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F 000	INITIAL COMMENTS Annual Licensure and Certification Survey Licensure Survey for Subpart U: Alzheimer's Unit 300.700	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance	F 225		6/20/14

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

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F 225	Continued From page 1	F 225		

with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to obtain witness statements for an allegation of abuse and failed to report an allegation of abuse immediately to the Administrator for one of four residents (R3) reviewed for abuse, in a sample of 15.

Findings include:

An abuse investigation dated 5-09-14 documents that R3 struck R16, "in the face with an open hand." The investigation does not include an interview with R16, the subject of the abuse, as part of the investigation.

An abuse investigation dated 5-23-14 documents that, "R3 stated to R2, 'Wake up, wake up," and then R3 open handedly slapped R2 across R2's right cheek." The investigation does not include an interview with R2, subject of the abuse, as part of the investigation.

An Abuse Investigation, dated 4/09/14, documents an allegation of physical abuse by R3 against R19 occurring at approximately 9:00 p.m. The Abuse Investigation documents E1 (Administrator) was notified on 4/10/14 at 6:30 a.m.

On 5/29/14 at 10:02 a.m., E1 indicated staff

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F 225	Continued From page 2 usually do report all abuse allegations to (E1) immediately, but was uncertain as to why there was a delay in reporting the 4/09/14 incident. A facility policy on Abuse and Neglect dated 3-31-14 states, "An abuse/neglect report should be initiated which includes written statements from alleged perpetrator, along with any witnesses...The IN-HOUSE supervisor will then IMMEDIATELY go to the resident and initiate an investigation...Follow the abuse/neglect checklist." An abuse/neglect checklist (undated) states, "Obtain witness statements."	F 225		
F 226 SS=C	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure operational policies and procedures regarding the abuse, identifies any allegation of abuse will be reported immediately to the Administrator. This failure has the potential to affect all 61 residents that live in the facility. Findings include: The Facility Policy titled "Abuse and Neglect", under "Section (5.) Protection of Residents", documents "Any employee/volunteer who becomes aware of perceived, actual or possible	F 226		6/20/14

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F 226	Continued From page 3 abuse or neglect of a resident shall immediately respond by directly confronting the person who is allegedly abusing or neglecting the resident.....Notify the IN-HOUSE SUPERVISOR immediately and as safely possible (Notify Administrator/DON/Nursing office staff if in the building.)" An Abuse Investigation, dated 4/09/14, documents a allegation of physical abuse by R3 towards R19 occurring at approximately 9:00 p.m. The Abuse Investigation documents E1 (Administrator) was notified the following day, on 4/10/14 at 6:30 a.m. On 5/29/14 at 10:02 a.m., E1 indicated staff usually do report all abuse allegations to (E1) immediately, but was uncertain as to why there was a delay in reporting the 4/09/14 incident. E1 concluded that the verbiage in the Abuse and Neglect Policy was not exactly clear that all allegations of abuse need to be immediately reported to the Administrator. The Resident Census and Condition Report, dated 5/27/14 and signed by E1 (Administrator), documents 61 residents live in the facility.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by:	F 241		6/20/14

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F 241	Continued From page 4 Based on observation and record review the facility failed to keep a resident's door closed during resident cares for one of nine residents (R3) reviewed for privacy/dignity in a sample of 15. Findings include: On 5-27-14 at 12:40p.m. E5 and E6 (Certified Nurse Aides) transferred R3 to the bathroom using a mechanical lift. E5 removed R3's pants and incontinence brief, and then E6 lowered R3 onto the toilet. E5 left R3's room two different times while R3 was exposed and on the toilet. Each time E5 left R3's room, the bathroom and bedroom doors were left open. A facility policy on Resident Privacy dated 6-07-11 states, "Privacy involves the protection of the patient's body..." The policy also states, "The privacy curtain and the room door should be shut while care is given."	F 241		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by:	F 314		6/20/14

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F 314	Continued From page 5	F 314		

Based on observation, interview, and record review the facility failed to identify a wound as a pressure ulcer and failed to provide a pressure reduction device as ordered by the physician, for one of two residents (R3) reviewed for Pressure Ulcers in a sample of 15.

Findings include:

A nurse's note dated 5-19-14 entered by E13 (Wound Nurse/Alzheimer's Unit Director) documents that R3 had developed two wounds to the right and left inner buttocks. The left inner buttocks measured 6cm (centimeters) x 4cm x less than 0.1cm and the right inner buttocks measured 5cm x 2.5cm x less than 0.1cm. The nurse's note does not indicate the cause of R3's wounds.

R3's pressure ulcer risk assessment (Braden Score) date 5-27-14 documents that R3 is a moderate risk for developing a pressure ulcer which was unchanged from a previous assessment.

On 5-27-14 at 12:55p.m. R3 was receiving perineal care by E5 and E6 (Certified Nurse Aides). R3 had an area of solid deep red discoloration which was not diffuse but localized to the coccyx and gluteal fold with two open wounds with partial thickness loss of skin layers to the right and left buttock.

On 5-29-14 at 9:35a.m. E13 stated that R3's wounds were caused from R3's incontinence and not considered pressure ulcers.

A policy on Pressure Ulcer Prevention and Assessment (undated) documents that any

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F 314	Continued From page 6 resident with a pressure ulcer, " ...risk of moderate or high will have a pressure ulcer prevention program initiated." The policy documents, "Limit incontinence and address incontinence..." for pressure ulcer prevention. The policy documents that a stage II pressure ulcer may be categorized by, "A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater." The policy documents, "Preventive measures may include...pressure relieving devices..." R3's Physician's Order Sheet dated 5-16-14 states, "Pressure relieving device to wheelchair at all times," following the physician notification of R3's wounds. On 5-27-14 from 11:25a.m. to 12:40p.m. R3 was seated in a wheelchair with no pressure relieving cushion in place. On 5-27-14 at 2:25p.m. E13(Wound Nurse/ Alzheimer's Unit Director) verified that R3 was suppose to have a pressure relieving device in the wheelchair. E13 also verified that R3's wheelchair did not have any pressure relieving device in place.	F 314		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		6/20/14

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review the facility failed to provide adequate supervision to prevent a resident (R3), with a documented history of physically threatening behaviors toward female residents, from physically injuring three female residents. These failures involved one of seven residents (R3) reviewed for accidents/incidents in a sample of 15 and resulted in harm. R3 grabbed and twisted a female resident's arm (R19) causing a skin tear, and open handedly slapped two other female residents (R3, R16) in the face on two separate occasions.

Findings include:

R3's electronic medical record dated as current documents that R3 has diagnoses which include Dementia with Behavior Disturbances and General Psychosis.

R3's Care Plan dated 4-1-14 documents that R3 has physical behaviors towards others and instructs staff to, "Monitor me for safety and the safety of others."

R3's electronic Care Plan includes an undated intervention stating, "Monitor me closely when I approach female residents as to what my intentions are as I have a history of being physically aggressive with them."

A facility Report of Alleged Abuse/Neglect dated 4-09-14 documents that R3 was being pushed in the wheelchair by R19. R3 grabbed R19's arm and twisted it causing a skin tear. The report

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concluded, "Due to both residents having a diagnosis of Dementia, our objective will be to keep these incidents to a minimum."

A facility Report of Alleged Abuse/Neglect dated 5-09-14 documents that R16 was sitting in the TV room, "...staff was entering the room ...they saw R3 place R3's hand on R16's right arm and struck R16 in the face with an open right hand." The report concluded, "Due to both residents having a diagnosis of Dementia, our objective will be to keep these incidents at a minimum."

A facility Report of Alleged Abuse/Neglect dated 5-23-14 documents that while R3 and R2 were seated in the TV room, "R3 stated to R2, 'Wake up, wake up,' and then R3 open handedly slapped R2 across R2's right cheek." The report concluded, "Due to both residents having a diagnosis of Alzheimer's our objective will be to keep these incidents at a minimum."

On 5-27-14 at 11:25a.m. R3 was alone in R3's room sitting in a wheelchair, while watching TV. No staff was present and no staff were visible in the hallway.

On 5-29-14 at 9:15a.m. E13 (Alzheimer's Unit Director) stated, "We try to keep R3 away from other residents when R3 is having behaviors." E13 verified that R3 might sometimes be left alone with other residents. E13 verified that R3 has had physically aggressive behaviors with female residents. E13 stated, "The CNAs (Certified Nurse Aides) are suppose to notify the nurses," when R3 starts having behaviors. E13 stated that the nurses are then suppose to document R3's behaviors and what interventions/approaches were used to alleviate

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the behaviors in the nurse's notes.

On 5-29-14 at 9:15a.m. E7 (Licensed Practical Nurse) stated, "The CNAs are suppose to tell the nurse when R3 has behaviors." E7 stated, "Often the nurse doesn't usually know about behaviors until the end of the shift..." E7 indicated that there are two CNA's (Certified Nurse Aides) scheduled each shift to care for residents in the Alzheimer's Unit. E7 stated that the nurse generally stays outside the Alzheimer's unit, on the other side of the double doors, at the nurse's station, and out of eye contact with the Alzheimer's Unit's residents. E7 verified, "there may not be eye contact with all residents at all times," because the two CNA's may go in and out of other resident's rooms, and one CNA may leave the Alzheimer's unit to help residents residing in another area of the facility.

R3's behavior tracking dated 12-01-13 to 5-28-14 documents that R3 had physically aggressive or threatening behaviors over 90 times during that time frame including 4-09-14, twice on 5-09-14, and twice on 5-23-14.

Nurse's notes dated 4-09-14 do not include documentation that R3 had threatening or physical behaviors towards other residents on that date, or if any interventions/approaches were used to prevent or alleviate R3's behaviors. The nurse's notes do not include documentation that R3 had been "monitored for safety or the safety of others" prior to R3's twisting R19's arm.

Nurse's notes dated 5-09-14 do not include documentation that R3 had threatening or physical behaviors towards other residents on that date until after R3 slapped R16. The nurse's

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notes do not include documentation that R3 had been "monitored for safety or the safety of others," prior to R3 slapping R16.

Nurse's notes dated 5-23-14 do not include documentation that R3 had threatening or physical behaviors towards other residents on that date. The nurse's notes did not include documentation that R3 had slapped R2 until 5-24-14. The 5-23-14 nurse's notes do not include documentation that R3 had been "monitored for safety or the safety of others," prior to R3 slapping R2 or after the incident.

On 5-28-14 at 1:00p.m. E2 (Director of Nurses) and E3 (Assistant Director of Nurses) stated that R3's behaviors had been escalating recently since R3 had been in the hospital. E2 and E3 were unable to state what interventions/approaches had been initiated to prevent R3's physical aggression toward other residents.

Based on observation, interview and record review, the facility failed to ensure personal safety alarms were properly placed for one of seven residents (R3) reviewed for falls in a sample of fifteen and failed to provide adequate supervision to a resident with Dementia, follow the fall reduction policy and implement fall prevention interventions to reduce the risk of falls for one of seven residents (R2) reviewed for falls in the sample of 15. This failure resulted in R2 sustaining a head laceration and an intracranial hemorrhage.

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Findings include:

1. A current computer generated diagnosis list, documents R2 has diagnosis which include Cerebral Vascular Accident (4/2014), Dementia with behaviors, and Alzheimer's Disease. A current computer generated demographic form, documents R2 was admitted on 3/25/14 and resides on the locked Dementia Unit. A Minimum Data Set dated 5/1/14, documents R2 has moderately impaired cognition and requires extensive assistance with ambulation. An Admission Fall Risk Assessment dated 3/25/14, documents R2 has a history of falls prior to admission and scored a 17 putting R2 at high risk for falls.

A Fall Reduction Monitor Devices Policy dated 10/4/12, documents residents who score 10 or above on the Fall Risk Assessment, or who have a history of falls will be reviewed for potential benefit from the use of a fall reduction monitor. Monitors used may include: mobility monitors, pad sensor monitors, or motion sensor monitors.

Nurses Notes dated 3/25/14 through 5/27/14, document R2 has had twelve falls since admission on 3/25/14 (3/27/14, 3/28/14, 4/7/14, 4/9/14, 4/9/14, 4/9/14, 4/13/14, 4/14/14, 4/30/14, 5/1/14, 5/16/14, and 5/18/14).

A Fall Report dated 3/27/14 at 7:55 a.m., documents R2 got up independently and fell in the bathroom and sustained a hematoma on the right side of R2's head. A Fall Report dated 3/27/14, documents a new intervention for R2 to utilize a personal mobility monitor at all times.

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On 5/28/14 at 2:40 p.m., E3 (Assistant Director of Nursing) verified R2 did not have a fall monitor in place on admission per fall policy.

A Fall Report dated 3/28/14 at 10:00 p.m., documents R2 fell getting out of bed. R2 sustained a 1.5 centimeter (cm) by 0.5 cm laceration to the back of R2's head and a light bruise to R2's left hip. A Fall Report dated 3/28/14, documents corrective actions taken included to place the personal alarm where R2 is unable to reach it. A Fall Report dated 3/28/14, documents R2 was admitted to the hospital on 3/29/14 with diagnosis of Cerebral Vascular Accident (Stroke).

Nurses Notes dated 4/2/14, documents R2 was in the hospital from 3/29/14 to 4/2/14.

A Fall Report dated 4/7/14 at 6:00 p.m., documents R2 fell in the Dayroom and new interventions were to recommend a Psychiatric evaluation and obtain a urinalysis.

A Fall Report dated 4/9/14 at 5:50 p.m., documents R2 fell in the dining room and new interventions implemented were to obtain a urinalysis (repeat from 4/7/14 fall intervention) due to R2's restlessness/hallucinations, R2 to see psychiatrist this week for behavior.

A Fall Report dated 4/9/14 at 7:55 p.m., documents R2 was having hallucinations and fell in front of the nurse's station, witnessed by a staff nurse. A Fall Report dated 4/9/14 at 7:55 p.m., documents urinary urgency noted and order received to obtain a urinalysis.

A Fall Report dated 4/9/14 at 9:05 p.m.,

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documents R2 fell out of wheelchair while leaning forward. A Fall Report dated 4/9/14 at 9:05 p.m., documents R2 stated R2 was trying to get something off the floor..."(R2) hallucinating, floor was clean and dry with no objects present for resident to grab at." A Fall Report dated 4/9/14 at 9:05 p.m., documents interventions were to send R2 to the hospital due to increased falls and hallucinations.

Nurses notes dated 4/13/14 documents R2 was readmitted to the facility from hospital.

A Fall Report dated 4/13/14 at 6:20 p.m., documents R2 fell in out of the wheelchair in the hallway, during change of shift. A Fall Report dated 4/13/14, documents new interventions to provide (tender, loving, care) to R2 when having hallucinations, provide diversional activities as R2 will allow, and attempt to keep R2 in sight of staff as much as possible. A Fall Report dated 4/13/14, documents "(R2) did not have medication for hallucinations or behaviors. New order for Zyprexa 2.5 milligrams daily."

A Fall Report dated 4/15/14 at 2:35 p.m., documents R2 fall in R2's room and R2 was observed on the floor with head and neck positioned against the west wall. R2's pants were down around R2's ankles and urine was noted on the floor. A Fall Report dated 4/15/14, documents "(R2) does have poor balance and uses either a walker or wheelchair, both of which were in (R2's) room though apparently no attempt was made to use them. (R2) was recently started on Zyprexa (4/14/14). (R2) was last seen approximately one hour prior when (R2) was assisted to bed per daughter. A Fall Report dated 4/15/13, documents contributing factors of R2's diagnosis

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of Dementia, R2 continues to hallucinate, and R2's need to urinate and did not call for help (R2 has moderately impaired cognitive skills). A Fall Report dated 4/15/14, documents intervention to send R2 to the emergency room for evaluation.

A Hospital History and Physical dated 4/15/14, documents R2 was admitted to the hospital Intensive Care Unit with a right sided intracranial hemorrhage.

Nurses Notes dated 4/18/14, document R2 was readmitted from the hospital.

On 5/29/14 at 1:10 p.m., E3 (Director of Nursing) stated R2 was having "hallucinations" and would not stay sitting down. E3 stated "for example, (R2) would think there were dogs playing on the floor and (R2) would get up out of the chair." E3 verified R2 had 12 falls since admission and fell three time in less than three and a half hours on 4/9/14. E3 stated "we don't have enough staff to provide 1:1 supervision." E3 verified that interventions had been repeated on several of R2's falls and interventions used were not effective in preventing R2 from falling.

On 5/27/14 at 12:15 p.m., Z1 (R2's Power of Attorney) stated R2's falls have "set (R2) back."

2. R3's Physician's Order Sheet dated 5-06-14 states, "Chair alarm at all times."

On 5-27-14 at 11:25a.m. R3 was alone in R3's room while seated in a wheelchair and without a chair alarm in place. From 12:15p.m. to 12:55p.m. R3 was again seated in a wheelchair without a chair alarm in place.

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F 323	Continued From page 15 On 5-27-14 at 12:55p.m. E6 (Certified Nurse Aide) verified that R3's wheelchair did not have a chair alarm attached, stating, "I think R3 just has an alarm on the bed." On 5-28-14 at 10:10 E13 (Director of Alzheimer's Unit) verified that R3's wheelchair should have had a chair alarm attached, stating, "It was on R3's recliner," and had not been moved to the wheelchair. Based on record review, interview, and observation the facility failed to secure potentially hazardous cleaning agents and sharp objects. This has the potential to affect one of one residents (R12) confused and independently mobile residents in the sample of 15 and seven residents (R12, R20, R21, R22, R23, R24, R25, R26) on the supplemental sample. Findings include: On 5/27/14 at 2:09 p.m. and 5/29/14 at 11:30 a.m., a unlocked cabinet contained two bottles of antibacterial all purpose cleaner and one bottle of deodorant absorbent powder. Both of the cleaning agents labels document keep out of reach of children. This cabinet was in the unlocked middle hall shower room. Facility's Material Safety Data Sheet, dated 6/23/09, documents the antibacterial all purpose cleaner is corrosive. The cleaner causes eye damage and skin irritation, and it is harmful if swallowed.	F 323		

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F 323	Continued From page 16 Facility's Material Safety Data Sheet, dated 9/17/97, documents dust from the deodorant absorbent powder may be irritating to skin and eyes. Inhalation of the powder may produce respiratory irritation. Facility's chemical storage policy, dated 12/29/11, documents that all hazardous chemical are kept in closed and locked cabinets. Facility's sharps disposal policy, dated 2/4/13, documents that all sharps will be in locked storage until use. On 5/29/14 at 12:25 p.m., E1 (Administrator) stated, "All shower rooms are locked at all times with key pads. Razors and chemicals should be stored in a locked area."	F 323		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 328		6/20/14

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F 328	Continued From page 17 review the facility failed to follow a physician's order for oxygen use and failed to have a licensed nurse discontinue the administration of oxygen for one of two residents (R3) reviewed for oxygen in a sample of 15. Findings include: On 5-27-14 at 12:30p.m. R3 was sitting in the dining room in a wheelchair with oxygen tubing attached to R3's nose. The other end of the oxygen tubing was attached to an oxygen machine which was set to deliver 3L/m (three liters per minute) to R3. At 12:40p.m. E5 and E6 (Certified Nurse Aides) assisted R3 with toileting. E5 removed R3's oxygen tubing then both E5 and E6 assisted R3 to go into the bathroom. R3's oxygen tubing was not reapplied until 1:10p.m. A Physician's Order dated 5-23-14 documents that R3 has oxygen to be administered at 2L/m (two liters per minute). On 5-29-14 at 9:35a.m. E5 (Certified Nurse Aide) verified that R3 was suppose to wear oxygen continuously. An Oxygen Administration Policy dated 4-15-13 states, "Liter flow, turning O2 (oxygen) on or off...will be adjusted by licensed nurses ONLY according to physician's orders."	F 328		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or	F 329		6/20/14

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F 329	Continued From page 18 without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to follow the Psychotropic Medication Policy regarding documentation of behaviors, non-pharmacological interventions, medication efficacy and side effect monitoring for two of three residents (R2 and R3) reviewed for antipsychotic medication in a sample of 15. Findings include: A Psychotropic Medication Program Policy (date unknown), documents facility staff will ensure that all psychotropic medications are properly ordered, monitored for effectiveness, and side effects...Resident Assessment will begin when	F 329		

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facility staff determines the resident is exhibiting unwanted behaviors that place the resident, or their peers in danger...Interdisciplinary Team will attempt to identify any potential causes for the untoward behavior...Behavior Tracking will be instituted at this time to provide documentation of the frequency and intensity of the behavior occurrence...the initial plan for treatment of behaviors will include such alternatives as diversional activities, change in environment, psycho-social programming, etc...When all alternatives have been exhausted, the use of psychotropic medications may be deemed necessary by the attending Physician...All efforts are to be documented in the resident record...Use of Psychotropic medication must have a supporting diagnosis...the observation for side effect of the psychotropic medication will begin immediately...behavior tracking is to be completed on "targeted" behaviors for all psychotropic medications that are used for mind/mood altering purposes...documenting the effectiveness of approaches...the plan will be addressed in the residents overall plan of care and program goals will address both dose reduction and targeted behaviors.

On 5/28/14 at 10:00 a.m., E3 (Assistant Director of Nursing) stated "we only document behaviors, not the interventions attempted or the outcomes." E3 stated "we didn't know what approaches to use to help prevent (R2's) behaviors." E3 stated R2 has "hallucinations." E3 stated R2 was frequently attempting to stand up and ambulate without assistance and R2 had numerous falls. E3 stated "for example (R2) would think there was a dog by (R2) and stand up to get the dog." E3 stated R2 was hallucinating. E3 verified R2 was not on any antipsychotic medication on

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admission.

1. On 5/27/14 at 12:15 p.m., Z1 (R2's Power of Attorney) stated R2 has imaginary friends. Z1 stated R2's dementia has worsened and R2 no longer knows any family members. Z1 stated R2 requires more supervision than R2 was getting at home. Z1 stated R2 has been started on new medication "that has really slowed (R2) down."

A current computer generated demographic sheet documents R2 is 77 years old and was admitted on 3/25/14. A current computer generated diagnosis list, documents R2 has diagnoses which include Cerebral Vascular Accident (4/2014), Dementia with behavior disturbances, Alzheimer's Disease, Depression with Anxiety, and Dysuria. A Minimum Data Set Assessment dated 5/1/14, documents R2 has moderately impaired cognition and R2 has "other behaviors not directed towards others." Behavior Tracking dated 3/25/14 through 5/28/14, documents R2 exhibits behaviors of repetitive physical movement, wandering, resisting care, and repetitive verbalizations.

A Medication Administration Record dated 5/2014, documents R2 medications include, Zoloft (Antidepressant) 100 milligrams (mg) daily, Zyprexa 2.5 mg at noon (first ordered on 4/14/14), and Zyprexa 5 mg at bedtime (first ordered on 4/18/14).

R2's Plan of Care dated 5/1/14, documents "it was noted on 4/8/14 that (R2) was leaning forward in (R2's) wheelchair rubbing finger on the floor. (R2) told staff (R2) was connecting the dots on the floor and (R2) also described to staff the

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small dogs that were playing on the floor." R2's Plan of Care dated 5/1/13, documents R2 began taking Zyprexa for hallucinations/dementia.

A Fall Report dated 4/13/14, documents R2 had been restless and hallucinating prior to fall, trying to reach to floor while sitting in wheelchair and getting up out of wheelchair without assistance. A Fall Report dated 4/13/14, documents R2 "did not have medication for hallucinations or behaviors. New orders to start Zyprexa 2.5 mg daily at noon."

On 5/29/14 at 1:10 p.m., E3 (Assistant Director of Nursing) verified R2's diagnosis for the use of Zyprexa was Dementia with behaviors and hallucinations. E3 stated R2 was a harm to self because R2 "kept falling." E3 stated R2 was not a harm to others. E3 verified R2's Zyprexa was increased to a total of 7.5 milligrams (mg) per day on 4/18/14. E3 stated R2 was initially put on Zyprexa 2.5 mg per day on 4/14/14, was admitted to the hospital, and returned with the Zyprexa increased an additional 5 mg per day on 4/18/14. E3 stated "I thought the maximum daily dose was 7.5 mg per day." E3 stated "since (R2) was in the hospital during the last increase I don't know why it was increased." E3 verified R2 had only been on the Zyprexa 2.5 mg for four days before the increase was made to 7.5 mg per day. E3 verified the facility did not perform an initial assessment when the Zyprexa was started for R2. E3 verified R2 was not assessed by the Psychiatrist until 4/24/14. E3 verified R2's plan of care not include individualized non-pharmacological interventions, R2 targeted behaviors, specific side effects of Zyprexa use, or goals and parameters to monitor R2's condition or to reduce/monitor R2's Zyprexa

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F 329	Continued From page 22 use. A Pharmacist Consultation report dated 4/22/14,documents R2 has a diagnosis of Dementia, receives an antipsychotic medication (Zyprexa), and R2 has recently experienced a stroke. A Pharmacist Consultation report dated 4/22/14, documents "Please assess and document the benefits of continuing (Zyprexa) outweigh the risks, including adverse cerebral vascular events, in this individual (R2) with a history of stroke, and consider discontinuing antipsychotic therapy..."an FDA (Federal Drug and Administration) warning identifies an increased risk of mortality in elderly individuals receiving antipsychotic medications for Behavior or Psychiatric Symptoms of Dementia (BPSD)." A Pharmacist Consultation report dated 4/22/14, documents research recommends "avoiding antipsychotic's for BPSD (Behaviorial and Psychotic Symptoms of Dementia) due to an increased risk for stroke and mortality unless nonpharmacological options have failed and the patient's behaviors are documented as a threat to self or others." A Pharmacist Consultation report dated 4/22/14, documents R2's physician responded to the pharmacist recommendation on 4/29/14 with the statement "the FDA warning is based on presumed outcomes." R2's physician provided no further documentation regarding R2's use of Zyprexa. On 5/29/14 at 1:15 p.m., Z2 (Consulting Pharmacist) stated the recommended maximum daily dose of Zyprexa is 5 milligrams per day. 2. R3's electronic medical record dated as current documents that R3 has diagnoses which include Dementia with Behavior Disturbances and	F 329		

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General Psychosis.

A Physician's Orders Sheet dated 5-23-14 documents that R3 has medications which include Risperdal 0.5mg (milligrams) two times daily which has been increased twice since 5-09-14, Ativan 0.5mg every six hours as needed, Donepezil 10 mg every evening, Namenda 10 mg two times daily.

R3's CNA (Certified Nurse Aide) behavior tracking dated 12-01-13 to 5-28-14 documents that R3 had physically aggressive or threatening behaviors over 90 times and over 175 other behaviors which include being resistive to cares, yelling/screaming, anger towards self and others. The behavior tracking does not include any interventions/approaches were used to prevent or alleviate R3's behaviors.

On 5-29-14 at 9:15a.m. E13 (Alzheimer's Unit Director) stated, "We try to keep R3 away from other residents when R3 is having behaviors." E13 stated, "The CNAs (Certified Nurse Aides) are suppose to notify the nurses," when R3 starts having behaviors. E13 stated that the nurses are then suppose to document R3's behaviors and what interventions/approaches were attempted to stop the behaviors in the nurse's notes.

On 5-29-14 at 9:15a.m. E7 (Licensed Practical Nurse) stated, "The CNAs are suppose to tell the nurse when R3 has behaviors." E7 stated, "Often the nurse doesn't usually know about behaviors until the end of the shift..."

Alleged Abuse/Neglect logs dated 4-09-14 to 5-23-14 document that R3 had three altercations with other residents during that time: 4-09-14,

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5-09-14, and 5-23-14.

Nurse's notes dated 4-09-14 do not include documentation that R3 had threatening or physical behaviors towards other residents on that date. The nurse's notes do not indicate individualized non-pharmacological interventions/approaches were directed at preventing or relieving R3's behaviors. The nurse's notes do indicate that R3 was administered Ativan, "...when R3 became antsy in bed and began yelling out."

Nurse's notes dated 5-09-14 do not include documentation that R3 had threatening or physical behaviors towards other residents on that date until after R3 slapped R16. The nurse's notes do not indicate individualized non-pharmacological interventions/approaches were directed at preventing or relieving R3's behaviors, but the notes do document that R3's antipsychotic medication, Risperdal, dosage was increased.

Nurse's notes dated 5-22-14 state, "Resident yelling out and grabbing at other individuals...prn (as needed) Ativan given and removed from sitting room..." The nurse's notes do not indicate individualized non-pharmacological interventions/approaches were used to prevent or relieve R3's behavior prior to administering the Ativan.

Nurse's notes dated 5-23-14 do not include documentation that R3 had threatening or physical behaviors towards other residents on that date, or that individualized non-pharmacological interventions/approaches were directed at preventing or relieving R3's

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F 329	Continued From page 25 behaviors. The nurse's notes do document that R3's antipsychotic medication, Risperdal, dosage was again increased. On 5-28-14 at 1:00p.m. E2 (Director of Nurses) and E3 (Assistant Director of Nurses) stated that R3's behaviors had been escalating recently since R3 had been in the hospital. E2 and E3 were unable to state what interventions/approaches had been initiated to prevent R3's behaviors and physical aggression toward other residents besides increasing R3's psychoactive medications.	F 329		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431		6/20/14

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The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review the facility failed to keep narcotics in a separately locked area of the medication cart for one of 13 residents (R13) on a sample of 15, and 10 residents on the supplemental sample (R21, R27, R28, R29, R31-R36).

Findings include:

On 5-28-14 from 11:18a.m. to 12:10p.m. E16 (Registered Nurse) was administering resident medications. On two occasions during the medication pass, E16 unlocked a single lock to the medication cart and removed Hydrocodone/Acetaminophen (Norco) from a mutidose blister pack which was stored in the cart with all non-narcotic medications. E16 verified that the facility does not keep Hydrocodone/Acetaminophen in a separately locked compartment.

On 5-28-14 at 12:45p.m. E2 (Director of Nurses) was reading a facility medication storage policy which stated, "All controlled substances are to be kept double-locked for safe keeping." E2 stated,

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NORTH ADAMS HOME	2259 EAST 1100TH STREET MENDON, IL 62351

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F 431	Continued From page 27 "That's not right, because we don't." E2 then retrieved another facility policy called Storage and Expiration of Medications, Biologicals, Syringes and Needles dated 1-01-13 which states, "Facility should store schedule II controlled substances and other medications deemed by Facility to be at risk for abuse or diversion in a separate compartment within the locked medication carts..." E2 verified that Hydrocodone/Acetaminophen (Norco) is a medication at risk for abuse. A list of residents on Hydrocodone/Acetaminophen, provided by E3 (Assitant Director of Nursing) on 5/29/14, identifies the following residents as potentially affected by this failure: R13, R21, R27, R28, R29, R31, R32, R33, R34, R35 and R36.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection	F 441		6/20/14

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(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review the facility failed to perform hand hygiene after resident cares for one of 13 residents (R3) reviewed for infection control practices in a sample of 15.

Findings include:

On 5-27-14 at 12:40p.m. E5 and E6 (Certified Nurse Aides) were assisting R3 with toileting. E5 and E6 applied gloves then using a mechanical lift transferred R3 into the bathroom. E5 removed R3's pants and incontinence brief then E6 lowered R3 onto the toilet. E5 removed the gloves and left R3's room without performing hand hygiene to assist another resident. E5 returned to R3's bathroom a few minutes later

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F 441	Continued From page 29 and reapplied gloves. E5 used the mechanical lift to lift R3 off the toilet while E6 cleansed R3's perineal area of bowel movement. Without removing gloves or performing hand hygiene, E6 pulled up R3's incontinence brief and pants and assisted E5 in transferring R3 back to bed. E6 assisted E5 in repositioning R3 and then pulled R3's bed linens up and over R3. E5 and E6 removed their gloves and left R3's room without performing hand hygiene. On 5-29-14 at 9:25a.m. E6 (Certified Nurse Aide) verified that hand hygiene should be performed after perineal/ incontinence care, after soiled gloves are removed, and before leaving a resident's room. A policy on Hand Washing dated 3-04-14 states, "Hand washing should occur by all employees at the following times:...Before and after contact with any resident...Immediately or as soon as possible following contact with...body fluids...Immediately or as soon as possible after removal of gloves..."	F 441		
F 469 SS=C	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain a pest free environment. This failure has the potential to effect all 61 residents residing in the facility.	F 469		6/20/14

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F 469	Continued From page 30 Findings include: On 5/27/14 at 10:00 a.m., a spider was noted inside a cabinet in the kitchen. On 5/27/14 at 9:00 a.m., a spider was noted on the floor in the conference room. On 5/28/14 at 10:40 a.m. (during Group Interview), R4 stated the facility does have spiders and ants. R4 stated "I've seen pretty good sized spiders in the shower room several times and the South Dining Room has ants on the tables and window frames. A Resident Census and Condition Report completed by E1 (Administrator) on 5/27/14, documents there are 61 residents residing in the facility.	F 469		
F 520 SS=C	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.	F 520		6/20/14

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A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.

Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure the Director of Nursing and Medical Director attended each Quarterly Quality Assurance Committee Meeting. This failure has the potential to affect all 61 residents living in the facility.

Findings include:

The facility policy, titled "Quality Assurance Meetings", documents "record attendance - QA (Quality Assurance) minutes should show who was present, who was not and who was excused."

The documented "Record of Meetings" for the 3/13/14 Quarterly Quality Assurance Meeting identifies E15 (Medical Director) as absent. The documented "Record of Meetings" for the 6/13/13 Quarterly Quality Assurance Meeting identifies E2 as absent.

On 5/29/14 at 10:10 a.m., E1 (Administrator) stated the facility policy is to hold a Quarterly Quality Assurance Meeting with E15 (Medical Director) and E2 (Director of Nursing) in

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F 520	Continued From page 32 attendance. E1 confirmed the Quality Assurance attendance records were accurate. The Resident Census and Condition Report, dated 5/27/14 and signed by E1 (Administrator), documents 61 residents live in the facility.	F 520		