

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

PRINTED: 02/20/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345003	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/05/2015
NAME OF PROVIDER OR SUPPLIER SILAS CREEK REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3350 SILAS CREEK PARKWAY WINSTON-SALEM, NC 27103		
(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 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and physician interview the facility failed to notify the physician of resident behaviors for 1 of 4</p>	F 157	<p>Resident #3 no longer resides at the facility.</p> <p>The nurses utilize the 24 hour report from Point Click Care (PCC) during shift to shift report to ensure any resident changes have been documented and reported to the physician and responsible party. The nursing management team also reviews the 24 hour report and new physicians order listing report each morning during Clinical rounds to ensure the residents, physicians, and family members have been notified of any incidents, falls, or other significant changes.</p>	3/5/15	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



Administrator

2/27/15

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 157	<p>Continued From page 1 residents (Resident #3)</p> <p>Findings included:</p> <p>Resident #3 was admitted to the facility on 1/8/2015. Her diagnoses included Cerebral Artery Occlusion with infarct (stroke); late effects of Cerebrovascular Disease; Tracheostomy (breathing tube); Gastrostomy (feeding tube); Dysphagia (difficulty swallowing) due to Cerebrovascular Disease; Speech and Language deficit due to Cerebrovascular Disease; Lack of Coordination; Muscle Weakness; Hemiplegia (paralysis of one side of the body) Affect due to Cerebrovascular Disease; and Acute Respiratory Failure.</p> <p>A hospital discharge summary dated 1/8/2015 revealed Resident #3 experienced acute onset of speech difficulty, gaze to the right and weakness to the left face, upper and lower extremities on 12/16/2014. Resident #3 received thrombolytic therapy, intravenous Labetalol (used to treat high blood pressure) and required Ativan (antianxiety medication) for management of extreme agitation. A MRI (radiology exam) confirmed a large ischemic infarct (stroke). A Tracheostomy was placed on 12/23/2014 with oxygen therapy and a Gastrostomy was placed on 12/24/2014. The medication Klonopin (antianxiety) was discontinued at discharge.</p> <p>The admission Minimum Data Set (MDS) dated 1/15/2015 coded Resident #3 as no speech for speech clarity; sometimes able to make self understood and understand others. Her vision was coded highly impaired. A staff assessment for mental status revealed Resident #3 's memory was intact and she was independent in</p>	F 157	<p>The licensed nursing staff have been re-educated on the need to inform the resident, the residents' physician and responsible party immediately, when there is an injury, significant change in the resident's condition or treatment plan, a decision has been made to transfer the resident from the facility and if there is a change in the resident's room or roommate.</p> <p>Newly hired Licensed Nurses will be educated during their orientation period, on the need to inform the resident, the residents' physician and responsible party immediately when there is an injury, significant change in the resident's condition or treatment plan, a decision has been made to transfer the resident from the facility and if there is a change in</p>		

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F 157	<p>Continued From page 2</p> <p>cognitive skills for daily decision making. The MDS did not code any mood (e.g. fidgety or restlessness) or behaviors (e.g. hitting and kicking). Resident #3 ' s functional status was extensive assistance to total dependent on staff for activities of daily living.</p> <p>An Admission nurse note dated 1/8/2015 at 9:30 PM revealed (in part) hospitalized on 12/16/2014 for large right CVA with left side paralysis. ...New placement of Tracheostomy 12/23/2014. Restless and moves around in bed a lot.</p> <p>Nurse Note dated 1/10/2015 at 8:30 AM read, " [Resident #3] is very fearful. "</p> <p>Nurse Note dated 1/11/2015 at 12:15 AM read, " [Resident #3] is non verbal this PM -tearful at intervals. "</p> <p>Nurse Note dated 1/11/2015 at 4:27 AM read, " She (Resident #3) is still fearful. "</p> <p>Nurse Note dated 1/12/2015 at 8:18 AM read, " ...she (Resident #3) still gets anxious especially during trach care. "</p> <p>Nurse Note dated 1/16/2015 at 4:13 AM read, " [Resident #3] has episodes of restlessness. "</p> <p>Nurse Note dated 1/17/2015 at 9:55 PM revealed Resident #3 was hitting at [family], throwing her legs out of bed and slapping hand away. Resident #3 was on Klonopin (antianxiety medication) before the CVA and [written] in doctor communication book to see if Resident #3 needed something for withdraw.</p> <p>Nurse Note dated 1/18/2015 at 3:48 PM read, "</p>	F 157	<p>the resident's room or room-mate.</p> <p>The Director or Nursing will audit the nursing documentation of ten resident charts a week for three (3) months. The results of the weekly audits will be presented to the Quality Assurance (QA) committee for a minimum of three months. The Quality Assurance and Performance Improvement Committee will review the audits and make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three (3) months.</p>		

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F 157	<p>Continued From page 3</p> <p>Received orders for Wellbutrin (antidepressant) for anxiety. "</p> <p>Nurse Note dated 1/18/2015 at 10:36 PM read, " Agitation noted this PM. Hitting at [family] and throwing her legs out of the bed. Very restless kicking legs out of the bed. "</p> <p>Nurse Note dated 1/19/2015 at 10:38 PM read, " Resident (Resident #3) agitation level increased hitting bed crying resident pulled out trach replaced by this writer ... " and included the nurse practitioner was at the bedside and orders were received for one time dose of Ativan.</p> <p>Nurse Notes dated 1/20/2015 included Resident #3 ' s family reported Resident #3 stated she fell out of bed on Sunday night 3rd shift and put herself back into the bed.</p> <p>Nurse Note dated 1/21/2015 at 2:48 PM " Restless and agitated throughout early AM hours. Thrashing around and banging bed rails and headboard. Pulled [oxygen] off over and over. Pulled trach out. Staff unable to calm resident. Bed lowered to lowest position. At 4 AM, while thrashing around, she rolled out of bed into the floor. "</p> <p>Nurse Note dated 1/21/2015 at 2:52 PM included Resident #3 pulled off her oxygen supply during an oral therapy trial ending the trial.</p> <p>Nurse Note dated 1/21/2015 9:03 PM read, " Agitation noted this PM hitting at family and throwing her legs out of bed. Very restless kicking legs out of bed. "</p> <p>Nurse Note dated 1/24/2015 at 4:12 AM noted</p>	F 157			

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F 157	<p>Continued From page 4</p> <p>Resident #3 removed trach collar.</p> <p>Nurse Note dated 1/24/2014 at 8:25 AM revealed Resident #3 ' s [family] found the resident lying in bed with the entire Tracheostomy [tube] pulled out. Unsuccessful attempts were made to replace the tube. Resident #3 was transported to the hospital and the current size 6 tube could not be replaced and was replaced with a smaller size 4.</p> <p>An interview on 2/4/2015 at 2:37 PM with Nurse #7 revealed [Resident #3 ' s] behavior was " all over the place. " Nurse #7 pulled at everything a lot of times e.g. wound dressing, gtube, trach, and trach dressing.</p> <p>An interview on 2/4/2015 at 4:24 PM with Nurse #6 revealed Resident #3 was anxious and always grabbing at stuff, throwing her legs off the bed, hitting family, and thrashing.</p> <p>An interview on 2/4/2015 at 4:58 PM with Nurse #1 revealed Resident #3 was young, restless, frustrated, and had trouble communicating. Nurse #1 reported Resident #3 was anxious every time she coughed and when Nurse #1 was suctioning the trach. The family was very nervous and here daily. Resident #3 would turn from side to side and would hang her leg out. An additional interview on 2/5/2015 at 3:19 PM revealed Resident #3 was agitated, situational, and would throw her leg out of bed forcefully. The nurse reported she documented in the physician communication book about a possible withdraw from Klonopin after a conversation with family.</p> <p>An interview on 2/5/2015 at 11:42 AM with Nurse #9 revealed at 4:00 AM Sunday/Monday a nurse assistant informed Nurse #9 that Resident #3</p>	F 157		
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F 157	<p>Continued From page 5</p> <p>was on the floor. She was positioned on her left side, her left arm was bent back, and her head was resting on her left arm. Staff put her back in bed. An additional interview at 2:00 PM revealed Nurse #9 was aware of Resident #3 ' s behaviors (documented as restless and agitated in nurse notes) and when she mentioned the behaviors to the first shift nurse (Nurse #6) the nurse said Resident #3 did it all the time.</p> <p>An interview on 2/5/2015 at 2:06 PM with the Unit Manager revealed Resident #3 kept her legs out of the bed and pulled and tugged at everything. The Unit Manager reported when she went in to provide care Resident #3 ' s family had to hold her arm still. The Unit Manager reported she did not feel Resident #3 was as aware of things as they [the family] thought she was or she was doing it intentionally. The Unit Manager reported Resident #3 ' s behavior was more anxiety than twitching. " It was an anxiety. "</p> <p>On 2/5/15 at 3:45pm with Nurse #8 said, " If a resident was exhibiting increased anxiety/behaviors we are able to get an emergent psych [mental health] consult. At the very least we should call and notify the doctor. "</p> <p>An interview on 2/5/2015 at 3:20 PM with the Medical Director revealed the facility had a mental health group contracted for the residents at the facility. The question was how to manage because the trend in skilled nursing facilities was to avoid psychotropic medications (mood altering). The physician reported that the mental health consult had not been done. There was an automatic [standing order] consult for behaviors and the consultant could come see a resident emergently if requested. The physician was</p>	F 157			

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F 157	Continued From page 6 unaware of the frequency of Resident #3 ' s behaviors and reported the staff did not inform her. She would have expected a consult for Resident #3 based on nurse notes.	F 157			
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with residents, resident family member and staff, the facility failed to answer resident call bells in a timely manner and provide assistance, for residents needing assistance, to maintain dignity for 2 of 4 residents (Residents #2 and #1) reviewed for dignity. Findings included: 1. Resident # 2 was admitted 9/5/2014. Her diagnoses included mood disorder, diabetes, hypertension, depression, gait abnormality and anxiety. The Minimum Data Set (MDS) dated 12/4/14 indicated she was moderately cognitively impaired, had adequate hearing, clear speech, was able to be understood and understood others. There were no behaviors exhibited and she rejected care 1-3 days out of 7 days. She required extensive assistance of one person for toilet use, dressing and personal hygiene, and physical help in part of bathing. She was always incontinent of bowel and bladder. During an interview on 2/5/15 at 4:00 pm, when	F 241	Resident concerns regarding the timeliness of staff answering call lights were addressed individually with resident #1 and resident #2 on February 27, 2015 by the Resident Care Coordinator. The Resident Care Coordinator shared the facility's plan of action to ensure that call lights are answered in a timely manner. All residents in the facility have a Department Manager assigned as their "Guardian Angel." Residents are asked during the week day Guardian Angel rounds if their needs are being met and if the call lights are answered in a timely manner. Resident care and call light concerns are immediately addressed and documented as a grievance to ensure appropriate follow up.	3/5/15	

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F 241	Continued From page 7 asked if staff treated her with dignity and respect, Resident #2 stated, " I had a fall when I was getting out of bed and slid down the side of the bed. The only thing that was hurt were my feelings. I first got up because I was trying to get someone ' s attention to help me. I rang the call bell. It was about 15 minutes that I was waiting. I spoke to someone yesterday about having to wait as long as an hour sometimes for the call light to be answered. I have a clock in my room that I can see directly in front of me that works. When I ring my bell it is because I need something like changing. It infuriates me to have to wait so long because I feel like they don ' t want to help me. Staff have also said things like ' You are a big woman. You are going to have to lose some weight. You are stout. ' It is very disrespectful how they speak about my size. They are so disrespectful sometimes. There is one [aide] on night shift that told me to shut up. I was asking for them to change me and told them I had been laying there 45 minutes waiting. She said ' shut up and just wait. ' That was about 3 weeks ago. I tell [the Patient Care Coordinator] just about every time it happens but it doesn ' t change. I have told her that I want a grievance form filled out. I never saw a form and no one ever has come back to talk to me about it at all. That night shift especially is a mess. I have told staff that I was going to complain and was told ' No one can do anything to me. ' I have had to holler out to get help and was told to stop hollering. They also comes in and turn my light off without asking what I need. The other night this week I turned on the light at 1:30 am and no one came until 5:30 am. I needed to be changed. I have told many staff about not being dry. " Resident #2 indicated during her interview that she has felt so disrespected and has been so frustrated, due to	F 241	Facility staff have been re-educated on the expectation to answer call lights in a timely manner to ensure the residents needs are being met and that their dignity is maintained. Newly hired facility staff will be educated during their orientation on the expectation to answer call lights in a timely manner to ensure their needs are being met and that their dignity is maintained. Call light response times will be monitored by utilizing a call light audit. The audit form will be completed by the Resident Care Coordinator to ensure call lights are being answered in a timely manner. The audit will be randomly performed during all		

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F 241	Continued From page 8 feeling ignored by staff and very lengthy wait times when she pushes her call bell, that she " has not been nice to [staff] at times " because of the level of her frustration. Resident #2 further indicated that staff response to call bell lights has not improved " at all " since the first time she mentioned her concerns to the Resident Care Coordinator " months ago. " During an interview on 2/5/15 at 4:30 pm with the Resident Care Coordinator, regarding Resident #2 ' s call bell concerns, she stated, " I remember [Resident #2] speaking of wait times on 3rd shift primarily. I did an in-service. It has been within the past month. I have only taken 2 concerns from her. One was during a resident council meeting and one was this week. " The Resident Care Coordinator indicated that she felt like the concerns had been resolved. 2. Resident #1 was originally admitted to the facility on 12/8/09 and most recently readmitted on 12/18/14. Her diagnoses included paraplegia and depression. The MDS dated 12/23/14 indicated she was cognitively intact, rejected care 1-3 of 7 days and did not have behaviors. She was totally dependent with toilet use and bathing and required extensive assistance with personal hygiene. She was always incontinent of bowel and bladder. She had adequate hearing and vision, clear speech, and was able to be understood and understands others. During an interview on 2/5/15 at 10:06 am, when asked if staff treated her with dignity and respect, Resident #1 stated, " They don ' t always treat me with respect. Sometimes when I ring my bell it takes 30 minutes to 1 hour for them to come in here to change me or to get me a drink. I have a clock and have my watch and can keep time, so I know how long it is. " An observation of the	F 241	three shifts and at different times during the shifts. The audit will be completed daily for 2 weeks, weekly for 10 weeks and then monthly x 3 months. Any concerns identified when completing the audit will be addressed immediately. The call light audit results will be reviewed monthly for a minimum of three (3) months in the facility's QA meeting. Any identified issues will be discussed and recommendations followed to ensure ongoing compliance and determine the need for further audits beyond three (3) months.		

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F 241	Continued From page 9 resident ' s room revealed a working clock on the wall, which indicated the correct time. The resident also was wearing a working watch, with the correct time, on her right wrist. The resident ' s family member, who was present in her room during the interview, indicated on 2/5/15 at 10:15 am that she visited Resident #1 regularly and has " more than once " seen the resident push her call bell and staff not respond and provide care for " 30 minutes to an hour. " She indicated this was a and on-going concern.	F 241			
F 319 SS=D	483.25(f)(1) TX/SVC FOR MENTAL/PYSCHOSOCIAL DIFFICULTIES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, nurse practitioner interview and physician interview the facility failed to recognize or identify the signs or symptoms of psychosocial adjustment to the nursing home and to her medical condition for 1 of 1 resident (Resident #3). Findings included: Resident #3 was admitted to the facility on 1/8/2015. Her diagnoses included Cerebral Artery Occlusion with infarct (stroke); late effects of Cerebrovascular Disease; Tracheostomy (breathing tube); Gastrostomy (feeding tube); Dysphagia (difficulty swallowing) due to	F 319	Resident #3 no longer resides at this facility. A review of all resident records will be completed by the Social Service Director/designee to identify their psychosocial needs. Careplans will also be reviewed and revised accordingly. The physician will be notified and a consult made for the facility's contracted mental health group for any resident found to have unaddressed needs.	3/5/15	

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NAME OF PROVIDER OR SUPPLIER SILAS CREEK REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3350 SILAS CREEK PARKWAY WINSTON-SALEM, NC 27103		
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F 319	<p>Continued From page 10</p> <p>Cerebrovascular Disease; Speech and Language deficit due to Cerebrovascular Disease; Lack of Coordination; Muscle Weakness; Hemiplegia (paralysis of one side of the body) Affect due to Cerebrovascular Disease; and Acute Respiratory Failure.</p> <p>A hospital discharge summary dated 1/8/2015 revealed Resident #3 experienced acute onset of speech difficulty, gaze to the right and weakness to the left face, upper and lower extremities on 12/16/2014. Resident #3 received thrombolytic therapy, intravenous Labetalol (used to treat high blood pressure) and required Ativan (antianxiety medication) for management of extreme agitation. A MRI (radiology exam) confirmed a large ischemic infarct (stroke). A Tracheostomy was placed on 12/23/2014 with oxygen therapy and a Gastrostomy was placed on 12/24/2014. The medication Klonopin (antianxiety) was discontinued at discharge.</p> <p>An Order for resident #3 dated 1/8/2015 read, Refer to Mental Health as needed.</p> <p>An Admission nurse note dated 1/8/2015 at 9:30 PM included (in part) hospitalized on 12/16/2014 for large right CVA with left side paralysis. ...New placement of Tracheostomy 12/23/2014. Restless and moves around in bed a lot.</p> <p>Nurse Note dated 1/10/2015 at 8:30 AM read, "[Resident #3] is very fearful."</p> <p>Nurse Note dated 1/11/2015 at 12:15 AM read, "[Resident #3] is non verbal this PM -tearful at intervals."</p> <p>Nurse Note dated 1/11/2015 at 4:27 AM read, "</p>	F 319	<p>Licensed nursing staff members have been re-educated on the correct procedure to notify the mental health group in an emergent situation should a resident's condition warrant.</p> <p>Newly hired Licensed Nurses will be educated during their orientation period on the correct procedure to notify the mental health group in an emergent situation should a resident's condition warrant.</p> <p>Prior to, or upon admission, the Director of Nurses or designee, will review available records to ensure the facility is able to meet the needs of each potential admission. The Interdisciplinary Team (IDT) will review new admissions records each morning in the daily stand-up meeting to determine the resident's needs to be addressed on the initial plan of care.</p> <p>The Social Service Director will complete chart audits on the newly admitted residents each week x 4 weeks, then every 2 weeks x 4 weeks to ensure their mental and</p>		

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F 319	<p>Continued From page 11</p> <p>She (Resident #3) is still fearful. "</p> <p>Nurse Note dated 1/12/2015 at 8:18 AM read, " ...she (Resident #3) still gets anxious especially during trach care. "</p> <p>Resident #3 was care planned on 1/12/2015 for dependent on staff for activities, cognitive stimulation, and social interaction related to physical limitations and immobility.</p> <p>The admission Minimum Data Set (MDS) dated 1/15/2015 coded Resident #3 as no speech for speech clarity; sometimes able to make self understood and understand others. Her vision was coded highly impaired. A staff assessment for mental status revealed Resident #3 ' s memory was intact and she was independent in cognitive skills for daily decision making. The MDS did not code any mood (e.g. fidgety or restlessness) or behaviors (e.g. hitting and kicking). Resident #3 ' s functional status was extensive assistance to total dependent on staff for activities of daily living. The care areas for psychosocial well-being, mood, and behaviors were not triggered for Resident #3 ' s plan of care.</p> <p>Nurse Note dated 1/16/2015 at 4:13 AM read, " [Resident #3] has episodes of restlessness. "</p> <p>Nurse Note dated 1/17/2015 at 9:55 PM included Resident #3 was hitting at [family], throwing her legs out of bed and slapping hand away. Resident #3 was on Klonopin (antianxiety medication) before the CVA and [written] in doctor communication book to see if Resident #3 needed something for withdraw. [Welbutrin antidepressant started]</p>	F 319	<p>psychosocial needs have been addressed and met. The results of the audits will be presented at the monthly QA meeting for minimum of three (3) months. The Quality Assurance and Performance Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three (3) months.</p>		

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F 319	<p>Continued From page 12</p> <p>Resident #3 was care planned on 1/18/2015 for impaired cognitive function or impaired thought processes related to late effects of the CVA (stroke). Approaches included: Resident #3 needed supervision/assistance with all decision making. Monitor/document/report to the physician any changes in (in part) difficulty expressing self.</p> <p>Resident #3 was care planned on 1/18/2015 for impaired visual function related to legal blindness.</p> <p>Resident #3 was care planned on 1/18/2015 for communication problems related to the Tracheostomy. Approaches included monitor for physical/non verbal indicators of discomfort or distress.</p> <p>Resident #3 was care planned on 1/18/2015 for oxygen therapy related to Tracheostomy status and Respiratory Failure. Approaches included (in part) monitor for signs and symptoms of respiratory distress which included restlessness.</p> <p>Resident #3 was care planned on 1/18/2015 for a Tracheostomy related to Respiratory Failure. Approaches included: (in part) ensure that trach ties are secure at all times and monitor for restlessness and agitation.</p> <p>Resident #3 was care planned on 1/18/2015 for limited physical mobility related to Muscle Weakness, Lack of Coordination related to late effects of CVA, CAD (coronary artery disease) and Respiratory Failure. Resident #3 had a potential for falls due to the above.</p> <p>On 1/18/2015 a nurse practitioner (NP) progress</p>	F 319		

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F 319	<p>Continued From page 13</p> <p>note included an impression/plan for Anxiety/Depression to start a low dose Welbutrin.</p> <p>Nurse Note dated 1/18/2015 at 3:48 PM read, Received orders for Welbutrin for anxiety.</p> <p>An Order dated 1/18/2015 Welbutrin 75 mg (milligrams) two times a day for anxiety, for 4 days. [Welbutrin caused nightmares]</p> <p>Nurse Note dated 1/18/2015 at 10:36 PM read, " Agitation noted this PM. Hitting at [family] and throwing her legs out of the bed. Very restless kicking legs out of the bed. "</p> <p>Nurse Note dated 1/19/2015 at 10:38 PM read, " Resident (Resident #3) agitation level increased hitting bed crying resident pulled out trach replaced by this writer ... " The nurse practitioner was at the bedside and orders were received for one time dose of Ativan.</p> <p>An Order dated 1/19/2015 included Ativan (antianxiety medication) 0.5 mg now x1 dose only, Klonopin (antianxiety medication) 0.25mg twice a day as needed for agitation for 5 days.</p> <p>A record review of Resident #3 ' s Medication Administration revealed Ativan for agitation was administered on 1/19/2015 at 8:38 PM as a one time only dose.</p> <p>Nurse Notes dated 1/20/2015 read, Resident #3 ' s family reported Resident #3 stated she fell out of bed on Sunday night 3rd shift and put herself back into the bed.</p> <p>On 1/20/2015 a NP progress note included an impression/plan Resident #3 was having</p>	F 319			

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F 319	<p>Continued From page 14</p> <p>nightmares since starting Welbutrin. She had the same side effect prior to admission when attempted. Welbutrin discontinued and Depakote (anticonvulsant medication used for behaviors) and Namenda (dementia medication) started. The NP noted that Resident #3 had a short course of Ativan.</p> <p>An Order dated 1/20/2015 included Depakote 250 mg twice a day; Namenda 5 mg daily and discontinue Welbutrin.</p> <p>Nurse Note dated 1/21/2015 at 2:48 PM read, " Restless and agitated throughout early AM hours. Thrashing around and banging bed rails and headboard. Pulled [oxygen] off over and over. Pulled trach out. Staff unable to calm resident. Bed lowered to lowest position. At 4 AM, while thrashing around, she rolled out of bed into the floor. "</p> <p>Nurse Note dated 1/21/2015 at 2:52 PM included Resident #3 pulled off her oxygen supply during an oral therapy trial ending the trial.</p> <p>Nurse Note dated 1/21/2015 9:03 PM read, " Agitation noted this PM hitting at family and throwing her legs out of bed. Very restless kicking legs out of bed. "</p> <p>A record review of Resident #3 ' s Medication Administration Record revealed one dose and the only dose of Klonopin, ordered as needed for a 6 day period, was administered on 1/21/2015 at 11:23 PM.</p> <p>An electronic medication administration record note dated 1/21/2015 at 11:23 PM noted restlessness.</p>	F 319			

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F 319	<p>Continued From page 15</p> <p>Nurse Note dated 1/24/2015 at 4:12 AM noted Resident #3 removed trach collar.</p> <p>Nurse Note dated 1/24/2014 at 8:25 AM included Resident #3 's [family] found the resident lying in bed with the entire Tracheostomy [tube] pulled out. Unsuccessful attempts were made to replace the tube. Resident #3 was transported to the hospital and the current size 6 tube could not be replaced and was replaced with a smaller size 4.</p> <p>A review of hospital records dated 1/24/2015 revealed trach stoma was intact and trach was absent. Resident #3 pulled trach out sometime during the night and it was replaced with a size 4.</p> <p>Nurse Note 1/25/2015 at 12:27 AM included pain medication was given to Resident #3 for a complaint of left hip pain. Resident #3 's family insisted the physician be called due to pain in Resident #3 's left hip and agitation. Medications and radiology exams were ordered. The family requested to have Resident #3 taken to the hospital for further evaluation.</p> <p>A Nurse Note dated 1/25/2015 at 2:47 PM revealed the family of Resident #3 requested she go to the hospital for a neurological evaluation. Resident #3 transported.</p> <p>An interview on 2/4/2015 at 2:37 PM with Nurse #7 revealed Resident#3 's behavior was " all over the place. " Nurse #7 pulled at everything a lot of times e.g. wound dressing, gtube, trach, and trach dressing.</p> <p>An interview on 2/4/2015 at 4:24 PM with Nurse #6 revealed Resident #3 was anxious and always</p>	F 319			

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F 319	<p>Continued From page 16</p> <p>grabbing at stuff, throwing her legs off the bed, hitting family, and thrashing. On 1/25/2015 Resident #3 pulled at her trach. Nurse #6 revealed Resident #3 's family suggested she go to the hospital for an evaluation because something was not right.</p> <p>An interview on 2/4/2015 at 4:58 PM with Nurse #1 revealed Resident #3 was young, restless, frustrated, and had trouble communicating. Nurse #1 reported Resident #3 was anxious every time she coughed and when Nurse #1 was suctioning the trach. The family was very nervous and here daily. Resident #3 would turn from side to side and would hang her leg out. An additional interview on 2/5/2015 at 3:19 PM revealed Resident #3 was agitated, situational, and would throw her leg out of bed forcefully. Nurse #1 reported she talked to the family and they informed her she was on an antidepressant, (verbalized) Klonopin prior to admission. Nurse #1 reported she thought Resident #3 was having withdrawals from Klonopin. During the conversation with the family Resident #3 put her thumbs up (indicating yes) when talking about Klonopin. Nurse #1 felt like Resident #3 wanted to be on Klonopin. When asked about her (Nurse #1) ability to provide a different means of intervention/evaluation she replied she would need a physician order for a psychiatric consult. Nurse #1 reported Resident #3 was all over the place and she had discussed with family in depth about her behaviors. Nurse #1 reported Resident #3 would have benefited from a medication.</p> <p>An interview on 2/5/2015 at 10:35 AM with Nurse #4 revealed Resident #3 's behaviors were irritable at times, grabbing at rails and trach. She complained of being uncomfortable. Nurse #1 did</p>	F 319			

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F 319	<p>Continued From page 17</p> <p>not feel the behavior was consistent and reported repositioned her or provide her pain medication and she was fine.</p> <p>An interview on 2/5/2015 at 11:42 AM with Nurse #9 revealed at 4:00 AM Sunday/Monday a nurse assistant informed Nurse #9 that Resident #3 was on the floor. She was positioned on her left side, her left arm was bent back, and her head was resting on her left arm. Staff put her back in bed. An additional interview at 2:00 PM revealed Nurse #9 was aware of Resident #3's behaviors (documented as restless and agitated in nurse notes) and when she mentioned the behaviors to the first shift nurse (Nurse #6) the nurse said Resident #3 did it all the time.</p> <p>An interview on 2/5/2015 at 8:00 AM with the occupational therapy assistant who worked with Resident #3 revealed Resident #3 would always fidget and wiggle in the bed.</p> <p>An interview on 2/5/2015 at 11:20 AM with Resident #3's physical therapist revealed Resident #3 could not use the left side of her body and it was not possible for her to get herself back in the bed from the floor. She reported Resident #3 was capable of throwing herself out of the bed. The physical therapist reported she would not leave Resident #3 unattended when she was up in the chair.</p> <p>An interview on 2/5/2015 at 2:06 PM with the Unit Manager revealed Resident #3 kept her legs out of the bed and pulled and tugged at everything. The Unit Manager reported when she went in to provide care Resident #3's family had to hold her arm still. The Unit Manager reported she did not feel Resident #3 was as aware of things as</p>	F 319			

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F 319	<p>Continued From page 18</p> <p>they [the family] thought she was or she was doing it intentionally. The Unit Manager reported Resident #3 's behavior was more anxiety than twitching. " It was an anxiety. " The Unit Manager reported the day Resident #3 went to the emergency room there was no apparent reason for her to go.</p> <p>An interview on 2/5/2015 at 2:41 PM with the facility Nurse Practitioner (NP) revealed Resident #3 had decannulated herself twice and there was a concern if her behaviors were stroke v/s mood stabilization. The NP revealed she did order the Ativan because Resident #3 was really agitated. Depakote was the first line medication for mood stabilization of a resident who had a stroke. Benzodiazepine (Ativan) used to treat anxiety disorders were a last result. The NP reported Resident #3 had weaned herself off Benzodiazepines [Klonopin] prior to her arrival to the facility.</p> <p>An interview on 2/5/15 at 3:45pm with Nurse #8 " If a resident was exhibiting increased anxiety/behaviors we are able to get an emergent psych [mental health] consult. At the very least we should call and notify the doctor. "</p> <p>An interview on 2/5/2015 at 3:20 PM with the Medical Director revealed the facility had a mental health group contracted for the residents at the facility. The question was how to manage because the trend in skilled nursing facilities was to avoid psychotropic (mood altering) medications. The physician reported that the mental health consult had not been done. There was an automatic [standing order] consult for behaviors and the consultant could come see a resident emergently if requested. The physician</p>	F 319			

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F 319	Continued From page 19 was unaware of the frequency of Resident #3 ' s behaviors and reported the staff did not inform her. She would have expected a consult for Resident #3 based on nurse notes. An interview on 2/5/15 at 3:20 PM with the Director of Nursing indicated there was no referral made to psychiatric services [mental health] and stated, " She was a resident [Resident #3] that I felt like we were just trying to get settled medically before we addressed the behaviors. "	F 319			
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	Resident #3 no longer resides at this facility. A facility wide audit will be completed to identify residents receiving psychotropic medication and ensure those residents have appropriate psychosocial assessments and interventions implemented prior to the administration of psychotropic medications. Resident careplans will be reviewed and updated to reflect the interventions to be used.	3/5/15	

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F 329	<p>Continued From page 20</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, nurse practitioner interview, and physician interview the facility failed to implement psychosocial interventions to address behaviors associated with 1 of 1 resident (Resident #3) adjustment to the nursing home and a new medical condition prior to the administration of psychotropic medications: Ativan, Welbutrin, Depakote, and Namenda.</p> <p>Findings included:</p> <p>Resident #3 was admitted to the facility on 1/8/2015. Her diagnoses included Cerebral Artery Occlusion with infarct (stroke); late effects of Cerebrovascular Disease; Tracheostomy (breathing tube); Gastrostomy (feeding tube); Dysphagia (difficulty swallowing) due to Cerebrovascular Disease; Speech and Language deficit due to Cerebrovascular Disease; Lack of Coordination; Muscle Weakness; Hemiplegia (paralysis of one side of the body) Affect due to Cerebrovascular Disease; and Acute Respiratory Failure.</p> <p>A hospital discharge summary dated 1/8/2015 revealed Resident #3 experienced acute onset of speech difficulty, gaze to the right and weakness to the left face, upper and lower extremities on 12/16/2014. Resident #3 received thrombolytic therapy, intravenous Labetalol (used to treat high blood pressure) and required Ativan (antianxiety medication) for management of extreme agitation. A MRI (radiology exam) confirmed a large ischemic infarct (stroke). A Tracheostomy</p>	F 329	<p>Nursing staff will be re-educated on the process of implementing and documenting these interventions prior to the usage of psychotropic medications. Newly hired Licensed Nurses will be educated during their orientation period on the process of implementing and documenting these interventions prior to administering psychotropic medications.</p> <p>The Interdisciplinary team will assess and monitor the appropriateness of the psychotropic medications and the effectiveness of the psychosocial interventions for each resident via the Minimum Data Set (MDS) process. Monthly, the Consultant Pharmacist reviews both the psychotropic medications and interventions as part of each drug regimen review. If, at anytime during the assessment or monitoring process the psychosocial interventions are</p>		

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F 329	<p>Continued From page 21</p> <p>was placed on 12/23/2014 with oxygen therapy and a Gastrostomy was placed on 12/24/2014. The medication Klonopin (antianxiety) was discontinued at discharge.</p> <p>Physician Orders for resident #3 dated 1/8/2015 Refer to Mental Health as needed.</p> <p>An Admission nurse note dated 1/8/2015 at 9:30 PM revealed (in part) hospitalized on 12/16/2014 for large right CVA with left side paralysis. ...New placement of Tracheostomy 12/23/2014. Restless and moves around in bed a lot.</p> <p>Nurse Note dated 1/10/2015 at 8:30 AM read, "[Resident #3] is very fearful. "</p> <p>Nurse Note dated 1/11/2015 at 12:15 AM read, "[Resident #3] is non verbal this PM -tearful at intervals. "</p> <p>Nurse Note dated 1/11/2015 at 4:27 AM read, " She (Resident #3) is still fearful. "</p> <p>Nurse Note dated 1/12/2015 at 8:18 AM read, "...she (Resident #3) still gets anxious especially during trach care. "</p> <p>Resident #3 was care planned on 1/12/2015 for dependent on staff for activities, cognitive stimulation, and social interaction related to physical limitations and immobility.</p> <p>The admission Minimum Data Set (MDS) dated 1/15/2015 coded Resident #3 as no speech for speech clarity; sometimes able to make self understood and understand others. Her vision was coded highly impaired. A staff assessment for mental status revealed Resident #3 's</p>	F 329	<p>found to be lacking or inappropriate, the Director of Nurses will be notified and the Interdisciplinary Team (IDT) will make the needed changes and update the resident's careplan.</p> <p>The Director of Nurses or designee will complete audits of 5 resident records receiving psychotropic medications to ensure non-pharmacological interventions are utilized prior to administering the medications. Audits will be conducted weekly for one month, then monthly for a minimum of three (3) months. The Director of Nurses will report the results of the audits to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits and make recommendations to ensure compliance will be sustained ongoing; and determine the need for further auditing beyond the three (3) months."</p>		

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F 329	<p>Continued From page 22</p> <p>memory was intact and she was independent in cognitive skills for daily decision making. The MDS did not code any mood (e.g. fidgety or restlessness) or behaviors (e.g. hitting and kicking). Resident #3 ' s functional status was extensive assistance to total dependent on staff for activities of daily living. The care areas for psychosocial well-being, mood, and behaviors were not triggered for Resident #3 ' s plan of care.</p> <p>Nurse Note dated 1/16/2015 at 4:13 AM read, " [Resident #3] has episodes of restlessness. "</p> <p>Nurse Note dated 1/17/2015 at 9:55 PM included Resident #3 was hitting at [family], throwing her legs out of bed and slapping hand away. Resident #3 was on Klonopin (antianxiety medication) before the CVA and [written] in doctor communication book to see if Resident #3 needed something for withdraw. [Welbutrin antidepressant started]</p> <p>Resident #3 was care planned on 1/18/2015 for impaired cognitive function or impaired thought processes related to late effects of the CVA (stroke). Approaches included: Resident #3 needed supervision/assistance with all decision making. Monitor/document/report to the physician any changes in (in part) difficulty expressing self.</p> <p>On 1/18/2015 a Nurse Practitioner (NP) progress note included an impression/plan for Anxiety/Depression to start a low dose Welbutrin.</p> <p>Nurse Note dated 1/18/2015 at 3:48 PM read, Received orders for Welbutrin for anxiety.</p> <p>An Order dated 1/18/2015 Welbutrin 75 mg</p>	F 329			

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F 329	<p>Continued From page 23</p> <p>(milligrams) two times a day for anxiety, for 4 days. [Welbutrin caused nightmares]</p> <p>Nurse Note dated 1/18/2015 at 10:36 PM read, " Agitation noted this PM. Hitting at [family] and throwing her legs out of the bed. Very restless kicking legs out of the bed. "</p> <p>Nurse Note dated 1/19/2015 at 10:38 PM read, " Resident (Resident #3) agitation level increased hitting bed crying resident pulled out trach replaced by this writer ... " and included the nurse practitioner was at the bedside and orders were received for one time dose of Ativan.</p> <p>An Order dated 1/19/2015 Ativan (antianxiety medication) 0.5 mg now x1 dose only, Klonopin (antianxiety medication) 0.25mg twice a day as needed for agitation for 5 days.</p> <p>A record review of Resident #3 ' s Medication Administration revealed Ativan for agitation was administered on 1/19/2015 at 8:38 PM as a one time only dose.</p> <p>Nurse Notes dated 1/20/2015 read, Resident #3 ' s family reported Resident #3 stated she fell out of bed on Sunday night 3rd shift and put herself back into the bed.</p> <p>On 1/20/2015 a NP progress note included an impression/plan Resident #3 was having nightmares since starting Welbutrin. She had the same side effect prior to admission when attempted. Welbutrin discontinued and Depakote (anticonvulsant medication used for behaviors) and Namenda (dementia medication) started. The NP noted that Resident #3 had a short course of Ativan.</p>	F 329		

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F 329	<p>Continued From page 24</p> <p>An Order dated 1/20/2015 included Depakote 250 mg twice a day; Namenda 5 mg daily and discontinue Welbutrin.</p> <p>Nurse Note dated 1/21/2015 at 2:48 PM read, " Restless and agitated throughout early AM hours. Thrashing around and banging bed rails and headboard. Pulled [oxygen] off over and over. Pulled trach out. Staff unable to calm resident. Bed lowered to lowest position. At 4 AM, while thrashing around, she rolled out of bed into the floor. "</p> <p>Nurse Note dated 1/21/2015 at 2:52 PM included Resident #3 pulled off her oxygen supply during an oral therapy trial ending the trial.</p> <p>Nurse Note dated 1/21/2015 9:03 PM read, " Agitation noted this PM hitting at family and throwing her legs out of bed. Very restless kicking legs out of bed. "</p> <p>An electronic medication administration record note dated 1/21/2015 at 11:23 PM noted restlessness.</p> <p>A record review of Resident #3 's Medication Administration Record revealed one dose and the only dose of Klonopin, ordered as needed for a 6 day period, was administered on 1/21/2015 at 11:23 PM. Welbutrin was administered 4 times between 1/18/2015 and 1/20/2015. Depakote for behaviors and Namenda for anxiety were ordered as daily medications administration was started on 1/21/2015 through discharge on 1/25/2015.</p> <p>Nurse Note dated 1/24/2015 at 4:12 AM noted Resident #3 removed trach collar.</p>	F 329			

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F 329	<p>Continued From page 25</p> <p>Nurse Note dated 1/24/2014 at 8:25 AM included Resident #3 's [family] found the resident lying in bed with the entire Tracheostomy [tube] pulled out. Unsuccessful attempts were made to replace the tube. Resident #3 was transported to the hospital and the current size 6 tube could not be replaced and was replaced with a smaller size 4.</p> <p>An interview on 2/4/2015 at 4:58 PM with Nurse #1 revealed Resident #3 was young, restless, frustrated, and had trouble communicating. Nurse #1 reported Resident #3 was anxious every time she coughed and when Nurse #1 was suctioning the trach. The family was very nervous and here daily. Resident #3 would turn from side to side and would hang her leg out. An additional interview on 2/5/2015 at 3:19 PM revealed Resident #3 was agitated, situational, and would throw her leg out of bed forcefully. Nurse #1 reported she talked to the family and they informed her she was on an antidepressant, (verbalized) Klonopin prior to admission. Nurse #1 reported she thought Resident #3 was having withdrawals from Klonopin. During the conversation with the family Resident #3 put her thumbs up (indicating yes) when talking about Klonopin. Nurse #1 felt like Resident #3 wanted to be on Klonopin. When asked about her (Nurse #1) ability to provide a different means of intervention/evaluation she replied she would need a physician order for a psychiatric consult. Nurse #1 reported Resident #3 was all over the place and she had discussed with family in depth about her behaviors. Nurse #1 reported Resident #3 would have benefited from a medication.</p> <p>An interview on 2/5/2015 at 10:35 AM with Nurse #4 revealed Resident #3 's behaviors were</p>	F 329			

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F 329	<p>Continued From page 26</p> <p>irritable at times, grabbing at rails and trach. She complained of being uncomfortable. Nurse #1 did not feel the behavior was consistent and reported repositioned her or provide her pain medication and she was fine.</p> <p>An interview on 2/5/2015 at 11:42 AM with Nurse #9 revealed at 4:00 AM Sunday/Monday a nurse assistant informed Nurse #9 that Resident #3 was on the floor. She was positioned on her left side, her left arm was bent back, and her head was resting on her left arm. Staff put her back in bed. An additional interview at 2:00 PM revealed Nurse #9 was aware of Resident #3 ' s behaviors (documented as restless and agitated in nurse notes) and when she mentioned the behaviors to the first shift nurse (Nurse #6) the nurse said Resident #3 did it all the time.</p> <p>An interview on 2/5/2015 at 2:06 PM with the Unit Manager revealed Resident #3 kept her legs out of the bed and pulled and tugged at everything. The Unit Manager reported when she went in to provide care Resident #3 ' s family had to hold her arm still. The Unit Manager reported she did not feel Resident #3 was as aware of things as they [the family] thought she was or she was doing it intentionally. The Unit Manager reported Resident #3 ' s behavior was more anxiety than twitching. " It was an anxiety. "</p> <p>An interview on 2/5/2015 at 2:41 PM with the facility NP revealed Resident #3 had decannulated herself twice and there was a concern if her behaviors were stroke v/s mood stabilization. The NP revealed she did order the Ativan because Resident #3 was really agitated. Depakote was the first line medication for mood stabilization of a resident who had a stroke.</p>	F 329		
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F 329	<p>Continued From page 27</p> <p>Benzodiazepine (Ativan) used to treat anxiety disorders were a last result. The NP reported Resident #3 had weaned herself off Benzodiazepines [Klonopin] prior to her arrival to the facility.</p> <p>On 2/5/15 at 3:45 PM Nurse #8 said, " If a resident was exhibiting increased anxiety/behaviors we are able to get an emergent psych [mental health] consult. At the very least we should call and notify the doctor. "</p> <p>An interview on 2/5/2015 at 3:20 PM with the Medical Director revealed the facility had a mental health group contracted for the residents at the facility. The question was how to manage because the trend in skilled nursing facilities was to avoid psychotropic medications (mood altering). The physician reported that the mental health consult had not been done. There was an automatic [standing order] consult for behaviors and the consultant could come see a resident emergently if requested. The physician was unaware of the frequency of Resident #3 ' s behaviors and reported the staff did not inform her. She would have expected a consult for Resident #3 based on nurse notes.</p> <p>On 2/5/15 at 3:20 PM the Director of Nursing reported there was no referral made to psychiatric services [mental health] and stated, " She was a resident [Resident #3] that I felt like we were just trying to get settled medically before we addressed the behaviors. "</p>	F 329		