STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355044	A. BUILDING _____ B. WING _____	08/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTRAIL BETHEL HOME	615 6TH ST SE STANLEY, ND 58784

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey, started on 08/13/12 and completed on 08/16/12, the sample included three (3) residents for complete review, nine (9) residents for focused review, and two (2) closed records for review. The sample included four (4) additional residents to verify specific concerns during the survey.	F 000		
F 248 SS=E	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, record review and staff interview, the facility failed to provide an ongoing, meaningful activity program to meet the physical, mental, and psychosocial needs for 4 of 5 sampled residents (Resident #1, #2, #3, and #4) dependent on staff for activities and identified by the facility with a diagnosis of dementia and behaviors. Failure to provide meaningful activities designed to reflect each resident's interests and lifestyle has the potential to increase residents' behaviors and negatively impact a resident's sense of self-worth and belonging. Findings include: Review of the facility's activity calendar for the week of survey identified the following activities:	F 248		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kris Braun
TITLE: Administrator
(X6) DATE: 9/17/2012

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 248	Continued From page 1 * Monday, August 13th - 9:00 a.m. Exercise, 11:00 a.m. Memories, 2:30 p.m. Bible Study, 3:15 p.m. Rhythm Band, 6:45 p.m. Evening activity * Tuesday, August 14th - 9:00 a.m. Exercise, 10:30 a.m. Women's Club, 1:00 p.m. One-to-One visits, 2:30 p.m. Bible Trivia, 3:15 p.m. Sing-A-Long, 6:45 p.m. Karoke * Wednesday, August 15th - 9:00 a.m. Exercise, 10:00 a.m. Nail Polishing, 2:00 p.m. Coffee, 2:30 p.m. Bingo, 6:45 p.m. Sing-A-Long *Thursday, August 16th - 9:00 a.m. Exercise, 11:00 a.m. Current Events, 1:30 p.m. Chapel Services, 2:00 p.m. Bingo, 5:00 p.m. Mass - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included depression, anxiety, dementia with delusional features and behavioral disturbance, and episodic mood disorder. The quarterly MDS, dated 06/12/12, identified the resident sometimes makes himself understood and sometimes understands others, short and long-term memory problems, severely impaired decision making, fluctuating inattention and disorganized thinking, and no mood or behavior problems. This MDS identified the resident required extensive assistance of one staff member for transfers and limited assistance of one staff member for ambulation. The admission MDS, dated 09/22/11, identified music and animals as very important activity preferences and group activities and going outside as somewhat important. The current care plan stated, ". . . Problem, Cognition: [Resident #2] has a dementia diagnoses . . . Approaches: . . . may have difficulty focusing and is easily distracted. He likes country music and anything to do with cattle	F248	1. The three residents (Resident #2, 3, and 4) that were affected had their activity assessments reviewed and activity care plans were reviewed and care plan updated. Resident #1 expired. 2. Any resident with the diagnosis of dementia has the potential to be affected as well as any resident that does not come out of their room for activities. 3. Forms were developed to document activities and 1:1 activities as well as refusals. Activity staff were instructed on forms. Documentation is done per shift. 1:1 activity will be done 3-5 times per week and as needed. Activity staff, volunteers and nursing staff were educated on allowing resident's with advanced dementia to participate in group activities as they are able. Individualized activity plans will be developed using tools such as the "activities by GDS levels" for those residents that have dementia. (GDS=Global Deterioration Scale) 4. QA will be done monthly X3 months and then quarterly for one year on activities plans and documentation. Activity staff, specifically Activity Director will monitor performance. 5. Corrective Action complete:	8/27/2012 9/1/2012 8/20/2012 9/17/2012 9/17/2012

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or ranching on the television . . . [Resident #2] is not able to adjust the channels or sound on the TV [television], so you need to do this for him. He also needs assistance with his electric lift chair . . . Problem, Mood/Behaviors: [Resident #2] has a short attention span, may be resistive to redirection and cares. [Resident #2] is at risk for changes in mood r/t [related to] anxiety, depression, and unfamiliar environment. Impaired socialization due to dementia . . . Approaches, Inform, invite, and escort [Resident #2] to activity groups of past and present interest such as music, special events, reading groups, etc. He is a passive observer at most groups . . . Do not ask him if he wants to do something - tell him it is time for 'this or that' . . . He does well in Activities and seems to enjoy watching and being around others . . . Problem, Psychosocial well-being . . . He loves to watch Western movies and anything else that has to do with cattle and other animals . . . Problem, Activities: Low keyed and quiet activities are best for [Resident #2] at this time . . . Approaches: Provide 1:1 [one-to-one] visits in room when doing cares and whenever possible . . . Enjoys sitting in his chair in his room and watching channel 57 on TV whenever possible . . . Looks at the daily paper when he wishes . . . Problem, Spiritual: . . . Provide Church Services 2 x week [two times per week] and ask him if he would like to attend. Provide Bible study 2 x week and see if he would like to attend. Provide Pastoral visits. When there is time read stories out of the guideposts to him . . ." Resident #2's "Room Care Plan" identified the resident enjoyed visiting, going up and down the hallways, and country music. The facility failed to specify how often the one-to-one visits will be completed.

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Review of Resident #2's activity attendance during the week of survey showed the resident participated in "Sensory Stimulation, Exercise (at 9:00 a.m.), Socializing, Music, Rhythm Band (at 3:15 p.m.), and TV" on August 13th; "Socializing and Sensory Stimulation" on August 14th; and "Exercise (at 9:00 a.m.), Socializing, Sensory Stimulation, Sing-A-Long (at 6:45 p.m.), and Music" on August 15th. A note written on the activity attendance calendar stated, "In [and] out of Bingo on 08/15/12 (at 2:30 p.m.). Just checking things out [and] smiling [at] the people playing Bingo."

Observations on August 13-16, 2012 showed Resident #2, at meals; self-propelling throughout the facility in his Merry Walker; sleeping in the recliner in his room; sleeping while sitting in his Merry Walker in the hallway or living area; or observing the action around him while sitting in his Merry Walker in the hallway, the dining room, or the living area. Observations showed staff provided no group or individual activities to Resident #2 during the day. On August 13th when the "Rhythm Band" activity occurred, observation showed Resident #2 self-propelling in his Merry Walker in the hallway (the activity record identified he attended).

Observation on 08/15/12 at 2:20 p.m. showed Resident #2 self-propelled his Merry Walker into the dining room. An unidentified Bingo volunteer told the resident, "No, no you can't come in here." Resident #2 remained in the dining room. Observation at 2:30 p.m. showed volunteers handing out Bingo cards to the residents, however, the volunteer failed to give Resident #2 a card.

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On 08/16/12 at 12:05 p.m., an administrative nurse (#5) stated staff/volunteers should give Resident #2 a Bingo card and allow him to participate within his capacity.

Observation on 08/15/12 at 3:50 p.m. showed Resident #2 sitting in his Merry Walker in the dining room alone with all the doors to the dining room closed. The CNA (#15) who found the resident stated, "that always happens."

On 08/15/12 at 4:33 p.m., Resident #2 stopped this surveyor and asked, "Are you coming to read?" Then the resident stated, "I wish you would." An activity staff member (#3) who overheard the conversation told the resident she was reading in the activity room and asked him to come. Resident #2 responded with a non-sensical statement and then the staff member smiled, walked away, and never re-attempted to take the resident to the activity.

During an interview on 08/16/12 at 12:45 p.m., an activity staff member (#3) stated she completed a one-to-one activity with Resident #2 that morning for approximately 15 minutes looking at a farm and ranch magazine. This staff member stated she hadn't charted the activity yet.

The facility failed to provide Resident #2 with consistent and individualized activities appropriate to his current physical, mental, and emotional status and failed to re-approach the resident or use a different, creative approach when the resident declined or responded in a non-sensical manner when asked to attend activities.

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- Review of Resident #1's medical record occurred on all days of survey. Diagnoses included Alzheimer's dementia with behavorial disturbance, depression, and anxiety. The admission MDS, dated 07/31/12, identified the resident rarely makes himself understood, rarely understands others, short and long-term memory problems, severely impaired cognition, inattention, disorganized thinking, and altered level of conscious. This MDS identified mild depression, physical and verbal behaviors impacting himself and other residents, rejection of care, and wandering. This MDS showed activities important to the resident included music, animals, going outside, and religion. The resident required limited assistance of two or more staff members for transfers and extensive assistance of one staff member for ambulation.

The current care plan stated, ". . . Problem, Activities - resident confused and is sometimes difficult to direct . . . Approaches, Provide Wii Golf for resident and encourage to do his best - he does get frustrated at times with it. Encourage family and friends to take him out to the golf course when they have time. Try to interest [Resident #1] in short term activities because of short attention span - Provide 1:1 visits with [Resident #1] and see if there are things he may be interested in doing. Trial use of Merry Walker to grant him independence when he is restless/allow him freedom to roam . . . Problem, Spiritual - [Resident #1] is Catholic and enjoys going to Mass . . . Approaches, Encourage [Resident #1] to attend Mass on Thursday afternoons - Direct him in the direction of the chapel. Provide communion weekly . . . Problem,

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Psychosocial well-being . . . Approaches . . . Staff will assist [Resident #1] to activities or attempt to visit with him about golfing or hunting, to help him adjust and maintain his well-being . . . " Resident #1's "Room Care Plan" identified the resident enjoyed church, evening activities, and watching activities. The facility failed to specify how often the one-to-one visits will be completed.

Review of Resident #1's activity attendance during the week of survey showed the resident participated in "Sensory Stimulation" on August 14th and 15th (not observed) and was a passive participant in "Sing-A-Long" (at 6:45 p.m.) on August 15th.

Observations from August 13-16, 2012 showed Resident #1 either at meals; sitting in his room in his recliner, in his Merry Walker or wheelchair; laying in bed; or sitting in the living area in his Merry Walker or wheelchair. The resident slept on and off throughout each day. Observations showed staff provided no group or individual activities to Resident #1 during the day.

During an interview on 08/16/12 at 12:45 p.m., an activity staff member (#3) stated Resident #1 doesn't come to group activities, she hasn't done any one-to-one activities with him, and confirmed the facility lacked a record of Resident #1's July activities. This staff member identified Resident #1's main activity consisted of frequent visits from family and identified the facility lacked activities for residents dependent on staff to provide them.

The facility failed to develop an ongoing, meaningful, and individualized activity program designed to meet the current physical, mental,

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and psychosocial needs for Resident #1, #2, #3, and #4. 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, restlessness, and aggressive behaviors; decrease the need for the Merry Walkers and for psychotropic medications; and improve the residents' quality of life.

- Review of Resident #4's medical record occurred on August 13-16, 2012 and identified diagnoses of dementia, anxiety, and agitation. In May 2012, Resident #4 sustained a stroke and the provider ordered "Comfort Cares" on 05/08/12. Resident #4's significant change MDS, dated 05/11/12, identified the resident as sometimes capable of making herself understood and able to understand others, continuously displayed behavioral symptoms of inattention and disorganized thinking, fluctuation with altered level of consciousness, displayed physical and verbal behaviors four to six days during the assessment period, and required extensive two-person physical assistance with transfers.

Resident #4's current care plan, dated 06/12/12, identified the following: "Problem: ACTIVITIES: Current diagnosis make unable to come out of room. Goals: 1:1 with resident. . . Approaches: Hold [resident name] hand and make her feel comfortable.
Problem: Spiritually: Approaches: Provide pastoral visits. Read spiritual things to [resident name] for short periods of time. Hard for her to hear or understand." Resident #4's "Room Care

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Plan," (located in each resident bathroom and used by the CNA), identified activities of "1:1 very necessary" and church. The facility failed to specify how often the one-to-one visits will be completed.

Review of Resident #4's monthly activity calendars identified the resident received activities in her room on 21 out of 31 days in May 2012 and the activity calendar lacked documentation for 10 days in May (11-14, 17-20, and 27-28); 6 out of 30 days in June 2012 and the activity calendar lacked documentation for 17 days (4, 5, 7-10, 15, 19, 20, 22-27, 29, and 30), 31 out of 31 days in July 2012, and 11 out of 15 days in August (01-15) and the activity calendar lacked documentation for four days (August 9-12). Facility staff completed eight one-to-one visits with Resident #4 (on May 16, 29, and 30, June 11-14, and August 14).

The facility failed to provide Resident #4 with consistent and individualized activities appropriate to her current physical, mental, and emotional status.

- Review of Resident #3's medical record occurred on August 13-16, 2012 and identified diagnoses of senile dementia with delusional features, mood disorder, paranoid type schizophrenia, and osteoarthrosis. Resident #3's quarterly Minimum Data Set (MDS), dated 06/15/12, identified the resident as usually capable of making herself understood and able to understand others, continuously displayed behavioral symptoms of inattention and disorganized thinking, displayed verbal behaviors

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four to six days during the assessment period, mild depression, and required extensive one-person physical assistance with transfers.

Resident #3's current care plan, dated 06/21/12, identified the following: "Problem: Activities - capable of making own decisions but needs encouragement. Because of physical condition at times doesn't leave room often; slowly encourage to attend activities. Approaches: Provide monthly calendar in room. Inform resident of daily activities. Encourage resident to attend activities she may enjoy- She enjoys bingo and those types of games. Encourage resident to stay out in lobby for evening activity. Encourage to sit in lobby and visit and read the papers.
Problem: Spiritual - Important part of her social life. Encourage and assist to attend spiritual activities. Approaches: Provide church services Thursday afternoons at 1:30 [p.m.] and Sunday morning at 10:00 [a.m.]. Provide Bible study Monday and Tuesday afternoon at 1:30 [p.m.] Provide pastoral visits. Provide communion monthly." Resident #3's "Room Care Plan," (located in each resident bathroom and used by the certified nurse aide [CNA]), identified activities of church, bible study, bingo, baking, and evening activity.

On the afternoon of 08/15/12, observation showed several residents attending Bingo in the facility's dining room. Observation failed to show Resident #3 present and/or passively listening to the bingo activity in the dining room.

Resident #3's Activities Progress Notes stated: 03/21/12 - " . . . She complains that she hurts all over. Try to encourage her to attend activities so

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that she could limber up her bones and muscles and she just states that it is impossible to move, it hurts all over. She likes to take care of her own things, but complains that everyone is stealing from her all the time and that she can't keep anything . . . She claims her eye sight is so bad that she can't read anything. Music was ok to listen to but most of the time she just didn't feel like listening. Everything else just doesn't seem to matter to her because no one cares that she hurts all over."

06/15/12 - ". . . suffers from a lot of arthritis pain and she just doesn't want to get out of bed. She does go to activities when she is up and about. She enjoys bingo so we do our best to persuade her to go to both bingos during the week. She does not wish to attend church very often or attend Bible study. Once in awhile she will sit in the lobby and visit with others. Lately her vision has seemed to have gotten worse so it is a lot harder for her to read anything. There are times that we go to visit with her and she just doesn't want to talk to anyone. Her family comes to visit her once in awhile, she usually gets on their cases about getting her out of here when they do come. She has threatened to call the cops and she has when she thinks others are stealing her things. She is quite paranoid of her things being taken and she gets very anxious about it."

During interview on 08/15/12 at 3:00 p.m., an activity staff member (#3) stated the facility tracks/documents a resident's activity attendance and participation by highlighting the activities the resident attended on the monthly activity calendar.

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F 248	Continued From page 11 Review of Resident #3's monthly activity calendars identified the resident attended activities on 15 out of 30 days in June 2012 and the activity calendar lacked documentation of participation or refusal for six days (4, 5, 15, 24, 26, and 28); 21 out of 31 days in July 2012 and the activity calendar lacked documentation of participation or refusal for six days (July 7, 9, 16, 23, 24, and 26); and 5 out of 15 days in August (01-15) and the activity calendar lacked any documentation of participation or refusal for three days (August 9, 11, and 12). Resident #3 exhibited more complaints of pain and the medical provided adjusted (increased) the resident's pain regiment in July 2012. Resident #3's increased in pain could have resulted in the resident's decreased participation in the facility's activity program. Resident #3's current activity care plan identified spirituality as "important part of her social life," while the 06/15/12 Activity Progress Note stated the resident does not wish to attend church or Bible study. The facility failed to revise Resident #3's activity program to address her current preferences and failed to offer and/or provide specific in room activities or one-to-one visits to the resident.	F 248		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the	F 274		

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F 274	Continued From page 12 resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete a comprehensive assessment for 1 of 1 sampled resident (Resident #3) who experienced a significant change in physical and behavioral status. Failure to complete a comprehensive assessment in response to Resident #3's physical decline and mood/behavior changes placed this resident at risk for continued decline and the lack of appropriate interventions to restore or maintain physical and mental function. Findings include: The Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, April 2012, pages 2-20 through 2-23 states, "Significant Change in Status Assessment (SCSA) . . . is appropriate when: There is a determination that a significant change (either improvement or decline) in a resident's condition from his/her baseline has occurred as indicated by comparison of the resident's current status to the most recent Comprehensive assessment and any subsequent Quarterly assessments; and The resident's condition is not expected to return to	F274	1. One resident was affected by the deficient practice. A significant change MDS for decline was started on the resident involved. A significant change for improvement was initiated on 9/14/2012 for resident #3 that was affected. 2. Any resident that has a decrease or increase in two or more areas on the MDS may be affected. A weekly MDS meeting is held and each resident will be discussed to detemine if improvement or decline has occurred . Twice weekly a resident review meeting is held and MDS coordinator and Care coordinator will track any declines or improvements to ascertain whether a Significant Change MDS is needed via a Kardex system. 3. MDS Coordinator and MDS team will follow the RAI manual in regards to significant change MDS' Discussion was held with MDS Coordinator, MDS team and administrator on August 24, 2012. MDS Coordinator reviewed criteria for Significant change with MDS team on 9/20/2012 at MDS meeting 4. QA monitoring will be done monthly X3 and then quarterly. Monitoring will be done by Care Coordinator. 5. Corrective Action completed:	8/24/2012 9/14/2012 8/20/2012 8/24/2012 9/20/2012 9/20/2012

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baseline within two weeks . . . A SCSA is also appropriate if there is a consistent pattern of changes, with either two or more areas of decline or two or more areas of improvement. This may include two changes within a particular domain . . . Decline in two or more of the following: . . . increase in the number of areas where behavioral symptoms are coded as being present and/or the frequency of a symptom increases for items in Section E (Behavior); Any decline in an ADL [activity of daily living] physical functioning area where a resided is newly coded as extensive assistance . . . ."

Review of Resident #3's medical record occurred on August 13-16, 2012 and identified diagnoses of senile dementia with delusional features, mood disorder, paranoid type schizophrenia, and osteoarthrosis. An annual Minimum Data Set (MDS), dated 03/20/12, identified the resident displayed verbal behaviors one to three days during the assessment period, required supervision with bed mobility, and independent in walking, locomotion on unit, and toilet use.

Resident #3's quarterly MDS, dated 06/15/12, identified the resident continuously displayed behavioral symptoms of inattention and disorganized thinking, displayed verbal behaviors four to six days during the assessment period, required extensive one person physical assistance with transfers and toilet use, and limited one-person physical assistance with walking.

During interview on 08/15/12 at 4:00 p.m., an administrative nurse (#5) confirmed Resident #3 declined in transfers, toilet use, and behavioral

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F 274	Continued From page 14 symptoms and the MDS nurse inaccurately coded Resident #3's June 2012 MDS assessment. Failure to conduct the SCSA limited the facility's ability to assess, care plan, and implement approaches regarding in Resident #3's status.	F309	1. For the 5 residents that were affected by the deficient practice, memos were issued to staff on August 16, 2012 regarding non pharmological approaches and documentation of behaviors.	8/16/2012
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide the necessary care and services to manage behavioral and psychological symptoms of dementia (BPSD) for 5 of 9 sampled residents (Resident #1, #2, #3, #4, and #9) and 1 closed resident record (Resident #13) identified by the facility with behaviors and a diagnosis of dementia. The failure to identify target BPSD, assess the reason/causative factor(s) for behaviors, implement appropriate individualized interventions (including non-pharmacological interventions) and establish accurate on-going monitoring of the behaviors has the potential for these residents not to obtain their highest practicable physical, mental, and psychosocial well-being.		Nurse's meetings and aide meetings were held to discuss the need to document non pharmological approaches prior to giving PRN anti-psychotic medications and the correct documentation process for behaviors. 2. Any resident that is currently on an anti-psychotic medication that is ordered on a PRN basis has the potential to be affected. 3. A PRN anti-psychotic medication administration sheet was developed and includes non-pharmological approaches that need to be trialed before administering medications. Licensed social worker reviewed with nursing staff specifically the nurse's aides the blue behavior log sheets and the need to document on the back side anything that is check marked on the front. Residents on PRN anti-psychotic medications will have a more targeted behavior log sheet to attempt to identify causes of behavior and if non-pharmological approaches will be successful in decreasing or eliminating the behavior. Residents on PRN anti-psychotic medications have had their care plans reviewed and revised. Nursing staff were educated at meetings held on August 17, 2012 and August 21, 2012.	8/21/2012 9/1/2012 9/10/2012 9/15/2012 9/10/2012 8/21/2012

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F 309	Continued From page 15 Findings include: Review of the facility policy titled "Mountrail Bethel Home . . . Behavior Policy and Procedure" occurred on 08/16/12. This policy, dated March 2012, stated, "Policy: All behaviors that are deviant from the resident's usual behavior, including agitated behavior or social norms will be documented anc managed, to protect the rights and dignity of all residents and staff . . . Facility personnel shall make every attempt at using the least restrictive or intrusive methods, utilizing positive approaches to change the behavior . . . Procedures: 1. Assess whether the resident presents an immediate danger to self or others. . . . 3. All behaviors will be documented on the resident's behavior log, located in the ADL [activities of daily living] binder at the nurse's station. Targeted behaviors will be charted on by nursing staff for residents on antipsychotics and anti-anxiety medications . . . Behavior Intervention Guidelines: 1. Staff need to differentiate problematic behavior which is a sign of stress and efforts to cope, from "troublesome" behavior, which may be annoying to staff but is not potentially harmful to the resident or other residents. 2. For those who are cognitively impaired, reducing environmental stimuli and restructuring daily care activities for simplicity and repetition may be effective in reducing agitation or uncooperativeness . . . 9. All progress notes should reflect either the successful or unsuccessful interventions or change in behaviors."		5. QA, specifically the QA manager will monitor PRN medication sheets monthly X3 months then quarterly for one year to ensure that non pharmological interventions are being tried prior to administering PRN medications. QA, specifically the licensed social worker, will monitor blue behavior logs for completeness of documentation and the targeted behavior sheets for completeness	9/17/2012 9/17/2012

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- Review of Resident #3's medical record occurred on August 13-16, 2012 and identified diagnoses of senile dementia with delusional features, mood disorder, paranoid type schizophrenia, and osteoarthrosis. Resident #3's quarterly Minimum Data Set (MDS), dated 06/15/12, identified the resident as usually capable of making herself understood and able to understand others, continuously displayed behavioral symptoms of inattention and disorganized thinking, and displayed verbal behaviors four to six days during the assessment period.

Resident #3's current care plan, dated 06/21/12, identified the following: "Problem: MOOD AND BEHAVIORS: She continues to hide things and then does not remember that she did this. [name of Resident #3] triggers at this time for repetitive health concerns, due to recent arm fracture [May 2011] [name of Resident #3] may have periods of sadness/crying . . . Depression diagnoses with more signs/symptoms at this time; little interest in the happenings around her and at times she has trouble sleeping due to her arm hurting her . . . Approaches: . . . She will need things repeated and explained . . . will not remember what it is that you told her earlier and she will repeat her stories. Go slow and make sure she has understood and that she is comfortable with the situation . . . Due to [name of Resident #3] memory loss and confusion she has had several months where she has been very concerned that someone in her house is stealing from her and is wanting her out of the house. She also voiced fears of being alone, not feeling well, and of things missing from her home. These fears continue to be very real to [name of Resident #3]

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. . . When [name of Resident #3] is complaining of not feeling well and is viably upset let her stay in her room, do not make her come out to meals. Give medications as ordered by physician or psych [psychiatric] consult. Notify them of changes or needs related to mood/behaviors."

Medications taken by Resident #3 included:
* Zoloft (a medication used to treat depression) 50 milligrams (mg) daily started on 12/06/11, and increased to 75 mg on 01/03/12.
* Risperdal (an antipsychotic medication used to treat schizophrenia) 0.5 mg twice daily (BID) started on 12/07/11, increased to 0.5 mg in the AM and 1.0 mg in the evening on 03/22/12, and increased again to 1.0 mg BID on 04/05/12.
* Dilaudid (an opoid medication used to treat moderate to severe pain medication) 1.0 mg three times daily (TID) started on 06/14/11 and increased to 2.0 mg TID on 07/12/12.
* Aricept (a medication used to treat mild to severe Alzheimer's disease) 5 mg po every evening.

The facility's "Behavior Logs" instruct the certified nurse aides (CNAs) to document any abnormal behaviors displayed by residents. Review of Resident #3's June - August 2012 Social Service "Behavior Logs" (staff are to place a check mark by the behavior the resident displayed and then write specific details about the behavior on the back side of the log) identified:
06/11/12 - Resident #3 refused morning cares.
06/19/12 - "Resident was hollering out . . . She would holler help [and] we would go in [and] ask her what she needed. If she was laying down she wanted to sit up [and] if she was sitting up she wanted to lay down. No matter what we did in a

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few minutes she was hollering again."
06/21/12 - "Resident has been on [call] light 7:45 [a.m.] to 11:30 [a.m.] about back pain . . . She yells not to touch me. It does matter what you do or try she isn't happy . . . ."
06/25/12 - "Constantly on light, has no recollection of what has [and] not happened. Every few minutes has a different problem [and] is very anxious. Screaming in hallways, can't make mind up. Insists on needing help with things she is capable of doing herself."
06/26/12 - "Constantly on light. Screaming for help when staff tried to help she would scream . . . ."
07/11/12 - Resident #3 had incontinent stool all over her room.
07/18/12 - The resident "was in a bad mood . . . ."
08/01/12 - Resident "very crabby and yelling at CNAs" and "irritable and not nice."
08/05/12 at 3:30 p.m. - "Resident was in main lobby leaning towards the floor saying she need [sic] to get her coins and her purse was down there. After returning her to her room she said that all her coins were missing and she couldn't play the games without them."

The June 2012 Behavior Log identified Resident #3 experienced complaints of back pain and episodes of excessive call light use, but failed to identify specific behaviors exhibited by the resident. The July 2012 Behavior Log identified an episode of incontinent stool in the resident's room and the resident in a "bad mood." The August 2012 Behavior Log identified Resident #3 as "crabby" and "irritable," but failed to explain why the CNAs documented the resident's demeanor as such and lacked identification of specific behavioral symptoms displayed by

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Resident #3.

A Physician Progress Note, dated 06/26/12, for Resident #3 stated, "1. Dementia. Stable. Continue with Aricept. Patient has been having some episodes of increased anxiety, paranoia though at present seems to be doing well . . . 6. Depression, anxiety with episodes of paranoia. Continue patient on Zoloft 75 mg every HS and Risperdal 1 mg BID . . . 8. Greater than 9 medications. Medication list reviewed. Patient stable on current plan. We will continue current course."

Resident #3's medical record identified the psychiatric health care provider (HCP) examined the resident on 12/06/11 for hallucinations and recommended the initiation of an antipsychotic medication (Risperdal) and an increase in her antidepressant medication of Zoloft to 50 mg. During the 01/03/12 visit, the psychiatric HCP documented the symptom/concern for Resident #3 as ". . . continues to believe someone is stealing her money . . . ." and recommended to increase Resident #3's Zoloft to 75 mg. During the 03/06/12 visit, the psychiatric HCP made no recommendations to Resident #3's medication regime and stated Resident #3 "thinks she is loosing her mind." On 03/22/12, the HCP increased Resident #3's Risperdal to 0.5 mg in the AM and 1.0 mg in the PM.

An Interdisciplinary Progress Note (IPN), dated 07/07/12, identified Resident #3 hollering in the dining room during breakfast and stated her back hurt. IPNs dated July 10 and 11 documented Resident #3's continued complaints of unresolved back pain. On July 12, facility nursing staff

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contacted the health care provider and received an order to increase Resident #3's pain medication (Dilaudid).

Review of Social Service Progress Notes from March-June 2012, lacked identification/documentation of specific behaviors problems or needs and related approaches/interventions to minimize/decrease existing mood and behavior problems and prevent further decline of Resident #3's mental and psychosocial functioning.

Review of Resident #3's medical record lacked identification of the specific behavioral symptom(s) displayed by the resident, and lacked individualized non-pharmacological interventions to manage her behavioral symptoms. The psychiatric HCP noted Resident #3 displayed hallucinations in January 2012, but failed to document any further BPSD during subsequent visits in March, April, and July 2012.

- Review of Resident #4's medical record occurred on August 13-16, 2012 and identified diagnoses of dementia, anxiety, and agitation. Resident #4's significant change MDS, dated 05/11/12, identified the resident as sometimes capable of making herself understood and able to understand others, continuously displayed behavioral symptoms of inattention and disorganized thinking, fluctuation with altered level of consciousness, and displayed physical and verbal behaviors four to six days during the assessment period.

Resident #4's current care plan, dated 06/12/12, identified the following: "Problem: MOOD AND

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BEHAVIORS: I am a pleasant lady that gets along well with others. If I am doing something wrong, please let me know so I can learn it the correct way . . . Approaches: . . . My family is supportive and visits frequently . . . Offer 1-1 visits with her, encourage her to tell you abut her family and if she wants assist her in phoning family members. [Resident #3] has recently been hitting out at staff, hollering more, and spitting out food, try to re-direct her and reassure her when providing cares. Also, when walking by her room be sure to offer her a drink of water. Is on "comfort cares" which means keep her comfortable while she is dying. Appetite lessened, medications kept to a minimum . . . Stays in her room most of the time. Seems to be comforted by having a teddy bear or other soft animal to hold . . . "

Review of physician orders for Resident #4 identified the HCP started the resident on Risperdal 0.5 mg sublingual BID on 05/08/12 and changed the order to as needed (PRN) on 05/11/12 (three days later).

Resident #4's PRN Medication Administration Records (MAR) from May-August 12, 2012 identified facility staff administered the PRN Risperdal three times in May for "crying out, and agitation/combative," eight times in June for "anxious and yelling out," six times in July for "hollering and restlessness," and four times in August for "anxiety and restlessness."

Review of Resident #4's IPNs stated:
05/08/12 at 8:30 a.m. - ". . . During AM cares hollering [and] swinging arms out . . . ."
05/08/12 at 10:30 a.m. - "[name of doctor] here to

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see resident. Resident continues to be agitated and combative [with] cares and calling out loudly. Assess [assessment] done. Noted to have [left] facial droop, weakness to [left] arm. . . . will contact family re: [regarding] further treatment for [questionable] CVA [cerebral vascular accident] or comfort cares."
06/01/12 at 7:00 a.m. - "Calling out to get help to turn, sit up. CNA assisted to do AM cares. When up in Broda chair, cont [continues] to say move me over, lift my arm, sit me up. Wanting to spit. Risperidone [one] mg given for anxiousness at 8:00 a.m."
06/10/12 at 7:30 a.m. - "Resident very agitated/yelling. Medicated [with] Risperidone . . . ."

Resident #4's IPNs from May-August 12, 2012 failed to specify the reason(s) for her "anxiety, restlessness, and yelling out." These IPNs failed to identify what non-pharmacological interventions facility staff attempted before administering PRN Risperdal.

Review of Resident #4's May 2012 social services "Behavior Log" (staff are to place a check mark by the behavior the resident displayed and then write specific details about the behavior on the back side of the log) identified:
05/02/12 - "Very combative" and "combative when trying to do ADLs [activities of daily living] [with] resident . . ."
05/03/12 - "Very confused . . ."
05/04/12 - "Completely confused - combative."
05/05/12 - "Resident was combative during cares . . . yelling about need all the help because doctor told her she had a stroke . . . ."
05/06/12 - Resident attempted to punch CNAs

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during assistance with a transfer.
05/07/12 - "Resident was out of it . . . She was verbally [and] physically aggressive towards staff. She was screaming that we were trying to kill her even when were not touching her . . ."
05/08/12 - "Resident very restless, flailing arms and legs in all directions, yelling [and] screaming, calling for her Mom [and] Dad . . ."
05/19/12 - Screaming, hitting, wanting to bit [sic] . . ."
05/23/12 - "Resident was swinging at staff when trying to lay resident down to rest."
05/29/12 - " . . . she started to say she just wanted to go with the Lord, then started to cry . . . ."

No "Behavior Logs" were completed for June-August 2012, indicating Resident #4 displayed no abnormal behaviors.

A Physician Progress Note, dated 05/08/12, identified Resident #4 displayed "more anxiety, more agitation, calling out at night," and inability to move her left side. The physician ordered Risperdal 0.5 mg twice daily.

Review of Resident #4's medical record lacked specific behavioral symptom(s) displayed by the resident in June, July and August 2012, and lacked individualized non-pharmacological interventions to manage her behavioral symptoms. The physician noted Resident #4 displayed anxiety, agitation, and calling out at night in May 2012, but failed to document any further behavioral symptoms during subsequent visits.

During interview on 08/15/12 at 4:00 p.m., an

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administrative nurse (#5) stated she expected each resident's chart (medical record) to identify/list the specific behavior(s) displayed by residents, and for nursing staff to attempt and document what non-pharmacological interventions (offering food, toileting, repositioning, one to one conversation, massages, activities, music) they tried prior to administering PRN antipsychotic medication. The administrative nurse (#5) further stated if non-pharmacological interventions failed to minimize or eliminate the behavior, then she expected nursing staff to administer PRN antipsychotic medications as ordered.

- Review of Resident #9's medical record occurred on August 15-16, 2012. Diagnoses included dementia, anxiety, and depression. Medications included citalopram (antidepressant) daily and Ativan (antianxiety) 1 mg three times a day as needed (PRN) for behavioral symptoms related to dementia.

The quarterly MDS, dated 06/05/12, identified Resident #9 wandered one to three days and behavioral symptoms of inattention and disorganized thinking fluctuated during the assessment period, severely impaired cognition, and rarely/never understands others. The MDS, dated 03/06/12, identified the resident wandered four to six days and the MDS, dated 09/09/11, identified wandering occurred daily.

Resident #9's current care plan, dated 06/13/12, stated, "MOOD/BEHAVIOR: . . . Anxiety with restlessness and agitation . . . Approaches: . . . impaired hearing and vision; which may alter her abilities to join in group activities or to participate

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without some guidance/cues. She has a short attention span. Be there for her-offer your assistance; let her be the judge as to what she needs. Medications per Doctor . . . [Resident name] will voice concerns about the functioning of her hearing aid. Check to see if it needs a new battery . . . Use Validation Therapy when visiting with her, go into her world, do no argue or attempt to reason with her . . . Special events that happen at the nursing home are interesting to [Resident name], but following the entertainment she will show increased restlessness and anxiousness. She gets confused and will feel that she needs to leave just like everyone else. [Resident name] will stop everyone that she passes by-asking them if they will help her to the bathroom . . . Staff are keeping track of when she is taken to the bathroom, and this will satisfy her at times . . ."

Review of Resident #9's May-August 2012 social services "Behavior Logs" (staff are to place a check mark by the behavior the resident displayed and then write specific details about the behavior on the back side of the log) identified documentation on 05/10/12 as "missing hearing aides" and on 05/17/12 as ". . . pancakes placed on her napkin . . ." The behavior logs lacked specific behavioral symptoms displayed by Resident #9.

Review of Resident #9's nurses notes from January-August 2012 identified two behaviors which resulted in the administration of PRN Ativan:
*01/21/12 at 6:00 p.m. - "[increased] wandering et [and] restless this shift, looking for scissors. Secure tab alarm intact. Sweaty et flushed,

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afebrile. PRN ativan given. Will monitor." *05/17/12 at 5:00 p.m. - "Has been getting increasingly more restless and difficult to redirect over past 2 hrs [hours]. Going into other residents rooms and rummaging through their belongings. Irritable when attempt made to redirect. PRN Ativan given . . ."

Review of Resident #9's PRN MAR from January-August 16, 2012 identified facility staff administered the PRN Ativan seven times in January, once in February, none in March, three times in April, five times in May, once in June, none in July, and three times in August. Facility staff documented restlessness, agitation, wandering, and anxiety for the "reason" they administered PRN Ativan.

The "Behavior Logs" failed to describe specific behaviors, hallucinations, or delusions the CNAs identified Resident #9 displayed, the possible triggers/causes for the behavioral symptoms, and the interventions used to address them, if any, prior to the administration of Ativan. Failure to identify possible causative factors which precipitated behaviors does not allow the facility to look for patterns in Resident #9's behaviors or develop and implement creative individualized interventions to decrease the behaviors.

- Review of Resident #13's medical record occurred on August 15-16, 2012 and identified diagnoses of Alzheimer's disease, dementia, delusional disorder, psychosis, anxiety, and depression. Resident #13's quarterly MDS, dated 02/29/12, identified the resident as rarely capable of understanding others or making herself understood, displaying a consistently

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reduced/slowed level of mental processing and fluctuating inattention, disorganized thinking, and altered level of consciousness, and displayed verbal and/or physical behaviors 4 to 7 days during the assessment period.

Resident #13's current care plan, dated 03/11/12, identified the following: "PROBLEM: MOOD AND BEHAVIORS: Diagnosis anxiety and depression. . . . [Resident #13's] mood/behaviors vary. at the present time she has repetitive verbalizations and is not able to communicate her needs. She may exhibit sad/worried/pained facial expressions. May pick at her skin, clothing or other objects around her. Withdrawal from activities of interest and limited abilities to participate. May have periods of sluggishness. May be resistive to cares-may be due to lack of understanding or pain. . . . APPROACHES: Allow [Resident #13] time to 'chant'. but you should see that she is in her room at this time. There are times she is 'chanting' because she is hungry, tired or cold. Check to see if she is thirsty, hungry, cold etc. [etcetera]. Also, offer her a drink, many times this will also help. . . . If she is anxious/restless/chanting, remove her to another area with less stimulation. . . . Also, turn her music on in her room, this is very calming to her. . . . Monitor and document all mood/behavior indicators on the behavior log. . . ."

Medications taken by Resident #13's include:
* Ativan 2 mg tid prn [as needed], started on 06/14/11.

Review of Resident #13's January-March, 2012 Social Services "Behavior Log" (Staff are to place a check mark by the behavior the resident

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displayed and then write specific details about the behavior on the back side of the log.) identified:
*January: "1-4-12, [Resident #13] is doing a lot of repeditive [sic] sounds and yelling. Let nurse know. anytime she had to be turned or moved [Resident #13] would start hitting out at staff . . . 1-29-12, Resident extremely tired. Slept thru [through] breakfast."
* February: The CNAs failed to document any abnormal behaviors displayed by Resident #13 and/or any interventions attempted by the staff.
* March: "3-3-12, Resident very aggitated [sic] at HS cares and rounds pinching, scrating [sic] and trying to bite."

The interdisciplinary and social service progress notes identified the following:
* 02/04/12 at 2:15 p.m., ". . . grabbing nurse."
* 02/05/12 at 9:00 p.m., "Lethargic this evening, unable to eat or take meds [medications]. arouses with HS [hour of sleep] cares. . . . Ativan given."
* 02/29/12, ". . . Staff has reported she has been short tempered/easily annoyed, has delusions, and has been physically and verbally aggressive to others. . . ."
* 03/08/12 at 1:00 p.m., "Area to (L) [left] great toe remains . . . Resident does . . . start chanting when palpating area. . . ."
* 03/15/12 at 9:00 a.m., ". . . Does holler out at times when touching area. . . ."
* 03/18/12 at 7:30 a.m., "Resident agitated [after] am cares done. [Increased] chanting. Gave Ativan . . . Chanting at x's [times] . . ."
* 03/19/12 at 4:10 a.m., ". . . Chanting . . ."
* 03/21/12 at 9:00 p.m., ". . . Chanting [at] times . . ."
* 03/27/12 at 9:50 p.m., ". . . Resident expired . .

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."

The PRN Medication Administration Record (MAR) for 2012 identified facility staff administered the following:
* January: 19 doses of Ativan
* February: 15 doses of Ativan
* March: 8 doses of Ativan

Review of Resident #13's medical record lacked identification of the specific behavioral symptom(s) displayed by the resident, and lacked individualized non-pharmalogical interventions to minimize/decrease her mood/behavioral symptoms.
- Review of Resident #2's medical record occurred on all days of survey. Diagnoses included depression, anxiety, dementia with delusional features and behavioral disturbance, and episodic mood disorder. The quarterly MDS, dated 06/12/12, identified the resident sometimes makes himself understood and sometimes understands others, short and long-term memory problems, severely impaired decision making, fluctuating inattention and disorganized thinking, and no mood or behavior problems. This MDS identified Resident #2 with a restraint used daily (Merry Walker).

Resident #2's current care plan stated, "Problem: Mobility . . . Approaches: . . . Uses a Merry Walker for independence in getting around the building. Direct and guide him as needed . . . Off load [and] remove from Merry Walker several x's [times]/ [each] day . . . Problem: Mood/Behaviors: [Resident #2] has a short attention span, may be resistive to redirection and cares. [Resident #2] is at risk for changes in mood r/t [related to] anxiety,

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depression, and unfamiliar environment. Impaired socialization due to dementia . . . Approaches: . . . Assess for physical/environmental changes that may precipitate changes in mood . . . Administer medication per physician orders and monitor for side effects . . . Inform, invite, and escort [Resident #2] to activity groups of past and present interest such as music, special events, reading groups, etc. He is a passive observer at most groups . . . [Resident #2] has dementia and does not understand much of the time. When doing cares or redirection do not pull or demand that he does something. You need to go into his world and time - he can not be rushed. If he is resistive do not continue, as it will only cause irritation. Do not ask him if he wants to do something - tell him it is time for "this or that." Offer him drinks and snacks; he will not remember that he needs nourishment. He may need cues and assistance. He does well in Activities and seems to enjoy watching and being around others . . ."

Resident #2's current medications included Seroquel (antipsychotic) 25 mg daily for dementia with mood disorder. The resident was admitted on the medication in September 2011. The resident's physician ordered PRN Seroquel 25 mg every day on 02/01/12. Review of the June-August 2012 PRN MARs showed no PRN Seroquel used.

According to Physical Therapy progress notes, the facility initiated Resident #2's Merry Walker on 02/07/12. Review of Physical Restraint assessments stated the following:
*02/10/12 - "Resident becomes restless/upset when trying to get up out of w/c [wheelchair] and

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walk. Gait unsteady. Seroquel required to [decrease] agitation. Will try Merry Walker to see if ability to get up on own will [decrease] agitation/ [decrease] Seroquel use . . ."
*06/12/12 - "Will continue [with] Merry Walker. Resident calmer, [decrease] use of antipsychotics prn to calm resident. Resident ambulates freely thru-out [throughout] facility . . ."

Observations throughout the survey showed Resident #2 always sitting or walking in his Merry Walker, unless in his bed, recliner, or dining room chair. Resident #2 exhibited no behaviors and staff reported no aggressive behaviors. The resident at times resisted cares, such as toileting, ambulating to a different location, etc, however, remained pleasantly confused the entire time.

Review of a progress note by Resident #2's mental health practitioner, dated 07/03/12, stated, ". . . Symptom/Concern: Wandering . . . Current Psychotropics: Seroquel 25 mg PO [every] HS . . . Interim History: No behaviors noted by nursing staff - has a Merry Walker that allows him to go all over the facility. No aggressive behavior noted. Recent evaluation for physical illness - no changes. Does a lot of wandering . . . Mental Status Exam: . . . unable to follow the line of discussion - repeats in word salad . . . Plan: Cont [continue] - Seroquel 25 mg HS . . ."

Review of Resident #2's primary care physician's notes identified the following:
*02/15/12 - ". . . Nursing notes reviewed . . . The patient offers no concerns . . . Assessment/Plan: 1. Severe dementia with mood disorder, behavioral issues, occasional agitation. I have added an additional Seroquel 25 mg p.o. [by

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mouth] q. [every] day p.r.n. though he appears to be doing better with his new walking chair. Do not see any benefit for Aricept or Namenda as this point in time . . ."
*04/17/12 - ". . . Nursing offer no concerns . . . They state that since implementing this Merry Walker they have not had to use any p.r.n. Seroquel. It has really helped with the agitation and aggressive behaviors . . . Assessment/Plan: 1. Dementia with mood disorders, agitation and behavioral issues. The behavior problems seem to be much better with the Merry Walker. As I said, he has not had to use any of the p.r.n. [as needed] Seroquel but we will continue to have that as needed in case they do need it . . ."
*06/13/12 - ". . . Nursing notes reviewed. No acute concerns. The patient does suffer from moderate to severe dementia . . . Assessment/Plan: . . . 2. Moderate to severe dementia with mood disorder and aggressive behaviors. Continue Seroquel 25 mg q.h.s. [every night] Patient is stable on this course . . . 4. Ataxic gait. We have provided the patient with a Merry Walker. This provides him increased stability, increased ability to ambulate and navigate the hall as well as the nursing home and at a safer manner. Before patient would forget to use walker. He appears to be more pleasant with more freedom and room to roam the nursing home with the Merry Walker . . ."

Review of the Interdisciplinary Progress Notes from his admission in September 2011 through August 2012 identified the resident wandered throughout the facility and at times, into other resident rooms. The progress notes noted two occurrences where Resident #2 exhibited aggressive behaviors. On 01/16/12 CNAs

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reported the resident hit and kicked them during evening cares, and on 01/29/12 Resident #2 wandered into another resident's room, went through her things, and "was swatting at her," upsetting the resident.

Review of Resident #2's May-August 2012 Social Services "Behavior Logs" (staff are to place a check mark by the behavior the resident displayed and then write specific details about the behavior on the back side of the log) identified the resident with multiple occurrences of being short-tempered/easily annoyed, having delusions, and wandering in May, June, July, and August. The logs identified one occurrence of physical aggression towards others in May and five occurrences of physical aggression towards others and four occurrences of verbal aggression towards others in August.

The behavior details documented by staff on the "Behavior Logs" identified the following entries:
*05/09/12 - " Resident keeps mixing liquids [and] foods [at] meals. Sometimes eats his food this way! "
*05/30/12 - "Resident refused to get up, was not cooperative and wouldn't toilet."
*07/30/12 - "[Resident #2] was in the dining room in his Merry Walker. He had his pants down. A dietary aide saw him. The [dietary aide] asked [Resident #2] to pull his pants up and he did pull them up."
The "Behavior Log" for August lacked specific details for the five physically and four verbally aggressive behaviors Resident #2 exhibited.

The "Behavior Logs" failed to describe the specific behaviors, hallucinations, or delusions

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the CNAs identified the resident was displaying, the possible triggers/causes for those behavioral symptoms, and the interventions used to address them, if any. Failure to identify possible causative factors which precipitated behaviors does not allow the facility to look for patterns in Resident #2's behaviors or develop and implement creative individualized interventions to decrease the behaviors.

The facility failed to accurately assess and monitor Resident #2's behaviors and failed to develop and implement individualized non-pharmacological interventions to address Resident #2's behavioral and psychological symptoms of dementia. The staff utilized the Merry Walker as the resident's primary assistive device, placed Resident #2 in the Merry Walker even when the resident was pleasant and calm, and failed to try other less restrictive interventions first to address his behaviors prior to putting him in the Merry Walker.

- Review of Resident #1's medical record occurred on all days of survey. Diagnoses included Alzheimer's dementia with behavioral disturbance, depression, and anxiety. The admission MDS, dated 07/31/12, identified the resident rarely makes himself understood, rarely understands others, short and long-term memory problems, severely impaired cognition, inattention, disorganized thinking, and altered level of conscious. The MDS identified mild depression, physical and verbal behaviors impacting him and other residents, rejection of care, and wandering. This MDS identified Resident #1 with a restraint used daily (Merry Walker).

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Resident #1's current care plan stated, "Problem: Activities: Resident confused and is sometimes difficult to direct . . . Approaches: . . . Trial use of Merry Walker to grant him independence when he is restless/allow him freedom to roam . . . Problem: Communication: [Resident #1] is unable to verbally communicate his wants or needs . . . will express his dissatisfaction, usually with his cares, by hitting out at staff, this is usually because he is unsure of what staff are going to do . . . Approaches: . . . When needing to perform cares, especially personal ones, staff will explain to [Resident #1] what they are about to do and allow extra time as he is a very private man and it may take time for him to adjust to new staff assisting him with personal cares . . . Problem: Mood/Behaviors: [Resident #1] appears to be a 'happy' person, but due to the dementia he does have some combative behaviors, especially when personal cares are needing to be completed . . . Approaches: . . . Staff will introduce themselves, when working with [Resident #1] and take time to explain what they are going to be doing with him . . . Staff will observe and document any physical or verbal outbursts in the behavior log book or appropriate progress notes section of the file . . . Staff will report any observable changes in behavior or mood to the Charge Nurse, DON [Director of Nursing] or LSW [Licensed Social Worker] . . . Problem: Psychosocial Well-being . . . Approaches: . . . Staff will assist [Resident #1] to activities or attempt to visit with him about golfing or hunting . . . Medications as ordered . . . Watch for side effects . . . Problem: ADLs [Activities of Daily Living] . . . Approaches: . . . often refuses assist from staff . . . If he becomes upset or agitated, let him be and reapproach at a later time

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if appropriate . . ."

Resident #1's current scheduled medications included Clonazepam (antianxiety) 1 mg BID, increased on 08/07/12; Zyprexa Zydis (antipsychotic) 5 mg under the tongue daily, ordered 07/24/12; and Zoloft (antidepressant) 50 mg daily, decreased on 08/07/12. The resident's PRN medications included Zyprexa 2.5 mg PO every six hours as needed, ordered on 07/24/12. Review of the PRN MARs for July and August 2012 showed Zyprexa 2.5 mg given for agitation on 07/24/12 at 1:25 p.m. and 9:30 p.m., and on 07/27/12 at 1:30 a.m.

A physician's order, dated 07/27/12, identified a Merry Walker to be used as needed to decrease Resident #1's agitation and restlessness. Review of an Interdisciplinary Progress Note, dated 07/27/12, stated, "Resident being trialed with Merry Walker to [decrease] agitation/restlessness. Resident not safe to ambulate independently and becomes agitated/aggressive when staff try to assist him. Order obtained from [name of physician] to use Merry-Walker and son . . . informed of purpose . . . and attempt to [decrease] agitation/restlessness rather than administer antipsychotic medications . . . restraint paperwork completed."

Observations throughout the survey showed Resident #1 frequently sitting in his Merry Walker. Staff placed the resident into the Merry Walker without Resident #1 exhibiting agitation/restlessness.

Review of a Social Service Progress Note, dated 08/03/12, stated, ". . . [Resident #1] has been

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striking out at staff, usually during his personal cares; this may be due to a privacy issue or not understanding what is going on. Staff continues to explain to [Resident #1] what they are doing and hopefully over time [Resident #1] will adjust to his new living environment and staff that are assisting him . . . According to the behavior log [Resident #1] has had instances being inattentive, disorganized thinking and lethargic. The logs also show that [Resident #1] has been both verbal and physical with staff while they are attempting to perform cares . . . staff did report that he is easily annoyed on a daily basis . . ."

Review of Resident #1's Interdisciplinary Progress Notes from his admission in July 2012 through August 2012 identified the following behaviors:
*07/24/12 - ". . . To dining room for dinner via w/c [after] dinner pt got out of chair and started amb [ambulating] in hall, assist to room via 2 CNA. Pt incont [incontinent] of urine attempted to toilet pt and complete skin assessment pt became upset and hitting this nurse. When attempted to hold pt hands so CNA could do incont care, pt squeezed this nurse's hand aggressively - prn med given [with] little effect . . ." (Zyprexa 2.5 mg given on 07/24/12 at 1:25 p.m. and 9:30 p.m.)
*07/26/12 - "Required assist of 4 to [change] brief. Res kicking [at] staff and resists cares. Res pacing up and down halls all evening."

Review of Resident #1's July-August 2012 Social Services "Behavior Logs" (staff are to place a check mark by the behavior the resident displayed and then write specific details about the behavior on the back side of the log) identified the resident with multiple occurrences of being

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short-tempered/easily annoyed and wandering in July and August, numerous occurrences of hallucinations and delusions in August, and seven occurrences of physical aggression towards others and four occurrences of verbal aggression towards others in July, and 14 occurrences of both physical and verbal aggression towards others in August.

The behavior details documented by staff on the back of the Social Services "Behavior Logs" identified the following entries:
*07/24/12 - "Resident was in the lobby walking by self. His pants were wet. Was assisted to his room. Refused to have CNAs help him take of [sic] wet cloths [sic]. Was very agitated and held on to his pants. Refused cares totally. Was hitting staff and extremely upset. Nurse in charge was informed."
*07/24/12 - "Resident was assisted by DON and three other people to change pants. Was still physically abusive to all those helping him."
*07/25/12 (entries throughout the day) - "Refused to go into the bathroom. Refused to let CNAs change or take his wet pants off . . . Refused to be toileted. Was getting upset. So was left to lay in bed to calm down . . . Was up wandering. Refused to be toileted again . . . Refused to let CNAs do ADLs. Was getting combative and refusing HS cares. Was pinching at CNAs and trying to kick while being assisted for PM cares . . . Resident was assisted to BR [bathroom]. Refused to go, became combative again, was hitting and kicking at CNAs. It took [sic] few people to change his wet brief and clothing. Punch [sic] at the CNAs and kicked me in the head, knocking off my glasses off my face while I was trying to put on clean cloths [sic]. Continued

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to be combative during all of this."
*07/28/12 - "Resident was hitting [and] punching CNAs when CNAs attempted HS ADLs."
*07/29/12 - "When taking Resident to the restroom he refused to pull down his pants, even tho [though] he was soaked, wife was in the room and thought she could convince him, once we attempted to pull his pants down he started to punch his wife, CNAs asked her to step back that we would deal with it, it took 3 of us to just change him. [Resident #1] refused to pull his pants down or even sit on the toilet."
*07/29/12 - "When putting [Resident #1] to bed, he punched CNA, and was very combative, it took 3 CNAs to get him to bed and refused to change pants. So went to bed with same clothes unable to change brief or remove pants."
*07/30/12 - "We could not get [Resident #1] to stand so we could put him in a regular chair. There were 3 of us who tried [and] we couldn't stand him."
*07/31/12 - "Pt [patient] was in room, we (3 CNAs) were trying to do his peri-care and sit him in recliner. Very upset with what we were doing. Twisted my hand and arm till it was hurting. Two aides had to pry his hand off my arm."
*08/01/12 - "During cares [Resident #1] became very combative and punched me in the stomach."
*08/02/12 - "During cares [Resident #1] became combative and was punching staff and kicking staff. Tried telling resident what we were doing and told him in steps."
* 08/03/12 - "Changing resident and he became combative hitting one CNA in the shoulder and another in the stomach."
*08/04/12 - "Changing resident and he became aggressive and combative. Hit CNA on chin."
*08/05/12 - "While getting resident ready for

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breakfast, he refused to get up. Reapproached with therapeutic [sic] fibbing but it didn't work. With 3 CNAs we were able to assist the resident with cares and dressing."
*08/05/12 - "While turning resident into laying position in bed resident kicked CNA in the stomach."
*08/06/12 - "When helping [Resident #1] to bed he was very combative he was punching and kicking CNAs, unable to do peri-cares."
*08/07/12 - "Resident refused AM cares, became physical with CNAs when attempting cares. Attempting to get weight on bath chair he refused [and] started kicking [and] punching CNAs. Resident began to laugh [and] said 'that's what you get.'"
*08/08/12 - "Resident was falling out of Merry-Walker while inside of another resident's room, he got up took a step and sat down on the middle strip almost tipping the Merry Walker and falling, I CNA [sic] screamed for help one nurse and another CNA. When we tried to sit him down correctly he punched the nurse in her abdomen."
*08/08/12 - "[Resident#1] was removed twice out of [name of another resident] room and once out of [name of a second resident] room, both ladys [sic] were yelling for someone to remove the man out of there [sic] rooms."
*08/10/12 - "Resident was [sic] out [at] staff's arm when tryin [sic] to do cares. Resident refused to go to the bathroom all am."
*08/14/12 - "Resident did strike out with hands and hit my arm. Did quit after few times of this. Very hard to transfer. Does not stand well [at] all for transfers."

The "Behavior Logs" failed to include specific details for all of the behavior symptoms identified

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F 309	Continued From page 41 on the logs, such as hallucinations, delusions, and all occurrences of physical and/or verbal aggressions the CNAs documented the resident was displaying (checked on the logs); the possible triggers/causes for those behavioral symptoms; and the interventions used to address them, if any. Failure to identify possible causative factors which precipitated behaviors does not allow the facility to look for patterns in Resident #1's behaviors or develop and implement creative individualized interventions to decrease the behaviors. The facility failed to accurately assess and monitor Resident #1's behaviors and failed to develop and implement individualized non-pharmacological interventions to address Resident #1's behavioral and psychological symptoms of dementia. The facility failed to develop creative approaches to address Resident #1's increased aggression during personal cares and failed to try other less restrictive behavioral interventions prior to initiating the Merry Walker (three days after the resident was admitted). The staff used the Merry Walker as the resident's primary assistive device and placed Resident #1 in the Merry Walker even when the resident was calm.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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F 323	Continued From page 42 This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, record review, and staff interview, the facility failed to provide assistive devices necessary to prevent accidents for 3 of 4 sampled residents (Resident #1, #2, and #10) observed without wheelchair foot pedals and for 2 of 4 sampled residents (Resident #1 and #2) requiring a gait belt for transfers. Failure to transport residents in wheelchairs with foot pedals during staff-assisted transport and to properly use a gait belt during staff-assisted transfers may result in falls and/or injuries to residents. Findings include: Review of the facility policy titled "Wheelchair Transportation" occurred on 08/16/12. This policy, revised July 2006, stated, "POLICY: Wheelchairs may be used to provide mobility and transportation for resident/patients according to their needs. When staff are propelling residents/patients in a wheelchair, the wheelchair must have foot pedals. The wheelchair will not be pulled backwards, except as needed to enter elevators, turn, etc . . . PROCEDURE: . . . 2. Prepare wheelchair for transfer . . . c. Bag placed on back of propelled resident/patient's wheelchair. Remove pedals if resident/patient is able to propel himself so pedals won't be in his way. Attach pedals again whenever resident/patient is being propelled as resident allows . . ." Review of the facility policy titled "Gait Belts for		1 Several residents were affected by the deficient practice of not using wheelchair pedals and all residents that use wheelchairs for transportation and/or Merry walkers had the potential to be affected. Any resident that requires assistance of one or two to transfer or ambulate require a gait belt and have the potential to be affected. A memo was issued on August 16, 2012 instructed staff on use of pedals and gait belts. A platform was made for residents that use the Merrywalker to place their feet on during transport if the resident refuses to ambulate. Staff will be encouraged to ambulate residents with use of gait belt that use Merrywalker rather than transport residents in the Merrywalker.	8/16/2012
			Aide meeting was held on August 17, 2012 and instruction was given by PT assistant on correct use of gait belts. Demonstration done with aides. Discussion/instruction given on transportation of residents and pedals on wheelchairs and injury potential. A nurse's meeting was held on August 21, 2012 and discussion was held on use of wheelchair pedals and proper use of gait belts.	8/21/2012
			3. As per policy all residents that require wheelchair transportation will have wheelchair pedals on. If resident refuses pedals, this will be documented and care planned. Resident that refuses pedals will be cued to lift feet during transport and staff will transport slowly.	8/21/2012
			4. QA monitoring will be done monthly X3 then quarterly for one year. QA manager will be the responsible for the monitoring.	
			5. Corrective Action completed:	8/21/2012

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Transfer" occurred on 08/16/12. This policy, revised June 2006, stated, "POLICY: 1. Gait belts are used to assist staff to safely perform pivot transfers, or ambulate residents/patients who need the assistance of one or more staff members . . . PROCEDURE: . . . 6. To transfer: a. Assist resident/patient to a standing position by grasping belt at the waist from underneath. b. Pivot resident/patient into chair or bed. 7. To ambulate: a. Assist resident/patient to a standing position by grasping belt at the waist from underneath. b. Standing on weaker side of resident/patient, wrap your arm around waist of resident/patient and grasp belt from underneath. c. Maintain a firm grasp on belt . . ."

- Review of Resident #1's medical record occurred on all days of survey. Diagnoses included Alzheimer's dementia with behavioral disturbance. The current Minimum Data Set (MDS), dated 07/31/12, identified short and long-term memory problems, severely impaired daily decision making, and limited assistance of two or more staff members for transfers and locomotion.

Observations of staff transferring/transporting Resident #1 during the survey showed the following:
*On 08/13/12 at 4:30 p.m., two certified nursing assistants (CNAs) (#2 and #9) transferred the resident from his bed to the Merry Walker (an enclosed walker/chair combination) using a gait belt. During the transfer, the CNAs (#2 and #9) held on to the gait belt with one hand and lifted under the resident's arms with their other hand. The CNA (#2) then pushed the resident out to the living area while he sat in his Merry Walker.

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During the transport, Resident #1's feet brushed along the floor. The CNA (#2) encouraged the resident to lift his feet, but the resident was unable to comprehend her request.
*On 08/14/12 at 10:15 a.m., two CNAs (#10 and #14) applied a gait belt around Resident #1's waist and transferred him from his Merry Walker to the recliner in his room. Rather than using the gait belt, both CNAs (#10 and #14) lifted under the resident's arms during the transfer.
*On 08/15/12 at 11:30 a.m., a CNA (#15) pushed Resident #1 in his Merry Walker from his room to the living area. During the transport, Resident #1's feet slid along the floor.
*On 08/15/12 at 12:02 p.m., a CNA (#17) pushed the resident in his Merry Walker from the living area to the dining room. During the transport, Resident #1's feet slid and caught on the floor.
*On 08/15/12 at 12:05 p.m., three CNAs (#14, #16, and #17) transferred Resident #1 from his Merry Walker to a dining room chair using a gait belt. A CNA (#17) failed to utilize the gait belt and lifted entirely under the resident's left arm during the transfer.

- Review of Resident # 2's medical record occurred on all days of survey. Diagnoses included dementia with behavioral disturbance. The current MDS, dated 06/12/12, identified short and long-term memory problems, severely impaired daily decision making, extensive assistance of one staff member for transfers, and limited assistance of one staff member for locomotion.

Observations of staff transferring/transporting Resident #2 during the survey showed the following:

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*On 08/14/12 at 9:45 a.m., a CNA (#17) walked backwards in front of Resident #2 and pulled his Merry Walker into his room from the corridor. Observation showed the resident dragging his feet on the floor as the CNA pulled him along. Once in his room, the CNA (#17) lifted under the resident's left arm to assist him to stand up and transfer to his recliner. Resident #2 was unsteady and his knees buckled during the transfer. The CNA (#17) failed to utilize a gait belt to transfer Resident #2.

*On 08/14/12 at 1:05 p.m., a CNA (#17) pushed Resident #2 in his Merry Walker from the living area towards his room. The resident's feet remained firmly planted on the floor and the CNA used force to propel the Merry Walker. Throughout the observation, the resident dragged his feet and would put his feet down to stop the momentum of the Merry Walker. The CNA (#17) continued to push the Merry Walker as the resident resisted with his feet planted on the floor. The CNA (#17) prompted the resident to pick up his feet, but the resident was unable to comprehend her request. Eventually the CNA (#17) stopped in the corridor just outside of the resident's room and stated she will try again later to get the resident into his room.

*On 08/14/12 at 5:05 p.m., a nurse (#7) pushed Resident #2 in his Merry Walker down the corridor to the living area. During the transport, the resident slid his feet on the floor and at times, "walked" his feet as the nurse pushed the Merry Walker.

During an interview on 08/16/12 at 12:05 p.m., an administrative nurse (#5) stated staff should not lift up on residents' arms during transfers and stated she expected staff to use a gait belt on

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Resident #2 when he needs staff assistance to stand.

- Resident #10's medical record, reviewed August 15-16, 2012, identified diagnoses including dementia with behaviors, bone/cartilage disorder, osteoporosis, and history of a fractured right ankle. The resident's annual MDS, dated 05/30/12, identified memory impairments, severely impaired decision making skills, and extensive assistance of one person required for locomotion on/off unit.

Observations showed the following:
* On 08/15/12 at 11:43 a.m. a nursing staff member (#1) transported Resident #10 down the hallway to the lounge in her Broda chair [high back wheelchair]. Resident #10's feet/shoes dragged under her chair and/or caught and bounced on the flooring as staff transported her in the chair.
* On 08/15/12 at 11:50 a.m., a nursing staff member (#1) transported Resident #10 from the lounge to the dining room in her Broda chair. Resident #10's feet/shoes caught and bounced on the transition strip as staff transported her in the chair.
* On 08/15/12 at 3:45 p.m., a CNA (#2) transported Resident #10 down the hallway to the restroom in her Broda chair. Resident #10's heels slid along the surface of the flooring and/or caught and bounced on the transition strip as staff transported her in the chair.
* On 08/15/12 at 4:40 p.m., a CNA (#3) transported Resident #10 from the lounge to the activity room in her Broda chair. Resident #10's feet/shoes slid along the surface of the flooring as staff transported her in the chair.

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F 323	Continued From page 47 * On 08/16/12 at 10:55 a.m., a CNA (#4) transported Resident #10 down the hallway to the lounge in her Broda chair. Resident #10's feet/shoes slid along the surface of the flooring and/or caught and bounced on the flooring as staff transported her in the chair. The staff members failed to place foot pedals on Resident #10's wheelchair, cue her to lift her feet/shoes, and ensure her feet/shoes cleared the floor during transport to avoid catching her feet on the flooring and potentially causing pain and/or injury. During an interview on 08/16/12 at 11:10 a.m., an administrative nursing staff member (#5) agreed staff should have provided cues and/or utilized assistive devices (wheelchair foot pedals) during transport.	F 323		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic	F 329		

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F 329	Continued From page 48 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, record review, and staff interview, the facility failed to monitor and assess for continued use and potential side effects of medications for 4 of 6 sampled residents (Resident #2, #3, #11, and #12) receiving scheduled antipsychotic medications. Providing antipsychotic medications without adequate indications for its use (Resident #2, #11, and #12) and failure to obtain baseline testing Abnormal Involuntary Movement Scale (AIMS, a rating scale used to measure involuntary movements such as tardive dyskinesia) prior to the initiation of an antipsychotic medication (Resident #3) placed these residents at risk of receiving unnecessary medications and experiencing adverse drug effects related to their use. Findings include: Review of the facility policy titled "Medication Management and Monitoring" occurred on 08/16/12. This policy, dated June 2007, stated, ". . . Procedure: . . . 5. The nursing staff will observe residents on psychoactive medications for possible adverse consequences and/or need to modify the dose of one or more medications . . .	F329	1.For the residents were affected by the deficient practice, 3 residents did not have dose reductions attempted or a documented reason for the lack of dose reduction. Two out of the three residents (resident #2 and #12) that were affected had orders written by Dr. Muller on August 15 and 16, 2012 to trial a dose reduction on the anti-psychotic medications. Resident #11 was seen by the psych HCP on 9/4/2012 and dose reduction was done with orders to eventually discontinue medication if able.	9/4/2012
			2. Any resident that is on anti-psychotic medications have the potential to be affected.	
			3. Dose reductions were done on the three residents affected and behavior monitoring will continue with adjustments made as warranted.	9/4/2012
			Education was provided at Medical Staff meeting to providers on gradual dose reductions and documentation on benefits outweight risks if dose reductions are not done.	8/29/2012
			Spread sheet was developed to assist with the tracking of the initiation of anti-psychotic medications and trial of dose reductions. Spreadsheet will also track AIMS testing and date of baseline AIMS.	8/24/2012
			Nursing staff were informed of need for baseline AIMS prior to initiation of anti-psychotic medications and to notify DON, Care Coordinator or MDS Coordinator if order is received for anti-psychotic med.	8/21/2012
			4. QA, specifically the QA manager, will monitor resident's scheduled anti-anxiety medications and/or anti-psychotic medications monthly X3 months, then quarterly for one year.	
			5. Corrective Action Completed:	9/17/2012

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7. The medication regimen is re-evaluated periodically to determine whether prolonged or indefinite use of a medication is indicated . . . GRADUAL DOSE REDUCTION (GDR): . . . 1. When a resident's clinical condition has improved or stabilized, the underlying causes of the original target symptoms have resolved, and/or non-pharmacological interventions, including behavioral interventions, have been effective in reducing the symptoms, the resident is evaluated for the appropriateness of a taper or GDR of the medication . . ."

- Review of Resident #2's medical record occurred on all days of survey. Diagnoses included depression, anxiety, dementia with delusional features and behavioral disturbance, and episodic mood disorder. The quarterly Minimum Data Set (MDS), dated 06/12/12, identified the resident sometimes makes himself understood and sometimes understands others, short and long-term memory problems, severely impaired decision making, fluctuating inattention and disorganized thinking, and no mood or behavior problems.

Resident #2's current medications included Seroquel (antipsychotic) 25 mg daily for dementia with mood disorder. The resident was admitted on the medication in September 2011.

Review of a progress note by Resident #2's mental health practitioner, dated 07/03/12, stated, ". . . Symptom/Concern: Wandering . . . Current Psychotropics: Seroquel 25 milligrams [mg] PO [by mouth] [every] HS [bedtime] . . . Interim History: No behaviors noted by nursing staff - has a Merry Walker that allows him to go all over the

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facility. No aggressive behavior noted. Recent evaluation for physical illness - no changes. Does a lot of wandering . . . Mental Status Exam: . . . unable to follow the line of discussion - repeats in word salad . . . Plan: Cont [continue] - Seroquel 25 mg HS . . ."

Review of Resident #2's primary care physician's notes identified the following:
*02/15/12 - ". . . Nursing notes reviewed . . . The patient offers no concerns . . . I have added an additional Seroquel 25 mg p.o. [by mouth] q. [every] day p.r.n. though he appears to be doing better with his new walking chair. Do not see any benefit for Aricept or Namenda as this point in time . . ."
*04/17/12 - ". . . Nursing offer no concerns . . . The behavior problems seem to be much better with the Merry Walker. As I said, he has not had to use any of the p.r.n. [as needed] Seroquel but we will continue to have that as needed in case they do need it . . ."
*06/13/12 - ". . . Nursing notes reviewed. No acute concerns. The patient does suffer from moderate to severe dementia . . . Continue Seroquel 25 mg q.h.s. [every night] Patient is stable on this course . . ."

Review of behavior details for the months of May-August 2012, written by staff on the "Behavior Logs," identified the following entries:
*05/30/12 - "Resident refused to get up, was not cooperative and wouldn't toilet."
*07/30/12 - "[Resident #2] was in the dining room in his Merry Walker. He had his pants down. A dietary aide saw him. The [dietary aide] asked [Resident #2] to pull his pants up and he did pull them up."

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Review of the Interdisciplinary Progress Notes from his admission in September 2011 through August 2012 identified two occurrences of aggressive behaviors. On 01/16/12 CNAs reported the resident hit and kicked them during evening cares, and on 01/29/12 Resident #2 wandered into another resident's room, went through her things, and "was swatting at her," upsetting the resident.

During an interview on 08/15/12 at 4:45 p.m., a CNA (#2) stated Resident #2 is confused and resists cares, but no longer "strikes out."

The facility failed to attempt a gradual dose reduction with Resident #2's scheduled Seroquel once the resident no longer displayed indications for continued use.

- Review of Resident #12's medical record occurred on August 15-16, 2012. Diagnoses included dementia with aggressive behaviors, depression, and episodic mood disorder. The annual MDS, dated 06/07/12, identified the resident makes himself understood and usually understands others, severely impaired cognition, trouble falling asleep or sleeping too much, and no behavior symptoms.

Resident #12's current medications included Risperdal (antipsychotic) 1 mg twice daily for dementia with aggressive behaviors, initiated on 06/10/11, and Sertraline (antidepressant) 100 mg daily for depression, initiated 06/10/11.

Review of Resident #12's mental health practitioner's progress notes identified the

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following:
*06/14/11 - ". . . Symptom/Concern: Aggressive behaviors . . . Current Psychotropics: Haldol [changed] 6/10 [06/10/11] to Risperdal 1 mg BID [twice daily]. Zoloft 100 mg [daily] . . . Interim History: In house [with] wife - is awakened when she requires assistance - Had been doing ok [with] the haldol - then experienced an [increase] in aggressiveness with staff when they assist his wife - unpleasant mood in A.M. Will not respond to requests of wt [weight] - bathing - other assistance . . . Mental Status Exam: . . . today family visiting - [Resident #12] was very calm - but can be very threatening . . . Plan: Inc [increase] Risperdal to 1 mg AM - 2 mg PM. Zoloft 100 mg PO [every] day . . ." (Resident #12's primary care physician disagreed with the recommended increase of Risperdal so medications stayed the same as ordered on 06/10/11).
*07/12/11 - ". . . Symptom/Concern: Aggressive behaviors . . . Interim History: Calmer - non aggressive toward staff with cares - very recent death of wife (also roommate) . . . Mental Status Exam: . . . bright affect - understands the loss of his wife . . . Plan: no changes . . ."
*09/05/11 - ". . . Symptom/Concern: Combative - agitated toward staff and peers . . . Interim History: No problems noted by staff . . . Mental Status Exam: . . . alert . . . Plan: no changes . . ."
*12/06/11 - ". . . Symptom/Concern: H/O [history of] being combative and aggressive dark mood . . . Interim History: Continues to do optimal toward all behaviors - Beautiful behaviors - enjoyable with staff and family . . . Mental Status Exam: . . . Bright, happy mood . . . Plan: no changes . . ."
*06/05/12 - ". . . Symptom/Concern: H/O combativeness . . . Interim History: No behaviors

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noted by nursing staff . . . Mental Status Exam: . . . very pleasant and agreeable . . . Plan: no changes . . ."

Review of Resident #12's May-August 2012 Social Services "Behavior Logs" identified the resident was short-tempered/easily annoyed four days in May, no behaviors in June or July, and was short-tempered/easily annoyed one day in August.

Review of the Interdisciplinary Progress Notes from May 2011 through August 2012 identified Resident #12 displayed no aggressive behaviors since May 2011.

On the afternoon of 08/15/12, a CNA (#15) stated Resident #12 "likes to be left alone" when asked what his behaviors consisted of.

During an interview on 08/15/12 at 3:15 p.m., a physician (#18) stated Resident #2 was combative when the facility first admitted him, but confirmed he may be ready for a gradual dose reduction. He also identified if Resident #12 no longer displayed aggressive behaviors it may be time for a gradual dose reduction.

The facility failed to attempt a gradual dose reduction with Resident #12's scheduled Risperdal once the resident no longer displayed indications for continued use.

- Review of Resident #11's medical record occurred on 08/16/12. Resident #11 entered the facility in January 2011. Resident #11's diagnoses included senile dementia with depressive features and paranoid schizophrenia. Resident #11's

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quarterly MDS, dated 04/02/12 and 06/30/12, identified the resident sometimes able to make herself understood and able to understand others. These MDSs identified no mood or behaviors during the assessment periods.

Review of Resident #11's usage of Risperdal showed:
01/2011 - Risperdal 0.25 mg twice daily
02/17/11 - Risperdal 0.25 mg in AM and 0.5 mg at HS

Review of Resident #11's psychiatric HCP (healthcare practitioner) notes showed:
*02/17/11 - Resident #11 experienced an increase with hallucinations. The HCP increased the evening dose of Risperdal to 0.5 mg.
*03/15/11 - Resident #11 displayed "no behaviors with the increased dosing" and "no further hallucinations."
*06/14/11 - "No striking out or verbal abuse during cares . . . Acclimated to her new home. No changes with current medications."
*09/05/11 - "GDR consideration to decrease and/or discontinue her psychotropics - past history and trials showed she has not faired well. Will continue [current dosing]."
*12/06/11 - The HCP addressed reducing Resident #11's antipsychotic medications and stated " . . . the positive response towards quality of life outweighs the risk."
*06/05/12 - Resident #11 displaying no behaviors. Attending activities. No behaviors towards peers. No changes (with medication regime).

The psychiatric HCP noted Resident #11's behavioral symptoms absent in March, June, September, and December 2011 and in June

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2012. Resident #11's medical record failed to identify what behavior(s) warranted the continued use of the Risperdal.

- Review of the facility policy titled "Abnormal Involuntary Movement Scale" occurred on 08/16/12. This policy, reviewed by the facility in July 2012, stated, "Policy: Psychoactive drugs may be prescribed for the management of psychotic disorders and/or behaviors of an aggressive nature. These drugs are approved treatment for these disorders, but are capable of causing profound motor effects. Most neuroleptic medications are anti-psychotics . . . In order to detect abnormal involuntary movements of individuals who take neuroleptic medications and to ensure early diagnosis and treatment of tardive dyskinesia, baseline and scheduled AIMS testing will be conducted . . . Procedure: 1. Residents shall be assessed for abnormal movement disorders . . . by the MDS nurse or by the visiting psych [psychiatric] nurse: a) upon recommendation for treatment with neuroleptic medication, prior to the administration of the drug . . . ."

Review of Resident #3's medical record occurred on August 13-16, 2012 and identified diagnoses of senile dementia with delusional features, mood disorder, paranoid type schizophrenia, and osteoarthrosis.

Resident #3's HCP initiated the use of Risperdal (an antipsychotic medication) 0.5 mg BID on 12/07/11, increased it to 0.5 mg in the AM and 1.0 mg in the evening on 03/22/12, and increased it again to 1 mg BID on 04/05/12.

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F 329	Continued From page 56 An Interdisciplinary Progress Note (IPN), dated 02/10/12 and written by an administrative nurse, identified a recommendation from the facility's consultant pharmacist of the need to obtain baseline AIMS testing for Resident #3 due to her use of Risperdal. This note stated, " . . . Will have the [psychiatric HCP] to complete when she returns in March [2012]." Record review identified the psychiatric HCP completed an AIMS test for Resident #3 on 04/03/12 (four months after beginning the Risperdal). During an interview on 08/15/12 at 4:00 p.m., an administrative nurse (#5) confirmed the facility failed to obtain baseline AIMS test for Resident #3 prior to beginning antipsychotic medication therapy.	F 329		
F 371 SS=E	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 observation, record review, review of professional reference, and staff interview, the facility failed to store food in a safe and sanitary	F 371		

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manner as observed in 6 of 6 personal refrigerators (Rooms 1, 11, 41, 47, 50 and 51). Failure to follow safe food sanitation practices has the potential to increase the risk of foodborne illness and can affect residents who eat food stored in these areas.

Findings include:

The 2012 Food Code, section 33-33-04-07 states, ". . . 2. Refrigeration facilities shall be provided to assure the maintenance of potentially hazardous food and shall operate at forty-one degrees Fahrenheit or less. . . ."

During the initial tour on 08/13/12 at 11:15 a.m., observation showed eight rooms containing personal refrigerators. Each refrigerator failed to contain a thermometer which would allow staff to monitor food storage temperatures. The following was observed in each personal refrigerator:
* Room 1, butter and milk.
* Room 11, butter, cheese, pudding, and yogurt.
* Room 47, an undated plastic container of cottage cheese.
* Room 50, butter, cream, and salad dressing.

On 08/15/12 at 11:00 a.m., observation showed the following in each personal refrigerator:
* Room 1, butter and milk.
* Room 11, butter, cheese, pudding, and yogurt.
* Room 41, butter and jam.
* Room 47, applesauce, cottage cheese, cream cheese, a fruit cup, juice, and sliced luncheon meat.
* Room 50, butter, half & half, jam, milk, and salad dressing. The resident stated, "They just cleaned it out yesterday. I'm so mad. They threw

1. Residents that have their own personal refrigerator in their room were informed of a change in process and need to montior temperatures daily and record temperatures and labeleing of prepared foods as to date placed in refrigerator. beginning on September 6, 2012. 8/17/2012 9/6/2012

One resident's refrigerator was unplugged and not working--therefore family removed refrigerator from resident room. 8/17/2012

Cleaning of refridgerators and labeling of foods were done 8/17/2012

Nursing and aide staff were informed at nursing and aide meetings held on August 17 and 21, 2012, that temperature monitoring was needed and resident would be responsible. Also informed that all prepared foods needed to be labeled as to date placed in fridge and discarded on the 4th day. Reviewed policy with staff. 8/21/2012

2. Any resident that had a personal refrigerator had the potential to be affected.

3. A policy on personal refrigerators was developed and no additional refrigerators will be allowed into the facility. Staff and residents educated on policy. 8/22/2012

Resident and family members were notified by the social worker by a letter of the new policy and need for daily monitoring of refridgerator temperature and of food placed in refridgerator. 9/6/2012

4. QA monitoring will be done by the Social Work department monthly X3 months then quarterly.

5. Corrective Action completed: 9/6/2012

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a bunch of stuff away."
* Room 51, sliced luncheon meat dated "08/03" and pudding.

On 08/16/12 at 9:40 a.m., the surveyor obtained a a thermometer reading of 45 degrees Fahrenheit in the personal refrigerator in Room 51. The refrigerator contained the items listed above.

On 08/16/12 at 9:42 a.m., observation showed a personal refrigerator in Room 47 with a thermometer reading 38 degrees Fahrenheit. This was the only personal refrigerator observed to have a thermometer inside. The refrigerator contained the items listed above. The resident stated, "They just checked everything. It should all be good. Oh, they just put that thermometer in there."

On 08/16/12 at 10:00 a.m., the surveyor obtained a a thermometer reading of 43 degrees Fahrenheit in the personal refrigerator in Room 11. The refrigerator contained the items listed above.

During an interview on 08/14/12 at 1:00 p.m. when asked who is responsible for maintaining personal refrigerators, an administrative dietary staff member (#6) stated, "Families take care of them. The facility puts it on the family to take care of."

During an interview on 08/14/12 at 3:00 p.m. when asked who is responsible for maintaining personal refrigerators, an administrative staff member (#5) stated, "Families or close friends are responsible for the fridges. We aren't having anything to do with this." When asked how the

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F 371	Continued From page 59 facility knows foods are being maintained at the proper temperature, she stated, "I don't know if we do know." During an interview on 08/16/12 at 11:10 a.m. when asked for a policy regarding maintaining personal refrigerators, the administrative staff member (#5) stated, "We have one. We're not following our own policy." The facility failed to provide their policy for review.	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the	F431	1. Medication carts are to be locked whenever the cart is not in the field of vision of the nurse. Memo's were issued to nursing staff regarding following of policy and procedure on August 16, 2012 and a nurse's meeting was held on August 21, 2012 with reivew of MBH's policy on locking of medication carts. 2. All residents had the potential to be affected. 3. Review of MBH's policy and procedure was done at nurse's meeting held on August 21, 2012. Memo was issued immediately after the survey was completed. 4. QA monitoring will be done monthly X3 then quarterly for a period of one year. The QA manager will be responsible for performing the montioring. 5. Corrective Action completed:	8/21/2012 8/21/2012 8/21/2012

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Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
Based on observation, review of facility policy, and staff interview, the facility failed to store all medications in a secure manner for 1 of 2 medication carts. Failure to store all medications securely could result in unauthorized access to medications.

Findings include:

Review of the facility policy "Medication Administration Policy and Procedure" occurred on 08/16/12. This policy, revised in 2007, stated, ". . . Procedure: . . . 23. Never leave the medication cart open and unattended if not within immediate eyesight . . ."

Observation of medication administration occurred on 08/15/12 at 8:30 and 8:45 a.m. The nurse (#8) placed a resident's medications in a cup, entered the dining room, and administered the medications to the resident. Observation showed the nurse's (#8) medication cart in the lounge area adjacent to the dining room, unsecured, and residents in lounge chairs and wheelchairs close to the cart.

Observation on 08/15/12 at 9:00 a.m. showed the

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	355044	A. BUILDING _____ B. WING _____	08/16/2012

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MOUNTRAIL BETHEL HOME	615 6TH ST SE STANLEY, ND 58784

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F 431	Continued From page 61 nurse (#8) in a resident's room and her medication cart parked in the hall, unsecured, and not within eyesight of the nurse. Observation showed Resident #2, identified by the facility as having dementia, walked by the medication cart. During an interview on the afternoon of 08/15/12, an administrative nurse (#5) stated she expected the facility nurses to lock the medication carts when they step away from the cart and no longer have view of it.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if	F 441		

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F 441	Continued From page 62 direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy and procedure, product label instructions, and staff interview, the facility failed to follow standards of practice to prevent the transmission of infections for 1 of 8 sampled residents (Resident #1) observed during pericares, for 1 of 1 sampled resident (Resident #4) identified in contact isolation, and regarding sanitization of 2 of 2 whirlpool tubs. Failure of facility staff to complete hand hygiene according to standards of practice, the practice of re-using contact isolation gowns, and failure to ensure sanitization of the whirlpool tubs between resident baths has the potential for the transmission of infections to occur within the facility. Findings include: Review of the facility policy titled "Pericare" occurred on 08/16/12. This policy, revised July 2006, stated, ". . . FOR BOWEL INCONTINENCE . . . 1. Put on disposable protective gloves. 2. Before using disposable wipes or cloth washcloth,	F441	1. Memo's were issued to nursing staff immediately following the survey regarding the need to wash/sanitize hands after removing gloves following peri care. Memo also addressed that the yellow isolation gowns are a one time use only and after use need to be placed in the soiled laundry. Memo was also issued outlining that the whirlpool tub needs to be cleaned for 10 minutes between each bath as per recommendations of the Apollo whirlpool tub manual. 2. All residents that require assistance with peri care had the potential to be affected. All residents had the potential to be affected also by improper use of isolation gowns. All residents that take whirlpool baths also had the potential to be affected by non consistent cleaning times of tub between baths. 3. Nurse's meetings and aide meetings were held on August 17 and 21, 2012 and staff reeducated on policies in regards to peri care, use of isolation gowns and cleaning of whirlpool tub between resident baths. Signs were posted in the whirlpool rooms as a reminder to staff to clean the whirlpool for 10 minutes between each bath. 4. QA, specifically the QA manager and/or care coordinator will monitor peri-care, isolation gown use and cleaning of whirlpool tubs between baths monthly x3 months then quarterly for one year. 5. Corrective Action completed	8/16/2012 8/16/2012 8/21/2012 8/21/2012

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wipe away as much of the stool as possible with toilet tissue . . . 3. Remove gloves. 4. Wash hands . . . FOR URINARY INCONTINENCE . . . 1. Apply disposable protective gloves. 2. Cleanse abdominal and pubic areas . . . 5. BOTH (male and female): . . . j. Remove gloves. k. Wash hands . . ."

- Observation on 08/13/12 at 4:30 p.m. showed two certified nursing assistants (CNAs) (#9 and #10) changed Resident #1's brief, incontinent with urine and stool. The CNA (#10) performed perineal cares, changed her gloves without performing hand hygiene, and then placed a clean brief. The other CNA (#9) provided additional cleansing to the resident's perineal area, removed her gloves, and donned new gloves without performing hand hygiene. Both CNAs (#9 and #10) assisted the resident with dressing, transferred the resident from his bed to his Merry Walker, put the supplies away, and then washed their hands prior to exiting the resident's room. The CNAs (#9 and #10) failed to perform hand hygiene after performing perineal cares prior to completing other tasks.

- On 08/14/12 at 4:00 p.m., observation showed a CNA (#2) removed Resident #1's brief, incontinent of urine, and removed her gloves. Another CNA (#11) completed pericares, placed a clean brief, removed her gloves, helped transfer the resident to his recliner, bagged the garbage, and then exited the resident's room. The CNA (#11) failed to perform hand hygiene after performing pericares. After assisting the resident to transfer, the first CNA (#2) gave Resident #1 a drink of water, changed his shirt, placed his call light, and then washed her hands prior to exiting

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the room. The CNA (#2) failed to perform hand hygiene after removing the incontinent brief, prior to performing other tasks.

During an interview on 08/16/12 at 10:20 a.m., a nurse (#12) stated she expected staff to perform hand hygiene immediately after completing pericares.

- Review of Resident #4's medical record identified the facility implemented contact isolation precautions in May 2012, related to the presence of methicillin resistant staphylococcal aureus in the resident's urine.

Observation on 08/14/12 at 10:20 a.m. showed a licensed nurse (#7) entered Resident #4's room to administer a rectal suppository to the resident. The licensed nurse (#7) washed her hands, placed a gown on to cover and protect her uniform, and donned gloves. After administering the medication, the licensed nurse (#7) removed her gloves, washed her hands, removed her gown, and hung the gown up on a hook on the wall in Resident #4's room.

During interview on 08/16/12 at 11:50 a.m., an administrative nurse (#5) stated gowns worn when caring for residents in contact isolation are "not re-useable" and she expected staff to obtain a new one each time they enter the room and have the potential for direct contact with the resident's body fluid.

- Review of the facility procedure titled "Disinfecting Procedure" occurred on 08/16/12. This procedure, revised August 2005, stated, " . . . Brush cleaning solution around the walls of the

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F 441	Continued From page 65 tub and chair keeping surfaces moist for 10 minutes . . ." Review of the label on the "Cid-A-L II" quaternary disinfectant, used to disinfect the whirlpool tub, identified surfaces must remain wet for 10 minutes to work effectively. During an interview on 08/16/12 at 10:00 a.m., a CNA (#13) stated she lets the whirlpool tub soak with disinfectant between baths for "just a couple of minutes." On the morning of 08/16/12 a CNA (#14) stated she "leaves the disinfectant on about five minutes" when disinfecting the whirlpool tub. The facility failed to ensure the disinfectant remained on the whirlpool tub surfaces for at least 10 minutes.	F 441		