STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355082	A. BUILDING _____ B. WING _____	C 03/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVE MARIA VILLAGE	**501 19TH ST NE JAMESTOWN, ND 58401**

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F 000	INITIAL COMMENTS An unannounced onsite complaint investigation survey was completed on 03/30/21. The concerns identified by the complainant were unsubstantiated.	F 000		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) 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 record review, review of facility policy, and staff interview, the facility failed to assess behaviors, develop, implement, and monitor the effectiveness of individualized approaches/interventions for 2 of 5 sampled residents (Resident #1 and Resident #3) identified with dementia and behaviors. Failure to assess, monitor and evaluate Resident #1 and #3's psychological status resulted in continued problematic behaviors, limited the facility's ability to meet the resident's physical and psychological needs, and may negatively impact the overall well-being for all residents with dementia and/or behaviors. Findings Include: Review of the facility policy titled "Behavior Management" occurred on 03/30/21. This policy, revised November 2019, stated, ". . . When a new behavior or an inappropriate behavior worsens, any Nurse or Social Service staff will document the occurrence in the Progress Notes . . . The Nurse or Social Service staff can initiate	F 745	1. CORRECTIVE ACTION FOR SPECIFIC RESIDENTS IDENTIFIED. Resident #1's care plan and interventions were reviewed and updated most recently on 4/5/21 and 4/12/21 by the facility interdisciplinary team, to include person-centered care that supports, and is specific to, dementia care needs and behavioral symptoms. Resident #1's attending physician was most recently updated on 4/15/21. Physician does not recommend a psychiatry referral at this time. Resident #3's care plan and interventions were reviewed and updated by the interdisciplinary team to include person-centered care that supports and is specific to dementia care needs and behavioral symptoms on 4/3/21. Resident #3's attending physician was most recently updated on 3/31/21, and again on 4/13/21. Resident #3 received a psychiatry referral on 4/8/21 and saw a	5/4/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/16/2021

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F 745	Continued From page 1 Daily Behavior Tracking Log if it seems warranted, listing the targeted behavior . . . Inform physician of any significant behaviors or changes as necessary . . . Behavior Management Plan . . . Initiate or update the care plan problem with current information . . . After five to seven days, resident's team evaluates occurrence for possible causes, patterns and/or trends along with appropriate interventions and decisions if continued tracking is needed . . . A summary of tracking is documented in the Interdisciplinary Progress Notes by Social Services staff and review of care plan for changes . . . Refer to psychiatrist as needed with attending physician and family consent . . ." - Review of Resident #1 medical record occurred on 03/30/21. Diagnoses included Alzheimer's Disease. The admission Minimum Data Set (MDS), dated 01/12/21, identified other behavioral symptoms not directed towards others. The current care plan failed to identify behaviors. Review of Resident #1's progress notes identified the following: * 01/26/21 at 7:52 a.m. - "Resident seems highly agitated this early evening into the night and does not redirect. . . . is alert with much confusion . . ." * 01/31/21 at 9:22 p.m. - ". . . Resident is alert with confusion . . . Was resistive to HS [evening] cares, not allowing staff to wash up and change clothing . . . Resident has been pleasant but unable to redirect easily this evening." * 02/01/21 at 11:58 a.m. - ". . . She does show confusion and has a diagnosis of Dementia . . ." * 02/01/21 at 6:26 p.m. - ". . . Resident is alert	F 745	psychiatrist on 4/14/21. Resident #3's behaviors will be monitored ongoing and reviewed on the facility's behavior management log through PointClickCare and will also be reviewed by facility's PIP (Performance Improvement Plan) committee until behaviors are adequately managed. 2. IDENTIFICATION OF OTHERS POTENTIALLY AFFECTED. All residents with dementia and behaviors are at risk for ineffective dementia/behavior management. 3. SYSTEMIC CHANGES. The facility Behavior Management Policy was reviewed and updated on 4/15/21 to include informing the physician of any significant behavior or status changes; to assess/address, and/or obtain necessary services in response to, resident behaviors; to develop and implement person-centered care plans that include and support dementia care needs and behaviors; to develop individualized interventions related to the resident's behaviors; and to review and revise care plan interventions that have not been effective when the resident has a change in condition or an increase in behaviors. The nurse managers and social workers were educated on the changes in this policy and the importance of person-centered care that supports, and is specific to, dementia care needs and behavioral symptoms on 4/15/21. The QAPI Director has implemented a facility	

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F 745	Continued From page 2 with confusion . . . Was resistive to HS cares, not allowing staff to wash up and change clothing . . . Resident has been pleasant but unable to redirect easily this evening." * 02/03/21 at 8:55 p.m. - ". . . 1930 [7:30 p.m.] . . . [Resident] called staff names, grabbed at staff and threatened to call police. . . . attempted to redirect and calm her . . . staff left the resident alone . . ." * 02/04/21 at 1:19 p.m. - (Social Worker) ". . . Behavior Observation form dated 2/3/2021 at 7:30pm was routed to SW [Social Worker] for review. Staff attempted to assist her to bed for the evening and she was verbally abusive, called staff names and threatened to call the police. She physically lashed out at staff and scratched one of the arms of the staff. Staff left her alone and retuned [sic] to see when she wanted to go to bed. She continued to refuse assistance and eventually went to bed by herself. She continues to show intermittent confusion throughout the day. She does not have a diagnosis to address her cognitive status, and her physician can eventually address this issue. . . ." * 02/06/21 at 12:03 a.m. - "Resident is alert with confusion. Mood was irritable prior to going to sleep. Yelling at staff and roommate to get out of her room. Reported she was going to call the police if staff didn't leave. . . . Divider curtain was pulled and staff left room. . . ." * 02/07/21 at 10:31 a.m. - "She is noted to be alert with some confusion. She becomes agitated and aggressive towards staff at times and refuses cares . . ." * 02/20/21 at 4:53 a.m. - "2/19/21 @ 2015 [10:15 p.m.] . . . resident tried to get into roommates bed to sleep. Roommate told her no, and resident became very upset. She told staff that she was	F 745	PIP specific to behavioral management that includes a multi-disciplinary committee, which shall include, but not be limited to, all social workers and nurse managers. This committee will begin meeting on 4/20/21. Education specific to utilizing Kardex and the behavior monitoring log was provided to both social workers on 4/13/21. Nurses were educated on same at the nurses meeting on 4/15/21. All staff will be educated on 4/20/21 about the importance of recognizing behaviors or new onset of behaviors, and staff will be reminded to notify a nurse and/or social worker about any such behaviors. 4. MONITORING. A QA tool has been developed and a random audit of ten resident care plans will be completed by QAPI Director or designee, weekly for ten weeks, then monthly thereafter, to assess care plans for residents diagnosed with dementia and behaviors, and assure that they are: a. Person-centered, and b. reviewed and revised when interventions are no longer effective and/or there has been a change in condition or an increase in behaviors. Results will be submitted to the QAPI committee for review and potential further action.	

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F 745	Continued From page 3 going to move out and proceeded to walk out of her room and down the hall. When informed she could come to the certified nursing assistant [CNA] desk to wait, resident yelled at staff and said "I don't need you to tell me what I can and Can't [sic] do." . . . calm voice, explanation of the situation, informed resident where her bed was, re-approached . . . Resident refused to take evening medications because she was still upset, she did however go to her own bed after a short time . . ." * 03/04/21 at 8:15 p.m. - ". . . 8:15pm . . . [Resident] Was standing with walker beside her roommates bed yelling get the hell out of my house, I never said you could come into my house. I'm calling the police on you for breaking and entering. . . . Called her son and asked him to talk with her. He tried but she kept telling him well if your [sic] in on this funny business then your [sic] gonna [sic] get into trouble also and that's on you because I;m [sic] calling the police . . . Kept out of room for awhile until she calmed down then took back and put to bed she went to sleep." * 03/05/21 at 1:34 p.m. - (Social Worker) "Author received a behavior observation on this resident for the dates and time of 3/4/2021 at 2015 [10:15 p.m.] stating that resident had been resting in bed prior to behavior happening. Staff found resident standing by her roommates [sic] bed yelling at her get the hell out of my house I never said you could come into my house, I'm going to call the police for breaking in entering on you. Staff got a wheelchair and took resident up to call her [son name] and let him talk with her. She didn't listen to him either, said to him if your [sic] in on this funny business you can go to jail also because I am going to call the police. . . ."	F 745		

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F 745	Continued From page 4 * 03/19/21 at 11:49 a.m. - (Social Worker) ". . . She has a diagnosis of dementia, and will have progressive cognitive decline due to this condition. . . ." * 03/23/21 at 3:43 p.m. - ". . . 4-5pm . . . Resident was very upset that she had gotten a new roommate. She used profanity and was very agitated. She told roommate and her husband to "get out of here", "this is my place", "I own this place". She also threatened to call the police. She stated that she paid for this farm and no one is taking it away from her. . . . Various staff used redirection at various times between 4-5 pm. CNAs, nurse and nurse manager gave explanations and redirections without success. . . ." * 03/29/21 at 3:43 p.m. - (Social Worker) "Author received a behavior observation form on resident for the date and time of 3/23/2021 at 1600-1700 [4-5 p.m.] stating that resident was unhappy about receiving a new roommate and her having her roommates husband in there visiting with the roommate. She was using profanities and stated she would call the police. . . . This resident was moved to a private room due to this being an issue with prior roommate as well. Will continue to follow as needed." Progress Notes identified Resident #1 displayed aggressive behaviors for two months to both staff and her roommates, facility staff failed to implement a Behavior Daily Tracking Log. Facility staff also did not provide information to show the resident's team met and addressed Resident #1's behaviors or discuss a referral to psychiatry. During an interview on 03/30/21 at 1:20 p.m. an administrative nurse (#1) stated staff noticed a	F 745		

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decline in Resident #1's cognitive condition when she moved to new room (approximately 2 months ago).

During an interview on 03/30/21 at 3:40 p.m. an administrative nurse (#2) stated a psychiatrist does not currently see Resident #1.

- Observation on 03/30/21 at 11:20 a.m. identified Resident #3 wandering the facility halls unassisted and without a cane. Resident #3 wandered near the front exit door. Four staff members approached, talking to the resident and attempting to assist her away from the entrance. The resident made several attempts to pull away. Staff then assisted Resident #3 away from the entrance and brought the facility dog to the resident. The resident pet the dog twice and started to walk away. Staff assisted the resident down the hallway.

Review of Resident #3's medical record occurred on 03/30/21. Diagnoses included unspecified dementia without behavioral disturbance.

Review of Resident #3's physician's order identified the following:
* A code alert (wander guard) ordered on 03/19/21 at 11:00 p.m.
* Ativan (medication to treat anxiety) 0.25 milligrams (mg) by mouth as needed for restlessness/anxiety ordered on 3/30/21 at 12:00 p.m.

Review of Resident #3's care plan, dated 03/19/21, identified a wander guard placed on resident's cane.

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F 745	Continued From page 6 Review of Resident #3's progress notes showed the following: * 03/17/21 at 3:33 a.m. - ". . . Resident was getting agitated that staff was in [the] room bothering [Resident] . . . [Resident] started to strike out at CNA and CNA then called another staff member in to attempt to assist [Resident]. Resident then started swinging [the] cane at staff. Resident then got up and grabbed the clipboard and threw it across the room . . . Resident refused to let staff obtain vital signs and refused toileting . . ." * 03/17/21 at 3:52 a.m. - "Resident is now out of bed and throwing things around in her room . . . [Resident] screamed, 'I can read your mind and know you have hate inside you.' [Resident] also repeatedly stated, 'You are just thinking about hate and the hateful thing [sic] you can do to me' . . . [Resident] then continued to scream variations of the phrases listed above . . . Author attempted to provide reassurance and redirect but failed with several attempts." * 03/17/21 at 3:29 p.m. - ". . . Resident does get fixated on a thought or idea and becomes difficult to redirect . . ." * 03/18/21 at 2:59 a.m. - ". . . Resident had wandered over to the Beauty Shop . . . Resident continued going into other individual's [resident's] rooms . . . Resident became more agitated . . .Then raised [the] cane, and began poking it at [staff] . . . " * 03/18/21 at 4:37 a.m. - "Resident went into [another resident's] room, pulled [the] blanket off him while he was sleeping. Resident was re-directed by CNA who was hit in front of other resident . . . " * 03/18/21 at 7:45 a.m. - "[Resident] has been displaying increased paranoia, agitation and has	F 745		

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been combative/resistive with staff throughout the overnight. Currently, [Resident] is standing in the hall way [sic] behind a chair very paranoid with her cane held like a bat. She has slept minimally . . ."
* 03/18/21 at 8:30 a.m. - "[Nurse Practitioner] voiced she would speak with primary care provider [PCP] and see if there is something that could be implemented into [Resident's] daily regimen to aid with overall symptom management."
* 03/18/21 at 9:40 a.m. - ". . . Indicated that [the Resident's] PCP will review the effectiveness of this medication and may opt into an order for Ativan to be given as needed to aid with symptom management . . ."
* 03/19/21 at 1:09 a.m. - ". . . [Resident] refused anything staff was trying to help her with and started to get combative. No interventions helped the situation."
* 03/22/21 at 1:17 p.m. - (Social Worker) ". . . [Resident] had physically combative behavior towards staff . . . Staff reported they attempted to change approach and verbal tone but did not have success in improving this situation . . ."
* 03/24/21 at 4:27 a.m. - ". . . Resident refused staff assistance . . . [Resident] yelled at staff repeatedly saying, 'None of you know how to do your jobs about keeping men and women apart.' [Resident] was fixated on this and became increasingly agitated . . . Both staff members reapproached with no success . . . Resident continued to refuse cares."
* 03/25/21 at 8:53 a.m. - (Social Worker) ". . . Staff reported that [Resident] refused assistance and became agitated with them . . . Staff have reported several incidences in which [Resident] becomes agitated towards them when

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approached and offered assistance of any kind . . . [Resident] becomes agitated, makes paranoid statements about staff being evil, having hate inside them, [Resident] is wandering into other residents rooms, [Resident] swings her quad-cane at staff in attempts to hit them, and generally causes a bit of chaos on the neighborhood . . . A code alert [wander guard] was placed on [Resident #3's cane] . . ."
* 03/25/21 at 4:47 p.m. - ". . . Resident found stripping [the] bed of linen and throwing items on the floor. Linen was saturated with water from toilet. Resident continuously talking about how toilet is broken . . . Resident then ambulating in and out of other residents room, attempting to sit on their furniture, hard to redirect . . . Resident dumped supplement on the wall in room."
* 03/26/21 at 4:15 p.m. - ". . . [Resident] is now up, hitting out at staff, throwing [her] cane, [and] throwing [her] phone . . ."
* 03/27/21 at 10:03 a.m. - " . . . [Resident] started to kick at me [staff] . . . [Resident] started hitting staff on arm repeatedly . . . This had no effect until we [staff] were done and left."
* 03/30/21 at 3:42 a.m. - ". . . Resident has been awake and wandering the halls all night . . . [Resident] decided to take her shirt off and would not put one back on . . . [Resident] started to get agitated with staff and refused to put a shirt back on. [Resident] said things like, 'No not around the neck it reminds me of hanging people' . . . Staff then tried to assist [Resident] with putting on a hospital gown which was a failed attempt as well. [Resident] walked the hall bare on the top half of her body for a couple hours. Staff constantly had to keep [Resident] out of other residents' rooms and on the lane . . . [Resident] continues to try to leave the lane and enter other residents' rooms.

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F 745	Continued From page 9 [Resident] gets agitated when staff attempt to redirect, calling us [staff] stupid and swearing at us [staff] . . ." Progress Notes identified Resident #3 displayed behavioral disturbances for the past two weeks. These behaviors included aggression towards staff, inappropriately removing her own clothing, and wandering into other residents' rooms. Facility staff failed to initiate a Behavior Management Plan was initiated, evaluate occurrences for possible causes, patterns and/or trends; and implement appropriate interventions, including continued tracking is needed, and/or a referral to psychiatry. For Resident #1 and #3, the facility failed to: * Inform the physician of any significant behaviors or changes, * Assess/address, and or obtain necessary services for resident's behaviors, * Develop and implement person-centered care plans that include and support the dementia care needs and behaviors, * Develop individualized interventions related to the resident's behaviors, and * Review and revise care plans that have not been effective when the resident has a change in condition or an increase in behaviors. These items listed place all residents with dementia and behaviors at risk for ineffective dementia/behavior management.	F 745		