STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355046	A. BUILDING _____ B. WING _____	01/26/2012

RECEIVED
FEB 13 2012
Division of Health Facilities

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN ACRES MANOR	1 E MAIN ST CARRINGTON, ND 58421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on January 23, 2012 and completed on January 26, 2012 the sample included four (4) residents for complete review, nine (9) residents for focused review, and two (2) closed records for review. The sample included one (1) additional resident to verify specific concerns during the survey.	F 000		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, the facility failed to assess specific resident behaviors for causative/precipitating factors, develop and implement specific individualized interventions, and monitor the effectiveness of the interventions and revise them accordingly for 2 of 8 sampled residents (Resident #1 and #8) identified with behaviors, including obsessive compulsive, socially inappropriate, and wandering. The facility did not allow the residents the opportunity to experience a potentially attainable improved quality of life and placed residents at risk of retaliation from other residents and injury from falls. Findings include:	F 250	F250 1. Resident #1 has passed away thus no changes have been made. Resident #8 the cause for her increased anxiety/depression resulting in behaviors of increased obsessive compulsiveness will be analyzed with the information obtained used to determine the cause precipitating the situation thus implementing an individualized intervention to decrease the risk for falls, harm from others, and risk of side effects. (See attachment A Resident #8 Care Plan). 2. All residents with identified behaviors have the potential to be affected by this practice.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	ADMINISTRATION	2-10-12

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

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F 250	Continued From page 1 Review of the facility policy titled "Policy For Behaviors" occurred on 01/26/12. This policy, undated, stated, "PURPOSE: To determine individuals that may have behaviors and how they may affect the safety of other residents, staff members or themselves. POLICY: the behavior log will be followed on any individuals deemed necessary by the Care Plan Committee, the Quality Assurance Committee or any nursing staff. . . . 5. The care plan will reflect what goals/procedures will be implemented." Review of the facility policy titled "Falls - Clinical Protocol" occurred on 01/26/12. This policy, dated 12/01/11, stated, ". . . 3. Risk factors for subsequent falling include lightheadedness or dizziness, multiple medications . . . environmental hazards . . ." - Review of Resident #8's medical record occurred on all days of survey and included diagnoses of anxiety, depression, and obsessive compulsive disorder. Resident #8's significant change Minimum Data Set (MDS), dated 11/19/11, identified moderately impaired cognition, and no behavioral symptoms. The MDS identified two or more falls with no injury since the prior assessment. Resident #8's most recent MDS, dated 12/23/11, identified cognitively intact, behavioral symptoms; verbal and other behavorial symptoms not directed towards others, and wandering. The MDS identified two or more falls with no injury. Review of Resident #8's nurse notes included the	F 250	3. New policies on Problematic Behavior Management-Clinical Protocol, and Behavior Assessment and Monitoring along with a revised Behavior Monitoring Log have been implemented. This includes the staff using protocol to identify pertinent interventions, other than medications, for the nature and causes of the individual's problematic behavior. (See attachments B, C, and D) per Char Christenson DON on 2/14/12 at 1450 CQuigley RN 4. QA ~~committee~~ coordinator will evaluate the Behavior Monitoring Log for residents identified with problematic behaviors to assure an individualized intervention has been put into place to assist staff when dealing with the resident and improve the resident's quality of life. This will be done weekly times one month, monthly times one quarter and quarterly times one year. 5. 04/02/2012 #3. Social Service staff were trained on new policies/procedures on 2/13/12. CNA's were trained on 2/14/12. Nursing staff will be trained on 2/29/12. MDS staff were trained on 2/10/12. per phone call c Char Christenson DON on 2/15/12 @0834. CQuigley, RN	

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F 250	Continued From page 2 following: 01/03/12 - 1:30 p.m. "Res [resident] using toothpaste on a cloth to scrub her toilet. Explained housekeeping does that et [and] just need to call them if needed . . ." 01/08/12 - 8:00 p.m. "Res in room using toothbrush and paste to scrub toilet. 'There is S-H-I-T on it.' Nothing visible on toilet explained housekeeping cleans toilet. Calling [staff name] 'fat ass' who needs to mind her own business unable to redirect kept getting louder." 01/24/12 - 5:00 a.m., ". . . noted groggy admits slower to move but continues to reorganize - CNA earlier noted [resident] [with] H2O [water] basin washing floor in front of recliner - carrying basin [with] 2 hands et pushes walker refuse help. . . " A review of the nurse notes from 12/27/11 to 01/14/12 identified six entries where the resident was found on the floor in her room or bathroom. A nurses note, dated 01/01/12 at 3:30 a.m., indicated the resident was found on the floor in her room with her head against her roommate's table leg and she sustained a bump and 1.3 cm (centimeter) laceration on her forehead. Review of Resident #8's certified nurse aide (CNA) charting listed the following: 01/01/12 - "Resident still up at 1:30 am going on about wipes, said she only use [sic] 2 and half the bag is gone. . . ." 01/07/12 - "Resident very loud w/ [with] other residents when speaking to them. Also interrupting in others daily cares." 01/01/12 - "Resident digging through roommates things, when CNA asked what she was doing resident flipped CNA off and told her to shut up" 01/08/12 - "Resident was trying to take care of	F 250		

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F 250	Continued From page 3 roommate when CNAs came in . . . res wouldn't let go of roommates w/c [wheelchair] when CNA tried to tell her to let go she put her fist up . . ." 01/08/12 - "Resident very loud w/ other residents. Resident was going thru [sic] housekeeping closet to find something to clean her toilet." 01/10/12 - "wandering in hallway." A review of the Social Services Notes listed the following: 12/12/11 - ". . . observed trying to give water to a resident. It was explained to her the dangers and she could not give any resident any type of food/drink . . . Encouraged her to not be so vocal with residents as they may not like having her in their face. She said 'Oh I know I talk too much.'" 12/15/11 - ". . .often gets into other resident's faces & [and] often touches them. She has been holding roommates hand and having her face very close. Informed [Resident #8] she needs to not be so close to her or any other resident as they may strike out & she could get hurt. [Resident #8] laughed 'Oh know [sic] she likes me to be close & talk to her, I'm not stupid'" 12/20/11 - ". . . trying to put a clothing protector on [a male resident]. He kept telling her 'no' & pushing her hands away . . . she then attempted to remove his hat and again he pushed her hands aside. This writer finally convinced her she could not continue & stopped. Educated her as to what she was doing & why she could not. . . ." 01/09/12 - ". . . trying to assist other residents . . . [administrator's name] and this writer addressed that she could put a call light on but could not do anything else very difficult to redirect." 01/18/12 - "[resident] to be followed on the weekly behavior log due to difficulty redirecting & attempting to help residents and not following	F 250		

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F 250	Continued From page 4 directions . . ." 01/19/12 - ". . . Dgter [daughter] called to come & get update on mother's behaviors . . . It was determined that if behaviors didn't improve she would have to go back to a private room. . . . " Resident #8's "Behavior Monitoring Log" listed the following: 01/19/12, 9:454 a.m., Behavior Observed, "confrontation in room yelling" Response to Behavior, Soc. Wk [social worker] contacted dgter & mtg [meeting] held [Resident] informed would have to move to a private room if continued." 01/21/12 - Behavior Observed, "spoke to nurse @ [at] length no good for anything several negative comments" Response to Behavior, "Nurse listened & Ativan given" Even though Resident #8 exhibited behaviors in December no behavior monitoring was implemented until January 19. Review of a fax to the physician, dated 01/23/12, stated, ". . . daughters and staff seeing more depression, wishes she could jump in a river and drown just wants to end it all - agitation continues to be noted - was seen by you with medication changes on 01/10/12." The physician responded by increasing Lexapro to 30 mg daily and Ativan 1 mg 3 times a day. Review of Resident #8's physician's orders prior to the increases on 01/23/12 listed the following medications: - Ativan (an antianxiety medication) 0.5 mg (milligram) 1 time a day and 1 mg at hour of sleep - Clomipramine (an antidepressant) 50 mg at hour of sleep, started on 01/10/12.	F 250		

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F 250	Continued From page 5 - Lexapro (an antidepressant) 20 mg During the noon meal on 01/24/12, observations of Resident #8 showed her sleeping at the table. Staff would cue her to eat and she would fall asleep again. During the afternoon, observations showed the resident in her room arranging items in her closet. At 3:00 p.m. two CNAs assisted the resident to the bathroom. Observation showed the resident had trouble lifting her feet to walk. An observation at 5:55 p.m. the same day showed the resident sleeping at the supper table. Review of resident #8's current care plan failed to address specific behaviors of assisting other residents and cleaning. Some of the resident's behaviors were associated with anxiety, depression, and obsessive compulsiveness. It lacked individualized interventions that could assist staff when dealing with the resident and improve this resident's quality of life. Refer to F280 During the survey, observations indicated that facility staff failed to engage Resident #8 in functional tasks or diversional activities. During an interview in the morning of 01/26/12, an administrative nursing staff member (#1) indicated being unaware that Resident #8 had been going through the housekeeping closet on 01/08/12. On the afternoon of 01/26/12, the administrative nursing staff member (#1) provided information regarding the incident on 01/08/12 and Resident #8. "On return from the evening meal resident had removed key from door frame and opened	F 250		

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F 250	Continued From page 6 closet. Immediate intervention had taken place with CNA and Nurse monitoring resident as she looked through closet. Nothing was removed or attempted to be removed. Housekeeping key is on a hook on the door frame." During an interview in the morning of 01/26/12, a social services staff member (#6), indicated they lacked a specific behavior plan for Resident #8, but she was started on the behavior log monitoring on 01/19/12. The facility provided no information to indicate they use this information to track/or trend Resident #8's behaviors. The facility failed to determine a cause for increased depression/anxiety resulting in behaviors of increased obsessive compulsiveness. Analyzing this information could determine the causes or precipitating situations that resulted in increased anxiety and behaviors. The staff failed to consider nonpharmacologic interventions to comfort the resident or ease her anxiety. Failure to determine and implement individual interventions, when behaviors were first noted in the beginning of December, placed Resident #8 at risk for increased falls, risk of harm from other residents and risk of side effects from increases in antipsychotic medications. - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included Alzheimer's dementia, agitation, anxiety, dementia with inappropriate behavior, and reactive confusion. A significant change MDS, dated 01/12/12, identified severely impaired cognition, and delirium symptoms. In addition, this MDS identified Resident #1 showed tendencies of verbal behavioral symptoms	F 250		

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F 250	Continued From page 7 directed toward others; and other behavioral symptoms not directed toward others. This MDS identified these behaviors impacted Resident #1 by putting him at risk for illness or injury; interfered with his care; and interfered with his participation in activities and social interactions; impacted others by intrusion on their privacy or activity; and disruption of their care or living environment. This MDS identified Resident #1 rejected care; wandered; experienced hallucinations; and his behavior worsened since the last MDS. During initial tour, on 01/23/12 at 12:35 p.m., observation of Resident #1 showed he wore a wander guard bracelet on both wrists. During an interview, on 01/26/12 at 12:40 p.m., nursing staff members (#1, #5, and #6) indicated Resident #1 wore two wander guards due to an incident where he stated he "cut it off." The staff members (#1, #5, and #6) clarified Resident #1 did not cut off the wander guard, but tore it off and was heading outside when staff discovered he had removed the wander guard bracelet. Observations during all days of survey revealed Resident #1 ambulated independently, but required supervision to meals and activities. On the morning of 01/26/12 the resident began moving furniture from his room into the common area near his room. An unidentified staff member intervened and assisted the resident to move some of his furniture back into his room. Review of Resident #1's nurses notes identified the following:	F 250		

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F 250	Continued From page 8 * 01/13/12 at 4:00 a.m. "Comes into hall sits on chair - 'here Kitty Kitty' [no] cat present - agreeable to go to bed." * 01/13/12 at 2:30 p.m. "Has got down on his hands et [and] knees . . . several [times] this [after]noon. . . ." * 01/14/12 at 8:00 p.m. "Was on hands [and] knees cleaning bathroom floor. Refused assistance. . . ." * 01/15/12, no time, "Restless removed cover off of heat register. Difficult to redirect." * 01/16/12 at 5:00 a.m. "Resident in hallway completely naked. Redirected easily back to room. Assisted him [with] redressing et back to bed. . . ." * 01/16/12 at 9:30 a.m. "Very restless - walking [up] et [down] halls. Dressing et undressing. Stands naked in hallway. . . ." * 01/18/12 at 2:00 a.m. "Resident found standing in his room doorway holding his flat screen TV. Nurse put the TV down [and] redirect [sic] him [with] some difficulty back to bed." * 01/19/12 at 3:15 p.m. "Resident found crawling on floor in room. Redirected easily to chair in room. . . ." * 01/22/12 at 6:30 a.m. "Resident walking in hallway caring [sic] a few personal items. Asks 'how do I get out of here? Where's the door?' Redirected resident to chair in dining room on Prairie." * 01/22/12 at 6:45 a.m. "Door alarms sounding. Found resident by Prairi [sic] View exit closing door. Was heading out the door [with] personal items, but was coming back in when this nurse found him. Stated 'Burr, it's cold out there!' Redirected back to Prairie dining room et waited for breakfast." * 01/22/12 at 1:30 a.m. [sic] "Resident in	F 250		

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F 250	Continued From page 9 diningroom [sic] [with] table turned on it's side. Talking about 'fixing the wedge.' Assured resident table was fixed et okay. Redirected back to room easily." * 01/22/12 at 2:00 p.m. "Called to resident's room. Sitting on floor beside the bathroom door . . . Because the resident was not harming himself or others, allowed him to continue as he was becoming aggitated [sic]." Same day at 2:15 p.m. "[Another Resident] standing in resident's doorway asking if he was all right. Redirected [other resident] back to extended dining room et explained to her that his nurse would assist this resident. Asked this resident if he would like to stand up et sit in his chair or on his bed instead of the floor. Started to kick et hit at this nurse, telling me to 'get the hell out of here.' Continues to talk about 'fixing the wedge.' Kicking feet at T.V. stand et bedside table. . . ." * 01/23/12 at 12:00 a.m. "Pt [patient] found sitting in large dining room [with] his wet pj [pajama] bottoms lying on the floor along [with] incontinent product. Redirected back to his room - put dry products [and] pj's on [and] Pt went back to bed [without] difficulty." Certified nurse aide charting concerning behaviors identified the following: * 11/30/11 "Resident came to Nurse's Desk and asked to use the phone at 1:00 AM." * 12/30/11 "Resident confused, wandering halls, up [and] down most of the night." * 01/01/12 "Resident wandering in hall. Wanted us to turn lights all on at midnight. Was found in [another resident's room]." Refusal of care documented on 14 days between December 1st and January 24th.	F 250		

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F 250	Continued From page 10 Review of the social service notes from 10/10/11 to 01/09/12 failed to address Resident #1's wandering and socially inappropriate behaviors and therefore failed to develop, implement, and evaluate plans to address these behaviors. Review of the medical record showed Resident #1 wandered into other rooms at night. The record lacked evidence of an interdisciplinary team approach based upon Resident #1's wandering at night. Failure of the facility to assess the precipitating factors of why Resident #1 wandered in specific areas at night and to develop, then implement, interventions to deter this behavior and monitor the effectiveness could result in Resident #1's continued wandering. Wandering into another resident's room could frighten the resident and/or lead to altercations between residents. Resident #1's current care plan failed to address specific behaviors such as repeated entry into specific resident rooms, entering common areas in a state of undress, of taking things apart/fixing them, and his risk of elopement. Refer to 280. During an interview, on 01/26/12 at 12:40 p.m., nursing staff members (#1, #5, and #6) identified interventions for Resident #1's behaviors used by the weekday staff included having the resident spend time with the social worker for diversion. These staff members failed to identify interventions available for use by the night and weekend staff when the social worker is not usually present.	F 250		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		

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F 280	Continued From page 11 The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, the facility failed to review and revise the care plan for 4 of 8 sampled residents (Residents (#1, #8, #10, and #12). Failure to evaluate and revise the care plan as the residents' status changes has the potential to affect staff's understanding of the resident's problems/concerns and required interventions, limits staff's ability to communicate resident care issues, and may lead to lack of/or inconsistency in cares. Findings include: - Record review for Resident #10 occurred on	F 280	F280 1. Residents #1 and #10 have passed away thus the care plans were not revised. Resident's #8 and #12 care plans have been revised to include specific behaviors with individualized interventions. (See attachment A Resident #8 care plan and E Resident # 12 care plan) 2. All residents with identified problematic behaviors have the potential to be affected by this practice. 3. New policies on Problematic Behavior Management-Clinical Protocol, Behavior Assessment Monitoring along with a revised Behavior Monitoring Log which includes individualized care plan updates with pertinent interventions, other than medication, has been implemented. (See attachment B,C, D)	

Staff were or will be trained on the new policies as follows:
~~Social Service staff on~~ all training to SS staff.
MDS Staff 2/10/12
CNA's on 2/14/12
Nursing staff on 2/29/12
per phone call c Char Christenson DON on 2/15/12 @ 0834 CAcooperRN

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	355046	A. BUILDING _____ B. WING _____	01/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN ACRES MANOR	1 E MAIN ST CARRINGTON, ND 58421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 12 January 25-26, 2012. The facility admitted the resident with diagnoses of Alzheimer's dementia, agitation, reactive confusion, and anxiety. Resident #10's current Minimum Data Set (MDS), dated 01/23/12, identified short and long term memory problems, severe cognitive impairment, behavioral symptoms not directed at others, and rejection of care. Review of Resident #10's Nurses Notes identified the following: * 04/21/11 at 1:30 p.m., "Res [resident] was brought to activity room as resident has been hollering out very loudly - Husband had been sitting [with] her [and] act. [activity] staff director [name] witnessed husband slap res across the face very hard in order to quiet her down - had also seen husband squeeze her cheeks just prior to slapping her. Husband was told actions were not appropriate [and] we cannot allow physical contact of that form. Husband stated he was her husband [and] that was the only thing that controlls [sic] her behavior [and] that he's been doing that for a long time. . . " * 04/22/11 at 8:30 a.m., "Conference held [with] daughter, [name], [and] [IDT] interdisciplinary team, regarding issues [with] [resident's name] [arrow up] behaviors, [and] incident [with] husband [name] on 04/21/11. Daughter in agreement [with] contacting Dr [name] for medication adjustment. . . " Review of Resident #10's current comprehensive care plan identified the following: "Problem: Limited contact related to significant confusion. Approaches: . . . Family supportive and visits often. . . Problem: Alteration in mood and behaviors related to alzheimers dementia	F 280	4. QA coordinator ~~committee~~ will evaluate care plan for residents identified with behaviors to assure an individualized residents specific care plan is in place to assist the staff when dealing with residents and to improve residents quality of life. This will be done weekly times one month, monthly times one quarter and quarterly times one year. 5. 04/02/2012 A per Char Christenson on 2/14/12 at MSD	

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F 280	Continued From page 13 with agitation and anxiety disorder. Socially in appropriate behavior of holloring [sic]/screaming, resisting cares. Psychotropic drug use. Restlessness and reactive confusion. Approaches: . . . Family supportive and will assist as needed as able. . . Problem: Alteration in cognition related to Alzheimer's dementia with short and long term memory impairments. Inattention, disorganized thinking, altered level of consciousness. History of psychomotor retardation. Impaired decision making. Reactive confusion. . . Approaches: . . . Family visits frequently and is supportive. . . " During an interview on, 01/26/12 at 12:45 p.m., an administrative nurse (#1) and RN (#4) confirmed Resident #10's current care plan lacked interventions to address her husband's aggressive behavior, including approaches to ensure Resident #10's safety. - Review of Resident #8's medical record occurred on all days of survey and included diagnoses of anxiety, depression, and obsessive compulsive disorder. Review of Resident #8's nurse notes included the following: 01/03/12 1:30 p.m. - "Res [resident] using toothpaste on a cloth to scrub her toilet. Explained housekeeping does that et [and] just need to call them if needed . . ." 01/08/12 8:00 p.m. - "Res in room using toothbrush and paste to scrub toilet. . . ." 01/24/12 - 5:00 a.m., " . . . noted groggy admits slower to move but continues to reorganize - CNA earlier noted [resident] [with] H2O [water] basin washing floor in front of recliner -carrying basin	F 280		

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F 280	Continued From page 14 [with] 2 hands et pushes walker refuses help. . . " Review of Resident #8's certified nurse aide (CNA) charting listed the following: 01/01/12 - "Resident still up at 1:30 am going on about wipes, said she only use [sic] 2 and half the bag is gone. . . ." 01/07/12 - "Resident very loud w/ [with] other residents when speaking to them. Also interrupting in others daily cares." 01/01/12 - "Resident digging through roommates things, when CNA asked what she was doing resident flipped CNA off and told her to shut up" 01/08/12 - "Resident was trying to take care of roommate when CNAs came in . . . res wouldn't let go of roommates w/c [wheelchair] when CNA tried to tell her to let go she put her fist up . . ." 01/08/12 - Resident very loud w/ other residents. Resident was going thru housekeeping closet to find something to clean her toilet." Review of Resident #8's current care plan listed the following: PROBLEM: "Alteration in mood related to anxiety and depression. Current mood indicators of feeling tired or having little or no energy. Psychotropic use. 12/29/11 trouble sleeping. 1/24/12 obsessive compulsive d/o [disorder] APPROACHES ensure optimal level of comfort, psych [psychology] consult, redirection or diversional activity as needed, antidepressants per order, monitor side effects, encourage activity participation, socialization, Family supportive, contact as needed, provide emotional support as needed with active listening TLC, Social worker to consult resident and family on discharge planning. Antianxiety medication per order and as needed as outlined, monitor for side effects	F 280		

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F 280	Continued From page 15 PROBLEM: "Alteration in cognition with short-term memory impairments and impaired decision making inattention-talks frequently and loudly may be disruptive at times. APPROACHES: . . . Redirect resident as needed if disruptive." During an interview in the morning of 01/26/12, social services staff member (#6), indicated the care plan lacked a specific behavior plan for Resident #8. The facility failed to review and revise Resident #8's care plan in response to the resident's increase in anxiety and behavior. - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included Alzheimer's dementia, agitation, anxiety, dementia with inappropriate behavior, and reactive confusion. Social Service notes concerning behaviors identified the following: * "10/26/11 [Resident #1's] family decided to put a phone in his room. . . . told him he can't call till after 8:00 AM in the morning. . . ." * "11/14/11 Dgt. [daughter] [name] here requesting her dad's phone be unplugged and out of site from 9 PM till 8 AM. He has been calling different children during the night. She has also requested staff don't ask if he wants to attend activities, just take him. He tells family he is bored and then sleeps. . . ." * "12/13/11 Very agitated today. Insisting Son is coming to take him. Increased confusion. Son [name] called and came and [Resident #1] settled. Son stated family recognizing [Resident	F 280		

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F 280	Continued From page 16 #1] declining mentally." * "01/05/12 [Resident #1] is alert/oriented to some persons not always place/time. . . . Able to express self, not always appropriately. Remains ambulatory [and] walks as desires. . . . [Resident #1] likes to socialize though as [sic] difficult [time] connecting thoughts. . . ." * "01/09/12 [Resident #1] has been more confused, difficult to redirect and seeing things. Family also aware and see the decline." Nursing and CNA documentation regarding Resident #1's behaviors, identified he wanders into other resident's rooms and attempts to elope from the building. Review of Resident #1's care plan, dated 01/18/12, listed the following: "Problem: Alteration in mood related to anxiety and agitation. Dementia with inappropriate behavior. Psychotropic use. Decline noted with mood and behaviors. . . . Approaches: Give resident choices as much as possible; Ensure optimal level of comfort; Redirection or diversional [sic] activity as needed; Antipsychotic medication per order, monitor for side effects; Encourage activity participation, socialization; Family supportive, contact as needed; Provide with emotional support as needed with active listening, TLC [tender loving care]; Antianxiety medication as needed, monitor of side effects is [sic] used; If agitation, anxiety, or behaviors noted with cares, attempt cares at a later time or a different caregiver; Wanderguard [sic] as outlined; Psych [psychiatrist] consults; Wife calls resident twice a week. He can call his children anytime after 8AM. Phone in residents room; Aims every 6 months. . . .	F 280		

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F 280	Continued From page 17 Problem: Alteration in cognition related to alzheimers dementia, with short-term memory impairments and impaired decision making. Decline noted with cognition. . . . Approaches: Reality orientation or cueing as needed. Validation therapy as needed; Monitor for cognitive health statues changes; Reminsice [sic] with resident. Encourage activity participation and socialization; Assist with decision making, contacting family as needed; Med per order." The facility failed to review and revise Resident #1's care plan and provide specific interventions to address his behaviors of repeated entry into other resident rooms, entering common areas in a state of undress, of taking things apart/fixing them, and risk of elopement. - Review of Resident #12's medical record occurred January 25-26, 2012. Diagnoses included Alzheimer's disease, dementia, depression, agitated dementia, and anxiety. An annual MDS, dated 12/01/11 identified severely impaired cognition, and rejected care. Social Service notes concerning behaviors identified the following: * "09/12/11 [Resident #12] alert/oriented to some persons not always place/time. Able to express self, not always appropriately. Ambulates [with] use of walker. . . ." * "11/09/11 Very agitated today, wanting to find husband. Difficult to redirect. Attempted to take back to room but found her way to front door [times two]." * "12/01/11 [Resident #12] is alert oriented to some persons [and] room. . . . Able to express self not always appropriately. Ambulates per self	F 280		

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F 280	Continued From page 18 with walker. . . ." Nursing documentation concerning behaviors identified the following: * 01/06/12 at 6:00 p.m. "Wore outdoor coat to dining room. Returned to room [after] supper and emptied closets et drawers 'to clean'." * 01/12/12 at 2:10 p.m. ". . . amb [ambulating] in hall. FWW [front wheeled walker] by door - refused to use while amb - states 'I'm just getting a little exercise" - pleasant." * 01/13/12 at 9:10 p.m. "Has clothes folded in several piles on bed, tables - states she's giving items to children . . ." * 01/16/12 at 5:00 p.m. "Has multiple stacks of clothing throughout room. Continues to 'pack to go home'. " Review of Resident #12's care plan, dated 01/18/12, listed the following: "Problem: Alteration in mood related to anxiety and depression. Psychotropic drug use. Mood improved, no current mood indicators. 11/08/11 agitated dementia. Goal: She will have no side effects to the psychotropic medication TNR. She will be offered emotional support TNR. Approaches: Antianxiety medications per order, monitor for side effects; Antidepressant medication per order, monitor for effects; Redirection or diversional [sic] activity as needed; Encourage activity participation, socialization; Family supportive, husband visits daily; Med per order; Provide with emotional support as needed with active listening, TLC; Psych consults; Wanderguard [sic] system; If resistive with cares, attempt at a later time or a different caregiver. Approach calmly, friendly."	F 280		

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F 280	Continued From page 19 The facility failed to review and revise Resident #12's care plan and provide specific interventions to address her behaviors of repeated folding and stacking clothing and attempts to exit the building. During an interview, on 01/26/12 at 12:40 p.m., nursing staff members (#1, #5, and #6) confirmed the care plans for Resident #1 and Resident #12 lacked specific interventions for the identified behaviors.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, and staff interview, the facility failed to follow accepted standards of practice regarding transcription of physician orders for 1 of 1 supplemental resident (Resident #16). Failure to ensure the accurate transcription of medication orders has the potential for residents to receive the wrong dose of medication. Findings include: Kozier & Erb's, "Fundamentals of Nursing, Concepts, Process, and Practice, 9th ed., Pearson, page 852, states "Communicating a Medication Order: . . . "A drug order is written on the client's chart by a primary care provider or by a nurse receiving a telephone or verbal order	F 281	F281 1. Resident's #16 MAR was immediately changed to state the correct dosage with Physician verification. 2. Any resident with medication orders have the potential to be affected by this practice. 3. A new policy Reconciliation of Medications on Return from Hospital has been implemented as well as labels which will be applied to the Physicians Orders to verify the reconciliation has been completed and any findings of discrepancies with resolutions made at that time. (See attachment F, G). Nurses will be trained on new policy/procedure on 2/29/12. per phone call ē Char Christenson DON on 2/15/12 @ 0834. CDeeper, RN	

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F 281	Continued From page 20 from a primary care provider. . . The medication order is then copied by a nurse or clerk to a Kardex or medication administration record (MAR). . ." - Observation during medication pass on 01/24/12 at 8:00 a.m., showed a nurse (#2) preparing Resident #16's medication for administration. The physician's order and the medication label identified Lorazepam (Ativan) 0.5 milligrams (mg) by mouth (po) two times a day (BID). The MAR identified Lorazepam (Ativan) 0.25 mg po BID. The nurse identified the discrepancy between the medication label and the MAR, did not administer the medication, and notified an administrative nurse (#1). The record identified the wrong dose recorded on the MAR for 11 of 12 doses administered in the past 6 days. During an interview on the morning of 01/24/12 an administrative nurse (#1) stated the facility needed to update the MAR with the correct dose to be administered.	F 281	4. QA coordinator and or Director of Nursing will monitor all hospital readmissions for medication reconciliation weekly times one week, monthly times one quarter and quarterly times one year. 5. 04/02/2012	