STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0154	**Tell the resident completely about his or her health status, care and treatments.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, the facility failed to inform one resident (#1) of a laboratory test performed of twenty-seven residents reviewed. The findings included: Resident #1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED] Medical record review of the Minimum Data Set (MDS) dated [DATE], revealed the resident scored fifteen of fifteen on the Brief Interview for Mental Status (BIMS) indicating intact cognitive skills and no memory impairment. Interview with the Nursing Home Administrator (NHA) on May 7, 2012, at 1:50 p.m., in the NHA office, revealed a urine drug screen was completed on the resident on May 3, 2012, without the resident's knowledge or consent. Interview with the Director of Nursing (DON) on May 9, 2012, at 9:10 a.m., in the front lobby, confirmed the facility completed a urine drug screen on the resident without the resident's knowledge or consent. C/O #**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** #**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**
F 0157	**Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, and interview, the facility failed to notify the physician to receive an order for [MEDICATION ORDERS REDACTED] The findings included: Resident #20 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Observation on May 15, 2012, at 9:30 a.m., in the west hallway, revealed Licensed Practical Nurse (LPN) #4, preparing multiple herbal medications to administer to Resident #20, including Dandelion Leaf, Hawthorn Berry, [MEDICATION NAME], Bilberry Leaf, and Vitamin C. Further observation revealed these medications were stored in zip lock bags labeled with the herbal medication name and strength, if applicable, and did not include the resident's name, medication expiration date, ordering physician's name, dispensing instructions, or pharmacy label. Medical record review of the Medication Administration Record [MEDICATION ORDERS REDACTED] Medical record review of the physician's order [REDACTED]. Interview on May 15, 2012, at 1:30 p.m., with LPN #2, at the nurse's station, confirmed the medications were brought to the facility in zip lock bags by the resident and the physician had not been notified to obtain an order for [MEDICATION ORDERS REDACTED]
F 0164	**Keep each resident's personal and medical records private and confidential.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to provide privacy during a treatment for [DIAGNOSES REDACTED]. The findings included: Observation on May 15, 2012, at 8:10 a.m., in the resident's room, revealed Licensed Practical Nurse (LPN) #2 failed to close the resident's room door and pull the window curtains closed during administration of insulin in the resident's abdomen with the resident's shirt pulled up to fully expose the bare abdomen. Further observation revealed staff and residents walked by the resident's room in the hallway and the resident's room window was within direct observation from the parking lot during the injection. Interview on May 15, 2012, at 8:20 a.m., with LPN #2, in the west hallway, confirmed privacy was not provided for the resident during the insulin administration.

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

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

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F 0164	(continued... from page 1)
F 0166	**Try to resolve each resident's complaints quickly.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, facility policy review, and interview, the facility failed to resolve a grievance for one resident (#1) of twenty-seven residents reviewed. The findings included: Resident #1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED] Medical record review of the Minimum Data Set (MDS) dated [DATE], revealed the resident scored fifteen of fifteen on the Brief Interview for Mental Status (BIMS) indicating intact cognitive skills and no memory impairment. Observation and interview with Resident #1 on May 7, 2012, at 10:50 a.m., in the resident's room, revealed two weeks ago the resident requested maintenance clean a fan belonging to the resident and when maintenance returned the fan to the resident it no longer worked. Continued interview at this time revealed the facility had not talked to the resident regarding the fan not working after being cleaned and the resident had reported the broken fan to the Administrator. Review of facility policy Filing Grievances/Complaints updated January 2000, revealed "...any resident may file a grievance...the allegation will be investigated...Administrator will review findings...determine what corrective actions...need to be taken...the resident will be informed of the findings..." Interview with the Administrator on May 7, 2012, at 1:50 p.m., in the Administrator's office, revealed the Administrator had been aware of the broken fan. Continued interview at this time confirmed the fan was not working when returned to the resident and the Administrator stated, "nothing but a liar, I refuse to talk to the resident about the fan, and I refuse to continue to write up grievances regarding this resident." Interview with the resident on May 15, 2012, at 3:00 p.m., in the physical therapy office, confirmed the facility had not discussed the grievance with the resident and the grievance was still unresolved. C/O #**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** #**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**
F 0172	**Give the resident the right to receive visitors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, review of Resident's Rights, and interview, the facility failed to provide visitor access for one resident (#1) of twenty-seven residents reviewed. The findings included: Resident #1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED] Medical record review of the Minimum Data Set (MDS) dated [DATE], revealed the resident scored fifteen of fifteen on the Brief Interview for Mental Status (BIMS) indicating intact cognitive skills and no memory impairment. Observation and interview on May 7, 2012, at 11:00 a.m., in the resident's room, revealed the resident sitting in an electric wheelchair. Interview at this time revealed the resident had a visitor on May 3, 2012, and the facility took the keys to the visitor's van to prohibit the resident from visiting and leaving the facility with the visitor. Telephone interview with a detective from the local county Sherriff's Department on May 8, 2012, at 1:50 p.m., revealed a 911 (emergency) call had been made to the Sheriff's Department from a visitor on May 3, 2012, stating the facility had taken the visitor's keys to the visitor's van and refused to allow the visitor to visit with the resident. Review of the facility's resident rights documentation in the admission packet, no date, revealed "...may have visitors...with persons of their choice..." Interview with the Administrator on May 7, 2012, at 1:50 p.m., in the Administrator's office, confirmed the facility had taken the visitor's keys on May 3, 2012, and denied the visitor access to the resident until the Sheriff's Department instructed the facility to give the keys back to the visitor. Interview with the MDS Coordinator on May 14, 2012, at 11:20 a.m., in the Director of Nursing's office, revealed the MDS Coordinator had taken the keys from the visitor of Resident #1. Continued interview at this time confirmed the facility failed to allow the resident access to the visitor. C/O #**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** #**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**
F 0221	**Keep each resident free from physical restraints, unless needed for medical treatment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility policy, medical record review, observation, and interview, the facility failed to complete a restraint assessment for twelve residents (#1, #2, #4, #10, #12, #14, #16, #17, #18, #19, #22, #26) and failed to obtain a physician's order [REDACTED]. The findings included: Review of the facility policy, "Restraint Use", revealed "...If evaluation shows the need for physical restraint the physician will be notified for direction/order...with use of any restraint the resident must be observed q (every) 30 minutes and position changed (at) least q 2 hours...Before any restraint orders are obtained, the following steps must be completed and the need deemed necessary. A restraint assessment, including alternatives must be completed..." Resident #17 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED] Medical record review of the Minimum Data Set (MDS) dated [DATE], revealed the resident had severe impairment in cognitive skills. Medical record review of a Nursing progress note [DIAGNOSES REDACTED]..MDS/Care Plan Quarterly Assessment completed...continues to require the use of restraints for...safety (and) well-being. Reevaluated for the least restrictive type of restraint. Will continue with side rails up in bed x 2..."

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F 0221	

(continued... from page 2)

Medical record review of the MDS dated [DATE], revealed no side rail used as a restraint.

Medical record review of the care plan dated April 4, 2012, revealed "...Restraint: (resident) requires use of bil (bilateral) side rails up...reassess need for restraints Q (every) 3 months..."

Medical record review of the Fall Risk Evaluation dated April 4, 2012, revealed the resident was at risk for falls.

Review of the facility investigation dated July 25, 2011, revealed " ...Resident crawled to foot of bed (and) climbed out of bed between bed rail (and) foot of bed. Resident was observed on the floor. No injuries...approaches were in place at time of incident...Side rails x 2 up. Bed in lowest position...Bed alarm added to bed..."

Observation on May 9, 2012, at 8:45 a.m., revealed the resident lying on the bed with full padded side rails in the raised position.

Interview on May 9, 2012, at 9:50 a.m., with the Director of Nursing (DON), at the front desk, confirmed no physician's order [REDACTED].

Resident #22 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]

Medical record review of the MDS dated [DATE], revealed the resident had moderately impaired cognitive skills and bed rails used daily as a restraint.

Observation on May 15, 2012, at 9:30 a.m., revealed the resident lying on the bed with bilateral full side rails in the raised position.

Interview on May 15, 2012, at 12:00 noon, with the DON, in the front lobby, confirmed no assessment for the use of the side rails had been completed.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Resident #2 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]

Medical record review of the MDS assessment dated [DATE], revealed the resident was severely cognitively impaired, had a history of [DIAGNOSES REDACTED]. Continued MDS review revealed the resident was not coded for any type of physical restraint.

Medical record review of the Care Plan (CP) dated February 21, 2012, revealed a care plan entry dated August 19, 2011, for weights to be added to the base of the merry-walker(an assistive device for ambulation). Continued CP review revealed an entry dated January 21, 2012, instructed side rails to be up bilaterally when in bed. Continued CP review revealed a care plan update dated January 30, 2012, to add a seatbelt to the merry-walker.

Medical record review of a Nurse's Note (for resident #1) dated September 13, 2011, revealed "...(res #2) tried to climb over bed rails...assisted back in the bed..." No investigation or new interventions were documented. Resident #2's Nurse's Notes do not include notation of the resident attempting to exit the bed over the side rail.

Observation of Resident #2 in the resident's room, on May 7, 2012, at 10:00 a.m., revealed the resident lying on the bed, with full side-rails up bilaterally.

Observation on May 7, 2012, at 2:30 p.m., revealed the resident ambulating throughout the facility with a merry-walker. The resident had a seatbelt secured around the waist in the merry-walker, and the merry-walker had weights at the base to prevent the resident from tipping the device over. The resident was confused and mumbling to self. The resident could not exit the merry-walker independently when prompted.

Observation on May 8, 2012, at 3:45 p.m., revealed the resident in the facility "circle area," in a reclined geri-chair with lap top tray secured across the lap. The resident was restless and attempting to exit the chair by leaning to the right.

Interview with the DON, at the time of the observation, confirmed the recliner is a restraint with the tray table across the resident to prevent the resident from rising independently, the merry-walker and the seatbelt for the merry-walker, as well as the bed side rails in the up position, are all physical restraints. The DON further confirmed the facility's restraint policy had not been followed, the comprehensive assessment was innaccurate, there was no physician's order [REDACTED].

Resident #4 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]

Medical record review of the resident's MDS assessment dated [DATE], revealed the resident had severe cognitive deficits, the resident was ambulatory with the use of a walker, and the resident was not restrained.

Observation of the resident on May 8, 2012, at 2:00 p.m., revealed the resident ambulating in the hallway with a walker and Physical Therapy providing stand by assistance.

Observation of the resident on May 9, 2012, at 8:20 a.m., revealed the resident lying on the bed, with the left side of the bed against the wall and half side rails up, in the mid bed position, on the right side of the bed.

Observation of the resident on May 14, 2012, at 10:05 a.m., revealed the resident lying on the bed, with the side rail on the right side of the bed in the down position. The left side of the bed was against the wall.

Interview with the DON, on May 15, 2012, at 11:25 a.m., at the nurse's station, confirmed the side rail on the right side of the bed is a restraint when in the up position, the left side of the bed was against the wall. The DON further confirmed the facility's restraint policy had not been followed, the comprehensive assessment was inaccurate, there was no physician's order [REDACTED]

Resident #10 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]

Medical record review of the resident's MDS assessment dated [DATE], revealed the resident had severe cognitive deficits, and the resident required extensive staff assistance with all ADLs (Activities of Daily Living). The MDS included side rails and a chair to prevent rising coded as retraints.

Medical record review of a Physician's Telephone Order dated February 26, 2012, revealed "...side rails X 2 (bilaterally) per family request for safety."

Medical record review of the Care Plan dated February 21, 2012, revealed the resident was care planned for restraints, with the intervention of placing a tray table across the resident when seated in the geri-chair. The care plan was not updated to include the side rails.

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F 0221	

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Observation of the resident on May 9, 2012, at 7:35 a.m., revealed the resident in the room seated in geri-chair with the tray table across the resident. The resident was confused and mumbling to self. The resident was unable to exit the chair when prompted.

Observation of the resident on May 9, 2012, at 10:00 a.m. revealed the resident in the room, seated in the geri-chair with the tray table across the resident, the resident was agitated and screaming incoherently.

Observation of the resident on May 14, 2012, at 2:20 p.m., revealed the resident in the "circle area " in the geri-chair with the tray table across the lap. The resident was confused and mumbling to self.

Interview with the DON, on May 14, 2012, at 2:25 p.m., at the nurse's station, confirmed the resident was restrained by the tray table and the facility's restraint policy had not been followed, there was no physician's order [REDACTED]

Resident #14 was readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]

Medical record review of the MDS assessment dated [DATE], revealed the resident had severe cognitive deficits, was chair or bed bound, was ambulatory with the use of a wheelchair, and was not restrained.

Medical record review the Care Plan revealed a restraint care plan had been implemented on October 7, 2010, and discontinued as "resolved" November 2010, due to the "...res (resident) now in gerri-chair."

Observation of the resident in the "circle area" on May 9, 2012 at 1:00 p.m., revealed the resident in a reclined geri-chair with pillows to each side of the body.

Observation of the resident on May 14, 2012, at 9:45 a.m., revealed the resident in the room in a reclined geri-chair. Resident was anxious and confused, and was unable to exit the chair independently.

Interview with the DON, at the time of the observation, confirmed the recliner is a restraint if the chair prevents the resident from rising independently. The DON further confirmed the facility's restraint policy had not been followed, the comprehensive assessment was inaccurate, there was no physician's order [REDACTED].

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Resident #19 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]

Medical record review of the Minimum Data Set (MDS), dated [DATE], revealed the resident was moderately impaired cognition and required extensive assistance with activities of daily living, toileting and bathing.

Medical record review of the Care Plan, dated January 8, 2012, revealed "...side rails up on both sides while resident is in bed..."

Medical record review on May 14, 2012, at 11:30 a.m., revealed no pre-restraint assessment, no side rail assessment or physician's order [REDACTED]

Observation on May 14, 2012, at 10:00 a.m., in the resident's room, revealed the resident lying in the bed with the use of two full side rails.

Interview with the Director of Nursing (DON), on May 15, 2012, at 8:15 a.m., in the DON office, confirmed the facility did not perform a pre-restraint assessment or side rail assessment, and two side rails were in use when the resident was in the bed and the facility did not obtain a Physcian's Order for the side rails.

Resident # 26 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED].

Medical record review of the MDS, dated [DATE], revealed the resident had moderate impairment of cognitive skills and highly impaired vision.

Medical record review of the Care Plan, dated January 26, 2012, revealed "...bilateral side rails X (times) 2..."

Observation on May 15, 2012, at 1:35 p.m., in the resident's room, revealed the resident lying in the bed with both side rails up and in use.

Interview with the Director of Nursing (DON), on May 15, 2012, at 2:15 p.m., in the DON office, confirmed the facility did not perform a side rail assessment, two side rails were in use when the resident was in the bed and the facility failed to obtain a physician's order [REDACTED]

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Resident #1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]

Medical record review of the MDS dated [DATE], revealed the resident scored fifteen of fifteen on the Brief Interview for Mental Status (BIMS) with intact cognitive skills, no memory impairment and restraints were not used.

Medical record review of the Care Plan dated March 15, 2012, revealed "...SR (side rails) up times 2 to prevent...falling OOB (out of bed)..."

Medical record review of the Resident Plan of Care Instructions, no date, revealed "...restraint 2 bed rails..."

Medical record review revealed no signed consent for use of the restraints, and no pre-restraint or side rail assessment. Further medical record review revealed no Physician order[DIAGNOSES REDACTED]

Review of the facility policy, "Restraint Use", revealed "...If evaluation shows the need for physical restraint the physician will be notified for direction/order...with use of any restraint the resident must be observed q (every) 30 minutes and position changed (at) least q 2 hours...Before any restraint orders are obtained, the following steps must be completed and the need deemed necessary. A restraint assessment, including alternatives must be completed..."

Observation on May 15, 2012, at 8:00 a.m., in the resident's room, revealed the resident lying on the bed with the full side rails on the bed and the bed rails in the up position bilaterally.

Interview with the Director of Nursing (DON) on May 14, 2012, at 11:30 a.m., in the DON office, confirmed no pre-restraint assessment or side rail assessment had been completed and no Physician order[DIAGNOSES REDACTED]

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F 0221	(continued... from page 4) Resident #12 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED] Medical record review of the MDS dated [DATE], revealed the resident scored a twelve of fifteen on the BIMS with moderately impaired cognitive skills and bed rail restraints were used daily. Medical record review of the Care Plan last reviewed on April 4, 2012, revealed "...at risk for falls...side rails up x (times) 2...remind resident not to stand without assist..." Observation on May 9, 2012, at 8:00 a.m., in the resident's room, revealed the resident lying on the bed with the full side rails on the bed and the bed rails in the up position bilaterally. Interview with the DON on May 14, 2012, at 11:30 a.m., in the DON office confirmed no pre-restraint assessment or side rail assessment had been completed and no Physician order[DIAGNOSES REDACTED] Resident #16 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED] Medical record review of the MDS dated [DATE], revealed the resident was moderately impaired for decision making, is totally dependent for all activities of daily living, and physical restraints (bed rail and trunk restraint) used daily. Medical record review of the Care Plan noted as last reviewed on June 16, 2011, revealed "...restraints...low bed with padded rails...SR x (times) 2 when in bed..." Observation on May 9, 2012, at 9:30 a.m., in the resident's room, revealed the resident lying on the bed with the full side rails on the bed and the bed rails in the up position bilaterally. Observation on May 15, 2012, at 11:30 a.m., in the activity room, revealed the resident sitting in a wheelchair with the shoulder straps in place. Interview with the DON on May 14, 2012, at 11:30 a.m., in the DON office, confirmed no pre-restraint or quarterly restraint assessments had been completed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Resident #18 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED] Medical record review of the MDS dated [DATE], revealed the resident had short and long term memory problems, required extensive assistance with ambulation and activities of daily living, and used restraints daily. Medical record review of a Care Plan last reviewed on March 1, 2012, revealed "...side rails up times 2..." Medical record review revealed the resident had no signed consent for the use of the restraints and no pre-restraint assessment and no side rail assessment. Further medical record review revealed no Physician order[DIAGNOSES REDACTED] Medical record review of a Nurse's progress note [DIAGNOSES REDACTED]..resident crawled between foot board and bed rail...observed on floor..." Observations on May 14, 2012, at 1:00 p.m. and May 15, 2012, at 2:11 p.m., in the resident's room, revealed the resident lying in bed with full side rails on the bed and in the up position bilaterally. C/O #**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** #**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** #**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** #**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**
F 0223	**Protect each resident from all abuse, physical punishment, and being separated from others.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of staff written statements, review of facility policy, observation, and interview, the facility failed to protect four (#1, #2, #11) residents from abuse of twenty-seven residents reviewed. The facility's failure to protect the residents from abuse placed resident #1, #2, in Immediate Jeopardy. (Immediate Jeopardy is a situation in which the provider's noncompliance with one or more requirements of participation, has caused or is likely to cause, serious harm, injury, impairment or death). The Administrator and Director of Nursing were informed of the Immediate Jeopardy in the Administrator's office, on May 15, 2012, at 2:10 p.m. The Immediate Jeopardy constitutes substandard quality of care and was effective October 20, 2011 and is ongoing. An extended survey was conducted on May 15, 2012. The findings included: Review of the facility's admission policies (not dated) revealed "...Nursing Home Residents Rights...#6. Each resident will receive adequate and appropriate health care and protective services to maintain the highest level of well being and ensure the safety of the residents." Resident #1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED] Medical record review of the Minimum Data Set (MDS) dated [DATE], revealed the resident scored fifteen of fifteen on the Brief Interview for Mental Status (BIMS) indicating intact cognitive skills and no memory impairment; had no mood symptoms; required total

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F 0223	(continued... from page 5)

assistance with activities of daily living (ADL); had impairment of upper and lower extremities; and used an electric wheelchair for mobility.

Medical record review of the Care Plan dated March 15, 2012, revealed "...if res (resident) continues to curse...escorted or told to go to room for a 10 min (minute) cool down period...res not allowed to curse outside...room if res is not cooperative escort to room and disengage (turning off the source of electric power resulted in resident being unable to propel self) W/C (wheelchair) for 10-15 min...ensure safety and leave the room..."

Medical record review of a nurse's note dated March 19, 2012, at 10:00 a.m., revealed "...having a [MEDICAL CONDITION]..."

Medical record review of a nurse's note dated March 19, 2012, at 10:44 a.m., revealed "...Doctor notified of possible [MEDICAL CONDITION]..."

Review of a written statement by Certified Nurse Aide (CNA) #5 dated May 25, 2011, revealed "...(I) spoke up and informed (resident #1)...(he) would be staying in bed for 15 min which is in...care plan punishment for cussing..."

Review of a written statement by Licensed Practical Nurse (LPN) #1 dated June 24, 2011, revealed "...told (resident #1)...(I) would disengage...chair...disengaged...chair...pushed to...room and door left cracked for 15 minutes per care plan..."

Review of a written statement by CNA #1 dated June 24, 2011, revealed "...the nurse was pushing (resident #1's) wheelchair that had been disengaged...to...room..."

Review of a typed statement and signed by CNA #2 dated June 24, 2011, at 2:45 p.m., revealed "...power cord was taken from...power chair...(resident #1) was left in room for awhile...cooled down and was allowed to come out of...room..."

Review of a written statement by CNA #3 dated June 24, 2011, revealed " ...nurse stated the other resident took priority...(resident #1) became irate cursing...nurse told...to stop...(resident #1) continued resulting in wheelchair being disengaged...taken to...room...after allotted time was let out..."

Review of a written statement by CNA #4 dated August 31, 2011, revealed "(Resident #1)...cussing the nurse...(nurse stated) you don't want to get a shot and be in your room do you..."

Medical record review of a nurse's note dated September 20, 2011, at 5:25 a.m., revealed "...Pt (patient-resident #1) upset started cussing...W/C disengaged due to behavior..."

Medical record review of a nurse's note dated September 20, 2011, at 7:04 a.m., revealed "...CNA let (resident #1) know (resident #1) was talking about (CNA)...(resident #1) became defensive and started arguing again...escorted back to room..."

Medical record review of a nurse's note dated October 19, 2011, at 11:40 p.m., revealed "(resident #1) continues to speak loudly outside of room...asked...to go to room...refused...(resident #1 stated) didn't have to...(staff) disengaged chair...pushed...to room (resident #1) saying...were assaulting...told (resident #1) needed to be quiet...disregarded all instructions..."

Medical record review of a nurse's note dated October 20, 2011, at 12:15 a.m., revealed "(Resident #1) yelling and cursing from room ...W/C remains off to attempt to keep others asleep ..."

Medical record review of a nurse's note dated October 20, 2011, at 3:00 a.m., revealed "...continuing to keep (resident #1) safe and in...room to minimize disturbances to other residents..."

Medical record review of a nurse's note dated October 20, 2011, at 3:30 a.m., revealed "(Resident #1)...in room to maintain...safety and have facility as quiet as possible..."

Medical record review of a nurse's note dated October 20, 2011, at 4:45 a.m., revealed "...reminded (resident #1) care plan to go to bed at 10:30 p.m...can do what...want...continuing to keep resident safe in...room and out of hallways..."

Medical record review of a nurse's note dated October 20, 2011, at 6:20 a.m., revealed "(Resident #1)...still in...chair in...room..."

Medical record review of a nurse's note dated October 20, 2011, at 10:48 a.m., revealed "...resident (#1) sitting in chair asleep..."

Medical record review of a nurse's note dated October 20, 2011, at 12:00 p.m. (noon), revealed "(Resident #1's)...W/C still disengaged...C/O (complains of) not being taken care of...(resident #1) did want to lay down which according to care plan is on third shift (10:00 p.m to 6:00 a.m.)...been primarily sleeping in chair all morning..."

Observation and interview on May 7, 2012, at 10:50 a.m., in the resident's room, revealed the resident sitting in the electric wheelchair; was alert and oriented. Interview with the resident revealed, "I have a bedtime at 10:30...I don't always want to go to bed at 10:30. They disengage my wheelchair sometimes...I don't want them to do that...I want that off my care plan. They sometimes block my wheelchair...I don't like that. The Director of Nursing's (DON"s) husband blocked me in and touched my arm...I don't want him in my room...he threatened me." Continued interview with the resident revealed "...two other employee's husbands came to the facility and threatened me; the staff make me eat last; when left in the wheelchair I can't use the call light; and I'm limited to thirty minutes for baths."

Interview with CNA #9 (day shift supervisor) on May 7, 2012, in the front lobby, confirmed the staff are instructed to disengage the resident's electric wheelchair, place the resident in the resident's room, and shut the door if the resident starts cussing.

Interview with housekeeping supervisor on May 8, 2012, at 10:40 a.m., in the physical therapy room, confirmed the housekeeping supervisor had asked the resident, more than once, while holding a mirror "...when you look in a mirror do you see a monkey?" Further interview at this time with the housekeeping supervisor confirmed the resident reported to the housekeeping supervisor that the DON's husband threatened (not defined) the resident and the housekeeping supervisor reported it to the Nursing Home Administrator (NHA). (Report dates unknown and not documented.)

Interview with the Administrator on May 8, 2012, at 1:50 p.m., in the Administrator office, confirmed the housekeeping supervisor had asked the resident do you see a monkey when you look in the mirror; the staff disengaged the resident's electric wheelchair when the resident cursed; and the electric wheelchair disengagement was on the care plan. Continued interview at this time confirmed the Administrator was aware of two employee's husbands speaking to the resident, about the resident's behaviors; and the alleged abuse had not been investigated. Further interview at this time confirmed the NHA was unaware of the resident's right related to seclusion and no allegations of abuse had been investigated since December 23, 2010.

Interview with the DON on May 8, 2012, at 12:25 p.m., in the front office, confirmed the alleged abuse by the DON's spouse had not been reported due to the DON had been present. Continued interview at this time revealed the DON could not deny or confirm if the spouse touched the resident. Further interview at this time with the DON confirmed the DON had been aware that two other employee's spouses had spoken with the resident regarding the cursing; unaware of date; and had not reported or investigated the alleged abuse.

Telephone interview with CNA #6 on May 8, 2012, at 1:55 p.m., confirmed the resident curses staff frequently; instructed by DON per the care plan to place the resident in the resident's room; disengage the electric wheelchair; check every fifteen minutes; the

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	44E200	A. BUILDING _____ B. WING _____	05/15/2012

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAURELBROOK SANITARIUM	114 CAMPUS DRIVE DAYTON, TN 37321

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0223	

(continued... from page 6)

resident was to go to bed at 10:30 p.m.; and if the resident refuses to go to bed leave the resident up until first round was completed. (First round refers to the time it takes for all other residents to be checked, cleaned, or put to bed. Th exact amount of time for this to occur varies.)

Interview with the DON on May 8, 2012, at 2:35 p.m., in the front office, confirmed the resident curses the staff frequently; care plan intervention was to place the resident in the resident's room; disengage the electric wheelchair; check the resident every ten to fifteen minutes; close the door if the resident yells; the resident was unable to use the call light while up in the electric wheelchair; the resident had no means to call the staff; and has a history of [MEDICAL CONDITION] activity.

Interview with LPN #8 on May 8, 2012, at 2:55 p.m., at the nurse's station, confirmed the resident curses the staff frequently; the CNA had been instructed to "...place the resident in the resident's room when cursing; disengage the electric wheelchair; thirty minutes at most; shut the door if the resident starts yelling..." and the resident was unable to use the call light while up in the electric wheelchair.

Interview with Registered Nurse #1 on May 8, 2012, at 3:00 p.m., at the nurse's station, confirmed the resident curses the staff frequently; instructed to leave the resident in the resident's room; shut the door if the resident starts yelling; and disengage the electric wheelchair.

Telephone interview with the DON's spouse on May 9, 2012, at 8:45 a.m., confirmed the spouse came to the facility March 6, 2012, heard the resident cursing the DON and went to the doorway of resident #1. Further interview at this time confirmed the spouse informed the resident not to use "that" language with the female staff; the spouse placed the hands on the electric wheelchair of the resident; and the resident did not want to talk to the spouse.

Telephone interview with CNA #10 on May 14, 2012, at 3:25 p.m., revealed the CNA had been on the phone with the facility in May 2011; resident #1 cursed the CNA; the CNA's spouse had been aware of the resident's cursing; the CNA's spouse went to the facility "spoke" to the resident about cursing the CNA. Further interview at this time revealed facility staff witnessed the spouse talking with the resident. Continued interview at this time revealed the CNA informed the Administrator and DON and unaware if other staff reported the alleged verbal abuse.

Interview with the DON on May 14, 2012, at 9:45 a.m., in the DON office, revealed on October 19, 2011, around midnight the resident had been cursing the staff; the resident refused to quit cursing; the resident's electric wheelchair had been disengaged; the resident had been placed in the resident's room without a call light; the resident had not been able to call for assistance except by yelling; the resident had a known history of [MEDICAL CONDITION] activity; the resident's electric wheelchair had been left disengaged for twelve hours; the resident requested to go to bed at the end of the twelve hours and had been informed bedtime was on third shift.

Telephone interview with the Medical Director (MD) on May 14, 2012, at 2:30 p.m., revealed placing the resident with a known [MEDICAL CONDITION] disorder and known [MEDICAL CONDITION] activity in the resident's room, disengaging the electric wheel chair and without access to the call light would be an appropriate intervention for the resident's behavior of cursing the staff. Further interview confirmed the MD stated he had no expectations of the frequency the resident should be checked on while in seclusion.

Telephone interview with Nurse Practitioner (NP) #1 on May 15, 2012, at 3:12 p.m., revealed placing the resident in the resident's room, disengaging the electric wheelchair, without a call light is seclusion, and in the NP #1's professional opinion was not an appropriate intervention for behaviors of cursing the staff.

Resident # 2 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]

Medical record review of the Minimum Data Set (MDS) assessments dated November 4, 2010, (prior to incident) and Februaury 23, 2012, (current assessment) revealed the resident was severely cognitively impaired, has a history of wandering, and required limited staff assistance with ADLs (Activities of Daily Living).

Review of a statement provided by the LPN (Licensed Practical Nurse) assigned to resident #2's care on December 6, 2010, at 5:32 a.m., revealed "...resident #2 lying on floor in front of toilet...jerking motions in all four extremities ...(LPN) had to get between them with force to stop resident #3 from kicking...assisted resident #2 up and out of bathroom ...EMS called...dgtr (#2's daughter) notified...lacerations and abrasions noted around right eye...left ear had blood on it..."

The medical record review revealed no documentation resident #3 received social service assessments or psychosocial interventions related to known behaviors and no additional supervision related to behaviors had been implemented.

Interview on May 14, 2012, at 3:40 p.m., in the therapy room, with Social Services, confirmed no behavior management program was documented for resident #3.

Interview with the DON, outside the Administrator's office, on May 8, 2012 at 2:00 p.m., confirmed no behavior management program was documented and no additional interventions were documented to ensure the other residents safety related to resident #3's documented behavior of violence towards wandering residents.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

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Resident #11 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]

Medical record review of the Minimum Data Set, dated dated dated [DATE], and March 1, 2012, revealed the resident had severe impairment in cognitive skills.

Medical record review of a Nursing progress note [DIAGNOSES REDACTED]..3:30AM Resident sitting on edge of bed looking at a pile of feces that...had just purposely pooped in the middle of...room. Over this past week...has done this and finger painted with feces. CNAs (certified nursing assistants) relay that this resident is having increased behaviors of this sort. Sitting in hallway, nearly naked; in and out of resident's room nearly naked, does not redirect well. When told to clean feces from the floor (resident) reached down with bare hands to reclaim it. This after being told to use toilet tissue...has been awake the entire shift..."

Interview on May 9, 2012, at 9:15 a.m., in the therapy room, regarding the incident on January 6, 2012, with the Director of Nursing, stated "That's terrible" and confirmed the intervention was not appropriate for this behavior.

Interview on May 14, 2012, at 1:30 p.m. with Licensed Practical Nurse #3, (incident on January 6, 2012 documented by this nurse) by phone, confirmed the resident was asked to clean up the bowel movement from the floor. Continued interview with Licensed Practical Nurse #3 stated, "(resident) was supposed to correct it...if (resident) did something unreasonable."

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F 0223	(continued... from page 7) Interview on May 14, 2012, at 3:25 p.m., in the hall, with CNA (certified nursing assistant) #17, confirmed resident has had finger painting with feces and will try to redirect when this occurs. Interview on May 14, 2012, at 3:40 p.m., in the therapy room, with Social Services, confirmed the incident on January 6, 2012, is abuse. C/O # **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**, #**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**, #**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**
F 0226	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of the facility policy, review of personnel files, observation, and interview, the facility failed to thoroughly investigate allegations of abuse for three (#1, #16, #11) residents of twenty-seven residents reviewed, failed to check the abuse registry for six of six personnel files reviewed, and failed to inservice direct care staff on abuse in 2011 and no abuse inservices currently in 2012. The facility's failure to thoroughly investigate allegations of abuse placed resident #1, #16, #11 in Immediate Jeopardy. (Immediate Jeopardy is a situation in which the provider's noncompliance with one or more requirements of participation, has caused or is likely to cause, serious harm, injury, impairment or death). The Administrator and the Director of Nursing were informed of the Immediate Jeopardy in the Administrator's office on May 15, 2012, at 2:10 p.m. The Immediate Jeopardy constitutes substandard quality of care and was effective October 20, 2011, and is ongoing. An extended survey was conducted on May 15, 2012. The findings included: Review of the facility policy, "Abuse Investigations", revealed "...Should an incident or suspected incident of resident abuse, neglect or injury of an unknown source be reported, the administrator, or his/her designee, will appoint a member of management to investigate the alleged incident..." **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Resident #1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED] Medical record review of the Minimum Data Set (MDS) dated [DATE], revealed the resident scored fifteen of fifteen on the Brief Interview for Mental Status (BIMS) with intact cognitive skills and no memory impairment; had no mood symptoms; required total assistance with activities of daily living (ADL); had impairment of upper and lower extremities; and used an electric wheelchair for mobility. Medical record review of the Care Plan dated March 15, 2012, revealed "...if res (resident) continues to curse...escorted or told to go to room for a 10 min cool down period...res not allowed to curse outside...room if res is not cooperative escort to room and disengage (remove source of electricity) W/C (wheelchair) for 10-15 min...ensure safety and leave the room..." Review of a written statement by CNA #3 dated June 24, 2011, revealed "...nurse stated (to resident #1) the other resident took priority...(resident #1) became irate cursing...nurse told...to stop...continued resulting in wheelchair being disengaged...taken to...room...after allotted time was let out..." Medical record review of a nurse's note dated October 19, 2011, at 11:40 p.m., revealed "(resident #1) continues to speak loudly outside of room...asked...to go to room...refused...(stated) didn't have to...(staff) disengaged chair...pushed...to room...(resident #1) saying ...(staff) were assaulting...told (resident #1) needed to be quiet...(resident #1) disregarded all instructions..." Medical record review of a nurse's note dated October 20, 2011, at 12:15 a.m., revealed "(Resident #1) yelling and cursing from room...W/C remains off to attempt to keep others asleep..." Medical record review of a nurse's note dated October 20, 2011, at 3:00 a.m., revealed "...continuing to keep (resident #1) safe and in...room to minimize disturbances to other residents..." Medical record review of a nurse's note dated October 20, 2011, at 3:30 a.m., revealed "...(Resident #1) in room to maintain...safety and have facility as quiet as possible..." Medical record review of a nurse's note dated October 20, 2011, at 4:45 a.m., revealed "...reminded (resident #1)...care plan to go to bed at 10:30 p.m...(resident said) can do what (I) want...continuing to keep resident safe in...room and out of hallways..." Medical record review of a nurse's note dated October 20, 2011, at 6:20 a.m., revealed "...(resident #1) still in...chair in...room..."

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	44E200	A. BUILDING _____ B. WING _____	05/15/2012

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0226	

(continued... from page 8)

Medical record review of a nurse's note dated October 20, 2011, at 10:48 a.m., revealed "...resident (#1) sitting in chair asleep..."

Medical record review of a nurse's note dated October 20, 2011, at 12:00 p.m., revealed "...W/C still disengaged...(resident #1) C/O (complains of) not being taken care of...(resident #1) did want to lay down which according to care plan is on third shift (10:00 p.m.-6:00 a.m.)...been primarily sleeping in chair all morning..."

Medical record review of a nurse's note dated July 7, 2011, at 4:07 p.m., revealed "...resident (#1) reports...another resident...grabbed me..."

Observation and interview on May 7, 2012, at 10:50 a.m., in the resident's room, revealed the resident sitting in the electric wheelchair; was alert and oriented. Interview with the resident revealed, the Director of Nursing's (DON) spouse "blocked me in and touched my arm...I don't want...in my room...threatened me." Continued interview with the resident confirmed two other employee's spouses have come to the facility and threatened the resident.

Interview with housekeeping supervisor on May 8, 2012, at 10:40 a.m., in the physical therapy room, confirmed resident #1 reported to the housekeeping supervisor that the DON's spouse threatened the resident and the housekeeping supervisor reported it to the Administrator but unaware of the date.

Interview with the DON on May 8, 2012, at 12:25 p.m., in the front office, confirmed the alleged abuse by the DON's spouse had not been reported to the Administrator. Further interview confirmed the DON had been aware that two other employee's spouses had "spoken" with the resident regarding the cursing; was unaware of the date; and had not reported or investigated the alleged abuse.

Interview with the Administrator on May 8, 2012, at 1:50 p.m., in the Administrator's office, confirmed the staff disengaged the resident's electric wheelchair when the resident cursed; and the electric wheelchair disengagement was on the care plan. Continued interview at this time confirmed the Administrator had been aware of two employee's spouses speaking to the resident about the resident's behaviors but did not consider that abuse to the resident; unaware that on July 7, 2011, resident #1 reported another resident grabbed the resident and the alleged abuse had not been investigated. Further interview at this time confirmed the Administrator no allegations of abuse had been investigated since December 23, 2010, and the facility's policy related to "Abuse Investigation" had not been implemented.

Resident #16 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]

Medical record review of the MDS dated [DATE], revealed the resident was moderately impaired for decision making, and was totally dependent for all activities of daily living, and eating.

Medical record review of the Interdisciplinary Care Plan last review June 16, 2011, revealed "...difficulty swallowing at times...give verbal encouragement to finish meal...feed at all meals..."

Medical record review of a Nurse's note dated February 19, 2012, at 4:45 p.m., revealed "...Observed resident's (family member)...using excessive force while attempting to feed...displaying anger and intolerance...resident was refusing to eat..."

Interview with the MDS Coordinator on May 14, 2012, at 11:00 a.m., in the DON's office, confirmed the MDS Coordinator witnessed resident #16's family member using force and displaying anger on February 19, 2012, and reported it to the Administrator. Further interview at this time revealed the family member was forcing the spoon in the resident's mouth and the family member's tone was angry.

Interview with the Administrator on May 14, 2012, at 1:40 p.m., in the Administrator's office, confirmed the Administrator had knowledge of the alleged abuse of resident #16; called the family member of the resident, and no investigation or documentation of the incident had been completed.

Resident #11 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]

Medical record review of the Minimum Data Set, dated dated dated [DATE], and March 1, 2012, revealed the resident had severe impairment in cognitive skills.

Medical record review of a Nursing progress note [DIAGNOSES REDACTED]..3:30AM Resident sitting on edge of bed looking at a pile of feces that...had just purposely pooped in the middle of...room...When told to clean feces from the floor (resident) reached down with bare hands to reclaim it. This after being told to use toilet tissue...has been awake the entire shift..."

Interview on May 9, 2012, at 9:15 a.m., in the therapy room, regarding the incident on January 6, 2012, with the Director of Nursing, stated "That's terrible" and confirmed no investigation had been completed.

Review of six personnel files for direct care staff hired since 2009, revealed no abuse registry check had been completed prior to assigning staff to provide resident care.

Interview with the front office manager on May 15, 2012, at 3:00 p.m., in the front office, revealed the front office manager was responsible for checking the abuse registry and the abuse registry had not been checked for six of six personnel files.

Interview with the Administrator on May 15, 2012, at 3:15 p.m., in the Administrators office, confirmed the facility failed to provide an inservice on Abuse to the direct care staff in 2011 or in 2012.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

C/O #**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** #**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0226	(continued... from page 9)
F 0241	**Provide care for residents in a way that keeps or builds each resident's dignity and respect of individuality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, and interview, the facility failed to promote care that maintained or enhanced dignity during a meal time for two residents (#16 and #23) of twenty-seven residents reviewed. The findings included: Resident #16 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED] Medical record review of the MDS dated [DATE], revealed the resident was moderately impaired for decision making and was totally dependent for all activities of daily living and eating. Observation on May 15, 2012, at 8:00 a.m., in the activity room, revealed the resident in the activity room, sitting in the wheelchair being fed breakfast by Certified Nurse Aide (CNA) #16. Observation on May 15, 2012, at 8:10 a.m., in the activity room, revealed CNA #16 standing in front of Resident #16 feeding the resident. Resident #23 was admitted to the facility with [DIAGNOSES REDACTED] Medical record review of the MDS dated [DATE], revealed the resident was severely impaired for daily decision making, inattention continuously present, totally dependent on staff for eating, no swallowing disorder, obvious or likely cavity or broken natural teeth, and was on a mechanically altered diet. Observation on May 15, 2012, at 8:05 a.m., in the activity room, revealed Resident #23 sitting in a wheel chair, CNA #16 standing in front of Resident #23 feeding the resident with a sixty cc (cubic centimeters) syringe and Resident #16 poking Resident #23 in the head with finger. Interview with the Director of Nursing (DON) in the activity room, confirmed the facility failed to maintain or enhance dignity during dining for two Residents #16 and #23, the activity room was small and the staff must stand to feed the residents.
F 0242	**Make sure each resident has the right to have a choice over activities, their schedules and health care according to his or her interests, assessment, and plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, and interview, the facility failed to allow one resident (#1) to make choices of twenty-seven residents reviewed. The findings included: Resident #1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED] Medical record review of the Minimum Data Set (MDS) dated [DATE], revealed the resident scored fifteen of fifteen on the Brief Interview for Mental Status (BIMS) with intact cognitive skills and no memory impairment. Medical record review of the Care Plan dated March 15, 2012, revealed "...to go to bed at 11:30 pm...allow to make choices...not allowed to curse outside of room..." Medical record review of a Behavior Note dated October 19, 2011, at 10:45 p.m., revealed "...instructed resident of care plan that states needs to go to bed when 3rd shift (10 p.m. - 6:00 a.m.) first gets here...said no didn't have to...restated we need to follow care plan..." Medical record review of a Nurse's Note dated October 20, 2011, at 12:00 p.m., revealed "...W/C (wheelchair) still disengaged (remove battery)...C/O (complains of) not being taken care of...did want to lay down which according to care plan is on third shift...been primarily sleeping in chair all morning..." Medical record review of a Behavior Note dated March 2, 2012, at 11:30 p.m., revealed "...asked resident if...wanted to go to bed...told to get out of...room...per...care plan...needed to go to bed..." Observation and interview with the resident on May 7, 2012, at 10:45 a.m., in the resident's room, revealed the resident sitting in a motorized wheelchair. Interview at this time revealed the facility had given the resident a bedtime of 10:30 p.m., and the resident does not want to go to bed at 10:30 p.m. Interview with the Director of Nursing (DON) on May 8, 2012, at 2:30 p.m., in the front office, confirmed the facility had given the resident a bedtime (when 3rd shift arrives), it is care planned, and the staff had been instructed to follow the care plan. Continued interview at this time confirmed if the resident refuses to go to bed when 3rd shift arrives, the resident must wait until the staff complete the first round (checking all residents) and the resident does not have a choice when the resident goes to bed. Interview with the DON on May 14, 2012, at 8:45 a.m., in the DON office, revealed the resident requested to go to bed on October 20, 2012, at 12 noon, the resident was informed according to the Care Plan bedtime was on third shift and the facility failed to allow the resident a choice of when to go to bed. C/O #**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** #**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0242	(continued... from page 10)
F 0250	**Provide medically-related social services to help each resident achieve the highest possible quality of life.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, and interview, the facility failed to provide social services adequate to meet the needs of one (#1)resident of twenty-seven residents reviewed. The findings included: Resident #1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED] Medical record review of the Minimum Data Set (MDS) dated [DATE], revealed the resident scored fifteen of fifteen on the Brief Interview for Mental Status (BIMS) with intact cognitive skills, no memory impairment verbal behavioral symptoms directed toward others occurred four to six days per week (less than daily), and rejection of care occurred four to six days per week (less than daily). Continued review of the MDS revealed the resident required total staff assistance for transfers, and activities of daily living. Medical record review of an Interdisciplinary Care Plan, dated March 15, 2012, revealed "...problem: behavior...inappropriate/disruptive behavior...displays persistent anger with staff...easily annoyed..." Medical record review revealed no Social Services progress note [DIAGNOSES REDACTED] Medical record review of a Nurse's Note dated September 20, 2011, at 5:25 a.m., revealed "...Pt (patient) upset started cussing..." Medical record review of a Nurse's Note dated October 20, 2011, at 12:15 a.m., revealed "yelling and cursing from room..." Medical record review of a Nurse's Note dated March 6, 2012, at 8:04 p.m., revealed "...continues to curse...unable to have CNA's help...at this time due to...behaviors..." Interview with the Director of Nursing on May 16, 2012, at 8:40 a.m., in the front office, revealed Resident #1 was known to curse, place demands on the staff, and this frequently upset other residents. Interview continued and confirmed a behavior management program had not been established for the resident. Telephone interview with the Nurse Practitioner #1 on May 15, 2012, at 3:12 p.m., confirmed Resident #1 was [DIAGNOSES REDACTED]. Interview with the Social Service Director on May 14, 2012, at 3:30 p.m., in the physical therapy office, confirmed had been aware of the resident's behaviors; aware of intervention of seclusion for behaviors; had never addressed the residents behaviors; the resident attends Community Mental Health Center off the campus; and the Social Service Director had no contact with the mental health center. C/O #**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** #**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**
F 0278	**Make sure each resident receives an accurate assessment by a qualified health professional.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, and interview, the facility failed to ensure accuracy of the Minimum Data Set (MDS) for six residents (#1, #13, #16, #2, #4, and #14) and failed to complete a feeding assessment for two residents (#23, and #24) of twenty-seven residents reviewed. The findings included: Resident #1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED] Medical record review of the MDS dated [DATE], revealed the resident scored fifteen of fifteen on the Brief Interview for Mental Status (BIMS) with intact cognitive skills, no memory impairment and restraints were not used. Continued review of the MDS revealed no diagnosis for [MEDICAL CONDITION] disorder for Resident #1. Medical record review of the Care Plan dated March 15, 2012, revealed "...SR (side rails) up times 2 to prevent...falling OOB (out of bed)..." Medical record review of Resident Plan of Care Instructions no date revealed "...restraint 2 bed rails..."

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	44E200	A. BUILDING _____ B. WING _____	05/15/2012

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAURELBROOK SANITARIUM	114 CAMPUS DRIVE DAYTON, TN 37321

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F 0278	

(continued... from page 11)

Medical record review of Physician Recapitulation Orders dated May 2012, revealed "...DX: ([DIAGNOSES REDACTED]

Observation on May 8, 2012, at 8:00 a.m., in the resident's room, revealed the resident asleep, lying on the bed, the side rails up times two, and the call light in place.

Resident #13 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]

Medical record review of the MDS dated [DATE], revealed the resident had long term memory problem, and required supervision for activities of daily living. Continued MDS review revealed no diagnosis for [MEDICAL CONDITION] Disorder for Resident #13.

Medical record review of the Care Plan dated February 23, 2012, revealed "...[MEDICAL CONDITION]...resident will remain free of injury..."

Medical record review of Physician Recapitulation Orders dated May 2012, revealed "...DX: ([DIAGNOSES REDACTED]

Resident #16 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]

Medical record review of the MDS dated [DATE], revealed no diagnosis for [MEDICAL CONDITION] Disorder.

Medical record of the Care Plan dated last review June 16, 2011, revealed "...restraints...low bed with padded rails...SR x (times) 2 when in bed...[MEDICAL CONDITION] disorder...if [MEDICAL CONDITION] occurs try to prevent injury..."

Medical record review of the Physician Recapitulation Orders dated May 2012, revealed "...DX: [MEDICAL CONDITION] Disorder..."

Interview with MDS Coordinator on May 14, 2012, at 11:20 a.m., in the Director of Nursing (DON) office, confirmed the MDS for Resident's #1, #13, and #16 were not accurate.

Resident #2 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]

Medical record review of the admission MDS assessment dated [DATE], revealed the resident was severely cognitively impaired, had a history of [DIAGNOSES REDACTED]. Continued MDS review revealed the resident was not coded for any type of physical restraint.

Observation of Resident #2 on May 7, 2012, at 10:00 a.m., lying on the bed, with full side-rails up bilaterally. The resident's call light was within reach. There was a merry-walker at the resident's bedside.

Observation on May 7, 2012, at 2:30 p.m., revealed the resident ambulating throughout the facility in a merry-walker. The resident had a seatbelt secured around the waist in the merry-walker, and the merry-walker had weights at the base to prevent the resident from tipping the device over. The resident was confused and mumbling to self. The resident could not exit the merry-walker independently when instructed to attempt.

Observation on May 8, 2012, at 3:45 p.m., revealed the resident in the facility "circle area," in a reclined geri-chair with lap top tray secured across the lap. The resident was restless and attempting to exit the chair by leaning to the right.

Interview with the DON, at the time of the observation, confirmed the recliner is a restraint with the tray table across the resident to prevent the resident from rising independently, the merry-walker and the seatbelt for the merry-walker, as well as the bed side rails in the up position, are all physical restraints. The DON further confirmed the comprehensive assessment was inaccurate.

Resident #4 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]

Medical record review of the MDS assessment dated [DATE], revealed the resident with severe cognitive deficits, the resident was ambulatory with the use of a walker, and the resident had no restraint.

Observation of the resident on May 9, 2012, at 8:20 a.m., revealed the resident lying on the bed with the left side of the bed against the wall and half side rails up, in the mid bed position, on the right side of the bed.

Observation of the resident on May 14, 2012, at 10:05 a.m., revealed the resident lying on the bed, with the side rail on the right side of the bed in the down position. The left side of the bed was against the wall.

Interview with the DON, on May 15, 2012, at 11:25 a.m., at the nurse's station, confirmed the side rail on the right side of the bed is a restraint when in the up position, with the left side of the bed against the wall. The DON further confirmed the comprehensive assessment was inaccurate.

Resident #14 was readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]

Medical record review of the resident's MDS assessment dated [DATE], revealed the resident had severe cognitive deficits, was chair or bed bound, was ambulatory with the use of a wheelchair, and had no restraint.

Observation of the resident in the "circle area" on May 9, 2012 at 1:00 p.m., revealed the resident in a reclined geri-chair with pillows to each side of the body. The resident was confused.

Observation of the resident on May 14, 2012, at 9:45 a.m., revealed the resident in room in reclined geri-chair. Resident was anxious and confused, and was unable to exit the chair independently.

Interview with the DON, at the time of the observation, confirmed the recliner is a restraint if the chair prevents the resident from rising independently. The DON further confirmed the comprehensive assessment was inaccurate

Resident #23 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]

Medical record review of the MDS dated [DATE], revealed the resident was severely impaired for daily decision making, inattention continuously present, totally dependent on staff for eating, no swallowing disorder, obvious or likely cavity or broken natural teeth, and a mechanically altered diet.

Medical record review of an Interdisciplinary Care Plan dated last reviewed June 16, 2011, revealed "...assist with feeding as needed...honey thickened liquid 2/7/12..."

Medical record review of a Resident Plan of Care Instructions, no date, revealed "...can be fed using a syringe..."

Medical record review of a Dietician note dated March 26, 2012, at 4:13 p.m., revealed "...honey thick liquids...vegan/pureed...fed with syringe but sometimes won't open mouth..."

Medical record review of a Physician Recapitulation Orders May 2012, revealed "...Diet - N/A (non applicable) honey thickened liquids..."

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F 0278	(continued... from page 12) Observation on May 15, 2012, at 8:05 a.m., in the activity room, revealed Resident #23 sitting in a wheel chair, Certified Nurse Assistant (CNA) #16 feeding the resident with a sixty cc (cubic centimeters) syringe. Interview with CNA #16 on May 15, 2012, at 8:10 a.m., revealed the syringe contained pureed oatmeal, peanut butter, and milk. Observation with the DON on May 15, 2012, at 8:18 a.m., in the activity room, revealed CNA student #1 feeding Resident #23 with a syringe containing milk that had not been thickened and the DON instructed the student to thicken the milk. Observation on May 15, 2012, at 11:30 a.m., in the activity room, revealed the resident being fed by CNA #6 with a spoon. Interview with the DON on May 15, 2012, at 10:30 a.m., in the DON office, confirmed the facility failed to complete a feeding assessment to determine the need and safety of feeding the resident with a syringe. Resident #24 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED] Medical record review of a MDS dated [DATE], revealed the resident was severely impaired for daily decision making, inattention present fluctuates, totally dependent on staff for eating, no swallowing disorder, and a mechanically altered diet. Medical record review of the Interdisciplinary Care Plan dated March 22, 2012, revealed "...mechanically altered diet...tolerate consistency of food without evidence of choking...pureed diet texture...offer small bites...remind to swallow...monitor for S/SX (signs and symptoms) aspiration...use a sippy cup for all liquids..." Medical record review of a Dietitian note dated March 26, 2012, at 8:54 a.m., revealed "...takes a while to swallow...receiving honey thick liquids..." Medical record review of a Physician Recapitulation Orders May 2012, revealed "...Diet Pureed...honey thickened liquids..." Observation on May 15, 2012, at 11:30 a.m., in the resident's room, revealed the resident being fed by CNA #16 with a 60 cc syringe. Interview with the DON on May 15, 2012, at 10:30 a.m., in the DON office, confirmed the facility failed to complete a feeding assessment to determine the need for feeding the resident with a syringe. C/O #**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** #**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** #**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**
F 0279	**Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, and interview, the facility failed to develop a comprehensive care plan for one resident (#18) of twenty-seven residents reviewed. The findings included: Resident #18 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED] Medical record review of the Minimum Data Set (MDS) dated [DATE], revealed the resident had short and long term memory problems, required extensive assistance with activities of daily living, and required extensive assistance with eating. Medical record review of a Dietary progress note [DIAGNOSES REDACTED]..having to assist...more lately with eating...needs more encouragement..." Medical record review of a Dietary progress note [DIAGNOSES REDACTED]..cannot feed...self...requires encouragement drinking and eating..." Medical record review of a Dietary progress note [DIAGNOSES REDACTED]..needs assistance w/ (with) eating..." Medical record review of a Care Plan last reviewed on March 1, 2012, revealed no care plan for assistance with meals. Observation on May 14, 2012, at 4:53 p.m., in the dining room, revealed the resident sitting at a dining table with an untouched supper tray sitting on the table and a spoon lying in the pureed meat. Continued observation at 4:56 p.m., revealed Certified Nursing Assistant (CNA) #13 scooped meat onto the spoon and laid the spoon back on the resident's plate. Continued observation revealed another resident sitting at the same table stated "pick up your spoon and eat." CNA #13 then walked away from the table. Continued observation revealed the resident continued to sit at the table not eating with the hands folded and resting on the lap. Continued observation at 5:09 p.m., revealed the resident continued to sit at the table not eating and no staff attempted to assist or encourage the resident to eat. Continued observation at 5:16 p.m., (twenty-three minutes later) revealed CNA #14 assisted the resident with eating. Interview with the Director of Nursing (DON) on May 14, 2012, at 5:10 p.m., in the dining room, confirmed "within five minutes I would expect staff to assist with feeding and attempt to encourage resident every couple of minutes." Interview with CNA #14 on May 14, 2012, at 5:16 p.m., in the dining room, confirmed the resident would self feed if (resident) liked the food, but "will eat food even if (resident) doesn't like it if someone feeds (resident)." Interview with the DON on May 15, 2012, at 1:05 p.m., outside the MDS Coordinator office, confirmed the facility failed to complete a comprehensive care plan to include assistance with meals.
F 0280	**Allow the resident the right to participate in the planning or revision of the resident's care plan.** **Allow the resident the right to participate in the planning or revision of the resident's care plan.**

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F 0280	(continued... from page 13) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, and interview, the facility failed to evaluate and update the care plan for one resident (#1) of twenty-seven residents reviewed. The findings included: Resident #1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED] Medical record review of the Minimum Data Set (MDS) dated [DATE], revealed the resident scored fifteen of fifteen on the Brief Interview for Mental Status (BIMS) indicating intact cognitive skills and no memory impairment and exhibited behaviors four to six days weekly. Medical record review of the Care Plan dated March 15, 2012, revealed no intervention or medications for [MEDICAL CONDITION] Disorder. Medical record review of a Nurse's Note dated March 19, 2012, at 10:00 a.m., revealed "...having a [MEDICAL CONDITION]..." Medical record review of a Nurse's Note dated May 19, 2012, revealed "...doctor notified of [MEDICAL CONDITION]..." Medical record review of Physician Recapitulation Orders dated May 2012, revealed "...DX: (diagnosis) [MEDICAL CONDITION] Disorder...[MEDICATION NAME] ([MEDICAL CONDITION] medication) 500 mg (milligram) tablet...TID (three times a day)...[MEDICATION NAME] ([MEDICAL CONDITION] medication) 200 mg...TID..." Observation on May 7, 2012, at 10:50 a.m., in the resident's room, revealed the resident sitting in an electric wheelchair, alert and oriented. Interview with the MDS Coordinator on May 14, 2012, at 11:28 a.m., in the Director of Nursing (DON) office, confirmed the care plan had not been updated to reflect interventions for [MEDICAL CONDITION] Disorder and [MEDICAL CONDITION] activity. C/O #**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** #**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**
F 0281	**Make sure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, and interview, the facility failed to write and follow a physican's order for vital signs and neurological checks for one resident (#19) and failed to obtain a physician's order [REDACTED]. The findings included: Resident #19 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED] Medical record review of the Minimum Data Set (MDS), dated [DATE], revealed the resident was moderately cognitively impaired and required extensive assistance with activities of daily living, toileting and bathing. Medical record review of a Nurse's Note dated December 22, 2011, at 7:30 a.m., revealed "...resident in bath room in shower chair. Certified Nurse Assistant (CNA) observed resident fall sideways out of the shower chair, landing on the right side. Resident was assessed for injuries, small contusion noted to right side of forehead. No other injuries noted. Neuro checks started..." Medical record review of the "Vital Sign Flow Sheet with Neuro Checks" dated December 23, 2011 and December 24, 2011, revealed"...frequency q (every) 4 hours per shift for 24 hours, then qs (every shift) X (times) 24 hours..." Medical record review of the physician's order [REDACTED]. Medical record review of the Vital Signs Flow Sheet revealed on December 24, 2011, at 8:00 a.m., 4 p.m. and 10 p.m., no vital signs or neuro check information was documented on the resident's record. Observation on May 14, 2012, at 4:55 p.m., in the resident's room, revealed the resident sitting in the wheelchair with a clip alarm in place. Telephone interview with Licensed Practical Nurse (LPN) #5, on May 15, 2012, at 10:30 a.m., revealed "...I called the doctor about the fall and received orders for the vital signs and the neuro checks for every 4 hours for the first 24 hours, then every shift for 24 hours...I forgot to write the order and communicate this to the oncoming shift..." Interview with the Director of Nursing (DON) and the MDS Coordinator on May 14, 2012, at 3:30 p.m., in the DON office, confirmed the physicians telephone order was not transcribed for the vital signs or the neurological checks and the facility failed to follow the physician's order [REDACTED] Resident #20 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Observation on May 15, 2012, at 9:30 a.m., in the west hallway, revealed LPN #4, preparing multiple herbal medications to administer to Resident #20, including Dandelion Leaf, Hawthorn Berry, [MEDICATION NAME], Bilberry Leaf, and Vitamin C. Further observation revealed the medications were stored in zip lock bags labeled with the herbal medication name and strength, if applicable, and did not include the resident's name, medication expiration date, ordering physician's name, dispensing instructions, or pharmacy label. Medical record review of the Medication Administration Record [MEDICATION ORDERS REDACTED] Medical record review of the physician's order [REDACTED]. Interview on May 15, 2012, at 1:30 p.m., with LPN #2, confirmed the herbal medications were brought to the facility in zip lock bags by the resident and had been administered daily during May 2012, without a physician's order [REDACTED]

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F 0281	(continued... from page 14) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**
F 0309	**Provide necessary care and services to maintain the highest well being of each resident .** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, the facility failed to control pain for one resident (#18) and failed to follow physician's order [REDACTED]. The findings included: Resident #18 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED] Medical record review of the Minimum Data Set (MDS) dated [DATE], revealed the resident had short and long term memory problems, and required extensive assistance with ambulation and activities of daily living. Medical record review of a Nurse's progress note [DIAGNOSES REDACTED]..resident climbed between bedrail and footboard...observed sitting on the floor..." Medical record review of a Radiology Report of the pelvis dated September 25, 2011, revealed, "...severe [MEDICAL CONDITION] of both hips...no acute fracture is appreciated..." Medical record review of a Nurse's progress note [DIAGNOSES REDACTED]...resident returned from (Hospital)...discharge instructions...return in 6-8 hours if pain does not improve..." Medical record review of a Nurse's progress note [DIAGNOSES REDACTED]...Pt (patient) yells when turned by staff members..." Further review of a Nurse's progress note [DIAGNOSES REDACTED]...resident showed extreme pain during shift rotations and during get-up time...resident given 1000 mg (milligram) of Tylenol...no improvement in pain..." Further review of a Nurse's progress note [DIAGNOSES REDACTED]...resident complains of pain when walking...given pain medication...still 2 hrs (hours) later in excoriating (excruciating) pain..." Continued review of a progress note [DIAGNOSES REDACTED]..physician contacted due to patient's severe R (right) leg pain...order given for [MEDICATION NAME] (narcotic)..." Medical record review of a facility Medication Record dated September 2011 and October 2011, revealed [MEDICATION NAME] was administered for pain management. Medical record review of a Nurse's progress note [DIAGNOSES REDACTED]...still in tremendous pain...yelling when turned...or change of position..." Continued review of a Nurses's Note at 4:14 p.m., revealed, "...screaming out in pain when care done..." Medical record review of a (mobile imaging) Patient Report of the right femur (hip) xray dated September 27, 2011, revealed, "...no fracture is seen..." Medical record review of a Nurse's progress note [DIAGNOSES REDACTED]...slept through the night...c/o (complains of)...hurts up inside..." Medical record review of a Physician's Note dated October 5, 2011, revealed, "...had a fall last week and xray was no fx (fracture) noted but continued pain..." Medical record review of a Nurse's progress note [DIAGNOSES REDACTED]...seen by (medical director) new orders for x-ray of right femur..." Continued review of a Nurse's progress note [DIAGNOSES REDACTED]...received results...acute fracture...send to (hospital) to consult orthopedic..." Medical record review of the Nurses' progress note [DIAGNOSES REDACTED]. Resident #7 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The resident was discharged from the facility on February 13, 2012. Medical record review of a Nursing progress note [DIAGNOSES REDACTED]..Resident to Dr. (Doctor) appointment at 9:00 a.m...Staff members has tried to contact (named hospital) 3 or 4 times to see if (resident) is coming back today..." Medical record review of a Nursing progress note [DIAGNOSES REDACTED]..Pt.(patient) returned from (named hospital) via ambulance at 6:30 p.m..." Medical record review of the physician's order [REDACTED]..HD ([MEDICAL TREATMENT]) on Tu (Tuesday)/Th (Thursday)/Sat (Saturday) per (named [MEDICAL TREATMENT] clinic)..." Medical record review of a Nursing progress note [DIAGNOSES REDACTED]...scheduled for [MEDICAL TREATMENT] at (named [MEDICAL TREATMENT] clinic) today at 3PM...will be going by ambulance...At 4:00 pm...spoke with...(named [MEDICAL TREATMENT] clinic) re: (regarding) No transportation to the clinic today. ([MEDICAL TREATMENT] Clinic) will try to work (resident) in on Monday..." Medical record review of a Nursing progress note [DIAGNOSES REDACTED]..called (named hospital) to talk with resident's case manager...to ask the reason why resident wasn't picked up on 9-24-11 for [MEDICAL TREATMENT]...(case manager) wasn't there another case manager...called me back to say...was looking into the problem...called ([MEDICAL TREATMENT] clinic)...([MEDICAL TREATMENT] clinic) stated they were set to take (resident) but...(named ambulance) stated that (named hospital) had not sent the medical

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F 0309	(continued... from page 15) necessity form to them yet to transport...(named ambulance) called and said they will pick up resident on 9-27-11..." Medical record review of a Nursing progress note [DIAGNOSES REDACTED]..was taken via ambulance around 2PM to go to (named [MEDICAL TREATMENT] clinic) but was deferred to (named hospital) on the way due to resident blood sugar being too low..." Medical record review of a Nursing progress note [DIAGNOSES REDACTED]..Taken, via...ambulance to...schedule [MEDICAL TREATMENT] appointment..." Medical record review of a Nursing progress note [DIAGNOSES REDACTED]..Received phone call...at [MEDICAL TREATMENT] clinic to report that...had given Res (resident) 3 amps of D50% ([MEDICATION NAME] 50%) res. Blood sugar was in the 30s and they got it to come up but it kept dropping. Res. being transported via ambulance to (named hospital) per POA (power of attorney) request..." Medical record review of a Nursing progress note [DIAGNOSES REDACTED]..Pt. returned from (named hospital)..." Interview on May 8, 2012, at 8:45 a.m., with the Director of Nursing, in the therapy room, confirmed the physician's order [REDACTED]. c/o #**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**
F 0314	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of the facility policy, observation, and interview, the facility failed to identify a pressure ulcer and failed to provide treatment timely for a pressure ulcer which caused harm for one resident (#6) and failed to provide treatment timely for a pressure ulcer for one resident (#7) of twenty-seven resident's reviewed. The findings included: Resident #6 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED] Medical record review of a Nursing progress note [DIAGNOSES REDACTED]..Weekly skin assessment done: assessed all areas of the skin with clothes off paying special attention to bony areas, under arms, breasts, groin, buttocks, arms and legs-resident has small red area to back of left leg, just below buttock. No other wounds noted... " Medical record review of a Physical Therapist progress note [DIAGNOSES REDACTED]..Pt. (patient) is saying that ...thinks...could walk just as well if not better without the thigh brace on left. Also stating that entire shoe will have to be replaced on the left b/c (because) it is too tight...does not like the therapist to pull the straps tight but prefers them lose (loose). I told (resident) I cannot allow them to be lose due to too much friction and slipping in the shoe...has an open wound on 2nd dorsal toe which is bandaged. Medical record review of a Nursing progress note [DIAGNOSES REDACTED]..weekly skin assessment done...small spot with loose skin around seemingly old wound on back of left thigh right below left buttock, no redness...looks healed...Second and fourth digits of left foot with band-aids. Resident refused to have them removed for assessment...no signs of inflammation noted around band-aids. No other wounds noted..." Medical record review of a wound assessment worksheet dated May 3, 2012, revealed 1st toe left foot with redness, 2nd toe left foot with redness, 3rd toe left foot measured 1.3 cm (centimeters) length and 1.2 cm width, wound base with eschar/slough. Medical record review of a physician's order [REDACTED]..[MEDICATION NAME] to toes daily. Cover with light dressing...Vitamin C 500mg (milligrams) po (by mouth) BID (twice a day) x 2 wks (weeks) Zinc 200mg po Q (every) day x (times) 2 wks check [MEDICATION NAME] level if low...start protein powder 2 scoops Q day x 2 wks..." Medical record review of a Medication Record dated May 2012, revealed "[MEDICATION NAME] to open wound on toes of L (left) foot Q day cover (with) light dressing..." Further review of the Medication Record dated May 2012 revealed treatment to the toes was not initialed as provided until May 3, 2012. Medical record review of a Nursing progress note [DIAGNOSES REDACTED]..Weekly skin assessment done...3 toes on Lt (foot) have rub abrasions which are being treated as ordered..." Medical record review of a wound assessment worksheet dated May 9, 2012, revealed, "...(left) foot...[MEDICAL CONDITION]...Eschar/Slough...first toe L (length) 0.2 W (width) 0.2 D (depth) 0...2nd toe L 0.1 W 0.1 (no depth)...3rd toe L 0.3 W 0.4 D 0..." Medical record review of a wound assessment worksheet dated May 14, 2012, revealed, " ...L foot-toes...1st toe L 0.3 W 0.4...2nd toe L 0.2 W 0.3...3rd toe L 0.6 W 0.6..." Review of the facility's policy, "Pressure Sores" , revealed "...If a resident is admitted with or develops a pressure sore, he/she will receive appropriate care and treatment to heal and prevent further development of other pressure sores..." Observation of the resident's wounds on the left foot, on May 8, 2012, at 9:00 a.m., with Licensed Practical Nurse (LPN) #2 revealed [MEDICAL CONDITION] wounds to the top of the first, second, and third toes as described by LPN #2. Interview on May 8, 2012, at 11:00 a.m., with the Wound Care Nurse, at the nursing station, confirmed the nurse was not aware of the wounds on the toes until May 3, 2012, and no orders were obtained to treat the wounds until May 3, 2012. Interview on May 8, 2012, at 12:30 p.m., with the Physical Therapist, at the nursing station, confirmed the wounds were open on April 25, 2012. Interview on May 8, 2012, at 1:50 p.m., with the Director of Nursing, at the nursing station, confirmed the facility had not identified when the pressure ulcers developed on the toes of the left foot, and confirmed a delay in treatment to the wounds. Resident #7 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The resident was discharged from the facility on February 13, 2012.

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F 0314	(continued... from page 16) Medical record review of a Nursing progress note [DIAGNOSES REDACTED]..Pt. (patient) returned from (named hospital) via ambulance at 6:30 p.m..." Medical record review of a Nursing Home physician's order [REDACTED]..cont (continue) L (left) leg decubitus ulcer care per...wound care orders..." Medical record review of a Nursing progress note [DIAGNOSES REDACTED]..Received report that resident had returned to facility with decubitus ulcers. [MEDICAL CONDITION] to sacral area, left heel (and) ankle. [MEDICAL CONDITION] to left calf. Treatment nurse to evaluate (and) obtain MD (Medical Doctor) orders for treatment...Please disregard [MEDICAL CONDITION] ulcer as noted above. Further evaluation reveals that resident came back with an unstageable ulcer..." Medical record review of a physician's order [REDACTED]..[MEDICATION NAME] to LLE (left lower extremity) wounds, cover with [MEDICATION NAME] Ag and [MEDICATION NAME] daily..." Medical record review of the Wound Assessment Worksheet dated September 28, 2011, revealed, "...L heel...Length 1.7 cm (centimeters) Width 1.7 cm Depth (question mark)...Eschar...(upper) L ankle...Length 0.8 cm Width 0.4 cm Depth (question mark)...Eschar...L calf...Length 1.7 cm Width 3.0 cm Depth 0 cm...Slough..." Medical record review of the treatment for [DIAGNOSES REDACTED]..L heel-clean (with) wound cleaner, [MEDICATION NAME] to Eschar. Cover with [MEDICATION NAME] Ag (and) cover (with) [MEDICATION NAME] Q (every) day...L ankle: clean (with) wound cleaner apply [MEDICATION NAME] Ag (and) cover (with) [MEDICATION NAME]...L calf-posterior aspect: [MEDICATION NAME] to wound, cover (with) [MEDICATION NAME] Ag (and) [MEDICATION NAME] ..." Continued review revealed treatment was not initialed as provided until the 27th. (September, 2011) Medical record review of a progress note [DIAGNOSES REDACTED]..Skin Integrity No alterations..." Interview on May 8, 2012, at 8:40 a.m., with the Director of Nursing, in the therapy room, confirmed wound care was not provided until physician order[DIAGNOSES REDACTED] Interview on May 14, 2012, at 11:25 a.m., with the Wound Care Nurse, at the nursing station, confirmed the nurse was not aware of the wound care orders when discharged from the hospital on September 22, 2011. c/o #**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**
F 0323	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of the facility policy, review of the facility investigation, review of the manufacturer's information, observation, and interview, the facility failed to provide supervision to prevent accidents for eight (#5, #4, #18, #3, #2, #14, #19, #21, #26) residents of twenty-seven residents reviewed. The facility's failure to supervise to prevent accidents placed residents #18, #3, #2, #4, #14, #19, #26 in Immediate Jeopardy. (Immediate Jeopardy is a situation in which the provider's noncompliance with one or more requirements of participation, has caused or is likely to cause serious harm, injury, impairment or death). The Administrator and Director of Nursing were informed of the Immediate Jeopardy, in the Administrator's office on May 15, 2012, at 2:10 p.m. The Immediate Jeopardy constitutes substandard quality of care and was effective October 20, 2011, and is ongoing. An extended survey was conducted on May 15, 2012. The findings included: Resident #5 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED] Medical record review of resident #5's Initial Psychosocial History (from the transferring mental health hospital), dated May 20, 2010, revealed resident #5 with: worsening psychosis; paranoia; flashbacks of stabbing someone; agitation; and rapid mood swings. Medical record review of the nursing facility's admission History and Physical revealed the facility's Medical Director and Administrator were aware of resident #5's " ...significant dementia ...and behavioral disturbance ..." when resident #5 was transferred from the mental health hospital to the facility on [DATE]. Medical record review of the admission MDS assessment, dated September 3, 2010, revealed resident #5 was ambulatory, was cognitively impaired and the resident's behaviors and " ...mental functioning varied over the course of the day ..." Interview with the Administrator, on May 7, 2012, at 11:00 a.m., outside the Administrator's office, confirmed documents forwarded at the time of the residents transfer into the facility (from the psychiatric hospital) indicated a history of aggression and violent behaviors. Medical record review revealed there was no psychiatric consultation or behavior management treatment plan initiated for resident #5 from admission on August 23, 2010 to discharge on February 5, 2011. Review of a facility investigation dated October 29, 2010 revealed resident #5 had a " ...history of aggression ...resident argument at picnic ...escalated into a fist fight ..." The only intervention initiated by the facility was to separate the two residents. Medical record review of a nurse's note dated October 30, 2010, revealed " ...antagonistic toward another resident ...acts as if could become combative with little to no instigation ...staff to monitor resident's activity to provide intervention as needed." No new interventions were implemented for supervision. Medical record review nurse's note dated December 25, 2010, revealed resident #5 was " ... very agitated ...angry ..." and threatened to " ...hurt someone, if that's what it takes to get out of here ..." There was no increased supervision implemented related to the resident's threat. Medical record review of a nurse's note dated January 21, 2011, revealed " ...resident expressed feelings of anger and aggression. He stated " ...if I don't get some help I'm going to hurt someone ..." The resident was medicated with Ativan (anti-anxiety medication) 0.5 mg (milligrams), by mouth. No other intervention for increased supervision was documented related to the threat.

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F 0323	

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Medical record review of the Psychoactive Drug-Behavior Monitoring Record from August 2010 through February 2011, revealed documentation the resident had exhibited intermittent anger and confusion.

Medical record review of the Medication Administration Record [MEDICATION ORDERS REDACTED]" ...increased agitation" on January 12, 21 (twice), 22, 25 and 27 , and February 2, 3 (twice) and 4, 2011.

Review of a facility investigation dated February 5, 2011, revealed at 9:45 a.m. " ...(resident #4) was sleeping in his room when another resident (#5) went into his room and started hitting him with a cane." Resident #4 was transferred to the emergency room , treated for [DIAGNOSES REDACTED].

Resident #4 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]

Medical record review of resident #4's MDS (Minimum Data Set) assessment dated [DATE], revealed the resident was severely cognitively impaired and required limited to extensive staff assistance for activities of daily living.

Interview with the NHA (Nursing Home Administrator) May 7, 2012, at 1:10 p.m., in the Administrator's office, confirmed the abuse and the facility failed to protect resident #4 from abuse which resulted in a fractured left ankle.

Resident #18 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]

Medical record review of the Minimum Data Set (MDS) dated [DATE], revealed the resident had short and long term memory problems, required extensive assistance with ambulation and activities of daily living, and used restraints daily.

Medical record review of a facility care plan, last reviewed on March 1, 2012, revealed "...side rails up times 2..."

Medical record review of a nurse's progress note [DIAGNOSES REDACTED]..resident crawled between foot board and bed rail...observed on floor..."

Medical record review of a facility investigation dated August 10, 2011, revealed "...got out of bed & (and) fell ...devices in use...siderails...2..."

Medical record review of a nurse's progress note [DIAGNOSES REDACTED]..resident climbed between bedrail and footboard...observed sitting on the floor..."

Medical record review of a facility investigation dated September 25, 2011, revealed "...devices in use...siderails ...2..."

Observations on May 14, 2012, at 1:00 p.m., and May 15, 2012, at 2:11 p.m., in the resident's room, revealed the resident lying in bed with full side rails on the bed and in the up position bilaterally.

Interview with Director of Nursing (DON) on May 15, 2012, at 7:50 a.m., at the nurses' station, confirmed the resident "possibly fell climbing out of the bed" and confirmed placing the resident in bed with side rails up is "not the best option...we may need another plan."

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Resident #3 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED].

Medical record review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed no behaviors exhibited by the resident and no cognitive deficits were documented on the comprehensive assessment.

Review of a statement provided by the DON (Director of Nursing) dated December 22, 2010, revealed " ...Resident (#3) stays in his room and does not come out ...has a history of hitting people who wander into his room ...One other incident in [DATE]." No investigation or documentation related to the October 2010 incident could be produced by the facility..

Review of a statement provided by the LPN assigned to resident #2's care on December 6, 2010, at 5:32 a.m., revealed, resident #2 wandered into a shared bathroom, not his own, and was found " ...(resident #2) lying on floor in front of toilet ...jerking motions in all four extremities ...(LPN)had to get between them with force to stop resident #3 from kicking ...resident #3 tried to hit me (LPN) and was cursing at me ...assisted resident #2 up and out of bathroom ...EMS called ...dgtr (#2's daughter) notified ...lacerations and abrasions noted around right eye ...left ear had blood on it ..."

Review of a consultation by the Mobile Crisis Response Team dated December 6, 2010, revealed " ...client (resident #3) stated ...assaulted the resident who came into room ...would not leave ...struck (resident #2) today because resident #3 can't rely on staff to get other people out of his room ...he pays the rent on room and others shouldn't be allowed in ..." Mobile Crisis concluded resident #3 was " ...not appropriate for involuntary committal." Resident #3 was transferred to a psychiatric unit for a "...higher level of care..."

Resident # 2 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]

Medical record review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed the resident was severely cognitively impaired, had a history of [DIAGNOSES REDACTED].

Medical record review revealed resident #2 had a history of [DIAGNOSES REDACTED]. No details of the fall or new interventions were documented.

Medical record review of the care plan dated February 21, 2012, revealed an entry dated January 12, 2011, revealed, "...resident tried to crawl in bed with another resident (#1) and fell ..."

Medical record review of a Nurse's Note (for resident #1) dated September 13, 2011, revealed, "...(res #2) tried to climb over bed rails...assisted back in the bed..." No investigation or new interventions were documented.

Medical record review of a Nurse's Note dated February 29, 2012, at 4:00 p.m.revealed, "...Resident (#2) was in geri-chair and managed to tip it over on it's side with resident still in it..." Continued review of the February 29, 2012, Nurse's Notes revealed an entry at 4:20 p.m., documenting, " Resident again tipped over in geri-chair..." The resident was assessed and assisted back to the geri-chair. No new interventions to prevent the resident from tipping over in the geri-chair were documented.

Medical record review of a facility investigation dated March 1, 2012, revealed an investigation of the 4:20 p.m. fall, noting the resident sustained a "...skin tear to the left elbow and a contusion to te left side of head..." The intervention was to "...ambulate the resident for 15 min (minutes) Q (every) shift."

Interview with the DON, outside the Administrator's office, on May 8, 2012, at 2:00 p.m., confirmed the facility failed to ensure

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F 0323	

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resident #2's safety.

Resident #14 was readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]

Medical record review of a Nurse's Note dated July 8, 2011, revealed " ...Pt (patient) fell out of her w/c (wheelchair) very small mark mid forehead ..."

Review of a facility investigation of the fall dated July 9, 2011, revealed an intervention of "...resident must not be left unattended in w/c."

Medical record review of a Nurse's Note dated August 5, 2011, revealed " ...resident tumbled out of her w/c at 5:33 PM ..."

Review of an incomplete facility investigation dated August 6, 2011, revealed no details related to the incident and the only intervention documented was "...resident to bed after lunch."

Medical record review of a Nurse's Note dated August 25, 2011, revealed "...was found lying on floor of dining room next to w/c where she was sitting for dinner...skin abrasion to right...hip area ..."

Review of a facility investigation dated August 25, 2011, revealed the only new intervention was "...place in bed after meals."

Medical record review of a Nurse's Note dated December 25, 2011, revealed "...10:00 am resident found laying semi-prone on floor of lobby ...assistance back to w/c...egg sized lump noted in hairline top of R (right) head..." No investigation was completed by the facility regarding the incident and no new fall interventions were implemented.

Medical record review of a Care Plan update dated February 1, 2012, revealed "...resident left unattended in w/c in room and fell out ..."

Medical record review of the Nurse's Notes for February 1, 2012, revealed "...unwitnessed fall...resident's room..."

Review of a facility investigation dated February 2, 2012, revealed a previous intervention not to leave the resident unattended in w/c had not been followed and no new interventions to prevent falls were implemented.

Medical record review of the resident's Minimum Data Set (MDS) assessment dated [DATE], revealed the resident had severe cognitive deficits, was chair or bed bound, was ambulatory with the use of a wheelchair, and was not restrained.

Medical record review of a Physical Therapy Fall Risk assessment dated [DATE], revealed "...Ambulation screen...Max (maximum)Assist + 1-2...for all ambulation, transfers and balance."

Medical record review of a Nurse's Note dated May 8, 2012, revealed " ...resident was in circle area...when...fell on floor..." No investigation of the fall was completed and no new interventions were implemented.

Interview with the DON (Director of Nursing) in the front office, on May 15, 2012, at 9:15 a.m., confirmed the investigations noted above were incomplete and the resident continued to experience falls, with no new interventions to reduce falls risk and keep the resident free of injuries related to falls.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Resident #19 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]

Medical record review of the Minimum Data Set (MDS), dated [DATE], revealed the resident was moderately impaired with cognitive skills and required extensive assistance with activities of daily living, toileting and bathing. Further review of the medical record revealed the resident suffered falls on the following dates: June 28, 2011, December 22, 2011, and January 7, 2012.

Medical record review of the Resident's Care Plan, dated May 14, 2012, revealed an intervention dated February 7, 2011, "...clip alarm on at all times..."

Medical record review of a nurse's note, dated June 28, 2011, at 1:48 p.m., revealed "...at 1:15 p.m., resident fell out of...chair in the hallway ...was asleep and tumbled onto the floor, causing a marble sized bump to the forehead, slightly right of the middle...no other signs of pain or discomfort was noted..."

Review of facility investigation, dated June 28, 2011, at 1:15 p.m., revealed "...monitors/alarms: none..."

Interview with the Director of Nursing (DON), on May 14, 2012, at 3:30 p.m., in the DON office, confirmed the clip alarm was not on the resident at the time of the fall on June 28, 2011.

Review of the resident's Care Plan, dated November 11, 2011,revealed "...2 person assistance at all times...maxi lift with all transfers...chair alarm on at all times..."

Medical record review of a nurse's note, for resident #19, dated December 22, 2011, at 7:30 a.m., revealed "...resident in bath room in shower chair. Certified Nurse Assistant (CNA) observed resident fall sideways out of the shower chair, landing on the right side. Resident was assessed for injuries, small contusion noted to right side of forehead. No other injuries noted. Neuro checks started..."

Review of facility investigation, dated December 22, 2011, at 7:20 a.m., revealed "...CNA stated to nurse that resident was in the bathroom in the shower chair... CNA observed resident fall sideways out of shower chair landing on right side...CNA stated that the shower chair did not have a seat belt...". Continued review of the facility documentation revealed "...shower chair seat belt repaired by maintenance..."

Interview with CNA #11, on May 15, 2012, at 11:30 a.m., in the shower room, the CNA stated "I was giving another resident a bath and the resident was in the shower room to use the bathroom...the resident leaned forward and fell out of the shower chair to the right side...the resident did not have a seat belt in use for the shower chair and the belt was not on shower chair..."

Telephone Interview with Licensed Practical Nurse (LPN) #5, on May 15, 2012, at 10:30 a.m., revealed the LPN was notified by CNA #11 regarding the resident falling out of the shower chair. Further interview revealed "...the CNA told me the resident slipped on the floor and I don't remember if the straps were on the shower chair..."

Interview with the Director of Nursing (DON) and the MDS Coordinator, on May 14, 2012, at 3:30 p.m., in the DON office, confirmed the resident did not have a seat belt in use with the shower chair. Further interview confirmed the shower chair did not have safety belts in place, no documentation of the use of the chair alarm and the resident was left unattended. Continued interview with the MDS coordinator and the DON revealed the maintenance department did not have any documentation regarding the repair of the shower chair.

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F 0323	(continued... from page 19) Resident # 21 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED] Review of the Minimum Data Set (MDS), dated [DATE], revealed the resident scored a 15 on the Brief Interview for Mental Status (BIMS) indicating the resident was cognitively intact. Observation on May 14, 2012, at 1:30 p.m., in the West Wing hallway, revealed the resident in a Hoyer Lift and sling (device used for providing safe lift and transfer for residents) being transported down the hallway from the shower room to the resident's room by Certified Nurse Assistant (CNA) #12. Further observation revealed the resident was suspended in the air by the lift and the resident's body was covered with a white sheet. Review of Manufactures "important information", # ARJO, AB 2011, on May 15, 2012, revealed "...Do not use the toilet sling for lifting and transportation apart from toilet related situations..." Review of facility policy, Hoyer Lift Instructions, with no date, revealed "...10. Two people required for all mechanical transfers to ensure safety ..." Interview with CNA #12, on May 14, 2012, at 1:30 p.m., in the hallway outside the resident's room, confirmed the resident was transported from the shower room back to the resident's room in the Hoyer Lift with one caregiver in attendance. Interview with the Physical Therapist, on May 15, 2012, at 1:00 p.m., in the West Wing hallway, confirmed the residents were transported using the lift, down the hallways before and after showers. Continued interview confirmed two people are required for safe transfers. Interview with the Director of Nursing (DON), on May 14, 2012, at 2:00 p.m., in the DON office, confirmed two people are required to ensure safety of the resident during transfer and one CNA was in attendance. Resident # 26 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Medical record review of the MDS, dated [DATE], revealed the resident had moderate impairment of cognitive skills and highly impaired vision. Medical record review of a Nursing progress note [DIAGNOSES REDACTED]...res (resident) fell out of bed landed on the floor L (left) side ...hematoma forehead...skin tear left thumb...transfer to hospital..." Review of facility investigation, dated August 4, 2011, at 2:15 p.m., revealed "...investigation revealed faulty side rail...Update: repair side rail immediately...8/4/11 side rail repaired..." Observation on May 15, 2012, at 11:00 a.m., in the dining hall, revealed the resident sitting in a Geri-chair asleep and with a clip alarm in use. Interview with Director of Nursing (DON) and the MDS Coordinator, on May 15, 2012, at 12:30 p.m., in the nurse's station, confirmed the faulty side rail caused the resident to fall on August 4, 2011. Further interview with the MDS coordinator confirmed the facility failed to investigate the cause of the faulty side rail, what was fixed on the side rail or a descriptive assessment of the incident. C/O #**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** #**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**
F 0363	**Make sure menus meet the resident's nutritional needs and that there is a prepared menu by which nutritious meals have been planned for the resident and followed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation,interview, review of resident council meeting minutes, and review of dietary menus, the facility failed to ensure menus included portion sizes for five of five weeks, failed to ensure planned menus were followed, and failed to ensure mechanically altered menus were consistent with the regular menu for two of two lunch meals observed. The findings included: Observation of the tray line on May 14, 2012, at 9:50 a.m., in the dietary department, revealed the staff serving casserole and potatoes with a green scoop (#6 scoop=2/3 cup), peas and carrots with a slotted serving spoon (unknown quantity), pureed tomatoes and pureed fiber protein with a grey scoop (#8 scoop=1/2 cup). Interview with the Dietary Manager on May 14, 2012, at 10:05 a.m., in the dietary office, revealed the green scoop contained 2 2/3 ounces, the grey scoop contained ? cup, and the slotted spoon portion size was unknown. Further interview with the Dietary Manager

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F 0363	(continued... from page 20) confirmed the menus provided for the last five weeks signed by the Registered Dietician (RD) had no portion sizes. Telephone interview with the RD, on May 14, 2012, at 1:50 p.m., confirmed the menus had been prepared by an outside dietetic company, did not have portion sizes, and current dietary standards for menu preparation were to indicate measured portions. Observation of the tray line on May 15, 2012, at 11:20 a.m., revealed the pureed desert for a [MEDICAL CONDITION] resident was unavailable and was substituted with a regular pureed desert and approved by the Dietary Manager. Review of Resident Council meeting minutes for May 9, 2012, revealed complaints from residents regarding dietary menus not being followed. Interviews with residents in the group meeting on May 14, 2012, at 3:00 p.m., revealed complaints from all five residents present about the facility not following the planned menus. Observation on May 14, 2012, at 11:20 a.m., in the dietary department, revealed the following items were being served for lunch: linkett casserole, mashed potatoes, carrots and peas (substituted for green beans), carrot salad, and pureed tomatoes, and pureed fiber protein. Review of the planned menu for May 14, 2012, signed by the RD revealed: linkett casserole, green beans, bread and butter, cole slaw, frosted pineapple, and cookies. Observation on May 15, 2012, at 11:30 a.m., in the dietary department revealed the following items were served for lunch: chicken tetrazzini (substituted for lentil loaf), collard greens, bread and butter (substituted for mashed potatoes and gravy), and pureed diced tomatoes. Review of the planned menu for May 15, 2012, signed by the RD revealed: lentil loaf, mash potatoes, gravy, collard greens, bread and butter, diced tomatoes, and fruit cocktail cake. Interview with the Dietary Manager on May 15, 2012, at 1:20 p.m., in the dietary department, confirmed the planned menus were not followed and the pureed diet always consisted of the items which had been served on the regular menu the previous day, and differed from the day's regular menu.
F 0367	**Make sure that special or therapeutic diets are ordered by the attending doctor.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, and interview, the facility failed to provide a therapeutic diet for two residents (#23, and #24) of twenty-seven residents reviewed. The findings included: Resident #23 was admitted to the facility with [DIAGNOSES REDACTED] Medical record review of the Mimimum Data Set (MDS) dated [DATE], revealed the resident was severely impaired for daily decision making, inattention continuously present, totally dependent on staff for eating, no swallowing disorder, obvious or likely cavity or broken natural teeth, and on a mechanically altered diet. Medical record review of an Interdisciplinary Care Plan last reviewed on June 16, 2011, revealed, "...assist with feeding as needed...honey thickened liquid 2/7/12..." Medical record review of a Resident Plan of Care Instructions, no date, revealed, "...can be fed using a syringe..." Medical record review of a Physician Orders for Scope of Treatment (POST) dated September 11, 2009, revealed "...[DEVICE] for a defined trial period..." Medical record review of a Physician Recapitulation Orders dated May 2012, revealed, "...Diet - N/A (non applicable) honey thickened liquids..." Medical record review of Mobile Dental Services notes dated March 8, 2011, March 29, 2011, May 18, 2011, September 15, 2011, and January 5, 2012, revealed the resident had been treated. Medical record review of a Nurse's Note dated September 15, 2011, at 1:00 p.m., revealed a care plan meeting by way of telephone with the resident's daughter and no indication the resident was to be fed by a syringe. Medical record review of a Dietary Manager note dated September 15, 2011, at 2:45 p.m., revealed, "...complete feed and at times requires a syringe to feed..." Medical record review of a Dietician note dated September 22, 2011, at 9:33 a.m., revealed, "...fed with syringe as needed..." Medical record review of a Dietician note dated December 28, 2011, at 9:40 a.m., revealed, "...continue POC (plan of care)..." Medical record review of a Dietician note dated March 26, 2012, at 4:13 p.m., revealed, "...honey thick liquids...vegan/pureed...fed with syringe but sometimes won't open mouth..." Observation on May 15, 2012, at 8:05 a.m., in the activity room, revealed Resident #23 sitting in a wheel chair, Certified Nurse Aide (CNA) #16 feeding the resident with a sixty cc (cubic centimeters) syringe. Interview with CNA #16 on May 15, 2012, at 8:10 a.m., revealed the syringe contained pureed oatmeal, peanut butter, and milk. Observation with the Director of Nursing (DON) on May 15, 2012, at 8:18 a.m., in the activity room, revealed CNA student #1 feeding resident #23 with a syringe containing milk that had not been thickened and the DON instructed the student to thicken the milk. Interview with the CNA Instructor on May 15, 2012, at 9:50 a.m., in the front office, confirmed CNA student #1 had not been trained to feed with a syringe.

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F 0367	(continued... from page 21) Resident #24 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED] Medical record review of a MDS dated [DATE], revealed the resident was severely impaired for daily decision making, inattention fluctuates, totally dependent on staff for eating, no swallowing disorder, and on a mechanically altered diet. Medical record review of the Interdisciplinary Care Plan dated March 22, 2012, revealed, "...mechanically altered diet...tolerate consistency of food without evidence of choking...pureed diet texture...offer small bites...remind to swallow...monitor for S/SX (signs and symptoms) aspiration...use a sippy cup for all liquids..." Medical record review of a Physician Recapitulation Orders dated May 2012, revealed, "...Diet Pureed...honey thickened liquids..." Medical record review of a Physician Orders for Scope of Treatment (POST) dated May 1, 2009, revealed, "...no [DEVICE]..." Medical record review of a Dietary note dated March 22, 2012, at 11:43 a.m., revealed, "...some days...confused and won't eat at all or very little..." Medical record review of a Dietitian note dated March 26, 2012, at 8:54 a.m., revealed, "...takes a while to swallow...receiving honey thick liquids..." Observation on May 15, 2012, at 11:30 a.m., in the resident's room, revealed CNA #16 feeding the resident with a 60 cc syringe and a straw for water. Interview with CNA #16 on May 15, 2012, at 11:45 a.m., in the resident's room, revealed the CNA gave the resident water not thickened, and places water in the resident's pureed food so it would go through the syringe. Interview with the DON on May 15, 2012, at 10:30 a.m., in the DON office, confirmed the facility failed to obtain a physician's order [REDACTED]. Continued interview at this time confirmed the Medical Director had not addressed [DEVICE]s with resident #23 and #24's families; and the therapeutic diet was altered by thinning resident #23's diet with thin milk and resident #24's diet with thin water.
F 0371	**Store, cook, and serve food in a safe and clean way.** Based on observation and interview the facility failed to provide sanitary conditions in the food preparation and food storage areas of the dietary department. The findings included: Observation of the dietary department on May 14, 2012, from 9:50 a.m. until 10:15 a.m., revealed in a cabinet over the prep table were two open boxes of vanilla wafers and graham crackers, unsealed and undated, the shelf was dirty with debris, and tiles were missing on the backsplash of the prep table. Further observation revealed a juicer with dried food debris on the shaft, a mixer with dried food debris, the microwave plate had dried food debris and the microwave table was dirty, the two ovens had food buildup inside, and the backsplash behind the burners had build up of black debris. Observation in the food preparation area revealed a window unit air conditioner with a dusty grill blowing in the food preparation area. Observation of the reach in cooler revealed six of six doors had mold on the door seals, the bottom center compartment had a trim piece missing, and one staff had personal food items stored in the cooler, undated. Observation of the dry storage area revealed seventeen stainless steel containers with a black sticky build up on the exterior of the canisters. Interview with the Dietary Manager on May 14, 2012, from 10:05 a.m. until 10:10 a.m., in the dietary department, confirmed open food items were to be sealed and dated, the dietary equipment and air conditioner was in need of cleaning, the reach in refrigerator seals needed replacing, and staff food was not to be stored in the resident refrigerator.
F 0406	**Give or get specialized rehabilitative services per the patient's assessment or plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on faciltiy investigation review, medical record review, and interview the facility failed to obtain and/or provide specialized mental health rehabilitation services for one resident (#5) of twenty-seven residents reviewed. The facility's failure placed resident #4 in Immediate Jeopardy (a situation in which the provider's non-compliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident). The NHA and DON (Director of Nursing) were informed of the Immediate Jeopardy on May 15, 2012 at 2:10 p.m., in the Administrator's office. The Immediate Jeopardy was effective December 6, 2010, and is ongoing. An extended survey was conducted on May 15, 2012. The findings included: Resident #5 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED] Medical record review of the admission MDS assessment, dated September 3, 2010, revealed resident #5 was ambulatory, cognitively impaired and the resident's behaviors and "...mental functioning varied over the course of the day ..." Medical record review of resident #5's Initial Psychosocial History (from the transferring psychiatric facility) dated May 20, 2010, revealed resident #5 had: worsening [MEDICAL CONDITION]; paranoia; flashbacks of stabbing someone; agitation; and rapid mood swings. Medical record review of the admission History and Physical (from the transferring psychiatric facility), revealed the facilities Medical Director and Administrator were aware of resident #5's "...significant dementia ...and behavioral disturbance..." when resident #5 was transferred from a psychiatric hospital to the facility on [DATE]. Medical record review revealed there was no psychiatric consultation or behavior management treatment plan initiated for resident #5 from admission on August 23, 2010, to discharge on February 5, 2011. Review of a facility investigation dated October 29, 2010 revealed resident #5 had a "...history of aggression...resident argument at picnic ...escalated into a fist fight..." The only intervention implemented by the facility was to separate the two residents.

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F 0406	(continued... from page 22) Medical record review of a nurse's note dated October 30, 2010, revealed "...antagonistic toward another resident...acts as if could become combative with little to no instigation...staff to monitor resident's activity to provide intervention as needed." No new interventions were documented. Medical record review nurse's note dated December 25, 2010, revealed resident #5 was "... very agitated...angry..." and threatened to "...hurt someone, if that's what it takes to get out of here..." There was no investigation or intervention implemented related to the threat, by the facility. Medical record review of a nurse's note dated January 21, 2011, revealed "...resident expressed feelings of anger and aggression. Stated "...if I don't get some help I'm going to hurt someone..." The resident was medicated with [MEDICATION NAME] (anti-anxiety medication) 0.5mg (milligrams), by mouth. No investigation or intervention was documented related to the threat. Medical record review of the Psychoactive Drug-Behavior Monitoring Record revealed documentation the resident had exhibited anger and confusion on four seperate occasions from August 2010 through February 2011 with no additional interventions or referrals by the facility. Medical record review of the Medication Administration Record [MEDICATION ORDERS REDACTED]"...increased agitation" on January 12, 21 (administered twice), 22, 25 and 27 , and February 2, 3 (administered twice) and 4, 2011. Review of a facility investigation dated February 5, 2011, revealed at 9:45 a.m., "...(#4) was sleeping in room when another resident (#5) went into room and started hitting resident with a cane." Resident #4 was sent to the emergency room , treated for [DIAGNOSES REDACTED]. Resident #5 was not readmitted to the facility. Interview with the NHA (Nursing Home Administrator) , on May 7, 2012, at 11:00 a.m., outside the Administrator's office, confirmed documents forwarded at the time of the residents transfer into the facility, indicated a history of aggression and violent behaviors. Continued interview with the NHA confirmed resident #5 was not provided psychiatric services after multiple threats of violence, and expressing anger and anxiety on multiple occasions. Interview with the DON, outside the Administrator's office, on May 8, 2012 at 2:00 p.m., confirmed no psychiatric services consult or behavior management program was implemented for resident #5, and no additional interventions were documented. Interview with the Medical Director(MD), by phone on May 14, 2012, at 2:17 p.m., revealed the MD stated "...makes the decisions regarding psychiatric consults." The MD denied remembering either incident of resident to resident abuse. When questioned regarding specific threats made by resident #5 such as "...if I don't get some help I'm going to hurt someone..." the MD stated "...such statements are made...all the time..." The Medical Director confimed there was no specific behavior management program employed by the facility. C/O #**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**
F 0428	**At least once a month, have a licensed pharmacist review each resident's medication(s) and report any irregularities to the attending doctor.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, the facility failed to notify the physician timely of pharmacy consultant reports for two residents (#1, and #12) of twenty-seven residents reviewed. The findings included: Resident #1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED] Medical record review of a Pharmacy Consultation Report dated September 1, 2011, revealed, "...please recheck BMP (Basic Metabolic Profile lab work) to monitor K+ (potassium) frequent changes in Lasix (diuretic)..." Continued review of the Pharmacy Consultation Report revealed the Physician was not notified until February 29, 2012 (181 day delay). Medical record review of a Pharmacy Consultation Report dated March 6, 2012, revealed, "...please consider change 4pm-5pm doses of Baclofen (muscle relaxant) 20 mg, (milligram) ibuprofen (antiinflammatory) 600 mg, and oxybutynin (anticholinergic) to prn (as needed) DC (discontinue) the 10 pm dose of Miralax (constipation) change carbamazepine (anticonvulsant) to hs (hour of sleep)..." Continued review revealed the Physician had not been notified of the report on May 15, 2012. (a sixty-four day delay). Resident #12 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED] Medical record review of a Pharmacy Consultation Report dated April 2, 2012, revealed "...omeprazole (for reflux) 40 mg qd (every day)...consider decrease to 20 mg..." Continued review of the Pharmacy Consultation Report revealed the Physician did not respond until April 25, 2012. Medical record review of a Pharmacy Consultation Report dated May 1, 2012, revealed "...assess possible need for increase in pain meds(medications)...receives frequent..." Continued review of the Pharmacy Consultation Report revealed the doctor had not been notified of the report as of May 15, 2012 (a fourteen day delay). Interview with the Director of Nursing (DON) on May 15, 2012, at 9:10 a.m., in the front lobby, confirmed the facility failed to notify the physician of the pharmacy recommendations in a timely manner. C/O #**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** #**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**
F 0431	**Maintain drug records and properly mark/label drugs and other similar products according to accepted professional standards.**

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F 0431	(continued... from page 23) Based on observation, review of facility policy, and interview, the facility failed to ensure medications were labeled for two of two medication carts observed and failed to separate internal and external medications for one of two medication carts. The findings included: Observation of medication cart #1 at the nurse's station on May 15, 2012, at 1:00 p.m., revealed one vial of Levemir (long-acting insulin) 100 u/ml (units per milliliter), 10 ml vial, with no date opened documented on the vial. Further observation revealed a sticker placed on the vial with a "discard date of 6/28," 45 days from the day of the observation on May 15, 2012. Review of the manufacturer's recommendations revealed, "Keep at room temperature...for up to 42 days." Continued observation of medication cart #1 revealed a vial of Fluphenazine decanoate (long-acting antipsychotic) 25 mg/ml (milligrams per milliliter), 5 ml vial with no documentation of date opened or a discard date. Interview with Registered Nurse (RN) #1 and Licensed Practical Nurse (LPN) #4 on May 15, 2012 at 2:15 p.m., at the nurse's station, confirmed the vials of medication did not accurately reflect expiration dates. Continued interview with LPN #4 on May 15, 2012, at 2:45 p.m., in the hallway, revealed the Fluphenazine decanoate expired 28 days after opening. Observation of medication cart #2 on May 15, 2012, at 2:30 p.m., revealed, in the bottom drawer, five ziplock bags labeled with the names of herbal medications and no resident name or date. Interview with LPN #2, on May 15, 2012, at 2:30 p.m., at the nursing station, confirmed the 5 five ziplock bags of capsules containing Dandelion Leaf, Hawthorne Berry, Tumeric, Bilberry Leaf, and Vitamin C, had no original containers, no label, no manufacturer instructions, no record of pharmacy review, no dosage instructions and no expiration date. Observation of medication cart #2 on May 15, 2012, at 2:30pm, at the nursing station, revealed oral medications including Tylenol (pain reliever), Benadryl (antihistamine), and Vitamin C (vitamin), were stored with external medications, including Nystatin Cream (anti-fungal) 100,000 u/GM (gram) 30 GM tube, three tubes of Triple Antibiotic Ointment Cream 1 oz (ounce), and Pain Relieving Cream 4 oz tube. Betadine (anti-bacterial cleanser), sunscreen, Kionex (medication to lower potassium), Johnson's Baby Shampoo, insulin syringes, Vitamin C and multiple bottles of oral medications were stored together in the same drawer. Review of facility policy Family Supplied Medication revealed, "...The facility will also use medications purchased for a resident from a dispensing pharmacy...if the following conditions are met...The medication name, dosage form, and strength have been verified by the nurse accepting the medication...the medication container is clearly labeled in accordance with pharmacy procedures for medication labeling and packaged in manner consistent with pharmacy guidelines for medications...including the resident's name, specific directions for use, including route of administration, medication name, strength of medication, physician's name, date medication is dispensed, quantity, expiration date...Herbal supplements are used by our resident's in accordance with the above procedures. They must be kept in original containers with expiration date clearly visible..." Interview with LPN #2, on May 15, 2012, at 2:30 p.m., at the nursing station, confirmed internal and external medications were to be stored separately and were not properly labeled.
F 0441	**Have a program that investigates, controls and keeps infection from spreading.** Based on observation, interview, and review of manufacturer's instructions, the facility failed to ensure clean linen was stored in a sanitary manner in the overflow linen closet; failed to perform hand hygiene during medication pass for one Licensed Practical Nurse (LPN # 4) of five LPNs observed; and failed to follow manufacturer's recommendations to provide sanitary medication administration for one of two medication carts. The findings included: Observation of an overflow linen storage room on May 14, 2012, at 11:20 a.m., revealed clean linen was stored below cobwebs, debris was on the ceiling and walls, and clean sheets stored in the room had debris on them. Interview with the Laundry Manager on May 14, 2012, at 11:20 a.m., at the doorway of the overflow linen storage room, confirmed debris had fallen onto the clean linen and the linen was not stored in a sanitary manner. Observation of a medication pass on May 15, 2012, at 7:50 a.m., in a resident's room revealed LPN#4 administered medication to a resident, washed the hands, touched the resident's food and tray items, and without washing the hands, exited the room, dispensed medications for resident #14, and entered the resident's room and administered medications. Interview with LPN #4 on May 15, 2012, at 7:50 a.m., in the hallway, confirmed the LPN failed to wash the hands after assisting one resident with a meal and prior to preparing the next resident's medication. Observation of medication cart #2, on May 15, 2012, at 2:30 p.m., at the nursing station, revealed an opened 30 cc (cubic centimeter) syringe with pink liquid in and on the syringe, stored in the bottom right drawer with liquid medications. Observation of the label revealed "30 cc leur-lock Single-Use Syringe ...DO NOT REUSE ..." Interview with LPN #2 on May 15, 2012, at 2:30 p.m., at the nursing station, confirmed the syringe was soiled with a pink liquid and was re-used multiple times to dispense one resident's liquid medication.
F 0490	**Be administered in an acceptable way that maintains the well-being of each resident .** Based on medical record review, review of facility policies, observation, and interview, the facility failed to be administered in a manner to ensure four (#1, #2, #4, #11) residents were free from abuse, failed to investigate allegations of abuse, failed to provide staff in-services on abuse, failed to provide supervision to ensure twelve (#14, #3, #2, #4, #5, #19, #26, #1, #12) residents were provided a safe environment, and failed to ensure one resident was provided mental health services (#5) of twenty-seven residents reviewed. The facility's failure placed the residents in Immediate Jeopardy. (Immediate Jeopardy is a situation in which a provider's noncompliance with one or more requirements of participation has caused or is likely to cause serious harm, injury, impairment or death). The Administrator and Director of Nursing were informed in the Administrator's office of the Immediate Jeopardy on May 15, 2012, at 2:10 p.m.

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F 0490	(continued... from page 24) The Immediate Jeopardy was effective October 20, 2011, and is ongoing. An extended survey was conducted on May 15, 2012. The findings included: Interview with the Administrator on May 8, 2012, at 1:50 p.m., in the Administrator's office, confirmed no allegations of abuse had been investigated since December 23, 2010, and the facility's policy related to "Abuse Investigation" had not been implemented. Interview with the Administrator on May 15, 2012, at 3:15 a.m., in the Administrator's office, confirmed the facility failed to provide in-services on Abuse to the direct care staff in 2011 and none to date in 2012. Refer to F223 - the resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. Refer to F226 - the facility must develop and operationalize policies and procedures for screening and training employees, protection of residents and the prevention, identification, investigation, and reporting abuse, neglect, mistreatment, and misappropriation of property. The purpose is to assure the facility is doing all that is within its control to prevent occurrences. Refer to F323 - 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. Refer to F406 - the facility must assure that residents receive necessary rehabilitative services to prevent avoidable physical and mental deterioration and to assist them in maintaining their highest level of functional and psychosocial well-being. C/O # , # , # , #
F 0497	**1) Review the work of each nurse aide every year; and 2) give regular in-service training based upon these reviews.** Based on review of facility documentation review and interview, the facility failed to provide twelve hours of in-service education per year for six of twenty-two Certified Nurse Aides (CNA) employed. The findings included: Review of facility documentation titled Currently Employed Staff revealed twenty-two CNA's employed by the facility. Review of facility documentation of total in-service hours for January 2011 through December 2011 revealed six of twenty-two listed did not have the twelve hours of the required in-service education. Interview with the Director of Nursing on May 15, 2012, at 3:15 p.m., in the front office, confirmed the facility failed to provide twelve hours of in-service education for the Certified Nurse Aides employed.
F 0498	**Make sure that nurse aides show they have the skills and techniques to be able to care for residents' needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to ensure Certified Nurse Assistant Students were trained to provide services to one resident (#23) of twenty-seven residents reviewed. The findings included: Resident #23 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED] Medical record review of the Minimum Data Set, dated dated dated [DATE], revealed the resident was severely impaired for daily decision making, inattention continuously present, totally dependent on staff for eating, no swallowing disorder, obvious or likely cavity or broken natural teeth, and a mechanically altered diet. Medical record review of an Interdisciplinary Care Plan dated last reviewed June 16, 2011, revealed, "...assist with feeding as needed...honey thickened liquid 2/7/12..." Medical record review of a Resident Plan of Care Instructions no date revealed, "...can be fed using a syringe..." Observation with the Director of Nursing (DON) on May 15, 2012, at 8:18 a.m., in the activity room, revealed CNA student #1 feeding Resident #23 with a syringe containing milk that had not been thickened and the DON instructed the student to thicken the milk. Interview with the CNA Instructor on May 15, 2012, at 9:50 a.m., in the front office, confirmed CNA student #1 had not been trained to feed with a syringe.
F 0500	**Employ or obtain outside professional resources providing services in the nursing home that meet professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility contracts, the facility failed to provide a [MEDICAL TREATMENT] contract. The findings included: Review of the facility contracts on May 15, 2012, revealed no [MEDICAL TREATMENT] contract.

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F 0500	(continued... from page 25) Review of a [MEDICAL TREATMENT] contract received by fax from the facility on May 16, 2012, revealed the agreement was dated May 15, 2012.
F 0501	**Choose a doctor to serve as the medical director to create resident care policies and coordinate medical care in the facility.** Based on medical record review, facility policy review, observation, and interview, the Medical Director failed to provide oversight and participate in the development of policies and procedures to ensure resident safety, ensure residents were free from abuse, and ensure that residents with mental illness/behaviors were provided psychiatric services. The Medical Director's failure to collaborate with the facility to develop and implement policies and procedures related to resident safety placed resident's #2, #4, #5, #14, #18, #19, and # 26 in Immediate Jeopardy; placed resident #1, #2, and #4 in Immediate Jeopardy related to abuse, and placed resident #5 in Immediate Jeopardy for failure to provide mental health services. (Immediate Jeopardy is a situation in which a provider's noncompliance with one or more requirements of participation has caused or is likely to cause serious harm, injury, impairment or death). The Nursing Home Administrator and the Director of Nursing (DON) were notified of the Immediate Jeopardy on May 15, 2012, at 2:10 a.m., in the Administrator office. The Immediate Jeopardy was effective October 20, 2011, and is ongoing. The findings included: Telephone interview with the Medical Director (MD) on May 14, 2012, 2:17 p.m., revealed the MD attended the Quality Assurance Committee Meetings; was involved in implementation of facility policies and procedures related to safety or abuse; and there was no system in place to identify abuse, safety, and no behavior management program. Continued interview revealed the MD had not been aware of the facility's intervention of seclusion for resident #1's behaviors. The MD stated "...it would be an appropriate intervention for a resident cursing staff..." Refer to F223 - the resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. Refer to F226 - the facility must develop and operationalize policies and procedures for screening and training employees, protection of residents and the prevention, identification, investigation, and reporting abuse, neglect, mistreatment, and misappropriation of property. The purpose is to assure the facility is doing all that is within its control to prevent occurrences. Refer to F323 - 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. Refer to F406 - the facility must assure that residents receive necessary rehabilitative services to prevent avoidable physical and mental deterioration and to assist them in maintaining their highest level of functional and psychosocial well-being. C/O # , # , # , #
F 0504	**Make sure medically necessary lab services/tests are ordered by the attending physician.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, the facility failed to obtain a physician order[DIAGNOSES REDACTED] The findings included: Resident #1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED] Medical record review of the Minimum Data Set (MDS) dated [DATE], revealed the resident scored fifteen of fifteen on the Brief Interview for Mental Status (BIMS) indicating intact cognitive skills and no memory impairment. Interview with the Nursing Home Administrator (NHA) on May 7, 2012, at 1:50 p.m., in the NHA office, revealed a urine drug screen was completed on the resident on May 3, 2012, without the resident's knowledge. Medical record review of the Physician Orders for May 2012, revealed no Physician order[DIAGNOSES REDACTED] Interview with the Director of Nursing (DON) on May 9, 2012, at 9:10 a.m., in the front lobby, confirmed the facility completed a urine drug screen on the resident without a Physician Order. C/O #**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** #**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**
F 0507	**Keep complete, dated lab records in the resident's file.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, the facility failed to file laboratory results on the clinical record for one resident (#1) of twenty-seven residents reviewed. The findings included:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	44E200	A. BUILDING _____ B. WING _____	05/15/2012

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAURELBROOK SANITARIUM	114 CAMPUS DRIVE DAYTON, TN 37321

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0507	(continued... from page 26) Medical record review of the Minimum Data Set (MDS) dated [DATE], revealed the resident scored fifteen of fifteen on the Brief Interview for Mental Status (BIMS) indicating intact cognitive skills and no memory impairment. Interview with the Nursing Home Administrator (NHA) on May 7, 2012, at 1:50 p.m., in the NHA office, revealed a urine drug screen was completed on the resident on May 3, 2012, without the resident's knowledge and the resident was not aware of the results. Medical record review of the Physician Orders for May 2012, revealed no Physician order[DIAGNOSES REDACTED] Interview with the Director of Nursing (DON) on May 9, 2012, at 9:10 a.m., in the front lobby, confirmed the facility completed a urine drug screen on the resident and the results were not on the clinical record. C/O #**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** #**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**
F 0519	**Have an agreement with at least one or more hospitals certified by Medicare or Medicaid to make sure residents can be moved quickly to the hospital when they need medical care.** Based on facility documentation and interview the facility failed to have a written transfer agreement with a hospital. The findings included: Review of facility documentation requested for extended survey on May 15, 2012, revealed no written transfer agreement between the facility and a hospital for transfer of residents if medically appropriate. Interview with the Administrator and the Director of Nursing in the physical therapy room on May 15, 2012, at 6:00 p.m., confirmed no agreement could be provided.
F 0520	**Set up an ongoing quality assessment and assurance group to review quality deficiencies quarterly, and develop corrective plans of action.** Based on review of the Quality Assurance (QA) Committee attendance records, facility investigation reviews, facility policy reviews, observations, and interviews the facility failed to ensure the Quality Assurance Committee identified resident's safety, falls, behavior management care planning, mental health rehabilitative services, abuse, and injuries of unknown origin as potential areas for quality improvement. The facility's failure to review data and formulate/implement improvement plans placed all the residents in Immediate Jeopardy (a situation in which the provider's non-compliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident). The NHA (Nursing Home Administrator) and DON (Director of Nursing) were informed of the Immediate Jeopardy on May 15, 2012, at 2:10 p.m., in the Administrator's office. The Immediate Jeopardy was effective October 20, 2011, and is ongoing. An extended survey was conducted on May 15, 2012. The findings included: Review of facility investigations related to behaviors, resident to resident abuse, falls, and injuries of unknown origin revealed the facility had not utilized the data from the investigations, to track, trend, and address resident safety concerns (both individually and globally), or to use the data gained in formulating strategies to ensure resident safety for all residents residing in the facility. Interview with the Administrator May 7, 2012, at 1:10 p.m., in the Administrator's office, confirmed resident to resident abuse had occurred on more than one occasion. Continued interview revealed the facility did/does not have a behavior management plan or policy for a population of residents with high incidences of behavioral issues. Interview with the DON, outside the Administrator's office, on May 8, 2012, at 2:00 p.m., confirmed that no behavior management plan had been developed or utilized by the facility and the interventions in place were not adequate to ensure resident safety. The DON further confirmed that resident falls had not been recently addressed as a Quality Assurance issue. Interview with the Medical Director (MD), by phone on May 14, 2012, at 2:17 p.m., revealed the MD is a QA Committee member and attends quarterly meetings. The MD makes the decisions regarding psychiatric and other health related consultations for the residents. The MD denied remembering the incidents of resident to resident abuse or specific concerns related to resident safety. The Medical Director confirmed there was/is no specific behavior management policy employed by the facility. Refer to F223 - the resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. Refer to F226 - the facility must develop and operationalize policies and procedures for screening and training employees, protection of residents and the prevention, identification, investigation, and reporting abuse, neglect, mistreatment, and misappropriation of property. The purpose is to assure the facility is doing all that is within its control to prevent occurrences. Refer to F323 - 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. Refer to F406 - the facility must assure that residents receive necessary rehabilitative services to prevent avoidable physical and mental deterioration and to assist them in maintaining their highest level of functional and psychosocial well-being. C/O # , # , # , #

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0520	(continued... from page 27)