

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION <i>Poc # 2</i>	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445292	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/07/2016
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NAME OF PROVIDER OR SUPPLIER BEECH TREE MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 240 HOSPITAL LANE, PO BOX 300 JELICO, TN 37762
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(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
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F 000 INITIAL COMMENTS

Complaint investigation #38161, #39026, and #39085 were completed on June 21-July 7, 2016, at Beech Tree Manor. No deficiencies were cited related to the complaint investigation #39026. Deficiencies F-157, F-280, and F 323 were cited under 42 CFR PART 483, Requirements for Long Term Care Facility related to complaint investigation #38161 and #39085.

F 157 SS=D 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)

A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

F 000

Disclaimer: Preparation and/or execution of this Plan of Correction does not communicate admission or agreement by the provider of the truth of the facts alleged or any conclusion set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of the federal and state law.

F 157

TAG: F 157

Criterion 1- How corrective action will be accomplished for those residents affected by the violation(s).

On July 27th, 2016, the physicians of resident's #5 and #6 were notified of the altercation occurring on 3/18/16.

Criterion 2- How the facility will identify other residents affected by the same violation(s).

The Quality Assurance Nurse will look back through all incident reports occurring since January 1, 2016 to identify any other events that were not reported to the doctor. Any physicians who need to be notified will be notified.

8/15/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Charles W. Wheeler, LHA</i>	TITLE <i>Administrator</i>	(X6) DATE 8-10-16
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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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The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on review of facility policy, medical record review, review of facility investigation, and interview, the facility failed to notify the physician of an altercation for two (#5 and #6) of five residents reviewed for behaviors affecting others.

The findings included:

Review facility policy, Notification of Resident/Patient Change in Condition, revealed, "Our Facility's clinicians will notify the resident, his/her attending physician...if there is a crucial/significant change in the resident's condition...1. Notify the resident's attending physician...at the earliest possible time, during waking hours, if there is a change in condition..."

Medical record review revealed Resident #5 was admitted to the facility on April 16, 2013, with diagnoses including Traumatic Brain Injury post Motor Vehicle Accident, Rhabdomyolysis, Dermatophytosis, Affective Disorder, Psychosis, Difficulty walking, Hallucinations, Hemiplegia, and Vascular Dementia.

Medical record review of the Minimum Data Set (MDS) dated December 29, 2015, revealed Resident #5 had the ability to understand others, scored a 12 on the Brief Interview for Mental Status (BIMS) and verbal behavioral symptoms directed toward others occurring less than daily.

F 157 Criterion 3- The measures that will be put into place or systemic changes made to ensure the violation(s) will not recur.

1. The DON or designee will continue to review each incident investigation to verify the physician was notified and documented appropriately.
2. Day shift nursing staff were re-trained regarding the notification of physicians and family members/responsible parties by the staff development coordinator on Friday August 5th, the remainder of the staff will be re-trained by Wednesday, August 10th, 2016.

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Continued review revealed the resident required limited assistance for bed mobility, transfers, walk in room, dressing and toilet use; extensive assistance for personal hygiene; was totally dependent on staff for bathing; and the resident used the wheelchair as a mobility device.

Medical record review of the Care Plan revised November 5, 2015, revealed, "I have a diagnosis of psychosis with aggressive behavior and I am combative with my care." Care plan interventions included: "I like my door to remain closed, I need a stop sign wander strip placed over my door to decrease other resident from wandering in my room, provide me with frequent reminders to ask for assistance if a resident wanders in my room and I need them removed"; and to provide resident with cues and redirection.

Resident #6 was admitted to the facility on February 11, 2013, with diagnoses including Muscle Weakness, Pseudobulbar Affect and Dementia.

Medical record review revealed the MDS dated January 25 and April 19, 2016, revealed Resident #6 had short and long term memory problems, moderately impaired cognitive skills and behaviors of inattention and disorganized thinking indicating Delirium. Review revealed the resident walked in room independently, required supervision to walk in the corridor and locomotion on the unit, and used a wheelchair as a mobility device. Review revealed wandering was not exhibited for the resident.

Medical record review of the Care Plan (undated) revealed, "I have impaired cognitive function and I usually understand others related to my

F 157

Criterion 4- How the facility will monitor its corrective actions to ensure that the violation(s) is being corrected and will not recur.

The DON or designee will continue to review each incident investigation to verify the physician was notified and documented appropriately. Any failure to notify the physician will be addressed immediately and discussed monthly during the routine QAPI meeting, including the Administrator, Director of Nursing, Medical Director, Unit Managers, MDS Coordinators, Food Service Director, Social Service Director, Activity Director, A/R Billing Specialist, Business Office Associate, Purchasing Director, Maintenance Director, Housekeeping/Laundry Supervisor, Rehab Services Manager Staff Development Coordinator, Quality Assurance/Infection Control Nurse, Medical Records Director.

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Alzheimer's Dementia. I wander at times".
Continued review of the Care Plan revealed (undated) interventions including encourage me to attend activities, and I am easily redirected and enjoy being around other people.

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Medical record review of a Resident to Resident Altercation Report dated March 18, 2016 revealed Resident #6 wandered into Resident #5's room and resident #5 ~~and~~ started twisting the arm of Resident #6. Continued review revealed the immediate intervention included the residents were separated and placed on every 15 minute checks. Continued review revealed there was no physical injury present on assessment for Resident #5 or Resident #6. Continued review of the investigation revealed the Physician of Resident #5 and Resident #6 was not notified with explanation written as "No injury to resident" for each resident.

Interview with the Director of Nursing (DON) in the conference room on June 23, 2016, at 12:15 p.m., confirmed the physician notification was not completed for Resident #5 and Resident #6.

Interview with the DON by telephone on July 6, 2016, at 10:30 a.m., confirmed the altercation is a significant change in condition requiring physician notification.

F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO
SS=E PARTICIPATE PLANNING CARE-REVISE CP

F 280

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

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A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on review of facility policy, medical record review, review of facility investigation, observation, and interview, the facility failed to revise the care plan following an altercation for 3 (#5, #6, #7) of five residents reviewed for behaviors affecting others; and failed to revise the Care Plan following a fall one (#1) of 3 residents reviewed for falls.

The findings included:

Review of facility policy titled Behavioral Assessment, Intervention, and Monitoring, revised 1/2016, revealed..."The interdisciplinary team will evaluate behavioral symptoms in residents to determine the degree of severity, distress, and potential safety risk to resident, and develop a plan of care accordingly..."

Review of facility policy Falls and Fall Risk,

F 280 TAG: F-280

Criterion 1- How corrective action will be accomplished for those residents affected by the violation(s).

Care plans for residents # 5, # 6, and # 7 were reviewed and updated to reflect all current effective interventions. Resident # 1 is now deceased of natural causes, unrelated to any incident.

Criterion 2- How the facility will identify other residents affected by the same violation(s).

All residents who have had a history of falls or behaviors affecting others during the past 30 days will be reviewed by the Quality Assurance Nurse and any care plans that have not been updated, will be updated to reflect appropriate interventions.

8/15/16

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F 280	<p>Continued From page 5</p> <p>Managing, revised 6/2016, revealed, "1. The staff, with the input of the attending physician, will identify appropriate interventions to reduce the risk of falls...4. If falling recurs despite initial interventions, staff will implement additional or different interventions or indicate why the current approach remains relevant..."</p> <p>Resident #5 was admitted to the facility on April 16, 2013, with diagnoses including Traumatic Brain Injury post Motor Vehicle Accident, Rhabdomyolysis, Dermatophytosis, Affective Disorder, Psychosis, Difficulty walking, Hallucinations, Hemiplegia, and Vascular Dementia.</p> <p>Medical record review of the Re-entry Minimum Data Set (MDS) dated 12/29/15, revealed Resident #5 had the ability to understand others, scored a 12 on the Brief Interview for Mental Status (BIMS) and verbal behavioral symptoms directed toward others occurred less than daily. Continued review revealed the resident required limited assistance for bed mobility, transfers, walk in room, dressing and toilet use; extensive assistance for personal hygiene; was totally dependent on staff for bathing; and the resident used the wheelchair as a mobility device.</p> <p>Review of the Care Plan revised 11/5/15, revealed, "I have a diagnosis of psychosis with aggressive behavior at I am combative with my care...I like my door to remain closed, I need a stop sign wander strip placed over my door to decrease other resident from wandering in my room (dated 7/17/15)...Provide me with frequent reminders to ask for assistance if a resident wanders in my room and I need them removed (dated 10/28/15)... provide resident with cues and</p>	F 280	<p>Criterion 3- The measures that will be put into place or systemic changes made to ensure the violation(s) will not recur.</p> <p>During investigation review by the Interdisciplinary Team (Administrator, Administrator In Training, Director of Nursing, Unit Managers, Quality Assurance/Infection Control Nurse, MDS Coordinator, MDS Nurse, Food Services Director, Social Services Director, Activity Director, A/R Billing Specialist, Business Office Associate, Purchasing Director, Maintenance Director, Housekeeping/Laundry Supervisor, Rehab Services Director, Staff Development Coordinator, Medical Records Director) in morning meeting, the team will review current interventions and eliminate any that are ineffective and establish new interventions and update care plan accordingly. The review of incidents includes the following concepts: not all accidents are avoidable; and it is reasonable to accept some risks as a trade-off for the potential benefits, including resident dignity, self-determination, and control over one's daily life.</p>	
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F 280

Continued From page 6 redirection (dated 11/5/15)".

Resident #6 was admitted to the facility on 11/11/13, with diagnoses including Muscle Weakness, Pseudobulbar Affect and Dementia.

Medical record review of the Quarterly MDS dated 1/25/15 and 4/19/16, revealed the resident had short and long term memory problems, moderately impaired cognitive skills and behaviors of inattention and disorganized thinking indicating Delirium. Continued review revealed the resident walked in room independently, required supervision to walk in the corridor and locomotion on the unit, and used a wheelchair as a mobility device. Further review revealed wandering was not exhibited for the resident.

Review of the Care Plan (undated) revealed the focus 'I have impaired cognitive function and I usually understand others related to my Alzheimer's Dementia. I wander at times'. Review of the Care Plan revealed (undated) interventions including "encourage me to attend activities...I am easily redirected and enjoy being around other people".

Resident #7 was admitted to the facility on 11/6/14, with diagnoses including Dementia with Behavior Disturbances, and Major Depressive Disorder.

Medical record review of the Significant Change MDS dated 4/4/16, revealed an ability to sometimes understand others; had a score of 1 on the BIMS; required limited assistance for bed mobility, walking in room and corridor, extensive assistance for transfers, dressing, toilet use, and personal hygiene; and was totally dependent on

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Criterion 4- How the facility will monitor its corrective actions to ensure that the violation(s) is being corrected and will not recur.

A Quality Assurance tool to review effectiveness of interventions has been developed and will be completed by our Quality Assurance Nurse and reviewed monthly during our routine QAPI meeting including the Administrator, Director of Nursing, Medical Director, Unit Managers, MDS Coordinators, Food Service Director, Social Service Director, Activity Director, A/R Billing Specialist, Business Office Associate, Purchasing Director, Maintenance Director, Housekeeping/Laundry Supervisor, Rehab Services Manager Staff Development Coordinator, Quality Assurance/Infection Control Nurse, Medical Records Director, beginning August 22nd, 2016.

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the staff for bathing. Continued review revealed the resident did wander 1-3 days; the wandering did not place the resident at significant risk of getting to a potentially dangerous place and the wandering did not significantly intrude on the privacy or activity of others.

Medical record review of the Care Plan dated 11/17/14, revealed..."I have impaired cognitive function related to my severe Dementia and I may unknowingly wander into another resident's personal space...check placement of my wander guard each shift (dated 11/17/14)...provide me with frequent cues and direction as needed (dated 11/16/15)".

Review of a Resident to Resident Altercation Report dated 3/18/16, revealed Resident #6 wandered into Resident #5's room and Resident #5 and started twisting the arm of Resident #6. Continued review revealed the immediate intervention included the residents were separated and placed on every 15 minute checks. Continued review revealed no physical injury present on assessment for Resident #5 or Resident #6. Continued review of the facility investigation revealed the cause as "Resident (#5) does not like other residents in his room."

Medical record rview of the Care Plan for Resident #5 revealed the intervention dated 3/18/16 included "I need ongoing reinforcement to ring my light if anyone wanders into my personal space" with an original intervention date of October 28, 2015.

Review of the Care Plan for Resident #6 revealed the resident was placed on 15 minute checks for 24 hours and no additional intervention beyond

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F 280	<p>Continued From page 8</p> <p>24 hours was implemented to reduce the risk of an altercation.</p> <p>Interview with the Director of Nursing (DON) in the conference room on 6 /23/16, at 12:15 PM, confirmed the investigation is not sufficient to determine if the stop sign was in place at the time of the incident; and confirmed there is no new intervention on the Care Plan following the altercation for Resident #5 or Resident #6 to reduce the risk of an altercation.</p> <p>Medical record review of the Annual MDS dated 3/22/16, revealed Resident #5 had a BIMS score of 10, had one episode of physical and verbal behavior symptoms directed toward others putting others at significant risk for injury. Continued review revealed the resident required limited assistance for bed mobility, transfers, dressing and toilet use; extensive assistance personal hygiene; was totally dependent on staff for bathing; and the resident used the wheelchair as a mobility device.</p> <p>Review of a Resident to Resident Altercation Report dated 5/12/16, revealed Resident #5 had an altercation when a resident removed the 'stop sign' and wandered into his room. Review of the report revealed Resident #7 came out of Resident #5's room yelling 'Help, Help' and Resident #5 stated Resident #7 attempted to climb in bed with Resident #5. Review revealed Resident #7 had scratches/skin tears on left side of face, nose and lower lip. Review revealed the residents were separated and placed on 15 minute checks. Review revealed both residents remained in the facility and not require additional outside intervention.</p>	F 280		

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Review of the Care Plan for Resident #5 revealed "Related to event on 5-12-16-Ensure that my wander strip is up in front of my door."

Review of the Care Plan for Resident #7 revealed 15 minute checks as ordered for 24 hours, and treatment to scratch areas to face. Review of the Care Plan revealed no intervention beyond 24 hours for the reduction in risk of an altercation.

Review of the Psychiatric Progress Note dated 5/16/16, revealed Resident #5 was seen for follow up per facility request for concerns including refusing care and increased agitation. The progress note indicated the resident displayed no symptoms of psychosis, anxiety, or depression and no worsening of the ongoing diagnoses. Review of the recommendations included the addition of Lamictal 25 milligrams (mg) daily for mood lability, impulse control, and agitation; and Ativan 0.5 mg to be administered twice daily.

Interview with the DON in the conference room on 6/23/16, at 3:35 PM, confirmed the Care Plan for Resident #7 did not include a new intervention following the incident to reduce the risk of an altercation. •

Review of the Resident to Resident Altercation Report dated 6/4/16, revealed staff heard Resident #6 scream, staff entered room of Resident #5 and saw Resident #5 holding the hands of Resident #6's behind her head and smiling, and Resident (#6) was "crying out in distress."

Review of the Resident to Resident report revealed the immediate intervention included both

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residents were separated and placed on 1:1 observation. Continued review of the report revealed Resident #5 had no injuries and Resident #6 had red marks on the front, sides, and back of neck. Review revealed the family and physician were notified and the physician recommended Resident #5 be sent out for a psychiatric and medication evaluation. Continued review revealed Resident #5 remained on 15 minute checks when in the room and on 1:1 supervision when out of the room until transferred to a Geropsychiatric unit on 6/6/16. Review revealed Resident #6 remained in the facility on 15 minute checks for 24 hours.

Review of the Care Plan for Resident #5 revealed the interventions dated 6/4/16 for 1:1 supervision, 6/6/16 transferred out to Geropsych unit, and 6/15/16 was moved to a room off of the Secure unit to a less wandering population.

Review of the care plan for Resident #6 revealed 15 minute checks for 24 hours and 'resident separated and calmed.' Review of the care plan revealed no additional intervention following the altercation was put in place to reduce the risk of an altercation.

Interview with the DON on 6/22/16, at 2:45 PM, in the conference room, confirmed the facility failed to implement a new or different intervention for Resident #5 following the altercations on March 18; and failed to implement a new or different intervention for Resident #6 following altercations on 3/18/16; and failed to implement a new or different care plan intervention for Resident #7 following the altercation on 3/12/16.

Resident #1 was admitted to the facility on

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F 280 Continued From page 11
11/1/12, with diagnoses including Abnormality of Gait, Fracture of Clavicle, Extrapyrmidal Movement Disorder, Diaphragmatic Hernia, Dementia, Schizoaffective Disorder, Bipolar Disorder, Delusions, Anemia, Heart Failure, and Pneumonia.

Review of the Re-entry Minimum Data Set (MDS) dated 6/18/15, revealed the resident had the ability to usually make others understand and usually understands others; a BIMS score of 6 indicating poor recall ability and temporal orientation; and sign of Delirium (disorganized thinking) was continuously present. Continued review revealed the resident required supervision to eat, limited assistance to walk in the room and locomotion on the unit, extensive assistance to walk in the corridor, dressing, toileting, and personal hygiene, and was totally dependent on staff for bathing. Continued interview revealed the resident was incontinent of bladder and bowel and was on a toileting program.

Review of the Care Plan (undated) revealed..."I am at risk for falls related to my weakness and use of psychotropic medications...Remind and encourage resident to ask for assistance before getting up unassisted (dated 5/22/15); Keep my bed in low position and call light within reach (undated); Provide me with frequent reminders to use assistive devices or use call light when needing assistance (undated); and remind and encourage me to ask for assistance before getting up (undated)."

Review of the facility's Accident/Incident Investigation Report dated August 13, 2015, revealed the resident was observed on the floor on the left side with complaint of left shoulder and

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NAME OF PROVIDER OR SUPPLIER BEECH TREE MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 240 HOSPITAL LANE, PO BOX 300 JELICO, TN 37762
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F 280 Continued From page 12

head pain; the call bell was in reach; the resident had an assist device of a wheelchair; and was not using it when the fall occurred. Review of the staff statement in the investigation report revealed the resident had no signs or symptoms of head injury or fracture and was sent to the Emergency room (ER) for evaluation, and was returned to the facility without injury.

Review of the care plan for falls revealed the intervention dated 8/13/15, 'Bed and chair alarm and check function and placement every shift'.

Review of the facility investigation dated 8/25/15, revealed the resident was found sitting on the bathroom floor "crying and holding head...and stated I was going to pack my clothes to go teach, I fell and hit my head." Continued review revealed the resident had been walking in the room and had lost balance prior the fall. Continued review revealed the resident was sent to the Emergency Room for evaluation and returned to the facility without injury. Review of the facility investigation revealed the alarm was sounding at the time of the fall and the intervention of a Therapy evaluation was implemented after the fall.

Review of the Fall Risk Assessment completed 8/25/15, revealed a score of 12 indicating a high risk for falls.

Review of the Quarterly MDS dated 9/17/15, revealed the resident's BIMS score of 6, had continuously present disorganized thinking, and the level of assistance required for activities of daily living remained unchanged as the resident required supervision to eat, limited assistance to walk in the room and locomotion on the unit,

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F 280	<p>Continued From page 13</p> <p>extensive assistance to walk in the corridor, dressing, toileting, personal hygiene, and was totally dependent on staff for bathing.</p> <p>Review of the facility investigation dated 9/22/15, revealed the resident was observed sitting in the resident's room on the floor, "no injuries, no (complaints) of pain or distress..." Continued review revealed the resident stated, "I just sit down." Continued review revealed the alarm was in use, but was not functioning..." the resident had turned it off." Continued review revealed the resident had been sitting in the chair prior to the fall. Continued review of the facility investigation revealed the intervention to "reduce resident time alone."</p> <p>Review of the Fall Risk Assessment completed 9/22/15, revealed a score of 12 indicating a high risk for falls.</p> <p>Review of the Care Plan for falls revealed, "Event 9/22/16 see IDT (Interdisciplinary Team) note."</p> <p>Review of the Progress Note dated 9/23/15, revealed,"(Resident) has a bed and chair alarm, staff provide her with frequent reminders to use the call lite and ask for assistance. (Resident) will use...wheelchair and will walk occasionally as...desires... IDT (Interdisciplinary) team feels that best intervention at this time is to continue with current interventions and for (resident) to continue to ambulate as...desires and to help maintain...sense of independence..."</p> <p>Review of a facility investigation dated 9/28/15, (6 days after previous fall) revealed the resident was observed sitting in the resident's room on the floor next to the wall. The resident stated, "I slid</p>	F 280		

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F 280 Continued From page 14

down the wall and sit in the floor." Continued review revealed the alarm was in use, "the resident had turned alarm off and took it out of... wheelchair." Continued review revealed the resident had been walking in the room prior the fall and had loss of balance. Continued review revealed the resident had no assessed injuries and had no complaints of pain. Continued review revealed the interventions in place at the time of the fall were chair alarm and bed alarm. • Continued review of the facility investigation revealed the intervention to "Reduce resident time alone: develop a team plan, watch resident more closely if possible."

Review of the Care Plan for falls revealed the alarms were not discontinued and the entry "See IDT note dated 9-30-15 related to event on 9/28/15."

Review of the Progress Note dated 9/30/15 revealed, "IDT note related to event on 9/28/15, (resident #1) has impaired memory and thought process. ...has interventions in place to help prevent falls...uses a wheelchair and will use a cane when walking at times...prefers to be as independent as much as possible. Placing a restraint to...wheelchair could possibly cause a decline in...adl (activities of daily living) function and could increase behaviors. IDT team feel to continue with all current interventions and provide frequent reminder and cues for assistance and encourage activity participation."

Review of the Care Plan for falls revealed "Activities to help decrease my time alone" and dated 9/28/15.

Review of the Fall Risk Assessment completed

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F 280	Continued From page 15 9/28/15, revealed a score of '21' indicating a high risk for falls. Review of the facility investigation dated 10/2/15, (5 days after previous fall) revealed the resident was observed lying on floor in the resident room and complained of Hip pain. Continued review revealed the resident had been walking in the room prior the fall. Continued review revealed the X-Rays of both hips were negative for fracture. Review of the Care Plan for falls revealed the intervention of "Related to event dated 10/2/15, continue to provide frequent reminders to ask for assistance and provide me frequent visual checks" was implemented. Review of the Fall Risk Assessment completed 10/2/15, revealed a score of 24 indicating a high risk for falls. Interview and review of the fall Care Plan with the DON on 6/22/16, at 12:45 PM, confirmrd the resident had 5 unwitnessed falls in less than 2 months and had no major injury from the falls. Continued interview confirmed the resident had a low BIMS score indicating poor recall therefore the repeated intervention to "remind the resident" to use the call light or call for assistance was not appropriate. Continued interview with the DON verified the intervention of the chair alarm was not discontinued when the resident turned it off therefore making it an ineffective intervention. Interview with the DON confirmed the faciliity failed to revise the care plan with new, different, effective or appropriate interventions to reduce the risk of a fall.	F 280			

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F 323 F 323 SS=D	Continued From page 16 483.25(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. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, medical record review, review of facility investigation, observation, and interview, the facility failed to provide sufficient supervision to prevent 3 (#5, #6, #7) wandering residents from entering into the room of one (#5) resident with known desire to not have others in the room, of five residents reviewed for behaviors affecting others. The findings included: Review of facility policy titled Behavioral Assessment, Intervention, and Monitoring, revised 1/2016, revealed..."The interdisciplinary team will evaluate behavioral symptoms in residents to determine the degree of severity, distress, and potential safety risk to resident, and develop a plan of care accordingly..." Resident #5 was admitted to the facility on 4/16/13, with diagnoses including Traumatic Brain Injury post Motor Vehicle Accident, Rhabdomyolysis, Dermatophytosis, Affective Disorder, Psychosis, Difficulty walking, Hallucinations, Hemiplegia, and Vascular	F 323 F 323	TAG: F-323 Criterion 1- How corrective action will be accomplished for those residents affected by the violation(s). Resident #5 moved to a unit with less wandering residents, to reduce the risk of wandering residents entering his personal space. Criterion 2- How the facility will identify other residents affected by the same violation(s). All residents on the locked unit are at risk for a wandering resident entering their room. There are currently 43 residents on the locked unit with 10 residents who wander into other people's personal space without understanding they are being invasive. There are currently 55 resident on the skilled nursing unit (where resident #5 was transferred) and none of the residents on that unit wander aimlessly without understanding personal space boundaries.
8/15/16			

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Continued From page 17
Dementia.

Medical record review of the Re-entry Minimum Data Set (MDS) dated 12/29/15, revealed Resident #5 had the ability to understand others, scored a 12 on the Brief Interview for Mental Status (BIMS) and verbal behavioral symptoms directed toward others occurred less than daily. Continued review revealed the resident required limited assistance for bed mobility, transfers, walk in room, dressing and toilet use; extensive assistance for personal hygiene; was totally dependent on staff for bathing; and the resident used the wheelchair as a mobility device.

Medical record review of the Annual MDS dated 3/22/16, revealed Resident #5 had a BIMS score of 10, had one episode of physical and verbal behavior symptoms directed toward others putting others at significant risk for injury.

Review of the Care Plan revised 11/5/15, revealed, "I have a diagnosis of psychosis with aggressive behavior at I am combative with my care...I like my door to remain closed, I need a stop sign wander strip placed over my door to decrease other resident from wandering in my room...Provide me with frequent reminders to ask for assistance if a resident wanders in my room and I need them removed... provide resident with cues and redirection."

Resident #6 was admitted to the facility on 11/11/13, with diagnoses including Muscle Weakness, Pseudobulbar Affect and Dementia.

Medical record review of the Quarterly MDS dated 1/25/15 and 4/19/16, revealed the resident had short and long term memory problems,

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Criterion 3- The measures that will be put into place or systemic changes made to ensure the violation(s) will not recur.

1. A new class of nursing assistants became certified in July 2016, increasing our certified nursing assistant staff by eight (8) persons, which allows for increased supervision.
2. Continue with 24 hour, 7 day a week RN staffing, effective since May 2016, for optimal supervision.
3. Mandatory training for facility staff utilizing a DVD of an Alzheimer's Expert, regarding dementia care and approach. Training completed on 7/29/16 by Staff Development Coordinator.

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F 323	<p>Continued From page 18</p> <p>moderately impaired cognitive skills and behaviors of inattention and disorganized thinking indicating Delirium. Continued review revealed the resident walked in room independently, required supervision to walk in the corridor and locomotion on the unit, and used a wheelchair as a mobility device. Further review revealed wandering was not exhibited for the resident.</p> <p>Review of the Care Plan (undated) revealed the focus 'I have impaired cognitive function and I usually understand others related to my Alzheimer's Dementia. I wander at times'. Review of the Care Plan revealed (undated) interventions including "encourage me to attend activities...I am easily redirected and enjoy being around other people".</p> <p>Resident #7 was admitted to the facility on 11/6/14, with diagnoses including Dementia with Behavior Disturbances, and Major Depressive Disorder.</p> <p>Medical record review of the Significant Change MDS dated 4/4/16, revealed an ability to sometimes understand others; had a score of 1 on the BIMS; required limited assistance for bed mobility, walking in room and corridor, extensive assistance for transfers, dressing, toilet use, and personal hygiene; and was totally dependent on the staff for bathing. Continued review revealed the resident did wander 1-3 days; the wandering did not place the resident at significant risk of getting to a potentially dangerous place and the wandering did not significantly intrude on the privacy or activity of others.</p> <p>Medical record review of the Care Plan dated 11/17/14 and revised 4/13/16, revealed..."I have</p>	F 323	<p>Criterion 4- How the facility will monitor its corrective actions to ensure that the violation(s) is being corrected and will not recur.</p> <p>DON or designee will continue to review each incident report and meet with Interdisciplinary Team (Administrator, Administrator In Training, Director of Nursing, Unit Managers, Quality Assurance/Infection Control Nurse, MDS Coordinator, MDS Nurse, Food Services Director, Social Services Director, Activity Director, A/R Billing Specialist, Business Office Associate, Purchasing Director, Maintenance Director, Housekeeping/Laundry Supervisor, Rehab Services Director, Staff Development Coordinator, Medical Records Director) to determine accident hazards related to supervision and or assistive devices. The QA nurse will track all incidents and observe for trends, the IDT will review monthly during routine QAPI meeting including the Administrator, Director of Nursing, Medical Director, Unit Managers, MDS Coordinators, Food Service Director, Social Service Director, Activity Director, A/R Billing Specialist, Business Office Associate, Purchasing Director, Maintenance Director, Housekeeping/Laundry Supervisor, Rehab Services Manager Staff Development Coordinator, Quality Assurance/Infection Control Nurse, Medical Records Director, and as needed.</p>

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F 323	<p>Continued From page 19</p> <p>impaired cognitive function related to my severe Dementia and I may unknowingly wander into another resident's personal space...check placement of my wander guard each shift...provide me with frequent cues and direction as needed."</p> <p>Review of a Resident to Resident Altercation Report dated 3/18/16, revealed Resident #6 wandered into Resident #5's room and Resident #5 and started twisting the arm of Resident #6. Continued review revealed the immediate intervention included the residents were separated and placed on every 15 minute checks. Continued review revealed no physical injury present on assessment for Resident #5 or Resident #6. Continued review of the facility investigation revealed the cause as "Resident (#5) does not like other residents in his room."</p> <p>Medical record review of the Care Plan for Resident #5 revealed the intervention dated 3/18/16 included "I need ongoing reinforcement to ring my light if anyone wanders into my personal space" with an original intervention date of October 28, 2015.</p> <p>Interview with the Director of Nursing (DON) in the conference room on 6 /23/16, at 12:15 PM, confirmed the investigation is not sufficient to determine if the stop sign was in place at the time of the incident.</p> <p>Review of a Resident to Resident Altercation Report dated 5/12/16, revealed Resident #5 had an altercation when a resident removed the 'stop sign' and wandered into his room. Review of the report revealed Resident #7 came out of Resident #5's room yelling 'Help, Help' and Resident #5</p>	F 323	<p>Safety committee (consisting of members from the following departments: Dietary, Central Supply, Nursing Assistant, Restorative, MDS, Activities, Housekeeping, Laundry, Maintenance, and Therapy) monitors for any accident hazards and addresses them immediately, in an effort to be proactive in accident prevention. The Safety committee reports to the IDT monthly during routine QAPI meeting and as the need arises.</p>	

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stated Resident #7 attempted to climb in bed with Resident #5. Review revealed Resident #7 had scratches/skin tears on left side of face, nose and lower lip. Review revealed the residents were separated and placed on 15 minute checks. Review revealed both residents remained in the facility and not require additional outside intervention.

Review of the Care Plan for Resident #5 revealed "Related to event on 5-12-16-Ensure that my wander strip is up in front of my door."

Review of the Psychiatric Progress Note dated 5/16/16, revealed Resident #5 was seen for follow up per facility request for concerns including refusing care and increased agitation. The progress note indicated the resident displayed no symptoms of psychosis, anxiety, or depression and no worsening of the ongoing diagnoses. Review of the recommendations included the addition of Lamictal 25 milligrams (mg) daily for mood lability, impulse control, and agitation; and Ativan 0.5 mg to be administered twice daily.

Review of the Resident to Resident Altercation Report dated 6/4/16, revealed staff heard Resident #6 scream, staff entered room of Resident #5 and saw Resident #5 holding the hands of Resident #6's behind her head and smiling, and Resident (#6) was "crying out in distress."

Review of the Resident to Resident report revealed the immediate intervention included both residents were separated and placed on 1:1 observation. Continued review of the report revealed Resident #5 had no injuries and

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

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OMB NO. 0938-0391

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F 323	<p>Continued From page 21</p> <p>Resident #6 had red marks on the front, sides, and back of neck. Continued review revealed the family and physician were notified and the physician recommended Resident #5 be sent out for a psychiatric and medication evaluation. Continued review revealed Resident #5 remained on 15 minute checks when in the room and on 1:1 supervision when out of the room until transferred to a Geropsychiatric unit on 6/6/16. Review revealed Resident #6 remained in the facility on 15 minute checks for 24 hours.</p> <p>Review of the Care Plan for Resident #5 revealed the interventions dated 6/4/16 for 1:1 supervision, 6/6/16 transferred out to Geropsych unit, and 6/15/16 was moved to a room off of the Secure unit to a less wandering population.</p> <p>Interview with the DON on 6/22/16, at 2:45 PM, in the conference room, confirmed the facility was aware Resident #5 did not want residents to enter the room; and confirmed the facility failed to supervise and prevent Resident #6 and Resident #7 from entering the room of Resident #5.</p>	F 323		