STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	05/19/2012

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F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to update a care plan for a resident who had repeated aggressive behaviors towards other residents for 1 of 1 cognitively impaired resident's with behaviors (Resident #64). Findings include: Resident #64 was admitted on 3/3/12 with diagnoses including Dementia, Diabetes Type II and hypertension.	F 279	Resident #64 no longer resides in the center. An audit was completed of current resident care plans with aggressive behaviors and they were reviewed and updated as needed at point of discovery by Social Worker on 5/18/2012. Education of the licensed nurses was provided on 5/18-19/2012 by Director of Nursing regarding placing residents with aggressive behavior on1:1, notification of physician, referral to recreation director for further interventions, use of the behavior monitoring tool and updating care plans with new interventions.	6/19/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deorgeann Moore, RN | TITLE: NHA | (X6) DATE: 6/14/12

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 279	Continued From page 1 Review of the Admission Minimum Data Set (MDS) assessment dated 5/10/12 revealed Resident #64 had short and long term memory problems and was moderately impaired in decision making. He was also coded as having physical, verbal and other behaviors towards others. The behaviors were not considered to put the resident or others at physical risk of injury but were identified as interfering with the resident ' s care and participation in activities, intruding on the privacy of others and disrupting the living environment. Wandering behaviors were also identified and the resident was assessed as able to walk independently. On 3/10/12 at 6:50 PM a Change of Condition report revealed Resident #64 and Resident #139 were heard yelling at each other on 200 hall and were observed kicking each other. The note also indicated the incident was observed by a Nursing Assistant who stated that Resident #64 initiated the altercation. The intervention was to redirect Resident #64 from going down 200 hall while Resident #139 was up in the hallway. Review of the Care Plan dated 3/13/12 revealed a behavior care plan with a goal of not more than 3 episodes (of behaviors) a week. The interventions were: -allow resident time to vent feelings/needs -approach in calm friendly manner -assess and manage unmet needs -document interventions and resident response -encourage resident to attend activities of choice and adjust time spent to resident attention span/tolerance -listen to resident needs and adjust plan as appropriate	F 279	Director of Nursing\designee will conduct rounds to identify any resident with aggressive\inappropriate behaviors across all 3 shifts daily for 30 days and than 3 times a week across all 3 shifts for 30 days with corrective action at point of discovery. Findings will be reported to the Administrator. Any trends identified will be reported to the Quality Improvement Committee for recommendations and further follow-up.	

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F 279	Continued From page 2 -listen to resident and try to calm Review of the Care Plan Evaluation note dated 3/13/12 at 11:19 AM revealed the incident on 3/10/12 was summarized in the note. No interventions were identified. A Care Plan Meeting Late Note dated 3/13/12 at 11:21 AM revealed the incident on 3/10/12 was discussed as well as the resident's exit seeking and combative behavior. The intervention identified was " SW (Social Worker) is working on placement. " A Care Plan Evaluation note dated 3/14/12 at 3:03 PM revealed " Wander guard continues. Wanders in/out of rooms and facility, constantly redirected per staff. " No new interventions were identified. On 3/17/12 at 9 PM a Change of Condition report revealed Resident #64 was observed hitting his room mate (Resident #173) with a balled up blanket. Review of the Incident Reports dated 3/17/12 for Resident #64 and Resident #173 revealed the intervention was have them sleep in separate rooms for the night. On 3/18/12 (no time noted) Incident Reports for Resident #64 and Resident #173 revealed Resident #173 was sitting in his wheelchair in his room eating supper and his room mate Resident #64 hit him on the right cheek with a plate. Resident #173 had a red mark on his cheek after the incident. Review of the Care Plan Evaluation note dated 3/20/12 at 10:58 AM revealed the incident on	F 279		

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F 279	Continued From page 3 3/18/12 was summarized in the note. No new interventions were identified. Review of the Care Plan Meeting Notes dated 3/21/12 at 8:15 AM revealed the incidents on 3/17/12 and 3/18/12 noted above were discussed. The note also indicated that Resident #64, had wandering behaviors, attempted to leave the facility and was not easily directed. The interventions discussed were that Resident #64 was being assessed for locked unit placement and a room change was suggested. Resident #64 was then moved to a room on 200 Hall (from 100 Hall). On 3/22/12 at 2:50 PM a Change of Condition report revealed Resident #64 was bitten by Resident #139. Review of the Incident Reports dated 3/22/12 for Resident #64 and Resident #139 revealed that Resident #64 called Resident #139 a " black boy " (racial comment). This slur upset Resident #139, who had diagnoses including Mental Retardation, and he bit Resident #64. The bite drew blood from the left middle finger of resident #64. Review of the Care Plan Evaluation note dated 3/26/12 at 1:23 PM revealed the incident on 3/22/12 was summarized in the note. No new interventions were identified. Review of the nursing notes on 3/26/12 at 3:01 PM revealed " This pt (patient) walking down the hall and another patient turned around and said something to him and he responded and the other patient hit him in the groin area. No injury noted. Both patients were separated. " Review of the incident log for 3/1/12 - 3/31/12 revealed	F 279		

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

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F 279	Continued From page 4 this incident was not listed. The other resident was not identified. Review of the Care Plan Evaluation note dated 3/27/12 at 11:15 AM revealed the incident on 3/26/12 was summarized in the note and that no new interventions were identified. The interventions listed were: " cont (continue) to redirect and seek placement on locked unit. " The 4/6/12 Physician's Telephone Orders revealed an order to take Resident #64 to the bathroom upon rising, before and after meals, at bedtime and as needed to prevent him from urinating on the carpet. Review of the care plan revealed this intervention was not listed in the care plan. On 4/10/12 at 2:37 PM a Change of Condition report revealed Resident #64 hit Resident #173 in the face. When asked why he hit Resident #173 he said " he did not look good. " Under additional interventions it read " called to Life Works (a behavioral health services company) for consult, medications decreased per pharmacy recommendations, called physician for re-evaluation. " Review of the 4/11/12 11:41 AM Care Plan Meeting notes revealed Resident #64 was discussed in the Interdisciplinary Team meeting. The note indicated Resident #64 was sent to the Emergency Department on 4/10/12 as ordered but was not admitted and returned to the facility with no new orders. The note also indicated that the Physician had done a Gradual Dose Reduction of Resident #64 ' s anti-anxiety medications (lorazepam) and revealed the plan "	F 279		

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F 279	Continued From page 5 will get MD (Medical Doctor) to re-evaluate meds (medications) d/t (due to) aggressive behavior. Review of the Care Plan Evaluation note dated 4/11/12 at 11:43 AM revealed the same information as noted in the 4/11/12 11:41 AM Care Plan Meeting note. On 4/21/11 at 5 PM a Change of Condition report revealed that Resident #64 grabbed Resident #173 from behind the head and pulled. The note read, in part, " combative behavior continues with this pt (patient) targeting other res (resident) consistently. " The intervention for this incident was to separate the residents. On 4/25/12 at 8:15 PM a Change of Condition report revealed " Nurse had to take resident's hand off walker because he was trying to take it from room mate again. " It also indicated that the room mate, Resident #241, had asked Resident #64 to get off Resident #241 ' s bed and then Resident #64 threw the walker at Resident #241, but it did not hit him. Resident #64 was taken down the hall by staff at that time. The physician was notified and gave an order for lorazepam 1 mg (milligram) now. Review of the Behavior Care Plan revealed it was reviewed on 5/2/12 with no changes. On 5/6/12 at 8:10 PM a Change of Condition report revealed Resident #64 walked up behind Resident #173, grabbed his right arm and pulled it back and was cursing and verbally threatening during this incident. The intervention implemented at this time was to separate the residents. In addition, the note revealed the	F 279		

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F 279	Continued From page 6 nurse contacted the Social Worker (SW) at this time and was told to call the behavior unit at the hospital to see if a bed was available. When the nurse called she was told there was a bed available but Resident #64 was not a candidate. Under additional interventions it read " SW to talk to RP about Alzheimer unit placement 5/7/12. Review of the Care Plan Evaluation note dated 5/7/12 at 9:36 AM revealed the incident on 5/6/12 was summarized in the note and there were no new interventions. The interventions that were reiterated were: " working on placement at behavioral center and no new beds available. Will continue to monitor and redirect as needed. " Review of the Physician's Progress Note dated 5/8/12 revealed " Alzheimer dementia, will check labs, needs alternative placement, will discuss with SW, nurse reports pt continues with agitated behavior. " Review of the laboratory results dated as collected on 5/9/12 revealed the CBC and CMP were within normal limits. On 5/11/12 a Room Change note revealed the resident was transferred to 300 hall. On 5/11/12 at 2:06 PM a nursing note revealed Resident #64 drew back to hit another resident (unnamed) but staff intervened. There were no incident reports for this occurrence. On 5/11/12 at 10 PM a nursing note revealed Resident #64 was combative with staff, urinating on the floor and going in and out of other resident ' s rooms and messing with their belongings. "	F 279		

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F 279	Continued From page 7 Other pt are yelling get out of here and leave that alone. Pt goes to his old room on 200 hall trying to get to his old room to lay down to go to sleep and there are other pt in that room. Pt. real confused since room change. " " IM Ativan (lorazepam) given in right deltoid. " On 5/14/12 at 11:05 PM a nursing note revealed Resident #64 was combative with staff and wandering in and out of resident rooms. The note read, in part, " female residents telling this nurse they are ' scared ' . Has come up the hall several times half dressed. " The physician was notified and lorazepam IM was given with 3 staff to assist. On 5/15/12 at 7:45 PM a Change of Condition report revealed Resident #64 smacked Resident #173. Resident #64 was removed from the area and then slammed a door that caught the foot of a staff member. The note also read, in part, " staff reports pt exhibited exit seeking behavior. " " Pt then observed several times placing hands inappropriately and in a sexual manner on various staff members. " The Physician's Telephone Orders dated 5/15/12 revealed an order for lorazepam 0.5 mg now x 1 (no route specified). Review of the Medication Administration Record for 5/15/12 revealed IM lorazepam 0.5 mg was given at 8 PM. On 5/15/12 at 9:30 PM a nursing note revealed " Resident ' s behavior continues. Staff unable to monitor pt 1:1. Repeat call made to (family member), asked to visit with pt to calm mood, behaviors. (Family member) walking with pt throughout facility. No further combative or	F 279		

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F 279	Continued From page 8 sexually aggressive behaviors noted. " Interview with Nurse #1 on 5/17/12 at 3:30 PM revealed that she used redirection to intervene when Resident #64 would approach other residents or go in other rooms. When asked if residents are ever placed on 1:1 observation she stated that they do not have staffing for 1:1 but have done it for residents who have suicidal ideation. Nurse #1 added that sometimes they call the family to come and sit with the resident and sometimes families pay for a sitter. Interview with the Acting Administrator and Administrative Staff #1 revealed that they were aware of Resident #64's aggressive behaviors and that room changes and medication changes had been initiated to try and manage his behaviors. Administrative Staff #1 indicated that they were seeking locked unit placement for Resident #64 as he was not appropriate for the facility and they had tried to send him to the hospital but he was returned to the facility without being admitted. He also said that they were doing all they could and that there had not been any injuries from the incidents involving Resident #64. Interview with Administrative Nurse #1 on 5/18/12 at 1:20 PM revealed that it was difficult to predict Resident #64's aggressive behavior as it was sporadic. When asked how Resident #173 and other residents were being protected from physical attacks by Resident #64 she stated they tried to have staff monitor him 1:1 after an incident happened, and sometimes they would call his daughter to come and stay with him. Administrative Nurse #1 said that the other	F 279		

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F 279	Continued From page 9 interventions they had tried were medication changes and they were seeking alternate placement. She indicated that alternate placement on a locked unit would be most appropriate for Resident #64 and would protect the other residents. Administrative Nurse #1 denied being aware of any resident ' s being scared of Resident #64 and stated he was on a toileting program and closely monitored to manage his behavior. Interview with the Social Worker (SW) on 5/18/12 at 1:30 PM revealed that room changes had been done to protect other residents. She did not know why Resident #64 was still in a semi-private room and continued to have room mates despite his history of having aggressive incidents with room mates. When it was pointed out that Resident #173 had been attacked 6 times she acknowledged this was still occurring and that was one of the reasons they were seeking alternate placement for Resident #64. She said that at this time she had no discharge options for Resident # 64. She acknowledged that in the meantime the facility was responsible to protect other residents but she did not know what other interventions could be added beyond what was already being done.	F 279		
F 323 SS=K	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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F 323	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on record review and staff, physician and resident interview the facility failed to implement effective interventions to prevent repeated resident to resident physical aggression for 1 of 1 cognitively impaired resident's with aggressive behaviors (Resident #64). Findings include: Immediate Jeopardy began on 3/17/12 at 9 PM when Resident #64 was observed hitting his roommate, Resident #173, with a balled up blanket. He subsequently hit his roommate Resident #173 on 3/18/12 at 5:50 PM before a room change was initiated. There was one act of aggression against Resident #139, four more attacks against resident #173 as well as one act of aggression against a new room mate, Resident #241. Interventions documented included redirection, room changes and medication changes but were insufficient to prevent repeated acts of aggression and attacks on other residents. The Administrator was notified of the Immediate Jeopardy on 5/18/12 at 10:40 AM. The Immediate Jeopardy was removed on 5/19/12 at 12:10 PM after the Credible Allegation was validated through staff interviews, record review and observations. The facility remained out of compliance at a scope and severity level" D " (an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) to ensure that the	F 323	F323 Resident #64 no longer resides in the center. An audit was completed that identified residents who were demonstrating aggressive behaviors and this was completed on 5/19/12 by the DON/Designee. No other residents were identified at the time of the audit.	6/19/2012

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F 323	Continued From page 11 policies and procedures implemented by the facility could be reviewed and evaluated by the Quality Assurance Committee. The facility was also in the process of ensuring the completion of the employee training. Resident #64 was admitted on 3/3/12 with diagnoses including Dementia, Diabetes Type II and hypertension. Scheduled medications ordered on admission included: 100 mg (milligrams) daily Zoloft (an antidepressant), Namenda 5 mg twice a day (used to treat the symptoms of dementia), Aricept 10 mg at bedtime (used to treat the symptoms of dementia), Ativan (lorazepam) 0.5 mg twice a day (an anti-anxiety medication), depakote 125 mg three times a day (a seizure disorder medication often used to treat mania or other mood disorders), trazadone 2 mg at bedtime for insomnia (an antidepressant). Review of the Physician's Telephone Orders dated 3/4/12 revealed an order to discontinue the AM dose of Namenda, an order for lorazepam 0.5 mg (milligrams) every six hours as needed and an order for check wander guard placement every shift. The 3/7/12 9:20 PM nursing note revealed that Resident #64 had been wandering all shift, he stripped off his clothes and was cursing and threatening staff. Resident #64 was confused but alert to name. The intervention implemented was constant redirection. The physician was notified by leaving a message in the Doctors in-box and the Responsible Party (RP) was notified. Review of the Admission Minimum Data Set	F 323	Dementia specialist was consulted on 5/18/12 for education regarding residents with aggressive behaviors. Facility received training materials regarding aggressive behaviors on 5/18/12 at 11:50am. Administrative, direct care and ancillary staff were immediately educated by the Director of Nursing/designee on 5/19/12 and continue to be educated as needed and appropriate. Residents identified as demonstrating aggressive behavior to other residents will immediately be placed on 1:1 supervision by nursing personnel/designee. Attending physician/designee will be notified of any aggressive behaviors by nursing supervisor/designee via telephone immediately upon discovery. Non-pharmacological interventions will be referred to recreation	

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F 323	Continued From page 12 (MDS) assessment dated 5/10/12 revealed Resident #64 had short and long term memory problems and was moderately impaired in decision making. He was also coded as having physical, verbal and other behaviors towards others. The behaviors were not considered to put the resident or others at physical risk of injury but were identified as interfering with the resident's care and participation in activities, intruding on the privacy of others and disrupting the living environment. Wandering behaviors were also identified. The MDS also revealed that Resident #64 was independent with most activities of daily living except he required extensive assistance of 1 person for dressing, toileting and personal hygiene. He also required set up assistance to eat. According to the MDS Resident #64 was steady while walking and transferring and had no range of motion limitations. On 3/10/12 at 6:50 PM a Change of Condition report revealed Resident #64 and Resident #139 were heard yelling at each other on 200 hall and were observed kicking each other. The note also indicated the incident was observed by a Nursing Assistant who stated that Resident #64 initiated the altercation. The intervention was to redirect Resident #64 from going down 200 hall while Resident #139 was up in the hallway. The physician was notified by leaving a message in the Doctors in-box and the RP was notified. Review of the Incident Reports for Resident #64 and Resident #139 revealed no injuries occurred during this incident. The Physician's Telephone Orders dated 3/10/12 revealed an order to discontinue the PM dose of Namenda.	F 323	director/designee for intervention upon discovery. Director of Nursing/designee will implement physician medication and/or non-pharmacological interventions at the time the orders are received. A monitoring tool for aggressive/inappropriate behaviors was developed on 5/18/12. This tool includes observations for behaviors, triggers for the behavior and interventions. An audit was completed by the Director of Nursing/Designee on resident care plans for all residents who had documented behaviors on 5/18/2012. With corrective actions added to care plans as appropriate during the audit process.	

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F 323	Continued From page 13 Review of the Care Plan dated 3/13/12 revealed a behavior care plan with a goal of not more than 3 episodes (of behaviors) a week. The interventions were: -allow resident time to vent feelings/needs -approach in calm friendly manner -assess and manage unmet needs -document interventions and resident response -encourage resident to attend activities of choice and adjust time spent to resident attention span/tolerance -listen to resident needs and adjust plan as appropriate -listen to resident and try to calm On 3/17/12 at 9 PM a Change of Condition report revealed Resident #64 was observed hitting his room mate (Resident #173) with a balled up blanket. The physician was notified by leaving a message in the Doctors in-box and the RP was notified. Review of the Incident Reports dated 3/17/12 for Resident #64 and Resident #173 revealed no injuries occurred during this incident and that the intervention was have them sleep in separate rooms for the night. On 3/18/12 at 5:50 PM a Change of Condition report revealed Resident #64 had a " Change of Condition behaviors " , no details about the incident were present. The Physician was notified but there was no notation indicating the RP was notified. Review of the Incident Reports for Resident #64 and Resident #173 revealed Resident #173 was sitting in his wheelchair in his room eating supper and his room mate Resident #64 hit him on the right cheek with a plate. Resident #173 had a red mark on his cheek after	F 323	Director of Nursing/designee will conduct rounds to identify any aggressive/inappropriate behaviors across all 3 shifts daily x 30 days and then 3 times per week across all 3 shifts x 30 days. Interdisciplinary team will discuss/address all behaviors and interventions implemented with effectiveness weekly with customer at risk meetings. Findings will be reported to the Quality Improvement Committee for review of trends and additional action items as needed x 90 days.	

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F 323	Continued From page 14 the incident. Review of the Physician's Telephone Orders dated 3/18/12 (no time noted) revealed an order to increase Zoloft to 150 mg every day to decrease agitation. The physician was notified by telephone but there was no notation indicating the RP was notified. Review of the Medication Administration Record for 3/18/12 revealed the first dose of Zoloft 150 mg was given at 8 PM on 3/18/12. Review of the Care Plan Meeting Notes dated 3/21/12 revealed the incidents on 3/17/12 and 3/18/12 noted above were discussed. The note also indicated that Resident #64, had wandering behaviors, attempted to leave the facility and was not easily directed. The interventions discussed were that Resident #64 was being assessed for locked unit placement and a room change was suggested. Resident #64 was then moved to a room on 200 hall (from 100 hall). On 3/22/12 at 2:50 PM a Change of Condition report revealed Resident #64 was bitten by Resident #139. The physician and Nurse Practitioner were notified and the RP was notified. The interventions referred to a new order but the Physician' s Telephone Orders revealed no new orders from 3/18/12 to 4/1/12. Review of the Incident Reports dated 3/22/12 for Resident #64 and Resident #139 revealed that Resident #64 called Resident #139 a racial comment. This slur upset Resident #139, who has diagnoses including Mental Retardation, and he bit Resident #64. The bite drew blood from the left middle finger of resident #64.	F 323		

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F 323	Continued From page 15 On 4/1/12 the Physician's Telephone Orders revealed an order to decrease the 8 AM lorazepam dose to 0.25 mg then on 4/8/12 to decrease the 8 PM lorazepam dose to 0.25 mg, then on 4/15/12 to discontinue the 8 AM lorazepam dose and on 4/22/12 to discontinue the 8 PM lorazepam dose. The 4/6/12 Physician's Telephone Orders revealed an order to take Resident #64 to the bathroom upon rising, before and after meals, at bedtime and as needed to prevent him from urinating on the carpet On 4/10/12 at 2:37 PM a Change of Condition report revealed Resident #64 hit Resident #173 in the face. When asked why he hit Resident #173 he said " he did not look good. " The Nurse Practitioner was notified and the RP was notified. Under additional interventions it read " called to Life Works (a behavioral health services company) for consult, medications decreased per pharmacy recommendations, called physician for re-evaluation. " Review of the Incident Reports for Resident #64 and Resident #173 revealed no injuries occurred as a result of this incident. Review of the Physician's Telephone Orders dated 4/10/12 revealed an order to send Resident #64 to the Emergency Department for geriatric behavior evaluation. Review of the 4/11/12 Care Plan Meeting notes revealed Resident #64 was discussed in the Interdisciplinary Team meeting. The note indicated Resident #64 was sent to the Emergency Department on 4/10/12 as ordered but was not admitted and returned to the facility	F 323		

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F 323	Continued From page 16 with no new orders. The note also indicated that the Physician had done a Gradual Dose Reduction of Resident #64's anti-anxiety medications (lorazepam) and revealed the plan " will get MD (Medical Doctor) to re-evaluate meds (medications) d/t (due to) aggressive behavior. On 4/21/11 at 5 PM a Change of Condition report revealed that Resident #64 grabbed Resident #173 from behind the head and pulled. The note read, in part, " combative behavior continues with this pt (patient) targeting other res (resident) consistently. " The intervention for this incident was to separate the residents. The physician was notified by leaving a message in the Doctors in-box and the RP was notified. Review of the Incident Reports for Resident #64 and Resident #173 revealed no injuries occurred as a result of this incident. On 4/25/12 at 8:15 PM a Change of Condition report revealed " Nurse had to take resident's hand off walker because he was trying to take it from room mate again. " It also indicated that the room mate, Resident #241, had asked Resident #64 to get off Resident #241's bed and then Resident #64 threw the walker at Resident #241, but it did not hit him. Resident #64 was taken down the hall by staff at that time. The RP was notified and the physician was notified and an order for lorazepam was given. Review of the Incident Reports dated 4/25/12 for Resident #64 and Resident #241 revealed there were no injuries as a result of this incident. The Physician's Telephone Orders for 4/25/12 revealed an order for lorazepam 1 mg by mouth now. Review of the Medication Administration	F 323		

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F 323	Continued From page 17 Record for 4/25/12 revealed this medication was given at 8:30 PM. On 5/6/12 at 8:10 PM a Change of Condition report revealed Resident #64 walked up behind Resident #173, grabbed his right arm and pulled it back and was cursing and verbally threatening during this incident. The intervention implemented at this time was to separate the residents. In addition, the note revealed the nurse contacted the Social Worker (SW) at this time and was told to call the behavior unit at the hospital to see if a bed was available. When the nurse called she was told there was a bed available but Resident #64 was not a candidate. The nurse then informed the SW and RP according to the note. Under additional interventions it read " SW to talk to RP about Alzheimer unit placement 5/7/12. " Review of the Incident Reports dated 5/6/12 for Resident #64 and Resident #173 revealed no injuries occurred as a result of this incident. Review of the Physician's Progress Note dated 5/8/12 revealed " Alzheimer dementia, will check labs, needs alternative placement, will discuss with SW, nurse reports pt continues with agitated behavior. " The Physician's Telephone Orders for 5/8/12 revealed the following laboratory work was ordered for the following morning: CMP (complete metabolic profile), CBC (complete blood count), vitamin D level and TSH (Thyroid Stimulating Hormone). Review of the laboratory results dated as collected on 5/9/12 revealed the CBC and CMP	F 323		

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F 323	Continued From page 18 were within normal limits. On 5/11/12 a Room Change note revealed the resident was transferred to 300 h Hall. On 5/11/12 at 2:06 PM a nursing note revealed Resident #64 drew back to hit another resident (unnamed) but staff intervened. There were no incident reports for this occurrence. On 5/11/12 at 10 PM a nursing note revealed Resident #64 was combative with staff, urinating on the floor and going in and out of other resident ' s rooms and messing with their belongings. " Other pt are yelling get out of here and leave that alone. Pt goes to his old room on 200 Hall trying to get to his old room to lay down to go to sleep and there are other pt in that room. Pt. real confused since room change. " " IM Ativan (lorazepam) given in right deltoid. " The Physician's Telephone Orders dated 5/11/12 revealed an order for decrease Depakote to 125 mg three times a day (was 250 mg twice a day) and an order for IM (intramuscular) lorazepam 0.5 mg now. Review of the Medication Administration Record for 5/11/12 revealed the lorazepam was given at 10:15 PM and the new Depakote order was started on 5/12/12 at 8 AM. The 5/14/12 Physician's Telephone Orders revealed an order for IM lorazepam 0.5 mg now. Review of the Medication Administration Record revealed lorazepam 1 mg IM was given at 11 PM. On 5/14/12 at 11:05 PM a nursing note revealed Resident #64 was combative with staff and	F 323		

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F 323	Continued From page 19	F 323		

wandering in and out of resident rooms. The note read, in part, " female residents telling this nurse they are ' scared ' . Has come up the hall several times half dressed. " The physician was notified and lorazepam IM was given with 3 staff to assist.

On 5/15/12 at 7:45 PM a Change of Condition report revealed Resident #64 smacked Resident #173. Resident #64 was removed from the area and then slammed a door that caught the foot of a staff member. The note also read, in part, " staff reports pt exhibited exit seeking behavior. " " Pt then observed several times placing hands inappropriately and in a sexual manner on various staff members. " The physician and RP were notified and the note indicated new orders were received " continued observation, Zoloft taper x (times) 2 weeks. Zyprexa 5 mg q (every) day to be initiated 5/16/12. Continue to monitor behavior. " Review of the Incident Reports dated 5/15/12 for Resident #64 and Resident #173 revealed Resident #173 was smacked in the back of the head and there were no injuries as a result of this occurrence. "

The Physician's Telephone Orders dated 5/15/12 revealed an order for lorazepam 0.5 mg now x 1 (no route specified). Review of the Medication Administration Record for 5/15/12 revealed IM lorazepam 0.5 mg was given at 8 PM.

On 5/15/12 at 9:30 PM a nursing note revealed " Resident's behavior continues. Staff unable to monitor pt 1:1. Repeat call made to (family member), asked to visit with pt to calm mood, behaviors. (Family member) walking with pt throughout facility. No further combative or

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F 323	Continued From page 20 sexually aggressive behaviors noted. " On 5/16/12 at 4:45 PM a nursing note revealed Resident #64 was wandering in and out of resident rooms and exit seeking. On 5/16/12 at 8:45 PM a nursing note revealed Resident #64 was redirected from multiple attempts to enter rooms on 100 Hall due to multiple previous resident to resident conflicts with residents on 100 Hall. Resident #64 became combative and refused to be redirected but eventually walked away. On 5/16/12 at 10:06 PM a nursing note revealed resident #64 went into his room and picked up his room mates TV and attempted to leave the room with it. The resident's family member was called to come and visit with the resident. Interview with Nurse #1 on 5/17/12 at 3:30 PM revealed she worked with Resident #64 primarily while he resided on 200 Hall. She worked Monday to Friday first shift on 200 Hall. She stated that one reason Resident #64 was moved was because he would call another resident on the hall (Resident #139) a racial comment which Resident #139 found upsetting. She stated that she used redirection to intervene She also said that to try and prevent problems between Resident #64 and Resident #241, while they were room mates, she would have the Nursing Assistants get Resident #64 up first and then he would generally not go back to his room during the day. She said that one time Resident #64 turned off Resident #241's CPAP (continuous positive airway pressure) machine. She added that Resident #241 was cognitively intact and told	F 323		

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F 323	Continued From page 21 Resident #64 to stop and he did, but then right before Resident #241 was discharged Resident #64 defecated on Resident #241's bed. Nurse #1 indicated that the physician was notified of all incidents and incidents were documented as required but review of the Medical Record from 3/3/12 - 5/18/12 revealed no information about either of these incidents. When asked if residents are ever placed on 1:1 observation she stated that they do not have staffing for 1:1 but have done it for residents who have suicidal ideation. Nurse #1 added that sometimes they call the family to come and sit with the resident and sometimes families pay for a sitter. During interview with resident #173 on 5/17/12 at 5 PM, when asked if anyone had ever hurt him at the facility he indicated he had been hurt and stated that " (name of resident #64) hit me 4 or 5 times." He indicated that he had been hurt. The Acting Administrator and Administrative Staff #1 were informed of the Immediate Jeopardy on 5/18/12 at 10:40 AM. Interview with the Acting Administrator and Administrative Staff #1 revealed that they were aware of Resident #64's aggressive behaviors and that room changes and medication changes had been initiated to try and manage his behaviors. Administrative Staff #1 indicated that they were seeking locked unit placement for Resident #64 as he was not appropriate for the facility and they had tried to send him to the hospital but he was returned to the facility without being admitted. He also said that they were doing all they could and that there had not been any injuries from the incidents involving Resident #64.	F 323		

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F 323	Continued From page 22 On 5/18/12 at 1 PM interview with Nursing Assistant #1 (NA #1) she stated that it was difficult to keep an eye on Resident #64 as she had other residents to take care of and 2 men on her hall who wandered, including Resident #64. She stated that she would go and look for Resident #64 frequently and make sure he was taken to the bathroom on rising, and before and after breakfast and lunch, so he wouldn ' t urinate on the floor in public places. On 5/18/12 at 1:15 PM interview with NA #2 revealed resident #64 needed constant cueing and had hit her, but not hard, on numerous occasions during care or redirection. She stated that he wandered a lot and she would have to go looking for him. She also said that Resident #64 would mess around with his room mates belongings. NA #2 had observed Resident #64 cursing at Resident #139 and calling him a racial comment and also saw when Resident #64 had started kicking Resident #139 (on 3/10/12). She added that Resident #139 had told her Resident #64 " picks on me. " NA #2 said she had also seen Resident #64 cussing at Resident #173 but she had never seen him hit Resident #173. Interview with Administrative Nurse #1 on 5/18/12 at 1:20 PM revealed that it was difficult to predict Resident #64's aggressive behavior as it was sporadic. When asked how Resident #173 and other residents were being protected from physical attacks by Resident #64 she stated they tried to have staff monitor him 1:1 after an incident happened, and sometimes they would call his family member to come and stay with him. Administrative Nurse #1 said that the other interventions they had tried were medication	F 323		

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F 323	Continued From page 23 changes and they were seeking alternate placement. She indicated that alternate placement on a locked unit would be most appropriate for Resident #64 and would protect the other residents. Administrative Nurse #1 denied being aware of any resident's being scared of Resident #64 and stated he was on a toileting program and closely monitored to manage his behavior. Interview with Nurse #2 on 5/18/12 at 1:25 PM revealed that after Resident #64 hit resident #173 on 5/6/12, she had been asked by the Social Worker to call to see if they had a bed available at the Geriatric Behavior Center. She stated that she was told Resident #64 was not a candidate because his behaviors were not due to a mental health disorder. Interview with the Social Worker (SW) on 5/18/12 at 1:30 PM revealed that room changes had been done to protect other residents. When it was pointed out that Resident #173 had been attacked 6 times she acknowledged this was still occurring and that was one of the reasons they were seeking alternate placement for Resident #64. She stated that the residents Responsible Party had been reluctant to agree to placement in a locked unit but had finally agreed. The SW said two programs had come to the facility to assess Resident #64 but in the end neither would admit him. She stated that he was sent out to the hospital for evaluation but was returned without being admitted. The SW added that the facility took him back because since he was not admitted to hospital they were required to take him back and if they did not the hospital would call the State with a complaint. She said that at	F 323		

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F 323	Continued From page 24 this time she had no discharge options for Resident # 64. She acknowledged that in the meantime the facility was responsible to protect other residents. During interview with the Physician on 5/19/12 at 11:50 he indicated that he had made changes to Resident #64's medications to try and manage his aggressive behavior and that alternate placement was needed. He also stated that it would take some time for medication changes to work and that the staff monitored the resident closely to redirect him. The physician acknowledged that Resident #64 continued to have aggressive behaviors particularly against Resident #173 but had thought that 1:1 staffing would be difficult for the facility to do. However, he acknowledged 1:1 staffing for resident #64 or residents like him would protect other residents and indicated his support for the facility placing residents on 1:1 as needed to protect other residents. He also noted that 1:1 staffing could be done as a Nursing Order. The facility provided an acceptable Credible Allegation of Compliance on 5/18/12 at 7 PM. Credible Allegation of Compliance Resident #64 immediately placed on 1:1 supervision by nursing personnel/designee on 5-18-12 @ approximately 10:55am. Person providing 1:1 supervision to notify nursing supervisor/designee if aggressive/inappropriate behaviors occur. Medical Director notified @ approximately 12:00pm with order to send resident to Geriatric Behavior Unit for evaluation. Resident #64 was taken off of 1:1 supervision	F 323		

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SALISBURY CENTER	710 JULIAN ROAD SALISBURY, NC 28147

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 25 and taken to a Geriatric Behavior Unit @ approximately 12:00pm. Social Services/designees will immediately begin interviewing all residents/family members to assess feelings of safety within Center and complete by 5/19/12. Findings will be reported to Administrator/DON for immediate corrective action as needed. Others with Potential to be Affected Any resident identified by any staff demonstrating aggressive behavior to other residents will immediately be placed on 1:1 supervision by nursing personnel/designee. All staff will be re-educated immediately/continuously by the Director of Nursing/designee on aggressive behaviors and completed by 5/19/12. Physician will be notified of any aggressive behaviors by nursing supervisor/designee by telephone immediately. Non-medication related intervention will be referred to Recreation Director/designee for interventions. Director of Nursing/licensed nurses will implement any physician order/non-pharmacological intervention upon notification. Measures and Systemic Changes Dementia Specialists was consulted via email on 5/18/12 for education regarding residents with aggressive behaviors. Facility received training materials regarding aggressive behaviors on 5/18/12 @ 11:50am. All staff including administrative, direct and ancillary will be educated by the Director of Nursing/designee on managing aggressive behaviors immediately/continuously by 5/19/12.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 26 Monitoring Director of Nursing/designee will conduct rounds to identify any aggressive/inappropriate behavior across all 3 shifts daily for 30 days and then 3 times a week across all 3 shifts for 30 days. Monitoring tool for aggressive/inappropriate behavior was developed on 5/18/12. This tool includes observation for all inappropriate/aggressive behaviors, triggers for the behavior and interventions. An audit will be conducted by Director of Nursing/designee for up to date care plans for anyone with documented behaviors. Presently, facility offers mental health services through ACTS for residents with inappropriate/aggressive behaviors or as needed for other mental health needs as determined by physician. Interdisciplinary Team will discuss/address all behaviors and interventions implemented with effectiveness as needed. Findings will be reported to QI committee for trends with corrective action taken as needed for 60 days (7-17-12). The credible allegation was verified 5/19/12 at 12:10 PM, as evidenced by staff interviews on managing aggressive behaviors and the option for 1:1 observation, reviewing care plans for residents with behaviors, reviewing behavior tracking and care plan audits, reviewing facility log for resident and family interviews about feeling safe, and interviewing residents and family members about feeling protected from harm. Resident #64 had been placed on 1:1 observation on 5/18/12 at 10 " 55 AM but was transferred to the hospital on 5/19/12 at 12 noon and was no	F 323		

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F 323	Continued From page 27 longer in the facility. Review of the Behavior tracking Forms revealed the audits were completed on all 10 residents currently in the facility with identified behaviors. The audits were completed on 2nd and 3 rd shift 5/18/12 and 1st shift 5/19/12 and no behaviors were identified. The tracking form had columns for tracking type of behavior, triggers and interventions and their effectiveness. Behavior and wandering care Plans were also reviewed for these 10 residents and updated as needed on 5/18/12. Review of the inservice materials revealed the information on Aggressive Behaviors in Dementia, Causes, Medical treatment, Management of Acute Aggression, Prevention, Important Tips and the facility policy Managing Problem Behaviors dated 1/1/04 with a hand written notation " any aggressive behavior start staff 1:1 and notify physician and try and involve recreation for non-pharmacological interventions. " All nursing staff present on 5/19/12 1st shift, as well as multiple ancillary and Management staff, were interviewed and stated they attended the inservice before starting their shift and were able to explain what they had learned about managing aggressive behaviors and the option for 1:1 staffing. Review of the facility log of resident and family interviews revealed all 99 percent completion and all residents or family members stating they felt safe. Multiple residents and family members were interviewed for verification with no concerns identified.	F 323		

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

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F 323	Continued From page 28 Interview with the Recreation Director on 5/19/12 at 11:46 revealed her department's role in providing non-pharmacological divisional interventions for residents with behaviors according to their needs and preferences.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALISBURY CENTER	710 JULIAN ROAD SALISBURY, NC 28147

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K 000	INITIAL COMMENTS This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type III protected construction, and is utilizing a delayed locking system arrangement on two doors in the facility. The facility is equipped with an automatic sprinkler system.	K 000	Light fixture that was blocking sprinkler head in the dietician's office will be moved by Maintenance Director by 8/29/2012. Maintenance Director/designee will perform an audit by 8/29/2012 and then quarterly x 1 year to identify any sprinkler heads that are blocked with corrective action taken as needed. Findings will be reported to the Administrator. All trends will be taken to the monthly QA committee for continued quality improvement.	8/29/2012
K 056 SS=D	CFR#: 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on the observations and staff interviews on August 16, 2012 following Life Safety item was observed as noncompliant, specific findings include:	K 056		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 9/27/12

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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K 056	Continued From page 1 The sprinkler head in the dieticians office just outside the dietary department was blocked by the light fixture in that room. CFR#: 42 CFR 483.70 (a)	K 056		