STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355092	A. BUILDING _____ B. WING _____	02/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILL TOP HOME OF COMFORT INC	95 HILL TOP DR KILLDEER, ND 58640

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 02/22/2011 and completed on 02/24/2011, the sample included 2 residents for complete review, 9 residents for focused review, and 1 closed record for review. In addition, 6 residents were added to the sample to verify specific concerns during the survey.	F 000		
F 224 SS=G	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy and procedure, and resident, staff, and group interview, the facility failed for 4 of 7 sampled residents (Resident #2, #4, #8, and #11) identified with behaviors, including wandering, and one unidentified resident with an incident negatively affecting a cognitively impaired resident (Resident #9) to: 1. Implement the facility's own policy to identify residents and/or situations with potential for the occurrence of injury, prevent resident to resident injury, and protect residents from recurring resident to resident injury. 2. Adequately assess resident behaviors, including monitoring for patterns/trends, causative factors, including time, place, persons involved, happening prior to and at time of behavior, etc, and implement appropriate interventions to	F 224	F 224 **1.** How corrective action will be accomplished for residents affected a. Resident #2- Transferred to a Memory Care Unit on 3/16/11. b. Resident #4, #8, #11 – See #2 identifying residents and #3 systemic changes. New forms below will be used to assess precipitating factors, determine interventions, and evaluate the effectiveness of interventions. (See also #1 under POC F250 for other interventions for these residents.) c. Resident #4 has only had one verbal altercation with another resident in the last 6 months. This altercation occurred on1/1/11, at the time the resident experienced a room move due to repairs that needed to be made in his room. He was in another room only a short time. He has not had any resident to resident confrontations since that time. He	4/7/11

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

Greg Armstrong — Administrator — 3/22/11

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 224	Continued From page 1 prevent behaviors from escalating. 3. Monitor the effectiveness of interventions and revise interventions as appropriate. 4. Implement an interdisciplinary approach to address behaviors which have the potential to result in resident to resident altercation. Failure to adequately assess and monitor residents' behaviors and implement effective interventions to prevent further abusive behaviors resulted in other residents being abused, intimidated, hollered at, harassed, and slapped. Findings include: Review of the facility policy/procedure titled "ABUSE AND NEGLECT PROHIBITION POLICY" occurred on 02/24/11. This policy, revised January 2002, stated, "Hill Top Homes's top priority is to provide a safe, clean comfortable and home like environment . . . Residents must not be subjected to abuse by anyone, including . . . other residents . . . Abuse shall be defined as follows: . . . 'Verbal Abuse' is defined as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to: threats of harm; saying things to frighten a resident, such as telling a resident that she will never be able to see her family again . . . 'Physical Abuse' - includes hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment . . . ABUSE INVESTIGATION . . . 1. Allegations of mistreatment, neglect, abuse, misappropriation of resident property and injuries	F 224	confrontations since that time. He has a private room. The precipitating factor in that confrontation was the room move. We did return him to his room as soon as the repairs were made. See also POC F250 for more interventions. d. For Resident #8, we will have physical therapy assess resident for need of the wheelchair. She may be able to walk, eliminating the risk of her backing into other residents. Until that time we will have occupational therapy assess her for devices to improve her safety in the wheelchair. Resident can transfer into a wheelchair when in the dining room and when she is at activities. She will have an occupational therapy evaluation for cognitively appropriate activities. Resident does like dolls and she may respond positively to one. e. Resident #11 will also have an evaluation by occupational therapy for unsafe maneuvers in the wheelchair. She will have an occupational therapy evaluation for cognitively appropriate activities. We	

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F 224	Continued From page 2 of an unknown source will be thoroughly investigated and documented using established procedures. The facility will take necessary steps to prevent further potential abuse while the investigation is in progress. 2. All alleged violations will be investigated thoroughly by a committee including the Administrator, Social Service designee, Director of Nursing, Department Supervisor and other deemed necessary by the Administrator . . . 6. The Administrator, Social Service Designee, Director of Nursing, and Department Supervisor and others as deemed necessary will meet to determine what action is needed to ensure the safety of the residents while the investigation is conducted . . . b. Examples of action for residents could include, but are not limited to, identification of residents whose personal histories render them at risk for abusing other residents, an assessment of appropriate intervention strategies to prevent occurrences, monitoring the resident for any changes that would trigger abuse behavior and reassessment of the strategies on a regular basis through care planning; making a room change; transfer for short term psychiatric assessment or for appropriate permanent alternate placement, or use of chemical or physical restraints as directed by physician order . . . 18. QA [Quality Assurance] monitoring is on-going. . . ." - During a resident interview on 02/23/11 at 8:20 a.m., Resident #3 (identified as interviewable) stated on a daily basis Resident #2 wanders into his room and lies on his roommate's bed. Resident #3 stated "it scares me" when Resident #2 comes into his room because he has witnessed her hitting the staff who retrieve her	F 224	will continue to try to determine causes for behaviors (See #3). f. In the future a situation like residents #9's will have a complete investigation using the *Resident to Resident Abuse Investigation* (See 3.f.). **2.** How ID residents having potential to be affected a. Residents with behaviors negatively impacting other residents have the potential to be affected. **3.** Measures or systemic changes a. When a resident behavior occurs that negatively impacts another resident, the charge nurse will note precipitating factors, describe the incident that occurred, interventions tried, and the outcomes of the interventions in the interdisciplinary notes. The other resident will be identified in the interdisciplinary notes by the medical record number. b. For residents that have behaviors that may negatively impact others, a *Behavior/Intervention Monthly Flow Record* will be maintained. The *Behavior/Intervention Monthly Flow*	

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F 224	Continued From page 3 from his room and he doesn't want her to hit him. He stated she yells at him or says "shut up" when he tries to tell her it isn't her room. - The group interview occurred on 02/23/11 at 1:00 p.m., with six residents in attendance. The residents identified Resident #1, Resident #2, Resident #4, Resident #8, and Resident #11 wandered into residents' rooms and around the facility at all hours of the day. Resident C stated Resident #2 "is a problem" and often wanders into her room and lies in the empty bed. Resident A stated Resident #2 frequently comes into her room both during the day and in the middle of the night and sits in her chair. Resident A explained even though Resident #2 has never hurt her, she is scared of her as she witnessed the resident being abusive to staff and other residents. Resident B identified Resident #2 once wandered into his room and hit him in the chest, causing him soreness for a few days. Resident D stated Resident #2 occasionally comes in his room during the night, sits in his recliner, and will hold her fist up and scream. Resident D indicated if Resident #2 ever hit him he would "hit her so hard he would lay her out on the floor." Resident D explained he has witnessed Resident #8 bumping into other resident's wheelchairs with her own wheelchair. - During a random resident interview on 02/23/11 at 10:05 a.m., Resident #14 stated Resident #2 pushed her in her wheelchair on approximately three separate occasions and the resident stated it scared her as Resident #2 goes too fast. - Observations of Resident #2 identified the following: * 02/22/11 at 1:45 p.m. - Resident #2 laid in	F 224	*Record* will include the behavior tracking including the number of behavior episodes, interventions tried, and outcomes of the interventions. c. Each identified resident will have a *Behavior Management Plan*, initiated and reviewed by the interdisciplinary team, listing the resident's behavioral symptoms, possible precipitators, interventions, and desired outcomes. This plan will be reviewed against the *Behavior/Intervention Monthly Flow Record* and against documentation in the Interdisciplinary notes. d. A *Behavior Tracking Form* (modified current QA form) will be kept for each resident with behaviors, monitoring for causative factors, patterns and trends including the time, place and persons involved (other residents involved will be identified by medical record number), and happenings prior to and at the time of the behavior. e. *Monthly Behavior Meetings* will continue, but will involve more complete evaluation of behaviors and effectiveness of interventions.	

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F 224	Continued From page 4 Resident #8's bed. A certified nursing assistant (CNA) (#4) stated, "She always does this. She lies in everyone's bed but her own." * 02/23/11 at 8:35 a.m. - Resident #2 laid in Resident #8's bed. * 02/23/11 at 8:50 a.m. - Resident #2 laid in Resident #13's bed. * 02/23/11 at 10:00 a.m. - Resident #2 pushed Resident #14 down the hallway in her wheelchair in a fast pace. Staff intervened. The above observations verified Resident #2 wandered into other residents' rooms, laid in their beds, and pushed residents in their wheelchairs, validating residents' concerns and fears expressed during the group and individual interviews. Review of Resident #2's medical record occurred on February 22-24, 2011. Diagnoses included dementia, aggression, and anxiety. Current medications for Resident #2 included: Celexa (an antidepressant) 40 milligrams (mg) daily, Geodon (an antipsychotic medication) 20 mg daily, Aricept (used for dementia) 10 mg daily, Namenda (used for dementia) 10 mg twice daily, and Ativan (an antianxiety medication) as needed. Resident #2's current Minimum Data Set (MDS), dated 12/08/10, identified severely impaired daily decision making skills, long-term and short-term memory problems, constant inattention, and a mood interview score of 13 (which indicated moderate depression). Resident #2's MDS showed wandering daily and independent ambulation without the use of assistive devices. Review of the MDS "QUARTERLY STATUS REPORT" for Resident #2, dated 12/08/10, stated, "COGNITIVE: [Resident #2] had difficulty	F 224	Members will be added to the interdisciplinary team, including nursing, social services, activities, and quality assurance. The next meeting is planned on 3/28/11. f. A *Resident to Resident Abuse Investigation Report* was developed. This form will be used by an interdisciplinary team including the Social Service Designee, Nursing Management and the Administrator to investigate possible abuse incidents. g. Residents that have been identified to negatively impact other residents may be evaluated for alternative placement in a more secure environment. h. Staff education- Nursing and activities staff will receive training regarding the resident to resident abuse policies and training on the new expectations and documentation requirements in their March departmental meetings. **4.** Completion Date 4/7/11. **5.** Monitoring performance for sustained solutions, QA plan	

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F 224	Continued From page 5 with long/short memory due to dementia secondary to Alzheimer's Disease. [Resident #2] had adequate hearing in quiet settings with some difficulty in noisier settings. [Resident #2] is blind in the right eye . . . [Resident #2's] aggressive behaviors have decreased significantly. [Resident #2] wonders [sic] hallways and into resident's rooms and is redirected by staff. . . ." Resident #2's last comprehensive assessment was an annual MDS, dated 06/08/10. This MDS identified moderately impaired daily decision making skills, long-term and short-term memory problems, persistent anger with self or others seen up to five days a week, unpleasant mood in the morning, sad/pained/worried facial expressions, and repetitive physical movements. Review of the "RAP SUMMARY" for Resident #2, dated 06/08/10, stated, ". . . Mood State: Resident will show anger towards others occasionally, including other residents and staff. She has easily been redirected when upset. She is occasionally restless, paces up and down the hallways at times, and has sad expression at times. She is restless during the day, which is when she will pace. . . . Behaviors: Resident will show irritation when staff attempts to do cares with her, and has shown anger. . . ." Review of the "QUARTERLY STATUS REPORT" for Resident #2's annual MDS, dated 06/08/10, stated, ". . . Social Interaction: . . . Much of her day is spent either in the Badlands Lounge watching TV or in the activities room . . . For the most part, she is pleasant when she is out amongst other residents, except for the 2 following incidents described here. On May 20th, she slapped another resident for no	F 224	a. Resident's identified to be at risk will have auditing of the medical record and review of documentation for completeness, including i. Causative factors ii. Time, place, and persons involved iii. Happenings prior to and at the time of behavior iv. Interventions tried and outcomes b. Residents with behaviors affecting other residents will be audited to determine if there is a need for alternate placement. c. Audits will be completed (by nursing management and/or the social serviced designee) bi-weekly x 2, at 2 and 3 months.	

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F 224	Continued From page 6 apparent reason. The other resident was not injured. Staff intervened at that time. Then, on May 24th, she was involved in an argument with a male resident where he wanted to sit in the same chair she is used to sitting in. At that time, she swung her foot at him and then stuck her tongue out at him. Staff intervened and diffused the situation . . . Mood State: [Resident #2's] mood has generally been good, with periodic episodes of anger and irritation, particularly during cares. She is restless some days, and will walk up and down the hallways. Eventually, she will find her seat in the Badlands Lounge, where she watches TV and those around her. She has psyche [psychiatric] involvement. . . ." Review of Resident #2's current care plan included the following mood and behavior problems: "Res shows occasional irritation, esp [especially] with cares. She also has shown anger towards other residents, esp [especially] if they try to sit in her favorite chair. Res also is restless often, pacing up and down the hallways," dated 06/08/10; "Aggressive towards other res when angry (slapping)," dated 06/28/10; and "Wandering hallways [and] into other res rooms," dated 12/08/10. The care plan listed the following approaches: acknowledge spiritual concerns; encourage expression; assess for depression; encourage independence with activities of daily living; give frequent reassurance; encourage out-of-room activity; explain all treatments and procedures carefully; observe for changes in mental status; encourage socialization with friends; observe closely around others, particularly when she is sitting in the Badlands Lounge; psychiatric involvement; medication changes; observe closely when in the hallway,	F 224		

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F 224	Continued From page 7 especially around other residents and in resident rooms; wanderguard; redirect as needed; move resident to a different area; walk with her and visit; and hold hand out for her to follow." Review of Resident #2's "Interdisciplinary Progress Notes" from May 2010 through February 2011 showed the following: * 05/20/10 at 10:40 p.m. - "Resident [#2] was sitting in TV lounge this [after] noon. Stood up and slapped another resident. [Resident #2] was lead out of area per RN [Registered Nurse]. [No] injuries to other resident." * 05/24/10 untimed - "Resident [#2] has a favorite chair she likes to sit in in the Badlands Lounge. A male resident sitting in chair and she told him to get out of the chair. He was upset but got out of chair and told her that it wasn't her chair, it belonged to this place. He shook his finger at her - she stuck her tongue out. He called her a cow [and] she swung her foot at him." * 06/11/10 at 5:00 p.m. - "Resident [#2] slapped the face of another resident in Badlands Lounge. Unknown as to why . . . Told her that's not allowed here [and] if there's trouble to call staff. She giggled. Will watch for addtl [additional] behavior this evening." * 06/28/10 at 10:00 p.m. - "[After] supper, resident [#2] walked up to another [resident] [and] slapped his face. [No] injury to him. Unknown what provoked her." * 07/04/10 at 12:25 p.m. - "Res [resident] attempted to hit another Res in hallway for no observed reason. Res upset today [and] is asking 'to go home.' Irritable with staff. If left alone calms." * 07/27/10 at 5:00 p.m. - "Res had behavior incident . . . Res got mad due to other res yelling at her to 'move, get out of here.' Res then hit	F 224		

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F 224	Continued From page 8 other res on arm. Res was educated." * 08/05/10 at 1:00 p.m. - "Res has been wandering often today. Has been in therapy several [times]. Res walked by another Res [and] brushed his shoulder as if to hit him [and] kept walking . . ." * 08/28/10 at 1:05 p.m. - "[Resident #2] went to chair in lounge were [sic] another resident was sitting, grabed [sic] onto his arm [and] pulled Res up [and] out of chair [and] other res sat [down] in his w/c. [Resident #2] then walked away as staff member came to assist. No injury noted." * 09/08/10 at 2:00 p.m. - "Resident [#2] wandering; hitting staff and other resident. Staff has attempted to educate resident regarding inappropriate behavior. Resident not expressing understanding. No injuries were received . . ." * 09/11/10 at 3:40 p.m. - "[Resident #2] went into lounge to sit in the chair that another Res was sitting in. She hit a Res X 3 [three times] upset he was sitting in the seat. Quickly got in between the two res [and] removed them from the area. The resident went to her rm [room]. No injury noted to either Res." * 09/11/10 at 4:30 p.m. - "Behavior: CNA [certified nursing assistant] reported this resident approached another female resident in a w/c and started stroking her hair . . . Res in [room number] cried out and [Resident #2] struck her across the face. CNAs immediately intervened." * 09/14/10 at 4:30 p.m. - "Activity aide reported combative action. [No] injuries [and] able to redirect." * 10/06/10 at 10:45 p.m. - "Resident [#2] was pacing frequently this evening and would walk in other resident's rooms . . ." * 10/11/10 at 11:00 p.m. - "Wandering. Even went up to Unit I. Impression given that she doesn't know where her room is located."	F 224		

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F 224	Continued From page 9 * 10/12/10 at 10:00 a.m. - ". . . Res reported to staff that res wandered into his room [and] hit him in the chest hard on the pm of 10/11/10. Res is wandering more [and] goes into other res rooms. Has angry look on her face at times . . ." * 10/13/10 untimed - ". . . She [Resident #2] wanders into other residents rooms [and] looks irritated or confrontational. OOB [out of bed] pacing all shifts." * 10/17/10 at 11:00 a.m. - "Resident [#2] became upset when staff attempted to redirect her while she was wandering. Resident continues to wander throughout facility." * Late entry for 10/15/10 6:30 a.m. to 11:30 a.m. - "Resident [#2] was in [room number] [and] entered BR [bathroom] where [resident room number] was toileting himself. Later she was in again attempting to lay down in his bed [without] him in it. Later [about] 11:30 a.m. was sitting quietly in [resident room number] rocking chair . . . Also redirected out of [social service] office." * 11/24/10 at 7:30 a.m. - "Resident [#2] wandering halls this am. Into male resident's room and laid down on his bed, resident [male] stated she has done this often." * 11/26/10 at 10:30 a.m. - "Resident [#2] ambulating, wandering throughout facility. Resident will lay in other residents beds . . ." * 01/11/11 at 2:00 p.m. - "Res [#2] wandering halls all shift. Yelled at staff once when attempting to redirect. Res went up behind a res in hall [and] kicked towards his butt, but did not connect. . . ." * 01/11/11 at 8:00 p.m. - "Resident [#2] was asked to leave [name of resident's room]. She was holding her pillow [and] went up [and] started hitting RN [with] it. Resident was redirected [and] she marched right up to another resident [and] was going to punch him, RN did catch her arm [and] [no] one was hurt. . . ."	F 224		

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F 224	Continued From page 10 * 01/15/11 at 9:20 a.m. - "Behaviors are vary [sic] irratic [sic] [and] irritable . . . 9:10 a.m. Pushed [resident room number] out of the way in hallway by DR [dining room] where feet were rammed into wall. Luckally [sic] Resident wearing shoes. No injury . . . Resident non verbal unless occasional outburst towards other [sic] of 1 to 3 loud words is shut up, what do you want. . . ." * 01/21/11 at 8:00 p.m. - "Wandering most of evening. CNA reported that when she tried to get her out of another resident's room that she slapped the staff member on the face." * 01/22/11 time unknown - ". . . Resident has pushed a male in his w/c. He usually sits between Badlands Lounge [and] Activities Room. Resident then was down on Unit I turned a resident's w/c around [and] started pushing it back towards Nurse's Station I. Resident said, 'I want to go to my room.' Brought [Resident #2] back to Unit II. She has wandered into several rooms. . . ." * 01/23/11 at 10:00 p.m. - ". . . Resident was pushing another resident in a wheelchair . . ." * Late entry for 01/25/11 at 7:05 p.m. - "[Resident #2] walked up to another resident with her hand open like she was going to hit him. Staff intervined [sic] and separated residents. . ." * 01/26/11 at 1:00 p.m. - "Resident [#2] was having increased behavior, pushing other residents in their wheelchair into a wall." * 01/29/11 at 4:30 p.m. - "Res [#2] pushed another Res in hall, other Res w/c bound, [Resident #2] pushed Res into closed door at NS [nurse's station]." * 01/29/11 at 7:50 p.m. - "Res walking in hall in Meadow Lane, another Res sitting in w/c in hallway. [Resident #2] walked past Res in w/c and attempted to strike other Res [with] her hand." * 01/13/11 [sic? 01/31/11?] at 7:10 p.m. - "Another resident told me that [Resident #2] hit	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355092	A. BUILDING _____ B. WING _____	02/24/2011

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F 224	Continued From page 11 her. She said [Resident #2] steals her clothes and jewelry. (No evidence that resident has done this or taking her clothes or jewelry.) Other resident said [Resident #2] came into room [and] when she told her to leave [Resident #2] took the full sling and swung it at her. She then said she hit her on the back and left the room. Instructed her to call if resident comes into room." * 02/10/11 at 3:30 p.m. - "Resident wandering during the day, in and out of other resident rooms. Staff attempted to assist resident out of other resident room and resident kicked her in wrist, no injuries were received . . ." * 02/13/11 at 2:00 p.m. - "Wandering a lot today. Was in [resident room number] bed resting this am. All over facility, in break room. Redirected easily, starts pacing elsewhere . . ." * 02/20/11 at 1:00 p.m. - ". . . Resident is wandering, going in and out of other residents rooms . . ." Review of Resident #2's "Social Service/Behavior Committee Notes" from May 2010 through February 2011 repeatedly identified the following as interventions for Resident #2's wandering and behaviors to other residents: "INTERVENTIONS: Medication [at] Dr's. [doctor's] recommendations. She has psyche [psychiatric] involvement. Staff observes her closely around other residents and their rooms . . ." During an interview on 02/23/11 at 5:15 p.m., an administrative nursing staff member (#5) stated when Resident #2 displayed wandering and aggressive behaviors, staff are instructed to gently lead her out of other residents' rooms as she doesn't understand simple directions. The staff member (#5) stated staff address her basic needs when she is wandering and being	F 224		

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F 224	Continued From page 12 aggressive, such as: they check if she is in pain, assist her to the toilet, offer food/beverage, or take her to an activity of her liking if one is going on. Failure of the facility to monitor, track, and trend Resident #2's behaviors and thoroughly assess the causative/precipitating factors leading up to, or resulting in Resident #2's aggressive and abusive behavior, develop and implement effective interventions (proactive approach versus reactive), as well as revise them as necessary; resulted in numerous altercations and harm to other residents. Through resident and group interviews, residents expressed their fear of Resident #2 as they witnessed her abusing other residents and staff members. Record review identified Resident #2 abused other residents and observations during the standard survey identified Resident #2 frequently wandered, lay in other residents' beds (validating residents' concerns and fears expressed during the group and resident interviews), and pushed residents' wheelchairs. Staff often searched for a period of time to locate Resident #2 who ambulated independently throughout the facility. These factors all contribute to the potential for Resident #2 to seriously injure another resident and/or for another resident to cause serious harm to Resident #2. - Review of Resident #4's medical record occurred on February 22-24, 2011. Diagnoses included Alzheimer's disease, dementia, psychosis, depression, and anxiety. Current medications for Resident #4 included: Aricept (used for Alzheimer's disease/dementia), Risperdal (used for Alzheimer's disease/behaviors), Namenda (used for	F 224		

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F 224	Continued From page 13 dementia), and Celexa (used for depression). Resident #4's quarterly MDS, dated 07/16/10, identified long-term and short-term memory problems and moderately impaired daily decision making skills. The quarterly MDS, dated 11/16/10, also identified continuous disorganized thinking, fluctuating inattention, delusions, behavioral symptoms not directed at others, wandering, assist with transfers, and supervision needed with walking in room/corridor and locomotion on/off unit. Review of the MDS "QUARTERLY STATUS REPORT" for Resident #4, dated 01/14/11, stated, "Cognitive: . . . When walking through facility hallways, [Resident #4] will at times go into other residents rooms. He requires assist with finding his room and the bathroom much of the time. . . . He . . . needs constant reminding as he forgets quickly. [Resident #4] does have periods in which he gets anxious and upset . . . Social Interaction: . . . he will show upset or anger if he is redirected away from a doorway as he is attempting to leave. . . ." Review of Resident #4's current care plan, dated 10/25/10, stated, " . . . Mood: Resident is frequently restless, wandering or pacing the hallways . . . . Beha [Behaviors]: . . . He will also occasionally wander into other resident rooms. In all instances, he is generally easily redirected - annoyed at times. . . . When in another res's [resident's] room, redirect him out to another area. Wanderguard. . . ." Review of Resident #4's "Interdisciplinary Progress Notes" from February 2010 through January 2011 showed the following:	F 224		

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F 224	Continued From page 14 * 02/24/10 at 2:45 p.m. - "Resident wandered into another residents room, he did argue with the other resident . . ." * 03/08/10 at 10:40 p.m. - "CNA reported that another resident told her that [Resident #4] came into his room and told him he was going to sleep in his bed tonight, as he bought the place and that this first resident would be the first one out of here." * 03/20/10 at 9:30 p.m. - "Heard voice in room. Resident on roommate's side of the room telling him that he needs to leave [and] to get out of here." * 04/17/10 at 5:12 p.m. - "Resident got up from the table as to leave, but went toward [room number] to talk. Resident [room number] yells out [at] resident "Go sit down [and] eat." [Resident #4] starts yelling back [at] him [and] moving towards [room number] . Nursing escorted him back to his chair [at] the table to continue his meal while another staff member escorted [room number] to [sic] Activity Room where there was less stimulation. . . . As resident [room number] was being taken to [sic] Activity Room, he requested staff members to take him to [Resident #4] to knock his block off." * 05/01/10 at 4:40 p.m. - "Resident went into rm [room number] . He told the resident in the bed to get out of his room. Resident in [room number] said no, that wasn't his room it was his. [Resident #4] told resident that he hated him, turned, and left the room [and] told staff nurse from Unit 1 that he sure took care of that bastard." * 06/04/10 at 4:00 p.m. - "Res. moved to private room . . . Son . . . informed . . . Informed him that res. continues to go into other res's rooms, insisting that their room is his. He has not shown aggression, only verbal . . ." * 06/26/10 at 1:00 p.m. - "Staff reporting that	F 224		

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F 224	Continued From page 15 resident wondering [sic] throughout hallways. Going into other residents' rooms. Telling the other residents to leave his room. . . ." * 07/14/10 at 7:30 p.m. - "Resident was aggressive towards another res. verbally, saying didn't like the looks of this other res. Said was going to take res. outside." * 07/17/10 at 6:58 p.m. - "CN [charge nurse] had noted resident going into Badlands Lounge, then very shortly thereafter hearing [room number] calling [Resident #4] an idiot and [Resident #4] challenging him to a fight. . . . I don't know what set him off other than possibly [room number] usually sits in that chair. [Resident #4] was medicated [with] Ativan . . ." * At 9:00 p.m. - ". . . I gave him Ativan until 8:00 p.m. So was quite effective in both controling threatening behavior [and] his hyperactivity/wandering. . . ." * 09/11/10 at 3:50 p.m. - "Res. was sitting in Lounge in chair. Another res. came by [and] hit him x 3 [three times] and [Resident #4's] coffee spilled onto his chest. Res. removed from area. . . ." * 01/01/11 at 11:00 a.m. - "Resident in [room number] [and] was going to BR bathroom] [and] coming over to resident in that room. [Resident #4] resided in this room recently a few nights until ceiling was repaired. Verbal confrontation was loud. CN [charge nurse] removed him from other resident. Both have strong unrelenting personalities." Review of Resident #4's "Social Service/Behavior Committee Notes" from April 2010 through February 2011 repeatedly identified the following symptoms: "SYMPTOMS: . . . He continues to wander throughout facility, and will use other residents' bathrooms for toileting or laying down.	F 224		

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F 224	Continued From page 16 He is on a toileting schedule though continues to use other residents' bathrooms and/or continues to attempt to leave facility to toilet. . . . He has also showed anger towards other residents who get too close to him, pushing them in their wheelchairs away from him. : "INTERVENTIONS: Medication [at] Dr's. recommendations. He has psyche [psychiatric] involvement. . . . Res. is given reassurance when particularly anxious. Suggested attendance at activities has been successful at times. . . ." Failure of the facility to assess the precipitating factors leading up to, or resulting in Resident #4's behaviors and/or wandering, develop and implement effective interventions, as well as revise them as necessary; resulted in numerous altercations with other residents. Record review identified Resident #4 has yelled at, threatened other residents and/or challenged them to fight, and has wandered into other residents' rooms. These factors all contribute to the potential for Resident #4 to injure another resident and/or for another resident to cause harm to him. - Review of Resident #8's medical record occurred on February 22-24, 2011. Diagnoses included Alzheimer's disease with behaviors, severe dementia, depression, anxiety, and insomnia. Current medications for Resident #8 included: Aricept (used for Alzheimer's disease/dementia), Risperdal (used for Alzheimer's disease/behaviors), Namenda (used for dementia), and Celexa (used for depression). Resident #8's quarterly MDS, dated 08/17/10, identified long-term and short-term memory problems and moderately impaired daily decision making skills. The quarterly MDS, dated 01/14/11,	F 224		

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F 224	Continued From page 17 also identified continuous disorganized thinking, fluctuating inattention, delusions, behavioral symptoms not directed at others, assist with transfers and supervision needed with walking in corridor and locomotion on/off unit. Review of the "RAP SUMMARY" for Resident #8, dated 05/17/10, stated, ". . . Behaviors: . . . Resident is frequently inappropriate . . . making repeated, disruptive statements during activities or in the hallways. She is not always easily redirected. . . ." Review of the MDS "QUARTERLY STATUS REPORT" for Resident #8, dated 11/16/10, stated, "Social Interaction: . . . She continues [sic] occasionally argumentative with particular residents . . . Staff intervenes in negative situations when needed. . . . Mood: . . . She continues to show irritability at times and occasionally will become angry when redirected. . . . Activity Plan: . . . . There are times that [Resident #8] will get into it with other residents and staff and can get out of control with name calling and swearing. . . ." Review of Resident #8's current care plan, dated 05/17/10, stated, " . . . Cognition: . . . Apply and maintain wanderguard alarm bracelet. . . . Beha [Behaviors]: . . . socially inapropriate, making repeated statements [and] asking repeated questions when in activities or in hallways. . . . When in hallways, use distractions. . . ." Review of Resident #8's "Interdisciplinary Progress Notes" from February 2010 through February 2011 showed the following: * 02/25/10 at 10:00 a.m. - "Staff has continuous reports of resident having several incidents of	F 224		

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F 224	Continued From page 18 inappropriate behaviors and disruptive behaviors. . . . Resident is difficult to redirect and can be confrontaitonal when approached by staff. Resident has made inappropriate sexual comments towards other male residents and other residents' male visiting family members. . . ." * 02/28/10 at 10:00 a.m. - ". . . Also made inappropriate advance toward church layman here providing communion . . ." * 03/10/10 at 3:15 p.m. - "Resident became upset at another resident whent [sic] the other resident sat in a chair in [sic] activity room. Resident became rude, attempted to stop [sic] other resident from sitting in the chair. Staff needed to move the other resident to calm resident. . . ." * 05/11/10 at 1:00 p.m. - ". . . Resident is often rude to staff and other residents. Has been reported to be very disruptive during activities, causing other residents to become upset. Activity staff attemps [sic] to redirect resident, often results in increased behaviors from resident. . . . Resident . . . will often attempt to help other residents, and at times risk her safety and the other resident. . . ." * 10/16/10 at 10:00 a.m. - "Resident wandering through out facility in her wheelchair. She will at times ambulate by herself . . . Resident is difficult to redirect. Will go in other residents' rooms at times. . . ." * 10/17/10 at 3:30 p.m. - "CNA said that yesterday resident told another resident to give back her w/c [wheelchair]. Resident was upset . . ." * 12/09/10 at 10:30 a.m. - "Resident wandering, following other residents inside their rooms. . . . Staff attemps [sic] to redirect resident, causing her to become upset. . . ." * 02/16/11 at 3:00 p.m. - ". . . Will rock back and forth [with] her feet in w/c to soothe herself, but	F 224		

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F 224	Continued From page 19 inadvertently bump into someone from behind [and] not realize her own actions caused this and start name calling until nursing/other staff can intervene. . . ." Review of Resident #8's "Activity Attendance Record" from September 2010 through December 2010 showed the following: * September 2010 - ". . . Yelling at another resident that he's stupid. Upset when I asked her to leave. . . ." * October 2010 - ". . . Disruptive . . . When she sees people holding something or looking at something she's been acusing [sic] them of stealing it from her. . . . Bothering residents . . ." * November 2010 - "Rude, disrupting ppl [people] while talking . . . telling another resident to 'shut up' . . ." * December 2010 - ". . . arguing [with] another resident, ordering her around . . . being very rude to other residents . . . tries to squeeze thru [through] spaces [and] people in her w/c where there is no room even when resident [and] staff ask her to go around . . . backed into a resident and then yelled at them . . . She moves back and forth constantly [and] hits people very often . . ." During an interview on 02/24/11 at 8:20 a.m., an activity staff member (#3) agreed Resident #8 has displayed aggressive behaviors towards others and wandering behaviors, stating, "She does run into others, but we have never had an injury caused by her running into someone." Review of Resident #8's "Social Service/Behavior Committee Notes" from April 2010 through February 2011 repeatedly identified the following symptoms: "SYMPTOMS: . . . Resident continues to attempt to assist other residents and needs	F 224		

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F 224	Continued From page 20 reminding not to do this. She can become angry with redirection. She also can be argumentative with other residents." Failure of the facility to assess the precipitating factors leading up to, or resulting in Resident #8's behaviors and wandering, develop and implement effective interventions, as well as revise them as necessary; resulted in numerous altercations with other residents. During the group interview, residents expressed they have witnessed her running her wheelchair into other residents. Record review identified Resident #8 has yelled at or hit other residents, accused them of stealing, attempted to stop them from sitting in a specific chair, backed into them with her wheelchair, and has wandered into other residents' rooms. These factors all contribute to the potential for Resident #8 to injure another resident and/or for another resident to cause harm to her. - Review of Resident #11's medical record occurred on February 23-24, 2011. Diagnoses included severe dementia and depressive disorder. Current medications included an antidepressant, Zoloft, daily. An annual MDS, dated 11/17/10, identified Resident #11 with sometimes able to make herself understood, sometimes able to be understood, and with severe cognitive impairment (BIMS score of 0). The MDS identified the resident with behavorial symptoms occurring one to three days a week of physical and verbal behavioral symptoms directed toward others, and other behavioral symptoms directed toward others. The MDS identified the resident wanders daily, and the wandering places the resident at significant risk of getting to a potentially	F 224		

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F 224	Continued From page 21 dangerous place, and the wandering significantly intrudes on the privacy of activities of others. A quarterly status report, dated 11/17/10, stated, ". . . continues with periodic behaviors this quarter. She continues resistive with cares hitting and slapping at staff. She also has had some behaviors towards other residents such as hitting out, biting, etc. . . . Roommate Relations: There have been no reported problems. . . . She remains confused and combative at times. . . . is all over the facility and at times is in other residents rooms. . . . enjoys watching TV in the Badlands Lounge with other residents. . . ." Resident #11's care plan identified the following problems and approaches: * severe cognitive impairment: "obs [observe] closely for comfort" * ". . . expresses anger at times and will holler at you. She also has a habit and [sic] bumping into people which is not good situation and others have been angry with her due to this behavior" with approaches for individual and small group activities, inviting, encouraging and reminding her to join in activities, encouraging her to participate in out of room activities, and visitations with family, other residents and staff; limiting background noises. The care plan lacked the inclusion of identifying factors that caused Resident #11 to become angry and holler or bump into people, and what type of interventions can be utilized to avoid this from occurring. * ". . . hx of showing anger towards staff, cursing and raising her fist at them during cares, or redirection. . . . Res. is restless at times & [and] wanders throughout the facility, at times into other res. rooms. She also will move her w/c [wheelchair] into other residents' space, upsetting	F 224		

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F 224	Continued From page 22 them" with approaches of ". . . Apply and maintain wanderguard alarm bracelet. Observe closely around other res. rooms. regular psyche involvement. Wanderguard. Observe closely when in the hallways, and redirect from other res. rooms. When in hallways, and redirect [sic] from other res. rooms. When in hallways or lounges, observe closely around other residents. Remove away from other residents if necessary. If particularly restless, and moving too close to others, spend 1:1 time with her. She appreciates attention given to her." Review of Resident #11's medical record identified the following entries: * 05/25/10: A family communication note stated: "[Resident's first name] attempted to hit another resident, the other resident did not provoke her. He was able to block the blow. No one was injured . . ." Interdisciplinary Progress notes dated: * 07/12/10: Social Service progress note: "DX: Dementia, Symptoms: On occasion, she shows irritability and anger with cares. Her normal expression is one of worry, exhibiting a facial grimace. She will whimper at times & is unable to express her needs. She repeats self & will mimic others. She is mobile in her wheel chair, at times moving too close to other residents. On July 3rd, she was particularly alert and was asking residents' questions and attempted to touch another resident's toes. With redirection, she became angry. On May 25th, for no determined reason, she attempted to slap another resident. There have been no other incidents since that time. Interventions: . . . Resident continues with psyche involvement. Staff intervenes when res. rolling too close to other residents. . . ." * 07/31/10 at 7:30 a.m.: ". . . bit a CNA when	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355092	A. BUILDING _____ B. WING _____	02/24/2011

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F 224	Continued From page 23 putting her into the stand-up lift." * 08/13/10 at 5:40 p.m.: ". . . bit a CNA when CNA reached over her plate to get a piece of watermelon. No skin was broken." * 08/15/10 at 3:20 p.m.: ". . . was about to bite her roommates fingers in Badlands lounge when resident from unit one call [sic] nursing to the scene & they were separated. Roommate was shaking her finger & yelling @ [Resident #11]." * 08/15/10 at 3:15 p.m. late entry: "While report @ nurses station going on CNA making rounds found resident in [with] [room number of another resident] being kissed by male resident. CNA removed [Resident #11] as this would have most likely been the choice of guardian." On the morning of 02/24/11, an administrative staff nurse (#2) identified the male resident as Resident #15 and stated Resident #11 wandered into Resident #15's room. * 08/18/10 at 4:00 p.m.: ". . . wheeled self up to another male res et [and] bit him in the arm. She then proceeded to start making a growling noise at him. Removed her from Res et brought to another area." On the morning of 02/24/11, an administrative staff nurse (#2) identified the male resident as Resident #16 and stated Resident #11 and Resident #16 were in the Badland's lounge when this incident occurred. * 08/30/10: A Social Service progress note failed to mention the two incidents of the resident biting staff, and then attempting to bite her roommate; found after wandering into Resident #15's room and being kissed by him; and actually biting Resident #16. * 09/27/10: A Social Service progress note: "On occasion, she shows irritability and anger with cares. . . . She is mobile in her wheel chair, moves quickly and at times will move too close to other residents, or will enter their rooms.	F 224		

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F 224	Continued From page 24 Interventions: . . . Resident continues with psyche involvement . . . Staff intervenes when res. rolling too close to other residents. This continues as a concern." * 10/25/10: A duplicative social service note from 09/27/10. * 11/09/10 at 4:30 p.m.: "Activity personnel noted resident was running into male resident in TV room. He asked her to quit but she didn't. Male resident kicked her w/c [wheelchair] backwards very hard & hollered at her to get out of the way and she hollered back to him. Resident removed from area." On the morning of 02/24/11, an administrative staff nurse (#2) identified the male resident as Resident #17 and stated Resident #11 and Resident #17 were in the Badland's lounge when this incident occurred. * 01/04/11 at 4:20 p.m.: "Activity aide said resident was sitting in front of the TV and hitting on the screen. Male resident was standing beside her and told her that she couldn't do that so she spit and hit at him. Activity aide took her into the activity room and she had no further episodes." On the morning of 02/24/11, an administrative staff nurse (#2) identified the male resident as Resident #18 and stated Resident #11 and Resident #18 were in the Badland's lounge when this incident occurred. * 01/06/11: A Social Service progress note stated: "On occasion, she shows irritability and anger with cares. . . . On Dec. 26th, during cares, resident slapped a CNA for no determined reason. There have been no aggressive incidents since that time. . . . On Nov. 9th, a male res. became upset with her because she got too close to him in her wheelchair. He pushed her away from him. Staff intervened. There have been no further incidents." * 02/11/11 at 2:00 p.m.: ". . . Resident is able to	F 224		

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F 224	Continued From page 25 propel herself in wheelchair. She does wander throughout facility. . . . Resident does not recognize people, does have a tendency to slap staff at times. . . ." The facility failed to implement proactive measures to prevent the incidents that occurred involving Resident #11. The facility failed to assess the precipitating factors leading up to, or resulting in Resident #11's behaviors, develop and implement effective interventions, as well as revise them as necessary which resulted in repeated incidents. This has the potential to cause harm to Resident #11 and/or other residents within the facility. - Review of Resident #9's medical record occurred on February 23-24, 2011. Diagnoses included dementia, anxiety, and depression. The most recent quarterly MDS, dated 01/20/11, identified the resident with long and short term memory problems, "rarely/never" able to make herself understood, "sometimes" able to understand others, and "severely impaired" in daily decision making. The MDS indicated Resident #9 required extensive assistance of one staff member for locomotion on and off the unit. Review of an "Interdisciplinary Progress Note" for Resident #9, dated 04/03/10 at 6:50 p.m., stated, "Heard w/c alarm sound. Resident on floor in Badlands Lounge lying on her right side. Male resident said he was trying to move her [and] she fell out of her chair [wheelchair]. (T.V. is in Badlands Lounge.) Able to move all extremities. In chair [with] two assist [and] gait belt . . ." At the time of the survey, the facility could not determine whether this incident was related to another resident's aggression due to the resident's	F 224		

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F 224	Continued From page 26 unknown identity. During an interview on 02/24/11 at 12:00 p.m., an administrative staff member (#2) stated the report for the incident occurring on 04/03/10 lacked the name of the male resident involved with Resident #9's fall from her wheelchair. The staff member (#2) stated none of the staff members at the facility could recall who the male resident was. The facility failed to thoroughly investigate and address this incident. By not knowing the identity of the resident who caused Resident #9 to fall from her wheelchair, the facility is unable to assess and monitor the unknown resident's behaviors and avoid future harm to other residents in the facility.	F 224		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy and procedure, record review, and staff interview, the facility failed to provide an ongoing, meaningful activity program to meet the physical, mental, and psychosocial needs for 2 of 3 sampled residents (Resident #1 and #2) identified by the facility as residents who wander into other resident rooms and/or outside of the facility. Failure to provide meaningful activities designed to reflect each resident's interests and lifestyle has the potential	F 248	F248 **1.** How corrective action will be accomplished for residents affected a. Resident #1 - Requesting Occupational Therapy assessment for cognitively appropriate activities. The care plan has been revised to reflect the residents' current capabilities. b. Resident #2- Discharged to a Memory Care Unit **2.** How ID residents having potential to be affected	4/7/11

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F 248	Continued From page 27 to negatively impact a resident's sense of self-worth and belonging. Lack of meaningful activities could have contributed to Resident #1 and Resident #2's wandering and mood/behavior symptoms, resulting in increased restlessness, agitation, and isolation. Findings include: Review of the facility policy/procedure titled "COGNITIVE IMPAIRMENTS" occurred on 02/24/11. This policy, revised January 2010, stated, "Policy It is the policy of this facility to * Offer meaningful activity programs to Residents who display disorientation to time, place, and/or person. * Provide activity programs to refect each Resident's individual needs, to enhance and promote each Resident's physical and mental status, and to promote cognitive health . . . Procedures The Activity Director/Staff will * Upon admission, during a change of condition review, or within general observations of the Resident's cognitive abilities, determine whether the Resident could benefit from a reality awareness program or modified activity programs to meet his or her individual needs. (Consultation and coordination regarding the Resident's needs will occur within the Interdisciplinary Team.) . . . * Modify activity programs to promote each Resident's meaningful participation by simplifying steps, adapting approaches, and modifying instructions. * Offer structured activities for Residents with Alzheimer's-type dementias to include gross motor and walking activities and music activities."	F 248	a. Cognitively impaired residents who have wandering and restlessness have the potential to be affected. **3.** Measures or systemic changes a. Cognitively impaired residents who have wandering and restlessness will be evaluated for an appropriate activity plan by Occupational Therapy. Activity staff will implement recommended plans. b. Activities personnel will develop programs targeted toward wandering cognitively impaired residents. Activity personnel will be trialing a number of new memory care activities geared toward the cognitively impaired residents to determine their interests. (See Activity Calendar.) c. For residents that have behaviors that may negatively impact others, an	

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F 248	Continued From page 28 Review of the facility policy/procedure titled "ROOM VISITS" occurred on 02/24/11. This procedure, revised January 2010, stated, " . . . Procedures The Activity Director/Staff will * Maintain a record of Residents who choose not to leave their room to attend activity programs, and Residents who have patterns of low participation or attendance in group activity programs. * Provide one-on-one based activity programs to the above stated Residents. The in-room activity programs will directly reflect the Residents' assessed individualized activity interests. * Train and coordinate support staff and trained volunteers to provide some of the in-room activities to the Residents. * Provide activity contacts according to each Resident's requests, needs, and interests. . . ." - Review of Resident #2's medical record occurred on February 22-24, 2011. Diagnoses included dementia, aggression, and anxiety. Resident #2's current Minimum Data Set (MDS), dated 12/08/10, identified severely impaired daily decision making skills, long-term and short-term memory problems, constant inattention, and a mood interview score of 13 (which indicated moderate depression). Resident #2's MDS also showed behavioral symptoms not directed at others and wandering daily, and independent ambulation without the use of assistive devices. The MDS identified the resident with impaired vision requiring corrective lenses, minimal difficulty hearing, absent of spoken words, rarely/never able to make herself understood, and sometimes able to understand others.	F 248	*Activities Behavior/Intervention Monthly Flow Record* will be maintained. The *Behavior/Intervention Monthly Flow Record* will include the behavior tracking including the number of behavior episodes, interventions tried, and outcomes of the interventions. d. Activities will incorporate the *Behavior Management Plan* which lists the resident's behavioral symptoms, possible precipitators, interventions, and desired outcomes. This plan will be reviewed against the *Activity Behavior/Intervention Monthly Flow Record* and documentation in other activity notes. e. The Activity Director will participate in the *Monthly Behavior Meetings* which will involve evaluation of behaviors and effectiveness	

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F 248	Continued From page 29 Review of Resident #2's current care plan, dated 06/08/10, identified the problem of "[Resident #2] attends a good amount of activities. She usually sits quietly and doesn't take part in the activity. She has also show [sic] anger at times to other residents and staff." Goals for this problem included "Will be a passive onlooker to 3-5 activities per week . . . To maintain acceptable level of activity through next review . . . Will be involved in activity pursuits 1/3 to 2/3 or [sic] the time." Approaches for these goals included "Invite, encourage and remind resident to join us in activities of preference. Assist to and from activities of interest. Encourage out of room visitations with family and friends. Use positive reinforcement for attempts at socialization. Take to hairdresser/barber every Thursday morning. Promote socialization with staff, family, [and] other residents. Furnish resident with own personal activity calendar. Give prior reminders before activity begins. Observe/monitor interest/participation in activities." Observations of Resident #2 occurred throughout the survey and revealed the following: * 02/22/11 at 1:45 p.m. - Resident #2 lay in Resident #8's bed. A certified nursing assistant (CNA) (#4) stated, "She always does this. She lays in everyone's bed but her own." * 02/22/11 at 3:00 p.m. - Sitting out in Badlands Lounge (TV area) (not actually looking at the TV) * 02/23/11 at 7:30 a.m. - Sitting on couch in Badlands Lounge * 02/23/11 at 8:35 a.m. - Laying in Resident #8's bed. * 02/23/11 at 8:50 a.m. - Laying in Resident #13's bed. * 02/23/11 at 9:20 a.m. - Laying in her own bed * 02/23/11 at 10:00 a.m. - Resident #2 pushed	F 248	of interventions (including offered activities the resident participates in). **4.** Completion Date 4/7/2011. **5.** Monitoring performance for sustained solutions, QA plan a. Resident's identified to be at risk will have auditing of the Activity record and review meaning ful activities and participation. b. Audits by the QA Coordinator and/or the Activities Director will be completed bi-weekly x 2, at 2 and 3 months.	

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F 248	Continued From page 30 Resident #14 down the hallway in her wheelchair in a rapid pace. After staff intervened, Resident #2 sat in a chair in Badlands Lounge not involved in any activity. * 02/23/11 at 12:20 p.m. - Laying in her own bed * 02/23/11 at 4:10 p.m. - Sitting in the activity room, staring at the floor, no staff interaction/stimulation, not involved in any activity * 02/24/11 at 8:35 a.m. - Sitting on the couch in the Badlands Lounge alone, not engaged in any activity Observation on all days of survey showed Resident #2 constantly wandered into other residents' rooms and throughout the facility and unable to stay in one place for any length of time. During an interview on 02/24/11 at 7:20 a.m., an activity staff member (#3) stated the "calendar" activity consisted of going to Resident #2's room each morning, and if she was in her room, staff would spend 2-5 minutes discussing the activity calendar for the day. The staff member (#3) stated staff attempted visiting with Resident #2, assisting her with her supplements/snacks, and giving her hand rubs multiple times during the day for 2-10 minutes if she was cooperative. The activity staff member (#3) stated she recognized the need for more stimulating and individualized activities for the residents in the facility with cognitive impairment, including Resident #2. - Review of Resident #1 medical record occurred on February 22-24, 2011. Diagnoses included Alzheimer's disease, depression, and anxiety. Resident #1's annual MDS, dated 01/11/11, identified severe impairment in daily decision making skills, short and long term memory problems, rarely or never understood, sometimes able to understand others, a mood interview	F 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 248	Continued From page 31 score of 19 which indicated moderately severe depression, and wandering behavior that occurred daily that intruded on others. Review of Resident #1's current care plan for activities identified the problem as "is confused, wanders and rarely stays for an activity. She also pulls her pants down to go to the bathroom in front of other residents." The care plan goal set is "Will participate in the following activities: beauty shop on Thursdays, coffee/snack time in the afternoons. Will be involved in at least one non-verbal activity per week. To maintain acceptable level of activity through next review." Approaches included: "Encourage out of room visitations with family and friends. Encourage individual and small group activities Assume unhurried manner. Allow ample time for tasks. Encourage out-of room activity. Provide 1:1 visits when unable to attend group programs. Provide emotional support. Discuss resident's previous activity experience. Encourage good decisions. Observe closely for responses to activity pursuits. Staff to be extremely attentive to communication attempts. Use positive reinforcement for attempts at socialization. Take [name] to have her hair done on Thursday mornings. Staff to be extremely attentive to communication attempts." Resident #1's care area assessment (CAA) for Cognitive Loss/Dementia, dated 01/11/11, stated, "Resident . . . is non-verbal for the most part. She	F 248		

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F 248	Continued From page 32 does not recognize her family. . . . has no recall ability. For daily decision making, she is severely impaired. Res. has s/s [signs and symptoms] of delirium, including inattention, disorganized thinking (mumbles incoherently), is at times lethargic, staring into space and moves slowly. She has look of confusion and being lost. Resident is unable to make herself understood due to her being non-verbal . . ." Resident #1's care plan and CAA for Cognitive Loss identify unrealistic staff expectations in her capabilities based on her assessment. She is also identified as non-verbal so it is unreasonable to expect she discuss her previous activity experience. On 02/22/11, at 3:05 p.m., Resident #1's husband sat in the rocker/chair in the resident's room. The surveyor visited with the husband. During the visit, Resident #1 slept in the bed and did not arouse. Resident #1 continued to rest in the bed at 4:50 p.m. On 02/23/11, Resident #1's day included primarily meals, snacks, toileting and walking (to and) from meals, as evidenced by the following observations: * breakfast in the dining room at 7:45 a.m. * ambulated by an unidentified certified nursing assistant (CNA) from the dining room to her room at 8:50 a.m., then assisted with toileting and personal cares by CNA (#7) * after toileting, the CNA (#7) asked the resident what she wanted to do, and Resident #1 provided no verbal response to the question. The CNA (#7) ambulated the resident to the rocker/chair in her room and gave her a glass of water. Observation showed the television on in the resident's room.	F 248		

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F 248	Continued From page 33 * 9:50 a.m., the resident slept in her rocker/chair in her room. * 10:10 a.m., Resident #1 drank a chocolate drink from a glass in her rocker/chair in her room, while she sat alone. * 11:30 a.m., a CNA (#7) assisted Resident #1 with toileting cares. * 11:50 a.m., Resident #1 sat at the lunch table. * 12:20 p.m., a CNA walked with the Resident #1 down the hall toward her room. * 1:30 p.m., a CNA (#7) assisted Resident #1 with toileting cares. An interview occurred on 02/24/11 at 8:20 a.m. with a supervisory staff member (#3) of the activities department. The staff member stated "Calendar Visit" on the monthly activity attendance record means activity staff visit with the resident for two to five minutes regarding what is on the calendar for the day; and one-to-one visits occur anywhere within the facility. The staff member stated the activity staff have been unable to get Resident #1 to "do anything." The staff member stated Resident #1 enjoys sensory type stimulation activities like having her hair done, hand and arm touch and massage, and stated Resident #1 will get up and walk away from an activity if she does not like it. The staff member identified if activities works on getting Resident #1 to drink during an activity, it will keep her in the activity. An interview occurred on 02/24/11 at 10:30 a.m. with a supervisory staff member (#3) of the activities department. The staff member stated the present activity program is not designed for residents with cognitive impairments and for residents with wandering behaviors.	F 248		

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F 248	Continued From page 34 The facility failed to develop an ongoing, meaningful, and individualized activity program designed to meet the current physical, mental, and psychosocial needs for Resident #1 and #2. The facility failed to consistently provide stimulating and engaging activities to these residents and failed to adapt their activity program to their changing needs. A well-developed and individualized activity program could potentially decrease the residents' wandering and aggressive behaviors and improve the residents' quality of life.	F 248		
F 250 SS=E	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy and procedure, record review, and resident, staff, and group interview, the facility failed to assess the specific resident behaviors for causative/precipitating factors, and develop and implement/revise appropriate interventions, as necessary; for 5 of 7 sampled cognitively impaired residents (Resident #1, #2, #4, #8, and #11) identified with behaviors, including aggressive, and wandering behaviors. Failure to address and monitor behaviors has resulted in residents striking out at other residents, and intruding on others, and has the potential to result in unintended resident to resident retaliation, and/or serious harm to residents.	F 250	F250 **1.** How corrective action will be accomplished for residents affected a. Resident #2- Transferred to a Memory Care Unit on 3/16/11. b. Resident #1, #4, #8, & #11's – See #3 systemic changes. (See also #1 under POC F224 for other interventions for these residents) c. Resident #1's toileting plan will be assessed. She has seen the urologist in the past who has given directives for her urinary care. Resident is no longer wandering at this time. She will have an occupational evaluation for cognitively appropriate activities.	4/7/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355092	A. BUILDING _____ B. WING _____	02/24/2011

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F 250	Continued From page 35 Findings include: Review of the facility procedure titled "ELOPEMENT PREVENTION PROGRAM" occurred on 02/24/11. This procedure, revised November 2003, stated, "Procedure 1. Assess resident upon admission and as needed regarding elopement potential. 2. If resident is determined to be an elopement risk staff will, * Apply Watch Mate band where appropriate * Implement mood and behavior management programs for residents with restlessness, agitation, confusion, and depression. * Use validation, diversion and redirection techniques. . . ." - During a resident interview on 02/22/11 at 4:35 p.m., Resident #5 (identified by the facility as interviewable) stated she was "very upset" with Resident #1 for entering her room and urinating on her personal belongings. Review of Resident #5's "Interdisciplinary Progress Notes" showed the following: 08/03/10 at 8:00 p.m. - "Very upset that resident in rm [room] [Resident #1] was in hers uninvited [and] sat on her couch. [Sic] that resident had urinated in room so she requested we wash the clothes [and] disinfect the couch [with] spray. Both done as asked." - During a resident interview on 02/23/11 at 8:20 a.m., Resident #3 (identified by the facility as interviewable) stated on a daily basis Resident #2 wanders into his room and lays in his roommate's bed. Resident #3 stated "it scares me" when Resident #2 comes into his room because he has witnessed her hitting the staff who retrieve her	F 250	d. Resident #4 will have shorter toileting intervals. We will also request a urology consult. He will have an occupational evaluation for cognitively appropriate activities. We will minimize environmental change. e. For Resident #8, we will have physical therapy assess resident for need of the wheelchair. She may be able to walk, eliminating the risk of her backing into other residents. Until that time we will have occupational therapy assess her for devices to improve her safety in the wheelchair. Resident can transfer into a regular chair when in the dining room and when she is at activities. She will have an occupational therapy evaluation for cognitively appropriate activities. Resident does like dolls and she may respond positively to one.	

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F 250	Continued From page 36 from his room and he doesn't want her to hit him. He stated she yells at him or says "shut up" when he tries to tell her it isn't her room. - The group interview occurred on 02/23/11 at 1:00 p.m., with six residents in attendance. The residents identified Resident #1, Resident #2, Resident #4, Resident #8, and Resident #11 wandered into other residents' rooms and around the facility at all hours of the day. The residents in attendance identified Resident #1 with a history of urinating in other resident's beds, and stated Resident #2 constantly lays in other resident's beds and sits in their chairs. Resident C stated Resident #2 "is a problem" and often wanders into her room and lays in the empty bed. Resident A stated Resident #2 frequently comes into her room both during the day and in the middle of the night and sits in her chair. Resident A explained even though Resident #2 has never hurt her, she is scared of her as she has witnessed her being abusive to staff and other residents. Resident B identified Resident #2 once wandered into his room and hit him in the chest, causing him soreness for a few days. Resident D stated Resident #2 occasionally comes in his room during the night, sits in his recliner, and will hold her fist up and scream. Resident D indicated if Resident #2 ever hit him he would "hit her so hard he would lay her out on the floor." Resident D explained he witnessed Resident #8 purposely bumping into other resident's wheelchairs with her own wheelchair. Resident D stated Resident #11 has taken items from his room in the past, but staff retrieved them. Resident B indicated Resident #4 took something from his room before, but he got it back from him. - Review of Resident #2's medical record	F 250	f. Resident #11 will also have an occupational evaluation for cognitively appropriate activities. Occupational therapy will also do a wheelchair seating evaluation for safety for her. She responds best to a calm quiet approach. We will determine other effective interventions from her behavior flow sheets. **2.** How ID residents having potential to be affected a. Residents with behaviors negatively impacting other residents have the potential to be affected. **3.** Measures or systemic changes a. When a resident behavior occurs that negatively impacts another resident, the charge nurse will note precipitating factors, describe the incident that occurred, interventions tried, and the outcomes of the interventions in the interdisciplinary notes. The other resident will be	

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F 250	Continued From page 37 occurred on February 22-24, 2011. Diagnoses included dementia, aggression, and anxiety. Current medications for Resident #2 included: Celexa (an antidepressant); Geodon (an anti-psychotic medication); Aricept and Namenda (both used for dementia); and Ativan (an anti-anxiety medication) for as needed use. Review of Resident #2's "Interdisciplinary Progress Notes" from May 2010 through February 2011 identified the following: the resident frequently wandered throughout the facility and into other residents' rooms where she would lay in their beds/chairs, she yelled at and physically hit other residents, pushed residents in their wheelchairs, and hit staff which frightened other residents who witnessed the incidents. Refer to F 224 The facility failed to assess and monitor Resident #2's behaviors and implement proactive approaches and interventions to minimize the resident's behaviors and lessen the fear and harm experienced by the other residents residing in the facility. - Review of Resident #4's medical record occurred on February 22-24, 2011. Diagnoses included Alzheimer's disease, dementia, psychosis, depression, and anxiety. The 07/16/10 Minimum Data Set (MDS) identified long-term and short-term memory problems and moderately impaired daily decision making skills, and the 11/16/10 MDS identified continuous disorganized thinking, delusions, and wandering. Review of the MDS "QUARTERLY STATUS REPORT" for Resident #4, dated 01/14/11, stated, "Cognitive: . . . When walking through	F 250	identified in the interdisciplinary notes by the medical record number. b. For residents that have behaviors that may negatively impact others, a *Behavior/Intervention Monthly Flow Record* will be maintained. The *Behavior/Intervention Monthly Flow Record* will include the behavior tracking including the number of behavior episodes, interventions tried, and outcomes of the interventions. c. Each identified resident will have a *Behavior Management Plan*, initiated and reviewed by the interdisciplinary team, listing the resident's behavioral symptoms, possible precipitators, interventions, and desired outcomes. This plan will be reviewed against the *Behavior/Intervention Monthly Flow Record* and	

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F 250	Continued From page 38 facility hallways, [Resident #4] will at times go into other residents rooms. He requires assist with finding his room and the bathroom much of the time. [Resident #4] also attempts to leave [sic] facility at times. He . . . needs constant reminding as he forgets quickly. . . . Social Interaction: . . . he will show upset or anger if he is redirected away from a doorway as he is attempting to leave. . . ." Review of Resident #4's current care plan, dated 10/25/10, stated, " . . . Mood: Resident is frequently restless, wandering or pacing the hallways. . . . Beha [Behaviors]: Resident wanders frequently not knowing what he is looking for. At times, he is searching for his pickup or a bathroom. He will attempt to leave the facility. He will also occasionally wander into other resident rooms. In all instances, he is generally easily redirected - annoyed at times. . . . When res. attempts to leave the facility, redirect him to an activity. . . . When in another res's [resident's] room, redirect him out to another area. Wanderguard. . . ." Review of Resident #4's "Interdisciplinary Progress Notes" from February 2010 through January 2011 showed the following: * 02/24/10 at 2:45 p.m. - "Resident wandered into another residents room, he did argue with the other resident . . ." * 03/08/10 at 10:40 p.m. - "CNA reported that another resident told her that [Resident #4] came into his room and told him he was going to sleep in his bed . . ." * 04/01/10 at 10:00 a.m. - Resident wandering through out facility, did attempt to exit facility through Meadow Lane exit. . . ." * 04/12/10 at 2:00 p.m. - "Resident wandering in	F 250	against documentation in the Interdisciplinary notes. d. A *Behavior Tracking Form* (modified current QA form) will be kept for each resident with behaviors, monitoring for patterns and trends including the time, place and persons involved (other residents involved will be identified by medical record number), and happenings prior to and at the time of the behavior. This will be reviewed at the monthly behavior meeting. e. *Monthly Behavior Meetings* will continue, but will involve more complete evaluation of behaviors and effectiveness of interventions. Members will be added to the interdisciplinary team, including nursing, social services, activities, and quality assurance. The next meeting is planned on 3/28/11. f. Residents that have been identified to negatively impact other residents may be	

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F 250	Continued From page 39 halls, attempting to exit facility twice. . . ." * 05/01/10 at 4:40 p.m. - "Resident went into rm [room number]. He told the resident in the bed to get out of his room. . . ." * 05/26/10 p.m. [exact time not provided] - "Res. carried soiled pull-up out to Nurses Station, stating we need to get rid of it because it was not his. . . . After supper, Res. found urinating in garbage can [at] Unit 1 bathrooms. Res. became very upset when asked what he was doing. Yelled out and cursed [at] nurse. . . ." * 05/28/10 2:00 p.m., "Resident wandering, attempting to exit facility looking for his spouse. . . ." * 06/06/10 at 11:00 a.m. - ". . . CN [charge nurse] responded to door alarm [at] end of Northern Drive. Resident saw CN coming [and] re-entered hallway, walking toward CN while waving his fist. . . . He went outside, urinated [and] tried to come back in. CN opened the door. . . ." * 06/26/10 at 1:00 p.m. - "Staff reporting that [sic] resident [sic] wondering [sic] throughout hallways. Going into other residents' rooms. Telling the other residents to leave his room. . . ." * 08/27/10 at 11:00 a.m. - "Resident went outside Meadow Lane door [and] voided [sic] . . ." * 01/01/11 at 11:00 a.m. - "Resident [sic] in [room number] [and] was going to BR bathroom] [and] coming over to [sic] resident in that room. . . . Verbal confrontation . . ." * 01/03/11 at 10:00 a.m. - ". . . Resident does wander at times, staff has discovered that his wandering is usually associated with him needing to be toileted. . . ." Refer to F224 for additional behaviors (yelling at, threatening other residents and/or challenging them to fight) identified in the February 2010 through January 2011 "Interdisciplinay Progress Notes."	F 250	evaluated for alternative placement in a more secure environment. g. Staff education- Nursing and activities staff will receive training on the new expectations for assessment of precipitating factors, trying new interventions, and assessing outcomes. New documentation requirements will also be reviewed in their March departmental meetings. **4.** Completion Date 4/7/11. **5.** Monitoring performance for sustained solutions, QA plan a. Resident's identified to be at risk will have auditing of the medical record and review of documentation for completeness, including i. Causative factors ii. Time, place, and persons involved iii. Happenings prior to and at the time of behavior	

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F 250	Continued From page 40 Review of Resident #4's "Social Service/Behavior Committee Notes" from April 2010 through February 2011 repeatedly identified the following symptoms: "SYMPTOMS: . . . He continues to wander throughout facility, and will use other residents' bathrooms for toileting or laying down. He is on a toileting schedule though continues to use other residents' bathrooms and/or continues to attempt to leave facility to toilet. Res. has attempted to leave the building and has a wanderguard on. . . . "INTERVENTIONS: Medication [at] Dr's. recommendations. He has psyche [psychiatric] involvement. . . ." During an interview on 02/24/11 at 8:30 a.m., two administrative nursing staff members (#2 and #5) stated staff address his basic needs when he is wandering and being aggressive, such as: staff are instructed to lead Resident #4 out of other resident's rooms and/or assist him to the toilet. Failure of the facility to assess the precipitating factors leading up to, or resulting in Resident #4's behaviors and wandering, develop and implement effective interventions, as well as revise them as necessary; resulted in numerous altercations with other residents and in Resident #4 wandering throughout the facility, into other residents' rooms, and outside the facility. Record review identified his wandering behavior often occurred at times directly related to the resident's need for toileting, even though he was on a toileting schedule. The record lacked identification of changes in the toileting schedule when these incidents occurred. - Review of Resident #8's medical record occurred on February 22-24, 2011. Diagnoses included Alzheimer's disease with behaviors,	F 250	iv. Interventions tried and outcomes b. Audits will be completed (by nursing management and/or the social serviced designee) bi-weekly x 2, at 2 and 3 months.	

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F 250	Continued From page 41 severe dementia, depression, anxiety, and insomnia. The 08/17/10 MDS identified long-term and short-term memory problems and moderately impaired daily decision making skills, and the 01/14/11 MDS identified continuous disorganized thinking and delusions. The 05/17/10 care plan stated, " . . . Apply and maintain wanderguard alarm bracelet. . . ." Review of Resident #8's "Interdisciplinary Progress Notes" from October 2010 through December 2010 showed the following: * 10/16/10 at 10:00 a.m. - "Resident wandering through out facility in her wheelchair. She will at times ambulate by herself . . . Resident is difficult to redirect. Will go in other residents' rooms at times. . . ." * 12/09/10 at 10:30 a.m. - "Resident wandering, following other residents inside their rooms. . . . Staff attemps [sic] to redirect resident, causing her to become upset. . . ." See F224 for additional behaviors (yelling at or hitting other residents, accusing them of stealing, attempting to help them, attempting to stop them from sitting in a specific chair, and backing into them with her wheelchair) identified in the February 2010 through February 2011 "Interdisciplinay Progress Notes." Failure of the facility to assess the precipitating factors leading up to, or resulting in Resident #8's behaviors and wandering, develop and implement effective interventions, as well as revise them as necessary; resulted in numerous altercations with other residents and in Resident #8 wandering throughout the facility and into other residents' rooms. - Review of Resident #1 medical record occurred	F 250		

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F 250	Continued From page 42 on February 22-24, 2011. Diagnoses included Alzheimer's disease, depression, and anxiety. Current medications for Resident #1 included: Remeron, an antidepressant; and Namenda, used for dementia. Resident #1's annual MDS, dated 01/11/11, identified severe impairment in daily decision making skills, short and long term memory problems, rarely or never understood, sometimes able to understand others, a mood interview score of 19 which indicated moderately severe depression, and wandering behavior that occurred daily that intruded on others. A quarterly status report, accompanying this MDS review, stated, ". . . She is alert and oriented to person. She requires extensive assist and cueing with all ADL's [Activities of Daily Living]. . . . is unaware of her location and will wonder [wander] through hallways and into other residents' rooms. Lately . . . has been easily redirected . . . does have periods that she gets anxious and upset. . . . Mood State: . . . is not expressive, but will occasionally smile at staff and is particularly comfortable when her husband is visiting. She makes her way around the facility, at times wandering into unauthorized areas such as the staff lounges, etc., or other residents' room. She is not always easily redirected out of the rooms she wanders into. She shows only occasional anger and upset during cares. . . . walks around the facility most every day and at times goes into other residents' rooms and will lay on their bed as well. She has adjusted to the routine and being here . . . " The Resident Assessment Protocol (RAP) Summary, completed for Resident #1's admission	F 250		

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F 250	Continued From page 43 MDS assessment, dated 03/17/10, also identified the resident with short and long term memory loss, difficulty understanding others and "ambulates through hallways frequently and at times found in other residents rooms. Requires redirection throughout the day. . . . has difficulty with daily decision making regarding her daily routines requiring supervision and cueing. . . ." Her Mood State RAP stated, ". . . has been wandering, restless, up at night. Her focus has been on looking for people, meetings, etc., and has been difficult to interest in anything else. She does not like being awakened in the morning and will react angrily towards staff. With [sic] redirection out of unsafe areas and residents' rooms, she has been angry and threatening. On first days of admit, she was yelling out, angry and difficult to reassure or console. She asks repeated questions and makes repeated statements. . . . Behaviors: Resident has been wandering, yelling out loudly - disruptive. She has also been threatening, verbal and resistive to cares. These behaviors have improved since first day of admit. . . . We will care plan." Review of Resident #1's current care plan included the following problems and approaches: * mood and behavior problem including wandering: "Assess for [signs and symptoms] of depression (withdrawal, appetite change). Med [medication] therapy. Attempt to engage resident in conversation, talking to her about past life . . . Husband visits often and walks with res. in hallways. He also spends time with her in her room. Invite resident to activities. If resident anxious and restless, determine if she	F 250		

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F 250	Continued From page 44 needs to use bathroom. Observe for changes in mental state & report to CN [charge nurse]. 1:1 [one on one] visits - to establish trust relationship. Apply and maintain wanderguard alarm bracelet. Analyze behavior for possible cause and effect relationship. (does she need to use the bathroom?) Attempt to involve in small group activities Give frequent reassurance and understanding Family visits; husband provides comfort to her Responds to calm approach, visitation with her. Medication therapy; psyche involvement." * difficulty making herself understood "Give clear & simple explanations and directions. Ask yes/no questions. Encourage to talk when possible. Allow time for response. Non-verbal assessment as needed. . . . has glasses. . . . dentures." * severe cognitive impairment "Keep explanations simple. Use task segmentation. Ask yes or no questions. Reality orientation during waking hours. Minimize distraction. Supervise closely to prevent elopement. . . . Verbal reminders, cues." Review of Resident #1's "Interdisciplinary Progress Notes" from July 2010 through January 2011 identified the following: * 07/23/10 at 1:45 p.m.: ". . . Resident has some increasing wandering on shift. Did go in staff lounge and had bowel movement on chair and floor. Staff was able to clean resident. . . ." * 07/27/10 Social Service's note: ". . . res. currently being treated for a UTI, which is affecting her behaviors, including increased confusion and resistance to cares. . . . Progression of dementia/alzheimer's also	F 250		

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F 250	Continued From page 45 discussed with husband. . . . It was explained to him that res. has been urinating in inappropriate spots which he said he was aware of. . . ." * 08/03/10 at 10:45 a.m.: "Resident confused, has short attention span, wandering in and out of other resident's room. Resident can be difficult to redirect. Resident is having complaints of pain and burning when voiding. She has a history of urinary tract infection. Staff will obtain an Urinalysis . . ." * 08/04/10 at 7:30 a.m.: "urinated on the floor of 1107 & bed of 1204 [after] supper. difficult to redirect/settle. continues to wander facility." * 08/14/10 at 10:00 p.m.: ". . . Wandering & crawling into others beds [after] HS [bedtime] cares done. . . ." * 08/30/10 Social Service note: "DX [diagnosis]: dementia SYMPTOMS: Resident wanders throughout the nursing home; restless at times. She continues to wander at times, and will go into other res. rooms. She continues to exhibit socially inappropriate behaviors, including pulling her pants down & urinating in other residents' rooms or in offices. She has a hx [history] of UTI's & was recently treated for one. Her behaviors will increase when she has a UTI. There have been no recent incidents of concern between res. [resident] & other residents. She is not always easily redirected. Res. is verbal and combative during cares, especially later in the day. INTERVENTIONS: Medication @ Dr's. recommendation. She has regular psyche involvement. Staff intervenes when wandering and gives frequent reassurance. She is on a toileting schedule." * 09/05/10 at 3:30 p.m.: Late entry for 08/30/10: "Resident sitting on another resident's bed." * 09/27/10 Social Service notes: SYMPTOMS: Resident has hx of wandering throughout the	F 250		

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	355092	A. BUILDING _____ B. WING _____	02/24/2011

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F 250	Continued From page 46 nursing home & not being easily redirected & was restless at times. This assessment period, she was lethargic & less responsive. Res. had been exhibiting socially inappropriate behaviors previously, including pulling her pants down & urinating in other residents' rooms or in offices. This is not a concern currently. . . . She has regular psyche involvement. Her psyche medications have been put on hold and she is being monitored for any changes." * 10/16/10 at 11:00 a.m.: "Resident up ambulating to and from meals . . . gait has been more steady . . . will wander in other resident's room, can be difficult to redirect at times." * 10/25/10 Social Services note: SYMPTOMS: "Resident has hx of wandering throughout the nursing home and not being easily redirected. This assessment period she is more alert and responsive. She has not displayed toileting in inappropriate places. She is not easily redirected and continues to wander. . . ." * 11/28/10 at 2:00 p.m.: "Resident ambulating, wandering . . ." * 11/30/10 at 2:00 p.m.: "Wandering a lot, unable to sit still, came out of room [without] pants x 1 (had pull up on). Voiding incontinent & continent. . . ." * 12/21/10: ". . . risk for falls. . . . She ambulates independently . . . She does need supervision at times due to wandering . . . She is on scheduled toileting. . . ." * 12/29/10 at 10:00 a.m.: ". . . is dependent with all of her ADL's; she is incontinent of bowel and bladder. Resident will at times undress in public and void . . . Staff . . . has educated her on the importance of proper nutrition, resident will not express understanding. . . . Resident ambulates by herself, does wander through out facility, does go into other residents room. Resident can be	F 250		

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F 250	Continued From page 47 difficult to redirect, will cooperate with some staff better than others. . . ." * 01/05/11 at 10:00 a.m.: ". . . Does not answer appropriately @ [sic] most times. Wanders in hall. . . ." * 01/06/11 Social Service Note: "Resident has hx of wandering . . . not being easily redirected. She continues alert and responsive. She periodically attempts to toilet in inappropriate places. She has been treated periodically for recurrent UTI's. Res. has been easily redirected and continues to wander. INTERVENTIONS: . . . Behavioral monitoring continues." * 01/10/11 at 10:00 p.m.: "Resident did not eat supper & even [sic] needed lots of encouragement to drink. Did go into one other room tonight and sat in the recliner in that room. Did hold her abd [abdomen] but she didn't answer when asked if she had pain. Did take a lot of encouragement to get her out of the room. . . ." * 01/12/11 at 2:00 p.m.: ". . . Resident alert, with confusion - does wander in and out of other residents rooms, laying in other resident's beds, and sitting in their chairs. Resident is difficult to redirect at times. Resident gait is unsteady at times, she does also shuffle. Resident can be difficult at times for cares, requires total assistance with toileting, she is incontinent of bowel and bladder. Resident will not always make needs known, will respond to simple yes and no questions." * 01/15/11 at 9:30 p.m.: "Staff found Res. sitting in another Resident's room sitting on buttock laying up against corner, assessed for injuries per nurse. No injuries noted . . ." On the morning of 02/24/11, an administrative staff nurse (#2) stated the resident sat on the floor, and the report did not identify the resident's room the fall occurred in.	F 250		

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F 250	Continued From page 48	F 250		

Record review identified the following:
* Resident #1 with on-going wandering behavior throughout the facility, either into other resident's rooms or other areas of the facility
* consistent staff difficulty redirecting Resident #1 when she wandered including removing her from other resident's rooms
* wandering related to Resident #1's basic need for toileting, including bowel and bladder function, even though the record identified she was on a toileting schedule. The record lacked identification of changes in the toileting schedule when these incidents occurred.
* Resident #1 with severe cognitive impairments, "short attention span," and staff attempts to utilize "education," "Reality orientation," and expecting the resident to "answer appropriately," and "express understanding." The charting identifies staff lacked a differentiation and understanding between reality orientation and validation therapy for residents with severe cognitive deficits.
* a care plan that failed to identify the problem of the resident being combative during cares and include approaches

The record lacked pertinent information necessary to track and trend Resident #1's behavior including:
* the specific resident's room (identified by a confidential identifier number) she fell in on 01/15/11 to determine the possible cause of the fall
* the specific resident rooms (by confidential resident identifier numbers) she wandered to

- Review of Resident #11's medical record occurred on February 23-24, 2011. Diagnoses included severe dementia and depressive

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F 250	Continued From page 49 disorder. An annual MDS review, dated 11/17/10, identified the resident with severe cognitive impairment, physical and verbal behavioral symptoms directed toward others, other behavioral symptoms directed toward others, and daily wandering. The MDS identified the wandering places the resident at significant risk of getting to a potentially dangerous place, and significantly intrudes on the privacy of activities of others, and the wandering behavior as unchanged from the the prior assessment. Review of Resident #11's medical record included entries (family communication notes, social service progress notes, interdisciplinary progress notes, quarterly status notes) dated between 05/25/10 and 02/11/11 including: frequently wandering throughout the facility and into other resident's rooms, found in another resident's room being kissed by a male resident due to her wandering behavior, spitting and/or striking out at residents, attempting to and actually biting residents and staff, running her wheelchair into other residents, and slapping staff during cares. Refer to F 224. Resident #11's care plan lacked the inclusion of identifying factors that caused Resident #11 to wander, become angry, run her wheelchair into people, and what type of interventions can be utilized to avoid these behaviors from occurring. An interview occurred on the morning of 02/24/11 with three administrative staff members (#2, #5 and #6). The staff members identified the facility does not do any specific behavior monitoring, tracking, trending, and analyzing of resident behaviors including assessing the specific behaviors for causative/precipitating factors, to	F 250		

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F 250	Continued From page 50 assist in developing and implementing interventions specific to the individualized behaviors, and evaluate resident's responses to those interventions on an ongoing basis. The staff members stated the facility has a behavior management committee, but the committee does not keep minutes. In addition, the staff members stated the facility had no policies on wandering residents, other than the elopement policy.	F 250	F371 1. How corrective action will be accomplished for item affected a. Sanitized the internal components of the ice machine on 3/9/11 2. How ID items having potential to be affected a. This is the only ice machine in the facility 3. Measures or systemic changes a. Maintenance and cleaning will be completed twice a year. The ice storage bin will be sanitized quarterly as per manufacturers recommendations. 4. Completion Date ~~3/31/11~~. 4/7/11 5. Monitoring performance for sustained solutions, QA plan a. QA coordinator will follow up in June to determine if the schedule is being followed.	4/7/11
F 371 SS=C	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on manufacturer's guidelines and staff interview, the facility failed to sanitize the internal components of the ice machine as recommended for 1 of 1 ice machine in the facility. Failure to ensure proper sanitization of the ice machine has the potential to cause foodborne illness and can affect all residents who use ice from the machine. Findings include: Review of the manufacturer's guidelines for the Scotsman Nugget Ice Maker-Dispenser occurred on 02/24/11. The guidelines stated, ". . . Maintenance and Cleaning should be scheduled	F 371		

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F 371	Continued From page 51 at a minimum of twice per year. Sanitizing of the ice storage bin should be scheduled for a minimum of 4 times a year. . . ." During the environmental tour on 02/24/11 at 10:30 a.m., the environmental services director (#1) stated the facility does not clean or sanitize the inside of the ice machine. The staff member (#1) stated she was unaware of the manufacturer's guidelines.	F 371		