STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355078	A. BUILDING _____ B. WING _____	11/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE JAMESTOWN	1300 2ND PL NE JAMESTOWN, ND 58401

(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 11/17/14 and completed on 11/20/14, the sample included five (5) residents for complete review, 12 residents for focused review, and three (3) closed records for review. The sample included two (2) additional residents to verify specific concerns during the survey.	F 000	F 225 Investigation/Allegations 1. Situation discussed with resident 5 and family. Restitution made in reference to the missing Fentanyl patch. 2. All residents who have a patch or any Class II narcotic have the potential to be affected. 3. Staff will identify the location the patch is applied to the resident. Nursing staff will check the placement of the patch every shift. If Class II Narcotic is missing, staff need to immediately report it to Nurse Manager. If Class II Narcotic is not found a twenty four hour report will be submitted to the Department of Health in less than twenty four hours. An investigation will be conducted, if theft is suspected the Jamestown Police Department will be notified. A five day report will be completed and submitted to the ND Department of Health with the conclusion of the investigation. Education was completed with Nurses, CNA's and Laundry Staff prior to January 4th, 2014. 4. The DON, designee in cooperation with the Executive Director will be responsible to ensure the Investigation/Allegation is completed. QA monitoring was implemented on 12/22/14. The DON or designee will monitor weekly for a month, monthly for three month, and then random audits as needed per QA committee recommendations. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting. 5. Date of Correction: 4th January 2015	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cheryl W. Pomeroy	Executive Director	12/23/14

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 225	Continued From page 1 The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy and procedure, and staff interview, the facility failed to ensure the misappropriation of a resident's property was reported to officials in accordance with State law for 1 of 1 sampled resident (Resident #5) identified with misappropriation of property. Failure to identify and report the misappropriation of property (controlled medication) places all residents at risk of not receiving prescribed medications. Findings include: Review of the facility policy titled "Vulnerable Adult - North Dakota" occurred on 11/20/14. This policy, revised 05/13, stated, ". . . PURPOSE: . . . Definitions: . . . 5. Misappropriation of resident property - The deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent . . . PROCEDURE: . . . 6. Reporting . . . g. The DON [director of nursing] or designee will call the report to the ND [North Dakota] Department of Health . . . On weekends or after business hours leave a message. The call should be made as soon as possible but	F 225		

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F 225	Continued From page 2 within 24 hours of notification. The final report of the investigation and results will be sent to the North Dakota Department of Health within 5 working days. . . ." Review of Resident #5's medical record occurred on all days of survey. Medications included a Fentanyl Patch (an opioid analgesic) 25 micrograms (mcg) with instructions to change every third day. A progress note, dated 09/06/14 at 9:27 a.m., stated, "CMA [certified medication aide] and charge nurse observed no pain patch which was placed last night. New patch placed to rear shoulder". Review of the September 2014 Medication Administration Record (MAR) identified a nurse applied a Fentanyl patch on 09/05/14 at 7:00 a.m. Staff checked for Resident #5's patch placement on 09/05/14 at 2:30 p.m. and at 11:00 p.m. On 09/06/14 at 9:27 a.m., staff discovered the patch missing, and placed a new patch on the resident. Review of the facility's investigation report identified the Fentanyl patch was never found. During an interview on 11/19/14 at 4:30 p.m., an administrative nurse (#15) stated the facility failed to report the missing Fentanyl patch to the state survey and certification agency.	F 225		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in	F 241		

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F 241	Continued From page 3 full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to promote resident dignity for 1 of 7 sampled residents (Resident #3) observed sleeping in bed. Providing housekeeping/maintenance services while Resident #3 slept does not maintain or enhance Resident #3's dignity or respect the resident's privacy and personal preferences. Findings include: Observation in the Special Care Unit on 11/18/14 at 8:57 a.m. showed Resident #3 asleep in bed. An unidentified maintenance staff member and an unidentified housekeeping staff member were both present in Resident #3's room. The maintenance staff member cleaned carpets with a carpet steamer, while the housekeeping staff member cleaned the bathroom and floor. Observation showed the two staff members conversing and the door to Resident #3's room open. At 9:10 a.m., observation showed the resident out of bed and getting dressed in his room. During an interview on the morning of 11/20/14, a supervisory nurse (#15) agreed staff members should wait to clean rooms until residents are up for the day.	F 241	F 241 Dignity 1. The facility will ensure a dignified environment for Resident 3 and that Resident 3 is cared for in a manner that preserves and improves the resident's dignity and respect. 2. All residents of the facility have the potential to be affected. The facility will ensure that staff promote dignity to all residents. This will be demonstrated by staff not interrupting a resident who is sleeping, by cleaning or standing in resident's doorway's talking. 3. All staff were educated on promoting dignity and respect to all residents prior to January 4th, 2015. 4. The DON or designee will be responsible to monitor resident dignity and respect. QA monitoring was implemented on 12/22.14. The DON or designee will monitor weekly for a month, monthly for three month, and then random audits as needed per QA committee recommendations. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting. 5. Date of Correction: 4th January 2015	
F 250 SS=G	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social	F 250		

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F 250	Continued From page 4 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 and staff interview, the facility failed to provide medically-related social services to meet the needs of 1 of 1 sampled resident (Resident #3) with sexual and wandering behaviors. Failure to adequately assess and monitor behaviors (including sexual, verbal, physical, and eloping behaviors), develop and implement effective interventions, and ensure collaboration with the facility's Interdisciplinary Team (including psychiatry and social services) to effectively and appropriately manage Resident #3's behaviors resulted in multiple episodes of sexual aggression toward other residents, repeated elopements from the special care unit (SCU) and the facility, and multiple episodes of physical aggression. Findings include: Review of Resident #3's medical record occurred on all days of survey. Diagnoses included dementia with behaviors, unspecified psychosis, and a history of elopement from the facility. Current medications included Risperdal (risperidone, an antipsychotic) 0.5 milligrams (mg) twice per day (BID) (initiated 08/23/14) and Xanax (alprazolam, an anxiolytic) 0.25 mg every 4-6 hours as needed (prn) (initiated 01/12/14), and Zoloft (an antidepressant) 25 mg every evening (initiated 09/03/14).	F 250	F 250 - Revised Social Services 1. The facility will conduct a complete Interdisciplinary Team (which includes Social Services) Assessment to determine the care needs of Resident #3. A Psychiatric Evaluation will be requested to ensure the resident care needs are met for Resident #3. 2. All residents who have behaviors have the potential to be affected. 3. When residents have behaviors or other care needs, staff will implement and document interventions. Social Services will be involved with all aspects of care for the residents and documentation will be completed. Social Services will then assess the resident and determine if a Psychological Evaluation is needed. The Primary Care Physician will be encouraged to review the resident's medications as well as the need to meet with family to collaboratively approach the behaviors. Nurses, CNA's & Social Services were educated prior to January 4th, 2015. 4. The Director of Social Services in cooperation w/ the department of Nursing will be responsible to monitor the social service needs of the residents. QA monitoring was implemented on 12/22/14. The Director of Social Services or designee will monitor weekly for a month, monthly for three month, and then random audits as needed per QA committee recommendations. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The Director of Social Services will submit a report of the monitoring results to the QA Committee at each scheduled meeting. 5. Date of Correction: 4th January 2015	

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The current MDS, dated 10/06/14, identified severely impaired cognition and "other" behaviors which occurred on 1-3 days of the 7-day look back period. The current care plan stated, ". . . I am an elopement risk/wanderer. I wander aimlessly, at times into other resident's rooms; demonstrate impaired safety awareness; disoriented to place, person and/or time along with a history of attempts to leave facility unattended seeking to exit via the doors and/or windows of the SCU. . . . wandergurad [sic] in place [date initiated 03/07/14] . . . Interventions/Tasks . . . Document wandering behavior and attempted diversional interventions in behavior charting . . . Distract me from wandering by offering pleasant diversions, structured activities, food, conversations, television, book. . . . I have a mood problem r/t [related to] Dementia dx [diagnosis] w/ [with] agitation and anxiety- wander and have tried to leave even when at home. I am an Elopement Risk and can be invasive into others rooms which puts me at risk. I can make sexual comments/touch others. I can be verbal (scream, swear) and/or have the potential to strike at others or staff. I have been resistive to staff assistance. I can undress in public areas. . . . Interventions/Tasks . . . 15 minute checks . . . Administer medications as ordered. . . . Provide diversional activities, such as: toilet, walk, snack, blocks, puzzles, reading. . . . Reapproach . . . Provide distraction and redirection . . ."

An interview with a staff nurse (#24) occurred on 11/17/14 at 11:40 a.m. During the interview, the nurse identified Resident #3 eloped multiple times from the special care unit (SCU). The nurse stated the certified nursing assistants (CNAs) hear the door alarming, but they are often busy in

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a resident's room and cannot answer the alarm right away.

A confidential interview occurred during the survey with two CNAs. One CNA stated, "It's tough, we could definitely use another person back here [in the SCU]." The other CNA agreed and stated, "Most of our time is spent trying to keep [Resident #3] in [the SCU]."

Refer to F353.

Nurses' notes identified the following sexually inappropriate behaviors:
*11/20/13 at 6:53 p.m.: ". . . Resident found leaning over a chair in room [number]. [Resident F] sitting in the chair. Resident had his pants unzipped and penis exposed. No physical contact noted. . . ."
*01/16/14 at 2:19 p.m.: ". . . Res. [resident] was sitting on [Resident G] bed with her, then res. stood and began unzipping his pants in front of her. CNA redirected residents and brought them out of the room. . . ."
*01/21/14 at 7:45 p.m.: ". . . Nurse came to SCU to obtain report from previous shift. CNA immediately informed me that resident was being inappropriate and he had taken his pants off in the living room. They also state that it was noted he had grabbed the hand of [Resident G] and tried to put her hand in his underwear. This act was stopped. Removed [Resident G] from area as [Resident #3] is upset and at times swatting his arms around. Staff attempted to convince resident to put his pants back on. He took them and threw them on the chair next to him, and is very upset. He is swearing at staff as well. . . ."
*01/28/14 at 5:37 p.m.: ". . . This nurse was called to the SCU at 1700 [5:00 p.m.] with a concern

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from the CMA [certified medication aide] on duty about an incident that occurred between [Resident #3] and [Resident G]. When I got to the unit I was told that one of the CNAs [certified nursing assistants] had walked into [Resident G] room and found [Resident G] on her bed with only a shirt on and [Resident #3] on top of her with no clothes on. . . ."

*01/28/14 at 9:28 p.m.: ". . . [provider name] faxed at this time an update of the incident with [Resident G]. This is the second time in one week that an incident has occurred between these two residents. . . . Resident's family very concerned about what they say are more frequent inappropriate and sometimes sexual behaviors. Spouse is upset that these keep happening, she state [sic] she feels that [Resident #3] is not being monitored properly. Reassured her that we are taking care of him well, and that sometimes he is quick to get out of our site. She was appreciative of the information, just stated she was concerned and worried. . . ."

*02/04/14 at 3:26 p.m.: ". . . CNA went into room [number] to check on resident and found [Resident #3] sitting in a chair with his pants down and [Resident G] was also standing with her pants down around her ankles and leaning over resident. Staff separated them without difficulty. . . ."

*02/04/14 at 9:42 p.m.: ". . . at 2050 [8:50 p.m.] CNA noted she had not seen [Resident #3] in a few minutes so she search [sic] in rooms. She found him in SCU room [number] with female resident [Resident G]. [Resident #3] had only a shirt and incontinent product one [sic], no pants. [Resident G] was fully clothed. They were hugging closely and swaying back and forth. Resident's [sic] separated, [Resident #3] assiste [sic] to put clothes back on. . . ."

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*02/07/14 at 1:45 p.m.: ". . . Resident has been pleasant and cooperative. After lunch, sitting near [Resident G] and holding her hand. . . ."

During an interview on the afternoon of 11/19/14, a licensed social worker (#29) stated the facility staff moved the female resident to a different room after the above incidents, although she could not remember exactly when the staff made the room change.

Nurses' notes identified the following successful elopements from the SCU:
*11/19/13 at 6:26 p.m.: ". . . Resident followed staff member out of the SCU unnoticed at 4:40 pm, he went to the front desk area and attempted to leave through the front doors. Was stopped from going outside with some resistence [sic]. Redirected back to the SCU with TLC [tender loving care]. Noted resident received a 0.7 cm [centimeter] skin tear to (L) [left] forearm during this time, possibly from when he went out the SCU door. . . ."
*03/13/14 at 1:32 p.m.: ". . . Talked with spouse at 9:25 a.m. [Resident #3] had eloped from the unit at 9:05 a.m. and was found out of rear parking lot. Discussed the use of wanderguard with her and she stated he would not wear one and that she was doubtful that we would get one on him. . . ."
*07/08/14 at 11:38 a.m.: ". . . Resident had an elopement attempt at 1115 Am. He got out the back door in SCU by room SCU-11. Walked around parking lot for several minutes stating 'I need to find my car. I am tired of this [expletive].' . . ."
*08/10/14 at 2:05 p.m.: ". . . Elopment [sic] attempt - Resident had not had any attempts to open any SCU doors until after lunch. At approx

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[approximately] 1215, he was able to open the main SCU door by holding the bar long enough. Staff heard door alarm and wanderguard alarm going off and immediately came to assess situation. Nurse noted resident shadow outside of main SCU door, and ran out door to redirect resident. . . ."
*08/19/14 at 9:25 a.m.: ". . . Resident had an elopement from SCU at 0845 [8:45 a.m.]. Got out main SCU door, unable to be redirected by staff, would become agitated with redirection attempts. Walked from SCU door to offices near front reception desk. . . ."
*08/19/14 at 5:47 p.m.: ". . . Resident had an elopment [sic] at 1645 [4:45 p.m.]. He got out the main SCU dooor [sic] and walked to the area near the front reception desk. . . . It took several staff but he eventually did redirect back to SCU with multiple staff, though he was very upset. After returning to SCU he continuously was near the SCU door, setting off the alarm, and trying to get out. . . . He was able to get out again at 1730 [5:30 p.m.]. Difficult to redirect, though was able to redirect him back to SCU. . . ."
*08/31/14 at 1:00 p.m.: ". . . Resident's son had been up visiting for about an hour. After he left, resident wanted to go with them and was trying to get out again. At this time, I heard the alarm sound but all the staff were tied up with another resident so couldn't get to the door within the 15 sec. [seconds]. As I got to the door, resident was outside and walking down the hall. . . ."
*09/02/14 at 10:45 a.m.: ". . . Resident held door open until safety lock opened and went out back door of facility. Caught by [staff name] therapy, she talked him into coming back into the unit . . ."
*10/11/14 at 7:21 p.m.: ". . . When resident pushed long enough on the door and was able to elope out into the hallway the other side of the

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unit door. Myself and another staff tried to redirect him when he postured and threatened to hit us '[expletive].' . . ."
*10/19/14 at 3:50 p.m.: ". . . Resident absolutely unable to be redirected after his wife left this afternoon. . . . Resident kept pushing on door and setting alarm. He was becoming violent and pushing at staff. . . . Resident pushed on door until it opened and he was in back employee hallway. 2 CNA's and 2 kitchen staff came to assist nurse in administering 0.5 ml (1 mg) of lorazepam IM. . . ."

Nurses' notes identified the following physically/verbally aggressive behaviors and exit-seeking/attempted elopements:
*11/22/13 at 8:20 a.m.: ". . . Resident has been pushing on SCU door this a.m. and trying to 'get out'. . ."
*12/05/14 at 1:56 p.m.: ". . . Resident is agitated, pacing around SCU. He is trying doors. Says he is 'leaving today ... going to Fargo and Gr [Grand] Forks.' . . ."
*01/10/14 at 7:37 p.m.: ". . . Resident has been difficult to redirect this evening. He has been wanting to get out of the SCU and all staff interventions to promote comfort or distraction failed. Resident was aggressively pushing tables around and lifting up chairs and pushing them across table top. . . ."
*01/12/14 at 1:32 p.m.: ". . . Resident has been trying to get out of SCU before and after lunchtime. Resident escalated after wife came to visit. She left after about 10 minutes due to his behavior. He was shoving chairs around and threatening to shove them through the wall. . . ."
*01/12/14 at 6:00 p.m.: ". . . Resident has been extremely difficult to redirect. Resident ate supper and has been standing by SCU door pushing on it

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since 1800 [6:00 p.m.]. He keeps stating that he needs to get out of here and is being very vulgar towards nurse and other residents. He is escalating into violent arm swinging. . . ."
*02/23/14 at 4:00 p.m.: ". . . anxious, wants to leave . . ."
*02/26/14 at 2:16 p.m.: ". . . Resident has been very restless since about 1230, walking back and forth and continually pushing on alarmed door to get out. Upset that they have in [sic] 'locked' in here and states the 'boss' is worthless and calling him swear words and [sic] well as saying he's going to hit him along side the head when he sees him. . . ."
*03/07/14 at 6:42 a.m.: ". . . Resident's windows in SCU [room number] were both unlatched and letting in cold air. It was discovered that a brush had been thrown in the snowbank and a toothbrush was wedged in the window casing. Resident has a suitcase packed in his room. . . ."
*03/08/14 at 7:04 p.m.: ". . . Resident has been anxious to get out since 1500 [3:00 p.m.] and was continuously redirected by nurses and CNA's. . . . Resident would not leave the exit door area and his agitation was escalating. . . ."
*03/10/14 at 1:00 a.m.: ". . . This RN [registered nurse] called to special care unit as resident upset/anxious per LPN [licensed practical nurse]. Resident peeing on door and floor, resident incontinent and had urine running down his pant leg. Resident swinging arms and attempting and threatening to hit this RN and other nursing staff. Resident charging at this RN as well. This RN attempted to find out why resident was upset and resident stated, '[expletive] you.' Resident would not take oral PRN [as needed] for agitation. This RN tried to offer multiple different distraction to resident and resident refused all attempts to redirect and continued with violent behaviors,

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threats, pounding, and kicking on walls and doors, and peeing on floor and self. This RN concerned about resident's safety and well being, staff safety and other residents confined in SCU. All attempts made to calm resident and not effective. [on-call physician] notified via phone and orders received for 5 mg IM Lorazepam [Ativan, an anxiolytic] and may repeat dose in one hour. [on-call physician] stated that if not effective resident would have to be transferred. . . ."
*03/10/14 at 1:21 p.m.: ". . . Received orders from [primary doctor] to increase risperidone to 0.25 mg BID and in 10 days increase to 0.5 mg by mouth every AM and stay on 0.25 mg PM . . ."
*03/22/14 at 7:41 p.m.: ". . . resident restless and upset. he is continuously trying to open locked doors and becomes upset with redirection. . . ."
*04/16/14 at 6:48 p.m.: ". . . angry at wife after visit. standing by door tu [sic] get out. . . ."
*04/22/14 at 10:53 a.m.: ". . . Made remark x 2 this a.m. that he was going to get a gun and 'shoot everyone.' . . ."
*04/24/14 at 4:08 p.m.: ". . . resident at door constantly, unable to redirect. . . ."
*04/30/14 at 12:16 p.m.: ". . . attempting to open doors, refused coffee, walk, reading newspaper, continues to pace. got window partially open in another room. . . ."
*04/30/14 at 3:57 p.m.: ". . . resident attempting to leave, yelping, demanding to go home for supper. . . ."
*04/30/14 at 6:36 p.m.: ". . . Resident anxious nd [sic] restless continues to qttempt [sic] to open door to scu. . . ."
*05/02/14 at 7:23 p.m.: ". . . Resident pushed window open in SCU [room number] and threw pants and brief outside. Window had to be pushed from outside to lock again. . . ."

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*05/04/14 at 6:58 p.m.: ". . . Resident threw mirror and razor out the window in SCU [room number]. . . ."
*05/09/14 at 8:16 p.m.: ". . . kicking at staff. Trying to get out the doors. Setting off alarms. Wanting to go with the wife and combine. . . ."
*05/09/14 at 9:45 p.m.: ". . . Continues to challenge the doors of the SCU. States he is going to get a gun and shoot the cops. . . ."
*05/17/14 at 5:20 a.m.: ". . . This nurse was called to SCU by CNAs at about 0430 [4:30 a.m.] due to [Resident #3] being very agitated and talking about leaving. He was walking to the door and pushing it and setting off the alarm frequently. He was difficult to redirect. . . ."
*05/20/14 at 2:42 a.m.: ". . . CNA's calling ststing [sic] that [Resident #3] was standing by the door to the unit trying numbers. When there to assess he was swearing, wanting to leave, stating the he needed to go to the bar and how the last time he went, he was the only one there. . . ."
*05/20/14 at 2:37 p.m.: ". . . Resident wondering [sic] to doors and wanting to go out. 'I'll throw a chair through the window.' Unable to redirect. . . ."
*05/20/14 at 4:20 p.m.: ". . . Continues to say he's going home. Going in to different rooms and trying to open windows. . . ."
*05/20/14 at 6:37 p.m.: ". . . Resident continues to wander around and talk about going home. Tries to open windows in other resident's rooms. Did get window open a crack and threw his shirt and one shoe out. . . ."
*05/25/14 at 1:50 p.m.: ". . . Resident has been wanting to leave since he got up this morning. Took all of his clothes out of the closet, and his fans, and moved them into small lounge because he was 'waiting for that door to get unlocked so I can go home.' . . ."
*06/02/14 at 6:31 p.m.: ". . . Since 5 p.m.,

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resident has been trying to open windows and doors. Swearing and wanting to leave. . . ."
*06/11/14 at 6:04 p.m.: ". . . Resident up and about in hall and pushing residents by door, several attempts to get out. Says it is raining and he needs to go he was supposed to leave hours ago. Difficult to redirect. Much inappropriate verbal usage. . . ."
*06/17/14 at 3:24 a.m. ". . . Res thinking he has to leave for something related to selling his car. Several attempts to go out the unit door between 7 pm & 8:30 pm. Staff directed res' attention away from door. Late entry for 06/16/14 8:30 pm. . . ."
*06/27/14 at 11:01 a.m.: ". . . Patient was very anxious waiting at door to leave and would not leave door. When this nurse redirected him to go sit down in the chair he grabbed hand and squeezed tightly and started swearing. . . ."
*07/25/14 at 8:17 a.m.: ". . . This am patient came out of room and went to the front exit and started kicking at door and slamming body against it trying to get out. During this time he was yelling he wanted to '[expletive] get out of here' he was talking about that he doesn't want to buy fish or eat fish, but there was no fish being served. . . ."
*08/02/14 at 12:07 p.m.: ". . . Resident has been attempting to leave unit several times during morning. . . . Resident pushing on door with alarm during lunchtime. Unable to redirect. Resident swearing and threatening to throw his hot coffee at CNA and nurse. . . ."
*08/03/14 at 11:44 p.m.: ". . . Earlier in the evening about 7:45 pm resident tried getting out door of unit, setting off alarm. . . ."
*08/09/14 at 9:24 a.m.: ". . . continuous exit seeking, increase in agitation, threatening to 'hit the door with a hammer.' . . ."
*08/19/14 at 9:24 a.m.: ". . . increased anxiety and agitation. had an elopment [sic] and has

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been trying to elope several times since being redirected to SCU. . . ."
*08/19/14 at 6:41 p.m.: ". . . Resident continuous with another elopment [sic], and in increasingly agitated and combative, has attempted to hit staff many times. Order obtained from [provider name] for 1 mg ativan IM q2h [every 2 hours] prn up to 3 mg total for agitation (for the night of 8-19-14 only). . . ."
*08/23/14 at 3:38 p.m.: ". . . Resident has been increasingly anxious and continuously exit seeking over the last hour. Nearly impossible to redirect, swears at staff and spouse when they talk to him. He is very agitated at times. Called a male staff from another wing over to see if that would help resident as he does at times responds [sic] better to male redirection. . . . [Resident #3's wife] agreeable to inquiring if it is appropriate for resident to be started on a scheduled dose of xanax or ativan. . . ."
*08/25/14 at 4:19 p.m.: ". . . Has been walking almost constantly this afternoon. In other rooms, attempting to push windows open. . . ."
*08/29/14 at 10:33 a.m.: ". . . Resident has been agitated all morning, attempting to get out both door and windows in residents rooms, difficult to redirect. . . ."
*08/30/14 at 11:16 a.m.: ". . . Resident has been restless all morning with increased anxiety as the shift progresses. . . . Standing at the door and pushing on the handle at times, continually asking me to open the door and calls me a liar when I say I can't. . . ."
*08/31/14 at 8:00 a.m.: ". . . As soon as resident was done eating, he started pushing on the door and stating he had to leave. Would push on handle until alarm would sound so staff would have to go intervene. . . ."
*08/31/14 at 12:41 p.m.: ". . . Resident still

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restless and anxious, wanting to leave and 'get out to the farm.' . . . The last time he was at the door he was leaning against the handle so the alarm couldn't be shut of [sic] and when I told him to move away he hit me with his elbow. I asked him not to hit me and he states 'I just shoved you.' . . ."
*08/31/14 at 12:45 p.m.: ". . . I have spoken with resident's wife several times over the past two days and she is aware of his anxiety/agitation. Still thinks he should be on something scheduled to even out his moods. . . ."
*08/31/14 7:05 p.m.: ". . . Resident has required direct 1-1 supervision due to standing at door and trying to get out. He will hold the lever in until it opens and then get angry when we won't let him out. Struck a nurse for the second time today . . ."
*09/02/14 at 4:21 p.m.: ". . . Fax from [physician name] states 'Increase risperidone to 0.5 mg BID starting tonight.' . . ."
*09/16/14 at 6:09 p.m.: ". . . multiple attempts to walk out door angry with staff. . . ."
*09/22/14 at 5:20 p.m.: ". . . Resident was able to open exit door by leaning on bar. Went a few steps out of the SCU. . . ."
*09/28/14 at 12:00 p.m.: ". . . resident is now angry trying to get out the door, swearing at staff . . ."
*10/02/14 at 3:45 p.m.: ". . . Resident has been requiring prn xanax for increased behaviors. Wife states that he gets mean and verbaly [sic] abusive when she visits. She requests meds [medications] be increased. Fax sent to [physician] requesting increase in Risperdal dose. . . ."
*10/03/14 at 4:00 p.m.: ". . . swearing. exit seeking. . . ."
*10/05/14 at 8:37 a.m.: ". . . resident wanting to leave, pushing on door, unalbe [sic] to redirect for

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F 250	Continued From page 17 any length of time . . ." *10/06/14 at 2:44 p.m.: ". . . [physician] re-faxed re: [regarding] behaviors and question if Risperdal dose can be increased. . . ." *10/06/14 at 4:04 p.m.: ". . . Wanting to leave after wife visited. Pushing on window in his room. Exit seeking. . . ." *10/08/14 at 2:09 p.m.: ". . . Call placed to Primary Physicians nurse to request response to 2 faxes for increase in medication for resident. . . ." *10/09/14 at 8:46 p.m.: ". . . res is consistently trying to leave the unit, agitated . . ." *10/10/14 at 7:23 a.m.: ". . . Res was constantly trying to open the door until he was able to open it and leave the unit. A cna was constantly with him and 2 cna were necessary to redirect him to [sic] back to the unit. . . ." *10/10/14 at 7:26 a.m.: ". . . Res has two cuts on left forearm. Res left the unit after been [sic] pushing the entrance door. After Cnas brought res back to the unit they found blood on their clothe [sic]. These are small cuts 1 x 0.5 cms [centimeters] that occurred while pushing the door to exit the Unit. . . ." *10/10/14 at 9:15 a.m.: ". . . Received [sic] fax from residents PCP [primary care provider] ordering a psych [psychological] consult. Appointment scheduled with [psychologist name] . . ." *10/20/14 at 4:27 a.m.: ". . . Pacing, pushing on doors, yelling. . . ." *10/21/14 at 10:46 a.m.: ". . . Received fax from [PCP] responding to behaviors and frequent elopement attempts on 10-19-14. He would like resident to be seen by psych for med management. Resident was seen by [psychologist] on 10-14-14. No reports or recommendations received [sic] yet. Fax was	F 250		

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sent to [psychologist] last evening requesting recommendations. . . ."
*10/21/14 at 5:30 p.m.: ". . . Received [sic] call from [psych doctor]. He will be visiting with [PCP] in the morning re: resident's psych eval. [evaluation]. Dementia is too advanced to benefit from a therapist. Need psychiatry to manage meds. . . ."
*10/23/14 at 3:24 p.m.: ". . . Author was caring for another resident, heard alarm, resident had pushed on door and was just exiting as I reached area. . . ."
*10/23/14 at 3:59 p.m.: ". . . rounds made by [PCP]. He will be in contact with [psych doctor] and check about possible changes with his medication regimen. . . ."
*10/25/14 at 12:50 p.m.: ". . . resident held alarmed door handle until it opened up and resident wondered [sic] out into hall. . . ."
*10/25/14 at 5:19 p.m.: ". . . resident going into other residents rooms and trying to open the windows. . . ."
*10/26/14 4:16 p.m.: ". . . unable to redirect. hitting out. pushed on door, out in hallway. brought back. . . ."
*10/26/14 at 4:20 p.m.: ". . . Pushed on door and went out. . . . Hard to redirect, brought back in to unit. Threatening. . . ."
*10/28/14 at 12:52 p.m.: ". . . After lunch resident kept going to the door and setting off the alarm, stating he needed to go home because his wife and kids were waiting for him. . . ."
*10/28/14 at 1:47 p.m.: ". . . Resident stood at the door and held the handle in so it would open. Staff were tied up with other resident's and by the time we get to him, he was outside the door. Resident sat in the chair at the table outside and refused to come back in. . . ."
*10/28/14 at 2:59 p.m.: ". . . Resident was trying

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to get out the front door again [sic], holding the handle down so the door would open. CNA was unable to get him to let go off [sic] the door so I intervened. Resident hit me in the chest with his hand and swore at me. Resident was able to get out of the door and was trying to go out the door to the outside. CNA was trying to stop him from getting out and I saw the administrator so called him over to help. Administrator was not able to convince resident to come back inside so we went and found resident's nephew, who is a worker here, and he was able to get resident to come back inside. . . . After nephew left, I gave resident IM Alprazolam [sic, Ativan] . . ."
*10/28/14 at 6:22 p.m.: ". . . Received a fax from [PCP] with order for Doxepin [an antidepressant] 10 mg po bid. . . ."
*10/29/14 at 3:43 p.m.: ". . . 1st dose of Doxepin given at 9 am when medication arrived. Has been groggy all day but had prn medication x 3 yesterday so unable to determine if any effects from new medication. . . ."
*10/30/14 at 5:27 p.m.: ". . . Woke up after spouse left, ate all of supper and then became very aggitated [sic]. Pushed on exit door, out into hallway, threatened to hit me, yelling, and swearing. . . ."
*10/31/14 at 9:27 a.m.: ". . . Unable to awaken resident for morning medications. . . . cannot awaken for meal at this time. . . ."
*10/31/14 at 10:11 a.m.: ". . . Call back from primary physician. Order to dc [discontinue] Doxepin and to hold insulin this am . . ."
*11/03/14 at 2:56 p.m.: ". . . Resident attempting to leave SCU, swearing and hitting at the staff. . . ."
*11/10/14 at 2:36 p.m.: ". . . Faxed [PCP] re: possibly increasing Zoloft [an antidepressant] dose. Was started on 25 mg po daily on 9/3/14.

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Resident's wife feels he is still depressed. He does continue to express feelings of sadness and lonliness [sic] at times. . . ."
*11/11/14 at 7:03 p.m.: ". . . increase [sic] agitation and attempts at getting off unit . . ."
*11/12/14 at 2:16 p.m.: ". . . Resident agitated, attempting to leave . . ."
*11/15/14 at 10:26 p.m.: ". . . Resident last few nights has been getting up during night, getting dressed and trying to get out doors. At times, CNA's might be in room then hear door alarm going off from Resident trying to get out. . . ."
*11/16/14 at 9:49 a.m.: ". . . Res. crying to this nurse saying that his is going to die today on and off for about 30 mins . . ."
*11/18/14 at 9:10 p.m.: ". . . increase [sic] restlessness, attempts to leave unit . . ."
*11/19/14 at 10:39 a.m.: ". . . res trying to get out, threating [sic] to kill everyone here . . ."

Review of Resident #3's medical record identified staff administered IM Ativan on 10/19/14 and 10/28/14 without a valid physician's order. See F333.

Social services progress notes identified the following:
*01/06/14 at 4:29 p.m.: ". . . Initiated [Resident #3] Annual assessment today. . . . He also noted that 2-6 days in the last 2 weeks he has had thoughts that he would be better off dead. . . . The unit manager was notified. There are no other concerns at this time. . . ."
*01/16/14 at 5:21 p.m.: ". . . [Resident #3] had a Care Conference today. . . ."
*02/12/14 at 11:38 a.m.: ". . . Per the Interdisciplinary Team of Eventide via Nursing, Activities, and Social Services, it is deemed in [Resident #3] best interest to continue placement

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in the 'Special Care Unit' of Eventide due to his exit seeking behavior. . . ."
*02/12/14 at 9:58 p.m.: ". . . [Resident #3's wife] appreciated the update per this Worker providing Social Services to the residents and/or families of the SCU along with wanting to confirm her support of [Resident #3] continual placement in the Special Care Unit commenting 'it wouldn't be safe for him anywhere else right now because he's always wanting to go or get out of there; with the cold weather, it just isn't safe.' . . ."
*07/11/14 at 2:14 p.m.: ". . . Care Conference was held . . . Placement on the Special Care Unit continues to be in [Resident #3] best interest due to the continual elopement attempts and/or exit seeking behaviors. . . ."
*10/15/14 at 5:25 p.m.: ". . . Care Conference was held . . . [Resident #3] has made and/or experienced elopements per the SCU with the overall plan to potential [sic] reassess meds along with anticipation of [Resident #3] overall needs. . . ."
*10/15/14 at 5:44 p.m.: ". . . [Resident #3's wife] met briefly with this Social Worker after the Conference reiterating the concern of [Resident #3], at times gets demanding and/or verbally aggressive per the request for [wife] to take him home. . . ."

The record lacked evidence of social services involvement except for quarterly care conference/progress notes. The record lacked evidence of assessment, monitoring, and/or intervention evaluation by social services regarding Resident #3's continued behaviors. When asked to provide further evidence of social services involvement in the management of Resident #3's behaviors, the facility provided no additional information.

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Physician progress notes stated the following:
*12/04/13: ". . . He also struggles with some anxiety and irritability. In fact, the nursing staff informed me he has had several more 'elopements' where he sneaks out of the special care unit. Sometimes, he will pull a chair up next to the exit door and just wait for a visitor to leave, so he can sneak out. They have noticed that there seems to be a pattern as to what time of the day this occurs. It seems to happen when he is a little more irritable and anxious. According to the nursing staff, his wife is requesting that we restart him on alprazolam during these times because it helped in the past. . . . PLAN: . . . We are going to start scheduling alprazolam. Please see orders. . . ."

Review of the medical record showed staff did not receive an order for scheduled alprazolam. During an interview on the morning of 11/20/14, a supervisory nurse (#16) stated staff did not start Resident #3 on a scheduled dose of alprazolam, and failed to follow up on the physician's recommendation.

*01/09/14: ". . . Lately, there has been problems with his anxiety and then agitated behavior. He also has been acting inappropriately by making sexual gestures towards some of the female residents. Last visit, I started him on scheduled alprazolam as a trial. Staff felt that maybe some of his behavior was related to times when he was anxious or maybe even a little confused and, therefore, almost paranoid. They have noticed some improvement and feel we should give it a little bit longer trial. . . . PLAN: . . . I am going to keep him on the same medications. We will give this alprazolam a little bit longer trial. . . ."

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Record review identified Resident #3's medication regimen did not include scheduled alprazolam.

*04/02/14: ". . . His main concern lately has been inappropriate behavior. He has had several elopements from the special care unit. At times he has been a little combative. Last visit I started him on low-dose Risperdal in the morning [0.25 mg every morning initiated 02/05/14]. Staff states that he has not had as much aggressive or inappropriate behavior. However, because of his dementia, he can be very time consuming. . . ."

Faxes to the physician identified the following: *08/28/14: ". . . The wife was wondering if Resident could have Xanax [alprazolam] 0.25 mg PO [by mouth] scheduled twice a day. He does get it PRN. Resident has been having more episodes of crying, trying to get out, agitated easily. . . ." The physician responded: " No change. I recently increased risperidone [and] started Zoloft."

Although staff requested scheduled Xanax on this date, record review identified the physician actually ordered the Xanax during his 12/04/13 visit, but failed to communicate this order to staff.

*10/02/14: ". . . Resident recieves [sic] Risperdal 0.5 mg BID. He has been needing more PRN Xanax due to [increased] behaviors. Wife states he gets mean towards her verbally during visits. Can Risperdal dose be increased? . . ." The physician responded by ordering a psychology consult, which Resident #3 attended on 10/14/14.

The psychologist's note, dated 10/14/14 stated the following: ". . . Given the significance of the

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cognitive deficits, [Resident #3] would not be a candidate for any type of psychotherapy, as she [sic] is not able to benefit from the learning necessary. He will need ongoing supervision and care for his well-being and the well-being of others around him. . . . If he continues to demonstrate ongoing behavioral problems, there may be benefit to having him be seen by psychiatry. . . ."

An additional fax to the physician, dated 10/19/14, stated, "Resident became combative and unable to redirect. Resident pushed through locked door of SCU into back hallway. He refused oral PRN Xanax. 1 mg (0.5 ml [milliliter]) of lorazepam IM given in [right] buttocks. After 20 minutes resident agreed to walk back into SCU. He is resting in bed. . . ." The physician responded, "Noted. Please request psyche reevaluation for med management as behaviors have been getting worse."

A fax to the psychologist, dated 10/20/14, stated, ". . . You saw [Resident #3] last week @ NH [nursing home]. He continues to require po Xanax often for agitation, [and] also received [sic] an IM dose yesterday. Please see accompanying nurses' notes. Can you please make some recommendations as to what meds we can suggest to [PCP] on a scheduled basis? [Resident #3's wife] wants to visit, but is afraid to. She would really like him on something scheduled for agitation. Please advise." The response stated, "[psychologist] will visit [with] [PCP]."

The record lacked evidence of a psychiatric reevaluation, medication regimen review/recommendations by the psychologist or

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F 250	Continued From page 25 PCP except the initiation of Doxepin on 10/28/14, which was then discontinued on 10/31/14), or any further collaboration after the above fax. During an interview on the morning of 11/20/14, a supervisory nurse (#16) stated she was unaware of a psychiatric reevaluation or further communication between the psychologist and Resident #3's PCP. The facility failed to initiate scheduled Xanax as recommended by the physician, failed to ensure timely involvement by social services as well as psychiatric services, and failed to implement an effective behavioral management plan which would allow Resident #3 to maintain his highest level of functioning and well-being. As a result, Resident #3 displayed aggressive and violent behaviors, sexually inappropriate behaviors toward other demented/confused residents, and multiple elopements from the SCU and the facility.	F 250		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed 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	F 280		

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F 280	Continued From page 26 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: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 12/19/13 Based on observation, record review, review of facility policy and procedure, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the residents' status for 2 of 17 sampled residents (Resident #4 and #6). Failure to review and revise the care plan limited staff's ability to communicate care needs and ensure continuity of care for each resident. Findings include: Review of the facility policy titled "Care Plans" occurred on 11/20/14. This policy, dated 2013, stated, "Purpose: To develop a care plan as a workable tool that reflects the actual care and condition of each resident. . . Procedure: . . . C. Documentation . . . 2. Care plans will be updated and changes will be made as they occur to ensure the most current plan for the resident. . . ." - Review of Resident #6's medical record occurred on all days of survey. Resident #6 was admitted to the facility on 03/08/13. Current diagnoses included multiple sclerosis, muscle weakness, and muscle spasm. Resident #6's	F 280	F 280 Care Planning 1. Residents 4 and 6 care plans were assessed for accuracy and updated. 2. All residents have the potential to be affected. Care plans are reviewed to ensure accuracy and updated as needed. Changes to the care plans are made when the need is identified. 3. Care Plans are reviewed and revised on admission as well as on every change of condition for each resident. Changes to the care plan will to be communicated to the appropriate staff and will be done immediately and appropriately. Staff will ensure the care plan accurately reflects the resident's current condition. Education will be completed for Nurses, CNA's and Therapy staff prior to January 4th, 2015. 4. The DON or designee will be responsible to monitor the Care Plan Process to accurately reflect the current condition of the residents. QA monitoring was implemented on 12/22/14. The DON or designee will monitor weekly for a month, monthly for three month, and then random audits as needed per QA committee recommendations. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting. 5. Date of Correction: 4th January 2015	

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F 280	Continued From page 27 Minimum Data Set (MDS), dated 10/23/14 identified the resident required total assistance of two or more staff for bed mobility and dressing. Observation on 11/18/14 at 8:30 a.m. showed two certified nursing assistants (CNA's) (#1 and #2) transferred Resident #6 into a wheelchair. After adjusting the resident in the wheelchair, the CNA (#1) fastened Resident #6's seat belt. Resident #6's care plan failed to identify the use of a seat belt in the resident's wheelchair. During an interview on 11/19/14 at 10:40 a.m., an administrative nursing staff member (#14) confirmed Resident #6's care plan failed to identify the use of the seat belt. This nurse stated Resident #6 has used the seat belt since admission to the facility and staff failed to complete an assessment and care plan the use of the seat belt. - Review of Resident #4's medical record occurred on all days of survey. The current care plan stated, ". . . Focus: Self care Deficit, I require assist with all adl's [activities of daily living] and mobility. . . . Interventions/Tasks: . . . TRANSFERS/AMBULATION: I require assist of 1 and medistand [mechanical stand lift] for transfers, ambulation per PT [physical therapy] only at this time . . ." Observation on 11/18/14 at 10:48 a.m. and 12:32 p.m. showed a certified nurse assistant (CNA) (#19) transferred Resident #4 with a gait belt. Observation on 11/18/14 at 4:40 p.m. showed a CNA (#20) transferred Resident #4 with a gait belt.	F 280		

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F 280	Continued From page 28 Review of the staff communication book stated, ". . . 11/11/14 [Resident #4] - now transfer with 1A [one assist] & [and] walker or grabbars. . . ." During an interview on 11/19/14 at 9:20 a.m., a physical therapy assistant (#21) stated Resident #4's transfer status changed the week before to assist of one.	F 280		
F 309 SS=E	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 record review and review of facility policy, the facility failed to provide the necessary care and services to manage behavioral symptoms of dementia for 6 of 6 sampled residents (Resident #2, #3, #9, #13, #14, and #17) and 1 closed resident record (Resident #18) identified with behaviors and on psychopharmacological medications. Failure to thoroughly assess the residents' behaviors and attempt non-pharmacological interventions prior to administering psychopharmacological medications may result in decreased physical, mental, and psychosocial well-being and negatively impact these residents' quality of life.	F 309		

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Findings include:

Review of the facility policy titled "Behavior Monitoring" occurred on 11/20/14. This policy, dated May 2013, stated, "Policy: It is the policy of Eventide to provide accurate resident assessment and documentation of mood and behavior symptoms and patterns, . . . Procedure: . . . All resident care personnel will document behavior as it occurs . . . *Information to be completed includes: date, shift, number of occurrences, response to approaches utilized and the specifics of the behavioral incident. . . ."

- Review of Resident #13's medical record occurred on November 19-20, 2014. Diagnoses included dementia with behavioral disturbances. Daily medications included Risperdal (antipsychotic) 0.5 milligrams (mg) (initiated 09/12/14) and Haldol (antipsychotic) 1 mg four times daily (initiated 10/02/14) As needed (PRN) medications included: Haldol 1 mg by mouth every 6 hours (initiated 09/12/14), Haldol 5 mg Intramuscular (IM) every 4 hours (initiated 09/12/14), Lorazepam (Ativan, an antianxiety) 0.5 mg to 1 mg Subcutaneous (SQ) every 6 hours (initiated 09/12/14), and Lorazepam 0.5 mg tablets 1 to 2 tablets every 6 hours (initiated 10/24/14).

Resident #13's quarterly Minimum Data Set (MDS), dated 08/20/14, identified problems with both long and short term memory, disorganized thinking, and no behavioral symptoms. The care plan stated, "Focus: The resident has impaired cognitive function/dementia or impaired thought processes r/t [related to] Disease Process . . . believes at times he is waiting for the doctors order to go home . . . tearful at times thinking his

F 309 - Revised Quality Care/Interventions

1. Resident's 3, 9, 13, 14 & 17 had their Care Plan reviewed for accuracy for appropriate Non-Pharmacological interventions. Changes to the Care Plans were made if needed. Resident 2 has passed away.
2. Any resident who currently is on Psychotropic medications and has a diagnoses of dementia has the potential to be affected.
3. When residents have behaviors, staff will implement and document interventions. Prior to dispensing prn medication staff will attempt and document interventions. Social Services will be involved with all aspects of care for the residents and documentation will be completed. Social Services will assess the resident and determine if a Psychological Evaluation is appropriate. Primary Care Physician will review the resident's medications as well as the need to meet with family to collaboratively approach the behaviors. Nurses, CNA's & Social Services were educated prior to January 4th 2015.
4. The DON or designee will be responsible to monitor the care and services needed to manage behavioral symptoms in residents. QA monitoring was implemented on 12/22/14. The DON or designee will monitor weekly for a month, monthly for three month, and then random audits as needed per QA committee recommendations. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.
5. Date of Correction: 4th January 2015

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wife is divorcing him and taking his money . . . Interventions/Tasks: *Administer meds as ordered . . . *Cue, reorient, and supervise as needed . . . *Enc. [Encourage] Diversional act. [activity] . . . visiting about the past, walks, snacks, etc . . . Focus: I have a mood problem r/t Dementia. I get agitated and wander and have tried to leave the unit . . . Interventions/Tasks: *Medication as ordered *monior [sic] increased aggression and wandering."

Review nurses' notes and medication administration record (MAR) from 08/01/14 through 11/19/14 identified Resident #13 received PRN Lorazepam 13 times and Haldol 14 times. Twenty three of the 27 times the resident received PRN medication, the facility staff failed to attempt non-pharmacological interventions prior to the administration.

- Review of Resident #17's medical record occurred on November 19-20, 2014. Diagnoses included Alzheimer's disease, dementia without behavioral disturbances, anxiety, and depression. Medications included Celexa (antidepressant) daily and Lorazepam, either orally or IM, every 4 hours PRN.

Resident #17's annual MDS, dated 08/08/14, identified problems with both long and short term memory, disorganized thinking, inattention, and wandering. The care plan stated, "Focus: I have depression *I will have episodes of crying and am not able to say why I am crying, I get anxious at times. *I have tried to leave the building at times . . . Interventions/Tasks: *Administer medications as ordered *Arrange for the resident's clergy or spiritual leader of choice to visit as requested . . . *Monitor/document/report s/sx [signs/symptoms]

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of depression . . . *The resident needs time to talk. Encourage the resident to express feelings."

Review of the nurses' notes and MAR from 08/01/14 through 11/19/14 identified Resident #17 received PRN Lorazepam 12 times. Twelve of twelve times the facility staff failed to attempt non-pharmacological interventions prior to the administration.

- Review of Resident #2's medical record occurred on all days of survey. Diagnoses included anxiety, obsessive-compulsive disorder (OCD), and dementia with behavioral disturbances. Medications included Seroquel (antipsychotic) twice a day, clonazepam (anticonvulsant used to treat anxiety) PRN, and Lorazepam PRN.

Resident #2's quarterly MDS, dated 09/27/14, identified severely impaired cognition, inattention, and verbal behaviors. The care plan stated, "Focus: I have a mood problem r/t anxiety/increased memory issues/w [with] fear of being alone; multiple health/non-health c/o [complaints of]; irritability; demanding; intolerant of roommates; embellishes statement/facts; worries nonstop . . . Interventions/Tasks: *1:1 [one to one] visits prn *administer medications as ordered . . . *Monitor/record mood to determine if problems seem to be related to external causes . . . *Monitor/record/report to MD [medical doctor] prn mood patterns s/sx of depression, anxiety, sad mood as per facility behaviour [sic] monitoring protocols *Move to a quieter area . . . *Offer snack or diversional act. prn"

Review of the nurses' notes and MAR from 08/0/14/ through 11/19/14 identified Resident #2

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received PRN Lorazepam and/or clonazepam 12 times. Twelve of twelve times the facility staff failed to attempt non-pharmacological interventions prior to the administration.

- Review of Resident #3's medical record occurred on all days of survey. Diagnoses included dementia with behaviors, and unspecified psychosis. Current medications included Risperdal 0.5 mg BID and Xanax 0.25 mg every 4-6 hours prn.

The current MDS, dated 10/06/14, identified severely impaired cognition and "other" behaviors occurring on 1-3 days of the 7-day look back period. The current care plan stated, ". . . I am an elopement risk/wanderer. . . . Interventions/Tasks . . . Document wandering behavior and attempted diversional interventions in behavior charting . . . Distract me from wandering by offering pleasant diversions, structured activities, food, conversations, television, book. . . . I have a mood problem r/t Dementia dx [diagnosis] w/ agitation and anxiety- wander and have tried to leave even when at home. I am an Elopement Risk and can be invasive into others rooms which puts me at risk. I can make sexual comments/touch others. I can be verbal (scream, swear) and/or have the potential to strike at others or staff. I have been resistive to staff assistance. I can undress in public areas. . . . Interventions/Tasks . . . 15 minute checks . . . Administer medications as ordered. . . . Provide diversional activities, such as: toilet, walk, snack, blocks, puzzles, reading. . . . Reapproach . . . Provide distraction and redirection . . ."

Review of Resident #3's MARs and nurses notes

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from 08/01/14 through 11/19/14 showed staff administered prn Xanax 54 times. Facility staff failed to attempt nonpharmacological interventions prior to administering the prn Xanax on 30 of these 54 occasions.

- Review of Resident #9's medical record occurred on all days of survey. Diagnoses included dementia without behaviors and Alzheimer's disease. Current medications included Lorazepam 0.5 mg BID, Lorazepam 0.5 mg QID prn, and Lorazepam 0.5 mg IM every 4 hours prn.

Resident #9's current MDS, dated 09/26/14, identified severely impaired cognition, and verbal behaviors occurring on 1-3 days of the 7-day look back period. The current care plan stated, ". . . I have Delusions and Depression at times . . . I have a history of talking about leaving, and have had attempts in the past to leave the facility which makes me a potential elopement risk. I have a history of frequent crying at times. I will call out and cry at times. . . . Interventions/Tasks . . . Cue, reorient, and supervise as needed. . . . Keep the resident's routine consistent and try to provide consistent care givers as much as possible . . . medication as ordered . . . Offer me reassurance when I express concerns about my family . . . Reminisce with the [sic] me using photos of my family and friends . . . Use task segmentation to support short term memory deficits.

Review of Resident #9's MARs and nurses' notes from 08/01/14 through 11/19/14 showed staff administered prn Lorazepam 14 times. Facility staff failed to attempt nonpharmacological interventions prior to administering the prn Lorazepam on eight of these 14 occasions.

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	355078	A. BUILDING _____ B. WING _____	11/20/2014

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F 309	Continued From page 34 - Review of Resident #18's medical record occurred on 11/20/14. Diagnoses included anxiety. Medications included Lorazepam PRN. The care plan stated, ". . . Focus: The resident has depression and anxiety . . . Interventions/Tasks: Administer medications as ordered. Monitor/document for side effects and effectiveness. Assist the resident, family, caregivers to identify strengths, positive coping skills and reinforce these . . . The resident needs time to talk. Encourage the resident to express feelings . . ." Review of the progress notes and medication administration record (MAR) from 08/01/14 through 10/31/14 identified Resident #18 received Lorazepam 22 times. 17 of the 22 times facility staff failed to attempt non-pharmacological interventions prior to the administration of the Lorazepam. Five of the 22 times facility staff failed to document indication for use. Two of the 22 times facility staff documented the result as ineffective and failed to provide follow up. - Review of Resident #14's medical record occurred on 11/20/14. Diagnoses included Alzheimer's disease and dementia with behavioral disturbance. Medications included Lorazepam 0.25 mg twice a day, Lorazepam 1-2 mg IM every four hours as needed, Lorazepam 1-2 mg SQ every 4 hours as needed, and Lorazepam 0.5 mg by mouth every two hours as needed for "anxiety-elopement risk". Resident #14's quarterly MDS, dated 09/30/14, identified long and short term memory problems. The current care plan stated, ". . . Focus: I have hx [history] of elopement attempts/wandering d/t [due to] impaired safety awareness and/or	F 309		

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F 309	Continued From page 35 disoriented to place. . . . Interventions/Tasks: . . . Distract me from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. . . ." Review of the nurses' notes and MAR from 06/01/14 through 09/30/14 identified Resident #14 received Lorazepam 18 times. 13 of the 18 times facility staff failed to attempt non-pharmacological interventions prior to the administration of the Lorazepam. Three of the 18 times facility staff failed to document indication for use. Facility staff administered IM Lorazepam five times in July 2014. Three of the five times facility staff failed to attempt to administer other forms of Lorazepam before administering IM Lorazepam.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 12/19/13. Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide the necessary services to promote	F 314		

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F 314	Continued From page 36 healing and prevent recurrence of pressure ulcers for 1 of 4 sampled residents (Resident #6) with pressure ulcers. Failure to properly utilize Resident #6's wheelchair cushion placed the resident at risk for recurrent or delayed healing of a pressure ulcer. Findings include: Review of the facility policy titled "Skin Assessment" occurred on 11/20/14. This policy, dated 2013, stated, ". . . Follow interventions for pressure relief, pressure reducing cushion if wheelchair bound. . . ." Review of Resident #6's medical record occurred on all days of survey. Current diagnoses included multiple sclerosis and pressure ulcer. The facility identified a current pressure ulcer that re-opened on 10/28/14 on Resident #6's right gluteal fold. Resident #6's Minimum Data Set (MDS), dated 10/23/14, identified the resident required total assistance of two or more staff for bed mobility. Resident #6's care plan stated, ". . . Focus: . . . Hx [history] of recurring pressure ulcers . . . spend the majority of the day sitting in w/c [wheelchair] . . . Interventions: Specialty cushion in w/c . . ." Resident #6's physician orders dated 07/23/14, stated, " . . . check air in roho [specialty cushion in wheelchair] cushion weekly . . ." Resident #6's Occupational Therapy treatment note, dated 11/21/13, stated, " . . . Resident verbalized that he was extremely uncomfortable in his chair. This therapist noted he was on a different cushion. Resident was repositioned on	F 314	F 314 Pressure Areas 1. Resident 6 reassessed for pressure, sheep skin removed from specialty cushion and care planned appropriately. 2. Any resident with a pressure area has the potential to be affected. 3. All care plans will be up to date with appropriate interventions. Nursing staff have been provided direction to follow Care Plan. If appropriate a therapy referral will be made for positioning. Education for Nurse, CNA's and Therapy staff will be conducted prior to January 4th, 2015 4. The DON or designee will be responsible to monitor the necessary services to promote healing and prevent recurrence of pressure ulcers. QA monitoring was implemented on 12/22/14. The DON or designee will monitor weekly for a month, monthly for three month, and then random audits as needed per QA committee recommendations. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting. 5. Date of Correction: 4th January 2015	

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roho and educated resident and nursing staff about differences between gel cushion, air cushion and custom fit. . . ."

Observation on 11/18/14 at 8:30 a.m. showed two certified nursing assistants (CNA's) (#1 and #2) transferred Resident #6 into the wheelchair. Prior to the transfer CNA #1 placed a roho cushion into the wheelchair and placed a cushion covered with sheep skin on top of the roho. CNA #1 stated, "this is his own personal cushion he likes."

Observation on 11/18/14 at 12:40 p.m. and 11/19/14 at 9:15 a.m. showed Resident #6 seated in a wheelchair with a roho cushion and on top of the roho, a cushion covered in sheepskin.

During an interview on 11/19/14 at 11:02 a.m., a certified occupational therapist assistant (COTA) (#10) stated Resident #6 has a roho cushion in his wheelchair. On 11/19/14 at 11:30 a.m., this therapist confirmed that Resident #6 had a roho cushion and a cushion covered with sheepskin on top of the roho. The COTA stated the sheepskin cushion was a personal choice made by the resident and not recommended by therapy. After educating the resident, he did agree to use only the roho cushion.

During an interview on the morning of 11/20/14, two CNA's (#11 and 12) stated Resident #6 uses two wheelchair cushions in his wheelchair.

During an interview on 11/20/14 at 8:45 a.m. with two administrative nursing staff members (#13 and #14), one staff member (#13) stated she expected staff to use only the wheelchair cushion recommended by therapy, as a second cushion would defeat the purpose of the specialty

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F 314	Continued From page 38 cushion.	F 314		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 12/19/13. Based on observation, record review, and family interview, the facility failed to ensure that residents with limited range of motion received appropriate treatment and services to prevent further decrease in range of motion for 1 of 1 sampled resident (Resident #5) who utilized a hand splint. Failure to apply the hand splint, as ordered by the physician, may result in Resident #5 experiencing discomfort and new or worsening contractures. Findings include: Review of Resident #5's medical record occurred on all days of survey. Diagnoses included hemiplegia (paralysis of one side of the body). Current physician orders included, "Left hand splint, on during day and off at night as resident allows." The current care plan stated, ". . . Focus: The resident has an ADL [activities of daily living]	F 318	F 318 Splints 1. Resident 5 will be assessed for use of the hand splint. 2. All residents who have hand splints have the potential to be affected. 3. All residents with hand splints will be reassessed. Care plans will be updated to reflect the current condition of the residents. If resident refuses splint, staff will encourage resident to utilize the splint as care planned. Nurse will document refusal and a therapy referral will be made as appropriate. Education will be conducted with Nurse, CNA and Therapy staff prior to January 4th, 2015 4. The DON or designee will be responsible to monitor the use and document of splints. QA monitoring was implemented. The DON or designee will monitor weekly for a month, monthly for three month, and then random audits as needed per QA committee recommendations. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting. 5. Date of Correction: 4th January 2015	

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F 318	Continued From page 39 Self Care Performance Deficit r/t [related to] Stroke, Limited Mobility. . . . Interventions/Tasks: . . . Left splint on during the day as res. [resident] allows, off at night . . ." Review of a "OT [occupational therapy] - Therapist Progress" note, dated 07/29/14, stated, ". . . Long Term Goals . . . Utilize Appropriate hand splint to reduce further progressing/development of contracture and for contracture prevention. . . . Patient continues to have functional deficits including Decreased ROM [range of motion], strength and endurance. . . ." During an interview on 11/17/14 at 5:10 p.m., a family member (#1) stated, staff do not consistently apply Resident #5's left hand splint. Observations on 11/18/14 at 9:36 a.m., 10:12 a.m., and 1:08 p.m., identified staff failed to apply Resident #5's left hand splint. Observations on 11/20/14 at 9:10 a.m. and 1:45 p.m. showed Resident #5's left hand splint sitting on the dresser. Facility staff failed to apply Resident #5's left hand splint as ordered and identified in the resident's care plan.	F 318		
F 323 SS=G	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.	F 323		

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F 323	Continued From page 40 This REQUIREMENT is not met as evidenced by: ELOPEMENT 1. Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure the safety of 3 of 3 sampled residents (Resident #3, #13, and #14) who wandered and exited the Special Care Unit (SCU) and/or the facility. Failure to ensure and maintain resident safety by providing adequate supervision, implementing effective interventions (a functioning wanderguard system, 15 minute checks, changes to the security code, etc.), and monitoring/reevaluating the interventions resulted in Resident #3, Resident #13, and Resident #14 eloping from the SCU and/or the facility on multiple occasions, including Resident #13 eloping a block and a half away without staff knowledge. Findings include: Review of the facility policy titled "Missing Residents" occurred on 11/20/14. This policy, dated May 2013, stated, "Policy: Eventide will assure the health, safety and welfare of all residents who are placed in our care. If a resident is missing, a search will be conducted. . . ." - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included dementia with behaviors, unspecified psychosis, and a history of elopement from the facility. Current medications included Risperdal (risperidone, an antipsychotic) 0.5 milligrams	F 323	F 323 Accidents 1. Elopement: a. Resident 3, 13, 14 being reassessed to ensure they are safe in their current environment. Water Temperatures: b. Not Applicable 2. Elopement: a. All residents who elope have the potential to be affected. Water Temperatures: b. All residents have the potential to be affected by water temperatures. 3. Elopement: a. Punch code will be changed on a monthly basis and wording will be used instead of numerals. Facility will eliminate the fifteen second egress bars in Special Care Unit. On the south emergency exist a punch pad will be placed for egress and an audible alarm will be sound when door is opened. We will be auditing doors for proper emergency egress. These audits will be conducted weekly for the first month after the egress bars have been eliminated. Education will be completed to All-Staff Prior to January 4th, 2015.	

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F 323	Continued From page 41 (mg) twice per day (BID) (initiated 08/23/14) and Xanax (alprazolam, an anxiolytic) 0.25 mg every 4-6 hours as needed (prn), and Zoloft (an antidepressant) 25 mg every evening (initiated 09/03/14). The current MDS, dated 10/06/14, identified severely impaired cognition, and "other" behaviors and wandering occurring on 1-3 days of the 7-day look back period. The current care plan stated, ". . . I am an elopement risk/wanderer. I wander aimlessly, at times into other resident's rooms; demonstrate impaired safety awareness; disoriented to place, person and/or time along with a history of attempts to leave facility unattended seeking to exit via the doors and/or windows of the SCU. . . . wandergurad [sic] in place . . . Interventions/Tasks . . . Document wandering behavior and attempted diversional interventions in behavior charting . . . Distract me from wandering by offering pleasant diversions, structured activities, food, conversations, television, book. . . . Identify pattern of wandering by assessing if my wandering is purposeful, aimless or escaping and/or am I looking for something or someone. . . . refuses to wear the wanderguard at times, rips it off. Wanderguard placed on res. [resident] belt loop as he allows . . ." An interview with a staff nurse (#24) occurred on 11/17/14 at 11:40 a.m. During the interview, the nurse identified Resident #3 eloped multiple times from the SCU. The nurse stated the certified nursing assistants (CNAs) hear the door alarming, but they are often busy in a resident's room and cannot answer the alarm right away.	F 323	Water Temperature: b. Water temperatures checks will be conducted on all wings four times daily for a month. An Outside Contractor was contacted and has reviewed our current hot water system. The Contractor provides recommendations to enhance our system. Staff will notify maintenance immediately if they identify water temperatures are outside of the normal range. All Staff will be educated on the new process prior to January 4th, 2014. 4. Elopement: a. The DON or designee will be responsible to monitor resident safety and supervision along with the implementing effective interventions to meet the needs of the resident. The DON or designee will monitor weekly for a month, monthly for three month, and then random audits as needed per QA committee recommendations. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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F 323	Continued From page 42 A confidential interview occurred during the survey with two CNAs. One CNA stated, "It's tough, we could definitely use another person back here [in the SCU]." The other CNA agreed and stated, "Most of our time is spent trying to keep [Resident #3] in [the SCU]." Refer to F353. A physician's order, dated 03/14/14, stated, "Put wanderguard on back loop of jeans in the am, whenever he gets dressed, remove from jeans when he undresses and place in med [medication] cart." Nurses' notes identified the following: *11/19/13 at 6:26 p.m.: ". . . Resident followed staff member out of the SCU unnoticed at 4:40 pm, he went to the front desk area and attempted to leave through the front doors. Was stopped from going outside with some resistence [sic]. Redirected back to the SCU with TLC [tender loving care]. Noted resident received a 0.7 cm [centimeter] skin tear to (L) [left] forearm during this time, possibly from when he went out the SCU door. . . ." *03/07/14 at 6:42 a.m.: ". . . Resident's windows in SCU [room number] were both unlatched and letting in cold air. It was discovered that a brush had been thrown in the snowbank and a toothbrush was wedged in the window casing. Resident has a suitcase packed in his room. . . ." *03/13/14 at 1:32 p.m.: ". . . Talked with spouse at 9:25 a.m. [Resident #3] had eloped from the unit at 9:05 a.m. and was found out of rear parking lot. Discussed the use of wanderguard with her and she stated he would not wear one and that she was doubtful that we would get one on him. . . ."	F 323	Hot Water Temperatures: b. The Director of Facilities or designee will be responsible to monitor facility hot water temperatures. QA monitoring was implemented on 12/22/14. The Director of Facilities or designee will monitor four times daily for a month and then daily thereafter. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The Director of Facilities will submit a report of the monitoring results to the QA Committee at each scheduled meeting. 5. Date of Correction: 4th January 2015	

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*05/02/14 at 7:23 p.m.: ". . . Resident pushed window open in SCU [room number] and threw pants and brief outside. Window had to be pushed from outside to lock again. . . ."
*05/04/14 at 6:58 p.m.: ". . . Resident threw mirror and razor out the window in SCU [room number]. . . ."
*05/17/14 at 5:20 a.m.: ". . . This nurse was called to SCU by CNAs at about 0430 [4:30 a.m.] due to [Resident #3] being very agitated and talking about leaving. He was walking to the door and pushing it and setting off the alarm frequently. He was difficult to redirect. . . ."
*05/20/14 at 2:42 a.m.: ". . . CNA's calling ststing [sic] that [Resident #3] was standing by the door to the unit trying numbers. When there to assess he was swearing, wanting to leave, stating the he needed to go to the bar and how the last time he went, he was the only one there. . . ."
*05/20/14 at 6:37 p.m.: ". . . Resident continues to wander around and talk about going home. Tries to open windows in other resident's rooms. Did get window open a crack and threw his shirt and one shoe out. . . ."
*06/17/14 at 3:24 a.m. ". . . Res thinking he has to leave for something related to selling his car. Several attempts to go out the unit door between 7 pm & 8:30 pm. Staff directed res' attention away from door. Late entry for 06/16/14 8:30 pm. . . ."
*07/08/14 at 11:38 a.m.: ". . . Resident had an elopement attempt at 1115 Am [11:15 a.m.]. He got out the back door in SCU by room SCU-11. Walked around parking lot for several minutes stating 'I need to find my car. I am tired of this [expletive].' . . ."
*08/10/14 at 2:05 p.m.: ". . . Elopment [sic] attempt - Resident had not had any attempts to open any SCU doors until after lunch. At approx [approximately] 1215 [12:15p.m.], he was able to

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open the main SCU door by holding the bar long enough. Staff heard door alarm and wanderguard alarm going off and immediately came to assess situation. Nurse noted resident shadow outside of main SCU door, and ran out door to redirect resident. . . ."
*08/19/14 at 9:25 a.m.: ". . . Resident had an elopement from SCU at 0845 [8:45 a.m.]. Got out main SCU door, unable to be redirected by staff, would become agitated with redirection attempts. Walked from SCU door to offices near front reception desk. . . ."
*08/19/14 at 5:47 p.m.: ". . . Resident had an elopment [sic] at 1645 [4:45 p.m.]. He got out the main SCU dooor [sic] and walked to the area near the front reception desk. . . . It took several staff but he eventually did redirect back to SCU with multiple staff, though he was very upset. After returning to SCU he continuously was near the SCU door, setting off the alarm, and trying to get out. . . . He was able to get out again at 1730 [5:30 p.m.]. Difficult to redirect, though was able to redirect him back to SCU. . . ."
*08/31/14 at 1:00 p.m.: ". . . Resident's son had been up visiting for about an hour. After he left, resident wanted to go with them and was trying to get out again. At this time, I heard the alarm sound but all the staff were tied up with another resident so couldn't get to the door within the 15 sec. [seconds]. As I got to the door, resident was outside and walking down the hall. . . ."
*09/02/14 at 10:45 a.m.: ". . . Resident held door open until safety lock opened and went out back door of facility. Caught by [staff name] [from] therapy, she talked him into coming back into the unit . . ."
*09/22/14 at 5:20 p.m.: ". . . Resident was able to open exit door by leaning on bar. Went a few steps out of the SCU. . . ."

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F 323	Continued From page 45 *10/10/14 at 7:23 a.m.: ". . . Res was constantly trying to open the door until he was able to open it and leave the unit. A cna was constantly with him and 2 cna [sic] were necessary to redirect him to [sic] back to the unit. . . ." *10/10/14 at 7:26 a.m.: ". . . Res has two cuts on left forearm. Res left the unit after been [sic] pushing the entrance door. After Cnas brought res back to the unit they found blood on their clothe [sic]. These are small cuts 1 x 0.5 cms [centimeters] that occurred while pushing the door to exit the Unit. . . ." *10/11/14 at 7:21 p.m.: ". . . When resident pushed long enough on the door and was able to elope out into the hallway the other side of the unit door. Myself and another staff tried to redirect him when he postured and threatened to hit us '[expletive].' . . ." *10/19/14 at 3:50 p.m.: ". . . Resident absolutely unable to be redirected after his wife left this afternoon. . . . Resident kept pushing on door and setting alarm. He was becoming violent and pushing at staff. . . . Resident pushed on door until it opened and he was in back employee hallway. 2 CNA's and 2 kitchen staff came to assist nurse in administering 0.5 ml (1 mg) of lorazepam IM. . . ." *10/25/14 at 12:50 p.m.: ". . . resident held alarmed door handle until it opened up and resident wondered [sic] out into hall. . . ." *10/26/14 at 4:16 p.m.: ". . . unable to redirect. hitting out. pushed on door, out in hallway. brought back. . . ." *10/26/14 at 4:20 p.m.: ". . . Pushed on door and went out. . . . Hard to redirect, brought back in to unit. Threatening. . . ." *10/28/14 at 1:47 p.m.: ". . . Resident stood at the door and held the handle in so it would open. Staff were tied up with other resident's and by the	F 323		

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F 323	Continued From page 46 time we get to him, he was outside the door. Resident sat in the chair at the table outside and refused to come back in. . . ." *10/28/14 at 2:59 p.m.: ". . . Resident was trying to get out the front door agian [sic], holding the handle down so the door would open. CNA was unable to get him to let go off [sic] the door so I intervened. Resident hit me in the chest with his hand and swore at me. Resident was able to get out of the door and was trying to go out the door to the outside. CNA was trying to stop him from getting out and I saw the administrator so called him over to help. Administrator was not able to convince resident to come back inside so we went and found resident's nephew, who is a worker here, and he was able to get resident to come back inside. . . . After nephew left, I gave resident IM Alprazolam [sic, Ativan] . . ." *10/30/14 at 5:27 p.m.: ". . . Woke up after spouse left, ate all of supper and then became very aggitated [sic]. Pushed on exit door, out into hallway, threatened to hit me, yelling, and swearing. . . ." *11/15/14 at 10:26 p.m.: ". . . Resident last few nights has been getting up during night, getting dressed and trying to get out doors. At times, CNA's might be in room then hear door alarm going off from Resident trying to get out. . . ." Observations in the SCU during the survey showed a fire exit door located in the SCU which led directly outside into a parking lot. The main exit door led to a hallway within the facility. Observation showed an exit door approximately 25 feet away from the main SCU door which led directly outside into a parking lot. During an interview on 11/19/14 at 4:25 p.m., a supervisory nurse (#16) stated the door in the SCU which leads to the parking lot is not equipped with a	F 323		

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wanderguard alarm system, nor is the exit to the parking lot located in the hallway outside the SCU. She stated only the main entrance to the SCU is equipped with a wanderguard alarm system; however, all three of these doors are equipped with a lock that must be released by pushing on the door for 15 seconds. The nurse stated that these three doors will open after 15 seconds, but an alarm will sound, alerting staff the doors are open.

- Review of Resident #14's medical record occurred on 11/20/14. Diagnoses included Alzheimer's disease and dementia with behavioral disturbance. Resident #14's quarterly MDS, dated 09/30/14, identified long and short term memory problems. Physician's orders stated, "Check wanderguards daily."

Resident #14's care plan stated, ". . . Focus: I have hx [history] of elopement attempts/wandering d/t [due to] impaired safety awareness and/or disoriented to place. . . . Goal: I will not leave facility unattended. My safety will be maintained. . . . Interventions/Tasks: 1:1 supervision PRN [as needed], Assist res. [resident] to sit closer to nurse's station prn to monitor whereabouts, Distract me from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Resident prefers to sit in the recliner by the birds or look out the big windows in the Lounge. Document wandering behavior and attempted diversional interventions. Husband/family request to be involved and will come and sit with res. as needed. Staff to notify family as needed for assistance. Identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Am I looking for something or

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someone? Does it indicate the need for more exercise? Intervene as appropriate. Medications reviewed prn, wanderguard placed and checked daily by staff to ensure that it is working. . . ."

Review of Resident #14's progress notes identified the following:
* 03/16/14 at 2:24 a.m. - "Resident up and wandering. Going door to door. got out dorrs [sic] x 2 with staff coming right behind her. walking hand in had [sic] in facility. Questioned if having pain and shakes head yes. Refuses when offerred [sic] tylenol.
* 03/16/14 at 1:45 p.m. - "CNA responded to sounding alarm at 10am, found resident standing on the sidewalk by front entrance, resident had gone out the door by the Wing 3+5 nurses station. Redirected easily. Assisted to her room, laid down on her bed at 10:30 am, CNA sat with her until she fell asleep, at 11:30 resident up walking, assisted to dining room, ate 100% of lunch. . . . Dr. [doctor] on call, notified of elopement. Husband . . . also notified. Rsident [sic] placed on 15 min [minute] checks."
* 04/01/14 at 5:30 p.m. - "Resident has been wandering since 1200 [12:00 p.m.] and has made multiple attempts to go outside. Comes back in with staff without resistance but then just walks to a different door. Had med aide [medication aide] give resident her 2 pm Lorazepam [an antianxiety medication] at 1pm. Resident settled down by 1330 [1:30 p.m.] and was resting on her bed. Husband and Dr. made aware. Husband came up around 1500 [3:00 p.m.] and spent time with her but after he left, she again went out the front door and had only her pj's [pajamas] on now. Came in with CNA without resistance."
* 04/01/14 at 7:00 p.m. - "At 7 pm tonight staff went running down hall and out the door saying,

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F 323	Continued From page 49 '[Resident #14] is outside'. CNA states she saw her walking on the street from end of wing 1 hallway and went out our back door and ran to catch her. At that time [name of staff member], our driver was returning from taking someone to an activity, saw staff member and resident, stopped and picked them up. That's when w/c [wheelchair] and blanket obtained and resident brought back into bldg [building]. No injury noted. Since it was her bath night, another CNA initiated her bath. Vitals taken after that. She had no shoes on and feet were wet, toes pink. Skin normal color since her bath. Husband notified and came to sit with her until she goes to sleep. [Name of Resident #14's step-daughter] here as well. Administer [sic] and nurse manager notified. Dr. on call notified and ER [emergency room] Dr. also noted incident and had no new orders. She has been noted to have 9 elopement attempts today." * 04/04/14 at 10:31 a.m. - "All doors in facility were checked per maintenance for proper functioning alarms and locking. Res. accutech [wanderguard] is checked daily by nursing for proper functioning. Res. has made no further attempts to exit seek. Res. has been more content. Husband continues to visit every day as he did before and sits with res. and attends activities." * 04/17/14 at 3:01 p.m. - "Resident went out door at the end of Wing 1 at 2:20 pm. Was easily brought back indoors by staff. Resident's husband here shortly after so aware of elopement. Dr. . . . faxed." * 05/23/14 at 8:00 a.m. - "At 750 [7:50 a.m.] patient was spotted outside on sidewalk. Administrator went out and redirected her back into the building. When patient came back in the alarms went off, but when went outside nothing	F 323		

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alarmed. Patient not hurt during incident. Left message with family about calling back. PCP [primary care provider] notified."
* 06/07/14 at 6:27 a.m. - "Resident up and dressed at 0530 [5:30 a.m.] this am. I noticed her walking rapidly toward lobby. I immediately followed her and caught her ready to go out front exit door. Taken to CNA and told needed to be watched close. At 0600 [6:00 a.m.] while in SCU giving med, received [sic] call we needed to look for her. She was found in back parking lot by staff coming to work. Husband notified and Dr faxed condition report."
* 06/07/14 at 5:23 p.m. - "At 1315 [1:15 p.m.] patient was seen trying to leave the building through the front door. Staff saw patient walk out first set of doors, and the alarm went off. Staff redirected resident back into building. Family aware."
* 06/18/14 at 9:31 a.m. - "Resident observed to be exit seeking this a.m. Will apply a second wanderguard to opposite wrist with plan to transfer to our SCU/locked unit when bed available. . . ."

During an interview on 11/20/14 at 1:00 p.m., an administrative staff member (#28) said the doors to the back parking lot and the main door were secured (equipped with an alarm) following the 04/01/14 incident. The doors were tested and worked properly and another wanderguard was placed on the resident on 05/23/14. The administrative staff member (#28) said the elopement investigations had been destroyed per policy.

- Review of Resident #13's medical record occurred on November 19-20, 2014. Diagnoses included dementia with behavioral disturbances.

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Physician's orders included a wanderguard, initiated on 07/18/14, and placement in the SCU, dated 09/15/14.

Resident #13's current care plan stated, "Focus: The resident has impaired cognitive function/dementia or impaired thought processes r/t [related to] Disease Process *8/27/14 left facility unattended Resident believes at times he is waiting for the doctors order to go home and will pack his bags and ask to go home. 9/20/14 elopement from SCU; elopement from SCU noon on 10/29/14. Punched in code 10/2/14 . . . 10/2/13 [sic] Elopement from SCU x 2 [twice] *tearful at times thinking his wife is divorcing him and taking his money. Knows how to read code to activate door and needs to be redirected when he is there. Attempted to leave 11/3/14 Stopped. 11/17/14 Exited SCU . . . Interventions/Tasks: *Administer meds as ordered . . . *Cue, reorient, and supervise as needed . . . *Enc. [Encourage] Diversional act. [activity] . . . visiting about the past, walks, snacks, etc . . . *Patient has wander guard [sic] in place for wandering. Focus: I have a mood problem r/t [related to] Dementia. I get agitated and wander and have tried to leave the unit . . . Interventions/Tasks: *Medication as ordered *monior [sic] increased aggression and wandering."

Review of Resident #13's progress notes identified the following:
*08/27/14 - "Resident has had an elopement tonight. Wife called at 2035 [8:35 p.m.] stating that resident was standing outside their house, which is 1 1/2 blocks north of Eventide. This writer told wife that two CNAs would be over to bring resident back via wheelchair. CNAs were able to bring resident back with some convincing

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that he needed to come back for his safety. Resident returned at 2100 [9:00 p.m.] with two CNAs. Resident was last seen by a CNA on Wing 2 at 2020 [8:20 p.m.] when he was sitting at the nurse's desk. Resident does have a wandergaurd [sic] on but no alarms were heard in the building. New wandergaurd [sic] was placed on resident upon return. It was checked and is working. . . ."
*09/06/14 at 5:16 p.m. - "Resident has been up out of his room for the majority of the day. Has gotten through first set of doors to go outside three times today. Wanderguard alarm has gone off all three times and resident was able to get redirected . . ."
*09/10/14 at 11:00 p.m. - "Res [resident] was very agitated this evening. Res was trying to leave the building saying that he was kidnapped. . . ."
*09/12/14 - "At 1340 [1:40 p.m.] resident eloped despite wanderguard. Resident was walking home, staff were unable to redirect resident, staff walked with resident home, . . . Staff were able to get resident back to facility. . . ."
*09/20/14 at 9:18 a.m. - ". . . Resident got out of the locked SCU, resident wanderguard alarm went off. . . ."
*09/30/14 at 5:42 p.m. - Resident read exit #'s [numbers] and left unit x 2 [twice] within 30 minutes . . ."
*10/02/14 - "Resident exited the SCU x 2 this morning at 0930 [9:30 a.m.] and again at 1005 [10:05 a.m.] Did not set door alarm off. Was able to open door using code. Wanderguard alarm sounded when door opened. . . ."
*10/25/14 at 5:17 p.m. - "resident was pleasant and visiting with staff prior to evening meal. after eating resident went through the SCU door and sounded alarm. . . ."
*10/29/14 at 12:39 p.m. - "Apparently punched code in following meal and exited unit. Was

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F 323	Continued From page 53 brought back to unit, from main part of facility. . . ." 11/10/14 at 2:25 p.m. - ". . . Did go to the door x 1 and attempt to punch in exit code. Did not get door open. . . ." A careplan review/update progress note, dated 11/03/14, regarding Resident #13's elopement stated, ". . . Able to read code numbers on unit door and will punch in code and leave. Also very quick and staff needs to be aware of where he is when they exit unit as he will be right there. . . ." Although Resident #13 eloped multiple times from the SCU by entering the security code, facility staff failed to provide evidence they changed the security code in response to Resident #13's elopements. The facility failed to provide adequate supervision and effective interventions to prevent Residents #3, #13, and #14 from eloping from the facility and/or the SCU. HOT WATER TEMPERATURES 2. Based on observation, review of professional literature, and staff interview, the facility failed to maintain safe water temperatures at hand washing sinks in resident rooms in 4 of 6 units (200, 300, and 400 wings, and the Special Care Unit). Failure to ensure safe water temperatures may result in injury/burns to residents of the facility. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined standards of practice	F 323		

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regarding hot water temperatures which states water may reach hazardous temperatures in hand sinks, showers, and tubs. Many residents in long-term care facilities have conditions that may put them at increased risk for burns caused by scalding. These conditions include: decreased skin thickness, decreased skin sensitivity, peripheral neuropathy, decreased agility (reduced reaction time), decreased cognition or dementia, decreased mobility, and decreased ability to communicate. Third degree burns can occur after five minutes of exposure to water at 120 degrees Fahrenheit (F), three minute exposure at 124 degrees F, one minute exposure at 127 degrees F, and 15 second exposure at 133 degrees F.

On 11/18/14 at approximately 11:45 a.m., a surveyor noted the water in the bathroom between the 200 wing and the Special Care Unit (SCU) as hot, obtained a thermometer, and measured the temperature. The temperature measured 129 degrees F.

On 11/18/14, between 11:55 a.m. and 12:20 p.m., the water temperatures measured in residents' bathroom sinks revealed the following hot water temperatures:
*Room 1 (SCU) - 134 degrees F
*Room 2 (SCU) - 133 degrees F
*Room 4 (SCU) - 130.9 degrees F
*Room 13 (SCU) - 120 degrees F
*Room 208 - 120.4 degrees F
*Room 303 - 130.6 degrees F
*Room 404 - 122.3 degrees F

An interview with the director of environmental services (#25) occurred on 11/18/14 at 12:40 p.m. This staff member stated he expected the hot water temperature in residents' rooms to

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F 323	Continued From page 55 measure about 110 degrees F. He stated the maintenance staff do random measurements of the hot water in residents rooms weekly and make adjustments if the temperature measures over 110 degrees F. The staff member (#25) agreed the above noted temperature measurements were high and would make adjustments immediately. During an interview on 11/18/14 at 3:45 p.m., a staff member (#25) and a maintenance staff member (#26) stated they checked the hot water temperatures throughout the facility and they are measured below 110 degrees F at this time. The staff member (#25) also stated adjustments were made to the mixing valves (hot and cold water mixed) and the water heater.	F 323		
F 329 SS=D	483.25(l) 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 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	F 329		

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F 329	Continued From page 56 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure drug regimens free from unnecessary medications for 2 of 14 sampled residents (Resident #5 and #9) on scheduled psychoactive medications. Failure to attempt gradual dose reductions (GDRs) (unless contraindicated) in an effort to discontinue these medications may result in residents receiving unnecessary medications and experiencing adverse consequences related to their use. Findings include: Review of the facility policy titled "Psychopharmacological Medication Use" occurred on 11/20/14. This policy, revised May 2013, stated, ". . . Gradual Dose Reduction/Tapering . . . Goals of Gradual Dose Reduction/Tapering are: determine lowest effective dose, discontinue medication that is no longer needed or beneficial, minimize exposure to increasing risk of adverse consequences . . . Rationale for continuing use must show the following has been evaluated: any changes/impairments in the resident's function, adverse consequences . . . target symptoms . . ." - Review of Resident #9's medical record	F 329	F 329 Unnecessary Drugs 1. Resident 3 & 9 will have a medication regime review conducted and a Gradual Dose Reduction will be completed if indicated. 2. Any resident who is currently taking a scheduled antipsychotic medication has the potential to be affected. 3. We have a Pharmacy Consultant to handle our pharmacy needs. Medication Regime Review will be completed by the consultant Pharmacist and a Gradual Dose Reduction will be done as indicated. A process has been implemented to expedite the Medication Regime Review with recommendations and Gradual Dose Reduction reviewed by Primary Care Physician. Approved changes are made to the Physician Orders and Care Plans changed as appropriate. Education will be provided to Nurses and Pharmacist prior to January 4th, 2015. 4. The DON or designee will be responsible to monitor Drug Regime Review's along with the need for Gradual Dose Reductions for resident's which will manage unnecessary medications. QA monitoring was implemented. The DON or designee will monitor weekly for a month, monthly for three month, and then random audits as needed per QA committee recommendations. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting. 5. Date of Correction: 4th January 2015	

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	355078	A. BUILDING _____ B. WING _____	11/20/2014

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F 329	Continued From page 57 occurred on all days of survey. Current medications included Risperdal (an antipsychotic), initiated 07/24/13, and at the current dose (0.25 milligrams twice a day) since 10/24/13. The medical record lacked evidence of a GDR attempt (or contraindications for a GDR attempt) within the last year. - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included depression and insomnia. Current medications included trazodone 75 mg (milligrams) every evening and sertraline 50 mg every day ordered on 07/22/14. Review of the "CONSULTANT PHARMACIST'S DRUG REGIMEN REVIEW NOTE," dated 09/22/14, stated, ". . . Please consider decreasing trazodone (an antidepressant) to 50mg daily, or decreasing sertraline (antidepressant) to 25mg daily, or document clinical contraindication to decreasing doses at this time. . . ." The physician's response, dated 09/26/14, stated, "Is stable. Will not [change] med [medication] dose." During an interview on the afternoon of 11/20/14, an administrative nurse (#15) confirmed the physician's response should include contraindications for a GDR attempt.	F 329		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the	F 333		

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F 333	Continued From page 58 facility failed to ensure residents remained free from significant medication errors for 1 of 1 sampled resident (Resident #3) who received a psychoactive medication (Ativan, an anxiolytic) without a physician's order. Failure to ensure Resident #3 had a current physician's order resulted in Resident #3 receiving an intramuscular (IM) Ativan injection on two separate occasions which has the potential to jeopardize the resident's health and safety due to adverse drug reactions. Findings include: The Nursing 2015 Drug Handbook, 35th Edition, Wolters & Kluwer, Pennsylvania, page 874-875, stated, ". . . lorazepam [Ativan] . . . ADVERSE REACTIONS . . . drowsiness, sedation, amnesia, insomnia, agitation, dizziness, weakness, unsteadiness . . . Use cautiously in elderly, acutely ill, or debilitated patients. . . ." Review of Resident #3's medical record occurred on all days of survey. Diagnoses included dementia with behaviors. Medications included alprazolam (Xanax, an anxiolytic) 0.25 milligrams (mg) every 4-6 hours as needed (prn). Resident #3's nurses' notes showed the following: *08/19/14 at 5:47 p.m.: ". . . Resident had an elopement at 1645 [4:45 p.m.]. He got out the main SCU [special care unit] dooor [sic] and walked to the area near the front reception desk. . . . He was able to get out again at 1730 [5:30 p.m.] . . ." *08/19/14 at 5:51 p.m.: ". . . ALPRAZolam - One tablet po [by mouth] every 4-6 hrs [hours] prn for anxiety/agitation: remains agitated and anxious, with continuously trying to elope and 2 successful	F 333	F 333 Medication Errors 1. Resident 3 orders were reviewed to ensure all medications have a Physician Order. 2. There is potential for all residents who have a scheduled anti-psychotropic medication as a one-time dose to be affected. 3. All medication errors will be reported and investigated according to policy. Medication will not be administer without a Physician's Order. Medications with a stop date will be entered appropriately. Education to Nurse/Unit Secretary staff will be conducted prior to January 4th, 2015. 4. The DON or designee will be responsible to make sure residents are free from significant medication errors. QA monitoring was implemented on 12/22/14. The DON or designee will monitor weekly for a month, monthly for three month, and then random audits as needed per QA committee recommendations. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting. 5. Date of Correction: 4th January 2015	

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elopment [sic] attempts since 1645 . . ."
*08/19/14 at 6:41 p.m.: ". . . Resident continuous with another elopment [sic], and is increasingly agitated and combative, has attempted to hit staff many times. Order obtained from [physician name] for 1 mg ativan IM q2h [every two hours] prn up to 3 mg total for agitation (for the night of 8-19-14 only). . . ."

A telephone order, dated 08/19/14, stated, "Per [on-call physician name] - 1 mg [milligram] Ativan IM Q2hr [every 2 hours] up to 3 mg total for agitation (for the night of 8-19-14 only)."

Review of Resident #3's Medication Administration Records (MARs) for the months of September, October, and November 2014 identified the order for IM Ativan remained on the MARs since the physician ordered the medication on 08/19/14. Review of the October MAR showed Resident #3 received IM Ativan on 10/19/14 and 10/28/14.

Nurses' notes further stated:
*10/19/14 at 3:50 p.m.: ". . . Resident absolutely unable to be redirected after his wife left this afternoon. . . . Resident kept pushing on door and setting alarm. He was becoming violent and pushing at staff. He refused to take an oral PRN xanax 0.25 mg. Resident pushed on door until it opened and he was in back employee hallway. 2 CNA's [certified nursing assistants] and 2 kitchen staff came to assist nurse in administering 0.5 ml [milliliters] (1 mg) of lorazepam IM. Resident sat on heater vent for 20 minutes and was finally willing to walk into SCU with nurse and CNA. Resident assisted to his bed where he is resting. . . ."
*10/28/14 at 3:00 p.m.: ". . . Resident was trying

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F 333	Continued From page 60 to get out the front door again [sic], holding the handle down so the door would open. CNA was unable to get him to let go off [sic] the door so I intervened. Resident hit me in the chest with his hand and swore at me. Resident was able to get out of the door and was trying to go out the door to the outside. CNA was trying to stop him from getting out and I saw the administrator so call him over to help. Administrator was not able to convince the resident to come back inside so we went and found resident's nephew, who is a worker here, and he was able to get resident to come back inside. I got resident coffee and his nephew convinced him that he was going to make sure the kids get picked up which was one of resident's concerns. After nephew left, I gave resident IM Alprazolam [sic, lorazepam] and her [sic] was very cooperative with it. . . ." *10/29/14 at 3:43 p.m.: ". . . 1st dose of Doxepin [an antidepressant] given at 9 a.m. when medication arrived. Has been groggy all day but had prn medication x3 yesterday so unable to determine if any effects from new medication. . . ." During an interview on the afternoon of 11/20/14, a supervisory nurse (#16) agreed the IM Ativan order was a one-time order, and staff administered it on two occasions in October without a physician's order.	F 333		
F 353 SS=E	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	F 353		

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F 353	Continued From page 61 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 section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 12/19/13. Based on observation, record review, group interview, and staff interview, the facility failed to ensure availability of qualified nursing staff, on a daily basis, to meet the needs of residents on 6 of 6 units (Special Care Unit, 100, 200, 300, 400, and 500 units). Failure to ensure availability of staff may have contributed to concerns regarding behaviors (Refer to F250); care and services (Refer to 309); pressure ulcers (Refer to F314), hand splints (Refer to F318); elopement (Refer to F323); and unnecessary medications (Refer to 329). Findings include: The facility's failure to meet the requirements as	F 353	F 353 Sufficient Staffing 1. Not Applicable 2. All residents of the facility have the potential to be affected. 3. A CNA position will be replaced by a Nurse on the PM & Night Shift. Utilization of Activity staff will be increased during peak activity periods in late afternoon and early evening. Float Staff will be educated on the re-alignment of duties and responsibilities. 4. The DON or designee will be responsible to monitor that resident's needs are being met. QA monitoring was implemented 12/22/15 in reference to F250, F309, F314, F318, F323, F329. The DON or designee will monitor per schedule noted in each POC. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting. 5. Date of Correction: 4th January 2015	

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F 353	Continued From page 62	F 353		

referenced above identifies a lack of sufficient and knowledgeable nursing staff to provide residents with needed nursing and related services. Refer to these requirements which include:

F250 - Failure to provide medically-related social services and behavior management interventions to a resident who displayed sexual, verbal, physical, and eloping behaviors.

F309 - Failure to ensure residents did not receive as needed psychopharmacological medications without first attempting non-pharmacological interventions to manage behaviors.

F314 - Failure to ensure staff implemented pressure relief interventions (a pressure reducing wheelchair cushion).

F318 - Failure to provide a resident with a hand splint in order to prevent a decrease in range of motion.

F323 - Failure to provide adequate supervision and effective interventions to prevent resident elopements.

F329 - Failure to ensure each resident's medication regimen if free from unnecessary drugs.

Ten residents (identified by the facility as interviewable) attended the group interview on 11/17/14 at 4:00 p.m. Three residents (Resident C, D, and E) voiced concerns of staff rushing and questioned if the facility had enough staff.

- An interview with a staff nurse (#24) occurred on 11/17/14 at 11:40 a.m. During the interview, the nurse identified two residents who eloped multiple times from the special care unit (SCU). The nurse stated the certified nursing assistants (CNAs) hear the door alarming, but they are often busy in

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F 353	Continued From page 63 a resident's room and cannot answer the alarm right away. - A confidential interview occurred during the survey with two CNAs. One CNA stated, "It's tough, we could definitely use another person back here [in the SCU]." The other CNA agreed and stated, "Most of our time is spent trying to keep [Resident #3] in [the SCU]." - During an interview on 11/17/14 at 5:40 p.m., a nurse (#22) stated there is not enough staff, not enough training for nurses, and no one knows where the emergency equipment is located. An observation on 11/20/14 at 10:40 a.m. showed a nurse (#3) failed to locate the emergency equipment when asked. - A confidential interview occurred during the survey with a nurse. The nurse stated, staff have too much to do and there is not enough staff to get it all done.	F 353		
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 12/19/13.	F 363		

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F 363	Continued From page 64 Based on observation, review of facility menus, review of resident tray cards, and staff interview, the facility failed to follow prepared menus during 2 of 2 meals observed in the special care unit (SCU) (evening meals on 11/17/14 and 11/18/14). Failure to follow menus as planned does not ensure the nutritional needs/preferences of residents are met. Findings include: Review of the facility menus occurred on all days of survey. The menu for the evening meal on 11/17/14 identified bread, margarine, jelly, and milk. The menu for the evening meal on 11/18/14 identified a dinner roll, margarine, and milk. Observation in the SCU during the evening meal on 11/17/14 showed staff failed to serve milk or bread to the 15 residents in the SCU. Observation in the SCU during the evening meal on 11/18/14 showed staff failed to serve milk or a dinner roll to the 15 residents in the SCU, although all residents' tray cards showed "dinner roll" and "milk" listed as meal items. In addition, Resident #13's tray card stated "Offer lg [large] glass of milk;" however, observation showed no staff offered the resident milk during the meal. During an interview on 11/20/14 at 9:25 a.m., a dietary supervisor (#17) stated staff should have served the SCU residents milk and bread, as the menu is the same for all units of the facility.	F 363	F 363 Menus/Prep 1. Not Applicable 2. All residents have the potential to be affected by this practice. 3. Food and Beverage will be offered too all residents according to their meal ticket. Education was provided to Nurses, CNA's and Dietary Staff prior to January 4th, 2014 4. The Director of Nutrition and Culinary Services, designee or other staff as directed will assure residents receive items as noted on their meal ticket. QA monitoring was implemented 12/22/14. The Director of Nutrition and Culinary Services or designee will monitor weekly for a month, monthly for three month, and then random audits as needed per QA committee recommendations. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The Director of Nutrition and Culinary Services will submit a report of the monitoring results to the QA Committee at each scheduled meeting. 5. Date of Correction: 4th January 2015	
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides	F 364		

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F 364	Continued From page 65 food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 12/19/13. Based on observation, resident group interview, review of facility policy, and staff interview, the facility failed to serve palatable milk at the proper temperature during 2 of 2 meals assessed with a test tray (noon meals on 11/18/14 and 11/19/14). Failure to ensure the palatability of foods may result in decreased meal intakes. Findings include: Review of the facility policy titled "Food Preparation and Service Guidelines" occurred on 11/20/14. This policy, revised 04/17/14, stated, ". . . Cold foods are served cold and maintained at 40 degrees or below. . . ." During the initial dietary tour, on 11/17/14 at 11:16 a.m., a dietary supervisor (#17) stated staff serve the noon meal in two settings, one at 11:00 a.m. and the other at 12:00 p.m. Ten residents (identified by the facility as interviewable) attended the group interview on 11/17/14, at 4:00 p.m. Two residents (Resident A and B) voiced concern of the facility serving warm milk. The assessment of milk temperatures occurred	F 364	F 364 Nutrition 1. Not Applicable 2. All residents have the potential to be affected by this practice. 3. Repairs were made to the refrigeration unit to enhance cooling capacity. Temperatures of the Milk are monitored at each meal. Nurse and CNA Staff will report resident complaints about temperatures in regards to food or beverage to the Director of Nutrition and Culinary Services immediately. Nurse, CNA and Dietary Staff will be educated prior to January 4th, 2015 4. The Director of Nutrition and Culinary Services or designee will monitor the temperature of milk. QA monitoring was implemented on 12/22/14. The Director of Nutrition and Culinary Services or designee will monitor daily for a three months, and then random audits as needed per QA committee recommendations. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The Director of Nutrition and Culinary Services will submit a report of the monitoring results to the QA Committee at each scheduled meeting. 5. Date of Correction: 4th January 2015	

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F 364	Continued From page 66 on 11/18/14 at 12:13 p.m. and 11/19/14 at 12:17 p.m. during the noon meals. The milk temperatures measured 54.8 degrees Fahrenheit (F) and 53 degrees F, respectively. Observation showed staff stored the cartons of milk in a deep plastic bin without ice during both of these meals. During an interview on 11/20/14 at 9:25 a.m., a dietary supervisor (#17) stated staff should serve cold foods at or below 41 degrees F.	F 364		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: GRADUAL DOSE REDUCTION 1. Based on record review, and review of the facility policy, the facility's consulting pharmacist failed to recognize and report medication irregularities and recommend a gradual dose reduction (GDR) for 1 of 5 sampled residents (Resident #9) on an antipsychotic medication. Failure to identify irregularities and recommend a gradual dose reduction may result in residents receiving unnecessary medications and	F 428		

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F 428	Continued From page 67 experiencing adverse reactions. Findings include: Review of the facility policy "Psychopharmacological Medication Use" occurred on 11/20/14. This policy, dated 2013, stated, " . . . Gradual Dose Reduction/Tapering of psychopharmacological medications will be done on the following categories . . . Antipsychotics . . ." Review of Resident #9's medical record occurred on all days of survey. Current medications included Risperdal (an antipsychotic), initiated 07/24/13, and at the current dose (0.25 milligrams twice a day) since 10/24/13. The medical record lacked evidence of a pharmacy recommendation for a gradual dose reduction of Risperdal in the last year. PHYSICIAN REVIEW 2. Based on record review, review of facility policy, and staff interview, the facility failed to ensure the attending physician reviewed and acted upon the consulting pharmacist's report for 2 of 17 sampled residents (Resident #6 and #12). Failure to identify irregularities and ensure the physician reviewed the consulting pharmacist recommendations has the potential to affect the resident's highest practicable level of functioning. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding the Drug Regimen Review which states	F 428	F 428 Drug Regimen Review 1. Resident 9 will have a medication regime review conducted and a Gradual Dose Reduction will be completed if indicated. 2. All residents have the potential to be affected by this practice. 3. We have a Pharmacy Consultant to handle our pharmacy needs. Medication Regime Review will be completed by the consultant Pharmacist and a Gradual Dose Reduction will be done as indicated. A process has been implemented to expedite the Medication Regime Review with recommendations and Gradual Dose Reduction reviewed by Primary Care Physician. Approved changes are made to the Physician Orders and Care Plans changed as appropriate. Education will be provided to Nurses and Pharmacist prior to January 4th, 2015. 4. The DON or designee will be responsible to monitor Drug Regime Review's along with the need for Gradual Dose Reductions for resident's which will manage unnecessary medications. QA monitoring was implemented on 12/22/14. The DON or designee will monitor weekly for a month, monthly for three month, and then random audits as needed per QA committee recommendations. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting. 5. Date of Correction: 4th January 2015	

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	355078	A. BUILDING _____ B. WING _____	11/20/2014

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F 428	Continued From page 68	F 428		

the pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.

Review of the facility policy title "Medication - Regimen Review" occurred on 11/20/14. This policy, dated 2013, stated, " . . . C. A 'Medication Regimen Review' form will be completed for each resident when needed. . . . The form will be provided to the practitioner so it can be reviewed and a response made on the form. . . ."

The facility's policy on Medication - Regimen Review is conflicting information with CMS guidelines, in regard to practitioner vs attending physician.

- Review of Resident #6's medical record occurred on all days of survey. The consulting pharmacist's drug regimen reviews, with recommendations completed on 01/14/14, 02/13/14, 04/13/14, 05/09/14, and 09/22/14, lacked evidence of physician review/recognition of the pharmacist's findings.

During an interview on 11/20/14 at 8:45 a.m. with two administrative nursing staff members (#13 and #14), the surveyor requested additional information to verify Resident #6's physician reviewed the pharmacist's recommendations. No further information provided.

- Review of Resident #12's medical record occurred on November 17-20, 2014. The consulting pharmacist's drug regimen reviews with recommendations completed on 04/14/14 lacked evidence of physician review/recognition of the pharmacist's findings.

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

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F 502 SS=D	Continued From page 69 483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the laboratory (lab) collection tubes (vacutainers) available for use by lab personnel and facility staff in 2 of 4 medication rooms (100/200 unit and 400 unit) had not expired. Use of expired vacutainers when obtaining blood samples from residents may result in inaccurate lab test results. Findings include: Observations in the facility's medication rooms occurred on 11/20/14 at 10:40 a.m. and revealed the following: * 100/200 unit - five yellow topped vacutainers expired in May 2014 * 400 unit - 13 yellow topped vacutainers expired in May 2014, two blue topped vacutainers expired in August 2014, and one green topped vacutainer expired in September 2014 During an interview on 11/20/14 at 1:15 p.m., an administrative nurse (#15) stated the facility does not have a policy or procedure on checking vacutainer expiration dates.	F 502	F 502 - Revised Lab Services Administration 1. Not Applicable 2. All residents have the potential to be affected by this practice. 3. Vacutainers that were identified as expired were destroyed. Vacutainers will be monitored by Support Services on a monthly basis and outdated products will be destroyed and replaced. 4. The DON or designee will be responsible to monitor lab supplies to ensure proper supplies are being used. QA monitoring was implemented on 12/22/14. The DON or designee will monitor monthly for three months, and then random audits as needed per QA committee recommendations. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting. 5. Date of Correction: 4th January 2015	
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520		

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F 520	Continued From page 70 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 facility's staff. 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. 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. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on review of the North Dakota Department of Health, Division of Health Facilities provider files and record review, the facility failed to maintain a Quality Assurance (QA) committee which identified and addressed quality issues; and failed to develop and implement appropriate plans of action to correct deficient practice and ensure compliance with federal requirements. Findings include:	F 520	F 520 QAA Committee 1. N/A 2. All residents have the potential to be affected by this practice. 3. The Quality process will follow the information listed in the Plans of Correction for F280, F314, F318, F353, F363 & F364. 4. The Director of Quality/Infection Control/Education or designee will be responsible to monitor the Quality Assurance Process. QA monitoring was implemented on cites F280, F314, F318, F353, F363 & F364. The Director of Quality/Infection Control/Education or designee will monitor weekly for a month, monthly for three month, and then random audits as needed per QA committee recommendations. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The Director of Quality/Infection Control/Education will submit a report of the monitoring results to the QA Committee at each scheduled meeting. 5. Date of Correction: 4th January 2015	

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F 520	Continued From page 71 Refer to F280, F314, F318, F353, F363, and F364 for specific findings. These six citations are repeat deficiencies. Failure to effectively utilize QA resulted in the facility not maintaining compliance in the following: *F280 - revising resident care plans *F314 - preventing pressure ulcers *F318 - hand splints to prevent contractures *F353 - adequate staffing *F363 - menus *F363 - palatability of foods	F 520		