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| F 000 | INITIAL COMMENTS<br><br>For the standard Medicare/Medicaid recertification survey started on October 20, 2014 and completed on October 23, 2014, the sample included 2 residents for complete review, 8 residents for focused review, and 1 closed record for review. | F 000 | Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. For the purposes of any allegations that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual. | |
| F 250 SS=D | 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE<br><br>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, review of facility policy and procedure, and staff interview, the facility failed to provide medically related social services to assist 2 of 4 sampled residents observed with behaviors (Resident #2 and Resident #8) to attain or maintain their highest practicable physical, mental, and psychosocial well-being possible. Failure to provide interventions for Resident #8 regarding her exit seeking and suicidal comments and ideations placed her at risk of self harm and injury. Failure to track and trend Resident #2's behaviors, identify specific residents involved in confrontations with Resident #2, and provide specific interventions for the resident's behaviors placed Resident #2, other residents, staff, and visitors at risk of injury and continued behaviors.<br><br>Findings include: | F 250 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Rita J Roffey | Administrator | 12-1-14 |

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

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| F 250 | Continued From page 1<br><br>Review of the facility policy and procedure, "Behavioral Causes and Interventions," occurred on 10/23/14. This document stated "PURPOSE: To aid in determining causes of behavior and appropriate interventions and strategies<br>CAUSAL FACTORS OF BEHAVIORS . . .<br>Is the behavior related to the resident's physical or emotional health? . . .<br>Is the behavior related to the environment? . . .<br>Is the behavior related communication? . . .<br>Is the behavior related to declining ability to perform tasks? . . .<br>Is the behavior related to the caregiver's approach? . . ."<br><br>- During the initial facility tour, on 10/20/14 at 1:15 p.m., observation identified Resident #2 propelling her wheelchair in the halls and approaching doors to other residents' rooms. Observation identified a velvet covered rope across a room doorway. When asked, a facility management staff member (#1) reported the facility used the rope to limit Resident #2's access to the room.<br><br>During the initial tour, on 10/20/14, observation also identified Resident #2 approached another resident's doorway and that resident "shooed" Resident #2 away from the door.<br><br>During interview, on 10/20/14 at approximately 2:10 p.m., a facility management staff member (#1) reported Resident #2 sits in her wheelchair in the hallway and attempts to kick or trip residents, staff, or visitors passing by.<br><br>Review of Resident #2's medical record occurred on October 20-23, 2014. The facility admitted the | F 250 | F250<br><br>Care plan for resident #2 has been reviewed and updated with specific interventions to address her behaviors. Care plan for resident # 8 has been updated with specific interventions to address exit seeking and suicidal ideations.<br><br>All residents that trigger on care watch for "behavior affecting others" have the potential to be affected in this area. The care plans will be reviewed for each resident to ensure that all behaviors have specific interventions. A **system change** has been made for EMR documentation for these residents. CNA's will be required to document every shift and PRN on these residents.<br><br>The social service director will analyze all documented behaviors weekly to note trends and will track progress with a progress note in the EMR. Mood and behavior interventions will be reviewed and care plans updated to ensure specific interventions are in place.<br><br>The QA Coordinator/Social Service Director will implement a Project Improvement Planning Team (PIP) that will assist the quality assurance team to focus on residents with behaviors. All | 12/07/14 |

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| F 250 | Continued From page 2<br>resident in August 2012. Current diagnoses included dementia and anxiety. The annual Minimum Data Set (MDS), dated 08/25/14, identified short and long term memory problems, inattention and disorganized thinking behaviors fluctuated, physical (hitting, kicking, abusing others) and verbal (threatening, screaming, cursing at others) behaviors occurred on one to three days during the seven day assessment period, wandering occurred daily with a significant risk to the resident, behaviors worsened since the prior assessment, dated 05/26/14, and locomotion on and off the unit required limited or extensive assistance of one person.<br><br>Resident #2's physician orders included the following and the date initiated:<br>*Secure care bracelet, 10/23/13<br>*Lorazepam (Ativan) 0.5 milligrams (mg), one tablet by mouth every hour, as needed (prn) for anxiety, 10/21/13<br>*Zoloft 50 mg, one tablet by mouth, daily for depression, 09/04/14<br><br>Physician progress notes identified the following:<br>*08/06/14 - ". . . The last 2 months have shown an increase in resistiveness to cares, with bathing, clothes changing. On occasion, the patient will hit out. . . ."<br>*08/27/14 - ". . . concern about escalated aggressive behavior. . . . without warning the patient will become viciously aggressive. She will reach out, grab people, attempt to hit them and be very, very angry. . . ."<br><br>Nurse's progress notes identified the following:<br>*07/12/14, 4:21 p.m. - ". . . Has been wandering up and down the halls and redirected from going into other residents rooms. . . ." | F 250 | residents with documented behaviors will be reviewed to ensure that the resident's mood and behavior is addressed on the care plan with specific interventions. The team will analyze the charting to look for trends and root cause. Specific interventions will be added to the care plans as necessary and the effectiveness will be evaluated. The team will meet weekly for one month, then bi-weekly for one month and then monthly for two months. At that time the team will evaluate the need to continue or if tracking and trending behaviors and implementing interventions can be assigned to the Quality of Life committee.<br><br>The nursing department and care team will receive education to review the "Behavior Causes and Interventions" policy and receive education on behaviors, interventions, documentation and communication.<br><br>Utilizing the list of triggered residents that are identified as having the potential to be affected in this area, the DON or designee will audit four residents care plans per month for four months to ensure the resident has specific interventions for all behaviors identified.<br><br>Results of the audits will be reviewed by the QA committee for recommendations and/or follow-up. | |

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| F 250 | Continued From page 3<br>*07/30/14, 12:28 a.m. - "Lorazepam tablet 0.5 mg . . . for anxiety . . . Resident pushing staff away, running into other residents with w/c [wheelchair], running into walls with w/c. Food, fluids given. 1:1 [one to one] with staff prior to medication."<br>*08/22/14, 10:01 a.m. - "Residient [sic] grabbed the med [medication] cart and yelled 'that's mine, go away'. When I tried to pull the cart away she started to swing at me with a bottle and walkie talkie, then started to kick. I asked for help and 2 staff came to help. She then proceeded to kick and yell and grab at the staff . . . went towards another resident grabbed her arm and swapped at her legs. Family called and they are coming to see her. Tried 3 times to get her to take prn ativan for behaviors."<br>*08/22/14, 11:24 a.m. - "Very aggressive with staff and residents. She has been hitting, yelling, pinching, slapping, trying to throw things . . . she took an ativan in pudding. . . ."<br>*08/22/14, 1:39 p.m. - "Aggressive behavior and hitting out towards staff and one altercation towards a resident. She was redirected. 1:1 visitation with staff. . . ."<br>*09/12/14, 9:45 p.m. - "Talked to son about incident of resident being hit on shoulder by another resident and that it was unprovoked, and that his mother is doing fine and denies pain."<br>*09/21/14, 3:51 p.m. - "Resident aggressive towards staff memebers [sic], as well as fellow residents. . . . Has attempted to kick another resident's wheelchair. Staff has been able to redirect resident . . ."<br>*10/07/14, 9:49 p.m. - "Resident aggressive towards staff members as well as residents, attempting to kick other residents wheelchairs, we redirected her away from residents . . . She sat next to the TV away from others, and behaviors have lessened. . . ." | F 250 | | |

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| F 250 | Continued From page 4 | F 250 | | |

The nurse's progress notes failed to identify the residents involved in these altercations.

Review of the the facility's investigation of the incident on 09/12/14 stated the following:
"Nursing Description: Resident was in her w/c and another resident came up behind her and hit her on the shoulder with his hand in a hacking like motion causing this resident to cry. No injury noted. No bruising or redness. . . .
Level of Pain: Hurts a Little More . . .
Notes, 09/12/04, [untimed], This nurse was informed of resident being hit on her left shoulder just minutes following the interaction with the aggressive resident who hit her on the shoulder. Examined left shoulder. No evidence of any pain. Resident was dosing [sic] in her w/c. No bruising, no swelling, and no pain evidenced thru palpation of shoulder. . . . Residents were separated at the time of the incident by nursing staff."
The investigation failed to identify the resident who struck Resident #2.

Resident #2's behavior documentation showed verbal and physical behaviors directed towards others, however failed to identify specific residents or staff involved.

Resident #2's current care plan, revised 08/28/14, stated "Focus, The resident is resistive to care R/T [related to] dementia . . . can hit out or become upset with staff when attempting cares. . . . Interventions, If resident resists with ADL's [Activities of Daily Living], reassure resident, leave and return 5-10 minutes later and try again. Provide 1:1 visit. Attempt non-pharmacological interventions, speak in soft calm voice, don't rush, offer music, reapproach, if in agitated state attempt to direct to a quiet setting, offer warm

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| F 250 | Continued From page 5<br>blanket."<br><br>Observation on all days of survey showed Resident #2 self propelled her wheelchair throughout the halls of the facility and approached the doorways of resident rooms other than her own.<br><br>During interview, on 10/23/14 at 8:00 a.m., two management staff members (#2) and (#3) verified resident behaviors directed toward staff or residents are not always identified and the facility did not track and trend resident altercation information.<br><br>Failure to identify residents involved in altercations with Resident #2 limited the facility's ability to identify patterns of behavior by the resident or directed towards the resident and develop appropriate interventions.<br><br>- Observation on 10/21/14, at 10:50 a.m., showed Resident #8's in the dining room visiting another resident. Resident #8 stated, "They just left me here." The other resident said something, and Resident #8 said she wanted to cry, left the table, and propelled herself from the dining room. An unidentified staff member returned Resident #8 to her place at the table, poured a glass of water, and gave it to the resident. As Resident #8 ate her dessert she stated, "I should throw myself in the river." Observation after the meal showed Resident #8 consumed only the dessert, she did not consume the egg, slice of toast, tomato juice, or chocolate beverage served. She did drink part of the glass of water.<br><br>Review of Resident #8's medical record occurred on October 22-23, 2014. Current diagnoses | F 250 | | |

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| F 250 | Continued From page 6 | F 250 | | |

included anxiety state, senile dementia with delirium, and depression. A quarterly MDS, dated 10/04/14, identified the resident had long and short term memory problems, experienced mood indicators of feeling down, depressed, hopeless and being short-tempered, easily annoyed 7 to 11 days, and experienced delusions without other behaviors.

Resident #8's physician orders included the following and the date initiated:
* Secure care bracelet to wheelchair, 04/16/14
* Lorazepam (Ativan) 0.5 mg every four hours prn for severe anxiety, 08/06/14
* Lorazepam 0.25 mg every four hours prn for mild to moderate anxiety, 08/06/14
* Lorazepam 0.25 mg every day for anxiety, 08/11/14
* Sertraline HCL (hydrochloride) 50 mg for depression, 06/04/14

Physician progress notes identified the following:
* 08/06/14 ". . . seen between recertification visits for concern about increased anxiety and agitation. This started about 2 weeks ago after a room change. There are times in the day when she is calm and comfortable, other times for no apparent reason she will get very anxious, paranoid, and yell at staff . . . but there are times when nothing seems to help much. . . . Assessment and Plan: Intermittent agitation of uncertain etiology. I think we will make a dose change for lorazepam. . . ."
* 09/10/14 ". . . Now again in the last weeks the patient is more angry and irritable in the evening. . . . We are using lorazepam on a p.r.n. basis, but that is not consistently effective. . . . As I talk with the patient, she is comfortable but later, as I see her in the hall, she is complaining and does seem

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| F 250 | Continued From page 7 | F 250 | | |

somewhat irritable. Hard to say if this is actually a function of depression or not. Certainly, in my view, she seems to have done somewhat better with a dose of sertraline. . . ."

Nurse's progress notes identified the following:

* 04/11/14, 1:02 p.m. "Resident went to the door in the north parlor and was able to get the door open and tried to go outside. Was half way out when writer was able to stop her and bring her back in."
* 04/15/14, 11:04 a.m. "Resident tried to leave the building 2 times this morning. Was redirected."
* 05/01/14, 6:28 p.m. ". . . kicking parlor exit door . . ." prn lorazepam administered.
* 05/07/14, 5:42 p.m. "yelling, exit seeking . . ." prn lorazepam administered.
* 06/01/14, 11:34 a.m. "Res is very adamant about leaving the building, she is yelling at staff, wants to call the 'company' to get her out of here. . . . She doesn't understand why she is kept locked in here. . . ." prn lorazepam administered.
* 06/07/14, 6:04 p.m. "agitated refused supper yellin (sic) exit seeking . . ." prn lorazepam administered.
* 06/09/14, 10:06 a.m. "Res has been going to each door in facility to try to leave. She has asked all staff to help her leave. Res is angry, sad, and anxious. . . . All interventions have been ineffective. She says, 'I would like to crawl in a hole. Nothing can help me feel better." . . ." prn lorazepam administered.
* 06/09/14, 6:01 p.m. "Resident anxious and exit seeking" prn lorazepam administered.
* 07/18/14, 3:00 p.m. "Res has been yelling at staff, visitors, and residents. . . . She is talking about being killed and is very unhappy. . . ." prn lorazepam administered.

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| F 250 | Continued From page 8<br>* 07/20/14, 2:17 p.m. ". . . resident was wandering into another residents room, was redirected into her own. irritated by the acknowledgement that she has a room-mate and stated 'how long do I have to put up with her'. . . . 'i'm just going to go out these doors and go left'. . . ."<br>* 08/05/14, 12:58 p.m. "Res is very upset, yelling at staff about being dumb, rummaging through her things, threatened to call the police. She heard the constructions workers outside her room and thought people trespassing. Threatening to kill others and saying staff will 'slit her throat.' She is also directing this to residents as well." prn lorazepam administered.<br>* 08/06/14, 3:11 p.m. "Res is yelling at the top of her lungs about getting help, she can't find her mother, that she is going to hurt someone, screaming that she is going crazy, etc. . . ." prn lorazepam administered.<br>* 08/06/14, 4:55 p.m. "[Resident #8] is upset shouting things about peoples siblings, asking where hers are, and stating if she doesn't get out of here she is going to burn the whole place down. . . ." prn lorazepam administered.<br>* 08/10/14, 1:25 p.m. "Res has been agitated and also sad. She is trying to find a way to get home. She has been demanding that someone help her (staff, residents, and visitors). She has been exit seeking. . . . Resident then saying, 'I don't know why I don't kill myself.' 'I'm going to go outside and lay in the road.' She has asked staff to 'take me outside and choke me.' . . . Emotions are fluctuating rapidly. . . ." prn lorazepam administered.<br>* 10/21/14, 11:20 p.m. "Resident sitting in her w/c in the North Lounge yelling loudly for the police. Resident also hallucinating- seeing people who were not present. Set door alarm off x 2 [two | F 250 | | |

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| F 250 | Continued From page 9<br>times] by pushing on the bar to try [and] open the door. . . ."<br><br>The care plan failed to identify Resident #8's exit seeking and suicidal ideations and provide interventions for staff to use in assisting the resident to cope with her feelings. Refer to F 280.<br><br>During an interview, on the morning of 10/23/14, facility administrative staff members (#2 and #3) identified the facility has not established a consistent program for the tracking and trending of behaviors.<br><br>Staff failed to assess and track/trend behaviors in an attempt to determine patterns and precipitating factors; to effectively manage Resident #8's behaviors, including exit seeking, suicidal ideation, and self harm; and to establish a comprehensive behavior management care plan including resident-specific behaviors with individualized interventions which were communicated to all staff; evaluate the effectiveness of the interventions in place; and recognize/assess the impact Resident #8's behaviors have on the well-being of other residents. | F 250 | | |
| F 278 SS=D | 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br><br>The assessment must accurately reflect the resident's status.<br><br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>A registered nurse must sign and certify that the | F 278 | | |

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| F 278 | Continued From page 10<br>assessment is completed.<br><br>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.<br><br>Clinical disagreement does not constitute a material and false statement.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), and staff interview, the facility failed to ensure the Minimum Data Sets (MDSs) accurately reflected the resident's status for 1 of 10 sampled residents (Resident #8) coded incorrectly on the MDS. Failure to code portions of the MDS correctly does not provide an accurate assessment of a resident's current status and needs and may prevent staff from developing an effective comprehensive care plan that meets the needs of the residents.<br><br>Findings include: | F 278 | F278<br><br>Section E0100 of the MDS for resident #8 has been modified to reflect the charting and re-submitted to the state and CMS on 11/26/14.<br><br>All residents that trigger on section E0100 of the MDS have the potential to be affected. Audits of section E0100 of the MDS of 6 residents will be completed by the DON or designee to evaluate if the coding matches the charting. If any coding discrepancies are found, the MDS will be modified and re-sent to the state and CMS.<br><br>The Care Plan team will receive education on coding the MDS section E0100 by a nurse consultant from the Good Samaritan Society on 12/04/14.<br><br>Audits on section E0100 of the MDS's of 4 residents with documented behaviors will be conducted monthly by the DON or designee for four months to ensure coding accurately reflects the charting.<br><br>Results of the audits will be reviewed by the QA committee for recommendations and/or follow-up. | 12/07/14 |

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| F 278 | Continued From page 11<br>The Long-Term Care Facility RAI User's Manual Version 3.0, October 2013, stated the following:<br>* Page E-2 and E-3, "E0100: Potential Indicators of Psychosis . . . Coding Instructions . . . Code based on behaviors observed and/or thoughts expressed in the last 7 days rather than the presence of a medical diagnosis. Check all that apply. . . . Check E0100B, delusions: if delusions were present in the last 7 days. A delusion is a fixed, false belief not shared by others that the resident holds true even in the face of evidence to the contrary. . . . Coding Tips and Special Populations . . . If a belief cannot be objectively shown to be false, or it is not possible to determine whether it is false, do not code it as a delusion. . . . If a resident expresses a false belief but easily accepts a reasonable alternative explanation, do not code it as a delusion. If the resident continues to insist that the belief is correct despite an explanation or direct evidence to the contrary, code as a delusion."<br><br>- Record review for Resident #8 occurred October 22-23, 2014. A quarterly MDS, dated 10/04/14, identified the resident experienced delusions. Review of the medical record during the assessment period 09/28/14 through 10/04/14 failed to show Resident #8 experienced delusions.<br><br>During an interview, on the morning of 10/23/14, an administrative nursing staff member (#2) confirmed facility staff coded the MDSs incorrectly for Resident #8. | F 278 | | |
| F 280 SS=E | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>The resident has the right, unless adjudged | F 280 | | |

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| F 280 | Continued From page 12<br>incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, review of facility policy and procedure, and staff interview, the facility failed to develop and implement a comprehensive care plan for 5 of 10 sampled residents (Resident #2, #3, #4, #5, and #8). Failure to develop and implement care plans for these residents limited the residents' ability to reach their maximum physical, mental, and social well-being and placed them at risk regarding behaviors (Resident #2), falls and fall prevention (Resident #2, #3, and #4), oxygen saturation (Resident #4), pressure ulcer treatment (Resident #5), and suicidal ideations (Resident #8).<br><br>Findings include: | F 280 | F280<br><br>Care plan for resident #2 has been updated to include specific interventions for behaviors and interventions for falls and fall prevention. Care plan for resident #3 has been updated to include interventions for falls and fall prevention and monitoring and interventions for oxygen saturation levels. Care plan for #4 has been updated to include interventions for when the resident disconnects the bed alarm. Care plan for resident #8 has been updated to include specific interventions for dealing with suicidal ideations. Care plan for resident #5 has been updated to include interventions for pressure ulcer treatment.<br><br>All residents have the potential to be affected by an inadequate care plan.<br><br>The nursing department and care plan team will receive education on the importance of following and updating care plans. Instruction will be given on a **system change** that all resident concerns and interventions not on the care plan be documented in a communication book. This would include falls, behaviors, pressure ulcers, exit seeking, oxygen use, etc. The MDS coordinator will be responsible to review the notations in the communication book and update care plans with specific interventions twice a week and PRN. | 12/07/14 |

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| F 280 | Continued From page 13<br>Review of the facility policy and procedure, "Care Plan," occurred on 10/23/14. This document, revised January 2009, stated "PURPOSE: To develop a comprehensive care plan using an interdisciplinary team approach.<br>POLICY: Residents will receive and be provided the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment. Each resident will have an individualized comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial and educational needs. . .<br>Care plans will also be reviewed, evaluated and updated when there is a significant change in the resident's condition . . . This plan of care will be modified to reflect the care currently required/provided for the resident. . . .<br><br>PROCEDURE: . . . 6. Formulating The Care Plan, The care plan is driven by identified resident issues/conditions and their unique characteristics, strengths and needs. . . . 8. Reviews, Reassessments And Updates, a. Care plans are to be reviewed with each MDS [Minimum Data Set] completed if there is a significant change in the resident's condition . . ."<br><br>- Review of Resident #2's medical record occurred on October 20-23, 2014. The facility admitted the resident in August 2012. Current diagnoses included dementia and anxiety. The annual MDS, dated 08/25/14, identified short and long term memory problems, inattention and disorganized thinking behaviors fluctuated, physical (hitting, kicking, abusing others) and | F 280 | The MDS coordinator or designee will audit 6 resident care plans to ensure that all problems and specific interventions are on the care plan. Then monthly audits will be conducted by the MDS coordinator or designee on four charts for four months.<br><br>Results of the audits will be reviewed by the QA committee for recommendations and/or follow-up. | |

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verbal (threatening, screaming, cursing at others) behaviors occurred on one to three days during the seven day assessment period, wandering occurred daily with a significant risk to the resident, and behaviors worsened since the prior assessment, dated 05/26/14.

Resident #2's Mood/Behavior Care Area Assessment (CAA), dated 08/27/14, identified the resident was short tempered, resisting cares, and reaching out to grab other residents.

Resident #2's current care plan, revised 08/28/14, stated "Focus, The resident is resistive to care R/T [related to] dementia . . . can hit out or become upset with staff when attempting cares. . . . Interventions, If resident resists with ADL's [Activities of Daily Living], reassure resident, leave and return 5-10 minutes later and try again. Provide 1:1 visit. Attempt non-pharmacological interventions, speak in soft calm voice, don't rush, offer music, reapproach, if in agitated state attempt to direct to a quiet setting, offer warm blanket."

Resident #2's medical record showed eight altercations with other residents for the period, July 12, 2014 to October 22, 2014. (Refer to F250.)

The care plan failed to address Resident #2's behaviors directed toward other residents or behaviors by other residents towards Resident #2, and interventions for staff to manage those behaviors.

- Resident #2's annual MDS, dated 08/25/14, identified the resident required extensive assistance of one person for transfers, walking in

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room did not occur, walking in corridor required extensive assistance of two or more persons, and two or more falls occurred without injury.

Resident #2's current care plan, revised 09/02/14, stated "Focus, The resident is at risk for further falls R/T unsteady gait and needs to use walker or wheelchair . . . Interventions, Encourage resident to participate in activities. Ensure that resident is wearing appropriate footwear when ambulating. Monitor resident for significant changes . . . Chair alarm . . . diversion and distraction . . ."

Observation of resident cares provided by facility staff showed staff members implemented the following fall prevention interventions not identified on the care plan: Resident #2 not left alone in her room while seated in her wheelchair; a low bed; and, a body pillow in bed.

- Review of Resident #3's medical record occurred on October 20-23, 2014 and identified Resident #3 experienced three falls between September 13, 2014 and October 22, 2014.

Resident #3's current care plan, dated 10/16/14, stated "Focus, The resident has had an actual fall with no injury R/T transferring self . . . Interventions, Ensure that resident is wearing appropriate footwear. Monitor resident for significant changes . . . Review bowel continence . . . and toileting plan."

Observations throughout the survey showed the facility staff implemented the following fall prevention interventions not identified on the care plan: a bed alarm, a low bed, and a fall mat.

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- Resident #3's current diagnoses included chronic obstructive pulmonary disease (COPD), shortness of breath, and anxiety. Physician orders included oxygen at 2 to 4 liters per minute via nasal cannula as needed for respiratory distress related to shortness of breath, dated 10/12/14. The medical record included weekly monitoring of oxygen saturation levels.

Resident #3's current care plan, dated 07/18/14, stated "Focus, The resident has COPD . . . Interventions, Monitor for difficulty breathing (Dyspnea) on exertion. . . . Monitor/document/report to health care provider prn any s/s [signs/symptoms] of respiratory infection . . . Monitor for s/s of acute respiratory insufficiency . . ."

Observations throughout the survey showed the facility staff intermittently administered oxygen to Resident #3 from an oxygen tank on his wheelchair and from an oxygen concentrator at his bedside.

Resident #3's care plan failed to include Interventions regarding oxygen for the resident or monitoring of his oxygen saturation levels.

During interview, on 10/23/14 at 8:00 a.m., two management staff members (#2) and (#3) agreed the care plans for Resident #2 and #3 should include interventions previously identified.

- Review of Resident #8's medical record occurred on October 22-23, 2014. Current diagnoses included dementia, anxiety state, senile dementia with delirium, and depression. A quarterly MDS, dated 10/04/14, identified the resident had long and short term memory

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problems, experienced mood indicators feeling down, depressed, hopeless and being short-tempered, easily annoyed 7 to 11 days, and experienced delusions without other behaviors.

Resident #8's current care plan, revised 10/10/14, stated, "Focus . . . The resident has impaired thought process R/T dementia E/B disorganized thinking and confuses family members as may have story correct but relationship mixed up as will talk about her sons but call them 'brothers' or when discussing death of daughter refers to her as 'mother' Has been attempting to leave facility unaware of safety needs. . . . Goal . . . Resident will be safe in their own environment as evidenced by not going outside unattended. . . . Interventions . . . Resident needs assistance with all decision making. . . . Communication: Reduce any distractions- turn off TV, radio, close door. Personal Alarm: secure care used to alert staff to resident's movement and to assist staff in monitoring movement. . . . Focus . . .The resident has depression and anxiety R/T dementia E/B need for medication. . . . Goal . . . Resident will exhibit indicators of depression, anxiety or sad mood less than daily by review date. . . . Interventions . . . Give resident adequate rest periods. Resident prefers, to lay down after brunch. Discuss with resident/family any concerns, fears, issues regarding health or other subjects as they arise. Resident's activities of choice are: visiting, devotions, communion & worship services, word games, reminisce, current events, parties & special events. Invite/Remind/Encourage her to attend. Non-pharmacological: Attempt non-pharmacological interventions such as offer warm blanket, 1:1 visits, go out in courtyard, activity of interest."

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Nursing documentation showed Resident #8 had made previous statements of wishing to harm herself, including suicidal ideations. (See F 250.)

The care plan failed to identify Resident #8's suicidal ideations and provide interventions for staff to use in assisting the resident to cope with her feelings.

- Review of Resident #5's medical record occurred on October 20-23, 2014. Current diagnoses included aftercare following joint replacement, restless leg syndrome, diabetes, and neuropathy. A significant change MDS, dated 10/13/14 identified intact cognition, and healed pressure ulcer.

Observation of Resident #5's left heel, on 10/23/14, at 10:50 a.m., showed a black/brown scabbed area the staff nurse (#5) measured as 2 cm (centimeters) by 3.5 cm. The nurse (#5) and Resident #5 identified this heel ulcer as present since the resident's hospital stay in April 2014. The nurse (#5) identified the resident wears prevalon relieving boots (a type of pressure relieving device) at night to promote healing.

Resident #5's current care plan, revised 10/14/14, stated, "Focus . . . The resident has potential for pressure ulcer development R/T diabetes, neuropathy, decreased mobility . . . Goals . . . Resident will have no further skin issues through review date . . . Interventions . . . Provide pressure reducing device on bed, chair. Notify nurse of any areas of skin breakdown: redness, blisters, bruises, discoloration, etc. noted during bath or daily care."

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The care plan failed to identify Resident #5's current pressure ulcer to the left heel and specific interventions for care and treatment to promote healing.

- Review of Resident #4's medical record occurred on October 20-23, 2014. Current diagnoses included left hemiplegia and epilepsy. A quarterly MDS, dated 09/15/14, identified moderately impaired cognitive abilities, extensive assistance of two or more staff members for bed mobility, extensive assistance of one staff member for transfers, and the resident experienced one fall which resulted in a non-major injury.

Resident #4's current care plan, revised 09/18/14, stated, "Focus . . . The resident is at risk for falls R/T CVA with left hemiparesis E/B needs assist, uses w/c [wheelchair] and cane. Resident on floor on [five dates identified] . . . Interventions . . . Monitor position of resident in bed on rounds at night and move away from edge of bed as needed. Personal Alarm: bed alarm used to alert staff to resident's movement and to assist staff in monitoring movement."

During the initial tour, on 10/20/14 at 1:45 p.m., an administrative staff member (#3) identified Resident #4 frequently disconnects the personal alarm.

During observations of Resident #4's room on 10/20/14 at 1:45 p.m., 10/21/14 at 10:15 a.m., and 10/21/14 at 3:10 p.m., the personal alarm laid disconnected on the floor next to the bed.

Record review showed Resident #4 experienced falls. Notes showed the resident's personal alarm

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| F 280 | Continued From page 20<br>did not actuate on occasion due to Resident #4 disconnecting the bed alarm.<br><br>The care plan failed to identify Resident #4 disconnects the personal alarm, thereby affecting the monitoring in place to assure the resident's safety. | F 280 | | |
| F 441 SS=D | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted | F 441 | | |

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| F 441 | Continued From page 21<br>professional practice.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, review of policy and procedure, and staff interview, the facility failed to ensure staff followed infection control practices for 1 of 1 supplemental resident (Resident #12) observed receiving blood glucose checks. Failure to disinfect the glucometer has the potential to spread infection to residents and staff.<br><br>Findings include:<br><br>Review of the "Cleaning and Disinfecting Blood Glucose Meters" procedure occurred on 10/22/14. The procedure, dated 11/11, stated: ". . . Clean the outside of the meter with a lint free cloth dampened with soapy water or isopropyl alcohol . . . Disinfecting . . . To disinfect the meter . . . use . . . Sani-Cloth Germicidal Disposable Wipe. . . ."<br><br>During observation on the morning of 10/21/14, a nursing staff member (#4) obtained a glucose meter from a bin in the treatment room and performed a glucose check on Resident #12. Following the procedure, the nurse cleaned the meter with an alcohol wipe and returned it back into the bin for use on other residents.<br><br>During interview on the afternoon of 10/21/14, an | F 441 | F441<br><br>Nursing staff member #4 has been re-educated on the procedure to clean the blood glucose meter. Resident #12 was not adversely affected by the inadequate cleaning.<br><br>All residents that have physician orders for blood sugar monitoring have the potential to be affected. Nurses were re-educated on the procedure "Cleaning & Disinfecting Blood Glucose Meter" at a nurses meeting on 11/13/14.<br><br>The list of residents identified as having the potential to be affected will be used for identification of residents for random quality audits to ensure staff is cleaning the blood glucose machine between residents.<br><br>The DON or designee will perform audits on staff members ensuring proper cleaning of the blood glucose meter between residents. The DON or designee will audit three residents weekly for two weeks, then three weekly for four weeks, then three monthly for three months.<br><br>Results of the audits will be given to the QA committee for review and follow-up. | 12/07/14 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355097 | A. BUILDING _____ B. WING _____ | 10/23/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - LARIMORE | 501 E FRONT ST LARIMORE, ND 58251 |

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|---|---|---|---|---|
| F 441 | Continued From page 22<br>administrative nurse (#2) stated the expectation is to clean the meter with a super sani-cloth wipe, and not an alcohol wipe. | F 441 | | |