. The ACUD stated, "I can't tell what they can see. What I got out of the notes is that he (Resident #4) was out of normal." The ACUD was asked what behaviors had increased at night that warranted the increase in the Depakote. The ACUD was not sure.</p>	F 309			

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F 309	<p>Continued From page 130</p> <p>Surveyor #16041 asked the ACUD if any nonpharmacological interventions were attempted before the Ativan and Depakote were increased. The ACUD stated she did not see any. The ACUD was asked what the process is for changing/increasing antipsychotic medications. The ACUD stated if the nurse feels it is necessary, they contact the physician for the order. Surveyor #16041 asked if changes like that are reviewed by the Behavior Committee prior to getting an order. The ACUD stated Resident #4 was not reviewed by the Behavior Committee.</p> <p>On 6/10/14 at 8:35 a.m., Surveyor #16041 spoke with the SW (Social Worker) and asked about his involvement in developing individualized care plans, particularly for those residents with behaviors. The SW said his involvement is limited and he is primarily responsible for adjustment difficulties and discharge planning. The SW indicated he is part of the Behavior Committee and some residents are discussed there, but he is not involved in developing individualized approaches for residents on the ACU (Alzheimer's Care Unit).</p> <p>On 6/10/14 at 7:45 a.m., Surveyor #16041 spoke with the ACUD. The ACUD stated care plans, "Don't have a lot in them. The staff have the knowledge." The ACUD stated residents are placed in one of three groups based on the level of their Dementia and staff are expected to provide appropriate activities.</p> <p>The ACUD showed Surveyor #16041 copies of Dementia Management Training Program definitions of the level of Dementia by colors: Greens are residents with mild cognitive</p>	F 309			

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F 309	<p>Continued From page 131</p> <p>impairments, Yellows have moderate cognitive impairment, and Reds have severely impaired cognition. Each color has specific activities based on the rating.</p> <p>The ACUD was asked how staff, who normally don't work on the unit are made aware of the specific psychosocial and physical needs of each resident. The ACUD stated all they need to know is what color the resident is and basic ADL cares. "They don't want or need to know anything else." The ACUD indicated there are 4 or 5 consistent staff on the ACU, the rest are staff from the main side that fill in on the ACU. Surveyor #16041 asked the ACUD how residents receive care consistent with their needs. The ACUD stated if the person is a "regular" fill in, she would expect the previous CNA or the nurse to "take them under their wing" and take them room to room and tell them about each resident and their needs.</p> <p>On 6/19/14, Surveyor #22548 requested copies of assessments or other documentation regarding specific information of Resident #4's manner in communicating needs, distress.</p> <p>The failure to provide individualized, person-centered care that addressed and responded to the needs of the residents with dementia, created a finding of immediate jeopardy. The immediate jeopardy that began on 6/3/14 was not removed at the time of exit from the survey as the facility had not fully implemented their removal plan at that time.</p> <p>PAIN</p>	F 309			

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F 309	<p>Continued From page 132</p> <p>Example #8:</p> <p>Resident #1 was admitted to the facility on 2/4/14 with a diagnosis of, but not limited to, Dementia, Depression, Anxiety, Chronic Back pain, COPD (Chronic Obstructive Pulmonary Disease), Gastroesophageal Reflux Disease (heart burn) and Stage 4 Emphysema.</p> <p>Resident #1's most current MDS (Minimum Data Set) was dated 5/13/14. It indicated Resident #1:</p> <p>~Requires limited assistance with one staff for bed mobility, ambulation, locomotion, and 2 assist for hygiene, dressing and toilet use; ~Removed was shortness of breathe with exertion and lying flat. He would continue with this problem with COPD and Acid Reflux Disease. ~Recently receiving scheduled pain medication, a pain assessment should be conducted which was not completed.</p> <p>Resident #1's care plan dated 2/4/14:</p> <p>~ "Needs Pain management and monitoring related to: Resident has hx [history] of chronic back pain. Resident has difficulty with word finding and making self understood, will not ask for medications. Recetnly [sig] noted with abdominal pain. ~" Interventions: ...Administer pain medication as ordered...Evaluate and Establish level or pain on numeric scale/evaluation tool...Evaluate characteristics and frequency/pattern of pain...Evaluate need for bowel management regimen...Evaluate need for routinely scheduled medications rather than PRN [as needed] pain med administration...Implement the patient's preferred non-pharmacological pain relief</p>	F 309			

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F 309	<p>Continued From page 133</p> <p>strategies...Observe for potential medication side effects...Staff to anticipate resident needs, monitor for non-verbal s/sx of pain and administer pain medication as indicated...</p> <p>~"Goals: dated 2/14/14: Will not experience a decline in function related to pain. Patient will achieve acceptable pain level goal. Will maintain adequate level of comfort as evidenced by no s/sx of unrelieved pain or distress, or verbalizing satisfaction with level of comfort."</p> <p>There are no CNA Care Plans to assist them in identifying indicators of pain and what approaches should be used to prevent any further altercations and/or aggressive moments.</p> <p>Surveyor #25989 reviewed the "Pain Management Guideline" by the facility, dated revised 2013.</p> <p>"Purpose: to provide guidelines for consistent assessment, management and documentation of pain in order to provide maximum comfort and enhanced quality of life.</p> <p>"Guidelines: Functions of appropriate pain management include, but are not limited to: ...Documenting pain assessment, interventions prior to giving medication and evaluation activities should be recorded in a clean and concise manner per the plan of care. If facility is utilizing EMAR, the nursing staff should utilize the electronic pain evaluation and nursing note link...</p> <p>"Assessment: Pain assessment tools: Numeric rating Scale, Verbal Descriptor Scale and *PAINAD (Pain in Advanced Dementia) are utilized to screen and assess pain level for cognitively intact and cognitively impaired residents..."</p>	F 309			

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F 309	<p>Continued From page 134</p> <p>Surveyor #25989 reviewed the (MAR) medication records since admission.</p> <p>~Documentation on the monthly MARs, indicates: "Pain scale rating 0-10 every shift for pain (order date 2/4/14)." Due to Resident #1 cognitive status he would not be able to understand the 0-10 pain scale.</p> <p>~ Review of the MARs indicated Resident #1 received Tylenol 650 mg:</p> <p>*Feb.: 6 doses; *Mar.: 10 doses; *Apr.: 8 doses; *May 1 - 6: 3 doses</p> <p>Surveyor #25989 requested Resident #1's pain assessments since admission and received a Pain Evaluation by the DON dated 5/6/14. The DON utilized the Pain Assessment in Advanced Dementia (PAINAD) tool. Location of Pain: lower back, joint. Pattern: intermittent. Descriptors: aching and dull. The pain does have an impact on quality of life/functioning such as sleeping, day to day activities, mood which limits activities. What makes the pain worse: ambulation , movement. Strategies: rest periods. Additional notes: noted to be restless at times, unable to verbalize discomfort.</p> <p>Surveyor #25989 asked the DON why this pain assessment was not completed upon admission. The DON stated she did not know but they were evaluating all of his behaviors and decided to look at possible pain and this should have been looked at before. The DON also stated the facility used to have a pain paper tool which had the assessment/pain scale, descriptors of the pain, nonpharmacological approaches tried prior to administering the medication and the evaluation piece. The DON stated this piece is not used in</p>	F 309			

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F 309	<p>Continued From page 135</p> <p>the computer system and now that she is aware of the problem, it will be addressed.</p> <p>~5/5/14, new order for Tylenol 1000 mg twice a day, continue the 650 mg every 4 hrs. as needed not to exceed 3000 mg of acetaminophen. Received 8 doses as-needed doses of Tylenol 650 mg from 5/6-5/31.</p> <p>~5/5/14, new order of Aleve Tab. 220 mg (Naproxen Sodium) twice a day. *only received 4 doses of Aleve.</p> <p>~5/7/14 a new order of Oxycodone HCL 5 mg twice a day.</p> <p>5/6/14 was the first time the facility comprehensively assessed Resident #1 for pain despite the knowledge of chronic pain. Since the time of admission, Resident #1 experienced significant distress which led to altercations with staff and the police being called. (Refer to Example #1.)</p> <p>*June 1-4, received 1000 mg scheduled Tylenol twice a day and 650 mg prn x 1 and Oxycodone HCL 5 mg twice a day.</p> <p>Example #9:</p> <p>Resident #11 was admitted to the facility on 11/29/10. Diagnoses include Alzheimer's Disease, Dementia, Colitis, Osteoarthritis, Gout, and Breast Cancer. On 5/5/14, Resident #11 was admitted to hospice.</p> <p>Resident #11's physician orders included scheduled pain medications of Tylenol 650 mg (milligrams) 3 times a day and Tramadol 50 mg 3</p>	F 309			

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F 309	<p>Continued From page 136</p> <p>times a day. Resident #11 also had orders for as-needed Tylenol 650 mg every 4 hours as needed for pain not to exceed 3000 mg per day, and Morphine 0.25 ml every 4 hours as needed for pain.</p> <p>Resident #11 also has an order for staff to complete a 0-10 pain rating each shift. According to Resident #11's MDS assessment dated 5/5/14, her BIMS (Brief Interview for Mental Status) score was 3, indicating severe cognitive impairments. A 0-10 pain rating scale would not be appropriate for Resident #11.</p> <p>Review of the MARs (Medication Administration Records) and Progress Notes reveal the following:</p> <p>~5/5/14 Morphine was administered at 6:36 a.m. There was no assessment documented describing the reason for the administration. The effectiveness of the medication is documented as "Unknown" on the MAR.</p> <p>~5/8/14 Morphine was administered at 12:24 p.m. was marked as effective. Pain rating was documented as a "5" on the MAR, however there was no assessment documented describing Resident #11's pain indicators. The effectiveness the medication is documented as "Effective" on the MAR, but there was no assessment to demonstrate that.</p> <p>~5/22/14 Morphine was administered at 9:22 a.m. for "Calling out." The effectiveness was marked as "Unknown."</p> <p>~6/2/14 Morphine administered at 8:26 a.m. for "pain." There was no documented assessment</p>	F 309			

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F 309	<p>Continued From page 137 describing the reasons for the administration. The effectiveness was documented as "Effective" without an assessment to demonstrate that.</p> <p>On 6/5/14, Surveyor #16041 spoke with the DON and asked about the use of a numeric pain scale for a resident with severe cognitive impairments. The DON stated it is not reasonable to ask a resident with cognitive impairments to rate their pain. Staff should be using an appropriate assessment per the dementia scale.</p> <p>LACK OF RN ASSESSMENT</p> <p>Example #10:</p> <p>Resident #12 was admitted to the facility on 3/28/11. Her diagnoses include Vascular Dementia, Alzheimer's, Hypertension, Congestive Heart Failure, and a history of Stroke.</p> <p>On 4/6/14, LPN-Y documented the following Progress Note for Resident #12:</p> <p>"Resident appeared pale in color while sitting at the table during dinner. Her head dropped and her right arm violently shook. Resident alert and oriented to self. Consulted charge RN. Advised to take vitals and monitor resident. Vital signs were taken temperature 97.9, oxygen saturation 94% on room air, blood pressure 124/53, pulse 58 respiration 18. RN advised. Residents pulse was checked at 2030 (8:30 p.m.) and was 64. No further episodes noted. Resident went to bed early. Resident monitored throughout the shift. RN notified of vital signs and residents condition."</p> <p>Review of documentation in Resident #12's medical record found that her pulse usually runs</p>	F 309			

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F 309	<p>Continued From page 138</p> <p>65-70 indicating that a pulse of 58 at the time of the incident may have been low for Resident #12.</p> <p>There was no evidence of an RN assessment of Resident #12's condition. Review of subsequent entries in Resident #12's Progress Notes found no evidence of monitoring or follow-up after the incident or when her her head dropped and her arm shook.</p> <p>On 6/10/14 at 4:15 p.m., Surveyor #16041 spoke with the DON (Director of Nursing). The DON was asked what the expectation is if there is a change in a resident's condition. The DON stated there is always an RN in house, and if there is change in condition, the RN should complete an assessment of the resident. Surveyor #16041 asked the DON about Resident #12's change in condition on 4/6/14. The DON stated the RN should have assessed and that a call to the physician may have been warranted.</p> <p>On 6/11/14 at 8:05 a.m., Surveyor #16041 spoke with RN-Z. RN-Z was the RN on duty the night of 4/6/14. RN-Z stated she can recall LPN-Y telling her about Resident #12, but could not recall if she had gone to the ACU (Alzheimer's Care Unit) to complete an assessment. RN-Z stated, "I'm sure if it was something spectacular, she (Resident #12) would've been in the hospital."</p> <p>On 6/11/14 at 8:15 a.m., Surveyor #16041 spoke with LPN-Y. LPN-Y stated she remembers the incident on 4/6/14. LPN-Y stated she notified RN-Z on duty and was directed to get vitals. LPN-Y stated she got the vitals and reported those to RN-Z. When asked if RN-Z came to the ACU to complete an assessment, LPN-Y stated she could not recall RN-Z assessing Resident</p>	F 309			

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F 309	Continued From page 139 #12.	F 309			
F 312 SS=F	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility did not ensure that residents who were unable to carry out activities of daily living, received the necessary services to maintain good personal hygiene. The deficient practices have the potential to affect all residents. Residents are not receiving scheduled showers due to a lack of staff to conduct the showers. Facility records validated that 31 out of 33 residents' showers are not occurring on a routine basis and with several weeks inbetween. Resident #11 is incontinence of bladder and requires the assistance of 2 staff for bathing and hygiene. After an episode of bladder incontinence, staff did not cleanse the urine residue from Resident #11's buttocks. Resident #5 required assistance with all aspects of activities of daily living. Resident #5 was observed multiple days during the survey not shaven and with dirty fingernails. This is evidenced by:	F 312			

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F 312	<p>Continued From page 140</p> <p>Example #1:</p> <p>During the Resident Group Interview conducted on 6/9/14 at 3:00 p.m., Resident #15 indicated she has not received a bath or shower for a couple of weeks.</p> <p>Surveyor #16041 reviewed Census and Condition of Residents completed by the facility as part of the survey. Upon entrance, the census was 51. According to the facility, no residents are independent with bathing/showering. 43 require the assistance of 1 or 2 staff and 8 are completely dependent.</p> <p>On 6/11/14, Surveyor #30570 met with the Director of Nursing (DON) regarding resident showers. The DON indicated at one point all showers were scheduled to occur in the morning and in February the showers were split by rooms, shifts, and resident preference as staff were having a hard time getting them done. The DON further explained at that time staff were inserviced on the need to inspect resident skin with showers and the need to fill out the skin inspection records. The DON expressed CNA staff were also instructed to take the skin inspection sheets to the nurse for review and return the sheets to the shower books. The DON explained this is a way to tell when residents received their bath or shower. The DON also indicated staff document showers in the electronic "Care Tracker" record.</p> <p>Surveyor #30570 requested and received "Weekly Skin Check" sheets for 33 residents. The sheets contain the following information: ~Shower, bed bath, shave, tub bath (Circle one). ~Fingernails: cleaned/clipped.</p>	F 312			

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F 312	<p>Continued From page 141</p> <p>~Toenails: cleaned/clipped.</p> <p>~Bruise, skin rash, reddened areas, open areas, new open areas.</p> <p>~Weekly weight.</p> <p>~Date/Time/CNA signature.</p> <p>~Reviewed by RN/LPN (Registered Nurse/License practical Nurse) for appropriate follow up, Date/Time/RN/LPN signature.</p> <p>The facility also provided a report titled "Group Bathing Type Report" which is printed from the CNA charting. The report was dated 2/1/14 through 6/4/14.</p> <p>Of the 33 reviewed, 2 show evidence of weekly shower/bathing. Review of the sheets (as of 6/11/14) and the report found the following information for the remaining 31 residents. Note: the term "Shower" is used for ease of reading, but it could also be a bed bath or tub bath:</p> <p>~Resident #26's "Weekly Skin Check" sheet is blank. No refusals.</p> <p>~Resident #25's last shower was documented 5/26/14. No refusals.</p> <p>~Resident #27's last shower was documented 6/5/14, however, prior to that her last shower was 5/8/14. No refusals.</p> <p>~Resident #28's last shower was documented 5/10/14. Prior to that, last shower was 4/19/14. No refusals.</p> <p>~Resident #29's last shower was documented 4/26/14. Prior to that, last shower was 3/22/14. Resident #29 had 2 refusals between 2/1/14 and 6/4/14. This does not account for the 4 weeks</p>	F 312			

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F 312	Continued From page 142 inbetween the last documented shower. ~Resident #30's last shower was documented 4/18/14. Prior to that, last shower was 12/6/13. Resident #30 had 4 refusals between 2/1/14 and 6/4/14. This does not account for the 10 weeks between 2/1/14 and 4/18/14. ~Resident #31's last shower was documented 4/25/14. Prior to that, last shower was 3/14/14. No refusals. ~Resident #32's last shower was documented 3/9/14. Prior to that, last shower was 1/16/14. No refusals. ~Resident #33's last shower was documented 4/9/14. No refusals. ~Resident #34's last shower was documented 5/27/14. No refusals. ~Resident #35's last shower was documented as 5/26/14. 2 refusals between 2/1/14 and 6/4/14. No indication as to when those refusals occurred. ~Resident #36's last shower documented was 4/15/14. 4 refusals between 2/1/14 and 6/4/14. This does not account for the 7 weeks since the last shower. ~Resident #37's last shower documented was 3/27/14. ~Resident #8's last shower documented was 11/8/13. 2 refusals. ~Resident #38's last shower documented was 5/2/14. No refusals.	F 312			

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F 312	Continued From page 143 ~Resident #39's last shower documented was 4/12/14. 2 refusals which do not account for the 7 weeks since the last shower. ~Resident #7's last shower documented was 5/19/14. Prior to that, last shower was 4/12/14. No refusals. ~Resident #10's last shower documented was 1/21/14. No refusals. ~Resident #17's last shower documented was 5/2/14. 2 refusals between 2/1/14 and 6/4/14. No indication as to when the refusals occurred. ~Resident #40's "April 2014" Weekly Skin Check sheet is blank. 1 refusal. ~Resident #41's last shower documented was 6/9/14, however, prior to this, the last shower was 5/2/14. No refusals. ~Resident #42's last 4 documented showers are 4/7/14, 3/30/14, 3/7/14, and 1/13/14. 1 refusal. ~Resident #9's last shower documented was 5/10/14. No refusals. ~Resident #43's last shower documented was 3/30/14. 2 refusals. ~Resident #44's last shower documented was 4/21/14. 1 refusal. ~Resident #45's "April 2014" Weekly Skin Check sheet is blank. No refusals. ~Resident #46's last shower documented was	F 312			

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F 312	<p>Continued From page 144 4/1/14. No refusals.</p> <p>~Resident #47's last shower documented was 4/22/14. 2 refusals.</p> <p>~Resident #48's last shower documented was 3/5/14. 8 refusals, which does not account for the 13 weeks since the last shower.</p> <p>~Resident #49's last shower documented was 5/8/14. 1 refusal.</p> <p>~Resident #5's last shower documented was 4/17/14. 1 refusal.</p> <p>On 6/10/14 at 7:00 a.m., Surveyor #30570 spoke with Staff-BB (Anonymous). Staff-BB indicated she often takes care of Resident #15. Surveyor #30570 asked Staff-BB when Resident #15 showers ofr baths. Staff-BB indicated Resident #15 likes to shower on Saturday mornings but due to current staffing issues, she has not received a shower for several weeks. Staff-BB further indicated residents in the facility have not received baths regularly for several months due to staffing.</p> <p>Staff-BB explained staff are to conduct a skin inspection with each resident's shower, fill out a skin check sheet and take it to the floor nurse for review. Staff-BB indicated many skin inspection sheets show some residents have not received baths or showers for months. Staff-BB further indicated CNAs also document in the Care Tracker when showers are given but the skin inspection/check sheets are more accurate in noting the frequency of showers and when the last shower was given.</p>	F 312			

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F 312	<p>Continued From page 145</p> <p>Staff-BB indicated a few weeks ago Resident #15 informed her she had washed her own hair in her sink because her head itched and she had not received a shower in many weeks. Staff-BB stated she went to the sink and there was evidence of soap bubbles in the sink and Resident #15 hair was wet at the time.</p> <p>On 6/10/14 at 7:30 a.m., Surveyor #30570 met with Staff-DD (Anonymous). Surveyor #30570 asked Staff-DD if there are enough staff to meet the needs of the residents and if residents are receiving showers or baths on a regular basis. Staff-DD explained resident showers and baths are not being given due to staffing. Staff-DD further explained 3 CNAs for morning cares is not sufficient staff to enable staff to conduct showers and bathes. Staff-DD indicated some residents have not received showers or baths since November, December and/or January.</p> <p>Staff-DD further explained the bath book which contains the schedule of resident showers also contain skin check sheets for each resident. Staff-DD indicated staff are to fill out the sheet with each shower that is given and when resident's skin is inspected. Staff-DD explained many of the skin check sheets indicate many months inbetween each resident's shower. (Refer to F353.)</p> <p>Example #2:</p> <p>Resident #11 was admitted to the facility in 2010 and has diagnoses that include Alzheimer's Disease, and Dementia with Behavioral</p>	F 312			

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F 312	<p>Continued From page 146</p> <p>Disturbances. Resident #11 also has a history of pressure ulcers and urinary tract infections.</p> <p>The most recent MDS assessment, dated 5/5/14, indicated Resident #11 is frequently incontinent of bladder and requires extensive assistance of staff for personal hygiene.</p> <p>Resident #11's current care plan is dated 5/23/14. There is one approach that addresses Resident #11's incontinence and states, "Provide thorough skin care after incontinent episodes and a barrier cream."</p> <p>On 6/9/14, Surveyor #16041 observed CNA-B (Certified Nursing Assistant) and RN-X (Registered Nurse) assist Resident #11 with incontinence care. CNA-B washed Resident #11's front peri area. Resident #11 was swearing and grabbed RN-X's uniform when CNA-B and RN-X rolled Resident #11 onto her side. CNA-B removed the wet brief and replaced it with a clean brief. CNA-B did not wash Resident #11's buttocks to remove any urine residue.</p> <p>Surveyor #16041 asked CNA-B how incontinence care should be completed. CNA-B stated she normally would have washed the buttocks, but Resident #11 was combative with cares. CNA-B stated she believed Resident #11 was having pain.</p> <p>Example #3:</p> <p>Resident #5 had current diagnoses including, but not limited to, arthritis, dementia, and anxiety.</p> <p>Resident #5's most current MDS (Minimum Data</p>	F 312		

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F 312	<p>Continued From page 147</p> <p>Set) indicated Resident #5: ~ Had a BIMS (Brief Interview for Mental Status) score of 0, indicating a severe cognitive impairment; and ~ Required extensive assistance with bathing, dressing, grooming, using the bathroom, and eating.</p> <p>Resident #5's care plan, dated 2/1/14, directed staff to assist Resident #5 with all aspects of activities of daily living.</p> <p>On 6/4/14 at 9:40 a.m., Surveyor #25803 observed Resident #5 seated in a Broda chair by the nursing station. Resident #5 was unshaven and had a dark substance embedded under the fingernails on both hands.</p> <p>On 6/5/14 at 8:20 a.m., Surveyor #25803 noted Resident #5 seated in a Broda chair by the nursing station. Resident #5 was noted to have several days growth of facial hair. Resident #5's fingernails on both hands were still embedded with a dark substance.</p> <p>On 6/9/14 at 1:00 p.m., Surveyor #25803 noted all of Resident #5's fingernails were dirty and embedded with a dark substance.</p> <p>On 6/10/14 at 6:50 a.m. Surveyor observed CNA-K assist Resident #5 with morning cares. Resident #5's fingernail were still embedded with a dark substance. CNA-K cleansed Resident #5's hands but did not clean Resident #5's fingernails.</p> <p>Resident #5's fingernails were not trimmed and cleaned until 6/11/14.</p>	F 312			

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F 312	Continued From page 148 Resident #5 went for 7 days without having his fingernails cleansed. On 6/11/14 at 8:15 a.m., Surveyor #25803 spoke with LPN-AA (Licensed Practical Nurse). LPN-AA stated she expected staff to follow all resident care plans. LPN-AA stated if the CNAs were unable to complete a task they should let the nurse know.	F 312			
F 315 SS=G	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility did not ensure that 3 of 7 sampled residents reviewed for catheters and bladder incontinence, received proper assessment, appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Resident #3 had an indwelling catheter inserted at the emergency room on 5/11/14 and was sent back to the facility with orders to remove the catheter in 2 weeks (5/25/14), push fluids and	F 315			

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F 315	<p>Continued From page 149</p> <p>monitor urine output. The indwelling catheter was removed on 5/29/14, 4 days late. Following removal, there was no bladder assessment or clinical monitoring. On 6/3/14, the catheter was reinserted after a family member identified abdominal distention to the facility. There was no intakes recorded or consistent urine output documented per physician orders. Resident #3 now has a urinary tract infection and is being treated with an antibiotic.</p> <p>Resident #4 has a diagnosis of Dementia with Behaviors, is frequently incontinent of urine and is documented as urinating in inappropriate places. The facility initiated a voiding pattern data collection tool and bladder assessment at the time of Resident #4's admission to the facility. The data collection is incomplete and indicates Resident #4 did not ask to use the bathroom and there was no evidence that he was assisted to use the bathroom. Resident #4 has had a number of falls related to his bladder incontinence.</p> <p>Resident #7 was to be assisted with incontinence care every 2 to 3 hours. Resident #7 also had a history of UTIs (Urinary Tract Infections) with the last noted UTI on 5/7/14. On 6/3/14, Resident #7 was not assisted with incontinence care for at least 6 hours and 30 minutes, at which point Resident #7's adult brief was noted to be saturated with both urine and stool.</p> <p>This is evidence by:</p> <p>Example #1:</p> <p>Resident #3 has diagnoses of, but not limited to, Advanced Dementia, and Functional and Urge</p>	F 315			

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F 315	<p>Continued From page 150 Incontinence.</p> <p>The MDS (Minimum Data Set) assessment, dated 3/22/14, indicated Resident #3 is severely cognitively impaired, frequently incontinent and requires extensive assistance of one staff for toilet use.</p> <p>Resident #3's physician orders indicate a medication change on 3/5/14 for Tramadol HCL 50 mg three times a day. This medication is for pain. According to 2013 Nursing Drug Handbook a side effect of Tramadol is urinary retention.</p> <p>A nursing note, dated 5/9/14, indicated Resident #3's wife reported yesterday that resident is not himself. Staff were to attempt to obtain a temperature and urine specimen.</p> <p>There was no follow-up documentation to the 5/9/14 entry.</p> <p>A progress note, dated 5/11/14, indicated resident was discovered kneeling on the floor in the hallway. Resident had a urinalysis done and facility is waiting for the results. Resident has frequency and urgency. Under assessment, the nurse documented that he has been very dizzy with very recent poor balance.</p> <p>The evening shift nurse documented on 5/11/14, that Resident #3's wife was visiting most of the day and thinks he should go to the emergency room because Resident #3 had not voided today and his abdomen is distended.</p> <p>The nurse documented abdomen slightly distended but soft and he has been more confused the last 2-3 days with unsteady gait.</p>	F 315			

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F 315	<p>Continued From page 151</p> <p>The physician was consulted with new orders to obtain a urine specimen for urinalysis with culture and sensitivity, may catheterize or obtain clean catch. RN-FF (Registered Nurse) straight cath (catheterized) Resident #3 with no return of urine.</p> <p>According to Fundamentals of Nursing, "...Insert the catheter steadily about 20 cm (8 in) or until urine begins to flow." (Rational, if no urine return, the catheter is not in far enough.)</p> <p>It should be noted that Resident #3 is not circumcised, therefore the staff would have to pull down the foreskin to clean the meatus and straight cath for urine, then pull the foreskin back into place.</p> <p>On 5/11/14, RN-FF documented that at 7:30 p.m., she was notified by the staff that Resident #3 foreskin is not covering head of penis and the head of the penis is swollen. Staff and writer unable to bring foreskin back into proper position covering head of penis. Resident is having discomfort. RN-FF updated the physician on the foreskin position and that resident has not voided the last 16 hours per wife and staff's failure to obtain urine via catheter. Received new orders to send resident to ER.</p> <p>RN-FF documented that she was updated by the physician at 9:00 p.m. that the emergency room obtained 500 cc of urine when he was catheterized. He will return with a Foley catheter in place and to keep in for 2 weeks until the swelling resolved. Instructions were given not to pull foreskin back until swelling is resolved.</p> <p>*Review of the Emergency Department note indicated the facility reported foreskin was</p>	F 315			

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F 315	<p>Continued From page 152</p> <p>trapped around the base of the glans of the penis, unable to reduce. The facility performed a straight catheterization and no urine came out. By the time the staff at the nursing home tried to reduce the foreskin back over the glans of the penis, they were unable to get it over the glans of the penis as the glans of the penis had become quite edematous (swollen) and erythematous (inflamed). He subsequently presents here for attempted reduction of the foreskin.</p> <p>A bladder scan was performed in the emergency room with revealed almost 800 cc of urine. Impression: Urinary retention with swollen glans of the penis. Plan: Foley catheter will be kept in place for 2 weeks. This was reviewed with the staff at Golden Living Center's Golden Age. Push fluids and monitor urine output.</p> <p>An entry on 5/12/14, indicated the NP reviewed the urinalysis results and Resident #3 was negative for urinary tract infection.</p> <p>Surveyor #25989 requested all of Resident #3's Intakes and Outputs during the two weeks (5/11/14 through 5/25/14). Surveyor #25989 received no fluid intakes. Outputs were hand documented on a pink sheet of paper with no indication where the outputs came from.</p> <p>Surveyor #25989 asked the DON (Director of Nurses) where did the outputs come from. The DON stated the nurses obtained the information from the nursing notes.</p> <p>Review of the pink sheet of paper indicated:</p> <p>~No outputs on the day shift on 5/12/14, 5/15/14, 5/16/14, 5/20/14, 5/26/14;</p>	F 315			

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F 315	<p>Continued From page 153</p> <p>~No outputs on the evening shift on 5/12/14, 5/15/14, 5/16/14, 5/18/14, 5/20/14, 5/21/14, 5/22/14, 5/26/14;</p> <p>~No outputs on the night shift 5/12/14, 5/15/14, 5/16/14, 5/17/14, 5/20/14, 5/21/14, 5/22/14, 5/24/14, 5/25/14, 5/27/14.</p> <p>Review of the medication/treatment/nurse's notes indicated the indwelling catheter was to be removed on 5/25/14. The NP (Nurse Practitioner) wrote an order for removal on 5/28/14 and the catheter was not removed until 5/29/14.</p> <p>On 6/5/14 at 2:45 p.m., Surveyor #25989 asked the DON why the catheter wasn't discontinued in 14 days per the physician order. The DON stated, "I think it was on the holiday weekend and we decided it could wait." When asked who she was referring to as "we," the DON stated, "I meant me." The DON stated she talked with the NP about discontinuing the catheter on 5/29/14. Surveyor #25989 informed the DON that Surveyor #25989 saw this order written on 5/28/14.</p> <p>Review of Resident #3's nursing notes from 5/29/14 (catheter was removed) to 6/3/14 (catheter was reinserted), do not indicate any type of bladder assessment and/or monitoring of urinary status, only a "Care Tracker" indicating how many times a person is incontinent/continent. There was no documentation of any intakes or outputs during this time. This information would be critical in monitoring for urinary retention.</p> <p>On 6/4/14 at 12:45 p.m., Surveyor #25989</p>	F 315			

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F 315	<p>Continued From page 154</p> <p>requested Resident #3's bladder assessment when the indwelling catheter was removed. The DON provided an incomplete bowel/bladder assessment dated 4/16/14. There was no bladder assessment completed after the indwelling catheter was removed. The DON stated, "I guess we should have done one."</p> <p>On 6/3/14 at 8:45 p.m., Surveyor #25989 observed family reporting to the nurse that Resident #3 had urinary distention. With the assistance of the family member, RN-EE inserted an indwelling Foley catheter in Resident #3.</p> <p>Review of the documentation by RN-EE stated Resident #3 had abdominal distention. RN-EE received an order to reinsert the catheter. RN-EE did not document what the output was or if she had any difficulty with the insertion. The physician also ordered that a urinalysis be done.</p> <p>Surveyor #25989 spoke with Resident #3's daughter-in-law who stated she was present and assisted with the catheter insertion and the nurse obtained 1100 cc urine. Resident #3's daughter-in-law stated that Resident #3 had urinary retention a couple of weeks ago and did not think the facility was monitoring any intake and outputs to determine if there was any further concerns with urinary output.</p> <p>On 6/4/14, physician ordered to administer Bactrim DS (double strength) 800/160 mg (milligram) one tablet twice a day for UTI (urinary tract infection) for 7 days.</p> <p>Example #2:</p>	F 315			

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F 315	<p>Continued From page 155</p> <p>Resident #4 was admitted to the facility on 11/21/13. Diagnoses include Alzheimer's Disease, Dementia with Behaviors, Functional Urinary Incontinence, and Elevated Prostate Specific Antigen which is most commonly associated with Benign Prostatic Hyperplasia (BPH).</p> <p>BPH is the enlargement of the prostate gland which compresses the urethra and impedes urine flow from the bladder (urine retention). This leads to a person needing to urinate frequently and with urgency.</p> <p>Resident #4's MDS assessments, dated 11/28/13 and 2/28/14, both indicate Resident #4 is frequently incontinent of bladder and is not on a toileting program.</p> <p>Resident #4's care plan, dated 3/14/14, includes a problem of "Alteration in elimination of bowel and bladder..frequent functional and urge bladder incontinence r/t (related to) cognition with dx (diagnosis) of Alzheimer's dementia, BPH..." initiated 11/21/13.</p> <p>Approaches all dated 11/21/13 include:</p> <p>"...Evaluate frequency/timing of incontinence episodes, noted to be frequently incontinent of bladder, does not always use toilet for elimination...Prompt and assist to toilet q (every) 1 1/2 to 2 hrs (hours) while awake as resident is not aware of appropriate time or place for elimination...Provide assistance of one with toileting needs, usually responds to prompting and assistance without difficulty...Use of pull ups for incontinence protection..."</p>	F 315			

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F 315	<p>Continued From page 156</p> <p>This plan was developed before the voiding pattern data collection period was completed.</p> <p>On 11/22/13, the facility began the "Incontinence Tracking: Day #1" form. The instructions say, "Hourly Check (6 am - 9 pm). Offer toileting every two hours if unable to communicate needs." The form indicated Resident #4 was "Dry" 7 of the 9 hours documented, and "Incontinent" the other 2 hours. Staff are to document if Resident #4 was toileted by circling either Y for yes or N for no. These were left blank.</p> <p>On 11/23/13, "Incontinence Tracking Day #2" form was started. The instructions for Day 2 state, "Prompt to void every hour (6 am - 9 pm). Greet resident. Wait 5 seconds for the resident to self-initiate request to toilet. Offer toileting every hour." The form indicated Resident #4 was "Dry" 12 times, "Incontinent" 2 times. 2 hours were not documented. Resident #4 voided 2 times, however there was no indication that he was prompted every hour to use the bathroom. Staff are to indicate if Resident #4 accepted the prompt to void or if he refused. These were left blank.</p> <p>On 11/24/13, "Incontinence Tracking Day #3" form was started. The instructions for Day 3 state, "Prompt void every 2 hours for 24 hours. Greet resident. Wait 5 seconds for the resident to self-initiate request to toilet." The form indicated Resident #4 was "Dry" 14 times and "Incontinent" 9 times. 1 hour was not documented. Again, staff did not document if Resident #4 was prompted to void every 2 hours, however there was documentation that he voided 3 times in the 24-hour period.</p>	F 315			

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F 315	<p>Continued From page 157</p> <p>By not consistently offering and/or documenting toileting activities, the evaluator cannot accurately determine an individualized program to assist Resident #4 in restoring as much normal bladder function as possible.</p> <p>On 6/5/14, Surveyor #16041 spoke with the DON about the bladder assessments. The DON indicated it is her expectation that staff assist residents to the bathroom. Surveyor #16041 asked if staff should wait for residents cognitive impairments to request to use the bathroom. The DON stated staff should not wait, they should be prompting the resident to use the bathroom. The DON indicated staff should be documenting this in "Care Tracker." Surveyor #16041 requested a copy of Resident #4's bladder activity from Care Tracker.</p> <p>On 6/5/14, Surveyor #16041 received the information. According to the report Resident #4:</p> <p>~Was incontinent 2 times and continent 2 times on 11/22/13; ~Was incontinent 2 times on 11/23/13; and, ~Was incontinent 2 times on 11/24/13.</p> <p>The additional information did not demonstrate that resident was toileted every 2 hours and/or every hour depending on the day of the Incontinence Tracking.</p> <p>Review of Resident #4's Progress Notes and Post Fall Investigations found that Resident #4 has had 4 falls in the last 3 months directly related to his incontinence. (Refer to F323.) Despite this, staff did not re-evaluate Resident #4's voiding patterns and bladder incontinence to develop and implement an individualized toileting</p>	F 315			

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F 315	Continued From page 158 program. Example #3: Surveyor #25803 completed a review of Resident #7's clinical record and noted the following. Resident #7 had current diagnoses including, but not limited to, congestive heart failure, anxiety, and historical UTIs. Resident #7's most current MDS (Minimum Data Set) was dated 5/15/14 and indicated Resident #7 had a severe cognitive impairment and required the assistance of 1 to 2 staff persons for all aspects of care. The MDS also indicated Resident #7 had a UTI in the last 30 days. Resident #7's elimination care plan, dated 5/6/12, directed staff to assist Resident #7 with "...check and change..." Resident #7 every 2 to 3 hours. Surveyor #25803 completed a review of Resident #7's urine cultures. Surveyor #25803 noted Resident #7 had a positive urine culture indicating a UTI on 5/9/14. Resident #7 was treated with an antibiotic. On 6/3/14 at 9:00 p.m., Surveyor #25803 observed CNA-GG (Certified Nursing Assistant) assist Resident #7 with incontinent care. Surveyor #25803 noted Resident #7's adult brief was saturated with both urine and stool. CNA-GG completed frontal peri care. Surveyor #25803 noted during frontal peri care that CNA-GG needed to complete multiple swipes in	F 315			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 315	Continued From page 159 order to remove all stool which had collected around Resident #7's meatus (entrance to urethra) and vaginal area. Surveyor #25803 spoke with CNA-GG following the observation. CNA-GG indicated she started work at 2:30 p.m. Surveyor #25803 asked CNA-GG when she last assisted Resident #7 with incontinence care. CNA-GG stated she hadn't been able to get to Resident #7 until she put her to bed at 9:00 p.m. Resident #7 was not assisted with incontinence cares for at least 6 hours and 30 minutes. On 6/11/14 at 8:15 a.m., Surveyor #25803 spoke with LPN-AA (Licensed Practical Nurse). LPN-AA indicated she expected the CNAs to follow resident care plans. LPN-AA stated if the CNAs were unable to complete a task including toileting, they were to let the nurse know.	F 315			
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility did not ensure that the resident environment was free from hazards	F 323			

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/25/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-GOLDEN AGE			STREET ADDRESS, CITY, STATE, ZIP CODE 720 E KINGS RD TOMAHAWK, WI 54487		
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F 323	<p>Continued From page 160 and/or that adequate supervision was provided. The deficient practice has the potential to affect more than a limited number of residents.</p> <p>On 6/11/14, water temperatures were found to be 120 degrees F (Fahrenheit). Maintenance staff indicated the mixing valve on the new boiler is in a location where it can be easily bumped. Despite this knowledge, temperatures were only checked once a day at the boiler and not in resident rooms, and no actions were taken to prevent an increase in water temperatures creating a hazard that has the potential to affect more than a limited number of residents.</p> <p>Since admission to the facility on 12/16/13, Resident #2 has had 10 falls. After each fall the facility did not critically analyze the fall and place appropriate interventions based on the the root cause of the fall. Resident #2 consequently had many falls, including injury falls.</p> <p>Since admission to the facility on 4/1/14, Resident #5 has had 4 falls. After each fall the facility did not critically analyze each fall and place appropriate interventions based on the root cause of the fall.</p> <p>Resident #8 has had 5 falls in the last 2 months. 3 of the falls were related to incontinence, yet there was no new bladder assessment completed to determine an individualized toileting plan.</p> <p>Resident #4 has had 5 falls in the last 3 months. 4 of the falls were related to incontinence, yet there was no new bladder assessment completed to determine an individualized toileting plan. After each fall, the facility did not develop and implement individualized approaches to prevent</p>	F 323			

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F 323	<p>Continued From page 161 Resident #4 from falling again.</p> <p>Resident #12 had a fall from bed. The facility's investigation found the bed alarm did not sound. There was no evidence that the alarm was reevaluated to determine if it remained appropriate for Resident #12. In addition, no new interventions to assist Resident #12 from rolling out of bed were implemented.</p> <p>This is evidenced by:</p> <p>The facility's "Falls Management Clinical Guidelines" dated 2013 states, "Following a resident's fall...Appropriate interventions are implemented...Care plan is updated."</p> <p>Example #1:</p> <p>According to Appendix PP of the State Operations Manual, a third degree burn (burn through all layers of skin and potentially through fat and muscle) can occur in 5 minutes if water temperatures are at 120 degrees Fahrenheit. Older adults have thinner skin, so hot liquids can cause deeper burns in even less time.</p> <p>On 6/11/14 at 11:45 a.m., Surveyor #30570 tested the water temperature in the bathroom sink in room 76. The water temperature was noted to be 120 degrees. Surveyor #30570 immediately checked the water temperature in room 35. The water temperature again registered at 120 degrees. Surveyor #30570 asked Resident #14, who resides in room 35, if her water has been hot. Resident #14 indicated her water has been "hot enough to make a cup of instant coffee."</p> <p>Surveyor #30570 immediately summoned M-R.</p>	F 323			

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F 323	<p>Continued From page 162</p> <p>Surveyor #30570 informed M-R of the water temperatures in the resident bathrooms. M-R checked the water gauge in the boiler room and informed Surveyor #30570 the water within the facility was running 120 degrees, indicating some one must have "bumped" the control valve when putting things away in the room. M-R further indicated the facility installed a new boiler in January 2014. With the installation of the new boiler, the location of the control valve moved from a wall mounted valve to a valve that hangs down from the boiler into the room. M-R indicated since the installation, he has had problems with people "bumping" the control valve. M-R further explained he had removed the handle of the control valve due to it being bumped. He further explained that the water takes time to drop in temperature.</p> <p>M-R expressed the water temperature is checked on a daily basis and routinely runs at 114 degrees. Surveyor #30570 asked M-R if records of his daily water temperatures are maintained. M-R provided Surveyor #30570 with a form titled "Preventative Maintenance for Golden Living Center-Golden Age." The form with an open date of 6/10/14 indicated the following:</p> <p>Meter Readings: Location: East-Last: 114 degrees F Location: West-First: 114 degrees F Location: West-Last: 114 degrees F Location: ACU-First: 114 degrees F Location: ACU-Last: 114 degrees F Location: New-First: 114 degrees F Location: New-Last: 114 degrees F</p> <p>Surveyor #30570 asked M-R what his response is when the water temperatures reach a high</p>	F 323			

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F 323	<p>Continued From page 163</p> <p>temperature. M-R responded the temperatures had never reached 120 degrees in the past. He further indicated he would inform the DON/nursing staff immediately.</p> <p>On 6/11/14 at 2:45 p.m., Surveyor #30570 met with the NHA regarding the water temperatures. Surveyor #30570 asked the NHA if he was aware of the water temperature concerns and the concern related to the control valve being "bumped." The NHA indicated he was not aware.</p> <p>Example #2:</p> <p>Surveyor #25803 completed a review of Resident #2's clinical record and noted the following.</p> <p>Resident #2's admitting diagnoses included, but not limited to, dementia, anxiety, and PTSD (Post Traumatic Stress Disorder).</p> <p>Resident #2's most current MDS (Minimum Data Set) was dated 3/25/14. The MDS indicated Resident #2:</p> <ul style="list-style-type: none"> ~ Was usually understood and sometimes understands; ~ Had a BIMS score of 0 indicating a severe cognitive impairment; ~ Had symptoms of delirium including inattention and disorganized thinking which did fluctuate; ~ Walked with supervision; ~ Required limited to extensive for bathing, dressing, grooming, eating, and using the bathroom; ~ Was frequently incontinent of bladder and always incontinent of bowels; and ~ Had 3 falls. 	F 323			

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F 323	<p>Continued From page 164</p> <p>Resident #2's CAA (Care Area Assessment) for falls was dated 12/27/13. The CAA indicated Resident #2 was at risk for falls, but had no falls prior to admission or since admission.</p> <p>Resident #2's fall care plan was dated 12/16/13. The care plan had the following approaches:</p> <p>~ 12/16/13, "...encourage rest periods daily to avoid overtiring...footwear to prevent slipping...keep environment well lit and free from clutter. Be mindful that food carts are in high traffic areas...as he mistaken it for a place to sit...evaluate...impact of medications [sic]..."</p> <p>~ 1/9/14, "...Gripper socks, family to take wool socks home...Observe for side effects of medications...Offer chair when noticing he is fatigued. Inform resident of where bed/chair is..."</p> <p>~ 5/29/14, "...Redirect when resident attempts to move furniture/chairs. Offer assist with ambulation/transfers as resident will tolerate..."</p> <p>~ 6/2/14, "...Broda chair with self release belt..."</p> <p>The facility utilized a form titled, "Post Fall Investigation/Plan" for documenting falls, fall analysis, and recommendations for interventions to prevent further falls.</p> <p>Surveyor #25803 completed a review of Resident #2's "Post Fall Investigation/Plan" forms since admission and noted the following.</p> <p>On 1/9/14, Resident #2 was found on the floor next to his bed. The facility noted Resident #2 was wearing wools socks which had no traction. The facility implemented gripper sock.</p> <p>On 2/2/14, Resident #2 was observed to be trying to sit on the food cart. Resident #2 was</p>	F 323			

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F 323	<p>Continued From page 165</p> <p>witnessed to fall onto his buttock when the food cart moved.</p> <p>Recommendations were to offer Resident #2 to rest on a dining room chair, and to keep the food carts out of high traffic areas.</p> <p>These 2 approaches had previously been care planned.</p> <p>On 2/15/14, Resident #2 was found crawling on the floor. A CNA (Certified Nursing Assistant) also reported while placing an adult brief, Resident #2 attempted to sit down without a chair behind him. The CNA consequently lowered Resident #2 to the floor.</p> <p>The first incident of Resident #2 found crawling on the floor was not documented as a fall. There was no investigation completed. After the second fall, there was no indication Resident #2 was assessed. There were no vital signs documented. There was no assessment of potential injury documented. According to the report, Resident #2 had been incontinent of bladder and had a staggered gait at times. Recommendations were to instruct Resident #2 where the bed was when giving cares.</p> <p>There was no assessment of Resident #2's bladder status to determine if Resident #2's current toileting plan was appropriate. There was no investigation into why Resident #2's gait had changed.</p> <p>On 5/5/14, Resident #2 lost his balance and fell onto his buttock when another resident entered his room. Resident #2 sustained a reddened area to the buttock. The facility identified</p>	F 323			

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F 323	<p>Continued From page 166</p> <p>Resident #2 had weakness, an unsteady gait, and weight loss. There was, however, no indication the facility clinically assessed the reason Resident #2 lost his balance and fell backwards. The facility obtained a pelvic and left hip x-ray. Both were negative for a fracture. There were no new approaches added to Resident #2's plan of care to prevent further falls.</p> <p>On 5/29/14, Resident #2 was witnessed to fall backwards onto his buttock when pushing a chair in the dining room. Resident #2 complained of back pain and sustained a contusion to the left elbow. The facility implemented to redirect Resident #2 when pushing furniture and to offer assistance for ambulation and transfers as Resident #2 would allow. This was Resident #2's second fall in which he fell backwards. While the facility implemented approaches, they were not based on a comprehensive assessment addressing the possible cause of the fall.</p> <p>On 5/31/14, Resident #2 was walking with a CNA to the bathroom when he became weak and was assisted to his knees. The facility implemented the use of a wheelchair for longer distances as Resident #2 would tolerate. This was not added to Resident #2's plan of care.</p> <p>On 6/1/14, Resident #2 was ambulating on the unit when he was noted to fall backwards striking his head on a wall. Resident #2 sustained an abrasion to the back of the head and complained of head pain. There were no new interventions added to Resident #2's care plan to prevent further falls.</p> <p>On 6/2/14 at 7:55 a.m., Resident #2 stood up from the dining room table and began to walk.</p>	F 323			

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F 323	<p>Continued From page 167</p> <p>While turning, Resident #2 lost his balance and fell onto his buttocks. There were no new interventions added to Resident #2's care plan to prevent further falls.</p> <p>On 6/2/14 at 12:00 p.m., Resident #2 was found sitting on the floor in the TV room. A nursing notes dated 6/2/14 indicated, "...Has been extremely agitated today and unable to sit for more than a few minutes at a time. Would pace to the point of being SOB (short of breath)..." Resident #2 sustained a skin tear to the left elbow. There were no new approaches added to Resident #2's plan of care to prevent further falls.</p> <p>On 6/2/14 at 2:35 p.m., Resident #2 was noted on the floor in the resident lounge. Prior to this time, Resident #2 had been noted as restless and ambulating in the hall. The facility placed Resident #2 into a Broda wheelchair with a seat belt.</p> <p>On 6/10/14 at 4:40 p.m. Surveyor #25803 spoke with LPN-V (Licensed Practical Nurse) about the facility's fall prevention program. LPN-V stated the nurses on the floor were responsible to begin the process of an investigation to determine the root cause of a fall and place an immediate intervention to prevent further falls. LPN-V stated the new interventions were then placed onto the care plan by the DON (Director of Nursing).</p> <p>On 6/11/14 at 3:10 p.m., Surveyor #25803 spoke with the DON about the facility's fall management program. The DON indicated she expected the nurses on the floor to investigate the cause of a fall and place immediate interventions. The DON indicated she reviewed all falls and adds to the fall report as needed. The DON stated falls were</p>	F 323			

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F 323	<p>Continued From page 168</p> <p>also reviewed at the facility's daily interdisciplinary meetings for added suggestions for fall prevention.</p> <p>Surveyor #25803 asked the DON about Resident #2's falls. The DON indicated Resident #2 had a dramatic decline in condition. The DON stated Resident #2 was very weak but still restless. The DON stated Resident #2 had multiple falls in one day. Surveyor #25803 asked the DON if the facility attempted 1:1 for Resident #2. The DON stated, "Not for any extended period of time." Surveyor #25803 asked the DON why. The DON stated she didn't know why.</p> <p>Numerous staff indicated that falls have increased because of the lack of staffing and the inability of staff to supervise residents. Cross reference F353.</p> <p>Example #3:</p> <p>Surveyor #25803 completed a review of Resident #5's clinical record and noted the following.</p> <p>Resident #5 had current diagnoses including but not limited to arthritis, dementia, and anxiety.</p> <p>Resident #5's most current MDS (Minimum Data Set) dated 5/8/14 indicated Resident #5:</p> <p>~Had a BIMS (Brief Interview for Mental Status) score of 0, indicating a severe cognitive impairment;</p> <p>~Had symptoms of delirium including inattention and disorganized thinking;</p> <p>~Had mood indicators of difficulty concentrating and being abnormally restless and fidgety;</p> <p>~Required extensive assistance with bathing,</p>	F 323			

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F 323	<p>Continued From page 169</p> <p>dressing, grooming, using the bathroom, and eating; ~Walked only once or twice; ~Was frequently incontinent of bladder and occasionally incontinent of bowels; ~Had a urinary tract infection in the last 30 days; ~Is not able to maintain balance without staff support; and ~Had 2 non-injury falls.</p> <p>Resident #5's fall care plan, dated 2/1/14, had the following approaches:</p> <p>~2/1/14, "...anti tippers...Call light or personal items available and in easy reach...foot wear to prevent slipping...environment well lit and free of clutter...Broda chair..." ~3/3/14, "...Offer resident activities...self release belt...w/chr (wheelchair) alarm..." ~3/27/14, "...Pain assessment...Sleep eval (evaluation) PT (Physical Therapy) screen Fall Prevention Program..." ~4/21/14, "...Toilet q (every) 2-3 hours..." ~5/1/14, "...Restraint belt..."</p> <p>Resident #5's most current fall risk assessment was dated 5/28/14. It indicated Resident #5 was at high risk for falls.</p> <p>Surveyor #25803 completed a review of Resident #5's nursing notes. On 2/1/14, an admission nursing note indicated the facility placed a seat belt on Resident #5's chair, a bed alarm, and landing strips at the bedside for fall prevention.</p> <p>These interventions were not added to Resident #5's plan of care.</p> <p>A nursing note on 2/8/14 indicated an alarm had</p>	F 323			

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F 323	<p>Continued From page 170 been added to Resident #5's chair.</p> <p>This was not added to Resident #5's plan of care.</p> <p>The facility utilized a form titled "Post Fall Investigation/Plan" which includes details regarding a resident fall, root cause analysis, and proposed interventions to prevent further falls.</p> <p>Surveyor #25803 completed a review of a "Post Fall Investigation/Plan" dated 3/4/14, regarding Resident #5's fall on 3/4/14. The form indicated Resident #5 had a fall out of the wheelchair while at an activity, had release the wheelchair seat belt, and had been incontinent. The root cause of the fall was noted as "restlessness."</p> <p>Recommendations to prevent further falls included to assess the need for an alarming seat belt in the wheelchair and to offer table top activities.</p> <p>According to Resident #5's nursing notes, an alarm had already been placed on the wheelchair. According to Resident #5's care plan, offering activities had already been care planned. Additionally, facility information indicated Resident #5 became restless when needing to use the bathroom. There was no indication the facility assessed Resident #5's bladder status to determine if Resident #5's toileting plan needed to be changed.</p> <p>Surveyor #25803 completed a review of a nursing note dated 3/8/14. The nursing note indicated Resident #5 had a seat belt, an alarm, and a lap buddy on the Broda chair. Surveyor #25803 was unable to determine when the lap buddy was placed. The use of a lap buddy was not noted on Resident #5's plan of care.</p>	F 323			

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F 323	<p>Continued From page 171</p> <p>Surveyor #25803 completed a review of a "Post Fall Investigation/Plan" dated 3/28/14. The form indicated Resident #5 had a fall on 3/27/14 while attempting to self transfer from the Broda chair after removing the lap buddy and seat belt. The root cause of the fall was noted as "restlessness."</p> <p>The form indicated the facility assessed Resident #5's pain, sleep, and requested physical therapy to assess. There were, however, no immediate approaches added to Resident #5's plan of care to prevent further falls.</p> <p>Surveyor #25803 completed a review of a "Post Fall Investigation/Plan" dated 4/22/14. The form indicated Resident #5 had a witnessed fall on 4/21/14 when staff observed Resident #5 lean forward then fall from the Broda chair. The form also indicated Resident #5 had been incontinent of urine.</p> <p>The root cause of the fall was again noted as "restlessness." New interventions to prevent further falls included to assist Resident #5 to the bathroom every 2 to 3 hours, to keep in line of sight, and ensure the lap buddy was in place.</p> <p>Resident #5's toileting program already included assisting with toileting every 2 to 3 hours. Keeping Resident #5 in line of sight was not added to Resident #5's care plan.</p> <p>Surveyor #25803 completed a review of a "Post Fall Investigation/Plan" dated 5/2/14. The form indicated Resident #5 had a fall on 5/1/14 from the Broda chair. The form indicated, "...Observed propelling self in wchr (wheel chair) per his usual just seconds before incident. Had Velcro self</p>	F 323			

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F 323	<p>Continued From page 172 release on, wchr alarm in place..."</p> <p>According to investigation, Resident #5 did not have the lap buddy on at the time of the fall.</p> <p>On 5/1/14, the facility placed a restraint.</p> <p>On 6/10/14 at 4:40 p.m., Surveyor #25803 spoke with LPN-V about the facility's fall management program. LPN-V stated the nurses on the floor were to begin the investigation into a fall and put immediate interventions into place following a fall. LPN-V stated she did not enter new approaches onto the care plan. LPN-V stated the DON (Director of Nursing) enters all new approaches onto care plans.</p> <p>On 3/11/14 at 3:10 p.m., Surveyor #25803 spoke with the DON about their fall management program. The DON indicated she expected the nurses on the floor to complete the initial investigation, determine the root cause of the fall, and place immediate interventions to prevent further falls. The DON indicated the facility interdisciplinary team then reviews falls during their morning meeting. Surveyor #25803 asked the DON if she ever implemented 1:1 for Resident #5. The DON indicated not for any extended periods of time.</p> <p>Example #4:</p> <p>Resident #8 was admitted to the facility on 11/12/10. Diagnoses include, but not limited to, Alzheimer's Disease, Urinary Incontinence and Congestive Heart Failure.</p>	F 323			

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F 323	<p>Continued From page 173</p> <p>Review of Resident #8's Annual MDS (Minimum Data Set) assessment dated 10/26/14, Quarterly Review MDS dated 4/28/14, CAAs (Care Area Assessment), progress notes, fall investigations and care plan lists:</p> <p>~MDS dated 10/26/14, indicated Resident #8 is severely cognitively impaired and is independent with transfers, bed mobility and ambulation. She is frequently incontinent of bladder, requires limited assist with toilet use and assist of 1 staff. The CAAs, dated 11/5/13, triggered for urinary incontinence but not falls.</p> <p>Review of the Quarterly Assessment, dated 4/28/14, indicated she requires set up with supervision for transfers, ambulation in room, has fallen and is on a toileting program. Supervision with 1 assist for bed mobility, ambulation in hallway, and limited assist of 1 staff for toilet use.</p> <p>~Review of the last bladder and bowel assessment indicated a plan to provide assistance to toilet as needed (revised 11/11/13).</p> <p>~Resident #8's care plan, 3/16/12, includes a problem, "Alteration in elimination of bowel and bladder urge and functional incontinence related to diuretic use and dementia. Does not typically alert staff to toileting needs...Risk for falls..." Interventions: last dated on 3/17/12 included: "Provide direction to bathroom during day on rising, before and after meals, outings, naps, HS; prompt on first rounds at noc if she is awake..."</p> <p>~Progress note, dated 4/1/14, indicated a fall at 5:30 a.m.: "Resident found on the floor in her room in a puddle of urine...has been independent</p>	F 323			

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F 323	<p>Continued From page 174</p> <p>with transfers and toileting. Resident had bare feet, but was using her cane appropriately. Resident should probably wear tread socks to bed so that she has safe footwear if she gets up to the B/R [bathroom.]</p> <p>~Fall Investigation report indicates: ..."last toileted on 3/31/14 at 10:30 p.m., wet." Plan is to wear gripper socks, to be awakened and offered toileting on first rounds at night.</p> <p>~ Care plan revised. This intervention was already applied under the Incontinence Care Plan. On 4/1/14, Falls Care Plan: added was: "gripper socks to bed, toilet on 1st rounds at noc."</p> <p>~Progress note, dated 5/1/14, at 5:25 p.m."...Resident found seated on floor with back against recliner....Noted to have recent decline in cognition, tends to refuse cares, has been recently refusing meals...Resident had been offered incontinence cares x 2 just prior to incident, refused becoming agitated both times. Also noted by staff to have some hearing impairment even with hearing aids in place. Lost balance.</p> <p>~Care Plan updated on 5/1/14 for PT/OT screen for decline. Request UA, House Supplement BID and encourage staff to use non-threatening approach-possible signs as hearing is not good even with hearing aids.</p> <p>~Progress note, dated 5/12/14, 1:00 p.m. "Resident found on floor next to bathroom door in room, inc (incontinent) of urine...did not move left arm when directed...did not move left leg on command...NP (nurse practitioner) here and assessed resident...NP called MD and received orders to send to ER for further eval." Resident was hospitalized overnight. Returned with diagnoses of Mild CVA (stroke) and UTI (urinary</p>	F 323			

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F 323	<p>Continued From page 175</p> <p>tract infection).</p> <p>~Care plan updated on 5/12/14, "noted to have R (right) sided weakness - To ER (emergency room) for eval (evaluation). TIA (transient ischemic attack), UTI Admin ATB (antibiotic) as ordered. PT/ST on return. OT screen. Reassess amb. (ambulatory) status, whether should be indep (independent) with assistance device. Falls Prevention Program." Incontinence was not addressed.</p> <p>~Progress note, dated 5/14/14 at 2:10 p.m. "Resident found by cna staff sitting upright in the middle of the floor in her bedroom. Her playing cards placed neatly around her and water pitcher and glass placed upright next to her." ~Care plan updated on 5/14/14 to include: "cont. (continue) ATB - F/U (follow-up) UA when ATB completed. Offer assistance with meals -freq. (frequently) refuses causes agitation. Monitor food/fluid intakes - Family refused tube feeding. Suggest hospice referral - family to consider. Bedside table to play cards that does not roll."</p> <p>~Progress note, dated 5/27/14 at 12:45 p.m., "Resident found sitting on the floor on her buttocks in front of her bed. Resident is more confused and is unable to verbalize what happened. ~Investigation report, dated 5/27/14, indicated, "Rolls/slid out of bed. Responding to bladder and bowel. Bare feet. No time listed when last voided. She was wet... Plan: Bed alarm for safety. Offer assistance with toileting when she awakens, even if it is noon meal, may not always comply with same." ~Care plan, updated on 5/27/14, to monitor blood pressure, update physician. New order to discontinue Hydrochlorothiazide, Vit D3, Aricept.</p>	F 323			

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F 323	<p>Continued From page 176</p> <p>Change meds to 12 noon, resident has been noncompliant with taking some. F/U UA scheduled. Bed alarm and offer toileting immediately on awaking - even if at noon. Cont. PT/OT.</p> <p>Surveyor #25989 requested the latest bladder and bowel assessment. Reviewed 10/15/13 bladder and bowel assessment. Even though only 3 falls were related to bladder incontinence, all of these falls occurred in the last 2 months. There has been a change in condition and there was no evidence of a bladder assessment being completed to possibly prevent any further falls related to toileting needs.</p> <p>Example #5:</p> <p>Resident #4 was admitted to the facility on 11/21/13. Diagnoses include Alzheimer's Disease, Dementia with Behaviors, and BPH (Benign Prostatic Hyperplasia).</p> <p>BPH is the enlargement of the prostate gland. When enlarged, the gland compresses the urethra and impedes the flow of urine from the bladder (urine retention). This leads the person with BPH to have bladder frequency as well as urgency.</p> <p>Resident #4's care plan also includes a problem, "At risk for falls..." also initiated 11/21/13. Approaches include, "Activity programming... Assess for pain. Assist with transfer when unsteadiness noted. Call light or personal items available...Encourage rest periods daily... Staff to toilet prior to nap... Footwear to prevent</p>	F 323			

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F 323	<p>Continued From page 177 slipping..."</p> <p>Resident #4's care plan, dated 3/14/14, included a problem of "Alteration in elimination of bowel and bladder..." initiated on 11/21/13. One of the approaches for this problem is, "Prompt and assist to toilet q (every) 1 1/2 to 2 hours while awake as resident is not aware of appropriate time or place for elimination." This approach has been in place since 11/21/13.</p> <p>Surveyor #16041 reviewed Resident #4's Post Fall Investigation/Plans (denoted with ~) and noted the following:</p> <p>~3/19/14 at 10:35 a.m. "Resident sleeping on bed. Awakened for toileting. Came into hall and turned to go back to room. Lost balance and fell to knees and then leaned forward onto hands. Was wearing gripper socks at the time of incident...was soiled when found."</p> <p>Resident #4's care plan was updated on 3/19/14 to include, "Monitor for increased inc (incontinence) while not feeling well. 15 min (minute) safety checks...PT/OT (Physical Therapy/Occupational Therapy) screen for ambulation-tends to lean forward."</p> <p>~3/23/14 at 7:30 a.m. "...Went to room...and found [sic] res (resident) sitting on the floor by the door and night stand. There was a puddle of urine on the floor by the door and res briefs were wet..." Contributing factors, "Resident unaware of appropriate place for urination. Known to void on floor at times. Does wear incontinence protection. Does not alert staff to toileting needs. Known to void frequently. No footwear on at time of fall. Incontinence protection wet."</p>	F 323			

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F 323	<p>Continued From page 178</p> <p>Resident #4's care plan was updated on 3/23/14 to include, "...Toilet q 1 - 1/2 hours while awake. Awaken at noc (night) on rounds for toileting. Gripper socks at all times..."</p> <p>Resident #4's care plan had already included approaches of "footwear to prevent slipping," and was also to be toileted every 1 1/2 to 2 hours while awake, both of which were implemented on 11/21/13.</p> <p>~5/4/14 at 9:00 p.m. "Resident was at opposite end of corridor just prior to fall. Staff members heard thud and found resident on floor with another resident. They had not had verbal altercation prior to incident. No physical or verbal altercation after the incident."</p> <p>Resident #4 was on 15 minute checks at the time of the fall. According to documentation, staff completed the checks. There were no new interventions added to Resident #4's care plan to prevent a similar incident from occurring in the future.</p> <p>~5/31/14 at 4:00 p.m. "Resident bent down on hands and knees with buttocks exposed, having a BM (bowel movement) in the middle of the hallway..."</p> <p>Resident #4 was on 15 minute checks at the time of this fall. Resident #4's care plan was updated to include, "Nap period in bed in afternoon after toileting. Offer toileting q 2 hours as resident will tolerate." The rest period with toileting assistance prior was implemented on 11/21/13. Every 2 hour toileting was also implemented on 11/21/13. No new interventions were developed and</p>	F 323			

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F 323	<p>Continued From page 179 implemented.</p> <p>~6/2/14 at 10:45 a.m., "Resident found laying on his belly on the floor in his room. Had just woke up prior to this. He had been changed in bed prior and medications had been administered...Root cause of fall appears to be that resident awoke at 10:30 (a.m.) urinated on the floor outside his door, then had wet feet and returned to room causing fall..."</p> <p>Resident was on 15 minute checks at the time of this fall. Resident #4's care plan was updated to include, "Assist to BR (bathroom) immediately upon rising then q 2 hours while awake...15 min checks..." The toileting schedule had been implemented since 11/21/13. 15 minute checks were in place since 3/19/14 and were being signed as completed on all dates of the falls.</p> <p>On 6/9/14, Surveyor #16041 requested a copy of all Resident #4's Bladder Assessments and Incontinence Tracking forms. The only forms received were initiated on 11/21/13, the date of Resident #4's admission. Even though 4 falls were related to his bladder incontinence, there was no evidence of an assessment being completed.</p> <p>On 6/10/14 at 7:45 a.m., Surveyor #16041 asked the ACUD (Alzheimer's Care Unit Director) about the repetitive care plan interventions. The ACUD said staff were confused with all the toileting approaches especially when that approach was already in place. The ACUD said she does not do anything with the care plans.</p> <p>Example #6:</p>	F 323			

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F 323	Continued From page 180 Resident #12 was admitted to the facility on 3/28/11. Diagnoses include Vascular Dementia, Alzheimer's Disease, and a history of Stroke. Resident #12's care plan, dated 8/1/13, included a problem of "At risk for falls..." initiated on 5/7/11. Approaches include bed alarm, bed in low position, concave mattress, and mattress on floor beside bed. A Post Fall Investigation/Plan, dated 5/30/14, indicated at 1:00 a.m., Resident #12 was found to have rolled out of bed and onto the mattress at bed side. The alarm was not sounding when she was found, but was working properly when tested. The investigation surmised Resident #12 was leaning against the bed and was asserting enough pressure on the bed alarm to prevent it from sounding. The only interventions put into place were monitoring for pain, bloody stools, and anxiety. There was no review of the alarm to determine if it was appropriate knowing it may not sound.	F 323			
F 329 SS=J	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. Based on a comprehensive assessment of a	F 329			

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F 329	<p>Continued From page 181</p> <p>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 observations, interviews, and record reviews, the facility failed to ensure that residents who had not received antipsychotic medications were not given the medications and those residents who did receive them received gradual dose reduction, and behavioral interventions. This resulted in physical, mental and psychosocial declines to 2 of 13 residents (Residents #2 and #1) and created a finding of immediate jeopardy.</p> <p>1. Resident #2 had a diagnosis of dementia. Resident #2 entered the facility after living independently at home. Resident #2 came into the facility walking without any type of assistive device, continent of bowel and bladder, and requiring limited assistance with ADLs (Activities of Daily Living). Prior to entering the facility, Resident #2 had never been on any type of psychoactive medication.</p> <p>After admission to the facility, Resident #2</p>	F 329			

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F 329	<p>Continued From page 182</p> <p>developed distressing behaviors defined by the facility as anger, fighting, aggression toward others, pacing, combativeness, yelling, shouting, crying, weeping, agitation, restlessness, delusions, hallucinations, and attempting to elope. While the facility identified the behaviors, there was no indication the facility completed a comprehensive assessment of Resident #2's medical, physical, mental nor psychosocial status to determine underlying causes of Resident #2's distressing behaviors. There was no care plan implemented based on Resident #2's specific individual needs directing staff on how to manage Resident #2's behaviors to minimize and/or eliminate the behaviors in order to improve Resident #2's quality of life and well-being.</p> <p>Instead, over a period of less than 2 months, Resident #2 was also placed on multiple psychoactive medications including Zyprexa, Ativan, Xanax, Citalopram, Mirtazapine, and Clonazepam. During the time the medications were being ordered and given, there was no indication the facility attempted nonpharmacological interventions based on Resident #2's individual needs prior to administering the medication, there were never any changes made to Resident #2's plan of care, and behaviors were not specifically identified nor quantified. Additionally, behavior monitoring sheets indicated Resident #2 had behaviors only for a period of for approximately the first 2 weeks after admission.</p> <p>During the time frame in which these multiple medications were being utilized, Resident #2 had a significant decline in overall functioning. There was no consideration on the part of the facility if the psychoactive medications were causing the</p>	F 329			

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F 329	<p>Continued From page 183</p> <p>decline in Resident #2's condition and/or making Resident #2's distressing behaviors worse.</p> <p>Lack of completing a comprehensive assessment to determine the root cause of Resident #2's distressing behaviors, including a comprehensive medication review and implementing an individualized care plan based on Resident #2's specific needs, led to a significant decline in Resident #2's overall functioning including physical functioning, psychosocial well-being, anorexia and weight loss, and falls.</p> <p>On 6/10/14, Resident #2 had a significant change in condition and clergy was called to administer last rites.</p> <p>2. Resident #1 was receiving Namenda twice a day. Namenda is an Anti-Alzheimer medication used for moderate to severe Alzheimer's dementia which has numerous side effects including, but not limited to, aggressiveness, agitation, anxiety, confusion, depression, dizziness, fatigue, hallucinations, pain constipation, incontinence, dyspnea, pneumonia, upper respiratory tract infection and falls. The facility did not develop a care plan with measurable goals and/or interventions to monitor for side effects. There was no evidence that Namenda was considered for the increased behaviors since this was the first new drug ordered.</p> <p>Resident #1 was receiving Seroquel (antipsychotic) medication for a diagnosis of "Vascular Dementia with Delusions." Targeted behaviors being monitored did not include delusions. Resident #1 did have an altercation with another resident and staff that involved the</p>	F 329			

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F 329	<p>Continued From page 184</p> <p>police during 2 different episodes which initiated the Seroquel. The facility did not create or implement a care plan and nonpharmacological interventions in an attempt to manage the behavior sought to be treated by the Seroquel. The care plan had no measurable goals to evaluate the ongoing need for the medication. On 5/18/14, the order was increased without adequate indications to do so. There was no evidence that nonpharmacological interventions were put into place prior to increasing the dose. In addition, there was no evidence that the facility assessed for any physical underlying cause of the behavior.</p> <p>Resident #1 also had an order for Ativan for agitation and restlessness. The plan of care does not address use of an antianxiety medication and does not include nonpharmacological interventions in an attempt to manage behavior sought to be treated by the Ativan. The care plan had no measurable goals to evaluate the ongoing need for the medication. The facility did not monitor to determine the frequency of episodes of anxiety, despite the frequent use of Ativan prn.</p> <p>On 4/10/14, the order was increased without adequate indication. There was no evidence that nonpharmacological interventions were put into place prior to increasing the dose. In addition, there was no evidence that the facility assessed for any physical underlying cause of the behavior. Resident #1 received 2.5 mg (milligrams) on 4 separate days, which is an excessive dose for the elderly.</p> <p>Resident #1 also has an order for Fluoxetine HCL (antidepressant) every day for depression. Targeted behaviors being monitored are pacing,</p>	F 329			

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F 329	<p>Continued From page 185</p> <p>restlessness and fearful. The plan of care does not address the use of antidepressant medication use and does not include nonpharmacological interventions in an attempt to manage behavior sought to be treated by the antidepressant. The care plan had no measurable goals to evaluate the ongoing need for the medication.</p> <p>The failure to provide person-centered care for residents with dementia instead of antipsychotic medication created a finding of immediate jeopardy. The immediate jeopardy began on 6/3/14. The NHA (Nursing Home Administrator) and RN Consultant were notified of the immediate jeopardy on 6/23/14 at 3:45 p.m. The immediate jeopardy was not removed by the exit date of the survey.</p> <p>In addition to residents in immediate jeopardy, the facility failed to ensure:</p> <p>~2 of 13 residents receiving antipsychotic medications received gradual dose reductions, adequate indications for use, adequate monitoring, and did not receive excessive doses (Residents #3, and #4).</p> <p>~1 of 13 sampled residents was free from unnecessary medications (antibiotics), when there was no indication for use.</p> <p>3. Resident #3 was receiving psychotropic medication with no clear indication of its use, no justification, no behavior monitoring, no nonpharmacological individualized interventions in place prior to administration of the medication, and no underlying medical cause was assessed prior to administering a psychotropic medication such as pain.</p>	F 329			

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F 329	Continued From page 186 4. For Resident #4: ~A request for a GDR (gradual dose reduction) of Resident #4's Depakote was declined by the physician without evidence that the GDR would be clinically contraindicated; ~The dosage of Depakote was increased without adequate indications; ~After a GDR of Ativan was attempted, Resident #4 had an altercation with a peer. The dose was immediately increased back to the original dose without any nonpharmacological interventions attempted; ~Resident #4 continues to receive Ativan at an excessive dose for elderly residents without adequate indications. 5. Resident #11 received 3 courses of antibiotics without adequate indications for use. This is evidenced by: Example #1 (also cross reference F309): According to the "Nursing 2013 Drug Handbook," Zyprexa is an antipsychotic medication and used to treat schizophrenia and bipolar disorder. Adverse reactions include, sleepiness, dizziness, neuroleptic malignant syndrome, abnormal gait, personality disorder, tardive dyskinesia, fever, orthostatic hypotension (low blood pressure when standing), urinary incontinence, rigidity, sweating. Overdose signs and symptoms included, agitation, aggressiveness, reduced level of consciousness, delirium, neuroleptic malignant syndrome, hypertension (high blood pressure) or hypotension (low blood pressure). The "Nursing 2013 Drug Handbook" indicated, "...Black Box Warning Drug may increase risk of	F 329			

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F 329	<p>Continued From page 187</p> <p>cardiovascular or infection-related death in elderly patients with dementia...isn't approved to treat patients with dementia-related psychosis..."</p> <p>According to the "Nursing 2013 Drug Handbook," Ativan is an anxiolytic and used to treat anxiety. Adverse reactions include drowsiness, sedation, agitation, dizziness, weakness, unsteadiness, hypotension, nausea, change in appetite. Overdose signs and symptoms include drowsiness, confusion, lethargy, ataxia (balance problems), hypotension, coma, death.</p> <p>According to the "Nursing 2013 Drug Handbook," Xanax is an anxiolytic and used to treat anxiety and panic disorders. Adverse reactions include insomnia, irritability, dizziness, anxiety, confusion, drowsiness, sleepiness, impaired coordination, ataxia, lethargy, restlessness, agitation, nightmare, syncope, hypotension, nausea, increased or decreased appetite, anorexia, increased sweating, and feeling warm.</p> <p>According to the "Nursing 2013 Drug Handbook," Citalopram is an antidepressant and used to treat depression. Adverse reactions include, sleepiness, orthostatic hypotension, anorexia, anxiety, agitation, dizziness, confusion, and fever.</p> <p>According to the "Nursing 2013 Drug Handbook," Mirtazapine is an antidepressant. Adverse reactions include sleepiness, dizziness, abnormal thinking, and confusion.</p> <p>According to the "Nursing 2013 Drug Handbook," Clonazepam is an anticonvulsant medication and used to treat seizures and panic disorders. Adverse reactions include drowsiness, agitation, ataxia, behavioral disturbances, confusion,</p>	F 329			

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F 329	<p>Continued From page 188 anorexia, and changes in appetite.</p> <p>All of the above drugs, with the exception of Mirtazapine, can cause anorexia, hypotension, and agitation.</p> <p>Resident #2's admitting diagnoses included, but were not limited to, dementia, anxiety, and PTSD (Post Traumatic Stress Disorder).</p> <p>Resident #2's admission MDS (Minimum Data Set) dated 12/23/13 indicated Resident #2: ~ Was able to make self understood and usually understood verbal content; ~ Had a BIMS (Brief Interview for Mental Status) score of 1, indicating a severe cognitive impairment; ~ Had delirium including inattention, and disorganized thinking which did not fluctuate; ~ Had no mood indicators; ~ Had verbal behavior symptoms 1 to 3 days; ~ Walked independently with supervision; ~ Required limited staff assistance with bathing, dressing, grooming, and using the toilet; ~ Frequently incontinent (of notation Resident #2's admission 3-day bladder log dated 12/16/13 through 12/18/13 indicated Resident #2 had 1 incontinent episode over the 3-day period); ~ Had no pain or falls; and ~ Weighed 144 pounds.</p> <p>Resident #2's most current MDS was dated 3/25/14 and showed a significant decline in his condition. Specifically, the MDS indicated Resident #2: ~ Was usually understood and sometimes understands; ~ Had a BIMS score of 0, indicating a severe cognitive impairment;</p>	F 329			

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F 329	<p>Continued From page 189</p> <ul style="list-style-type: none"> ~ Had symptoms of delirium including inattention and disorganized thinking which did fluctuate; ~ Had 3 mood indicators; ~ Rejected care, wandered, ~ Walked with supervision; ~ Required limited to extensive for bathing, dressing, grooming, eating, and using the bathroom; ~ Was frequently incontinent; ~ Had 3 falls; and ~ Weighed 120 pounds. <p>Observations made by Surveyor #25989 and #25803 during the course of the survey indicated Resident #2 had a further decline in overall functioning from March to June 2014. Resident #2 now requires extensive assistance of 1 to 2 staff persons for all aspects of care, including walking, has had numerous falls, and has had continued weight loss. (Refer to F274.)</p> <p>Resident #2's most current CAA (Care Area Assessment) for behavior was dated 12/17/13. Several components of the CAA are incomplete including "Nature of the behavior...Medication side effects...Illness or conditions that can cause behavior...Factors that can cause or exacerbate the behavior..." The CAA indicated, "... resident has verbal symptoms directed at others... Resident is a new admission...displayed verbal aggression towards others with recent placement...new orders for additional anti-anxiety medications, family...comes to facility when aggressive behavior displayed...Staff has discovered watching church videos are calming...bathing appears to calm resident...Will proceed to care plan to minimize risk and continue with interventions to calm resident at times of increased anxiety..."</p>	F 329			

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F 329	<p>Continued From page 190</p> <p>The CAA did not clinically assess nor critically analyze Resident #2's behaviors.</p> <p>Resident #2's behavior care plan was dated 12/16/13. The care plan indicated Resident #2 had behaviors of yelling, shouting, crying, agitation, combativeness, aggression, restlessness, and anger. The care plan had the following approaches:</p> <p>~ 12/16/13, "...Assist me to watch church video...Attempt interventions before my behaviors begin...Do not seat me around others who disturb me...Give me medications my doctor has ordered...Help me maintain my favorite place to sit...Help me avoid situations or people that are upsetting to me...may call family to assist in redirection...Let my physician know...if my behaviors are interfering with my daily living...Make sure I am not in pain... Offer me something I like as a diversion...tell me what you are going to do before you begin...Reduce external stimuli as possible, speak in gentle, calm, soft but firm voice..."</p> <p>~ 12/18/13, "...may bath to assist with calming..."</p> <p>~ 1/2/14, "...Administer medications as ordered..."</p> <p>~ 1/31/13, "...Monitor for s/sx (signs and symptoms) of anxiety towards others and attempt redirection..."</p> <p>None of the above interventions, with the exception of 2, are individualized based on Resident #2's specific needs.</p> <p>Surveyor #25803 completed a review of a facility form titled "Social History". Resident #2's "Social History" was not dated. It indicated Resident #2</p>	F 329			

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F 329	<p>Continued From page 191</p> <p>worked on a farm and worked as a painter, liked watching TV, bingo, gardening, and being out in the sun. The "Social History" did not include Resident #2's prior life patterns and preferences, and customary responses to things such as stress, anxiety, pain, hunger, and fatigue. The "Social History" did not include information obtained by Resident #2's family regarding how they managed Resident #2's responses to stressors while at home. The "Social History" also did not include Resident #2's life's pleasures.</p> <p>Surveyor #25803 completed a review of a hospital record dated 12/16/13 and titled "Discharge Summary." The "Discharge Summary" indicated Resident #2 lived at home. The "Discharge Summary" indicated Resident #2 was taken to the hospital after found wandering outside in the early morning hours. The "Discharge Summary" indicated, "...had several episodes, during this admission, where he seemed to be remembering events from the Korean War. At times, he would get somewhat emotional...On several occasions he did become a little agitated and he did make an attempt to leave the hospital...They found that if they walked him around and kept him busy, that he did better. Additionally, if he would sit with staff members, he did much better...he did have...Lorazepam (antianxiety medication)...Zyprexa (antipsychotic medication) order which he did not require..."</p> <p>The "Nursing Section" of the hospital discharge records indicated, "...enjoys sitting where there are people around. Needs supervision at all times. Continent bowel/bladder...No behaviors or agitation while hospitalized the last few days. Likes to be kept busy..."</p>	F 329			

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F 329	<p>Continued From page 192</p> <p>The facility did not capture the information regarding Resident #2 being a war veteran including flash backs from the war. There was no care planned direction to staff on how to manage Resident #2's flash backs.</p> <p>Surveyor #25803 completed a review of Resident #2's medication regimen. Dates the medications were started and/or changed are as follows. All drugs are noted in milligrams (mg).</p> <p>Zyprexa 12/16/13 2.5 mg every day as needed. 12/28/13 2.5 mg every day. 12/30/13 2.5 mg twice a day. 1/12/14 5.0 mg twice a day. 2/7/14 10 mg every day. 5/28/14 7.5 mg every day. 6/2/14 10 mg every day. 6/4/14 7.5 mg every day for one week. 6/12/14 5 mg every day.</p> <p>(Of note, surveyors entered the facility on 6/3/14 to begin the investigation.)</p> <p>Ativan 12/16/13 0.5 mg twice a day as needed. 12/19/13 0.5 mg every 4 hours as needed. 12/23/13 0.5 mg three times a day. On 12/30/13 the Ativan was discontinued.</p> <p>Xanax 1/3/14 0.5 mg three times a day as needed. 1/10/14 0.5 mg every day at bed time. Both doses of Xanax were discontinued on 2/12/14.</p> <p>Citalopram 2/3/14 2.5 mg every day.</p>	F 329			

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F 329	<p>Continued From page 193</p> <p>2/24/14 5.0 mg every day. This was the dose at the time of the survey.</p> <p>Mirtazapine 2/26/14 7.5 mg every day at bedtime. 3/19/14 15 mg every day at bedtime. 6/4/14 7.5 mg every day at bedtime. This was the dose at the time of the survey, which started 6/3/14.</p> <p>Clonazepam 2/12/14 0.5 mg twice a day. This was discontinued on 3/10/14. 2/12/14 0.5 mg every day as needed. This was discontinued on 3/10/14. 3/10/14 0.5mg three times a day as needed. This was the dose at the time of the survey, which started 6/3/14.</p> <p>From 12/16/13 through 2/12/14, all of the above medications were started with the exception of Mirtazapine. This was a period of less than 2 months.</p> <p>According to facility records, mirtazapine was started in an attempt to improve Resident #2's appetite.</p> <p>The facility utilized a form titled "Behavior Monthly Flow Sheet." Surveyor #25803 completed a review of Resident #2's "Behavior Monthly Flowsheets" and noted the following:</p> <p>~ December 2013. From the date of admission through 12/24/13, there were no behaviors documented. From 12/25/13 through 12/30/13, there were daily behaviors documented. Targeted behaviors were noted as "agitation," "pacing," and "striking out." The behaviors were</p>	F 329			

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

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F 329	<p>Continued From page 194</p> <p>not quantified. Documentation for the night shift was blank on all days.</p> <p>~ January 2014. From 1/1/14 through 1/7/14, the form is blank. From 1/8/14 through 1/13/14, Resident #2 had 7 episodes of behavior documented. Documentation on the night shift was blank for the entire month. Targeted behaviors were noted as "angry," "danger to others," and "fighting." The behaviors were not quantified.</p> <p>~ February 2014. From 2/1/14 through 2/28/14, Resident #2 had 23 episodes of behavior documented. Documentation on the day and evening shifts was not consistently completed. There was no night documentation for the entire month. Targeted behaviors were noted as "angry," "danger to others," and "fighting." The behaviors were not quantified.</p> <p>~ March 2014. From 3/1/14 through 3/31/14, Resident #2 had 3 episodes of behavior documented. Targeted behaviors were noted as "angry," "fighting," and "danger to others." Documentation on the day and evening shifts was not consistently completed. There was no night documentation for the entire month. The behaviors were not quantified.</p> <p>~ April 2014. From 4/1/14 through 4/30/14, there were no episodes of behavior documented. Targeted behaviors were noted as "angry," "fighting," and "danger to others." Documentation again on the day and evening shift was not consistently completed and there was no night documentation the entire month.</p> <p>~ May 2014. From 5/1/14 through 5/31/14, there</p>	F 329			

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F 329	<p>Continued From page 195</p> <p>were no episodes of behavior documented. Targeted behaviors were noted as "angry," "fighting," danger to others." Documentation again on the day and evening shift was not consistently completed and there was no night documentation the entire month.</p> <p>Surveyor #25803 completed a review of a facility form titled "Side Effects Monthly Flow Sheet." The form directed the user to code a multitude of side effects including hypotension, drowsiness, increased falls, anxiety, agitation, sweating, weakness, weight change, confusion, insomnia.</p> <p>Surveyor #25803 completed a review of Resident #2's "Side Effects Monthly Flow Sheet" from 12/16/13 through 6/5/14 except January 2014 flow sheet. January 2014 flow sheet was not received by Surveyor #25803. The "Side Effects Monthly Flow Sheet" indicated for all months reviewed, Resident #2 had indicators of potential side effects on only 2 occasions, both noted as drowsiness. None of the months reviewed were consistently completed on the day and evening shift. There was no night shift documentation during any month reviewed.</p> <p>Surveyor #25803 completed a review of Resident #2's nursing notes and MARs (Medication Administration Records) and noted the following:</p> <p>On 12/16/13 a nursing note indicated Resident #2 had been admitted to the facility. The nursing note indicated, "...Smiling & (and) pleasant...family reports appetite very good...ambulates independently & has had no recent falls per family...Requires set-up & cues by staff for all ADLs (Activities of Daily Living)..."</p>	F 329			

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F 329	<p>Continued From page 196</p> <p>According to the MAR, on 12/16/13, Resident #2 received Ativan 0.5 mg once. There was no indication for why, and no indication if nonpharmacological interventions were attempted prior to administering Ativan.</p> <p>On 12/17/13, a nursing note indicated, "...doing well with his new environment...had one episode of crying during lunch was given a PRN (as needed)..."</p> <p>According to the MAR, on 12/17/13, Resident #2 received Ativan 0.5 mg once. According to the nursing notes, Ativan was given for a one-time episode of crying. There was no indication that nonpharmacological interventions were attempted prior to administering the Ativan.</p> <p>On 12/18/13, there were no nursing notes.</p> <p>According to the MAR, Resident #2 was given 2 doses of Ativan. There was no indication why and no indication that nonpharmacological interventions were attempted prior to administering Ativan.</p> <p>On 12/19/13, a nursing note indicated, "...very restless, agitated, angry. Attempting to strike another resident. Yelling out at resident...pacing, shaking fists...Stated that he was going to 'pop him in his jaw'...Redirection...No intervention effective...call placed to Dr (doctor)...about increasing prn (as needed) Ativan...very agitated raising voice, entering into other resident's personal space...express concern about [sic] furnace not working [sic]..."</p> <p>There was no indication the facility attempted to determine why Resident #2 became so upset with</p>	F 329			

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F 329	<p>Continued From page 197</p> <p>another resident or why Resident #2 felt the furnace needed to be fixed. There were no new interventions added to Resident #2's plan of care to remove the stressors causing Resident #2's agitation. Instead, the facility obtained an order to increase Resident #2's Ativan.</p> <p>Resident #2 had a significant change in his demeanor since admission. There was no indication the facility completed a comprehensive clinical assessment to determine what the causative factors were, including reviewing the new medication, Ativan, which Resident #2 had been placed on.</p> <p>According to the MAR, on 12/19/13, Resident #2 received 2 doses of Ativan.</p> <p>Nursing notes continue:</p> <p>~ 12/20/13, "...doing well so far this shift, daughter was here...during breakfast...received PRN Ativan this am...shown behaviors such as raising voice to staff and trying to leave the unit...has been agitated most of the second half of the shift...PRN Ativan given...Interventions were mostly not effective..."</p> <p>On 12/20/13, Resident #2 received 3 doses of Ativan. Resident #2 was receiving increasing doses of Ativan. There was no indication the facility completed a comprehensive clinical assessment to determine the underlying causes of Resident #2's continued behaviors, and implemented specific individualized approaches to direct staff on how to manage Resident #2's behaviors.</p> <p>Nursing notes continue:</p>	F 329			

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F 329	<p>Continued From page 198</p> <p>~ 12/21/13, "...Had very minimal outbursts...weepy in the TV room..." According to Resident #2's MAR, on 12/21/13, Resident #2 received 3 doses of Ativan. There was no indication why and no indication that nonpharmacological interventions were attempted prior to administering Ativan.</p> <p>Nursing notes continue:</p> <p>~ 12/22/13, "...was given PRN at 0530 (5:30 a.m.) for increased agitation...removed cable cord from his TV and placed TV in the bathroom...pacing...agitated...trying to go home...given PRN..."</p> <p>According to Resident #2's MAR, on 12/22/13, Resident #2 received 3 doses of Ativan. There was no indication why and no indication that nonpharmacological interventions were attempted prior to administering Ativan. There was no indication the facility attempted to determine the causes of Resident #2's behaviors.</p> <p>Nursing notes continue:</p> <p>~ 12/23/13, "...Has been given prn Ativan while awake...has not had any prolonged episodes of agitation. Singing this am during breakfast, became weepy at times...Dr...informed that resident has used PRN Ativan frequently since admission. New order received to schedule Ativan 0.5 mg po (orally) TID (three times a day), continue PRN order..."</p> <p>Resident #2 had been in the facility for 1 week. In 1 week's time, Resident #2's medication was increased twice without first analyzing the triggers</p>	F 329			

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F 329	<p>Continued From page 199 to determine the cause of Resident #2's behaviors. There were no new interventions added to Resident #2's care plan.</p> <p>According to Resident #2's MAR, on 12/23/13, Resident #2 received 3 doses of Ativan.</p> <p>Nursing notes continue:</p> <p>~ 12/24/13, "...wandering...refused to eat supper..."</p> <p>According to Resident #2's MAR, Resident #2 received 5 doses of Ativan to equal 2.5 mg. There was no indication why and no indication that nonpharmacological interventions were attempted prior to administering Ativan.</p> <p>Nursing notes continue:</p> <p>~ 12/25/13, "...somewhat anxious and restless...Did medicate with prn Ativan. Ativan was ineffective during the noc (night)..."</p> <p>According to Resident #2's MAR, on 12/25/13, Resident #2 received 6 doses of Ativan to equal 3.0 mg. This exceeds the recommended per-day dosage for the elderly.</p> <p>There was no indication why and no indication that nonpharmacological interventions were attempted prior to administering Ativan.</p> <p>Nursing notes continue:</p> <p>~ 12/26/13, "...Has been pleasant of mood...stated that he plan to leave for 'home' later today causing disruption among a few residents...anxious and restless on and off most</p>	F 329			

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F 329	<p>Continued From page 200 of the shift. Two episodes of weeping. Wandering and unsettled...No aggressive behaviors to note..."</p> <p>According to Resident #2's MAR, on 12/26/13, Resident #2 received 4 doses of Ativan to equal 2.0 mg.</p> <p>There was no indication why and no indication that nonpharmacological interventions were attempted prior to administering Ativan.</p> <p>Nursing notes continue:</p> <p>~ 12/27/13, "...restless...pacing...stating that he has to do something, he has to leave...Prn Ativan given...Resident talking to people not there. Unable to redirect conversation..."</p> <p>According to Resident #2's MAR, on 12/27/13, Resident #2 received 5 doses of Ativan to equal 2.5 mg. There was no indication why and no indication that nonpharmacological interventions were attempted prior to administering Ativan.</p> <p>In addition to Resident #2's significant change in behavior, Resident #2 was hallucinating. There was no indication the facility completed a comprehensive assessment to determine the potential cause of Resident #2's hallucinations.</p> <p>According to the Long-Term Care Facility Resident Assessment Instrument Manual Version 3.0, potential indicators of psychosis include hallucinations and/or delusions. Hallucinations and/or delusions could be due to delirium typically caused by an acute treatable illness, infection, or reaction to medications.</p>	F 329			

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F 329	<p>Continued From page 201</p> <p>Nursing notes continue:</p> <p>~ 12/28/13, "Fax sent to Dr...concerning increase in agitation and medication changes made since hospitalization...received...orders for Zyprexa 2.5 mg daily and DC (Discontinue) scheduled dose of ativan...started making noise in room...discovered that he had thrown things in his room all over the room...stated when asked if he knew how the room came to be disrupted, that 'someone had come in and messed it up'...This is the second time this Resident has been disruptive on the unit since his admit...talking to people not there. Thought his chair in room was a little girl and yelled at it because it did not respond to him...yelling at another resident in the dining room...appeared to be angry...pacing...attempts made to redirect...Interventions attempted were not effective. Family was called to come in..."</p> <p>Resident #2 continued with symptoms of psychosis. Additionally behaviors were escalating and the facility called the family. Despite this, there was no comprehensive assessment completed to determine underlying causes of the psychosis and increasing behaviors. The facility's response was to obtain order for another medication, Zyprexa.</p> <p>According to Resident #2's MAR, on 12/28/13, Resident #2 received 3 doses of Ativan.</p> <p>Nursing notes continue:</p> <p>~ 12/29/13, "...Refused lunch...starting to pace the hallway, walking up to doors and testing out the door knobs. Able to redirect for approx (approximately) 45 min (minutes)...then starting to get slightly resistive with redirection. Talking</p>	F 329			

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F 329	<p>Continued From page 202</p> <p>about the 'lady who fell and does she need help.' Unable to redirect with this subject. Family called...Son...will be in shortly...started becoming tearful and then inconsolable...Daughter came to facility..."</p> <p>According to Resident #2's MAR, on 12/29/13, Resident #2 received no Ativan and 1 dose of Zyprexa 2.5 mg.</p> <p>Nursing notes continue:</p> <p>~ 12/30/13, "...restless...trying to leave unit via the fire exit door and banging the windows of the lunch room. When he was redirected by staff he became increasingly restless and disruptive to other residents. Family was called...agitated...calling out, pacing, moving furniture. Very difficult to redirect...Daughter...contacted and came in...New orders received to increase Zyprexa to 2.5 mg BID (twice a day) and d/c (discontinue) Lorazepam (Ativan)...seen by NP (Nurse Practitioner)...New order received for Zyprexa 2.56 [sic] PRN once in 24 hours for agitation/aggressive behaviors...resident continues with pacing, talking to people not there, wanting to go to work, wanting to go home..."</p> <p>According to Resident #2's MAR, on 12/30/13, Resident #2 received 2 doses of Ativan, (prior to the Ativan being discontinued) and 2 doses of Zyprexa.</p> <p>Resident #2's behaviors continued to escalate. Resident #2 also continued to show symptoms of delirium. Despite this, there was no comprehensive clinical assessment of Resident #2's condition to determine underling causes,</p>	F 329			

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F 329	<p>Continued From page 203</p> <p>there was no determination of what triggered Resident #2's behaviors, and there were no changes made to Resident #2's plan of care to direct staff on how to manage Resident #2's behaviors.</p> <p>The facility's response was again to obtain orders for more medication.</p> <p>Resident #2 had been in the facility for 16 days. During that period of time, Resident #2's Ativan was changed 4 times, including the order to discontinue it. Within a 48 hour time frame, Resident #2's Zyprexa was ordered and increased twice.</p> <p>Nursing notes continue:</p> <p>~ 12/31/13, "...pleasant in the am but became restless after lunch. Family was called in...became more restless towards the end of the shift stating that he had to leave to help his mother...difficult to redirect and becomes angry at staff when trying to redirect. He was disruptive to other residents in the TV room causing the others to become agitated and restless. Resident was taken to PT (Physical Therapy) and when he returned his mood was pleasant the rest of the shift..."</p> <p>According to Resident #2's MAR, on 12/31/13 Resident #2 received 3 doses of Zyprexa. There was again no indication why and no indication that nonpharmacological interventions were attempted prior to administering Zyprexa.</p> <p>On 1/1/14, the facility obtained an order for Resident #2 to be transferred to a hospital with a behavioral health center for medication</p>	F 329			

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F 329	<p>Continued From page 204</p> <p>adjustments and behavior management. The transfer never occurred. Resident #2's guardian indicated she was not in favor of the transfer.</p> <p>There was no behaviors documented in the nursing notes on 1/1/14.</p> <p>According to Resident #2's MAR, on 1/1/14, Resident #2 received the 2 scheduled doses of Zyprexa.</p> <p>Nursing notes continue:</p> <p>~ 1/2/14, "...going into other residents rooms and starting to remove items. Started talking about finishing the job...Kept point to the hand railing in the hall and stating that it needs to be lowered. Wanted to know when the other parts would be in. Redirected resident that...the working day is done. Prn (as needed) Zyprexa given..."</p> <p>Resident #2 was looking to fulfill the desire to be useful and to fix something, to work. Instead of meeting Resident #2's needs, Resident #2 was told no, your day is done and an as needed dose of Zyprexa was given without just cause.</p> <p>According to Resident #2's MAR, on 1/2/14, Resident #2 received 3 doses of Zyprexa.</p> <p>Nursing notes continue:</p> <p>~ 1/3/14, "...Resident seen by Dr...New orders to DC PRN Zyprexa, start PRN ativan 0.5mg tid (three times a day)...POA (Power of Attorney) updated...gave verbal consent for the PRN Xanax."</p> <p>Surveyor #25803 completed a review of the</p>	F 329			

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F 329	<p>Continued From page 205</p> <p>physician's progress note dated 1/3/14. The progress note indicated, "...was recently seen by...Nurse Practitioner, and Zyprexa p.r.n. was ordered to assist with agitation and aggressive behaviors. He is also having some hallucinations...He has had Paparazzo (Xanax) in the past, but that seemed to escalate his behaviors. The staff states he has not tried Ativan previously...discontinue the p.r.n. Zyprexa...Lorazepam (Ativan)...t.i.d. (three times a day) p.r.n..."</p> <p>According to Resident #2's clinical record, Resident #2 had been on Ativan in the past. The physician ordered Ativan, however, the facility obtained Xanax.</p> <p>From 1/3/14 through 1/10/14, there were no behaviors documented in Resident #2's nursing notes.</p> <p>According to Resident #2's MAR, from 1/3/14 through 1/10/14, Resident #2 received scheduled Zyprexa twice a day. On 1/7/14, 1/8/14, and 1/9/14 Resident #2 also received one PRN dose of Xanax each day. There was again no indication why and no indication that nonpharmacological interventions were attempted prior to administering Xanax.</p> <p>Nursing notes continue:</p> <p>~ 1/10/14, "discovered on the floor next to his bed...had been picking things out of the air, picking things off the floor which were not there...Dr...updated on increased restlessness & irritability. New orders...scheduled dose of alprazolam (Xanax) @ (at) HS (hour of sleep)..."</p>	F 329			

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F 329	<p>Continued From page 206</p> <p>Instead of completing a comprehensive clinical assessment, analyzing Resident #2's behaviors, determining probable cause, and updating Resident #2's care plan, Xanax was ordered scheduled as well as PRN.</p> <p>Nursing notes continue:</p> <p>~ 1/11/14, "...came out of his room with an angry affect & (and) threatening gestures & verbalizations...unable to ...redirect him...cornered both of us as we attempted to steer him away from other residents, and struck us several times. He went aggressively in & out of residents' rooms making threatening remarks & shaking his fist, overturning mattresses [sic] and cushions. He threw water & eventually got a towel which he used as a whip...contacted Dr (doctor) who ordered him transported to ER (emergency room)...made several papanoid [sic], delusional remarks. Ambulance staff & a police officer arrived shortly afterwards..."</p> <p>Resident #2 was transported to the ER and returned to the facility.</p> <p>A nursing note dated 1/11/14 indicated, "...ER reports all labs were normal with no UTI (Urinary Tract Infection) or pneumonia...Zyprexa increased..."</p> <p>Resident #2 has now had significant and distressing behaviors. Despite this, the facility did not complete an assessment analyzing Resident #2's behaviors to determine causative factors, including an adverse reaction to medications, in order to make changes to Resident #2's plan of care and give directives to staff on how to manage Resident #2's behavior. Resident #2's</p>	F 329			

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F 329	<p>Continued From page 207</p> <p>Zyprexa was subsequently increased.</p> <p>Nursing notes continue:</p> <p>~ 1/12/14, "...occasional pacing...given PRN medication for increased anxiety..."</p> <p>According to Resident #2's MAR, on 1/12/14, Resident #2 received 2 PRN doses and 1 scheduled dose of Xanax to equal 1.5 mg, 2 scheduled doses of Zyprexa to equal 7.5 mg. There was again no indication why and no indication that nonpharmacological interventions were attempted prior to administering PRN Xanax.</p> <p>On 1/13/14, there were no behaviors documented in Resident #2's nursing notes.</p> <p>According to Resident #2's MAR, on 1/13/14, Resident #2 received 1 scheduled and 3 PRN doses of Xanax to equal 2.0 mg, and 2 scheduled doses of Zyprexa to equal 10.0 mg.</p> <p>Nursing notes continue:</p> <p>~ 1/14/14, "...became somewhat agitated. Did require prn Ativan...did not wake for supper..."</p> <p>According to Resident #2's MAR, on 1/14/14, Resident #2 received 1 PRN dose of Xanax, and 2 scheduled doses of Zyprexa. The scheduled dose of Xanax was not given as Resident #2 was sleeping.</p> <p>Nursing notes continue:</p> <p>~ 1/15/14, "...poor appetite at times..."</p>	F 329			

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F 329	<p>Continued From page 208</p> <p>According to Resident #2's MAR, on 1/15/14, Resident #2 received scheduled Xanax and Zyprexa.</p> <p>Nursing notes continue:</p> <p>~ 1/16/14, "agitated at supper time, refused to eat...laid himself down...could not be woken up for HS (Hour of Sleep) meds (medications) after several attempts..."</p> <p>According to Resident #2's MAR, on 1/16/14, Resident #2 received 1 PRN dose of Xanax, and scheduled doses of Zyprexa. The scheduled doses of Xanax and Zyprexa were not given as Resident #2 was sleeping.</p> <p>There were no nursing notes from 1/17/14 through 1/19/14.</p> <p>According to Resident #2's MAR, on 1/17/14 and 1/18/14, Resident #2 received scheduled Xanax and Zyprexa. On 1/19/14, Resident #2 received 1 scheduled and 1 PRN dose of Xanax, and 2 scheduled doses of Zyprexa. There were no documented indications for administering the PRN doses.</p> <p>Nursing notes continue:</p> <p>~ 1/20/14, "...Agitated before supper..."</p> <p>According to Resident #2's MAR, on 1/20/14, Resident #2 received 1 scheduled and 2 PRN doses of Xanax and 2 scheduled doses of Zyprexa.</p> <p>Nursing notes continue:</p>	F 329			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/25/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-GOLDEN AGE			STREET ADDRESS, CITY, STATE, ZIP CODE 720 E KINGS RD TOMAHAWK, WI 54487		
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F 329	<p>Continued From page 209</p> <p>~ 1/21/14, "...refused HS cares X3 (three times), he was pulling away from staff and yelling at staff...became agitated when his hearing aids were taken out of his ears..."</p> <p>Removing Resident #2's hearing aids was not identified as one possible trigger for some of Resident #2's behaviors. There were no changes made to Resident #2's plan of care.</p> <p>According to Resident #2's MAR, on 1/21/14, Resident #2 received 1 scheduled dose of Xanax and 2 scheduled doses of Zyprexa.</p> <p>There were no nursing notes on 1/22/14 and 1/23/14. However, according to Resident #2's MAR of 1/22/14, Resident #2 received 1 scheduled dose and 1 PRN dose of Xanax and 2 scheduled doses of Zyprexa. On 1/23/14, Resident #2 received 1 scheduled dose and 2 PRN doses of Xanax and 2 doses of scheduled Zyprexa. There were no documented indications for receiving the PRN doses.</p> <p>Nursing notes continue:</p> <p>~ 1/24/14, "wandering...cranky...could not be woken up for supper...could not be woken up for meds or snack..."</p> <p>According to Resident #2's MAR of 1/24/14, Resident #2 received 1 scheduled dose of Xanax and Zyprexa. The Xanax and Zyprexa ordered at HS was not given as Resident #2 was sleeping.</p> <p>Resident #2 had now had several incidents when he could not be wakened. Despite the increased dose of Zyprexa, there was no comprehensive clinical assessment completed to determine the</p>	F 329			

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F 329	<p>Continued From page 210 cause of the sleepiness.</p> <p>Nursing notes continue:</p> <p>~ 1/25/14, "...roamed the halls all NOC long..."</p> <p>According to Resident #2's MAR, on 1/25/14, Resident #2 received 1 PRN dose and 1 scheduled dose of Xanax and scheduled Zyprexa.</p> <p>There were no nursing notes of 1/26/14. According to Resident #2's MAR Resident #2 received 1 PRN dose of Xanax and one scheduled dose of Zyprexa. Both Zyprexa and Xanax were not given at HS as Resident #2 was sleeping.</p> <p>Nursing notes continue:</p> <p>~ 1/27/14, "...restless at start of shift. Pacing in the fall, going into other resident's rooms, unable to sit still for more than 30 sec (seconds). Hard to redirect. Prn Xanax...this was not effective...continued to pace...Attempted to go out the door of the unit x 4...son-in-law called and did come in..."</p> <p>According to Resident #2's MAR, on 1/27/14, Resident #2 received 1 scheduled dose and 3 PRN doses of Xanax and scheduled Zyprexa.</p> <p>On 1/28/14 there were no nursing notes.</p> <p>Nursing notes continue:</p> <p>~ 1/29/14, "...in another Resident's room...convinced that this woman was his spouse...refused effort to given a xaxex</p>	F 329			

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F 329	<p>Continued From page 211</p> <p>[sic]...restless, pacing, attempting to exit unit to the outside. Reorientation [sic] not effective.."</p> <p>According to Resident #2's MAR, on 1/29/14, Resident #2 received 1 scheduled and 1 PRN dose of Xanax and scheduled Zyprexa.</p> <p>Nursing notes continue:</p> <p>~ 1/30/14, "...starting hitting and threatening staff...was offered a snack which he knocked to the floor...spitting at and scratching staff...Family called..."</p> <p>According to Resident #2's MAR, on 1/30/14, Resident #2 received 2 PRN doses of Xanax and one scheduled Zyprexa. The HS scheduled dose of Zyprexa and Xanax were not given as Resident #2 was sleeping.</p> <p>Nursing notes continue:</p> <p>~ 1/31/14, "...upset for an unknown reason and threatening to 'kill her' and 'beat her'..."</p> <p>According to Resident #2's MAR, on 1/31/14, Resident #2 received 1 PRN dose of Xanax and one scheduled Zyprexa. The HS scheduled dose of Zyprexa and Xanax were again not given as Resident #2 was sleeping.</p> <p>On 2/1/14 there were no nursing notes.</p> <p>Nursing notes continue:</p> <p>~ 2/2/14, "...Awoke at 10pm and became agitated. Entered room of female resident stating she is his wife, ordered staff to leave the room. Resident took another residents walker and threw</p>	F 329			

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F 329	<p>Continued From page 212</p> <p>it across the hallway, began pacing and continued to enter other residents rooms. Staff unable to calm patient, family notified. Son-in-law arrived..."</p> <p>~ 2/3/14, "...upset at beginning of NOC shift...seen by...NP RT (related to) increased agitation & aggression [sic]...agitated and aggressive towards staff...became aggressive during a bandage change and slapped writer in the face..."</p> <p>On 2/3/14, the NP ordered Citalopram 2.5 mg every day.</p> <p>Resident #2 now had another psychoactive medication ordered related to Resident #2's aggression and agitation on top of the Zyprexa and Xanax already ordered.</p> <p>There was no indication the facility completed a comprehensive clinical assessment to determine the underlying causes of Resident #2's continued distressing behaviors, including what triggered the behaviors prior to ordering another medication. There had been no tracking nor quantifying of targeted behaviors. There were no changes made to Resident #2's plan of care.</p> <p>Nursing notes continue:</p> <p>~ 2/4/14, "...appeared very sleepy at the beginning of this pm (evening) shift...unable to awaken resident for supper of HS snack or HS meds (medications)..."</p> <p>~ 2/5/14, "...restless, pacing the hall, moving furniture, Hallucinating, holding conversation with someone not there...attempting to exit the unit through end hall doors...refused fluids and snacks. Becoming more agitated with</p>	F 329			

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F 329	<p>Continued From page 213 redirection..."</p> <p>~ 2/6/14, "...aggressive [sic] and agitated early in this pm shift..."</p> <p>~ 2/7/14, "...seen by Dr...Dr. was updated on increased agitated & aggressive behavior...No dose reductions were made...Zyprexa was changed from 5mg BID (twice a day) to 10mg daily..."</p> <p>~ 2/8/14, "...Did pace hall in the am...been asleep since after supper unable to take his medications...refused supper..."</p> <p>~ 2/9/14, "...continues to be up and agitated..."</p> <p>~ 2/10/14, "...asleep since writer came to work...unable to give hs medication...RN requested that res (resident) be woke up and given medication..."</p> <p>~ 2/11/14, "...slept most of AM...When Resident awoke, he was again agitated...untrusting of staff and would not eat or drink anything...Noted that resident has repeatedly refused or been sleeping when HS Paparazzo (Xanax)...offered...Hs Paparazzo to be offered at 6 PM...exit seeking behaviors...Resident became violent with staff, striking staff...while staff was trying to redirect...behaviors started to escalate again later in the shift...family visited..."</p> <p>~ 2/12/14, "...pacing and pushing furniture up and down the hallway. Resident was not easily redirected..."</p> <p>On 2/12/14, the NP saw Resident #2 and discontinued both Resident #2's scheduled and PRN doses of Xanax. The NP also ordered Clonazepam 0.5 mg twice a day along with a PRN dose which could be given every 24 hours.</p> <p>Since admission, less than 2 months ago, Resident #2 had been on varying doses of Zyprexa, Ativan, Xanax, and Citalopram.</p>	F 329			

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F 329	<p>Continued From page 214</p> <p>Resident #2 was now being placed on Clonazepam.</p> <p>Since admission to 2/12/14, there had been no comprehensive clinical assessment to determine underlying causes of Resident #2's behavior. The facility had not identified what triggered Resident #2's behavior. A care plan had not been developed with specific individualized approaches based on underling causes and triggers of Resident #2's behaviors. Resident #2's behaviors had not been accurately documented and quantified. There would be no ability on the part of the facility to determine the effectiveness of medications used. There was no identification of potential side effects of medications used. Despite this, the facility obtained another order for another medication.</p> <p>Nursing notes continue:</p> <p>~ 2/13/14, "...pacing...moving furniture...ate a very small amount of supper..."</p> <p>~ 2/14/14, "...wandering...pacing..."</p> <p>~ 2/15/14, "...wandering...During dinner time he was wandering in the dining area disturbing other residents while eating. He grabbed the back of other residents chairs attemptin [sic] to move them...Was crawling on the floor in his room stating he is fixing the floor..."</p> <p>~ 2/17/14, "...Daughter felt that resident was more sedate...pacing...moving furniture...not able to be redirected...continually sitting on his bed talking to himself..."</p> <p>~ 2/18/14, "...sound asleep...Shaking Resident's arm and rubbing his hands while calling his name for 5 minutes did not do more that alter the rate of his breathing..."</p> <p>~ 2/19/14, "...unable to awaken resident enough</p>	F 329			

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F 329	<p>Continued From page 215</p> <p>to take 0600 (6:00 a.m.) medications...Appetite poor during the day..."</p> <p>~ 2/20/14, "...restless & pacing most of the shift. Would not sit long enough to eat...disrobing...Actively hallucinating...pacing...Trying to open door knobs on bare walls..."</p> <p>On 2/20/14 a dietary note indicated Resident #2's current weight was 133.4 pounds. The dietary note indicated Resident #2 weight on 2/5/14 was 141.3.</p> <p>Resident #2's admission weight was 144.4. Since admission, Resident #2 lost 11 pounds, 7.9 pounds of the 11 pounds was lost in a period of 15 days.</p> <p>While the facility implemented a number of dietary supplements, there was no comprehensive assessment, including assessing side effects of medications, to determine the underlying causes of Resident #2's weight loss.</p> <p>Nursing notes continue:</p> <p>~ 2/21/14, "...Did not sit down at table for either meal...Did push on end door x 1 (one time)...pacing..."</p> <p>~ 2/22/14, "...pacing and moving furniture...very sleepy..."</p> <p>~ 2/23/14, "...Wandering...Refusing breakfast...Attempted to unplug tv and radio in dining room and talking to unknown person...found...with clothes and undergarment off...Wandered to end of fall and took clothes off again...Wandering into hall and into dining room without clothes...yueiling [sic] at people to get our of his roo [sic] when no one was in</p>	F 329			

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F 329	<p>Continued From page 216</p> <p>there...combative and resistive with redirection. Son-in-law called...talking to people not there...offered supper but refused..."</p> <p>~ 2/24/14, "...wandering...he had removed his clothing..."</p> <p>~ 2/25/14, "...remained in bed through breakfast...wandering...did not come to dining room at dinner or eat anything..."</p> <p>~ 2/26/14, "...Continued with wt (weight) loss with lack of appetite reviewed with NP. New orders received for Mirtazapine..."</p> <p>Resident #2 was now disrobing, hallucinating, not eating, and had significant weight loss. Despite this, the facility did not complete a comprehensive clinical assessment to try and find out why. The facility obtained an order for yet another psychoactive medication.</p> <p>Nursing notes continue:</p> <p>~ 2/27/14, "...pacing..."</p> <p>~ 2/28/14, "...Clonazepam not given, unable to wake Resident. AM nurse will follow-up with a PRN with his AM meds..."</p> <p>According to Resident #2's MAR, from 1/2/14 through 2/6/14, Resident #2 received 1 of the 2 scheduled doses of Zyprexa. According to the MAR, the second dose of Zyprexa was not given as Resident #2 was either sleeping or refused. On 2/7/14, the dosing of Zyprexa was changed from 5.0 mg twice a day to 10 mg once a day. From 2/7/14 through 2/28/14, Resident #2 received the Zyprexa as ordered.</p> <p>According to Resident #2's MAR, from 1/2/14 through 2/28/14, Resident #2 received Clonazepam as ordered with the exception of 1</p>	F 329			

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F 329	<p>Continued From page 217</p> <p>dose which Resident #2 refused. The MAR did have multiple days where the morning dose of Clonazepam was not documented. Resident #2 was also given 3 PRN doses of Clonazepam.</p> <p>Nursing notes continue:</p> <p>~ 3/1/14, "...weight 130.0# (pounds)...Intakes...are very poor..."</p> <p>Resident #2 had now had a 14.4 pound weight loss since admission.</p> <p>Nursing notes continue:</p> <p>~ 3/2/14, "...wanders..."</p> <p>~ 3/4/14, "...only ate bites of food..."</p> <p>~ 3/5/14, "...wandering...complained of being tired..."</p> <p>~ 3/7/14, "...ate very little..."</p> <p>~ 3/8/14, "...attempted several time to awaken for 0800 (8:00 a.m.) medication and 0600 medication. Unable to awaken fully...increased lethargy and new medications. Orders received to hold clonazepam doses for today..."</p> <p>~ 3/10/14, "...Dr...updated on lethargy on Saturday Am...Order received to d/c (discontinue) scheduled Clonazepam, start Clonazepam 0.5 mg po TID/PRN (orally three times a day as needed)..."</p> <p>~ 3/14/14, "...pacing...moving furniture...refusing to keep clothes on...became violent with staff...sleeping in bed all shift. Unable to take his medications, difficult to arouse...unusually tired this afternoon, normally wanders and movers furniture...has not had any food or fluid intake throughout shift...blood glucose 64 (64 milligram per deciliter), B/P (blood pressure) 92/55...02 sat 98% (oxygen saturation 98 percent)... T</p>	F 329			

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F 329	<p>Continued From page 218 (temperature) 96.0...R (respirations) 16..."</p> <p>Of notation. According to facility records, Resident #2's blood pressure always ran greater the 100/ mmHg (millimeters of Mercury). A blood pressure of less than 100/ is a change in Resident #2's condition requiring a comprehensive assessment to determine why.</p> <p>This was the first assessment completed since Resident #2 was admitted to the facility. This was a significant change in Resident #2's usual behavior. Despite that, assessment was incomplete and did not include an assessment of all body systems, changes in functional status, appetite and weight changes, changes in behavior, use of medications including assessing for side effects.</p> <p>Nursing notes continue:</p> <p>~ 3/17/14, "...Pacing and moving furniture...became anxious and was given Clonazepam 0.5 mg..."</p> <p>~ 3/19/14, "...seen by...NP...informed of poor oral intakes...orders received to increase Mirtazapine to 15 mg po daily..."</p> <p>This was yet another increase in Resident #2's medication regimen.</p> <p>Nursing notes continue:</p> <p>~ 3/21/14, "...pacing..."</p> <p>~ 3/24/14, "...refused supper..."</p> <p>~ 3/24/14, "...Resident in continent/incontinent of bowel and bladder. Resident needs extensive assistance with some ADLs and limited assistance with others..."</p>	F 329			

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F 329	<p>Continued From page 219</p> <p>~ 3/25/14, "...Wt (weight) 121.2 pounds...down 7% in 4 weeks..."</p> <p>~ 3/28/14, "requires extensive assistance with most ADL's...generally incontinent of bowel and bladder...paces sometimes for an hour straight. Walking with him can be helpful but trying to remove him from the environment only seems to trigger more hostility from him as pacing is his 'work' at the time. He was a hard worker in lift that ran his own painting business and his recall of that time can be very vivid..."</p> <p>~ 3/29/14, "...continuously pacing up and down the hallway..."</p> <p>~ 3/30/14, "...did not eat lunch...pacing in hallway and moving furniture..."</p> <p>According to Resident #2's MAR, from 3/1/14 through 3/31/14, Resident #2 received Zyprexa, Clonazepam, Citalopram, and Mirtazapine as ordered. Resident #2 also received PRN Clonazepam 4 times.</p> <p>Nursing notes continue:</p> <p>~ 4/3/14, "...will sing when he is feeling very happy...enjoys Music Therapy...participant in Music and Memory with his own Ipod...loves pre-meal stories and often watches Bonanza..."</p> <p>This was the first time this information was brought forth since Resident #2 was admitted to the facility. None of this information is on Resident #2's plan of care.</p> <p>Nursing notes continue:</p> <p>~ 4/9/14, "...has been quite sleepy this shift...did not eat/drink much at supper. Entered another residents room and went to sleep there. Staff</p>	F 329			

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F 329	<p>Continued From page 220</p> <p>was abe [sic] to arouse resident later to take him to his room via w/ch (wheelchair). Resident did not ambulate much this shift..."</p> <p>This was again a significant change in Resident #2's activity level, historical behaviors, level of consciousness, and mobility. There was no comprehensive assessment completed an attempt to determine cause. There were no changes made to Resident #2's plan of care.</p> <p>Nursing notes continue:</p> <p>~ 4/10/14, "...poor appetite and needs extensive assistance with meals and personal cares. Incontinent of bowel and bladder..."</p> <p>~ 4/11/14, "...unable to make needs known...does not seem to understand verbal cues...does talk to imaginary people and tries to deal with imaginary situations..."</p> <p>~ 4/29/14, "...Crabby with morning cares...Refusing to eat or drink. Pacing the hall...Hallucinations noted. Talking about chasing away the boys that were sitting on the chair..."</p> <p>~ 4/30/14, "...ambulated in the hall most of the day. Would sit for short periods (5 min) at a time. Hallucinating..."</p> <p>According to Resident #2's MAR, from 4/1/14 through 4/30/14 Resident #2 received Citalopram, Mirtazapine, and Zyprexa as ordered. Resident #2 received no PRN Clonazepam.</p> <p>Nursing notes continue:</p> <p>~ 5/1/14, "...seen...by Dr...current weight 114.8, down from 131.4 on 3/10/14...continued with poor appetite...New order received for ST (speech therapy) eval (evaluation)..."</p>	F 329			

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F 329	<p>Continued From page 221</p> <p>Surveyor #25803 completed a review of a physician's progress note dated 5/1/14. The progress note indicated, "...staff has some concerns about his ability to swallow..."</p> <p>Nursing notes continue:</p> <p>~ 5/3/14, "...wandering...Appetite continues to be poor. Did not even want coffee this am. Picked at breakfast...Did not eat lunch...Had not sat for more than 5 minutes at a time..."</p> <p>Nursing notes continue:</p> <p>~ 5/8/14, "...Nutritional Review...Wt down...18% in 90 days...Remeron (Mirtazapine) has not appeared to have any significant effect on meal intake...eval Megace use...asked NP about starting Megace...NP stated she would have to discuss same with resident's daughter as it causes blood clots. Also suggested discussing palliative care with daughter..."</p> <p>According to the "Nursing 2013 Drug Information Handbook," Megace is an antineoplastic hormonal medication used to treat breast cancer as well as anorexia. Adverse reactions included blood clots, nausea, increased appetite, and pneumonia. The "Nursing 2013 Drug Information Handbook indicated, "...Start treatment...only after treatable causes of weight loss are sought and addressed...Drug is relatively nontoxic with a low risk of adverse effects..."</p> <p>On 5/12/14, the facility received an order to begin Megace. There were no other changes to Resident #2's medication regimen.</p>	F 329			

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F 329	<p>Continued From page 222</p> <p>Prior to starting Megace, there was no indication the facility "sought and addressed" the underlying causes of Resident #2's significant weight loss.</p> <p>Nursing notes continue:</p> <p>~ 5/29/14, "...witness falling backwards..."</p> <p>~ 5/31/14, "...walking to bathroom with nurses aide, resident slid to knees...B/P 91/44...t (temperature) 99.8...Weakness with ambulation..."</p> <p>According to Resident #2's MAR, from 5/1/14 through 5/31/14, Resident #2 received Citalopram, Mirtazapine, Zyprexa, and 2 PRN doses of Clonazepam as ordered. On 5/28/14, the dose of Zyprexa was decreased to 7.5 mg every day.</p> <p>Nursing notes continue:</p> <p>6/1/14, "...lost his balance falling backwards...Gait unsteady. Moved to wheelchair for support..."</p> <p>According to a fall investigation Resident #2's B/P (blood pressure) was 90/54.</p> <p>Surveyor #25803 did not receive all of Resident #2's nursing notes for 6/2/14. According to a "Post Fall Investigation/Plan," Resident #2 fell 3 times on 6/2/14 at 7:55 a.m, at 12:00 p.m. and at 2:35 p.m.</p> <p>Nursing notes continue:</p> <p>~ 6/2/14, "...placed in Broda chair with belt on. He attempted to slide under belt and would call out. Was taken out of chair and ambulated...Gait remains extremely unsteady..."</p> <p>~ 6/4/14, "...While ambulating with nurse,</p>	F 329			

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F 329	<p>Continued From page 223</p> <p>resident stated I'm done and let legs give out...BP...90/50..."</p> <p>~ 6/4/14, "...Noted to have decline in function. NP discussed resident's condition with resident's daughter...New orders...decrease Zyprexa to 7.5 mg daily x 1 wk (for 1 week) then 5 mg po daily, decrease Mirtazapine to 7.5 mg...d/c Megace..."</p> <p>~ 6/7/14, "...Will not wake up for meds...lethargic all shift. Sleeping at long intervals..."</p> <p>~ 6/8/14, "...would not eat...found of floor next to bed."</p> <p>~ 6/10/14, "...Ambulated to BR (bathroom). Became weak and plae [sic] while sitting on toilet...BP taken standing = 90/60. Weak..."</p> <p>Surveyor #25803 completed a review of a nursing note dated 6/10/14. The nursing note indicated Resident #2 had an auxiliary temperature of 99.2. This was equivalent to 101.2 orally.</p> <p>On 6/10/14 at 4:00 p.m., Surveyor #25803 spoke with Resident #2's guardian, Family-NN. Family-NN indicated she was Resident #2's daughter and came regularly to the facility. Family-NN indicated they thought they were going to "lose him" this afternoon as Resident #2 had an unresponsive episode.</p> <p>Nursing notes indicated clergy was called and administered last rites to Resident #2 on this date.</p> <p>To the date of survey, there was no comprehensive assessment completed of Resident #2's overall condition to determine cause and effect of Resident #2's behaviors, declining condition, use of medications, and medication side effects.</p>	F 329			

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F 329	<p>Continued From page 224</p> <p>On 6/3/14 at 6:10 p.m., Surveyor #25803 observed Resident #2 seated in a Broda chair with a seat belt on. RN-EE (Registered Nurse) indicated Resident #2 had an over-all decline in functioning, including many recent falls which required the use of the Broda chair and seat belt.</p> <p>On 6/10/14 at 3:30 p.m., Surveyor #25803 spoke with the ST (Speech Therapist). The ST indicated she was also the Rehab Director. Surveyor #25803 asked the ST about Resident #2. The ST indicated when Resident #2 came into the facility, Resident #2 was functioning at a much higher level than Resident #2 currently was. The ST indicated Resident #2 had a decline in overall functioning since admission. The ST also indicated she noted Resident #2 had a continued decline over the weekend. The ST indicated she was not aware of Resident #2 having any agitation or striking out during therapy sessions.</p> <p>On 6/10/14 at 4:00 p.m., Surveyor #25803 spoke with Family-NN. Family-NN indicated she was Resident #2's daughter, and came regularly to the facility. Family-NN indicated prior to coming into the facility, Resident #2 was living alone at his home and taking care of himself. Family-NN indicated Resident #2 was still cutting the grass, raking leaves, sitting on a swing outside, loved the sun, liked to play bingo, liked company, loved to tell stories, and became more depressed during the winter as there was nothing to do. Family-NN also described Resident #2 as being a "loner" but once Resident #2 got to know someone he was "loving and friendly." Family-NN indicated she had noted increasing confusion while at home but Resident #2 was on no medications of any kind to treat the confusion.</p>	F 329			

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F 329	<p>Continued From page 225</p> <p>Family-NN indicated since Resident #2's wife died, Resident #2 had been having flash backs from the Korean war.</p> <p>Family-NN indicated Resident #2 had a "first good week" at the facility, but then Resident #2 began to exhibit a lot of behaviors. Family-NN stated the facility called them many times to come in and sit with Resident #2. Family-NN stated coming in some times was OK but felt the facility needed to figure out how to manage Resident #2. Family-NN indicated Resident #2's behaviors are better now, however Resident #2 also had a decline in condition. Family-NN indicated Resident #2 had gotten so weak he couldn't stand up by himself.</p> <p>On 6/11/14 at 8:25 a.m., Surveyor #25989 observed LPN-W (Licensed Practical Nurse) and RN-LL (Registered Nurse) assist Resident #2 with cares. Surveyor #25989 noted Resident #2 required total assistance with care and 2 staff persons to transfer.</p> <p>On 6/11/14 at 8:40 a.m., Surveyor #25803 spoke with the ACUD (Alzheimer's Care Unit Director). The ACUD stated she was a teacher by trade but had spent many years working in the corporate world as a Director of Sales and Marketing. The ACUD indicated it was her job to manage the ACU and make sure it was running smoothly. The ACUD stated it was not her job to manage residents clinically from a nursing perspective, including the use of medications. The ACUD indicated she did inform residents physician or the NP (nurse practitioner) of resident behaviors, but never recommended medications of any kind.</p> <p>The ACUD indicated Resident #2 loved dogs.</p>	F 329			

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F 329	<p>Continued From page 226</p> <p>The ACUD stated they had a toy dog which they have used when Resident #2 was agitated. The ACUD indicated this had not been put on the care plan yet as she was still evaluating its effectiveness.</p> <p>The ACUD indicated when Resident #2 was admitted to the facility, there were initially no behaviors. The ACUD stated when Resident #2 started exhibiting aggressive behaviors she was "flabbergasted" and asked the family "where did this come from?"</p> <p>The ACUD stated since admission, Resident #2 has had a significant rapid decline. The ACUD was not sure why Resident #2 had such a decline but questioned if there was something medically going on or if it was just Resident #2's dementia progressing. The ACUD stated if she saw a change in a resident's condition, she was responsible to communicate these changes to nursing. The ACUD stated they did need better communication between herself, the CNAs (Certified Nursing Assistants), and nursing.</p> <p>Surveyor #25803 asked the ACUD why Resident #2 was on so many psychoactive medications. The ACUD indicated she did not know. Surveyor #25803 also asked the ACUD if the facility had discussed Resident #2's multiple medications and potential side effects as potentially causing Resident #2's behaviors. The ACUD stated they had not.</p> <p>The ACUD indicated they had a weekly meeting called grand rounds in which they discussed behavior issues with the interdisciplinary team.</p> <p>Surveyor #25803 completed a review of a form</p>	F 329			

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F 329	<p>Continued From page 227</p> <p>titled "Behavioral Meeting Review" for Resident #2. The "Behavioral Meeting Review" was dated 12/18/13, 1/9/14, 2/7/14, 3/28/14, and 4/24/14. None of the meeting notes contained information regarding the facility's review of what potentially triggered Resident #2's behaviors, specific recommendations for approaches based on what triggered Resident #2's behaviors nor a discussion of medication use and potential side effects.</p> <p>On 6/11/14 at 2:20 p.m., Surveyor #25803 spoke with LPN-AA (Licensed Practical Nurse) about the facility's process when a change in a resident's condition occurred. LPN-AA indicated as an LPN she would only gather information not requiring an assessment. LPN-AA stated she would refer the assessment to a RN (Registered Nurse).</p> <p>On 6/11/14 at 2:30 p.m., Surveyor #25803 spoke with the ADON (Assistant Director of Nursing). The ADON indicated she as well as the DON (Director of Nursing) read each resident's progress note every day. The ADON stated they would also talk with staff regarding changes in residents' conditions. The ADON stated any change in a resident's condition, she or another RN would make an assessment and then notify the DON. The ADON stated the DON "fielded everything." The ADON felt because of their process for follow-up on residents' condition was "splintered." The ADON also stated the ACUD and NP made most of the medication changes in the ACU.</p> <p>On 6/11/14, Surveyor #25803 spoke with Staff-T (Anonymous). Staff-T stated the ACUD was seeking orders for medications from the NP (Nurse Practitioner) without first consulting the</p>	F 329			

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F 329	<p>Continued From page 228 the nursing department.</p> <p>On 6/11/14, Surveyor #25803 spoke with Staff-PP (Anonymous). Staff-PP indicated there was a "disconnect" between the ACUD and the DON. Staff-PP stated the DON was aware of the number of medications being ordered but "didn't take a stand" against the use of the medications.</p> <p>On 6/11/14 at 3:10 p.m., Surveyor #25803 spoke with the DON about Resident #2. The DON stated Resident #2 has had a significant decline in condition. The DON stated the ACU was utilizing too many medications to manage behaviors instead of attempting a variety of interventions first. The DON stated medication changes have been based on 1 person's perception, instead of the interdisciplinary team.</p> <p>On 6/4/14 at 7:50 a.m., Surveyor #16041 spoke with the ACUD about resident behaviors. The ACUD was asked what interventions should be tried before the physician or the police are called. The ACUD stated, "I tell my staff to give the PRN (as needed medication), wait 20 minutes and then call me. Otherwise, they would be calling all the time."</p> <p>On 6/10/14 at 3:55 p.m., Surveyor #25803 noted Resident #2 seated in a Broda chair with a foot buddy and seat belt. Resident #2 was noted to be emaciated. Resident #2 was also noted to have constant mouth movements and intermittent methodical upward thrusts with his hips raising his buttocks off the chair.</p> <p>Observations by Surveyor #16041 throughout the day on 6/4/14, 6/5/14, 6/9/14,6/10/14, and 6/11/14 found Resident #2 the same as described above.</p>	F 329			

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F 329	<p>Continued From page 229</p> <p>On 6/11/14 at 8:35 a.m., Surveyor #25803 observed Resident #2 as noted in the observation noted above.</p> <p>Example #2 (also cross reference F329):</p> <p>Resident #1 was admitted to the facility on 2/4/14. Diagnoses include Dementia, Depression, Chronic Obstructive Pulmonary Disease, Gastroesophageal Reflux Disease and Coronary Artery Disease.</p> <p>The MDS (Minimum Data Set) assessment, dated on 2/12/14, indicated Resident #1 is severely cognitively impaired. Has signs of symptoms of Delirium, being present and fluctuates with difficulty focusing attention. Mood indicators of feeling tired, trouble concentrating on things, and restless. Behaviors consist of wandering occurring 4 to 6 days, but less than daily, which places the resident at risk of getting to a potentially dangerous places and intrudes on privacy of others. No pain. Shortness of breath with exertion and lying flat and has oxygen therapy. Receiving antidepressant medication.</p> <p>On 3/3/14, Resident #1 moved into the Acute Care Unit (Dementia unit).</p> <p>The MDS, dated on 5/13/14, indicated signs and symptoms of delirium, is not constant with inattention and now has disorganized thinking. Unable to determine any mood indicators. Behaviors of wandering are occurring 1 to 3 days and no longer a risk of getting to dangerous places. Having pain, remains to be short of breath with exertion and lying flat and has oxygen</p>	F 329			

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F 329	<p>Continued From page 230</p> <p>therapy as needed. Resident #1 now requires extensive assistance of 2 staff for dressing, hygiene and toilet use. Ambulation now requires limited assistance with one staff. Receiving antidepressants, antipsychotic and antianxiety medications.</p> <p>Review of Resident #1's care plan dated 2/4/14, "Focus Potential for drug related complications associated with use of psychotropic medications related to: Anti-depressant medication is prescribed for dx of depression, antianxiety medication prescribed for dx of anxiety. Antipsychotic is also used daily. Goal: Will be free of psychotropic drug related complications. Interventions: Assess for pain. Monitor for side effects and report to physician: Antidepressant-Sedation, drowsiness, dry mouth, agitation, skin rash..." "...Provide medications as ordered by physician and evaluate for effectiveness."</p> <p>There are no individualized interventions to be tried prior to giving prn psychotropic medications.</p> <p>Namenda</p> <p>On 2/7/14, physician order to start Namenda 5 mg every day for 7 days, then increase Namenda 5 mg to twice a day.</p> <p>Review of Resident #1's progress notes and care plans revealed no care plan was developed for the Namenda. Therefore, there was no goal for the treatment. There was no evidence that anyone was monitoring for side effects of Namenda.</p> <p>According to Nursing 2013 Drug Handbook:</p>	F 329			

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F 329	<p>Continued From page 231</p> <p>*CNS (central nervous system): stroke, aggressiveness, agitation, anxiety, ataxia, confusion, depression, dizziness, fatigue, hallucinations, headache, hypokinesia, insomnia, pain, somnolence, syncope, transient ischemic attack, vertigo.</p> <p>*CV (cardiovascular): heart failure, edema, hypertension.</p> <p>*GI (gastrointestinal): anorexia, constipation, diarrhea, nausea, vomiting.</p> <p>*GU (gastrourinary): incontinence, urinary frequency, UTI.</p> <p>*Musculoskeletal: Arthralgia (severe pain in the joint), back pain.</p> <p>*Respiratory: bronchitis, coughing, dyspnea, flu-like symptoms, pneumonia, upper respiratory tract infection.</p> <p>*Skin: rash.</p> <p>*Other: abnormal gait, falls, injury.</p> <p>Resident #1 had several of these side effects (aggressiveness, agitation, anxiety, confusion and dizziness) which resulted in other behavior medications being added. Frequent falls, and a hospitalization for pneumonia. Also, treatment for a rash, upper respiratory tract infection, and constipation.</p> <p>Resident #1's progress notes, from 2/7/14 through June 6/5/14, indicated no assessment, monitoring or evaluation was documented regarding the Namenda. (Refer to F309.)</p> <p>There was no care plan developed to monitor the Namenda for side effects, no goal was developed to determine the effectiveness of the medication and no individualized interventions were addressed.</p>	F 329			

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F 329	<p>Continued From page 232</p> <p>On 3/7/14, Physician progress note: "Continue his current medications. He seems to be tolerating the Namenda 5 mg p.o. b.i.d."</p> <p>On 6/6/14, progress note: "Resident seen on rounds by Dr...Also reviewed (pharmacy) consult related to Namenda indicating he would consider same (discontinue) after assessing response to Prozac d/c (being discontinued)..."</p> <p>Celexa</p> <p>On 3/14/14, Resident #1 had a physician order for Celexa (an antidepressant) 2.5 mg one tablet every day for 14 days, then increase to 5mg every day for depression. Resident #1 was already receiving Prozac, another antidepressant. This would be duplicative therapy.</p> <p>Review of Resident #1's March 2014 monthly behavior flow sheet indicated he was receiving Fluoxetine (Prozac) for pacing, restlessness and fearful. The Monthly Behavior Flow Sheets did not identify the addition of Celexa or what other signs and symptoms of depression resident was having that were different from before.</p> <p>Review of Resident #2's April monthly behavior flow sheet indicated he was receiving Prozac, Celexa and Ativan. Targeted behavior of agitation was added to the pacing, restlessness and being tearful. There was no clear indication what drug is being used for what behavior.</p> <p>Review of Resident #2's care plan does not indicate the use of Celexa, therefore there is no goal to evaluate the effectiveness of the medication and if any nonpharmacological interventions were tried prior to the medication</p>	F 329			

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F 329	<p>Continued From page 233 being ordered.</p> <p>On 4/18/14, Celexa was discontinued.</p> <p>Ativan</p> <p>On 3/3/14, the facility received physician orders to transfer Resident #1 from the main floor to ACU and to start Ativan (an anxiolytic) 0.5 mg every 6 hours as needed.</p> <p>Resident #1's wife was also a resident in the facility who was discharged to home on 3/8/14.</p> <p>Review of the care plan found that adjustment to a new living area and loss of his wife's presence at the facility were not addressed in the care plan.</p> <p>Review of Resident #1's medication record, progress notes, and monthly behavior flow sheets indicate:</p> <p>~Progress note on 3/5/14 states, "Resident grabbed the shirt of another Resident. Residents were seperated [sic] by CNA... and Resident was escorted to the TV room where he later had some APAP [tylenol] 650 mg and was later assisted to bed."</p> <p>The medication record indicated Ativan 0.5 mg was given at 12:32 p.m. and 8:02 p.m. There was no documentation that Ativan was even given or what triggered the behavior that would require Ativan to be given. The behavior monitoring flow sheet indicated targeted behavior was restlessness, pacing and agitation. Intervention consisted of redirection to his room.</p> <p>~Medication record on 3/7/14 indicated Ativan 0.5</p>	F 329			

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F 329	<p>Continued From page 234</p> <p>mg was given at 3:56 p.m. No progress note documented why the Ativan was given. The behavior monitoring flow sheet indicated 0 behaviors on 3/7/14.</p> <p>~Medication record on 3/8/14 indicated Ativan 0.5 mg was given at 8:02 p.m. No progress note documented why the Ativan was given. The behavior monitoring flow sheet indicated no behaviors on 3/8/14.</p> <p>~Medication record on 3/9/14 indicated Ativan 0.5 mg was given at 1:18 p.m. and 7:36 p.m. Progress note dated 3/9/14 states, "...Family members in this afternoon with res dog...Res does try talking but at times has a hard time making the words right using hand gestures. Res did have 2 x prn [as needed] medication for agitation." The behavior monitoring flow sheet: agitation section, addresses intervention on days for one-on-one, activity and redirection.</p> <p>~Medication record on 3/10/14 indicated Ativan 0.5 mg was given at 4:02 p.m. No progress notes documented that day or any documentation on the monthly behavior flow sheet.</p> <p>~ Medication record on 3/11/14 indicatd Ativan 0.5 mg was given at 2:17 p.m. No progress notes documented that day or any documentation on the monthly behavior flow sheet.</p> <p>~Medication record on 3/12/14 indicated Ativan 0.5 mg was given at 11:03 a.m. No progress notes documented that day. The behavior monthly flow sheet, under restless/pacing, indicated 5 episodes with interventions but does not specify what type of intervention and behaviors stayed the same.</p>	F 329			

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F 329	<p>Continued From page 235</p> <p>~Medication record on 3/13/14 indicated Ativan 0.5 mg was given at 10:26 p.m. No progress notes documented why Ativan was given and the behavior flow sheet is blank that day.</p> <p>~Medication record on 3/14/14 indicated Ativan 0.5 mg was given at 10:45 p.m. for a bath, effectiveness unknown. There was no progress notes that day and no documentation of behaviors on the monthly behavior sheet.</p> <p>~Medication record on 3/16/14 indicated Ativan 0.5 mg was given at 12:44 p.m. and 4:30 p.m. The 2nd dose was given prior the 6 hrs. as ordered by the physician.</p> <p>Progress note dated 3/16/14 states, "Resident is pacing all shift. At one point he was attempting to pick imaginary things of the floor. He began to crawl on the floor saying this needs to get fixed. He kneeled on the floor and became slightly unbalanced and tipped to his side...staff was able to re-direct him..."</p> <p>Behavior monitoring sheets indicated episodes of pacing and agitation, no interventions were tried and he remained the same.</p> <p>~Medication record on 3/17/14 indicated Ativan 0.5 mg was given at 4:39 p.m. No progress note related to behaviors. Behavior monitoring flow sheet indicated 3 episodes of agitation with no interventions tried.</p> <p>~Medication record on 3/19/14 indicated Ativan 0.5 mg was given at 1:15 a.m. for a bath, which was effective. There was no progress note addressing the bath or if there were any</p>	F 329			

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F 329	<p>Continued From page 236</p> <p>behaviors. The behavior monitoring flow sheet indicated 3 episodes of pacing/restlessness and use of redirection.</p> <p>~Medication record on 3/21/14 indicated Ativan 0.5 mg was given at 3:31 p.m., ineffective. No progress note documented that day. Behavior monthly flow sheet indicated 1 episode of agitation and interventions tried were one-on-one, fluids and food.</p> <p>On 3/22/14, progress note, "Resident discovered on the floor at 1:30 a.m. sitting in a puddle of urine...no evidence of injury..."</p> <p>Increase in Ativan</p> <p>On 3/24/14 a progress note, "New order for scheduled Ativan BID [twice a day]."</p> <p>Prior to increasing the medication, the facility did not develop and implement individualized interventions to address Resident #1 needs.</p> <p>~Medication record on 3/25/14 indicated Ativan 0.5 mg was given at 5:54 p.m., effective.</p> <p>Progress note SBAR-Change of Condition. "Situation: Resident ambulates independently about ACU. Staff heard noise and found resident in another resident's room, appears to have gone through bathroom...seen by CNA to bump resident into wall, abrasion to R elbow."</p> <p>Behavior monthly flow sheet indicated no behaviors that day.</p> <p>~Medication record on 3/26/14 indicated Ativan 0.5 mg was given at 2:10 p.m., ineffective.</p>	F 329			

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F 329	<p>Continued From page 237</p> <p>Progress note dated 3/26/14 at 4:00 p.m., does not address any behavior to warrant the Ativan. "Resident noted to have increased SOB (shortness of breath) with nonproductive cough, LS (lung sounds) diminished on R (right), expiratory rales on L (left) lower lobe...." "VS (vital signs) 157/79, 101.8 ax (axillary), 123, 36. Albuterol inhaler used. O2 sat (saturation) 86% on RA (room air). Noted to have increased anxiety. Examined by NP-O." Transferred to the hospital and was diagnosed with pneumonia.</p> <p>April 2014</p> <p>Resident #1 received Ativan 0.5 mg twice a day from 4/1/14 to 4/9/14.</p> <p>~ Medication review indicated Ativan 0.5 mg prn was given on 4/3/14 at 10:27 a.m. Progress note dated 4/3/14 states the NP-O was updated regarding "resident's increased irritability, restlessness & requesting cigarette yesterday PM. Staff reports that he is probably smoking when he goes out with spouse..." April behavior monitoring flow sheet indicated 1 episode of agitation with intervention of Ativan was ineffective.</p> <p>~Medication review on 4/3/14, indicated Resident #1's Celexa dose was increased to 5 mg a day.</p> <p>~Medication record on 4/9/14 indicated Ativan 0.5 mg was given at 3:37 p.m., effective. No progress note regarding any behaviors and the April behavior flow sheet was blank on 4/9/14.</p> <p>~Progress note dated 4/9/14 states Resident #1 was seen by NP-O who ordered, "increase</p>	F 329			

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F 329	<p>Continued From page 238</p> <p>Lorazepam (Ativan) to 0.5 mg po TID (three times a day)." This will be a total of 1.5 mg per day. The standard of practice for Ativan maximum dose for the elderly is 2 mg per day.</p> <p>Increase in Ativan</p> <p>Resident #1 received Ativan 0.5 mg TID from 4/10/14 through 4/30/14.</p> <p>Before increasing the medication, the facility did not develop and implement individualized interventions to address Resident #1's needs.</p> <p>~Progress note dated 4/12/14 states, "Resident observed having hallucinations this shift. Seen sitting on the edge of his bed talking to and petting his dog. Asked writer 'Isn't she a pretty dog?' Also asked for some water and a hot dog for the dog. Staff observed him 'walking' his dog with his arm extended, mimicking a person holding onto a leash. Talking to the dog: 'slow down' and 'that's a good girl.'"</p> <p>~Medication record on 4/17/14 indicated Ativan 0.5 mg was given at 6:19 p.m., effective. No progress note addressing any behaviors. Behavior monitoring flow sheet indicated episodes of pacing/restlessness and 4 episodes of agitation with medication as the intervention.</p> <p>~Medication record on 4/18/14 indicated Ativan 0.5 mg was given at 5:32 p.m., effective. Progress note dated 4/18/14 did not address any behavior. "New order to DC Celexa." No behaviors documented on the behavior flow sheet.</p> <p>~Medication record on 4/22/14 indicated Ativan</p>	F 329			

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F 329	<p>Continued From page 239</p> <p>0.5 mg was given at 12:47 a.m., effective. No progress notes on that day. No behaviors documented on the behavior monitoring log. No indication for the Ativan.</p> <p>~Medication record on 4/23/14 indicated Ativan 0.5 mg was given at 3:37 p.m., effective. No progress notes on that day. No behaviors documented on the behavior monitoring log. No indication for the Ativan.</p> <p>~Medication record on 4/30/14 indicated Ativan 0.5 mg was given at 12:44 a.m., unknown effectiveness and at 3:55 p.m., effective. Progress note on 4/30/14 does not indicate any behaviors. The behavior monitoring log indicated having episodes of restlessness, pacing and agitation. Interventions are one-on-one, redirect and return to room which were either the same or ineffective.</p> <p>May 2014</p> <p>Resident #1 received Ativan 0.5 mg TID from 5/1/14 through 5/30/14.</p> <p>~Medication record on 5/1/14 indicated Ativan 0.5 mg was given at 12:08 a.m and 5:44 p.m. **This is a total of 2.5 mg in 24 hrs. which is over the maximum dose for the elderly.</p> <p>Progress note dated 5/1/14 states, "Resident very agitated, swing fists at staff. Resident cursing at staff and other residents. PRN ativan was not effective."</p> <p>Behavior monitoring sheets indicate having behaviors of pacing, restlessness, tearful and agitation. Intervention was the Ativan.</p>	F 329			

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F 329	<p>Continued From page 240</p> <p>On 5/1/14 at 10:45 p.m., Resident had a fall with no injury.</p> <p>~Progress note on 5/4/14 states, "Called to resident's room at 7:15 a.m. Upon entering room resident had CNA by both arms and would not let go. Resident was in a very foul mood. Able to redirect to come to dining [sic] room for morning coffee and let go of CNA. Resident took two steps and then grabbed out to writer. Grabbed right wrist and started twisting. Able to redirect for very short time. Resident was shouting out 'help me' and started pacing the hall and into the dining room..." The Director of Nurses, family and police were notified of the event. Resident #1 was aggressive with the police officer and was hand cuffed prior to family arriving.</p> <p>Resident #1 received Ativan 0.5 mg at 8 a.m., noon and 8 p.m. and every 6 hrs. prn. for agitation. According to the progress note, Resident #1 received his a.m. behavior medications while family was present this morning.</p> <p>According to the medication record, Ativan 0.5 mg was given at 8:33 a.m. Family took resident for a home visit at 9:00 a.m., noon medications were sent with him.</p> <p>Progress note dated 5/4/14 at 2:23 p.m. states, "Resident returned to facility by wife. Resident is very quiet. Sits or stands watching all movements, not interacting with anyone. Wife stated resident was fine while at home with family."</p> <p>~Progress note dated 5/4/14 at 8:55 p.m. states,</p>	F 329			

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F 329	<p>Continued From page 241</p> <p>"called to ACU, two residents had an altercation ans [sic] were found on the floor in the hall ...currently sitting in lounge area with CNA, moving all extremities, usual incoherent speech, not paying attention to the other residents or staff, calm at this time, no bruising or redness noted, usual mentation."</p> <p>On 5/4/14 at 9:00 p.m., Resident #1 fell during the altercation. Neuro checks indicated a change in blood pressure and an elevated temperature of 99.1. No respiratory assessment was completed. Resident does have a diagnoses of COPD which increases anxiety and behaviors.</p> <p>~Medication review indicated that on 5/4/14 at 10:30 p.m., Ativan 0.5 mg was given. **This is a total of 2.5 mg in 24 hrs. which is over the maximum dose for the elderly and could cause adverse affects of the medication.</p> <p>Resident #1 went home with the family at 11:00 p.m.</p> <p>On 5/5/14, progress note at 3:45 p.m.,states, "Resident seen by ...NP-O who consulted with ...Psychiatric NP related to behaviors over past 24 hrs. New order received to schedule Aleve 220 mg po BID alternating with Acetaminophen 1000 mg BID, decrease Simvastatin to 40 mg daily, draw BMP (basic metabolic panel), CBC (complete blood count), TSH (thyroid stimulating hormone), decrease Floxetine (Prozac) to 10 mg po daily, starty [sic] Bengay to low back and joints Tid/PRN, start Seroquel (antipsychotic) 12/5 mg po daily at 4 PM and daily/PRN for dementia with delusions. Crisis unit also visited facility, did not feel resident was appropriate for referral at this time...Resident moved to private room on ACU</p>	F 329			

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F 329	<p>Continued From page 242 with staff to monitor activities while out of room..."</p> <p>It should be noted that the medication record indicated Resident #1 continued to receive prn Ativan with no clear indication and no nonpharmacological interventions were individualized and implemented prior to administering the Ativan to meet the resident needs. ~5/17 at 10:39 a.m. ~5/21 at 8:06 p.m. ineffective. ~5/22 at 11:20 p.m. ~5/26 at 5:17 p.m. & 9:04 p.m. which is greater than the maximum dose to be given to the elderly. ~5/27 at 9:14 p.m.</p> <p>Seroquel</p> <p>May 2014</p> <p>~Progress note dated 5/5/14 at 10:45 p.m. (time is not documented in real time) states, "Called to ACU by staff. Resident was holding onto both CNAs arms and they could not free themselves. Attempted to get resident to cooperate and redirect without success. Attempted to removed resident's hands but he only grabbed staffs arms tighter. was able to free one CNA but then grabbed other CNA with both hands on wrist. Call placed to son who came to facility and calmed resident."</p> <p>~Review of the medication record indicated Seroquel 12.5 mg can be given as needed 1 x per day for agitation/aggression related to Vascular Dementia with Delusions. Scheduled Seroquel 12.5 mg at 4:00 p.m. every day.</p> <p>No care plan was developed to address the</p>	F 329			

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F 329	<p>Continued From page 243</p> <p>Seroquel, therefore there is no goal to evaluate if the medication is effective or not, if any nonpharmacological interventions were tried prior to the medication being ordered and to monitor for side effects.</p> <p>Review of the May 2014 monthly behavior flow sheet does not have Seroquel listed on the form.</p> <p>~Progress note dated 5/6 states, "Resident in office in ACU talking to himself. Resident suddenly came out of the office, grabbed this writer by the wrist, twisting wrist and shoulder. CNA... contacted charge nurse...Resident given prn seroquel as per ordered. Medication was effective."</p> <p>Medication record indicated PRN Seroquel 12.5 mg was given at 7:47 p.m. There was no documentation that any nonpharmacological interventions were tried before administering the antipsychotic medication.</p> <p>~Progress note dated 5/8/14 states, "Resident has been mostly non-verbal this shift. Has been observing and watching everyone and every thing happening on the unit...Has been observed picking at unseen items on the floor and in the air. Some pacing noted. Did push a resident in her wheelchair against her wishes. With coaxing did let go of wheelchair. Did wandering into other residents rooms, many redirections given. After lunch resident started to get fidgety and agitated. Prn Sedroquel [sic] given..."</p> <p>Medication record indicated PRN Seroquel 12.5 mg was given at 2:03 a.m. and 1:00 p.m. No documentation if nonpharmacological interventions were tried.</p>	F 329			

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F 329	<p>Continued From page 244</p> <p>Increase in Seroquel dose</p> <p>~On 5/8/14, progress note states, "Called received from ...NP-O, order received to increase Seroquel to 12.5 mg po BID at 8 a.m. and 6 p.m., may have additional 12.5 mg po PRN x 2 in 24 hrs. each dose 6 hrs. apart."</p> <p>Before increasing the medication, the facility did not develop and implement individualized interventions to address Resident #1's needs.</p> <p>There were no progress notes documented after this increase from 5/8/14 until 5/12/14, therefore no monitoring of the increase in medication.</p> <p>~Medication record indicated on 5/13/14 at 3:13 a.m., Seroquel 12.5 mg was given. There are no progress notes documented. No behavior monitoring sheets for Seroquel. No indication that the antipsychotic medication should have been given.</p> <p>~Medication record indicated on 5/14/14 at 5:57 p.m., Seroquel 12.5 mg was given. Progress note dated 5/14/14 states, "Resident up upon start of shift. Resident pacing from room to middle of hall. Very confused, talking to unseen person...multiple one to one. Resident still unable to sit still. No c/o back pain..." "Resident was seen by ...NP, noted to have occ (occasional) cough..."</p> <p>No documentation of individualized nonpharmacological interventions were tried before administering an antipsychotic medication.</p> <p>~Medication record indicated on 5/17/14 at 10:40</p>	F 329			

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F 329	<p>Continued From page 245</p> <p>a.m., Seroquel 12.5 mg was given.</p> <p>~Progress note dated 5/17/14 at 9:34 a.m. states, "resident ate his breakfast & then began pounding on the DR [dining room] door screaming 'help.' Pacing about the unit, pounding on windows. ripping down curtains, turning over furniture, all the time yelling 'help.'" According to the progress note, NP-O was notified by the ACUD. New orders were received to increase Seroquel. Resident's family came in, he was given coffee & went outside with family for a brief time and is now resting quietly in his room.</p> <p>It should be noted that on his customary routine, Resident #1's most important thing is to go outdoors to enjoy the fresh air. According to the activity sheet, Resident #1 has not been outdoors except when family take him.</p> <p>Seroquel increase</p> <p>Review of the medication record indicated on 5/17/14, Resident #1's p.m. dose of Seroquel was increased from 12.5 mg to 25 mg.</p> <p>Before increasing the medication, the facility did not develop and implement individualized interventions to address Resident #1's needs. No care plan was developed regarding to the medications usage.</p> <p>~Medication record indicated on 5/18/14 at 11:12 a.m. and 8:06 p.m., Resident #1 received Seroquel 12.5 mg each time.</p> <p>~Progress note on 5/18/14 states, "... 1115 (11:15 a.m.) Resident becoming [sic] figity [sic] and wanting (his dog). PRN seroquel given at this</p>	F 329			

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F 329	<p>Continued From page 246</p> <p>time." "1145 (11:45 a.m.) Wife here with dog. Resident calm and eating lunch. Went outside on the patio area with wife for approx (approximately) 20 min. (minutes). Then came in and layed [sic] down for a nap on his bed." This intervention should have been implemented before the antipsychotic was given, thus eliminating the medication to be given.</p> <p>~Progress note on 5/18/14 states, " Resident given prn Seroquel at 2030 (8:30 p.m.). Wife called due to increase agitation. She came in and sat with him for 30 minutes. Resident became agitated yet again. His son was called and he arrived at 10:45 p.m. He relates that he will sit with him until he falls asleep." There were no nonpharmacological interventions tried.</p> <p>~Medication record indicated on 5/20/14 at 4:10 a.m., Seroquel 12.5 mg was given.</p> <p>Progress note on 5/20/14 does not mention any behaviors. There was no indication to give the prn Seroquel. However, the physician assessed Resident #1's cough. New orders for Azithromycin pak (antibiotic). Ordered x-ray which revealed bilateral lower lobe atelectasis.</p> <p>~Medication record indicated on 5/21/14 Seroquel 12.5 mg was given at 12:19 p.m. and 9:33 p.m. There were no progress notes documented on 5/21/14. No indication for the Seroquel to be given.</p> <p>~Medication record indicated on 5/22/14 Seroquel 12.5 mg was given at 6:46 p.m.</p> <p>There was no progress note documented of any behaviors. No indication for the Seroquel to be</p>	F 329			

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F 329	<p>Continued From page 247 given.</p> <p>~Medication record indicated on 5/26/14 Seroquel 12.5 mg was given at 9:07 p.m.</p> <p>Progress note dated 5/26/14 states, "Resident at 04:00 (4:00 a.m.) was aggressive with CNA...pushing her and attempting to take another Resident through the unit doors. Resident calls this other Resident ..., and talks about home. Resident given seroquel, PRN dose, APAP, and Ativan to decrease his anxiety and allow him to relax. Within 20 minutes Resident was lying in his bed, and ready to relax." There were no nonpharmacological interventions tried before administering the antipsychotic.</p> <p>~Medication record indicated on 5/28/14 Seroquel 12.5 mg was given at 12:29 a.m.</p> <p>Progress note dated 5/28/14 states, "Resident was awake during the noc. he was aggravated. This writer noted him to be attempting to punch the glass window in the activity area. Gave seroquel as per prn order. Gave tylenol for c/o (complaints of) back pain. Applied icy hot as per prn order. He still did not settle down. Notified daughter. She came and he finally went to sleep on the couch in the activity room. Snacks were provided, in attempts to settle him down earlier as well."</p> <p>*It should be noted that the Tylenol was given at 12:40 a.m., after the Seroquel was given. The medication record did not indicate that Icy Hot was given. Seroquel (antipsychotic) was being given before other interventions were tried first.</p> <p>~Medication record indicated on 5/29/14 Seroquel</p>	F 329			

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F 329	<p>Continued From page 248</p> <p>12.5 mg was given at 12:52 a.m. and 9:14 p.m.</p> <p>There are no progress notes documented on 5/29/14. There was no indication for the Seroquel to be given.</p> <p>~Medication record indicated on 5/31/14 Seroquel 12.5 mg was given at 0044 (00:44 a.m.).</p> <p>Progress note dated 5/31/14 states, "Resident up and down until 01:00 a.m., APAP 650 and Seroquel were given for comfort and agitation. Resident was still moving furniturw [sic] and going into other rooms at 03:30 (a.m.) When he was given Ativan to enc (encourage) rest and anxiety... daughter came in."</p> <p>June 2014</p> <p>Resident #1 continues to receive (this is not all inclusive, behavior meds and new meds since May 2014):</p> <p>~Seroquel 12.5 mg in a.m. and 25 mg on p.m. plus 12.5 mg prn every 6 hrs. for agitation related to Vascular Dementia with Delusions.</p> <p>~Ativan 0.5 mg TID and prn every 6 hrs. for agitation.</p> <p>~Fluoxetine HCL 10 mg every day for depressive disorder.</p> <p>~Namenda 5 mg BID related to Dementia without behavioral disturbance.</p> <p>~New medication on 5/28/14 of Benadryl HCL 25 mg BID for pruritis of skin.</p> <p>Discontinued 6/2/14:</p> <p>~Tylenol 1000 mg on 5/5/14 twice a day.</p> <p>~Oxycodone HCL 5 mg twice a day.</p> <p>~Miralax on 5/28/14 every day for constipation</p>	F 329			

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F 329	<p>Continued From page 249</p> <p>~Medication record dated 6/1/14 indicated Seroquel 12.5 mg was given at 11:06 a.m.</p> <p>Progress note dated 6/1/14 states, "Resident restless and tarding [sic] to move furniture around. Unable to redirect with this. PRN Seroquel given at 11:05 ...opened door and found resident tipping chair in room over...call placed to daughter ... and wife did come in with dog and resident did quiet down after they were..."</p> <p>There was no care plan with individualized interventions for the behavior. No documentation on what triggers the behaviors and no goals to determine which medication is effective or not.</p> <p>~Medication record dated 6/4/14 indicated Seroquel 12.5 mg was given at 2:21 a.m. and 8:23 a.m.</p> <p>Progress note dated 6/4/14 states, "Resident up and down from 01:00 to 02:15, Resident was given APAP 650 mg, Ativan, and Seroquel 12.5 mg with good results, but took an hour and a quarter to be effective." No documentation if nonpharmacological interventions were tried first before administering the antipsychotic medication.</p> <p>On 6/5/14 at 2:34 a.m., Resident #1 fell, found on the floor in his room sitting at the foot of bed. According to the investigation report, Resident #1 had a prn Seroquel on the p.m. shift of 6/4/14. Root cause is having increased insomnia. Plan: Medication review with NP and Pharmacy.</p> <p>The June 2014 behavior flow sheet indicated Seroquel and Benadryl were added to the Fluoxetine and Ativan listed on the form. Prior to</p>	F 329			

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F 329	<p>Continued From page 250</p> <p>this the Seroquel was not being monitored.</p> <p>It is hard to determine which behaviors and interventions were used for type of medication given. The facility uses a code system for types of interventions to be used. The interventions are not individualized for Resident #1's needs. The targeted behaviors on the form still state, "pacing, restless, tearful and agitated." Delusions are not being monitored for the use of Seroquel.</p> <p>The immediate jeopardy that began on 6/3/14 was not removed at the time of the exit from the survey (6/25/14) because the facility failed to fully implement their removal plan.</p> <p>Example #3:</p> <p>Resident #3 was admitted to the facility on 9/12/13 with diagnoses of Advanced Dementia, Anxiety, Functional and Urge urinary incontinence and Generalized Osteoarthritis in multiple sites.</p> <p>On 9/26/13, Resident #3's physician orders included an order for Ativan 0.5 mg every 6 hrs. as needed for anxiety, restlessness, agitation regarding to Anxiety state.</p> <p>Review of Resident #3's Social History does indicate that he worked in a motor shop, was in the Army, raised deer at his home, likes to greet people daily with Happy Birthday/Merry Christmas and if he is not acknowledged he gets angry. Stuffs paper products in clothing.</p> <p>Review of the Comprehensive MDS, dated 9/19/13, indicated it is very important to do his favorite activities and it is very important to go outside and get fresh air. There was no mention</p>	F 329			

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F 329	<p>Continued From page 251</p> <p>what his favorite activities are. Review of the most current quarterly MDS assessment indicated a change in condition; needing more assistance with ADLs and receiving antianxiety medications. Resident continues to wander almost daily which does not put him or others in danger.</p> <p>Review of the Resident #3's CAAs dated 9/18/14, completed by the ACUD indicated the following Analysis of Findings:</p> <p>~Nature of the problem: "walks up and down the corridor many times per day. Does not enter other peoples room and stays quiet." ~Seriousness of the behavioral symptoms is blank. ~Nature of the behavioral disturbances (resident interview, if possible; staff observation) is blank. ~Medication side effects that can cause behavioral symptoms is blank. ~Illness or conditions that can cause behavior problems is blank. ~Factors that can cause or exacerbate the behavior (from observation, interview, record) is blank. ~Cognitve status problems; Delirium and Dementia is checked. ~Other considerations is blank. ~Care Plan Considerations: Will behavior symptoms-Functional Status be addressed in the care plan? "yes." If care planning for this problem what is the overall objective? blank. Describe impact of this problem/need on the resident and your rationale for care plan decision. "Resident #3 exhibits pacing behaviors and has difficulty staying on task. He is pleasant but can get aggressive with cares if he doesn't like your</p>	F 329			

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F 329	<p>Continued From page 252</p> <p>answer. He is constantly searching for his wife. Will care plan to have interventions in place to redirect and monitor."</p> <p>Review of Resident #3's care plan, dated 9/12/13, indicates: "I have little or no awareness of safety, or boundaries related to others persona space (etiology choice here). Please help me remain in a living environment that meets and supports my need to safely wander such as a secured unit or specialized care unit..."</p> <p>There was no mention of continuous pacing and/or agitated (agitation does not describe the specific behavior). There are no triggers identified that increases Resident #3's continuous pacing and/or agitation. There are no individualized nonpharmacological interventions put into place to decrease Resident #3's anxiety prior to administering the prn Ativan. There are no goals written related to his agitation and need for the Ativan.</p> <p>Review of the monthly activity record does not indicate that he goes outdoors, which is one of his most important things he liked to do.</p> <p>Review of Resident #3's behavior monthly flow sheet indicated continuous pacing and agitation.</p> <p>An entry of Resident #3's progress notes dated 9/13/13, "Resident has been wandering the unit aimlessly...does well with redirection."</p> <p>On 9/14/13, progress note indicated: "Resident has been wandering the unit aimlessly going into others rooms and tends to wears others clothing...is no longer trying to leave the unit and is doing well with redirection..."</p>	F 329			

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F 329	<p>Continued From page 253</p> <p>On 9/15/13, progress note documented at 6:45 p.m. indicated: "Resident was trying to leave the ACU via the fire exit door. Writer attempted to stop resident by saying that we can not leave out of this door at this time and holding door shut. Resident became agitated and garbed [sic] by the throat in attempt remove writer form [sic] the area so that he could leave and go for a walk outside which is one of the activities he enjoyed while at home...another staff member who was able to distract the resident and redirect to the TV lounge..."</p> <p>No nursing documentation from 9/17/13 until 9/20/13. On 9/20/13 at 4:37 p.m., a progress note indicated, "has a sore throat and a bad cough."</p> <p>No nursing documentation from 9/21/13 until 9/26/13 regarding the sore throat or assessment of the bad cough. A nurse's note indicated the physician was updated on family's request for an antianxiety to promote resident's well-being. New order for Ativan 0.5 mg every 6 hrs. prn.</p> <p>Review of the Medication Adminisrtration Record (MAR), Monthly Behavior Flow Sheets and Progress notes indicate:</p> <p>~Sept. 2013: Ativan 0.5 mg given 4 times. No documentation of behavior characteristic or reassessment of the need for medication administration. 1 documented behavior of pacing in halls unable to sit 5 minutes. No nonpharmacological interventions tried prior to administration of the psychotropic medication. No behavior flow sheets.</p> <p>~Oct. 2013: Ativan 0.5 mg given 14 times. 4</p>	F 329			

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F 329	<p>Continued From page 254</p> <p>times no documented reason for the medication given. Documented behaviors of anxiety, agitation, restlessness, pacing, wandering and resistive of cares. No nonpharmacological interventions tried prior to administration of the psychotropic medication. No behavior flow sheets.</p> <p>~Nov. 2013: Ativan 0.5 mg given 14 times. 9 times no documented reason for the medication given. Documented behaviors of restlessness and anxious. No nonpharmacological interventions tried prior to administration of the psychotropic medication. No behavior flow sheets.</p> <p>~Dec. 2013: Ativan 0.5 mg given 14 times. 7 times no documented reasons for the medication given. Documented behaviors of restlessness, anxiety, agitated, pacing and increase behavior. No nonpharmacological interventions tried prior administration of the psychotropic medication. Behavior monitoring flow sheet implemented for triggers of #2 agitated and #8 continuous pacing. No nonpharmacological interventions were used prior to administration of the psychotropic medications.</p> <p>On 12/3/13, new order to given Tylenol 650 mg for complaints of aching knees and elevated temperature.</p> <p>Tylenol 650 mg given 6 times with the Ativan dose.</p> <p>~Jan. 2014: Ativan given 9 times. 4 times no documented reason for the medication given. Documented behaviors of agitation, pacing, irritable and in bed with another resident.</p>	F 329			

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F 329	<p>Continued From page 255</p> <p>Nonpharmacological approaches used 5 times; was one-on-one, Activity, Food, Fluids and Redirect 5 times. These approaches are canned words that are not individualized per assessment.</p> <p>Tylenol 650 mg given 9 times. 5 of those times were given with Ativan.</p> <p>Since pain has been identified as a precursor to the behaviors, Ativan administration has been decreased. The facility should have known that Resident #3 was having pain according to his history of chronic pain and previous injuries. Therefore, Ativan was being used without proper indication and justification.</p> <p>~Feb. 2014: Ativan 0.5 mg given 14 times. 4 times no documented reason for the medication given. Documented behaviors of restlessness, agitation and pacing.</p> <p>Nonpharmacological approaches used 3 times as above.</p> <p>Tylenol 650 mg given 10 times. 6 of those times were given with Ativan.</p> <p>~March. 2014: Ativan 0.5 mg given 9 times. 5 times documented with no reason. Documented behaviors of restlessness, agitation and pacing.</p> <p>Nonpharmacological approaches used 4 times which are the same as above.</p> <p>Tylenol 650 mg given 6 times. 3 of those times were given with Ativan.</p> <p>On 3/10/14, Tylenol 650 mg TID (three times a day).</p>	F 329			

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F 329	<p>Continued From page 256</p> <p>On 3/10/14, Tramadol 50 mg ordered every 4 hours as needed. Received 7 times with no nonpharmacological approaches prior to administering the medication. Tramadol is an Analgesic for moderate to moderately severe chronic pain.</p> <p>~April 2014: Ativan 0.5 mg given 8 times. Documented behaviors of agitation, pacing, swearing at staff, striking out and found in another persons bed. Nonpharmacological interventions were tried (same as above) and ineffective, however there was no evidence that anyone tried individualized approaches such as: taking outdoors or do his favorite activity. The approaches were identified on the initial MDS assessment.</p> <p>Tramadol 50 mg was given 4 times. No nonpharmacological approaches were tried prior to administration of the medication.</p> <p>On 4/14/13, Resident #3 had a witnessed fall; lost balance and fell on right side. Received Ativan at 7:29 a.m., scheduled Tylenol 8:00 a.m., Noon, 8:00 p.m. and Tramadol 50 mg at 7:47 p.m.</p> <p>~May 2014: Ativan given 3 times. No documentation 1 time. Documented behaviors of agitation and restlessness. Nonpharmacological approaches were tried 1 time which was ineffective.</p> <p>Medication changes:</p> <p>~On 5/5/14- Tramadol 50 mg three times a day. Received 20 doses.</p> <p>~On 5/13 & 5/14, Tramadol 25 mg three times a</p>	F 329			

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F 329	<p>Continued From page 257</p> <p>day, give with scheduled Tylenol. Received 5 doses then discontinued.</p> <p>~On 5/16/14, Discontinue Tylenol 650 mg TID.</p> <p>~On 5/16/14, Tylenol Extra Strength 1000 mg TID.</p> <p>~June 2014: As of 6/10/14, received Ativan 0.5 mg 1 time on 6/7/14 at 1:41 p.m. by medication aide. Behaviors documented was very anxious, keeps getting up. No nonpharmacological interventions tried prior Ativan administration. There was no evidence that the nurse was contacted to give permission to the medication aide to administer the medication. The medication aide documented that the medication was effective "started settling down right away."</p> <p>*On 6/7/14 at 2:48 p.m., Progress note indicated, "Resident had a fall, witnessed by staff..." No assessment documented. At 3:06 documented a SBAR-Change of Condition: "...Staff noted that his gait was unsteady however they were ambulating another resident who needs 1:1 assistance. He turned to go into bedroom door and lost his balance causing him to fall. Did not hit his head." "Assessment...He had c/o pain in the right flank however upon questioning family and staff, they stated he had this complaint for at least 3 days...VS=186/75, 82, 20, 96.9 MD...update with NNOs (no new orders)."</p> <p>Resident #3 had 4 falls since receiving Ativan (11/4/13, 12/11/13, 4/14/14, 5/11/14). Side effects of Ativan can include weakness and unsteadiness.</p> <p>Example #4:</p> <p>Resident #4 was admitted to the facility 11/21/13</p>	F 329			

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F 329	<p>Continued From page 258</p> <p>and has diagnoses of Alzheimer's Disease, Dementia with Behaviors, Insomnia, Elevated Prostate Specific Antigen which is most commonly associated with Benign Prostatic Hyperplasia (BPH) or enlarged prostate, Depression, and Pain.</p> <p>Depakote GDR</p> <p>Upon admission, Resident #4's physician orders included an order for Depakote 250 mg (milligrams) twice a day for Dementia with Behavioral Disturbances.</p> <p>In February 2014, the Consultant Pharmacist recommended a GDR of the Depakote. The recommendation form contains blanket statements for the physician to use in responding to the request. On 2/7/14, the physician responded by circling the blanket statement, "Risk of dose reduction outweighs benefits, as a reduction attempt would be likely to impair the resident's function, cause psychiatric instability by exacerbating an underlying psychiatric disorder, on increase distressed behavior."</p> <p>Review of the Physician's Progress Note dated 2/7/14 states, "...Continue with same dose of Depakote and Ativan..." There was no specific justification as to why a GDR of Depakote would be clinically contraindicated for Resident #4.</p> <p>Depakote Increase</p> <p>Surveyor #16041 reviewed Resident #4's progress notes for 5/1/14 which state, "Resident was seen on rounds...informed that the resident appears to be having increased behaviors during the noc (night) time hrs. (hours). New order</p>	F 329			

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F 329	<p>Continued From page 259 received to change Depakote Sprinkles to 250 mg in AM and 375 mg in PM..."</p> <p>Review of Resident #4's physician orders found that on 5/1/14, the order for Depakote was increased to 250 mg in the morning and 375 mg in the evening.</p> <p>Review of previous progress notes (back to February 2014) found entries in March 2014 when he was up at night and urinating in inappropriate places.</p> <p>The facility also completed the Behavior Monthly Flow Sheet. Review of March and April flow sheets found only 1 behavior of kicking and continuously pacing in 61 days.</p> <p>There was no evidence to support that an increase in the Depakote was warranted.</p> <p>Ativan</p> <p>Upon admission, Resident #4 had an order for Ativan 2 mg twice a day.</p> <p>An entry in the Progress Notes, dated 3/7/14 states, "...New orders decreasing scheduled Ativan...Gdn (Guardian) updated and very pleased with reduction in antianxiety medication."</p> <p>Resident #4's physician order was updated to include Ativan 1 mg twice a day.</p> <p>Review of Resident #4's MARs (Medication Administration Records) found that Resident #4 received the reduced dose of Ativan 3 times: evening of 3/7/14 and morning and evening on 3/8/14.</p>	F 329			

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F 329	<p>Continued From page 260</p> <p>An entry in Resident #4's Progress Notes dated 3/8/14 at 7:02 p.m. states, "Resident had altercation with another male resident...no known provocation. No injury noted to either resident. Noted that residents Ativan was decreased from 2 mg BID (twice a day) to 1 mg BID. (On-call physician) informed of incident. Received new order to restart Ativan 2 mg BID..."</p> <p>Surveyor #16041 asked the facility to contact the Registered Nurse who made the entry. Attempts to reach her during the survey were unsuccessful.</p> <p>Review of Resident #4's care plan found that he has a history of wandering. The other male resident, identified as Resident #18, was identified by staff as preferring privacy in his room. The facility's investigation indicated Resident #4 had entered Resident #18's room prior to the altercation. Despite having the above knowledge, there were no nonpharmacological interventions attempted prior to increasing Resident #4's antianxiety medication.</p> <p>Resident #4's current daily dose of Ativan is 4 mg total. This exceeds the daily dose threshold for anxiolytic medications. Because the facility has no individualized care plan in place to address Resident #4's behaviors, there is no justification for the excessive dose. (Refer to F279, F248, and F309.)</p> <p>On 6/10/14 at 4:10 p.m., Surveyor #16041 spoke with the DON (Director of Nursing). The DON was asked how the determination was made that Resident #4's behavior was related to dose reduction. The DON indicated she was not here at the time of the incident, so she didn't know</p>	F 329			

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F 329	<p>Continued From page 261</p> <p>what was tried. The DON stated, "I read the note too. Not sure how the determination was made."</p> <p>On 6/11/14 at 11:15 a.m., Surveyor #16041 spoke with the ACUD (Alzheimer's Care Unit Director) about Resident #4's altercation on 3/8/14 and the subsequent increase in the Ativan. The ACUD stated she was not in the facility during the altercation. The ACUD stated, "I can't tell what they can see. What I got out of the notes is that he (Resident #4) was out of normal."</p> <p>Surveyor #16041 asked the ACUD if any nonpharmacological interventions were attempted before the Ativan was increased. The ACUD stated she did not see any. The ACUD was asked what the process is for changing/increasing antipsychotic medications. The ACUD stated if the nurse feels it is necessary, they contact the physician for the order. Surveyor #16041 asked if changes like that are reviewed by the Behavior Committee prior to getting an order. The ACUD stated Resident #4 was not reviewed by the Behavior Committee.</p> <p>Example #5:</p> <p>The facility's undated Antimicrobial Stewardship Program policy and procedure states, "Antibiotics are not to be ordered unless the resident has been diagnosed with an infection...The definitions of infection outlined in the document, Surveillance Definitions of Infections in Long-Term Care Facilities: Revisiting McGeer Criteria, 2012, will be utilized for this purpose..."</p> <p>The article, "Surveillance Definitions of Infections in Long-Term Care Facilities: Revisiting McGeer</p>	F 329			

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F 329	<p>Continued From page 262</p> <p>Criteria" defines a UTI (Urinary Tract Infection) as having dysuria (painful urination) or fever and at least 1 of the following: acute costovertebral angle pain, suprapubic pain, gross hematuria, new or marked increase in incontinence, new or marked increase in urgency, and/or new or marked increase in frequency. In the absences of fever, 2 or more of the above symptoms must be present.</p> <p>The facility's Antimicrobial Stewardship Program policy and procedure also states, "...If the report shows more than two organisms it should be considered contaminated...A practitioner may provide orders for antimicrobials without meeting the criteria if he/she provides rationale for doing so..."</p> <p>Resident #11 was admitted to the facility on 11/29/10.</p> <p>Review of Resident #11's Progress Notes, Laboratory Results, and Physician Orders reveal the following:</p> <p>~Progress Note on 11/2/13 states, "Result of uric acid level is elevated at 8.4...Family called and informed of uric acid level...They state that Resident #11 does have a dx (diagnosis) of gout (a form of arthritis). They have observed that she tends to have flare ups when she has a UTI."</p> <p>A urine specimen was obtained on 11/4/13. The UA (urinalysis) also dated 11/4/13, indicated trace blood, high leukocytes, high white blood count, 1+ bacteria. Resident #11's physician started Resident #11 on Bactrim DS (double strength) 2 times a day for 7 days. There was no evidence that Resident #11 was symptomatic and did not</p>	F 329			

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F 329	<p>Continued From page 263</p> <p>meet the criteria for initiating antibiotics.</p> <p>On 11/5/13, the culture and sensitivity was received and indicated there were 3 organisms present in the sample with 1 predominate. According to the facility's policy and procedure, contamination of the sample should have been suspected. Resident #11 received the full 7-day course Bactrim even though there was no evidence to support the use of the antibiotic.</p> <p>~Progress Note on 3/8/14 indicated the on-call physician was notified of Resident #11's pain in her left wrist and family stating she has gout flare ups when she has a UTI. The physician ordered a UA. The urine specimen was obtained on 3/10/14.</p> <p>The UA results were received on 3/10/14 which stated, "Predominant organism probably contaminate; no susceptibility." Based on this finding, the lab did not complete a C&S. On 3/10/14, Resident #11's physician ordered Bactrim DS, twice a day for 7 days. Resident #11 had no signs or symptoms and there was no laboratory indication for antibiotic therapy. Resident #11 received the entire course of antibiotics without adequate indications for use.</p> <p>~Progress Note on 4/9/14 indicated Resident #11 was sent to the emergency room for evaluation of increased lethargy/weakness. Resident #11 returned to the facility on the same date with an order for Cipro 500 mg twice a day for 10 days, "...Discontinue if culture negative..."</p> <p>The UA results stated, "3 or more organisms; no predominant, possible contaminated spec (specimen)." Based on this finding, the</p>	F 329			

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F 329	Continued From page 264 laboratory did not complete a C&S. A note written by the DON (Director of Nursing) on the UA states, "4/11/14, Reviewed with Dr...cont (continue) Cipro as ordered." There was no evidence to support the continued use of the antibiotic. On 6/10/14 at 11:50 a.m., Surveyor #16041 spoke with the DON. The DON stated the physician can make a decision to start an antibiotic even if a resident doesn't meet the criteria. When asked why UAs were obtained for Resident #11 when she had no signs or symptoms of having an infection, the DON stated Resident #11 was on hospice and the antibiotics provided some comfort for her. Resident #11 was not admitted to Hospice until 5/5/14.	F 329			
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this	F 353			

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F 353	<p>Continued From page 265</p> <p>section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility did not have sufficient staff to meet resident needs.</p> <p>This has the potential to affect all 51 residents.</p> <p>This is evidenced by:</p> <p>This facility has a licensed capacity of 83 with a current census of 51. The facility has 4 wings, 1 of which is an Alzheimer's Care Unit with alarmed doors where 13 people reside.</p> <p>Surveyor #25989 received the facility's Resident Census and Conditions of Resident report. ADLs (Activities of Daily Living) is divided as being Independent, Assist of One or Two Staff, and Dependent.</p> <p>Bathing: 0 independent, 43 assist of 1 or 2, 8 dependent. Dressing: 2 independent, 47 assist of 1 or 2, 2 dependent. Transferring: 14 independent, 29 assist of 1 or 2, 8 dependent. Toilet Use: 9 independent, 36 assist of 1 or 2, 6 dependent. Eating: 26 independent, 22 assist of 1 or 2, 3 dependent.</p> <p>Resident conditions indicate the following:</p>	F 353			

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F 353	<p>Continued From page 266</p> <p>Bowel/Bladder Status - 42 are occasionally or frequently incontinent of bladder, 42 on a toileting program.</p> <p>Mobility - 28 are in a chair all or most of the time, 18 require assistance or assistive devices with ambulation.</p> <p>Mental Status - 22 have signs/symptoms of depression, 28 have a psychiatric diagnosis, 37 have a diagnosis of dementia or Alzheimer's Disease, 13 have behavioral health needs.</p> <p>Skin Integrity - 48 are receiving preventative skin care.</p> <p>Special Care - 3 receive Hospice, 1 receives Dialysis, 1 receives intravenous therapy, 3 receive tube feedings.</p> <p>On 6/3/14 at 8:05 p.m., Surveyor #25989 interviewed Resident #3's family member who stated, "When p.m.'s (afternoon shift) come in there is no CNA just a nurse. This also happens on the weekends. Usually there is a CNA, but they are pulled onto the main floor." Family stated that 2 nights ago, another family member saw a resident, dressed only in an incontinence brief, fall. The family member reported it to the nurse who was sitting at the computer, and she appeared hesitant to come and help. This family member also reported that family had to shower Resident #3 "because he made a mess" and there was no staff available to give him a shower. The family member also stated families are asked to help with cares because they are working short.</p> <p>On 6/3/14 at 8:15 p.m., Surveyor #25989</p>	F 353			

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F 353	<p>Continued From page 267</p> <p>interviewed RN-EE (Registered Nurse) who stated she was in the ACU by herself last Saturday night. The CNA went home at 7 p.m. and no one replaced her.</p> <p>On 6/3/14 at 8:30 p.m., Surveyor #25989 interviewed CNA-MM who stated that on Friday night (5/30/14), a CNA from another facility came to help. A LPN worked as a CNA which left only 1 CNA on West. CNA-MM was by herself and 2 nurses on. CNA-MM also stated she and another CNA can only work 1/2 shifts in the ACU due to injuries.</p> <p>On 6/4/13 at 7:48 a.m., Surveyor #25989 spoke with RN-J who stated she used to only work in the ACU but lately she is working all over. RN-J stated there are times when there is no nurse in the ACU. When the facility is short with nurses on the main side, then a Med Tech is back on the ACU.</p> <p>On 6/4/14 at 8:07 a.m., Surveyor #25989 spoke with the ACUD who stated last night around midnight, the alarms went off in the ACU courtyard and staff could not shut them off. The alarms first woke up Resident #4 and Resident #5. Later 5 other residents were up including Resident #1 who had just gotten to sleep. At this time, there was only 1 CNA in the unit.</p> <p>On 6/11/14, a.m. (morning) shift in the ACU, Surveyor #25989 observed RN-LL working on the floor as a CNA. RN-LL stated she is a new RN and never was a CNA except during clinicals. Surveyor #25989 also observed LPN-W passing medications in the ACU. LPN-W stated she only works in the ACU about 1 time every 3 weeks. Surveyor #25989 observed LPN-W stop her</p>	F 353			

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F 353	<p>Continued From page 268</p> <p>medication pass to help RN-LL do cares for Resident #2 who was full of a loose bowel movement. LPN-W states she does occasionally have to stop her medication pass to help the CNA on the main side, but it is not as time consuming as it is back in the ACU. LPN-W stated in the ACU they also pass breakfast.</p> <p>On 6/11/14 at 1:30 p.m., Surveyor #25989 interviewed CNA-Q who has worked at this facility for 25 years. CNA-Q stated showers are to be done every week, documented in the computer and also in a book up by the nurses' station. When working on West a person is usually alone and most residents take 2 staff for their showers. Lifts are to be 1 or 2 person for transfers. CNA-Q stated there are not enough CNAs for the number of residents here. CNA-Q stated Resident #8 will often refuse to have a shower so she probably hasn't had one for a long time. CNA-Q stated Resident #8's hair would be washed by the beautician but that hasn't been done in a long time. (Refer to F132.)</p> <p>On 6/3/14, Surveyor #25803 spoke with Staff-E (Anonymous). Staff-E indicated there was not enough staff to meet the needs of the residents in the facility. Staff-E stated there were a lot more falls because staff were unable to respond to alarms timely, residents were not assisted with eating timely, residents were not being assisted with going to the bathroom for long periods of time, following toileting programs "just doesn't happen," not using 2 staff for transfers when the care plan indicates 2, and resident restorative programs were not being followed. Staff-E stated staff try to complete resident cares according to their care plans, but because of not enough staff</p>	F 353			

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F 353	<p>Continued From page 269</p> <p>they need to "cut corners." (Refer to F315 and F323.)</p> <p>On 6/3/14, Surveyor #25803 spoke with Staff-F (Anonymous). Staff-F stated there was not enough staff to meet the needs of the residents. Staff-F stated showers don't get completed and there was no ability to make the shower up; restorative programs don't happen according to resident care plans, snacks don't get passed, residents don't get toileted like they should, more falls occur, and some residents don't get enough assistance to eat. (Refer to F312, F315, F323, F368.)</p> <p>On 6/3/14, Surveyor #25803 spoke with Staff-G (Anonymous). Staff-G stated there was not enough staff to meet the needs of the residents. Staff-G stated restorative programs don't get done, there was no ability to complete 1:1, showers were not getting done, staff were using 1 person for transfers when the care plan indicated the resident required 2, taking residents to the bathroom didn't happen like it should, and call lights do not get answered timely. (Refer to F312 and F309.)</p> <p>On 6/3/14, Surveyor #25803 spoke with Staff-H (Anonymous). Staff-H stated there was not enough staff to meet the needs of the residents. Staff-H stated staff were unable to respond appropriately to residents with behaviors, which caused resident behaviors to escalate as staff "put them off," and restorative programs were not occurring according to resident care plans. (Refer to F309 and F329.)</p> <p>On 6/3/14, Surveyor #25803 spoke with Staff-D (Anonymous). Staff-D stated there were not</p>	F 353			

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F 353	<p>Continued From page 270</p> <p>enough staff to meet the needs of the residents and because of that, residents were being neglected. Staff-D stated residents don't get assisted into bed as requested, showers were not getting done, residents were not getting shaved, residents were not getting the assistance they needed to eat, residents sat with food spillage on their clothing, residents were not being assisted to the bathroom timely, and more falls were occurring. Staff-D stated management was looking at numbers and not acuity and was not responsive to their concerns. Staff-D stated behavior issues were "really bad" on the Alzheimer's Unit because there wasn't enough staff to meet the behavioral needs of the residents. (Refer to F309, F312, F315, F323, and F329.)</p> <p>On 6/4/14 at 10:32 p.m., Surveyor #25803 spoke with CNA-C (Certified Nursing Assistant). CNA-C stated there were not enough staff to meet the needs of the residents. CNA-C stated staff were unable to reposition residents every 2 hours, assist residents to the bathroom according to their toileting plan, complete residents' restorative programs and more falls occurred as they "can't be 6 places at once." (Refer to F315.)</p> <p>On 6/4/14, Surveyor #25803 spoke with Staff-I (Anonymous). Staff-I indicated they were unable to meet the needs of the residents. Staff-I stated residents' teeth were not getting brushed, behaviors were not being managed, and 3 residents recently had a restraint put on instead of clinically managing these residents. (Refer to F221, F309, and F329.)</p> <p>On 6/10/14 at 2:00 p.m., Surveyor #25803 spoke with Resident #5's spouse. Resident #5's spouse</p>	F 353			

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F 353	<p>Continued From page 271</p> <p>indicated the facility was not sufficiently staffed. Resident #5's spouse indicated Resident #5 was often found with soiled clothing from food spillage and usually "soaked" from incontinence. Resident #5's spouse indicated because Resident #5 was usually found wet and many times would be stating he needed to use the bathroom, Resident #5's spouse surmised staff just wanted Resident #5 to "go to the bathroom in his pants." Resident #5's spouse stated Resident #5's teeth were not brushed and was often found unshaven. Resident #5's spouse also stated Resident #5 was found with food on his hands and face. (Refer to F312 and F315.)</p> <p>On 6/10/14 at 4:00 p.m., Surveyor #25803 spoke with Family-NN. Family-NN stated she felt the facility was not sufficiently staffed. Family-NN stated she has found Resident #2 "soaked to the neck." Family-NN also stated she had gotten numerous calls, sometimes during the middle of the night, requesting she come to the facility to manage Resident #2's behaviors. Family-NN stated Resident #2 was in a specialized Dementia Care Unit and feels staff should be managing Resident #2's behaviors. (Refer to F309 and F329.)</p> <p>On 6/10/14 at 8:15 a.m., Surveyor #25803 spoke with LPN-AA. LPN-AA stated staffing had been an issue for a long time, and staff were very "stressed" because of it. LPN-AA also stated there were not enough staff to deal with the behavioral issues on the Dementia Care Unit. (Refer to F309 and F329.)</p> <p>On 6/10/14, Surveyor #25803 spoke with Staff-OO (Anonymous). Staff-OO stated there were not enough staff to implement the</p>	F 353			

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F 353	<p>Continued From page 272</p> <p>behavioral management programs in the Dementia Care Unit. Consequently, resident behaviors were not being managed, which caused behaviors to escalate. (Refer to F309 and F329.)</p> <p>On 6/10/14, Surveyor #25803 spoke with Staff-T (Anonymous). Staff-T stated staffing was inadequate which has led to inadequate care. Staff-T stated there were increased falls and behaviors related to inadequate staffing. Staff-T also stated the DON (Director of Nursing) was not responsive to issues of staffing and the concerns resulting from it.</p> <p>On 6/11/14 at 3:10 p.m., Surveyor #25803 spoke with the DON. The DON stated she felt the facility was adequately staffed. The DON stated there were enough staff to take care of the needs of the residents in the facility.</p> <p>On 6/10/14, Surveyor #30570 spoke with Staff-BB (Anonymous). Surveyor #30570 asked Staff-BB if there are enough staff to meet the needs of the residents. Staff-BB indicated often times residents do not receive showers or baths for several weeks or months as there are not enough staff to complete them. Staff-BB indicted residents are not toileted or repositioned on the night shift with the current staffing of 3 CNAs. Staff-BB further indicated 2 CNAs cover 3 wings and 1 CNA covers the Alzheimer Care Unit (ACU). With one staff having to report to the ACU to cover break times and resident rounds, it leaves 1 CNA to cover the other 3 wings for long periods of time.</p> <p>Staff-BB expressed resident falls are occurring</p>	F 353			

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F 353	<p>Continued From page 273</p> <p>due to unmet needs and staff not being able to respond to their needs timely. Staff-BB further expressed residents are being placed in Broda type wheelchairs that prevent them from rising as a means to prevent them from falling as it restricts their movement. (Refer to F312 and F323.)</p> <p>Staff-BB indicated she works the overnight shift and often finds the nutrition cart with snacks that have not been handed out to the residents when she reports to work. Staff-BB further indicated she often is required to work the evening shift due to staffing shortages. Staff-BB stated the evening shift does not pass bed snacks to residents because there is no time to do so due to the staffing in the facility. (Refer to F368.)</p> <p>On 6/10/14, Surveyor #30570 met with Staff-DD (Anonymous). Surveyor #30570 asked Staff-DD if there are enough staff to meet the needs of the residents. Staff-DD explained resident showers and baths are not being given due to staffing. Staff-DD further explained 3 CNAs for morning cares is not sufficient. Staff-DD indicated some residents have not received showers of baths since November, December or January.</p> <p>Staff-DD further explained the main reason for resident falls is not enough staff to meet their needs. Staff-DD further expressed there are times on the ACU unit that are dangerous for staff and other residents when residents are up at night and upset. There are not enough staff to manage their behaviors. (Refer to F309, F312, and F329.)</p> <p>On 6/10/14 at 8:10 a.m., Surveyor #30570 met with CNA-HH regarding staffing at night on the</p>	F 353			

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F 353	Continued From page 274 ACU. CNA-HH is the primary night shift CNA for the ACU. Surveyor #30570 asked CNA-HH if there is sufficient staff on the ACU to meet the needs of the residents at night. CNA-HH indicted if several residents are awake it is difficult to get to the other residents. CNA-HH further expressed one gentleman will get up and go into other resident rooms causing altercations with peers. CNA-HH further explained he is difficult to redirect and it is difficult to get other staff down to the unit timely for assistance. CNA-HH expressed other residents are at risk for injury. CNA-HH explained she has been kicked by this resident and her arm has been twisted, causing injury because she could not get assistance as other CNAs were not available. (Refer to F309.) On 6/4/14, Surveyor #16041 interviewed Staff-JJ (Anonymous). Staff-JJ was asked about staffing levels. Staff-JJ stated staffing is hard, especially with only 1 CNA (Certified Nursing Assistant). Staff-JJ stated cares get done, but activities suffer. Staff-JJ stated several residents do better in 1-to-1 activities and that is not possible. Staff-JJ stated only group activities get done. (Refer to F248, F309, and F329.)	F 353			
F 368 SS=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the	F 368			

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F 368	<p>Continued From page 275 following day, except as provided below.</p> <p>The facility must offer snacks at bedtime daily.</p> <p>When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility did not offer a bedtime snack to all residents, with the exception of those on the Alzheimer's Care Unit, on a daily basis.</p> <p>This had the potential to affect 38 out of 51 residents.</p> <p>This is evidenced by:</p> <p>During the Resident Group Interview conducted on 6/9/14 at 3:00 p.m., Resident #15 indicated she is not offered a bedtime snack. Resident #17 also indicated he keeps cookies in his drawer because he is not offered snacks before bed by the facility.</p> <p>On 6/10/14 at 7:00 a.m., Surveyor #30570 spoke with Staff-BB (Anonymous). Staff-BB indicated she works the overnight shift and often finds the nutrition cart with snacks that have not been handed out to the residents when she reports to work. Staff-BB further indicated she often is required to work the evening shift due to staffing shortages. Staff-BB stated the evening shift does</p>	F 368			

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F 368	<p>Continued From page 276</p> <p>not pass bed snacks to residents because there is no time to do so due to the staffing in the facility. Staff-BB stated the snacks for specific residents, marked with their names, are for individuals that are at risk due to health reasons like diabetes. Those snacks and various other snacks are not offered or provided to residents unless residents come to the cart and request them.</p> <p>On 6/11/14 at 8:35 a.m., Surveyor #30570 spoke with the Nursing Home Administrator (NHA) regarding bedtime snacks for the residents. The NHA indicated he was not aware of a requirement that mandates residents are to be offered a bedtime snack. The NHA explained he is aware that residents at risk are to receive a snack before bed. He explained a snack cart is prepared by dietary and is available for residents to request a snack. The NHA was directed to the language of the regulation.</p> <p>On 6/11/14 at 12:10 p.m., Surveyor #30570 met with CNA-N regarding resident snacks at bedtime. CNA-N indicated she has worked a variety of shifts in the facility. She further explained snacks are available at the snack cart but staff do not go room to room and offer snacks</p> <p>On 6/11/14 at 8:35 a.m., Surveyor requested and received evening snack data for the residents in the facility from 6/4/14 to 6/10/14 from the facility Director of Nursing (DON). The DON provided Surveyor #30570 with Individual "Resident Meal Log" sheets.</p> <p>The data represents 52 residents who resided in the facility during the timeframe. During the 7 days intake of all or a portion of the bedtime</p>	F 368			

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F 368	Continued From page 277 snack was recorded as follows: Intake of all or a portion of the snack record 7 of 7 days=0 residents. Intake of all or a portion of the snack record 6 of 7 days=0 residents. Intake of all or a portion of the snack record 5 of 7 days=8 residents. Intake of all or a portion of the snack record 4 of 7 days=3 residents. Intake of all or a portion of the snack record 3 of 7 days=7 residents. Intake of all or a portion of the snack record 2 of 7 days=8 residents. Intake of all or a portion of the snack record 1 of 7 days=12 residents. Intake of all or a portion of the snack record 0 of 7 days=14 residents. The DON informed Surveyor #30570 the data does not reflect whether a snack is offered or refused. The data represents amount consumed.	F 368			
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by:	F 371			

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F 371	<p>Continued From page 278</p> <p>Based on observations and interviews, the facility did not ensure that food was served under sanitary conditions.</p> <p>On the ACU (Alzheimer's Care Unit)</p> <p>~ACU staff did not wear a hair restraint while serving food; ~ACU staff did not implement hand hygiene including glove use at appropriate times; ~ACU staff touched the rims of glasses with contaminated gloves; ~Bare hand food contact by staff and a resident were observed; ~There was no monitoring of temperatures of the food delivered to the ACU before being served to residents. ~Juices served to ACU residents were almost a month past the use by date; ~Separate utensils were not used in each food item while serving.</p> <p>The facility's main kitchen was observed to have dried food particles on ceiling tiles above the stove. The kitchen ceiling vents had visible dust hanging above areas where food is prepared. The facility's cooling log demonstrated improper cooling procedures.</p> <p>This is evidenced by:</p> <p>The US Department of Health and Human Services, Food and Drug Administration, 2013 Food Code, includes the following references:</p> <p>"Hair Restraints 2-402.11 Effectiveness. (A) Except as provided in ¶ (B) of this section, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and</p>	F 371			

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F 371	<p>Continued From page 279</p> <p>clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single service and single-use articles. (B) This section does not apply to food employees such as counter staff who only serve beverages and wrapped or packaged foods, hostesses, and wait staff if they present a minimal risk of contaminating exposed food..."</p> <p>The exception would not include the ACU staff who are taking food out of bulk containers, and placing it on individual resident plates as they present more than a minimal risk of contaminating food items.</p> <p>"Specifications for Receiving 3-202.11 Temperature. (D) TIME/TEMPERATURE CONTROL FOR SAFETY FOOD that is cooked to a temperature...and received hot shall be at a temperature of...135 F or above."</p> <p>Because the foods are being brought in bulk to the ACU, the expectation would be to ensure they are received and held at the appropriate temperature before serving to residents.</p> <p>ACU:</p> <p>~On 6/4/14, Surveyor #16041 observed the refrigerator on the ACU. The refrigerator was noted to have many spills on the glass shelves. There was a large amount of a red substance on the bottom of the refrigerator which was clearly visible through the clear crisper drawers. Within the red substance was crumbs. There were several spills and splatters down the front grill at the bottom of the refrigerator.</p>	F 371			

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F 371	<p>Continued From page 280</p> <p>~In the refrigerator were 5 pitchers of juice. A pitcher of apple juice and a pitcher of orange juice were both dated "5-6." The other 3 pitchers were dated 6-5. According to the North Dakota State University's "Food Storage Guide" reconstituted juice may be stored under refrigeration for no more than 6 days. These pitchers were observed on the cupboard on 6/5/14. CNA-B was observed to pour juices from these pitchers and serve it to the residents.</p> <p>~On 6/5/14 beginning at 7:20 a.m., Surveyor #16041 observed CNA-B (Certified Nursing Assistant) serve breakfast. Scrambled eggs arrived on the unit in a covered bowl. Muffins were on a tray.</p> <ol style="list-style-type: none"> 1. CNA-B did not have a hair restraint on while dishing the food onto the plates. 2. CNA-B did not take the temperature of the eggs before serving to residents. 3. CNA-B donned gloves, took the cover off the tray of muffins and the cover off the bowl of scrambled eggs. CNA-B opened cabinet doors to get plates, and drawers to get a serving spoon. Observations of the cupboard doors and drawers found them to be dirty especially at the handles. CNA-B did not remove her gloves or sanitize her hands before picking up a clean plate, serving eggs and picking up a muffin with contaminated gloves. 2 residents were served. <p>CNA-B removed the contaminated gloves and used hand-sanitizer. With bare hands, CNA-B proceeded to touch cart handles, and again entered the drawer for silverware. CNA-B did not</p>	F 371			

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F 371	<p>Continued From page 281</p> <p>implement hand hygiene before donning gloves.</p> <p>CNA-B picked up a clean plate, served eggs and picked up a muffin with her contaminated gloves. CNA-B then served Resident #12. Before setting down the plate, CNA-B moved a dirty cereal bowl with her gloved hands. CNA-B did not remove the gloves or perform hand hygiene.</p> <p>CNA-B then picked up a clean plate, served eggs and picked up a muffin with contaminated gloves. CNA-B served Resident #21. Before setting the plate down, CNA-B again moved a dirty cereal bowl with her gloved hands. CNA-B unwrapped Resident #21's muffin, touching the muffin with the contaminated gloves.</p> <p>CNA-B then picked up a clean plate, served eggs and picked up a muffin with contaminated gloves. CNA-B served Resident #23. Before setting the plate down, CNA-B again moved a dirty cereal bowl with her gloved hands. CNA-B unwrapped Resident #23's muffin, touching the muffin with the contaminated gloves.</p> <p>CNA-B served the last resident in the dining touching the clean plate and picking up the muffin with the contaminated gloves.</p> <p>CNA-B then pushed an over the bed table into the dining/kitchen area and again touched the clean plate and unwrapped the muffin with contaminated gloves. CNA-B then removed the gloves and sanitized her hands.</p> <p>CNA-B was observed to go into the refrigerator and get a gallon of chocolate milk. CNA-B opened the cabinet and retrieved 2 glasses. CNA-B touched the rim of each glass with</p>	F 371			

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F 371	<p>Continued From page 282</p> <p>contaminated hands. CNA-B then took Resident #23's glasses out of her pocket and set them on the table by her. CNA-B then went into the drawer to get clean silverware and put it on the over-the-bed table. CNA-B went back over to Resident #23, picked up her glasses, cleaned them, and assisted Resident #23 to put them on. CNA-B then went back to the over-the-bed table, touched the plate and glasses, and covered the plate with the cover that was on the bowl of eggs. CNA-B delivered the table and meal to Resident #1's room.</p> <p>~On 6/10/14 at 3:05 p.m., Surveyor #16041 made observation in the ACU kitchen/dining room. The ACUD had baked dinner rolls for an activity. Surveyor #16041 observed a roll cut in half sitting directly on a table. The ACUD was observed to pick up the roll with bare hands and place it on a plate. The ACUD asked Resident #24 if she would like butter and jam for her roll. Resident #24 sat down, put butter and jam on the roll and ate it.</p> <p>~On 6/11/14, Surveyor #16041 observed breakfast in the ACU.</p> <ol style="list-style-type: none"> 1. LPN-W was observed to pour milk and sugar on several bowls of cold cereal and served those to residents. LPN-W was not wearing a hair restraint. 2. LPN-W uncovered bowls filled with French toast. At no time did she take the temperature of the foods before serving to the residents. 3. LPN-W put on a pair of gloves. LPN-W opened the cupboards and took plates out and set them on the counter. LPN-W did not remove 	F 371			

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F 371	<p>Continued From page 283</p> <p>the contaminated gloves or wash her hands. LPN-W picked up 2 pieces of French toast with the contaminated gloves. As she gave the plate to the resident, she placed her hand on the table. LPN-W then served 2 more residents by picking up French toast wearing contaminated gloves. LPN-W picked up a set of silverware and cut up a resident's French toast.</p> <p>LPN-W then opened a drawer and got a serving spoon. LPN-W did not remove the contaminated gloves or wash hands. LPN-W then picked up 2 more pieces of French toast and put them on a plate for a resident. As LPN-W tried to set the plate down, a resident's juice and milk glass were in the way. LPN-W placed her contaminated glove hand on the tops of both glasses and slid them out of the way. The resident had drank from the glasses prior to the move and drank from them after they were moved.</p> <p>After all residents had been served, LPN-W removed the gloves. LPN-W lowered Resident #2's foot rest and pushed him closer to the table. LPN-W then went to the sink and washed her hands. However, when she turned off the water, she did not use a barrier, thereby recontaminating her hands. LPN-W continued with medication pass at this time.</p> <p>~On 6/11/14 Surveyor #16041 observed lunch on the ACU.</p> <ol style="list-style-type: none"> 1. The ACUD was serving lunch from bowls and containers. She was not wearing a hair restraint. 2. The ACUD did not take temperatures of the foods prior to serving to residents. 	F 371			

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F 371	<p>Continued From page 284</p> <p>3. The ACUD was observed to use the same utensil to serve fish, baked potatoes, and tomatoes. Each food item should have a separate utensil.</p> <p>4. The ACUD put fish, a half baked potato and a tomato half on a plate. She approached Resident #19, gave her the plate and said, "Resident #19 can you fix this for him (motioning to Resident #18) by peeling the skin off the potato?" The ACUD then walked back to the cart and continued to serve food. Resident #19 picked up the baked potato and peeled the skin off of it. She handed the plate to Resident #18 who began to eat the food.</p> <p>On 6/11/14, at approximately 10:00 a.m., Surveyor #16041 spoke with the DM (Dietary Manager). The DM was asked if temperatures were checked before the food was served in the ACU. The DM stated the temperatures are checked in the kitchen before the food is put in bowls and sent to the ACU. Surveyor #16041 confirmed the bowls and other containers are not insulated to assist in holding the temperatures. The DM stated she does random audits of food temperatures, but ACU staff do not check and record temperatures of foods received.</p> <p>The DM was asked about the use of hairnets when ACU staff are serving foods from the bowls. The DM stated she never thought of that and would check with the RD (Registered Dietitian).</p> <p>On 6/11/14 at 11:35 a.m., the DM approached Surveyor #16041 and stated the RD explained the ACU staff are considered hostesses and would not need a hairnet; a hairnet would only be needed by Dietary staff per their policy. It should</p>	F 371			

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F 371	<p>Continued From page 285</p> <p>be noted that the policy was written at a time when the ACU followed family style dining, allowing residents to serve their own foods with limited staff assistance.</p> <p>The DM was later asked about the observation of one resident preparing another resident's food and bare hand contact. The DM stated that was not appropriate. The DM was also asked about staff using the same utensil to serve 3 different food items. The DM stated each food should have their own utensils.</p> <p>Main Kitchen:</p> <p>On 6/10/14 at 12:00 p.m., Surveyor #30570 observed food service for resident lunch. Noted above the steam table and food preparation area, there was a vent in the ceiling in which visible dust was hanging from the vent. The ceiling tiles above the stove were dirty with visible dried food particles. Surveyor #30570 asked the Dietary Manager (DM) about the tiles and dust. The DM indicated a work order has been submitted to replace the tiles. The DM further explained maintenance cleans the vents but she is uncertain of the frequency.</p> <p>On 6/11/14 at 10:00 a.m., Surveyor #30570 again toured the facility's kitchen and noted the vents were free of dust, the ceiling tiles continued to contain dried particles of food. The DM indicated the vents are cleaned routinely every 6 months but she could not find record of the cleaning of the vents and that she had cleaned the vents. The DM further indicated new ceiling tiles are on order.</p>	F 371			

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F 371	Continued From page 286 Surveyor #30570 asked the DM about cooling procedures during the tour. The DM explained the procedures that were in keeping with current standards of practice. Surveyor #30570 requested documentation of cooling procedures. The DM provided Surveyor #30570 with a Cooling Log, dated 4/12/14 through 6/9/14, indicating no other records could be located. The Cooling Log contained the following: ~4/12=Chicken Breasts: ~Start Temp: (Temperature) Hot food=135 degrees Fahrenheit=178; ~Temp/hot food (2 hours) Must be 70 degrees Fahrenheit or lower=100; ~Temp/hot food (4 hours) (total 6 hours) must be 41 degrees Fahrenheit or less=40. Of Note: the temperature did not reach a cooling temperature of 70 degrees Fahrenheit or lower at the 2 hour time frame and no reheating of the chicken breasts was recorded demonstrating standards of practice.	F 371			
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections	F 441			

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F 441	<p>Continued From page 287</p> <p>in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interviews and record reviews, the facility did not maintain an Infection Control and Prevention Program to help prevent the development and transmission of disease and infection.</p> <p>The facility had an outbreak that affected the ACU (Alzheimer Care Unit). The outbreak onset was 3/18/14 with residents manifesting symptoms of of nausea, vomiting, and diarrhea. The facility</p>	F 441			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441	<p>Continued From page 288</p> <p>practice is to terminally clean resident rooms one time after the precautions are lifted. Current standards of practice indicate terminally cleaning after an outbreak is for at least 72 hours. This practice had the potential to affect all residents in the facility.</p> <p>Resident #9 was treated with an antibiotic (Macrobid) prior to urine culture and sensitivity without documented justification. Two days later urine culture results indicated that the clean catch had 3 or more organisms, no predominate, possible contaminated specimen. The antibiotic was continued with no justification. On 5/12/14, Resident #9 was hospitalized with diagnoses of mild stroke and UTI (urinary tract infection). On 5/14/14, the Nurse Practitioner gave orders to obtain a urinalysis one week after antibiotic (Nitrofurantoin) is completed. Follow-up urinalysis are not indicated if a resident is asymptomatic.</p> <p>Resident #11 was treated with antibiotics for a urinary tract infection that did not meet the criteria for initiation of treatment. Over use of antibiotics can lead to the development of antibiotic resistant organisms in individuals.</p> <p>Based on interviews, no one was cleaning the humidifier located in the center of the Alzheimer's Care Unit. Failure to clean components of a dehumidifier can increase airborne irritants and recirculate infections.</p> <p>Observations revealed Resident #5 was not assisted with hand hygiene prior to eating a meal.</p> <p>This is evidenced by:</p>	F 441			

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F 441	<p>Continued From page 289</p> <p>Example #1:</p> <p>According to the revised 2009 publication by the Wisconsin Division of Public Health, Bureau of Occupational and Environmental Health, and the Division of Quality Assurance titled "Recommendations for the Prevention and Control of Viral Gastroenteritis outbreaks in Wisconsin Long-term Care Facilities," "Enhanced cleaning and disinfection should continue for at least 72 hours after the last documented case."</p> <p>On 6/10/14 at 10:15 a.m., Surveyor #30570 questioned HS-U (Housekeeping Supervisor) on the terminal cleaning procedure during and following an outbreak. HS-U indicated Housekeeping thoroughly cleans each resident room after they are notified that the resident is no longer on precautions. The cleaning includes bleaching the resident bathroom and disinfecting all hard surfaces in resident rooms, such as bedside tables, bed rails, counters etc., using the A-456II-Disinfectant Cleaner. HS-U also indicated all curtains are pulled down and washed.</p> <p>On 6/11/14 at 12:20 p.m., Surveyor #30570 again met with HS-U. Surveyor #30570 shared the facility's standard of practice, which is the current standard of practice titled, "Recommendations for the Prevention and Control of Viral Gastroenteritis outbreaks in Wisconsin Long-term Care Facilities." HS-U responded she had recalled seeing the handout during the last outbreak in March but was not aware of the need to terminally clean for at least 72 hours.</p> <p>On 6/11/14 at 2:00 p.m., Surveyor #30570 met with the Director of Nursing (DON), who is the</p>	F 441			

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F 441	<p>Continued From page 290</p> <p>facility's Infection Control Preventionist. The DON indicated there were several residents on the ACU with symptoms of nausea, vomiting, and diarrhea with onset of 3/18/14. The DON indicated the outbreak control measures were initiated after the 2nd resident presented with symptoms.</p> <p>The DON further indicated she circulated the current standard of practice; "Recommendations for the Prevention and Control of Viral Gastroenteritis outbreaks in Wisconsin Long-term Care Facilities" immediately to all departments. Surveyor #30570 asked the DON if the current standard of practice included terminal cleaning for 72 hours. The DON indicated terminal cleaning should occur for at least 72 hours and she had assumed the Housekeeping Supervisor was following the current standard of practice as she had reviewed a copy in March when the facility experienced the outbreak.</p> <p>Example #2:</p> <p>The facility's undated Antimicrobial Stewardship Program policy and procedure states, "Antibiotics are not to be ordered unless the resident has been diagnosed with an infection. There are specific criteria that must be met in order for the resident to be identified as having a true infection. The definitions of infection outlined in the document, 'Surveillance Definitions of Infections in Long-Term Care Facilities: Revisiting McGeer Criteria, 2012,' will be utilized for this purpose..."</p> <p>The article, "Surveillance Definitions of Infections in Long-Term Care Facilities: Revisiting McGeer Criteria" defines a UTI (Urinary Tract Infection) as having dysuria (painful urination) or fever and at</p>	F 441			

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F 441	<p>Continued From page 291</p> <p>least 1 of the following: acute costovertebral angle pain, suprapubic pain, gross hematuria, new or marked increase in incontinence, new or marked increase in urgency, and/or new or marked increase in frequency. In the absences of fever, 2 or more of the above symptoms must be present.</p> <p>The facility's Antimicrobial Stewardship Program policy and procedure also states, "...If the report shows more than two organisms it should be considered contaminated...A practitioner may provide orders for antimicrobials without meeting the criteria if he/she provides rationale for doing so..."</p> <p>Resident #9 was readmitted from a one-day hospitalization following a fall on 5/12/14. Diagnoses included, but not limited to, Mild stroke, Urinary Tract Infection, Dementia, and Congestive Heart Failure.</p> <p>Review of Resident #9's Progress Notes, Laboratory Results, Physician Orders and Hospital Discharge Summary revealed the following:</p> <p>~Progress note on 5/2/14 states, "Resident noted to have decline in cognition with periods of agitation. Staff feel that she may be having difficulty hearing even with current hearing aids in place. Noted to become angry quite easily." Received new order from resident physician for UA (urinalysis) with C&S, also for PT/OT/ST eval and tx. Had fall from recliner in her room last evening. There was no evidence that Resident #9 had signs and symptoms of a UTI requiring a urinalysis.</p>	F 441			

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F 441	<p>Continued From page 292</p> <p>~Progress note on 5/3/14 states the results of urinalysis show WBC (white blood cell) count 0-1 (normal is 0-5), Nitrites are negative, Bacteria is 3+, specimen cultured. The results were reviewed by another physician who did not order the lab.</p> <p>~Progress note on 5/3/14 states Resident #9's temperataure is 96.9 F.</p> <p>~Review of urine culture, dated 5/4/14, indicated 3 or more organisms, no predominate, possible contaminated specimen. A note was written on the Lab culture report, "Reviewed...with no new orders."</p> <p>~Progress note on 5/5/14 states, "Resident seen by NP-O (Nurse Practitioner), reviewed UA with C&S. Noted that resident has had general decline with increased confusion, recent fall, sometimes forgetting to eat meals. Also aware that cathing resident would be traumatic for this resident... Macrobid 100 mg po (by mouth) BID (twice a day) x 5 days." These symptoms do not meet the criteria of an infection and would not require the initiation of an antibiotic.</p> <p>~Progress note on 5/12/14 states Resident #9 fell with right sided weakness noted. Orders obtained to send to the emergency room.</p> <p>~Progress note on 5/12/14 states, "Call rec'd (received) from Sacred Heart Hospital...resident was admitted to facility. Dx (diagnosis) of UTI and TIA (transient ischemic attack)..."</p> <p>~Review of hospital discharge summary dated on 5/13/14 states, "Final Diagnosis 1. Urinary tract infection. 2. Possible mild CVA (cerebrovascular</p>	F 441			

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F 441	<p>Continued From page 293</p> <p>accident). 3. Atrial fibrillation. 4. Congestive heart failure. 5. Hypertension. 6. Dementia. The urine culture ultimately came back showing E. coli which was sensitive to everything, including Nitrofurantoin (Macrobid). She was discharged back to the nursing home in improved stable condition on Nitrofurantoin."</p> <p>~Review of progress note dated 5/14/14 states, "Resident seen by NP-O, noted that speech remains incoherent. New order received for UA 1 week after ATB (antibiotic) completed."</p> <p>On 6/11/14 at 11:15 a.m., Surveyor #25989 spoke with the MD (Medical Director) regarding the facility Antimicrobial Stewardship Program and what his expectation is regarding to treat asymptomatic residents for UTIs and follow-up UA (urine analysis) after treatment for a UTI (urinary tract infection). The MD stated he would expect antibiotic treatment after the culture is completed but there is always an exception depending on the resident. The MD stated the facility should not order a follow-up UA if a resident is asymptomatic and again there is always an exception depending on the resident. The MD stated sometimes nursing calls with resident behaviors and "we are treating the nurses instead of treating the patient; the nurses need more education." The MD stated the hospital is now having monthly provider meetings so he will be able to talk about any nursing home issues that he learns about in quarterly meetings at the nursing home.</p> <p>Example #3:</p> <p>Resident #11 was admitted to the facility on 11/29/10.</p>	F 441			

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F 441	<p>Continued From page 294</p> <p>Review of Resident #11's Progress Notes, Laboratory Results, and Physician Orders reveal the following:</p> <p>~Progress Note on 11/2/13 states, "Result of uric acid level is elevated at 8.4...Family called and informed of uric acid level...They state that Resident #11 does have a dx (diagnosis) of gout. They have observed that she tends to have flare ups when she has a UTI."</p> <p>A urine specimen was obtained on 11/4/13. The UA (urinalysis) also dated 11/4/13 indicated trace blood, high leukocytes, high white blood count, 1+ bacteria. Resident #11's physician started Resident #11 on Bactrim DS (double strength) for 7 days. There was no evidence that Resident #11 was symptomatic and did not meet the criteria for initiating antibiotics.</p> <p>On 11/5/13, the culture and sensitivity was received and indicated there were 3 organisms present in the sample with 1 predominate. According to the facility's policy and procedure, contamination of the sample should have been suspected. Resident #11 continued on the Bactrim even though there was no evidence to support the use of the antibiotic.</p> <p>~Progress Note on 3/8/14 indicates the on-call physician was notified of Resident #11's pain in her left wrist and family stating she has gout flare ups when she has a UTI. The physician ordered a UA. The urine specimen was obtained on 3/10/14.</p> <p>The UA results were received on 3/10/14 which stated, "Predominant organism probably contaminate; no susceptibility." Based on this</p>	F 441			

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F 441	<p>Continued From page 295</p> <p>finding, the lab did not complete a C&S. On 3/10/14, Resident #11's physician ordered Bactrim DS, twice a day for 7 days. Resident #11 had no signs or symptoms and there was no laboratory indication for antibiotic therapy. Resident #11 received the entire course of antibiotics.</p> <p>~Progress Note on 4/9/14 indicates Resident #11 was sent to the emergency room for evaluation of increased lethargy/weakness. Resident #11 returned to the facility on the same date with an order for Cipro 500 mg twice a day for 10 days, "...Discontinue if culture negative..."</p> <p>The UA results stated, "3 or more organisms; no predominant, possible contaminated spec (specimen)." Based on this finding, the laboratory did not complete a C&S. A note written by the DON (Director of Nursing) on the UA states, "4/11/14, Reviewed with Dr...cont (continue) Cipro as ordered." There is no evidence to support the continued use of the antibiotic.</p> <p>On 6/10/14 at 11:50 a.m., Surveyor #16041 spoke with the DON. The DON confirmed that the McGeer criteria is used to determine if antibiotics are appropriate. The DON then stated the physician can make a decision to start an antibiotic even if a resident doesn't meet the criteria. When asked why UAs were obtained for Resident #11 when she had no signs or symptoms of having an infection, the DON stated Resident #11 was on Hospice and provided some comfort for her. Resident #11 was not admitted to Hospice until 5/5/14.</p> <p>Example #4:</p>	F 441			

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F 441	<p>Continued From page 296</p> <p>On 6/4/14 and 6/5/14, Surveyor #16041 made several observations of a black dehumidifier in the center of the ACU. The humidifier was running with each observation.</p> <p>On 6/4/14 at 9:55 a.m., Surveyor #16041 spoke with H-L (Housekeeping) and asked who does the cleaning of the humidifier. H-L stated that she had never done anything with the humidifier.</p> <p>On 6/4/14 at 10:00 a.m., Surveyor #16041 interviewed the ACUD (Alzheimer's Care Unit Director) and asked about the dehumidifier. The ACUD stated the dehumidifier is emptied 6 or 7 times a day. When asked who cleans the dehumidifier, the ACUD stated she hasn't seen anyone do anything with it besides empty it. The ACUD stated she was not sure who would be responsible.</p> <p>On 6/4/14 and again on 6/5/14, Surveyor #25989 requested information from the facility related to cleaning the dehumidifier, including any cleaning schedules. On 6/5/14, NHA-M (Nursing Home Administrator from sister facility) stated there was no information.</p> <p>A dehumidifier draws in the moist air. As it passes through the cooled coils, the moisture from the air condenses and collects in a reservoir in the dehumidifier cabinet. The air is then reheated and is exhausted back into the room. Failure to clean components of a dehumidifier can increase airborne irritants and recirculate infections. Example #5:</p> <p>Surveyor #25803 completed a review of Resident</p>	F 441		

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F 441	Continued From page 297 #5's clinical record and noted the following. Resident #5 had current diagnoses including but not to dementia. Resident #5's most current MDS (Minimum Data Set), dated 5/8/14, indicated Resident #5 required assistance with all aspects of ADLs (Activities of Daily Living). On 6/10/14 at 12:08 p.m., Surveyor #25803 observed CNA-CC assist Resident #5 into the dining room. Prior to this time Surveyor #25803 noted Resident #5 to be handling a multitude of objects including the hand rails, and positioning devices on Resident #5's Broda chair. Resident #5 was served lunch and began to eat a piece of cake with his hands. There was no hand hygiene offered prior to Resident #5 beginning to eat.	F 441			
F 490 SS=F	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility was not administered in a manner which enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and	F 490			

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F 490	<p>Continued From page 298</p> <p>psychosocial well-being of each resident. This is demonstrated by the number and seriousness of the deficiencies identified and issued at this survey.</p> <p>In all, 21 deficiencies were issued during this recertification, complaint, and extended survey. Two deficiencies (F309 and F329) identify substandard quality of care and immediate jeopardy. Two others (F253 and F312) identify substandard quality of care. One (F315) identifies actual harm. Five (F253, F312, F353, F441, F501, and F520) identified deficient practices at scope and severity level F, created a potential for more than minimal harm to all or most residents.</p> <p>This has the potential to affect all residents.</p> <p>This is evidenced by:</p> <p>The facility's administrative staff, including the Nursing Home Administrator, Department Managers, Nurse Managers and Unit Managers are responsible for ensuring the facility policies and procedures are being operationalized and implemented and that all systems are in place to safeguard residents and to ensure each resident is attaining or maintaining his or her highest practicable physical, mental, and psychosocial well-being. This was not occurring, as evidenced by the number of citations and the seriousness of the citations issued at this survey.</p> <p>The following tags were cited at a level of immediate jeopardy and identified substandard quality of care:</p> <p>F309 was cited at a scope/severity level of K</p>	F 490			

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F 490	<p>Continued From page 299</p> <p>(immediate jeopardy/pattern). The facility administration failed to ensure that residents with a diagnosis of dementia or Alzheimer's Disease received care in accordance with accepted standards of practice. Residents #1, #2, #3, #4, #5, #6, and #7 had behaviors that were not comprehensively assessed to differentiate between communication and identify potential triggers, had no individualized approaches or treatment to minimize the risk for behaviors developing or to deescalate behaviors, and with no monitoring/follow-up.</p> <p>In addition to the residents in immediate jeopardy, the facility failed to provide appropriate pain management for 2 of 11 residents reviewed for pain, and 1 of 2 residents was not provided with an assessment by a Registered Nurse when a change in condition was reported.</p> <p>F329 was cited at a scope/severity level of J (immediate jeopardy/isolated). The facility administration failed to ensure that residents' medication regimen were free from unnecessary medications. Residents #1 and #2 had behaviors that were being managed with multiple medication addition, discontinuations, dose and timing changes. Subsequently, Resident #1 was handcuffed by police as an intervention and Resident #2 was administered last rites.</p> <p>The following tags identified substandard quality of care:</p> <p>F253, S/S=F (Housekeeping and Maintenance Services). The facility failed to maintain a clean and comfortable interior in resident living areas. This has the potential to affect all residents. Air was stagnant and odors were predominate on 2</p>	F 490			

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F 490	<p>Continued From page 300</p> <p>of 4 wings. Flooring, walls and wallcoverings, furniture, handrails, doors and door jambs, and windows were in poor condition and/or dirty throughout the entire facility. Urine odors were noted in the hall and in furniture on the ACU. Mold was observed growing in food/fluid spills inside the handrails.</p> <p>F312, S/S=F (ADLs Care Provided for Dependent Residents). The facility administration did not ensure that residents who were unable to carry out activities of daily living, received the necessary services to maintain good personal hygiene. The deficient practices have the potential to affect all residents. Residents are not receiving scheduled showers due to a lack of staff to conduct the showers. Facility records validated that 31 out of 33 residents' showers are not occurring on a routine basis and with several weeks in between. Resident #11 is incontinence of bladder and requires the assistance of 2 staff for bathing and hygiene. After an episode of bladder incontinence, staff did not cleanse the urine residue from Resident #11's buttocks. Resident #5 required assistance with all aspects of activities of daily living. Resident #5 was observed multiple days of survey unshaven and with dirty fingernails</p> <p>The following tag identified actual harm:</p> <p>F315, S/S=G (Urinary Incontinence and Catheters). The facility administration failed to ensure that 3 of 7 sampled residents reviewed for catheters (Resident #3) and bladder incontinence (Residents #4 and #7) received proper assessment, appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p>	F 490			

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F 490	Continued From page 301 In addition to F253 and F312, the following tags identified deficient practices that had the potential to affect all residents: F353, S/S=F (Sufficient Nurse Staffing) Based on observations, interviews, and record reviews, the facility did not have sufficient staff to meet resident needs. F441, S/S=F (Infection Control) The facility had an outbreak that affected the ACU (Alzheimer Care Unit). The outbreak onset was 3/18/14 with residents manifesting symptoms of nausea, vomiting, diarrhea. The facility practice is to terminally clean resident rooms one time after the precautions are lifted. Current standards of practice indicate terminally cleaning after an outbreak for at least 72 hours. In addition, facility administration failed to implement their own Antimicrobial Stewardship Program by allowing 2 residents to receive antibiotic treatment for asymptomatic urinary tract infections. F501, S/S=F (Medical Director) The facility administration failed to involve the Medical Director in identifying, evaluating and resolving medical and clinical concerns that affect resident care, medical treatment, quality of care and quality of life. F520, S/S=F (Quality Assessment and Assurance) The facility failed to maintain an effective QA&A Committee and failed to evaluate systemic approaches to deliver care and services to residents. Ten additional deficiencies were issued. Administrative staff did not ensure that systems	F 490			

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F 490	Continued From page 302 were in place to make certain that residents received appropriate care and services as demonstrated by the following: F164 (Privacy and Confidentiality) The facility Administrative staff did not ensure that Residents #1 and #12's privacy was maintained when staff, including a Unit Manager, openly discussed these residents in front of other residents, visitors, and staff who would not have access to this information. F221 (Physical Restraints) The Administrative Staff failed to ensure that restraints were used to treat a medical symptom and not for staff convenience. Resident #5 and #2 had belt restraints due to falls. Falls is not considered a medical symptom. F248 (Activities) The Administrative Staff failed to provide an activity program consistent with residents' individual needs on the Alzheimer's Care Unit. F272 (Comprehensive Assessment) The Administrative Staff failed to ensure that comprehensive assessments were completed for those residents manifesting behaviors to identify underlying causes of the behaviors. F274 (Significant Change) The Administrative Staff failed to ensure that a comprehensive assessment was completed when Residents #1 and #2 had a significant change in status. F279 (Care plans). The facility failed to develop specific, individualized care plans for caring for residents with dementia.	F 490			

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F 490	<p>Continued From page 303</p> <p>F280 (Review and Revise Care Plans) The Administrative Staff failed to review and revise residents' care plans when indicated.</p> <p>F282 (Services Provided in Accordance with Care Plan) The Administrative Staff failed to ensure that staff followed resident care plans related to transfer assistance and toileting/incontinence care.</p> <p>F323 (Free of Accident Hazards/Supervision/Assistive Devices). The facility did not ensure the resident environment was free from hazards and/or adequate supervision was provided. On 6/11/14, water temperatures were found to be 120 degrees Fahrenheit. Maintenance staff indicated the mixing valve on the new boiler is in a location where it can be easily bumped. Despite this knowledge, temperatures were only checked once a day at the boiler and not in resident rooms, and no actions were taken to prevent an increase in water temperatures creating a hazard that has the potential to affect more than a limited number of residents. Residents #2, #5, and #8 all had multiple falls. Resident #12 had 1 fall. The facility administration failed to critically analyze each fall and did not initiate appropriate interventions based on the root cause of the fall.</p> <p>F368 (Frequency of Meals) The Administrative Staff did not ensure that staff offered a bed time snack to each resident.</p> <p>F371 (Dietary Services/Sanitary Conditions) The Administrative Staff did not ensure that staff followed sanitary guidelines while serving food in the ACU and did not ensure that proper cooling techniques were followed.</p>	F 490			

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F 490	Continued From page 304 Together, these citations identified system breakdowns throughout the facility in relation to resident care, dementia care, care planning, the use of psychotropic medications, the resident environment, and infection control. On 6/11/14, Surveyor #25803 spoke with Staff-T (Anonymous). Staff-T stated the nursing department was not managing the care of the residents in the facility. Staff -T stated this had led to inadequate care. On 6/11/14, Surveyor #25803 spoke with Staff-PP (Anonymous). Staff-PP stated the DON was micro-managing the nursing department and not utilizing her licensed staff. Staff-PP stated consequently system problems were not being identified and addressed including staffing issues.	F 490			
F 501 SS=F	483.75(i) RESPONSIBILITIES OF MEDICAL DIRECTOR The facility must designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to involve the medical director in assisting the facility to identify, evaluate, and address/resolve medical and clinical concerns and issues that affect resident care, medical care or quality of life; or are related to the provisions of services by physicians and other licensed health	F 501			

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-GOLDEN AGE			STREET ADDRESS, CITY, STATE, ZIP CODE 720 E KINGS RD TOMAHAWK, WI 54487		
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F 501	<p>Continued From page 305 care practitioners.</p> <p>This has the potential to affect all 51 residents.</p> <p>This is evidenced by:</p> <p>Six deficiencies F253 (housekeeping and maintenance), F312 (activities of daily living), F353 (staffing), F441 (infection control), F490 (administration) and 520 (quality assurance and assessment), were cited at this survey that had the potential to affect all 51 facility residents. Of these, F253 (quality of life) and F312 (activities of daily living) were identified as substandard quality of care.</p> <p>Additionally, two deficiencies, F309 (Quality of Care) and F329 (Unnecessary Medications), identified immediate jeopardy and substandard quality of care. These citations were in relation to dementia care and the inappropriate use/overuse of psychotropic medications.</p> <p>On 6/11/14 at 11:15 a.m., Surveyor #25989 and #25803 interviewed the medical director by phone. The following concerns were addressed:</p> <ul style="list-style-type: none"> ~Policy and procedure involvement, especially in the ACU (acute care unit) dementia residents. ~Multiple adjustments in psychotropic medications in the ACU without a comprehensive assessment to identify triggers, non-pharmacological interventions, history assessment, social worker involvement, and monitoring of effectiveness and side effects of medications. ~Antimicrobial Stewardship Program, not using the facility procedure of McGeers criteria for UTI (urinary tract infection) which by definition is 	F 501			

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F 501	<p>Continued From page 306</p> <p>treating asymptomatic residents and unnecessary medications. Starting antibiotic treatment before culture & sensitivity results are completed, with no documentation for justification and if the antibiotic is not sensitive medication is changed which increases the risk for developing a MDRO (multi-drug resistant organism). Practitioners ordering follow-up urinalysis after completion of antibiotic treatment without documented justification for asymptomatic resident.</p> <p>The MD (Medical Director) stated his involvement is "by default," as there was no one to do this. He stated most of his previous patients are now in the facility so he agreed to be the medical director. He said this is a lot of on-the-job training. The MD stated he visits the nursing home usually every week. He attends the quality assurance meeting quarterly, which is dictated by the Administrator and every week/month the facility has meetings where they will discuss resident issues with him. The facility does not have a lot of geriatric/dementia experience and we just recently have a nurse practitioner visiting 2 x week and hopefully this will help the facility.</p> <p>The MD stated he has not been involved with the development of the Dementia care policy and procedures because the facility has mostly corporate policies. When there is an issue, the facility will develop a policy, and he gets a photo copy and signs his name. The MD stated he was unaware of the increased use of antipsychotic medications in the ACU and thinks other physicians receive calls from nursing and that they then order a medication. He stated sometimes he thinks they are treating the nurse instead of the resident for the behaviors. He stated the nurse will call the on-call physician who</p>	F 501			

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F 501	Continued From page 307 will then order medications to treat the behavior. The MD stated education is a very important piece for the nursing staff. The MD stated he does feel that nonpharmacological interventions should be implemented first, and if the resident needs a medication, to start slow and titrate slow due the side effects. This facility and others really need professional geriatric psychiatric services and the facility also needs to be staffed appropriately. The MD stated practitioners should wait for the culture results before treating. However, there are some reasons you might want to treat first depending on the resident. UA should not be obtained if a resident is asymptomatic. The MD stated the hospital is now having monthly provider meetings where he can bring nursing home issues like these forward if he knows about it. He does feel the ACU needs more leadership and has never had the support such as social services to assist them. If the facility does not identify these concerns at the QAA (quality assurance and assessment) meeting, the medical director is not being involved and/or updated. Refer to F520.	F 501			
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the	F 520			

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F 520	<p>Continued From page 308 facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interview, and record review, the facility's Quality Assessment and Assurance (QAA) committee failed to evaluate systemic approaches to deliver care and services for residents with dementia.</p> <p>The facility's QAA committee did not develop and implement appropriate plans of action to ensure existing policies and procedures are consistent with current standards for the special needs of residents with dementia.</p> <p>This had the potential to affect all of the facility's residents.</p> <p>This is evidenced by:</p>	F 520		

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F 520	<p>Continued From page 309</p> <p>Surveyor #30570 requested and received the facility's policy titled "Clinical Guideline: QA & A Committee" with the latest revision date of 12/08. The Policy states the following:</p> <p>"The QA & A committee oversees the quality and effectiveness of living center operations and systems to meet the needs of the customers, to monitor and analyze facility key performance indicators to identify improvement opportunities; to evaluate facility progress towards improvement and to coordinate process improvement activities of facility associates."</p> <p>6/11/14 at 2:00 p.m., Surveyor #30570 met with the NHA (Nursing Home Administrator) regarding the facility's QAA committee involvement related to care and services for residents with dementia. The NHA explained the QAA committee meets monthly, with the Medical Director in attendance on a quarterly basis. The NHA explained the QAA committee addresses a variety of items to include the facility's Quality Measures and Quality Indicators that are below the 75% threshold.</p> <p>Surveyor #30570 asked the NHA about the QAA Committee involvement related to care and services for individuals with dementia. The NHA indicated the pharmacy consultant is involved with the committee. Surveyor #30570 asked the NHA about policy and procedures geared to the special needs for individuals with dementia. The NHA indicated he has not seen anything in the form of a policy in the 4 months he has worked at the facility. The committee has not yet addressed these policies and the Behavior Committee has fallen short of expectations with the first step of setting one up with a goal to meet quarterly.</p>	F 520			

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F 520	<p>Continued From page 310</p> <p>Surveyor #30570 asked how the committee monitors to assure staff receive training on the needs of individuals with dementia. The NHA indicated the facility provides initial and annual training through a computer program offered through "Copper Ridge" and the ACUD (Alzheimer Care Unit Director) is supposed to offer on-the-spot training related to specific individuals and their needs with review of resident care plans/care cards. The NHA indicated due to staffing issues, on-the-spot training has not occurred.</p> <p>The NHA expressed the QA & A Committee has not been effective due to the immediate needs and issues in the facility.</p> <p>On 6/11/14, Surveyor #25803 spoke with Staff-PP (Anonymous). Staff-PP stated the facility's Quality Assurance and Assessment Committee was not a functioning committee. Staff-PP stated there was no planning, no goal setting, no revision of plans discussed at the committee meetings.</p>	F 520			