STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355033	A. BUILDING _____ B. WING _____	07/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINES LIVING CENTER	1307 N 7TH ST WAHPETON, ND 58075

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 06/20/16 and completed on 07/06/16, the sample included four (4) residents for complete review, nine (9) residents for focused review, and two (2) closed records for review. The sample included one (1) additional resident to verify specific concerns during the survey.	F 000		
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 157		8/10/16

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

Electronically Signed | 07/26/2016

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F 157	Continued From page 1 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 record review and review of facility policy, the facility failed to notify the physician for 1 of 2 sampled residents (Resident #15) who experienced a significant change in condition. Failure to notify the physician of a resident's suicidal ideation (Resident #15) did not allow the physician to be fully informed of the resident's status, and provide appropriate treatment. Findings include: Review of the policy "Suicide Threats" occurred on 07/06/16. The policy, dated 12/07, stated, "Resident suicide threats shall be taken seriously and addressed appropriately. . . . 1. Staff shall report any resident threats of suicide immediately to the Nurse Supervisor/Charge Nurse. . . . 4. After assessing the resident in more detail, the Nurse Supervisor/Charge Nurse shall notify the resident's Attending Physician and responsible party, and shall seek further direction from the physician. . . . 7. If the resident remains in the facility, staff will monitor the resident's mood and behavior and update care plans accordingly, until a physician has determined that a risk of suicide does not appear to be present. . . ." Review of the closed record for Resident #15 occurred on June 22-23, 2016. Diagnoses included major depressive disorder, and history	F 157	1. Resident #15 was transferred and discharged from facility on 12/06/2015. Physician notified prior to transfer of change in condition on 12/06/2015. 2. All residents will be reviewed daily for change in condition, mood or behavior through shift to shift report, stand-up, and weekly IDT meetings. 3. Policy for Change in Condition and Suicide Threat were reviewed on 7/20/16. Education given to licensed nursing staff on 7/27/16. 4. Date certain will be 08/10/2016 5. Audits beginning 08/01/2016 will be completed initially by the Director of Nursing and/or Nurse Manager for any resident with a significant change in condition for prompt physician notification. Audits will be completed daily for one month, weekly x1 months, then monthly x3 months, then quarterly. Results of audits will be reported to the facility QA Committee. The Director of Nursing or designee will be responsible for overall compliance.	

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F 157	Continued From page 2 of dementia with paranoid behavior and hallucinations. The facility admitted the resident to a locked special care unit (SCU) and identified the resident with no behaviors upon admission. Three days after admission, the resident began verbalizing feeling of hopelessness which included writing "good-bye" letters to five family members. The facility failed to notify the resident's physician of the change in behavior. Six days following admission to the SCU, the facility transferred the resident to an acute care hospital due to a suicide attempt.	F 157		
F 203 SS=D	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except as specified in paragraph (a)(5)(ii) and (a)(8) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under	F 203		8/10/16

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F 203	Continued From page 3 paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days. The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy and procedure, and staff interview, the facility failed to notify the resident and/or the resident's family/legal representative, in writing, of a transfer, including the resident's right to appeal the action, for 1 of 2 sampled residents in a closed record (Resident #15) transferred to the hospital. Findings include:	F 203	1. Resident #15 was transferred and discharged from facility on 12/06/2015. 2. All residents who are transferred or discharged from the facility will have notification of their rights to appeal with the Notice of Transfer or Discharge form. Family or responsible party will be notified of transfer or discharge along with appeal rights. 3. The policy and procedure for	

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F 203	Continued From page 4 Review of the facility policy "Discharge and Transfer Notice" occurred on 06/23/16. The policy, dated 04/12, stated, "Purpose: To ensure timely notice . . . Policy: 1. The facility assumes responsibility for required timing of notice prior to a transfer or discharge. 2. The resident, the legal representative or interested family member/responsible party are notified . . . Timing of Notice . . . may be shortened by the facility in situations outside of the facility's control such as: . . . An immediate transfer or discharge is required by the resident's urgent medical needs . . . In these cases, the notice must be provided as soon as practicable before the discharge . . ." Review of Resident #15's medical record occurred on June 22-23, 2016. The record showed the facility transferred Resident #15 to the hospital on 12/06/15. The medical record lacked evidence the facility provided a discharge and transfer notice. Upon interview on the morning of 06/23/16, an administrative staff member (#4) did not know if the facility provided a notice.	F 203	Notification of Transfer or Discharge was reviewed on 7/27/16. Education was given to LSW on 7/28/16. Transfer and discharge packets will be created to include Notification of Transfer and Discharge. 4. Date certain will be 08/10/2016 5. Audits beginning 08/01/2016 for providing Notice of Transfer or Discharge form will be completed initially by the LSW or designee on residents who are transferred or discharged daily for 30 days, weekly x1 months, then monthly x3 months, then quarterly. Results will be reported to the facility QA Committee. The Social Services Director is responsible for overall compliance.	
F 205 SS=D	483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies	F 205		8/10/16

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F 205	Continued From page 5 regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on information received from an anonymous individual (B), record review, review of facility policy, and staff interview, the facility failed to provide the resident and/or the resident's family/legal representative a notice of the facility's bed-hold policy for 1 of 2 sampled residents (Resident #15) transferred to the hospital. Failure to provide the notice did not allow the resident, family/legal representative the opportunity to make a decision to hold or not hold the bed during the resident's hospital stay, and resulted in the facility refusing to allow the resident to return back to the facility. Findings include: Review of the "Bed Hold" policy occurred on 06/23/16. The policy, dated 05/14, defined the purpose of a bed hold notice is "To inform residents and their responsible parties of rights regarding bed holds during hospitalizations . . . Policy: 1. The nursing facility's bed hold policy applies to all residents regardless of payment	F 205	1. Resident #15 was transferred and discharged from facility on 12/06/2015. 2. Residents and/or responsible party will be educated on facility Bed Hold Policy on admission. Residents upon transfer to the hospital will receive the facility Bed Hold form. 3. The facility Bed Hold Policy was reviewed by interdisciplinary team. The Licensed Social Worker and/or designee will educate the social service department and the licensed nurses on the Bed Hold Policy on 8/4/16 and 8/9/16. The Bed Hold Policy will be given to all resident(s) and/or the legal representative with any transfer. 4. Date certain will be 08/10/2016 5. Audits beginning 08/01/2016 will be completed by the Licensed Social Worker/designee on all hospital transfers daily x1 month, weekly x3 months, then monthly x3 months.	

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F 205	Continued From page 6 source . . . 2. This policy requires two notices be issued. . . . The second notice, which specifies the duration of the bed hold policy, must be issued at the time of hospital transfer . . . Procedure: . . . Prior to or at the time of transfer of a resident for hospitalization . . . a nursing facility must provide to the resident, responsible party or legal representative written notice which restates and specifies the duration of the bed hold policy. If that is not possible due to extenuating circumstances (i.e. resident has gone to the hospital in an emergency), communicate the information by telephone . . . 3. For emergency hospital transfers, the responsible party or legal representative is provided with written notification within 24 hours of the transfer. . . A copy of the notification is retained in the medical record. . . ." Communication from an anonymous individual (B) received on 06/16/16 identified the facility refused to permit Resident #15 to transfer back to the facility after hospitalization. The anonymous individual reported working with the hospital and facility to return the resident back to the facility, and the family "decided to take him back home . . . as it was clear they [the facility] did not want him back . . ." Resident #15's medical record, reviewed on June 22-23, 2016, identified the facility transferred the resident to a hospital on 12/06/15 due to a medical emergency. The record included a progress note on that date which stated, ". . . Resident was discharged to [hospital] from [this facility] with a no bed hold. . . ." During an interview on the morning of 06/23/16,	F 205		

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F 205	Continued From page 7 an administrative staff member (#4) stated a bed hold notice was not given as the facility would not accept the resident back. A supervisory nursing staff member (#5) stated the facility did not give a bed hold notice due to the circumstances of the transfer and stated the resident needed psychiatric services. Failure to provide the resident, responsible party or legal representative the option for a bed-hold resulted in the hospital/family to seek alternative living arrangements/placement of the resident upon discharge from the hospital.	F 205		
F 222 SS=D	483.13(a) RIGHT TO BE FREE FROM CHEMICAL RESTRAINTS The resident has the right to be free from any chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure 1 of 3 sampled residents (Resident #3) with as needed (PRN) psychotropic medications remained free from chemical restraints. Failure to assess resident behaviors in an effort to determine causative/precipitating factors, develop a behavioral care plan, and implement individualized interventions in an attempt to manage behaviors resulted in the frequent utilization of psychotropic medications to control resident behavior. Findings include:	F 222	1. Resident #3 will have a medication regimen that is free from unnecessary and multiple prn psychotropic medications. A root cause analysis for resident behaviors was completed by the facility interdisciplinary team on 07/27/2016. An assessment was completed for resident #3 behavioral indicators to provide a care plan for appropriate and individualized interventions. The care plan interventions include non-pharmacological interventions to manage behaviors prior to receiving any prn psychotropic	8/10/16

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F 222	Continued From page 8 Review of the facility policy titled "Dementia Care and Antipsychotic Drug Use" occurred on 06/23/16. This policy, updated 04/13/16, stated, ". . . Staff will attempt to determine the root cause of symptoms such as hunger, pain, infection, or confusion resulting from loud noise or having a daily routine interrupted, etc. . . . The standard of practice is to provide care that keeps the resident comfortable and responds to their needs (and symptoms) without drugs whenever possible with the exception of when there is an immediate danger to the individual or another resident. Our staff will attempt to identify the causes of a resident's behavior before requesting a medication to address the symptoms. Our staff will try to utilize non-medication approaches before trying a medication. . . . Appropriate documentation regarding the types of behaviors as well as the non-medication approaches tried is to be done prior to the initiation of any medication is started [sic] unless medication is scheduled and effective in suppressing those behaviors. . . ." Review of the facility document titled "Algorithm for Treating Behavioral and Psychological Symptoms of Dementia (aka Problem Behaviors) occurred on 06/23/16. This document, dated 06/10/15, stated, ". . . Step 1: Identify, Assess, and Treat Contributing Factors . . . Step 2: Select and Apply Non-Pharmacological Interventions . . . Step 3: Monitor Outcomes and Adjust Course As Needed . . ." Review of the facility policy titled "Behavior Assessment and Monitoring" occurred on 06/23/16. This policy, revised February 2014,	F 222	medications. The prn anti-psychotic was discontinued on 7/22/2016. 2. The policy and procedures for psychotropic medication and behavior monitoring have been reviewed. All residents will have a medication regimen that is free from unnecessary psychotropic medications. An assessment will be performed quarterly and prn beginning 08/01/2016 for root cause analysis for all residents on psychotropic medications and residents with mood and behavior indicators. The interdisciplinary team will create care interventions. 3. The Director of Nursing and/or registered nurses will review all residents with prn psychotropic medications to assure their medication regimen is free from unnecessary drugs and physician orders for prn psychotropic medications to ensure orders specifically identify parameters for use. Education was provided on use of Psychotropic Medication and Treating Behavioral Symptoms on 7/27/2016. The Director of Nursing and/or registered nurse will review with all licensed nurses the documentation required prior to an following administration of any prn psychotropic medication to a resident, including non-pharmacological interventions used. 4. Date certain will be 08/10/2016 5. Audits beginning 08/01/2016 will be completed weekly by the Director of Nursing and/or registered nurse to ensure all residents with prn psychotropic medication orders have specific	

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F 222	Continued From page 9 stated, ". . . Problematic behavior will be identified and managed appropriately. . . . The interdisciplinary team will thoroughly evaluate new or worsening resident behavior in order to identify underlying causes and address any modifiable factors that may have contributed to the resident's change in condition . . . The interdisciplinary team will evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident, and develop a plan of care accordingly. . . The interdisciplinary team will develop a care plan with input from the resident and the family, to the extent possible. . . . The care plan will include, as a minimum: a. Interventions for the behavioral and/or psychosocial symptoms of the resident; b. Specific and measurable goals for targeted behaviors; and c. How the staff will monitor for effectiveness of the interventions. . . . Non-pharmacological approaches will be utilized to the extent possible to avoid or reduce the use of antipsychotic medications to manage behavioral symptoms, unless clinically contraindicated. . . . When medications are prescribed to behavioral symptoms, the care plan will include: a. Rationale for use; b. Specific target behaviors and expected outcomes; c. Dosage; d. Duration; e. Monitoring for efficacy and adverse consequences; and f. Plans (if applicable) for gradual dose reduction. . . . The staff will continue to document . . . specific information about problem behaviors or moods. . . . Interventions will be adjusted based on the impact on behavior and other symptoms, including any adverse consequences related to treatment. . . ."	F 222	parameters for use, and are free from unnecessary and multiple prn psychotropic medications, and when such medications are administered the documentation that is required prior to and following such administration has occurred. Audits will then be completed monthly for the first quarter, then quarterly thereafter. The Director of Nursing/designee is responsible for overall compliance.	

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Review of Resident #3's medical record occurred on June 21-23, 2016. Diagnoses included a history of a cerebrovascular accident (stroke), Alzheimer's disease, anxiety disorder, dementia with behaviors, and osteoarthritis. Resident #3's medication administration record (MAR) identified: "Ativan [an anxiolytic] . . . 0.5 mg [milligrams] . . . every 2 Hours - PRN for agitation, restlessness, such as hitting, spitting, crawling out of bed. . . .[ordered 01/20/16]" and "haloperidol [Haldol, an antipsychotic] . . . 0.5 mg . . . Every 6 Hours - PRN for nausea, restlessness, such as hitting, spitting, or crawling out of bed. . . .[ordered 01/20/16]" The current Minimum Data Set (MDS), dated 04/10/16, identified physical behaviors occurred on 4-6 days, other behavior occurred on 4-6 days, and rejection of care occurred on 1-3 days during the 7 day assessment period.

The resident's current care plan stated, ". . . PSYCHOTROPIC MEDICATION . . . Resident receives psychotropic medication r/t [related to] agitation, disrobing, restlessness, constant movement with inability to sit still secondary to diagnosis of anxiety, Alzheimer's, dementia with behavioral disturbances. . . . Approach . . . Administer medications: scheduled and PRN as ordered. Evaluate/record/report effectiveness and any adverse effects. . . . Refer to behavior plan of care . . ." Record review identified no behavior care plan for Resident #3.

Certified nursing assistant (CNA) documentation titled "behavior/intervention monthly flow record" identified behaviors of "Physical Aggression" and "Verbal Aggression." Theses flow sheets included spaces for staff to document the number of

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F 222	Continued From page 11	F 222		

behavior episodes, interventions attempted, and the outcome of the interventions. Review of these flow sheets for March 2016 through June 20, 2016 identified no behaviors occurred except one episode of verbal aggression on 05/03/16.

Review of Resident #3's MAR from April 2016 through June 20, 2016 identified staff administered PRN Haldol 16 times for the following reasons:
*06/16/16: "restless, calling out." No further behavior documentation.
*06/12/16: "restless." No further behavior documentation.
*06/05/16: "restless." No further behavior documentation.
*05/26/16: "anxiety/restlessness." No further behavior documentation.
*05/21/16: "very anxious." No further behavior documentation.
*05/17/16: "[increased] restlessness." No further behavior documentation.
*05/12/16: "[increased] restlessness." No further behavior documentation.
*05/11/16: "[increased] restlessness." No further behavior documentation.
*04/18/16: Haldol signed off on MAR, no reason for administration given. No further behavior documentation.
*04/14/16: "[increased] anxiety." No further behavior documentation.
*04/13/16 (Haldol and Ativan both given at 9:30 a.m.): "restless, agitated" and "restless, anxious, standing up." No further behavior documentation.
*04/09/16 (two separate administrations signed off on MAR, both untimed): A nurse's note, dated 04/09/16 at 4:21 p.m., stated, ". . . resident very agitated and trying to stand and asking where

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F 222	Continued From page 12 [husband's name] is and please don't let me fall. Unable to redirect. Gave food, took for walk, sat with resident. Nothing would work gave PRN Seroquel. [Resident #3's medical record identified no PRN order for Seroquel]." No further documentation related to the administration of two doses of PRN Haldol. *04/02/16: "restless, crawling out of bed [and] chair." No further behavior documentation. Review of Resident #3's MAR from April 2016 through June 20, 2016 identified staff administered PRN Ativan 34 times for the following reasons: *06/14/16 (administered at 12:15 p.m. and 9:00 p.m.: "restlessness" and "[increased] agitation." A nurse's note, dated 06/14/16 at 12:30 p.m., stated, "Tylenol #3 and Ativan given due to resident calling out for [husband], attempting to stand up on her own, pulling table cloth off table, and disrupting others while eating. . . ." No further behavior documentation regarding the 9:00 p.m. administration. *06/12/16: "[increased] agitation." No further behavior documentation. *06/11/16: "restlessness." No further behavior documentation. *06/10/16: A nurse's note, dated 06/10/16 at 7:24 p.m. stated, ". . . Very agitated after breakfast trying to stand up and repeating things over and over to the point of yelling. Gave Ativan and Tylenol with codeine was effective. . . ." *06/02/16: "restless, standing up." No further behavior documentation. *05/27/16: "anxiety." A nurse's note, dated 05/27/16 at 9:13 p.m., stated, ". . . Spouse pushed resident around in wheel chair until 5 PM to which spouse stated 'she just won't stay sitting	F 222		

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F 222	Continued From page 13 for me.' At 4PM resident was complaining of lower back hurting and anxious even though spouse was here. PRN Tylenol #3 along with Ativan given. . . ." *05/25/16: "[increased] agitation." No further behavior documentation. *05/11/16: "restlessness." No further behavior documentation. *05/02/16: "[increased] restlessness." No further behavior documentation. *05/01/16: A nurse's note, dated 05/01/16 at 9:23 a.m., stated, ". . . Res has been standing up constantly from her w/c [wheelchair]. Res is up by the desk. Res was c/o pain in her back, 'Oh, my back hurts.' Tylenol #3 1 tab [tablet] given and then continued to stand up out of w/c. Ativan given at 9:15 a.m. for restlessness. . . ." *04/30/16: "[increased] restlessness." No further behavior documentation. *04/26/16: A nurse's note, dated 04/26/16 at 11:17 a.m., stated, ". . . PRN Ativan 0.5 mg given at 1110 [11:10 a.m.] for increased restlessness and crying. Resident has been 1:1 [one to one] at this time. Resident continues to try to stand up out of her chair and continues to ask where [husband] is. . . ." *04/25/16: "[increased] restlessness." No further behavior documentation. *04/24/16 (administered at 1:10 p.m. and 6:30 p.m.): "restless" and "very restless." A nurse's note, dated 04/24/16 at 8:44 p.m., stated, "Ativan 0.5 mg given at 1:10 pm and 6:30 pm for restlessness resident was a 1 on 1 at these times. Resident was put in her room in bed and mat on floor. Resident is very content in her room on the mat. . . ." *04/23/16: "agitation." No further behavior documentation.	F 222		

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F 222	Continued From page 14 *04/22/16: "aggitation [sic]." No further behavior documentation. *04/21/16 (two administrations signed off on MAR, only one timed at 7:35 p.m.): "agitation." No further behavior documentation. *04/18/16 (administered at 4:30 p.m. and 7:00 p.m.): "[increased] aggitation [sic]." No further behavior documentation. *04/17/16: "[increased] aggitation [sic]." No further behavior documentation. *04/16/16: "[increased] aggitation [sic]." No further behavior documentation. *04/13/16 (administered at 9:30 a.m. and 2:30 p.m.): "restless, anxious, standing up" and "restless, agitated." No further behavior documentation. *04/09/16 (administered at 9:00 a.m. and 11:00 a.m.): "restless, agitated." A nurse's note, dated 04/09/16 at 4:21 p.m., stated, ". . . resident very agitated and trying to stand and asking where [husband's name] is and please don't let me fall. Unable to redirect. Gave food, took for walk, sat with resident. . ." No further documentation related to the administration of two doses of PRN Ativan. *04/08/16 (administered at 4:30 p.m. and 7:30 p.m.): "restless." A nurse's note, dated 04/08/16 at 8:07 p.m., stated, ". . . Resident has been very restless she is continually trying to crawl out of her chair. Resident has been 1 on 1 since 1 PM. This resident is very strong she has no problem pulling herself out of her w/c. it is a constant movement for this resident. . . ." *04/06/16: "c/o restless." A nurse's note, dated 04/06/16 at 3:30 p.m., stated, "Resident was very restless and continually trying to crawl out of her chair. PRN Ativan 0.5 mg given per order. . . ." *04/04/16 (administered at 6:45 a.m., 3:00 p.m.,	F 222		

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and 7:00 p.m.): "restless, agitated," "agitation," and "restless." A nurses' note, dated 04/04/16 at 6:47 a.m., stated, ". . . Res [resident] was in rock and go chair and res got self onto floor, left res on the floor for a short time and then assisted back into chair. Res restless, trying to stand up constantly. Ativan and Haldol given for restlessness." Another nurse's note, dated 04/04/16 at 9:13 p.m., stated, ". . . Resident very restless and agitated this shift. Ativan given at 1500 [3:00 p.m.] and 1900 [7:00 p.m.] due to agitation/restlessness. Haloperidol given at 2115 [9:15 p.m.] due to resident repeatedly crawling out of bed. . . ."

The facility failed to describe specific behaviors exhibited by Resident #3 that warranted the use of PRN psychotropic medications, and failed to consistently attempt non-pharmacological interventions prior to their administration.

During an interview on 06/22/16 at 5:55 p.m., an administrative nurse (#19) stated staff should write a note regarding the behaviors if they administer a PRN. She also identified Resident #3's care plan lacked information specific to behaviors and non-pharmacological interventions related to the behaviors.

During an interview on 06/23/16 at 8:26 a.m., an administrative nurse (#5) stated PRN psychotropic medications would not be the least restrictive intervention for Resident #3, and agreed staff should attempt non-pharmacological interventions first.

Staff failed to thoroughly evaluate Resident #3's behaviors; determine causative/precipitating

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F 222	Continued From page 16 factors, as well as patterns; develop and implement an individualized behavioral care plan, and attempt non-pharmacological interventions specific to Resident #3's needs. As a result, Resident #3 received multiple psychotropic medications which may not have been necessary to treat medical symptoms and may have instead been used for staff convenience and to control Resident #3's behavior.	F 222		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and review of facility policy, the facility failed to provide care in a manner and environment that maintains or enhances resident's dignity and respect for 1 of 3 sampled residents (Resident #5) on the special care unit. Failure to speak to Resident #5 in a dignified manner does not promote or enhance respect or recognize the resident's individuality. Findings include: Review of the facility policy titled "Quality of Life - Dignity" occurred on 06/23/16. This policy, revised August 2009, stated, "1. Residents shall be treated with dignity and respect at all times. 2. 'Treated with dignity' means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth. . . . 7. Staff shall	F 241	1. The facility staff will provide care and dialogue in a manner and environment that maintains and/or enhances resident #5's dignity and respect. 2. Policy Quality of Life-Dignity was reviewed. All facility staff will provide care and dialogue in a manner and environment that maintains and or enhances all residents' dignity and respect. 3. All staff will be educated 8/4/2016 or 8/9/2016 on providing care and dialogue in a manner and environment that maintains and/or enhances all residents' dignity and respect initially and then at least quarterly for one year. This education will also be include in new employee orientation.	8/10/16

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F 241	Continued From page 17 speak respectfully to residents at all times . . . 11. Demeaning practices and standards of care that compromise dignity are prohibited. . . ." - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included hemiplegia, dementia, and major depressive disorder. The quarterly Minimum Data Set (MDS) dated 06/11/16, identified severely impaired cognition and extensive assist of 1-2 persons for activities of daily living (ADL). Observation on 06/21/16 at 8:30 a.m., showed a certified nursing assistant (CNA) (#1) assist Resident #5 with personal cares. The CNA completed peri care, placed a new brief, and stated, "Gotta [sic] make sure those jewels are covered," in regards to Resident #5's anatomy. Review of nursing progress notes revealed the following: * 10/14/15 10:03 a.m. "Bath aid came in with another resident, resident got extremely upset when the door got closed before he could get out. Resident was kicking at staff and trying to hit staff. Resident was assisted to his room and per three person assist was assisted to the floor. . . ." * 10/14/15 10:30 a.m. "Resident maneuvered self into the hall, staff asked resident if he would like some help getting up, resident stated 'yes, [curse word].' Staff asked resident if he was done hitting and kicking at those walking by and resident tried to kick staff and hit them and said 'you go to [curse word].' Resident was then picked [up] by per two assist and brought back into his room d/t [due to] residents were coming down the hall. When resident was placed gently onto the floor resident almost kicked staff in the head and tried	F 241	4. date certain will be 08/10/2016 5. Audits will be assigned by the Administrator. Audits beginning 7/27/2016 will be completed initially by the departmental managers to ensure that staff are providing care and dialogue in a manner and environment that maintains and/or enhances all residents' dignity and respect. Audits will then be completed (on a minimum of 10 resident interactions) weekly for one month then monthly for one year. Results of monitoring will be reported to the QA Committee at each scheduled meeting (at least quarterly). The department manager will follow up on further education/ training on an as needed basis.	

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F 241	Continued From page 18 to swing body around to kick staff in the legs when trying to walk out of the room. . . ." * 10/14/15 1:32 p.m. "Nurse talked to resident and asked if he would like to be friends again resident stated 'I'm not mad at you, I don't hold grudges, are we done boxing?' Resident was assisted off the floor per two assist and the Hoyer lift. Resident is currently in his recliner and is in a good mood and even thanked staff for helping him off the floor." Facility staff failed to speak to, and treat Resident #5 in a manner and in an environment that maintained or enhanced the resident's dignity and respect in full recognition of his individuality.	F 241		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: INSULIN ADMINISTRATION 1. Based on observation and review of professional reference, the facility failed to follow professional standards of practice for 2 of 2 observations of insulin administration (06/21/16 at 7:55 a.m. and 4:45 p.m.). Failure to ensure staff offered food within the recommended time frame after rapid-acting insulin administration may result in hypoglycemia (low blood sugar). Findings include: The "Nursing 2015 Drug Handbook," 35th	F 281	1. Resident #4 will have food offered within the recommended time frame after rapid- acting insulin administration to prevent hypoglycemia. Resident #3 will have appropriate documentation and follow up documentation of prn medication administrations on the MAR. 2. All residents who receive rapid-acting insulin will be reviewed for insulin administration time and offered food within the recommended time frame to prevent hypoglycemia. All residents who receive a prn medication will have	8/10/16

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F 281	Continued From page 19 Edition, Wolters Kluwer, Pennsylvania, page 759-760, stated, ". . . NovoLog . . . Give NovoLog 5 to 10 minutes before start of meal. . . ." - Observation on 06/21/16 at 7:55 a.m. showed a licensed nurse (#2) administered 10 units of NovoLog insulin to Resident #4. Observation showed Resident #4 received her meal tray at 8:15 a.m. (20 minutes later). - Observation on 06/21/16 at 4:45 p.m. showed a licensed nurse (#7) administered 6 units of NovoLog insulin to Resident #4. Observation showed Resident #4 sitting at the dining room table with a only glass of water placed in front of her at 5:40 p.m. (50 minutes later). PRO RE NATA (PRN) MEDICATION ADMINISTRATION 2. Based on record review, review of professional reference, and staff interview, the facility failed to follow professional standards regarding administration of as needed (PRN) medications for 1 of 2 sampled residents (Resident #3) with prn psychotropic and pain medications. Failure to ensure appropriate follow up after administration of prn medications may result in unresolved anxiety, behaviors, and pain. Findings include: The Geriatric Medication Handbook, 7th ed., American Society of Consultant Pharmacists, page 148-150, stated, ". . . Steps of Medication Administration . . . P.R.N. medications administered appropriately and for proper	F 281	appropriate medication documentation and follow up documentation of prn medicationadministrations on the MAR. 3. Policy and procedure for medication administration was reviewed by the Director of Nursing. All licensed nurses were educated on medication policy and procedure and on the significance of all residents receiving a rapid acting insulin needing to be offered food within the recommended time frame to prevent hypoglycemia on 7/27/2016. The Director of Nursing Services and/or registered nurse educated all licensed nurses on 7/27/16 on appropriate documentation and follow up documentation of all prn medication administrations on the MAR. 4. 08/10/2016 5. Audits beginning 08/01/2016 will be completed weekly by the registered nurse to ensure that all residents who receive rapid-acting insulin are offered food within the recommended time frame to prevent hypoglycemia and that all prn medications have appropriate documentation and follow up documentation of prn medication administration on the MAR. Audits will then be completed weekly for one month, then monthly x3 months, and then quarterly for one year. Results of monitoring will be reported to the QA Committee at each scheduled meeting (at least quarterly). The Director of Nursing and/or designee will follow up on further education/training on an as needed basis.	

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indication; appropriate charting performed regarding: . . . Date . . . Time . . . Reason for giving the medication . . . Response after the medication is given . . ."

Review of Resident #3's medical record occurred on June 21-23, 2016. Diagnoses included Alzheimer's disease, anxiety, and osteoarthritis. Current medications included Ativan (an anxiolytic) 0.5 milligrams (mg) every two hours PRN, morphine concentrate 5 mg every 30 minutes PRN, Tylenol-Codeine #3 300-30 mg every four hours PRN, and haloperidol (Haldol, an antipsychotic) 0.5 mg every six hours PRN.

Review of Resident #3's medication administration records (MARs) from February 1, 2016 through June 23, 2016 identified the following administrations of PRN medication without documentation of the effectiveness of the medication:
*Ativan: 31 administrations
*Morphine: 12 administrations
*Haldol: 13 administrations
*Tylenol #3: 24 administrations

In addition, the MARs from February 1, 2016 through June 23, 2016 identified staff signed off medications as given; however, the medical record lacked evidence as to the reason for administration as well as the resident's response to the medication. This occurred with the following medications:
*Ativan: six administrations
*Morphine: six administrations
*Tylenol: four administrations
*Haldol: three administrations

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F 281	Continued From page 21 During an interview on 06/23/16 at 8:26 a.m., an administrative nurse (#5) stated she expected staff to document administration and follow up of PRN medications on the MAR.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to provide the necessary care and services for 1 of 7 sampled residents (Resident #9) who experienced a fall within the facility. Failure to complete a thorough assessment following a fall which resulted in a hip and arm fracture, prior to moving Resident #9 and implement appropriate actions based on that assessment may result in significant risk of further tissue/bone damage and increased pain. Findings include: Review of the policy "ACCIDENT/INCIDENT OCCURRENCE" occurred on 06/23/16. The policy, dated 07/14, stated, "STANDARD: Appropriate interventions are initiated and an Event is completed for: . . . All accidents or incidents where there is injury or the potential to	F 309	1. Resident #9 was transferred and received emergency care on 5/22/16. 2. All residents who fall will receive a thorough assessment including range of motion, full body check, vital signs and neurological assessment if suspected or actual head involvement prior to moving the resident to assure no further damage or increase in pain to resident. 3. The Director of Nursing and/or designee will educate all licensed nurses on 07/27/16 on the Accident/Incident Occurrence Policy including thorough assessment of resident after a fall prior to moving the resident. 4. 08/10/2016 5. Audits will be initiated on 08/01/16 and completed on all falls by the Director of Nursing and/or designee to ensure all residents who fall received a thorough	8/10/16

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F 309	Continued From page 22 result in injury. . . POLICY: Licensed nursing personnel are responsible for: a. Coordination/completion of a physical assessment of the resident at the time of the incident. . . . PROCEDURE: 1. If resident seen falling or is found on the floor and presumed to have fallen, an initial assessment that includes the following will be done: a. Range of Motion (ROM) b. Full body search c. Vital Signs d. Neurological Assessment (actual/suspected head involvement) 2. The resident should not be moved until the initial assessment is completed. . . . 7. Documentation in Clinical Notes should include an accurate description of the incident; results of the ROM; body search, and vital signs check; notification of physician and family; and remedial measures and treatments. . . . " Review of the policy "Assessing Falls and Their Causes" occurred on 06/23/16. The policy stated, "Purpose: The purposes of this procedure are to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. . . . After a Fall: 1. . . . evaluate for possible injuries . . . 2. If there is evidence of a significant injury such as a fracture or bleeding, nursing staff will provide appropriate first aid. 3. Once an assessment rules out significant injury, nursing staff will help the resident to a comfortable sitting, lying, or standing position, and then document relevant details. . . ." Review of Resident #9's medical record occurred on all days of survey. Diagnoses included Alzheimer's dementia and deep vein thrombosis prophylaxis. An addition to the diagnoses list on 05/22/16 included a fractured right hip, and a fracture of the right wrist.	F 309	assessment prior to moving the resident to assure no further damage or pain. Audits will then be completed weekly for one month, then monthly for one year. Results of monitoring will be reported to the QA Committee at each scheduled meeting (at least quarterly). The department manager will follow up on further education/training on an as needed basis.	

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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
F 309	Continued From page 23 Review of Resident #9's annual Minimum Data Set (MDS), dated 04/11/16, identified the resident with moderate cognitive impairment, independent in transfers and with no pain utilizing a scheduled pain medication. A significant change MDS, dated 05/31/16, identified the resident with severe cognitive impairment; required extensive assistance of two or more persons for transfers; and on scheduled, as needed, and non medication pain management all on a daily basis. Progress notes identified the following: * 05/22/16 at 10:32 a.m. stated, "Resident fell this morning in her room, having a hard time standing on right leg states it is burning bad. Is able to move it slightly. Right wrist is also starting to swell and she is having a hard time moving. Large bump on top right side of her head, starting to bruise. resident able to answer questions and verbalize what happened. Stated she just turned wrong and lost her balance. Daughter here at this time and has decided to take her to ER [emergency room] for x-rays. Assisted resident into vehicle and is on her way to the ER now." The medical record lacked evidence nursing staff completed a full body assessment, including ROM, to determine the possibility of significant injury sustained with the fall prior to moving the resident and prior to assisting the resident into the daughter's vehicle. In addition, nursing staff failed to provide appropriate first aid/care for the resident. The medical record identified the resident taken by personal car to the ER and transported by ambulance to an acute care hospital "with a fractured (R) [right] hip and wrist" and on	F 309		

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F 309	Continued From page 24 05/23/16 ". . . Resident had surgery and 2 pins placed to hip and surgery to wrist." The resident returned to the facility on 05/25/16. During interview on the morning of 06/23/16, a nursing administrative staff member (#5) stated she would have expected nursing staff to complete a full assessment of the resident after a fall including an assessment of ROM, and a neurological assessment if the resident hit their head. Nurses notes, dated 05/22/16, identified the resident expressed difficulty standing on her right leg, stating it was "burning bad" as well as pain and swelling to the right arm, all indicators of serious injury. The facility failed to complete a thorough assessment of Resident #9 following the fall and provide appropriate care to prevent additional injury.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of the facility policy and procedures, and staff interview, the facility failed to provide appropriate assistance with perineal cares for 3 of 7 sampled residents (Resident #3, #4, and #9) observed during personal cares. Failure to provide	F 312	1. Residents #3, #4, and #9 will be provided appropriate perineal care and hand hygiene to prevent infection and skin irritation. 2. All residents who are dependent on toileting will be provided appropriate	8/10/16

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F 312	Continued From page 25 appropriate perineal cares and hand hygiene has the potential to cause infection and skin irritation. Findings include: Review of the facility policy titled "Perineal Care" occurred on 06/22/16. This policy, dated 2015, stated, "Standard: Perineal care will be performed to residents twice a day, after each incontinent episode, or more often as needed. Perineal care promotes cleanliness and prevents infection . . . Pericare will be completed from cleanest to the dirtiest areas, with the urethral area considered the cleanest, the anal area the dirtest. Procedure: . . . PERICARE AFTER INCONTINENT EPISODE . . . remove feces with toilet paper, wipes, or washcloth and water. Cleanse perineum from front to back with premoistened wipe or washcloth and water. Cleanse any area of skin in contact with urine or stool to prevent skin irritation and/or skin breakdown . . ." Review of the facility policy titled "HANDWASHING" occurred on 06/21/16. This policy, dated June 2015, stated, "STANDARD: This facility considers hand hygiene as the primary means to prevent the spread of infections. POLICY: All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors . . ." - Review of Resident #4's medical record occurred on June 21-23, 2016. Diagnoses included dementia and a history of urinary tract infections (UTIs). The resident's current care plan identified, ". . . URINARY: Resident is incontinent	F 312	perineal care and hand hygiene to prevent infection and skin irritation. 3. The Director of Nursing and/or designee will educate all certified nursing assistants that provide personal care on proper perineal care and hand hygiene to dependent residents; education will be conducted on 08/04/16 and 08/09/16. 4. 08/10/2016 5. Audits will be initiated on 08/01/16 and completed by the licensed nurses on all certified nursing assistants that provide personal care on proper perineal care and hand hygiene. The licensed nurses will then complete random audits on a minimum of five certified nursing assistants per week for one month. Audits will then be completed monthly for first quarter and then quarterly for one year by the licensed nurses. Results of monitoring will be reported to the QA Committee at each scheduled meeting (at least quarterly). The Director of Nursing and/or designee will follow up on further education/training on an as needed basis.	

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of bladder . . . Assist of 2 for incontinence care; check and change every 2 hours and prn [as needed]. . . . Provide incontinence care after each incontinent episode . . ." The current Minimum Data Set (MDS), dated 04/18/16, identified total assistance from two or more people for toileting and personal hygiene, and always incontinent of bowel and bladder.

Observation on 06/21/16 at 9:10 a.m., showed two Certified Nurse Assistants (CNAs) (#8 and #10) provided to Resident #4 incontinence cares. The CNA (#10) rolled Resident #4 on her side and the other CNA (#8) removed the resident's soiled brief. Observation showed a large amount of incontinent stool on Resident #4's buttocks and perineal area. The CNA (#8) provided perineal cares from the back with toilet tissue and cleansing cream. Observation showed stool on the toilet tissue as the CNA (#8) wiped the perineal area twice from front to back without using clean toilet tissue.

Observation on 06/21/16 at 3:15 p.m., showed Resident #4 incontinent of urine and a large amount of stool. Each CNA (#9 and #11) assisted and observation showed both CNA's gloves visibly soiled with stool. Resident #4 reached down to scratch with both hands near her lower abdomen and CNA (#9) grabbed both hands with the soiled gloves and held them until the other CNA (#11) returned to the bedside. After both CNAs completed hand hygiene they transferred Resident #4 into the wheel chair. The CNA (#11) stated "I'll take you to the lounge so you can have your afternoon snack". Care plan stated "set up assist for meals". The CNA (#11) removed Resident #4 from her room and wheeled her to

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the lounge. Observation showed staff failed to provide hand hygiene to Resident #4.

Observation on 06/21/16 at 3:17 p.m. showed two CNAs (#9 and #11) assisted Resident #4 (who was incontinent of stool) with perineal care as she lie in bed. The CNA (#9) wiped the resident's buttocks and then, with bowel movement visible on the incontinence wipe, proceeded to wipe the resident's front perineal area.

- Review of Resident #3's medical record occurred on June 21-23, 2016. Diagnoses included Alzheimer's disease. The current care plan identified, ". . . URINARY: Resident is frequently incontinent of bladder . . . Provide incontinence care after each incontinent episode. . . ." The current Minimum Data Set (MDS), dated, 04/10/16, identified total assistance from two or more people for toileting and personal hygiene, and frequently incontinent of bowel and bladder.

Observation on 06/21/16 at 1:15 p.m., showed two CNAs (#8 and #11) provided incontinent cares to Resident #3. The CNA (#8) removed the wet brief, applied a new brief and failed to provide perineal cares.

- During incontinence cares on 06/21/16 at 9:35 a.m., a staff member (#3) provided perineal cares for Resident #9 after an incontinent loose bowel movement. The staff member provided the incontinence care utilizing toilet tissue, wiping the resident from front to back without always using the clean side of the toilet tissue or obtaining new toilet tissue before wiping toward the resident's

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F 312	Continued From page 28 frontal periarea. The staff member also did not complete frontal pericares. During interview on the morning of 06/24/16, an administrative staff member (#4) stated he would expect frontal pericares provided for incontinence care of a bowel movement.	F 312		
F 323 SS=J	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: ELOPEMENT 1. Based on observation, record review, resident interview, and staff interview, the facility failed to ensure the safety of wandering residents for 1 of 2 sampled residents (Resident #8) who eloped from the special care unit. Failure to ensure the functionality of a locked door from the courtyard prior to residents from the special care unit (SCU) utilizing the yard placed this resident and all residents from the special care unit at risk of injury when leaving the unit without staff knowledge. During the standard recertification survey on 06/22/16, the team determined a potential Immediate Jeopardy (IJ) situation existed. The IJ	F 323	1. Resident #15 was transferred and discharged from facility on 12/06/2015. Resident #8 had no adverse effects. Locks were placed on the fence gate in the courtyard (that is connected to the special care unit). The doors exiting the courtyard have been secured with keypad entry. The windows in the secured care now have a chain that does not allow them to open wide enough for elopement. 2. All residents are assessed with the RAI schedule for elopement risk. All residents who express indicators of suicide ideation will be promptly identified by all staff to ensure appropriate and prompt treatment and safe environment for resident identified. All residents with behaviors	8/10/16

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F 323	Continued From page 29 potential resulted from an observation at 10:00 a.m. in the courtyard which identified the 200 wing door did not latch shut. Residents from the special care unit have access to the courtyard. Review of Resident #8's medical record identified elopements from the courtyard. After observation and discussion, the survey team met at 10:09 a.m. and determined corrective action needed to occur. At this time, the team contacted the management staff at the State Agency (SA) to report the findings and to discuss a potential IJ situation. On 06/22/16 at 10:26 a.m. the survey team notified the facility administrator and the director of nursing that an IJ situation existed and that they must develop a plan for abatement. At 06/23/16 10:15 a.m. the facility provided an acceptable written plan of correction for the IJ. The survey team determined the IJ situation abated, abridged the scope and severity level to "D," and informed the administrator of this action. On 06/23/16 at 1:14 p.m., the State Survey Agency notified the Regional Office of the IJ. Findings include: - Review of Resident #8's medical record occurred on June 20-23, 2016. This facility admitted Resident #8 on 01/06/16 with a diagnosis which included dementia with behavioral disturbance. A quarterly Minimum Data Set (MDS), dated 04/05/16, identified the resident with severely impaired cognition; wandered one to three days in the last seven; walked independently in his room; and required one person setup help for walking in the corridor and locomotion on and off the unit.	F 323	(including elopement risk and suicide ideation) will have a care plan developed with appropriate interventions to ensure a safe environment for the residents. All residents will have physician orders and an evaluation for the appropriateness of placement in a locked secured unit 3. All staff will be educated by the Director of Nursing, Administrator and/or designee on the Suicide Threats policy to ensure understanding that they must report any resident threats of suicide immediately to the charge nurse. After assessing the resident in more detail, the charge nurse will notify the residents attending physician and responsible party to seek further direction from the physician for appropriate and immediate treatment of the resident at risk. BHS LSW Consultant provided education on the BHS Suicide Prevention Plan on 7/20/16 to the licensed social workers and director of nursing services. The Licensed Social Worker and/or designee will review all residents PHQ-9 to determine if resident is at risk for elopement risk and suicide ideation to ensure appropriate interventions in place for a safe environment for the residents. The Director of Nursing Services and/or registered nurse will ensure all residents have physician orders and an evaluation for the appropriateness of placement in a locked secured unit. Education will be completed with all staff in regards to changes in condition including mood and behavior and elopement risk. Engineering and clinical	

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F 323	Continued From page 30 Review of Resident #8's care plan, dated 01/15/16, stated, "Problem: Behavior Symptoms. Resident was wandering in hallways and peers room. 5/02/16 off unit. 5/28/16 off unit. . . . Approach: Staff will assess whether the behavior endangers the resident and/or others. Staff will intervene if necessary. Staff will avoid over-stimulation (e.g., noise, crowding, other physically aggressive residents). Staff will convey an attitude of acceptance toward the resident. Staff will maintain a calm environment and approach to the resident. . . . Problem: Cognitive Loss/ Dementia. Resident struggles with memory loss and wandering due to his Alzheimer's Dx [diagnosis]. and [sic] cognitive impairment. . . . Staff will repeat and clarify information as noted by resident's response. Staff will redirect and/or distract resident as needed by offering other activities and food options to decrease wandering. . . ." A care plan update, dated 06/21/16, stated, "Problem: Behavior Symptoms. Monitor when outdoors in courtyard, maintenance assessing keypad system for entrances and egresses of courtyard. Allow and encourage time outside in courtyard weather permitting-assure gate locked prior to assisting out in courtyard. . . . " An Elopement Risk Assessment, completed on 01/11/16, identified the following for Resident #8: ". . . Wandering with no rational purpose and attempting to open doors . . . recent move to facility . . . wandering in past 60 days . . . dementia . . . Based on assessment does resident present an elopement risk? Low. . . ." Nurse's notes identified the following:	F 323	staff will be educated on the new locking system of the gate, door and windows. Education will take place for all facility staff on 7/27/16, 8/4/16 and 8/9/16. 4. 08/10/2016 5. Audits will be completed by a Licensed Social Worker and/or designee on all residents to assure residents have been assessed for elopement risk and suicidal ideation including changes in mood and behavior weekly beginning 08/01/16 for one month, then monthly for one year. Audits will be completed by the Director of Nursing and/or designee beginning 08/01/16 to ensure all current residents have physician orders and an evaluation for the appropriateness of placement in a locked secured unit these audits will be completed monthly for one year. The locking system on the door, fence and windows will be audited by the Administrator and/or Maintenance Department to assure proper function starting 08/01/16, these audits will be completed on a weekly basis. Results of monitoring will be reported to the QA Committee at each scheduled meeting (at least quarterly). The Director of Nursing Services and/or Administrator will follow up on further education/training on an as needed basis.	

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F 323	Continued From page 31 * 06/02/16 10:24 a.m. - "Updated son with his weekly visit to this resident elopement on 5/31 [The actual date of the elopement was 05/28/16]. showed son how resident exited courtyard through another door he saw, and then exited another door that was directly in his path to be outside of facility. Discussed facility plan to secure both doors, currently working with security company. . . ." * 05/28/16 7:50 p.m. - "ELOPEMENT: Resident was let outside into the courtyard after supper so he could walk around. Nurse went back into SCU and was getting an update from CNA [certified nursing assistant] who is back there. At this time another CNA came into the unit and asked if this resident was supposed to be outside by the garbage bins. This nurse said no and ran out of facility followed by CNA to find resident. Resident got back by [name of college] track and was walking away from facility. This nurse ran up to resident and asked him what he is doing. . . . Resident was reluctant to follow staff but did walk with us back into the facility. . . . Resident back in special care and door is now locked." * 05/10/16 1:51 p.m. - "ELOPEMENT: Resident continues to be pleasantly confused this morning. Resident becoming agitated after dinner wanting to get out of facility and to go uptown; staff opened living room door for resident to wander in the courtyard and resident immediately went to the south 200 wing door and entered there and began walking down the hallway. Staff deterred resident back to the courtyard; resident wandered for some time again and went back in the south 200 wing door, RN [Registered Nurse] there to deter resident from continuing to elope and guided him back out to the courtyard. Resident then started trying to manipulate fence	F 323		

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F 323	Continued From page 32 in courtyard to leave the facility grounds. . . ." * 05/10/16 1:34 p.m. - "ELOPEMENT: Resident restless after lunch within the last 10 minutes. Was inquiring at SCU entrance doors about 'getting out of here.' Resident states he wants to go outside. RN did call back to SCU and spoke with staff. RN told staff to let him out the courtyard doors and see if this would pacify him. Resident had coat on and walked out SCU courtyard door right to south side entrance. He then opened door and was going to walk immediately across to second door to get out of the building. He was being monitored by staff. Staff then caught up with him in [sic] and attempted to get him to go back to SCU. Resident stated he needed to be outside. Staff let him back out in the courtyard and closed door tight. Resident wandering in courtyard went to north enterance [sic] and couldn't get door to open. Went to the fence and was playing with the chain. Came back to south entrance where another resident had gone outside from and resident again able to open door and ended up in the south hallway. He was trying to go out the other door that would exit building. . . ." * 05/02/16 4:08 p.m. - "ELOPEMENT: . . . Resident continued to wander around the SCU. This nurse was assisting another resident with cares when activities came back to see if there was anyone they could take outside for a walk. This nurse said that this resident has been asking to go out and would like to. Activities and this nurse could not find resident in his room or any other room. Home health staff brought resident back to SCU. When entering dinning [sic] room staff noticed that the window was open and the screen was taken off and that is how the resident escaped the unit. Resident screwed the	F 323		

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F 323	Continued From page 33 window open with fingers due to there being no crank on the window. . . ." * 05/02/16 3:25 p.m. - "ELOPEMENT: Resident climbed out dining room window and walked around the facility. He entered the south west door and was spotted by one of the home health nurses who assisted him back to SCU. . . . Communication sent to Social Services and Administration regarding this issue as this resident has attempted this in the past. Will continue to monitor resident and attempt to keep safe. Resident is high elopement risk. * 04/14/16 8:58 p.m. - " . . . Activities came back to SCU and opened the door so that some residents could enjoy the weather. This resident was told he could go outside at this time. . . . Resident was told that yes he could in fact go outside. Once outside he started to walk around and got to an area with an opened gate. Activity lady went to check on resident and saw the gate was open. She asked him to come back to the doors with him [sic] and he got very upset and got in her face. Activities told resident that his son was on the phone for him so he would come back inside. . . ." * 04/11/16 6:21 p.m. - "Many attempts to escape to the outside. He took the screen off dining room window and cranked window open by using his fingers. Crank was not on the window. Staff caught him stepping out of the window, hard to redirect . . ." The nurses notes identified the following elopement attempts and/or elopements made by Resident #8: * June 2016: three attempts to elope and exit seeking behaviors. * May 2016: five elopements, two episodes of exit	F 323		

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seeking behaviors.
*April 2016: one elopement, seven episodes of exit seeking behaviors.
* March 2016: eight episodes of exit seeking behaviors.

On 06/22/16 at 10:00 a.m. the survey team walked through the 200 wing door to the courtyard, the alarm failed to sound. When in the courtyard, the survey team was able to re-enter the building through the 200 wing door, the door did not latch, and the door alarm failed to sound. The survey team also walked directly across the hall from the courtyard door and exited to outside the facility, the door failed to alarm. The survey team was able to go out to the courtyard and back to the outside of the facility three times. The door failed to alarm each time.

Following this observation, an interview with an environmental service director (#12) on 06/22/16 at 10:55 a.m. identified when staff give a resident from the facility access to the courtyard, a staff member must turn off or disarm the system for the courtyard door. When asked when that system would be alarmed again, he stated the staff would re-alarm the door upon the resident returning into the building. The staff member (#12) confirmed another resident goes into the courtyard often and the nurse has to reset the alarm when he comes back inside which may leave the door disarmed for a period of time.

On 06/21/16 at 1:50 p.m. a CNA (#6) stated residents go out the 200 wing door leading into the courtyard and can return into the facility as the door opens from the outside.

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On 06/22/16 at 4:00 p.m. during a confidential interview Resident A stated, "My family takes me out into the courtyard. The door is left open so we can get back into the facility." (pointed to the 200 wing door leading into the courtyard)

During an interview with Resident #11 on 06/23/16 at 9:00 a.m., the resident identified he has access to the courtyard and could go in and out of the courtyard on his own as the door was usually open and he would access the courtyard several times a day. The most current MDS for Resident #11 identified him as cognitively intact and not a resident on the SCU.

During an interview with an administrative nurse (#5) on 06/22/16 at 10:26 a.m., the nurse (#5) stated staff are to be directly observing Resident #8 when in the courtyard. The nurse (#5) also stated that with seven residents on the special care unit the facility cannot justify more than one staff member to that area.

The facility failed to adequately monitor Resident #8 when in the courtyard, and failed to secure the courtyard which resulted in Resident #8's multiple elopements placing him and all residents from the special care unit at risk of injury when leaving the building without staff knowledge.

SUICIDAL ATTEMPT

2. Based on record review, the facility failed to recognize symptoms of suicidal ideation and avert a suicide attempt for 1 of 2 sampled residents (Resident #15) reviewed in a closed record. Failure to recognize suicidal indicators

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and respond appropriately, and ensure the environment was not conducive to potential for injury resulted in a suicide attempt within the facility.

Findings include:

Review of the closed record for Resident #15 occurred on June 22-23, 2016. Diagnoses included major depressive disorder, Alzheimer's disease, and history of dementia with paranoid behavior and hallucinations. The facility admitted Resident #15 to a locked special care unit (SCU). Six days following admission to the SCU, the facility transferred the resident to an acute care hospital due to a suicide attempt.

The medical record included a progress note, dated 12/02/15, which identified the resident "transfers per himself with no problems . . . independent in toileting and changing an ileostomy bag . . . a private person when it comes to personal cares and bathing . . . denies pain and has showed no negative behaviors." The record identified the resident oriented to self and family, hard of hearing and wore glasses.

Review of the progress notes identified the following progression regarding the resident's mental health status during the stay at the facility:
On 12/01/15:
* At 3:23 p.m. a nursing progress note: "ADMISSION: . . . has been feeling quite depressed and has been started on Celexa [antidepressant medication]. He does have . . . major depressive disorder . . . He has memory impairment to both short and long term. He requires cues and supervision for safety.

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Resident does have poor safety awareness and family is afraid he might elope, so he was placed in secured unit. He will be working with PT/OT [physical and occupational therapy] s/p [status post] TIA [transient ischemic attacks - mini strokes] . . . RN [registered nurse] did let resident know that with him being a new admission he will be on hourly safety checks to ensure he is okay. . . . Family has requested that news stories regarding politics, ISIS and terrorism not be brought up as resident gets very upset . . ."
* At 4:26 p.m. a social services progress note: "admission . . . for extreme anxiety & depression. . . ."
* At 9:00 p.m. a nursing progress note: "Skin assessment: . . . Noted; (L) [left] arm has scabbed over scratches, (L) index finger has (4) .50 cm [centimeter] cuts, (R) [right] index finger(1) .50 cut, (R) top of Thumb 1 cm cut . . . No areas of real concern at this time. . . ." During interview on the morning of 06/23/16, a supervisory nursing staff member (#5) said the medical record lacked information to determine the cause of the cuts on Resident #15's arm and hands.

On 12/02/15 at 11:26 a.m. a physical therapy aide (PTA) note: ". . . reports understands and accepts need for placement, though sad and lonely . . ."

On 12/03/15:
* At 8:51 a.m. a licensed practical nurse (LPN) wrote: "Resident refused to take his A.M. [morning] medications, resident wants to see his priest and his wife. Resident said 'I'm done, this is not the way God intended for me to live.' Medications will be attempted again later."

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F 323	Continued From page 38 * At 9:35 a.m. a registered nurse (RN) wrote: "MOOD/AMBULATION: RN visited with resident today. He [sic] mood is flat and he states he is feeling down. He said to RN, 'I have been watching the man across the hallway. All he does is sleep and come out of room to eat. Is that what is going to happen to me here?' RN acknowledged residents concern and fear and let resident know that he can be as active as he would like to be. . . . told resident that anytime he would like to go for a walk or sit in one of the common areas to ask for assistance. Will monitor." * At 2:31 p.m. the LPN wrote: "Medicare: Resident is alert and orient [sic] to person and place. . . . Resident walked up and down the halls twice this shift. Resident has been depressed this shift, wanting to stop taking his medications, talk to the priest, and wanting his wife to visit. . . . Resident was weepy on and off through out the day. . . . Nursing will continue to monitor." * At 3:22 p.m. the certified occupational therapy assistant (COTA) wrote: ". . . able to communicate, well, his negative, 'bummed-out', and hopeless feeling due to being 'abandoned' by his wife and left here at this facility. Pt [patient] reports he wrote 'good-bye' letters to his 5 children and wife. . . . Pt is a very sad man. He responded positively with encouragement and to take things 'one step at a time.'" On 12/04/15: * At 7:59 a.m. a PTA wrote: "pt reports with nursing confirmation that pt refusing medications/meals this a.m., requesting to see priest with desire for 'giving up'/end of life, though states will not harm self; . . ."	F 323		

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F 323	Continued From page 39 * At 12:10 p.m. a COTA wrote: ". . . Wife present, remained close to pt and provided constant cues which increased agitation during self-care tasks. She made a comment, 'we'll just hang a rope from the ceiling for you' when pt became frustrated/confused during minor ADL [activities of daily living] task. She then stated, 'I'm just kidding.'. . ." * At 1:44 p.m. the LPN wrote: "Resident's wife her [sic] all shift. Wife brought in 3 blade razors in for resident to shave. Razor and blades are in resident's closet. . . ." On 12/05/15: * At 10:15 a.m. and 7:22 p.m., an LPN wrote: ". . . Resident did have this author call his wife for assurance that she was coming this a.m. Resident is continually using his call light for no reason a lot of the time. Resident is quite needy and demanding. . . ." The progress notes showed the entry edited at 3:22 p.m. on 12/06/16 repeating the portion documented above. On 12/06/15: * At 3:41 p.m. a LPN wrote: ". . . Resident does state that he is lonely especially after his wife and family leave. Resident is continually using his call light for no reason a lot of the time. Resident is quite needy. . . ." * At 6:00 p.m. a LPN wrote: "This nurse took residents supper to him knocked on the door greeted resident he was sitting naked in a chair with blood on him, he told this nurse to get the hell out . . . I called 911 to report incident and get ambulance here. This nurse went back to the room to try and visually assess the situation. Resident was bleed [sic] from his hands bilaterally and from his left wrist. There was a lot	F 323		

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of blood on the floor in the bedroom and the bathroom in the stool in the bathroom. . . . he told me he wanted to die. . . . Suicide note found and the blades from inside a disposable razor. . . . He told this nurse that his biggest health problem was not his body it was in his head. He didn't think anyone could fix that so why live. . . . Resident was discharged to [hospital] from [this facility] with a no bed hold. . . . transported via . . . ambulance . . . for psych [psychiatric] eval [evaluation]. . . ."

On 12/07/15 at 11:04, a nurse wrote: ". . . Noted res [resident] had taken apart disposable razors. Found 1 razor blade head with blades removed and approx. [approximately] 12 blades lying around the room, covered with blood. Found package of disposable razors in room with 3 razors missing . . . Emergency personnel found a note in a hardcover book that res had been reading, stating that it was a suicide note . . ."

Review of the care plan did not identify any interventions for Resident #15's behaviors including elopement risk as identified by the family on admission. No changes occurred after the resident displayed symptoms of suicidal ideation.

The medical record lacked physician orders and an evaluation for the appropriateness for placement in a locked secured unit. Failing to evaluate the resident for proper placement may have adversely affected the resident's psychological and social well-being. Failure to develop interventions to address Resident #15's severe depression and suicidal ideation, and failure to recognize the presence of razors as a

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F 323	Continued From page 41 safety risk contributed to the resident's suicide attempt.	F 323		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. 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 sufficient fluid intake to maintain proper hydration and health for 2 of 13 sampled residents (Resident #3 and #4). Failure to frequently offer fluids placed residents at risk for dehydration, urinary tract infections (UTI), constipation, and fluid/electrolyte imbalances. Findings include: Review of the facility policy titled "HYDRATION" occurred on 06/22/16. The policy dated June 2015, stated, "STANDARD: Many risk factors for dehydration are present in residents in long term care settings. Therefore, each resident is provided with sufficient fluid intake, based on individual needs, to maintain proper hydration and health. POLICY: . . . Sufficient fluids (the amount of fluids needed to prevent dehydration) will be offered to the residents daily with their meal plan. Additional fluids will be offered with scheduled passes . . . Special utensils such as cut out cups, straws, sipping mugs will be used to help the residents better access adequate fluid intake . . . Residents will have water available in	F 327	1. Residents #3 and #4 will be provided sufficient fluids to maintain proper hydration and health. Resident #4 will have adaptive equipment (sippy cup) with appropriately thickened fluids per physician order at bedside and with all fluids offered. 2. All residents will be provided sufficient fluids to maintain proper hydration and health. All residents who require adaptive equipment for fluid intake will have appropriate equipment with appropriately thickened fluids per physician order (as applies per resident) at bedside and with all fluids offered. 3. The registered dietician and/or designee will develop a plan to ensure the sufficient amount of fluids needed to prevent dehydration will be offered to the residents daily with their meal plan. Additional fluids will be offered to residents at risk for dehydration with hydration passes between meals by the nursing department. The culinary department will ensure adaptive equipment and thickened liquids are	8/10/16

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F 327	Continued From page 42 their rooms unless they are on fluid restrictions. Anyone who requires thickened fluids will have it offered with hydration passes . . ." Review of Resident #3's medical record occurred on all days of survey. Diagnosis included, Alzheimer's disease, recent cerebral vascular accident (CVA), and poor oral intake. The resident's current care plan identified, ". . . URINARY: Resident is frequently incontinent of bladder . . . Goal . . . Resident will not exhibit s/sx [signs and symptoms] of UTI . . . Approach . . . Encourage fluids to adequate levels of hydration . . . ADL [activities of daily living] FUNCTION: . . . Approach . . . EATING: 1 assist, nectar thick and puree textures . . ." The current Minimum Data Set (MDS), dated 04/10/16, identified extensive assistance from one person for eating. Observation on 06/21/16 at 8:30 a.m., showed Resident #3 lying in bed. Two Certified Nurse Assistants (CNAs) (#8 and #14) transferred the resident out of bed and into her wheelchair with a hoyer lift (mechanical body lift). The CNAs (#8 and #14) failed to offer fluids during this observation. Observation on 06/21/16 at 1:17 p.m., showed two CNAs (#10 and #11) assisted Resident #3 from her wheelchair to her bed using a hoyer lift and checked/changed the resident's incontinence brief. The CNAs (#10 and #11) failed to offer fluids after providing care. Observation on 06/21/16 at 3:45 p.m., showed Resident #3 in her room sitting on a mattress on the floor. Two CNAs (#11 and #13) transferred	F 327	available and provided also in resident rooms for all residents who require such adaptations or per individualized plan of care. Director of nursing will educate all licensed nurses on 7/27/16 on hydration plan, importance of adaptive equipment and properly thickened fluids for residents (as it applies to residents). The Director of nursing and/or designee will educate all staff that are responsible for resident fluid intake on either date of 08/04/16 or 08/09/16 on hydration plan, importance of adaptive equipment and properly thickened fluids for residents (as it applies to residents). 4. 08/10/2016 5. Audits will be initiated on 08/01/16 by registered dietician and/or culinary manager to ensure all resident receive the sufficient amount fluids needed to prevent dehydration with their daily meal plan. Audits will also be initiated on 08/01/016 by the licensed nurses to ensure all residents at risk for dehydration receive additional fluids at hydration passes and residents who require adaptive equipment and or thickened liquids have such items available in their rooms or per individualized plan of care. Audits will then be completed monthly for first quarter and quarterly thereafter. Results of monitoring will be reported to the QA Committee at each scheduled meeting (at least quarterly). The Director of Nursing and/or designee will follow up on further education/training on an as needed basis.	

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Resident #3 from the mattress to her bed using a hoyer lift. The CNAs (#11 and #13) failed to offer fluids after the transfer.

Review of Resident's #4's medical record occurred on all days of survey. Diagnosis included dementia, constipation, and urinary tract infections (UTI's). The current Minimum Data Set (MDS), dated 04/18/16, identified extensive assistance from one person for eating.

Progress notes identified the following:
*02/08/16 at 6:58 a.m.: "NUTRITION . . . Discontinue Kennedy cups/covered tumblers at meals. Provide sippy cups to aide in adequate fluid intake. . . ."
*06/03/16 at 1:46 p.m.: ". . . Adaptive equipment is used for all liquids that are drinkable. . . ."
*06/13/16 at 10:27 a.m.: "NUTRITION . . . Spoke with nursing this date regarding communication received on 6/12/16 to trial nectar consistency liquids and mechanical soft textures. Per nursing, resident has coughed on regular liquids at meals and is refusing to wear dentures at times. RN [registered nurse] requesting SLP [speech/language pathologist] orders this date. Will provide trial of nectar consistency liquids and mechanical soft textures until SLP eval. [evaluation]. . . ."
*06/15/16 at 2:34 p.m.: "ST [speech therapy]: SLP provided clinical evaluation of swallowing and treatment x1 [one time] to address recent increased symptoms of dysphagia and to determine least restrictive diet texture and liquid consistency. SLP recommendation: Mechanical soft solids and nectar consistency liquids are determined to be appropriate . . ."

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F 327	Continued From page 44 Observation on 06/21/16 at 7:55 a.m., showed a mug (not a sippy cup) of unthickened water in Resident #4's room. Observation on 06/21/16 at 9:08 a.m. showed two CNAs (#8 and #10) transferred Resident #4 with a hoyer lift to her bed. Observation showed the mug of unthickened water at the bedside and no fluids offered. Observation on 06/21/16 at 10:34 a.m., showed Resident #4 lying in bed. Two CNAs (#10 and #11) checked the resident's brief (which was dry) and transferred her to the wheelchair using a hoyer lift. A CNA (#11) offered Resident #4 a drink of water from a mug of unthickened water by placing the straw to the resident's lips. The other CNA (#10) intervened and stated, "Doesn't she get thickened liquids?" The CNA (#11) stated, "Why is it in here?" and placed the mug back on Resident #4's bedside table. The CNAs (#10 and #11) failed to remove the unthickened liquids from Resident #4's room. Observation on 06/21/16 at 12:51 p.m. showed two CNAs (#10 and #11) transfered Resident #4 to her bed using a hoyer lift and checked/changed her incontinence brief. Observation showed the mug of unthickened water available at Resident #4's bedside and no fluids offered. Observation on 06/21/16 at 3:15 p.m., showed Resident #4 in bed and thickened water available at the bedside. Two CNAs (#9 and #11) completed cares and transferred Resident #4 into her wheelchair using a hoyer lift. The CNA (#11) offered Resident #4 nectar thick liquids.	F 327		

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F 327	Continued From page 45 During an interview on 06/21/16 at 3:28 p.m., a CNA (#11) identified she worked with the resident "last Thursday [06/16/16]." She stated Resident #4's water was unthickened at that time and "they changed her whole diet." Although the CNA interview and observations during the survey indicated unthickened water available in Resident #4's room, the trial of nectar thickened liquids had began on 06/13/16 (three days prior to unthickened water noted by the CNA in Resident #4's room). In addition, staff failed to provide appropriate adaptive equipment (i.e. sippy cups) in the resident's room to encourage and facilitate oral intake.	F 327		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 329		8/10/16

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F 329	Continued From page 46 drugs. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure a medication regimen free from unnecessary drugs for 1 of 3 sampled residents (Resident #3) who received as needed (PRN)psychotropic medications. Failure to determine the necessity of a medication prior to administration placed residents at risk of receiving unnecessary medications and suffering adverse consequences related to their use. Findings include: Review of the facility policy titled "Dementia Care and Antipsychotic Drug Use" occurred on 06/23/16. This policy, updated 04/13/16, stated, ". . . Staff will attempt to determine the root cause of symptoms such as hunger, pain, infection, or confusion resulting from loud noise or having a daily routine interrupted, etc. . . . The standard of practice is to provide care that keeps the resident comfortable and responds to their needs (and symptoms) without drugs whenever possible with the exception of when there is an immediate danger to the individual or another resident. Our staff will attempt to identify the causes of a resident's behavior before requesting a medication to address the symptoms. Our staff will try to utilize non-medication approaches before trying a medication. . . . Appropriate	F 329	1. Resident #3 will have a medication regimen that is free from unnecessary and multiple prn psychotropic medications. Resident #3's care plan was reviewed for appropriate and individualized behavior management interventions including non-pharmacological interventions and prn antipsychotic was also discontinued on 7/22/16. 2. All residents will have a medication regimen that is free from unnecessary and multiple prn psychotropic medications. Residents on psychotropic medications' care plans will be reviewed for appropriate and individualized behavior management interventions including non-pharmacological interventions. 3. The licensed social worker and/or designee will assure every resident with behaviors has a plan of care that includes non-pharmacological interventions. The Director of Nursing and/or registered nurses will review all residents with physician orders for prn psychotropic medications to assure resident is free from unnecessary psychotropic medications and if orders are needed the order will specifically identify parameters	

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	355033	A. BUILDING _____ B. WING _____	07/06/2016

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F 329	Continued From page 47 documentation regarding the types of behaviors as well as the non-medication approaches tried is to be done prior to the initiation of any medication is started [sic] unless medication is scheduled and effective in suppressing those behaviors. . . ." Review of Resident #3's medical record occurred on June 21-23, 2016. Diagnoses included a history of a cerebrovascular accident (stroke), Alzheimer's disease, anxiety disorder, and osteoarthritis. Current medications included Ativan (an anxiolytic) 0.5 milligrams (mg) every two hours PRN, morphine concentrate 5 mg every 30 minutes, Tylenol-Codeine #3 300-30 mg every four hours prn, haloperidol (Haldol, an antipsychotic) 0.5 mg every six hours prn. The resident's current care plan stated, ". . . PSYCHOTROPIC MEDICATION . . . Resident receives psychotropic medication r/t [related to] agitation, disrobing, restlessness, constant movement with inability to sit still secondary to diagnosis of anxiety, Alzheimer's, dementia with behavioral disturbances. . . . Approach . . . Administer medications: scheduled and PRN as ordered. Evaluate/record/report effectiveness and any adverse effects. . . . Refer to behavior plan of care . . ." Record review identified no behavior care plan for Resident #3. Review of Resident #3's MAR identified the following simultaneous administrations of PRN medication: *02/04/16 at 1:30 a.m.: Ativan and Tylenol given for "[increased] agitation" and "c/o [complains of] arm pain." *02/05/16 at 2:00 a.m.: Ativan and Tylenol given for "[increased] agitation" and "c/o arm pain."	F 329	for use. The Director of Nursing and/or registered nurse will educate all licensed nurses on 07/27/16 on the documentation required prior to and following administration of any prn psychotropic medication to a resident, including non-pharmacological interventions used. 4. 08/10/2016 5. Audits will be initiated on 08/01/16 and completed initially by the licensed social worker and/or designee to ensure all resident with behaviors have a plan of care that includes non-pharmacological interventions. Audits will be initiated on 08/01/16 and completed initially by the Director of Nursing and/or registered nurse to ensure all residents with a prn psychotropic medication order are free from unnecessary psychotropic medication and have specific parameters for use, and when such medications are administered the documentation that is required prior to and following such administration has occurred. Audits will then be completed weekly for first month, then monthly for first quarter and quarterly thereafter. Results of monitoring will be reported to the QA Committee at each scheduled meeting (at least quarterly). The Director of Nursing and/or designee will follow up on further education/training on an as needed basis.	

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F 329	Continued From page 48 *02/05/16 at 11:15 p.m.: Ativan and Tylenol given for "[increased] agitation [and] restlessness - crying out" and "for comfort." *03/18/16 at 12:00 a.m.: Tylenol #3 and Ativan given for "c/o back pain" and "[increased] agitation." *03/27/16 at 6:00 p.m.: Tylenol #3 and Ativan given for "c/o pain in her [right] arm" and "restless, agitated." *03/28/16 at 9:50 a.m.: Tylenol #3, Ativan, and Haldol given for "c/o back pain," "agitation," and "agitation." *04/02/16 at 2:00 a.m.: Tylenol #3 and Haldol given for "gen [general] discomfort" and "restless, crawling out of bed [and] chair." *04/04/16 at 6:45 a.m.: Haldol and Ativan given for "restless, agitated" and "restless, agitated." *04/13/16 at 9:30 a.m.: Haldol and Ativan given for "restless, agitated" and "restless, anxious, standing up." *04/25/16 at 12:05 p.m.: Tylenol #3 and Ativan given for "c/o tailbone pain" and "[increased] restlessness." *05/11/16 at 4:50 p.m. and 5:00 p.m.: Morphine and Haldol given for "c/o tailbone pain" and "[increased] restlessness." *05/17/16 at 11:07 a.m.: Tylenol #3 and Haldol given for "c/o back pain" and "[increased] restlessness." *05/26/16 at 11:15 a.m.: Tylenol #3 and Haldol given for "back pain" and "anxiety/restlessness." *05/27/16 at 4:00 p.m.: Tylenol #3 and Ativan given for "back pain" and "anxiety." *06/02/16 at 10:00 a.m.: Tylenol #3 and Ativan given for "c/o headache" and "restless, standing up." *06/09/16 at 11:50 a.m.: Ativan and Tylenol #3 given for "restless, anxious" and "c/o pain,	F 329		

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F 329	Continued From page 49 general disc. [discomfort]." *06/12/16 at 2:30 p.m.: Tylenol #3 and Haldol given for "c/o back ache" and "restless." *06/14/16 at 12:15 p.m.: Ativan and Tylenol #3 given for "restlessness' and "c/o back pain." *06/14/16 at 9:00 p.m.: Tylenol #3 and Ativan given for "c/o pain" and "[increased] agitation." During an interview on 06/22/16 at 5:55 p.m., an administrative nurse (#19) stated staff should write a note regarding the behaviors if they administer a PRN. She also identified Resident #3's care plan lacked information specific to behaviors and non-pharmacological interventions related to the behaviors. Administering multiple PRN medications simultaneously does not allow staff to determine if one medication alone would provide Resident #3 sufficient relief. Refer to F222	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:	F 371		8/10/16

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F 371	Continued From page 50 Based on observation, review of facility policy, and staff interview, the facility failed to prepare and serve food under sanitary conditions in 2 of 3 food service areas (North kitchen and Special Care Unit). Failure to ensure staff use quaternary (i.e., quat, a chemical sanitizer) solution appropriately, thoroughly dry utensils prior to storage, and avoid bare hand contact with ready-to-eat food may result in unsanitary dietary conditions and contribute to foodborne illness outbreak. Findings include: Review of the facility policy titled "Food Production Methods and Standards" occurred on 06/23/16. This policy, revised 08/02/06, stated, ". . . Tongs or other utensils are used in handling food, whenever possible. If it is necessary to use hands, they are thoroughly washed with hot water and soap and plastic gloves (single service) are worn. . . ." Review of the facility policy titled "Sanitizer Dispensing" occurred on 06/23/16. This policy, revised 07/23/14, stated, ". . . It is the policy of St. Catherine's Living Center, in compliance with F-Tag 371, to store, prepare, distribute, and serve food under sanitary conditions. This includes the proper sanitation level for food prep [preparation] surfaces. . . . 1. Fill bucket or spray bottle using smart sac dispenser. . . . 4. Test pH level of sanitizer by following directions as outlined on test strips. Proper pH level for this chemical sanitizer is 200 ppm [parts per million] not to exceed 1000 ppm. 5. Buckets of sanitizer should be changed out 3 times per day or when visibly soiled. . . ."	F 371	1. Culinary staff will use appropriate quaternary solution to ensure food contact surfaces are properly sanitized, thoroughly dry utensils prior to storage, and all staff will avoid bare hand contact with ready-to-eat food for residents to prevent unsanitary dietary conditions and foodborne illness outbreak. 2. Culinary staff will use appropriate quaternary solution to ensure food contact surfaces are properly sanitized, thoroughly dry utensils prior to storage, and all staff will avoid bare hand contact with ready-to-eat food for residents to prevent unsanitary dietary conditions and foodborne illness outbreak. 3. The current policy/procedure for food storage and sanitizer dispensing has been reviewed by culinary supervisor. All staff will be in serviced on either 8/04/16 or 8/09/16 regarding sanitizing all food service areas, thoroughly dry utensils prior to storage and avoiding bare hand contact with ready-to-eat foods. 4. 08/10/2016 5. Audits will be completed initially starting 08/01/16 by the culinary supervisor and/or designee to assure all sanitizer is appropriate quaternary solution to ensure all food contact surfaces are properly sanitized and utensils are thoroughly dried prior to storage, no bare hand contact with ready-to-eat foods so that residents who eat food prepared in the facility are not at risk for foodborne illness. Audits will then be completed weekly for one month, then monthly for for one year. Results of	

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F 371	Continued From page 51 Review of the facility policy titled "Dishwashing Procedures" occurred on 06/23/16. This policy, revised 06/12/13, stated, ". . . Dishes and utensils must be air dried. . . ." - Observation during the initial kitchen tour on 06/20/16 at 6:30 p.m. showed the following: *A dietary staff member (#16) washed dishes in the dish room, and a red (sanitation) bucket sat on the counter. When asked what type of chemical the bucket contained, the staff member stated the bucket did not contain a chemical, "just soap and water." The staff member identified she used the soap and water on counters and tables. A second dietary staff member (#15) cleared dishes in the dining room and identified he used the red bucket in the dish room to clean tables. When asked about a sanitizing solution, the staff member stated, "We don't normally use that on our shift." A supervisory dietary staff member (#18) then demonstrated how to fill buckets with quat solution using an automatic dispenser and the use of testing strips to the staff member (#16). The staff member (#16) stated, "I didn't know that. Now I know." *Five scoops used to serve food stored in a drawer. Observation showed the scoops were uninverted and had water pooled in the scoop. - Observation on 06/21/16 at 8:00 a.m., showed a certified nursing assistant (CNA) (#1) utilized bare hands and placed toast on 5 plates for residents to eat. - Observation in the Special Care Unit occurred on 06/21/16 at 2:13 p.m. When asked, a staff member (#1) stated she wiped off the tables in	F 371	monitoring will be reported to the QA Committee at each scheduled meeting (at least quarterly). Culinary supervisor and/or designee will follow up on further education/training on an as needed basis.	

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F 371	Continued From page 52 the unit after the noon meal using a spray bottle identified as "Triple S Enzyme Deodorant" (not an appropriate sanitizing chemical). Observation showed no quat available. During an interview on 06/21/16 at 12:46 p.m., a dietary staff member (#17) stated she fills a bucket with quat using the automatic dispenser and wipes down tabletops, counters, carts, and steam tables after each meal. During an interview on 06/23/16 at 9:49 a.m., a supervisory dietary staff member (#18) stated she expects staff to fill a bucket with quat at each meal, test the solution using testing strips, and wipe tables, counters, and steam tables after each meal. She stated staff should leave utensils in the clean area of the dish room until they are fully dry before storing them.	F 371		