DEPARTMENT OF HEALTH CENTERS FOR MEDICARE			PRINTED:6/30/2015 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 115385	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/21/2014
NAME OF PROVIDER OF SU PRUITTHEALTH - CRESTV		STREET ADDRES 415 PENDLETON	S, CITY, STATE, ZIP PLACE
	1 1 1 4 4 4 1 6 1	VALDOSTA, GA	
(X4) ID PREFIX TAG	1	cy, please contact the nursing home or the state surve EFICIENCIES (EACH DEFICIENCY MUST BE PI	
	OR LSC IDENTIFYING INFORM		
F 0157 Level of harm - Immediate jeopardy	of situations (injury/decline/roo **NOTE- TERMS IN BRACKET Based on clinical record review, f immediately consult with the phy	S HAVE BEEN EDITED TO PROTECT CONFIDE acility investigation summary review, and staff interv sician related to the sudden onset of verbal threats and	NTIALITY** iew, the facility failed to 1 aggression of one (1) resident
Residents Affected - Few	immediately consult with the phy (Resident #1), who made multiple #1), on the total survey sample of [DIAGNOSES REDACTED]. Int having no behaviors observed/reported ft that Resident #1's mood, [MEDIC Resident #1 ams going to get her, and #2 were a change in behavior and of Resident #1's aggressive behavior that Resident #1's aggressive behavior estima, having no pulse, and willed Resident #2, and Resident #3 situation in which the facility's no cause, serious harm, injury, impai informed of the immediate jeopar was identified to have existed on roommate, Resident #2, after Res neck, and nine (9) days after Nov. #1's voiced threats against Reside November 21, 2014. The facility' November 20, 2014. During an in Administrator acknowledged the Resident #2, but also acknowledg allegation of jeopardy removal wa and implemented by the facility y deficient practice was determined lower scope and severity of D wh resident behaviors, resident screen updating and implementation regg accordance with facility policies a with staff to ensure they were kno reporting of resident behavioral cl records were reviewed to ensure t residents, including the developm Resident #1's Admission Minimu which included, but were not limi [MEDICAL CONDITION] Disorder ([MEDIC Resident #1 was refusing care and escalating behaviors. In a 09/29/2 Resident #1 was refusing care and escalating behaviors. In a 09/29/2 Resident #1 was combative and n 10/01/2014 through 10/21/2014 d a 10/28/2014 Physician's Progress table. However, an 11/02/2014, 11:00 a.m. N pulse, and an electric cord around Medical Services and a police off involving Resident #2 (as docume on 11/02/2014, staff observed Res The facility IS documented that Res rift and usenally threatening o during the 11/18/2014, 12:45 p.m. Resident #2 Awas an ew behavior, 11/02/2014 regarding Resident #2. Resident #2 was an ew behavior, 11/02/2014 regarding Resident #2 interview, the Administrator ackn when she made multiple verbal th		I aggression of one (1) resident dent #2, the roommate of Resident e facility on [DATE] with ehaviors. Resident #1 was documented as 4 Physician's Progress Note documented DITION] were stable. However, on 11/02/2014, Resident #2, including If you don't 's verbal threats against Resident physician to inform the physician taff discovered Resident #2 not do to facility staff that she had uggravated assault. This resulted in a aused, or had the likelihood to tor and Corporate Consultant were liance related to the immediate jeopardy ented as stating she had killed her and with an electric cord around her entions in response to Resident vember 20, 2014, and was removed on a leated to the immediate jeopardy on ber 19, 2014 at 1:40 p.m., the was reported to have verbally threatened arding this change in behavior. An ective plans which had been developed nher 20, 2014, the immediacy of the actility remained out of compliance at a sight of staffs' monitoring of gram as indicated, resident Care Plan of resident behavioral changes, in reviewed. Interviews were conducted verning resident monitoring and the ensure resident safty. Resident flected the current status of gressive behaviors. Findings include: genoses, in Section 1 - Active Diagnoses, lux Disease, Diabetes Mellitus, and Skilled Nurses Notes (DSNN) entry for an's orders [REDACTED]. A 09/06/2014, 5:30 fused to take any medications. DSNN 99/16/2014, 11:30 a.m. DSNN entry 7:00 a.m. DSNN
REPRESENTATIVE'S SIGNA		TILL	(no) bill

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.

NTERS FOR MEDICARE	& MEDICAID SERVICES		FORM APPROVED OMB NO. 0938-0391
ATEMENT OF FICIENCIES D PLAN OF RRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 115385	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/21/2014
ME OF PROVIDER OF SU		STREET ADDRE	ESS, CITY, STATE, ZIP
JITTHEALTH - CRESTV	VOOD	415 PENDLETO VALDOSTA, GA	N PLACE A 31602
information on the nursing (4) ID PREFIX TAG	· ·	cy, please contact the nursing home or the state surv DEFICIENCIES (EACH DEFICIENCY MUST BE I	
0157	(continued from page 1)		
evel of harm - Immediate sopardy sesidents Affected - Few	with an electric cord unplugged a IS report further documented that that Resident #2's trachea was cru documented that on 11/13/2014, 1 above, Resident #1 was admitted behavioral problems including sla of threatening other residents. Nu and on 10/28/2014, the physician and mood were stable. However, despite Re threats against Resident #2 on 11/	/2014, upon responding to the room of Resident #2, nd on or near the resident's neck, and having no resp , based on sources close to the police department, R ished. This IS documented Resident #1 told a nurse Resident #1 was arrested and charged with felony m on [DATE] having [DIAGNOSES REDACTED]. R upping staff and pulling staffs' hair, but was not initi- rsing notes entries for October of 2014 documented noted Resident #1's [MEDICAL CONDITION] Dis sident #1 then exhibiting a significant change in beh '02/2014, the facility failed to consult with the physi- 1. Then, on 11/11/2014. Resident #2 was found in H	pirations and no pulse. This facility esident #2's autopsy report concluded consultant she killed Resident #2, and urder and aggravated assault. Based on the tesident #1 was documented to have exhibite ally documented to have a history Resident #1's behaviors had lessened, order, [MEDICAL CONDITION], Dementi avior by making multiple verbal cian regarding this significant
	threats against Resident #2 on 11/ change in behavior for Resident # neck, not breathing and having no and was charged with felony mur and Resident #2. The facility pres determined that the immediate jet interventions: 1. On 11/11/2014, 1 one-to-one staff observation until Interdisciplinary Team (consisting Services Director) completed Bef behavior screening had been initi- had physical or verbal behaviors i monitoring of these residents and have a behavior screen done upor behavior. 3. On 11/13/2014, the f Care Plans of all residents having needed, based on these reviews. F condition, and with any new beha record, making no recommendati Team would screen and review al admissions, and no resident woulf for aggressive or physical behavid Admission Audit Tool, which doo Notes/MR notation; any Consulta implemented a new procedure by Resident Behavioral Symptom Sc accuracy and completion of these the Behavior Management Docur this Form. This Form (a previous) Management Program, the trackin newly developed interventions. In the Behavior Management Log F ensure accuracy and completion cor doministrator dating and signing procedure by which a designated Support Unit on the hallways and Form allows for the documentatic Nurse and the identity of the staff Nurse and the identity of the staff were i observations of resident abuse. TI addressed how to identify abuse b patterns of behaviors. Staff were i batterns of behaviors. Staff were i huserkeepers; four (4) of five (5) Registered Nurses; seven (7) of si Partner, and MDS Nurse) that did Director, Financial Counselor, M. CNA staff, one (1) LPN staff, two Registered Nurse who had not be their return to work, and will not im-service is completed. 11. On 1 physician of a change in condition and seven (7) of eight (8) Registered huirs ewing receive training u re		cian regarding this significant ter room with an electric cord around her illed Resident #2, and was arrested nore information regarding Resident #1 JR) on 11/20/2014, and it was he facility had implemented the following dent #1 was immediately placed on 1/13/2014, the facility's retrosnnel, LPN Supervisor, and Social / resident. This process of resident is process and identified as having Monitoring Program, to ensure the ere necessary. All residents will ge in status, and with any new initially begun on 11/12/2014, of the onth. These Care Plans were revised as alally, with a significant change in tor reviewed Resident #1's medical rocedure by which the Interdisciplinary /ould apply to all new resident s mental condition and the potential ew will be documented on the nd Physical; PASRR Level II; Nurse' On 11/20/2014, the facility audit of a minimum of 10 percent of the in behavioral management, to ensure the hly audit of a minimum of 10 percent of or or seidents in the Behavior ntions, and the documentation of any audit of a minimum of 10 percent of a Behavior Management Program, to erved behaviors, including agitated or ove will be documented by the 1/20/2014, the facility implemented a ing Form, continuous rounds in the Memory the behavior. This Behavior Monitoring of the behavior(s) to the Charge the nurse of verification. If, during erved, this staff member was to intervene e Charge Nurse. This monitoring was the Memory Support Unit to begin the the process of reviewing resident eview revealed three (3) residents having Dne (1) of these residents was seen by a ning two (2) residents, identified with trist. On 11/20/2014, the facility' make a copy of each resident's PASRR, .9. On 11/20/2014, the facility' seer of areas. In-service training also tg, showing signs of being afraid, or abuse would be protected from any pyropriate. Staff were advised of istrator, who would then report the g was also provided regarding ture/certification verification. As of -service training. This number included aff; nine (9) of

EPARTMENT OF HEALTH AND HUMAN SERVICES ENTERS FOR MEDICARE & MEDICAID SERVICES			PRINTED:6/30/2015 FORM APPROVED OMB NO. 0938-0391	
FATEMENT OF EFICIENCIES ND PLAN OF ORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/21/2014	
ME OF PROVIDER OF SU	115385   PPLIER	STREET ADDR	ESS, CITY, STATE, ZIP	
UITTHEALTH - CRESTV	WOOD	415 PENDLETO VALDOSTA, G		
r information on the nursing	home's plan to correct this deficien	cy, please contact the nursing home or the state sur		
X4) ID PREFIX TAG	SUMMARY STATEMENT OF I OR LSC IDENTIFYING INFOR	DEFICIENCIES (EACH DEFICIENCY MUST BE MATION)	PRECEDED BY FULL REGULATORY	
F 0157	(continued from page 2)			
Level of harm - Immediate eopardy	monitor staff compliance with the aggressive behaviors which could	inistrator or Director of Health Services. This proce e facility's policies and procedures regarding residen have the potential to lead to resident abuse. Audit	nts having verbal and/or physically results will also be presented to the	
Residents Affected - Few	policies and procedures related to notification, and resident monitor actions implemented by the facili review of facility investigative de one-to-one observation on 11/11/ Step #1 of the CAJR referenced a which had been ongoing through screenings on residents for the pu- indicated in Step #2 of the CAJR which had been ongoing through reviewed and updated by the Inte accordance with Step #3 of the C that the Medical Director had rev the facility on [DATE]. This was a.m., a telephone call had been pl interview with the Administrator resident admissions, with no resis aggressive behaviors can be asses the Administrator, DON, ADON, accordance with Step #5 of the C Administrator confirmed that the Screening forms, the Behavior M for resident requiring behavioral On 11/21/2014, a 9:55 a.m. obser ongoing and continuous rounds fo documented on the Behavior Mo process of ongoing, continuous rule referenced above On 11/21/201 survey, was completed and verifi with the appropriate follow-up fo an 11/21/2014, 10:45 interview w referenced above On 11/21/201 survey, was completed nursing staff, Director, and the Admissions Cov yet completed this in-service train of the CAJR referenced above 4 Inservice Report Sign-In Sheet For specific for licensed nursing staff, Director, and the Admissions Cov yet completed this in-service train of the CAJR referenced above 4 Inservice documentation, to incli- conducted additional staff in-serv physician for changes in conditio will receive training upon their re 11/21/2014, an 11:20 a.m. intervi CAJR intended to provide ongoin residents having behavioral probl- this care. This was in accordance we phoredure y threefore, the not be fully evaluated at the time facility implemented a new proce continuous rounds in the Memory behavior. The use of this Behavior the 11/21/2014 date of survey exi of this Form and concomitant mo future date. In addition, on 11/20, training which included abuse pri subreviated survey; therefore, the not be fully evaluated at the time facility implement	y for the Committee's review and oversight of facili to the management of resident behaviors, the screeni ing. During this abbreviated survey, the State Surve ty, as reflected in the CAJR referenced above, with 2014 immediately after the incident involving Resi- bove On 11/21/2014, a sampled review of reside- bout the abbreviated survey, revealed that the Interdi tropse of ensuring appropriate resident placement in referenced above On 11/21/2014, a sampled revi- volt the abbreviated survey, was completed and veri rdisciplinary Team, as related to physically/verbally AJR referenced above On 11/21/2014, review of iewed Resident #1's medical record and submitted 1 in accordance with Step #4 of the CAJR referenced aced to Resident #1's medical record and submitted 1 in accordance with Step #4 of the CAJR referenced aced to Resident #1's physician, but the physician of 11:20 a.m. confirmed that the Interdisciplinary T lent being admitted until a review of the resident's 1 sed. This review will be documented using the Adr Admissions Personnel, an LPN Supervisor, and th AJR referenced above On 11/21/2014, facility do Administrator will be conducting monthly audits or magement services. This was in accordance with vation on the Secured Unit confirmed the presence or the purpose of observing for any resident aggress nitoring Form. In addition, it was confirmed by inte unds will be a permanent intervention. This was in at 4, a sampled review of resident records, which had ed that the Interdisciplinary Team had reviewed all residents needing additional psychiatric services. Tith a Corporate Nursing Consultant. This was in ac 4, review of facility staff in-service do crm review, revealed that the facility had conducted and CNA staff, regarding resident abuse and the Behavior ing will receive training upon their return to work. On 11/21/2014, review of facility staff in-service do rm review, revealed that the facility had conducted orth Astep #10 of the CAJR referenced above On 11 ude facility linservice Repo	ng of resident behaviors, physician ey Agency reviewed the corrective findings as follow: - On 11/21/2014, a Resident #1 was immediately placed on dent #1 and Resident #2, as indicated in nt records completed on that date, but sciplinary Team had conducted behavioral 1 the Behavioral Monitoring Program, as ew of multiple resident records, but fied that resident Care Plans had been y aggressive behaviors. This was in facility investigative documents confirmed a written summary of this information to 1 above. (Of note, on 11/20/2014 at 11:12 leclined interview.) - On 11/21/2014, 'eam will screen and review all new medical condition and potential for mission Audit Tool. This Team will include e Social Services Director. This was in cument review and interview with the f the Resident Behavioral Symptom anagement Log Forms, and resident Care Plan Step #6 of the CAJR referenced above of an assigned staff member to conduct sive behaviors. These rounds were rview with the Administrator that this accordance with Step #7 of the CAJR been ongoing throughout the abbreviated resident PASRR Level II Assessments, This action was also confirmed during cordance with Step #8 of the CAJR to include facility Inservice Report raining for staff, including (but not cal Records staff, the Maintenance r Management Policy. All staff having not This was in accordance with Step #9 becumentation, to include facility 1 additional staff in-service training, ement policies and the documentation of ceive training upon their return to 21/2014, review of facility staff view, revealed that the facility staff view, revealed that the facility staff view, revealed that the facility and admissions, and no resident will be or aggressive or physical behaviors ission Audit Tool. This was, however, a the 11/21/2014, exit date of this this newly-implemented procedure could ture date. On 11/20/2014, the (33) of en (11) housekeepers, four (4) of 7) of eight (8) Registered Mirse having /20/2014, hirty-three (33) of en (11) housekeepers, four (4) of 7) of	
	receive this in-service training up yet remaining to receive in-servic not be assessed at the time of sur- future evaluation and assessment assessment, supervision, and mor training regarding these issues, th	gistered Nurses, but the remaining three (3) LPN si on their return to work. Therefore, due to multiple i e training at the time of survey exit, their completic vey exit, and will need to be evaluated at a future tin of the facility's ongoing compliance with newly-im itoring of residents having aggressive behaviors, to e noncompliance continues, with the scope and sev	licensed and certified staff members on of this required training could me. Therefore, due to the need for plemented procedures regarding the b include pending staff in-service	
F 0282		as according to each resident's written plan of ca		
Level of harm - Immediate eopardy	**NOTE- TERMS IN BRACKET Based on clinical record review, t	IS HAVE BEEN EDITED TO PROTECT CONFIL facility investigation summary review, and staff into are Plan, related to verbal threats and aggression ex	DENTIALITY** erview, the facility failed to provide	
Residents Affected - Few ORM CMS-2567(02-99) evious Versions Obsolete	Event ID: YL1011	Facility ID: 115385	If continuation sheet Page 3 of 18	

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IAME OF PROVIDER OF SU PRUITTHEALTH - CRESTV	IPPLIER	STREET ADDRESS 415 PENDLETON	S, CITY, STATE, ZIP PLACE	
		VALDOSTA, GA 3 cy, please contact the nursing home or the state survey	1602	
(X4) ID PREFIX TAG		DEFICIENCIES (EACH DEFICIENCY MUST BE PRI	· · ·	
F 0282	(continued from page 3) #1) whose Care Plan specified m	nonitoring for socially inappropriate/disruptive behavior	r and who made multiple verbal	
Level of harm - Immediate jeopardy Residents Affected - Few	threats of harm against another re psychiatric evaluation/obtain a ps physician of medication regimen residents. Resident #1 was admiti identified the resident's use of [M non-compliance with the medicat [MEDICATION	ssident (Resident #2). The facility also failed to assess F sychiatric consultation as specified by the Care Plan, an noncompliance, also as specified by the Care Plan. The ted to the facility on [DATE] with [DIAGNOSES RED IEDICAL CONDITION] medication, and specified not tion regimen. However, even though during October of	Resident #1 for the need for a d failed to notify Resident #1's e total survey sample was eleven (11) ACTED]. A Care Plan for Resident #1 ification of the physician regarding 2014 Resident #1 refused her	
	NAMEJ 1 milligram (mg) dose o to indicate that the physician was Plan. Additionally, a Care Plan P inappropriate/disruptive behavior behavior. On 11/02/2014, Reside including If you don't get her, I a against residents was a new beha threats against another resident, a Plan. Also, despite Resident #1's there was no evidence to indicate the need for, a psychiatric consul breathing, having no pulse, and h killed Resident #2, and Resident situation in which the facility's mo cause, serious harm, injury, impa informed of the immediate jeopal was identified to have existed on roommate, Resident #2, after Res neck, and nine (9) days after Nov #1's voiced threats against Reside November 21, 2014. The facility November 20, 2014. During an ir evidence of physician notification interview, the Administrator ackt #1 verbally threatened Resident # Based on the corrective plans wh jeopardy removal on November 2 November 21, 2014. The facility management level staff oversight Behavior Management Program 4 physician notification of resident materials and records were revier policies and procedures governin the physician, to therefore ensure Care Plans accurately reflected tf interventions to address aggressiv assessment documented an admis behavioral symptoms one-to-thre 4:10 p.m. Daily Skilled Nurses N Resident #1's Socially inappropri- acident and/or adverse reactions of angpropriate/disruptive behavior Resident #1's Socially inappropri- documented another Problem/Ne related to cognitive impairment, as needed. An additional Care Pla fects and/or adverse reactions of a #1's 09/03/2014 admission physic physician of signs/symptoms of a #1's 000/03/2014 admission physic physician of signs/symptoms of	n eight (8) days and her [MEDICATION NAME] 2 mg notified of the resident's medication regimen noncomp roblem/Need for Resident #1 identified that she display r, and a Care Plan Approach specified that staff monitor nt #1 exhibited a new behavior by making multiple verf m going to get her, and I'm going to get that bh. How vior for Resident #1, the facility failed to implement, af ny specific method to ensure close monitoring of Resid Care Plan specifying she would be provided with a psy that, after this 11/02/2014 incident, Resident #1 was p tation. Subsequently, on 11/11/2014, Resident #2 (Resi aving an electric cord around her neck. Resident #1 stat #1 was arrested and charged with felony murder and ag oncompliance with the requirements of participation cat irment or death to residents. The facility's Administrato rdy on November 19, 2014 at 3:36 p.m. The noncompli. November 11, 2014, the date Resident #1 was document ident #2 was found to have no respirations, no pulse, at ember 2, 2014, when the facility failed to enact interve ent #2. The immediate jeopardy continued through Nov- implemented a credible allegation of jeopardy removal terview conducted on 11/19/2014 at 1:40 p.m., the Adn n regarding Resident #1's verbal threats against Residen nowledged that no new interventions for monitoring ha 20 on 11/02/2014. An allegation of jeopardy removal wi ich had been developed and implemented by the facility 20, 2014, the immediacy of the deficient practice was de remained out of compliance at a lower scope and sever of staffs' monitoring of resident behaviors, resident ser as indicated, resident Care Plan updating and implemen- behavioral changes, in accordance with facility policie: wed. Interviews were conducted with staff to ensure the g resident the look-back period. Section 1 - Active [ lotes (DSNN) entry for Resident #1 documented additic a Problem/Need dated 09/18/2014 which indicated that related to her [DIAGNOSES REDACTED]. Approach at dyerse medication reactions and/or of non-compliance cian's orde	bilance, as specified by the Care red socially r the resident in relation to her bal threats against Resident #2, rever, even though verbal threats fler this new behavior of verbal lent #1, as specified by the Care chiatric consultation if needed, rovided with, or was assessed for dent #1's roommate) was found not ted to facility staff that she had gravated assault. This resulted in a used, or had the likelihood to or and Corporate Consultant were ance related to the immediate jeopardy nted as stating she had killed her nd with an electric cord around her nitions in response to Resident ember 20, 2014, and was removed on related to the immediate jeopardy on ministrator acknowledged the lack of at #1. In an 11/19/2014, 2:30 p.m. d been put into place after Resident as received on November 20, 2014. y via a credible allegation of etermined to have been removed on ity of D while the facility continued reening and placement in the tation regarding resident behaviors, and s and procedures. In-service ey were knowledgeable about facility avioral changes to supervisors and ure that resident assessments and t and implementation of 14 Admission Minimum Data Set ented Resident #1 had shown physical DIAGNOSES REDACTED]. A 09/03/2014, onal [DIAGNOSES REDACTED]. Review ot t Resident #1 solayed socially tes included on this Care Plan to address in. Resident #1 S Care Plan red [MEDICAL CONDTION] medication obtaining a psychiatric consultation fent #1 had the potential for side in dApproaches included notifying the with the medication regimen. Resident 7.700 a.m. DSNN entry documented the ch morning for escalating behaviors. Review se revealed nursing staff documented the sident #1 was not taking 8.000 a.m. [MEDICATION NAME] 1 mg VAME] 2 mg dose on five (5) of cian would be notified of licate that Resident #1's physician was ME], on these thirteen (13) occasions s (NN) entry of 11/02/2014 at 11:00 tesident #2, who resided in room [ROOM hat an intramuscular dose of [MEDICATION MEDICATION	
	no evidence of her having made t During an on 11/18/2014, 12:45 j held a family picture in the face of for Resident #1. Further record re threatening behavior toward Resi 11/18/2014, 12:45 p.m. interview into place interventions, specific relation to this newly-exhibited ti specifying the Approach, as refer disruptive behaviors. Additional behavior toward Resident #2 on 1 [MEDICAL CONDITION] medi Resident #1 was assessed for the behavior of verbally threatening ; the nurse heard staff yelling (fror breathing, with no pulse and with	ident #1 and that staff were monitoring Resident #1. Re threats toward other residents before the 11/02/2014, 11 p.m. interview, Licensed Practical Nurse (LPN) DD stat of Resident #2 and verbally threatened her, which LPN view for Resident #1, however, revealed that even thou (dent #2 on 11/02/2014, and even though this was a new with LPN DD referenced above), there was no evidend to a method and/or frequency, to ensure close staff mor hreatening behavior toward other residents. This was de enced above, that staff would provide monitoring of the record review for Resident #1 revealed that, despite Res 11/02/2014, and despite Resident #1's current Care Plan cations and specifying a psychiatric consultation as nee need for a psychiatric evaluation after this 11/02/2014 another resident. Then, an 11/11/2014, 7:00 a.m. NN en n the resident's room) and responded to find Resident #1 an electric bed cord around Resident #2's neck. In an i	1:00 a.m. NN entry referenced above. ted that on 11/02/2014, Resident #1 had DD acknowledged was a new behavior ugh Resident #1 had exhibited v behavior for Resident #1 (per the ce to indicate that the facility put hitoring of Resident #1 in espite the Care Plan of Resident #1 e resident in relation to her sident #1's verbally threatening n noting the resident's need for sded, there was no evidence to indicate that incident involving the new trty for Resident #1 documented that 2 (Resident #1's roommate) not nvestigation summary (IS)	
	a.m. NN entry for Resident #1 re Resident #2 having no respiration near her neck. This IS further doo breathing and with no pulse), Res certified nursing assistant (CNA) staff member If you don't get her	to the 11/11/2014 incident involving Resident #2 (as de ferenced above), the facility documented that on 11/11/ as or pulse and on the floor of her room with the bed's e cumented that on 11/02/2014 (nine days prior to 11/11/2 sident #1 was observed to hold a family picture in the fa was redirecting Resident #1, Resident #1 stated I am g , I am going to get her, and later stated to the CNA I'm , ver, as indicated above, even though Resident #1 made	2014 at 7:00 a.m., the nurse noted lectric cord unplugged and on or 2014 when Resident #2 was found not ace of Resident #2, and as a oing to get you, then said to the going to get that bh	

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CORRECTION	NUMBER 115385		
NAME OF PROVIDER OF SU		STREET ADDRES	SS, CITY, STATE, ZIP
PRUITTHEALTH - CRESTV	VOOD	415 PENDLETON VALDOSTA, GA	
For information on the nursing	home's plan to correct this deficien	cy, please contact the nursing home or the state surve	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF I OR LSC IDENTIFYING INFOR	DEFICIENCIES (EACH DEFICIENCY MUST BE P.	RECEDED BY FULL REGULATORY
F 0282	(continued from page 4)	MATION)	
Level of harm - Immediate	Resident #2 on 11/02/2014 (per F	Resident #1's 11/02/2014, 11:00 a.m. NN entry and th ce to indicate that the facility initiated any additional	
jeopardy	ensure close monitoring of Resid	the third of the specified by Resident #1's Care Plan) on or 4, 2:30 p.m. interview, the Administrator acknowledg	after 11/02/2014, to ensure Resident
Residents Affected - Few	against Resident #2. Then, as doc 11/11/2014, Resident #2 was fou above revealed that, based on ver concluded that Resident #2's trac had killed Resident #2, and the IS assault. Based on the above, Resi displayed socially inappropriate/ the resident. Resident #1's Care F Approach specifying a psychiatri effects/adverse reactions related 1	//02/2014, no new interventions were developed relate sumented in the 11/11/2014, 7:00 a.m. NN entry for R ind not breathing and with no pulse. Further review of bal reports from sources close to the police departme hea was crushed. This IS further documented that Reis documented Resident #1 was arrested and charged v dent #1 had [DIAGNOSES REDACTED]. Resident # lisruptive behavior, with an Approach related to this l'an also identified the resident's receipt of [MEDICA c consultation as needed, and also identified Resident to [MEDICAL CONDITION] medication use, with an	tesident #1 referenced above, on i'the facility IS report referenced nt, an autopsy report for Resident #2 sident #1 told a nurse consultant she with felony murder and aggravated #1's Care Plan identified that the resident had behavior including the monitoring of L CONDITION] medication, with an #1's potential for side n Approach specifying notification of the
	physician of non-compliance wit specified by the Care Plan, of the occasions in October of 2014. Th against Resident #2, the facility f specified by the Care Plan, and ff specified by the Care Plan. Subse her neck, not breathing and havin Resident #2, was arrested, and w. information regarding Resident # presented a credible allegation of was removed on 11/21/2014, at w the discovery of the incident of th was later transferred out of the fa Administrator, DON, ADON, Ad	In the medication regimen. However, the facility failed resident's refusal of drug therapy, including [MEDIC en, when Resident #1 exhibited a new behavior on 11 ailed to develop interventions to ensure the close mor- uiled to evaluate Resident #1 to determine the need fo quently, on 11/11/2014, Resident #2 was found on th g no pulse. Resident #1 was documented as stating to as charged with felony murder and aggravated assault 1 and Resident #2, and F406 for more information re- jeopardy removal (CAJR) on 11/20/2014, and it was which time the facility had implemented the following nat date, Resident #1 was immediately placed on one- cility. 2. On 11/13/2014, the facility's Interdisciplinar Imissions Personnel, LPN Supervisor, and Social Servy resident. This process of resident behavior screening	I to notify Resident #I's physician, as CATION NAME], on thirteen (13) //02/2014 by making verbal threats nitoring of Resident #1, as r a psychiatric evaluation, also as e floor with an electric cord around facility staff that she had killed t. Cross refer to F323 for more garding Resident #1. The facility determined that the immediate jeopardy tinterventions: 1. On 11/11/2014, upon to-one staff observation until she y Team (consisting of the vices Director) completed Behavioral Symptom
	All residents screened during this were placed on the Behavior Moi behavioral interventions were neu upon significant change in status, completed a review, initially begi behaviors in the previous month. be reviewed quarterly, annually, facility's Medical Director review facility implemented a procedure This screening process would app review of the resident's mental cor resident screening and review wi name; the History and Physical; 1 the reviewer. 6. On 11/20/2014, t audit of a minimum of 10 percen in behavioral management, to ems monthly audit of a minimum of 1 management, to ensure the accur-	process and identified as having had physical or ver- nitoring Program, to ensure the monitoring of these re- ressary. All residents will have a behavior screen don , and with any new behavior. 3. On 11/13/2014, the fa un on 11/12/2014, of the Care Plans of all residents h These Care Plans were revised as needed, based on the with a significant change in condition, and with any n ved Resident #1's medical record, making no recomm by which the Interdisciplinary Team would screen ar oly to all new resident admissions, and no resident wco ndition and the potential for aggressive or physical b II be documented on the Admission Audit Tool, which PASRR Level II; Nurse' Notes/MR notation; any Con he facility implemented a new procedure by which th to f the Resident Behavioral Symptom Screening forr sure the accuracy and completion of these documentati acy and completion of this Form. This Form (a previc ts in the Behavior Management Program, the tracking	bal behaviors in the previous month sidents and to ensure that no further e upon facility admission, quarterly, acility's Interdisciplinary Team aving any physical or verbal hese reviews. Resident Care Plans will ew behavior. 4. On 11/14/2014, the endations. 5. On 11/19/2014, the di review all new resident admissions. Juld be admitted until a detailed ehaviors can be assessed. This h documents: the date; the resident's sultation Information; and a signature of e Administrator would conduct a monthly ns and resident Care Plans for residents . The Administrator will conduct a on Form for residents in behavioral justy existing form) allows for the
	conduct a monthly audit of a min all residents in a Behavior Manag document any observed behavior audits referenced above will be d forms. 7. On 11/20/2014, the faci Monitoring Form, continuous rou aggressive resident behavior. Thi interventions, the reporting of the behavior, and a signature of the nr Unit, behaviors were observed, the report the resident behavior to the member was immediately assign Interdisciplinary Team continued II Assessments. This review reve psychiatric consultation. One (1) on 11/20/2014 for the remaining a consultation with a psychiatrist Social Service Director will makk in the resident's medical record. S in-service training related to a nu	documentation of any newly developed interventions imum of 10 percent of the Behavior Management Log gement Program, to ensure accuracy and completion c s, including agitated or combative behaviors, per day ocumented by the Administrator dating and signing th lity implemented a procedure by which a designated unds in the Memory Support Unit on the hallways and s Behavior Monitoring Form allows for the document behavior(s) to the Charge Nurse and the identity of t urse of verification. If, during these continuous rounc is staff member was to intervene as necessary to de- e Charge Nurse. This monitoring was actually initiate ed to the Memory Support Unit to begin the continuou the process of reviewing resident Preadmission Scre- aled three (3) residents having PASRR Level II asses of these residents was seen by a psychiatrist on a reg two (2) residents, identified with recommendations fc . On 11/20/2014, the facility implemented a procedure a copy of each resident's PASRR, and initial and da 0. On 11/20/2014, the facility's Interdisciplinary Team mber of areas. In-service training was provided to sta rs what to report, and to whom to report observations	g Forms (a previously existing form) for of this Form. This Form serves to and per shift. These monthly form he review of each of the referenced CNA was to document, using the Behavior I resident areas to monitor for any tation of resident behaviors, he staff member reporting the ds conducted on the Memory Support secalate the behavior, and also to d on 11/11/2014, when the staff us rounds. 8. On 11/20/2014, the facility's ening and Resident Review (PASRR) Level sments with a recommendation for a ular basis. Appointments were made or a psychiatric consultation, to have e by which the Administrator or te that copy, which will then be kept a continued to provide staff ff to educate them in ways to
	physical and verbal resident beha residents having suspicious bruis resident suspected of any alleged from the facility, as deemed appr supervisor, leading up to the Adh corporate agencies. In-service tra reference checks, and licensure/c staff had received this in-service thirteen (13) of fourteen (14) LPI seventeen (17) of twenty (20) die heads (not including the DON, A including the Activities Director, Coordinator, and Housekeeping S (1) laundry worker, three (3) diet duty or on leave will receive this in-service is completed. Addition process, and quarterly, related to having verbal or physical behavio in-service training, originally init regarding the resident behavior in of eight (8) Registered Nurses, th	viors. This in-service training also addressed how to ing, showing signs of being afraid, or patterns of beha abuse would be protected from any further abuse by opriate. Staff were advised of reporting any alleged al ninistrator, who would then report the allegation of al ining was also provided regarding employment screet ertification verification. As of 11/20/2014, eighty-nin training. This number included thirty-three (33) of thi N staff; nine (9) of eleven (11) housekeepers; four (4) tary workers; seven (7) of eight (8) Registered Nurses DON, LPN Supervisor, Senior Care Partner, and MD Social Worker, Maintenance Director, Financial Cou Supervisor. The remaining four (4) CNA staff, one (1 ary workers, and one (1) Registered Nurse who had n in-service training upon their return to work, and will ally, going forward, all employees will receive trainin resident abuse, resident neglect, and the procedures b ors. 10. On 11/20/2014, the Interdisciplinary Team co iated on 11/14/2014, specifically intended for license nanagement policies and the documentation of resider irteen (13) of fourteen (14) LPN staff, and thirty-one training. The remaining two (2) Registered Nurses, or	identify abuse by observation of aviors. Staff were informed that any the removal of the alleged perpetrator buse immediately to their use to the appropriate State and ning, via criminal background checks, e (89) of one-hundred-and-two (102) irty-seven (37) CNA staff; of five (5) laundry workers; s; seven (7) of seven (7) department S Nurse) that did not include nurses, nnselor, Medical Records, Admissions ) LPN staff, two (2) housekeepers, one ot been available due to being off I not be allowed to work until ng upon hire during the orientation y which to deal with residents minued to conduct additional staff d nursing staff and CNA staff t behaviors. As of 11/20/2014, six (6) (31) of thirty-seven (37) CNA

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE			PRINTED:6/30/2015 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORDECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/21/2014
CORRECTION	NUMBER 115385		
NAME OF PROVIDER OF SU		STREET ADDRI	ESS, CITY, STATE, ZIP
PRUITTHEALTH - CRESTV	VOOD	415 PENDLETO VALDOSTA, G	
For information on the nursing	home's plan to correct this deficien	cy, please contact the nursing home or the state surv	vey agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF I OR LSC IDENTIFYING INFOR	DEFICIENCIES (EACH DEFICIENCY MUST BE MATION)	PRECEDED BY FULL REGULATORY
F 0282	(continued from page 5)	o being off duty or on leave will receive this in-serv	· · · · · · · · · · · · · · · · · · ·
Level of harm - Immediate jeopardy	work, and will not be allowed to conducted regarding the notificat 11/20/2014, eleven (11) of fourte	work until in-service is completed. 11. On 11/20/20 ion of the physician of a change in condition and of en (14) LPN staff and seven (7) of eight (8) Registe	14, staff in-service training was new resident behaviors. As of red Nurses had received this training.
Residents Affected - Few	will receive this in-service training completed. 12. On 11/20/2014, the Service Director audits of the Ad Behavior Symptom Screening For	ff and one (1) Registered Nurse who had not been an ng upon their return to work, and will not be allowed the facility implemented a new procedure by which the mission Audit Tool, Behavior Monitoring Form, Be rrm, Management Log Form, and Care Plan and PA:	d to work until in-service is he results of Administrator and/or Social chavior Management Documentation Form,
	the QA Sub-Committee each week for process will allow the QA Sub-C residents having verbal and/or ph Audit results will also be present facility staff conformance with fa screening of resident behaviors, p Survey Agency reviewed the corr findings as follow: - On 11/21/20 that Resident #1 was immediately Resident #1 and Resident #2, as i resident records completed on the Interdisciplinary Team had condu placement in the Behavioral Mon sampled review of multiple resid and verified that resident Care PL physically/verbally aggressive be 11/21/2014, review of facility inw medical record and submitted a w Step #4 of the CAJR referenced a #1's physician, but the physician confirmed that the Interdisciplina admitted until a review of the ress review will be documented using Personnel, an LPN Supervisor, an above On 11/21/2014, facility of be conducting monthly audits of Forms, the Behavior Managemen This was in accordance with Step Unit confirmed the presence of a observing for any resident aggres it was confirmed by interview wi intervention. This was in accordan resident records, which had been Interdisciplinary Team had review needing additional psychiatric sets forporate Nursing Consultant. Tf facility staff in-service document facility and conducted staff in-set staff, Social Services staff, MDS regarding resident abuse and the will receive training upon their re 11/21/2014, review of facility staff in-training, specific for licensed nur resident behaviors. All staff havin work. This was in accordance wit Administrator confirmed that the level oversight of the cassestment, reviewed by the QA Commit	rm, Management Log Form, and Care Plan and PA: or four (4) weeks, then monthly by the Administrato ommittee to monitor staff compliance with the facility syically aggressive behaviors which could have the de to the facility's QA Committee quarterly for the C cility policies and procedures related to the manage physician notification, and resident monitoring. Duri rective actions implemented by the facility, as reflec 114, a review of facility investigative documents, in glaced on one-to-one observation on 11/11/2014 in indicated in Step #1 of the CAJR referenced above. at date, but which had been ongoing throughout the lacted behavioral screenings on residents for the purp- tioring Program, as indicated in Step #2 of the CAJ ent records, but which had been ongoing throughout ans had been reviewed and updated by the Interdisc haviors. This was in accordance with Step #3 of the vestigative documents confirmed that the Medical D vritten summary of this information to the facility on vibove. (Of note, on 11/20/2014 at 11:12 a.m., a telef declined interview.) - On 11/21/2014, interview wit ry Team will screen and review all new resident ad- ident's medical condition and potential for aggressiv the Admission Audit Tool. This Team will include and the Social Services Director. This was in accordance with the Administrator that this process of ongoing, ac onsive behaviors. These rounds were documented on 1 th the Administrator that this process of ongoing, ac ince with Step #7 of the CAJR referenced above O ongoing throughout the abbreviated survey, was co wed all resident PASRR Level II Assessments, with rvices. This action was also confirmed during an 11. his was in accordance with Step #8 of the CAJR refe- ation, to include facility Inservice Report Sign-In SI vrice training for staff, including (but not limited to) staff, Medical Records staff in-service training up turn to work. This was in accordance with Step #9 of fin-service documentation, to include facility Inse- had conducted additional staff in-service	or or Director of Health Services. This ity's policies and procedures regarding potential to lead to resident abuse. Committee's review and oversight of iment of resident behaviors, the ing this abbreviated survey, the State ted in the CAJR referenced above, with cluding the facility IS, confirmed mmediately after the incident involving - On 11/21/2014, a sampled review of abbreviated survey, revealed that the pose of ensuring appropriate resident R referenced above On 11/21/2014, a t the abbreviated survey, was completed iplinary Team, as related to c CAJR referenced above On virector had reviewed Resident #1's n (DATE). This was in accordance with phone call had been placed to Resident h the Administrator at 11:20 a.m. missions, with no resident being ve behaviors can be assessed. This the Administrator, DON, ADON, Admissions unce with Step #5 of the CAJR referenced tor confirmed that the Administrator will , the Behavior Management Documentation equiring behavioral management services. 4, a 9:55 a.m. observation on the Secured ntinuous rounds for the purpose of the Behavior Monitoring Form. In addition, ontinuous rounds will be a permanent Dn 11/21/2014, a sampled review of mpleted and verified that the the appropriate follow-up for residents /21/2014, 10:45 interview with a erenced above On 11/21/2014, review of heet Form review, revealed that the the tappropriate follow-up for residents /21/2014, 10:45 interview tha a erenced above On rvice Report Sign-In Sheet Form pecific for licensed nursing staff tion of resident behaviors. All staff rm to work. This was in accordance ff in-service documentation, to include inducted additional staff in-service n for changes in condition and new eive training upon their return to 21/2014, an 11:20 a.m. interview with the nded to provide ongoing management is having behaviorar problems, will be care. This was in accordance with Step #12 veloped and implemented by the facility as deficient practice had been removed on Ily assessed to ensure ongoing which the I
F 0323	Make sure that the nursing hom	ne area is free from accident hazards and risks an	
Level of harm - Immediate		IS HAVE BEEN EDITED TO PROTECT CONFID	
jeopardy Residents Affected - Few	facility Behavior Management Pr	facility investigation summary review, facility Entit ogram Policy review, facility Behavior Managemer iew, the facility failed to provide supervision in rest	nt Documentation Form review, staff written
Residents Affected - Few	aggression exhibited by one (1) rr (Resident #2), to thus ensure the admitted to the facility on [DATH behaviors toward staff, including #1's behavior, and the resident wa indicated that Resident #1 had no	view, the facility failed to provide supervision in resp esident (Resident #1), who made multiple verbal th safety of Resident #2, The total survey sample was E) with [DIAGNOSES REDACTED]. After facility hitting staff and pulling staffs' hair. Interventions w as placed on a Behavior Management Program on 0 behaviors observed/reported daily from 10/01/2014 vior Management Program. The physician document	reats of harm against another resident eleven (11) residents. Resident #1 was admission, Resident #1 exhibited aggressive yere developed to address Resident 9/09/2014. Documented evidence then 4 through 10/21/2014, at which time she
EOPM CMS 2567(02.00)	Event ID: VI 1011	Encility ID: 115295	

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE o			PRINTED:6/30/2015 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/21/2014
	115385	CTREET ADDR	ESS OFTW STATE 71D
NAME OF PROVIDER OF SU			ESS, CITY, STATE, ZIP
PRUITTHEALTH - CRESTV		415 PENDLET VALDOSTA, G	
For information on the nursing	· · ·	cy, please contact the nursing home or the state sur	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF I OR LSC IDENTIFYING INFOR	DEFICIENCIES (EACH DEFICIENCY MUST BE MATION)	PRECEDED BY FULL REGULATORY
F 0323	(continued from page 6)		
Level of harm - Immediate		ood, Bipolar Disorder, and Schizophrenia were stab the resident's ongoing refusal of drug therapy, inclu-	
jeopardy	drug therapy, during October of 2	2014. On 11/02/2014, Resident #1 experienced a ch	ange in behavior and was reported by
Residents Affected - Few	her, and I'm going to get that b	le verbal threats against Resident #2, including If y h. However, even though these verbal threats again	ist Resident #2 represented a change in
		ility failed to put measures into place to ensure clos vior Management Program as specified by facility F	
		vior and verbal threats. Then, on 11/11/2014, facilit ad with an electric bed cord around her neck. Resid	
	facility staff that she had killed R	esident #2, and Resident #1 was later arrested and in a situation in which the facility's noncompliance	charged with felony murder and
	participation caused, or had the li	kelihood to cause, serious harm, injury, impairmen	t or death to residents. The
	The noncompliance related to the	orate Consultant were informed of the immediate ja immediate jeopardy was identified to have existed	on November 11, 2014, the date Resident
	#1 was documented as stating she no pulse, and with an electric cor	e had killed her roommate, Resident #2, after Resid d around her neck, and nine (9) days after Novemb	lent #2 was found to have no respirations, er 2, 2014, when the facility failed to
	enact interventions in response to	Resident #1's verbal threats against Resident #2. 1 was removed on November 21, 2014. The facility	The immediate jeopardy continued
	removal related to the immediate	jeopardy on November 20, 2014. During an interv	iew with the Administrator conducted on
	threats against Resident #2, furth	ninistrator acknowledged the 11/02/2014 incidents er stating that as a result of Resident #1's 11/02/201	14 verbal threats toward Resident
	#2, staff administered (the antian	xiety drug) Ativan intramuscularly to Resident #1, I, however, that the administration of Ativan to Res	and also redirected the two residents.
	residents were interventions in pl	ace prior to the 11/02/2014 incidents involving Reserved at that no new measures had been developed in	sident #1 making verbal threats against
	behavior involving verbal threats	on 11/02/2014. An allegation of jeopardy removal	was received on November 20, 2014. Based
	removal on November 20, 2014,	been developed and implemented by the facility w the immediacy of the deficient practice was determ	nined to have been removed on November 21,
		of compliance at a lower scope and severity of D wh nitoring of resident behaviors, resident screening an	
	Management Program as indicate	ed, resident Care Plan updating and implementation	regarding resident behaviors, and physician
	records were reviewed. Interview	d changes, in accordance with facility policies and s were conducted with staff to ensure they were kn	owledgeable about facility policies and
		onitoring and the reporting of resident behavioral c y. Resident records were reviewed to ensure that re-	
	accurately reflected the current st	atus of residents, including the development and in ndings include: Facility Entity Reported Incident In	nplementation of interventions to take (ERII) Number GA 575 dated
	11/12/2014 documented the facility	ity's report to the State Survey Agency of an incide his ERII documented that on 11/11/2014, facility s	nt involving two (2) facility residents
	unconscious, with a cord around	her neck. The ERII further documented that Reside	ent #1 stated she had an altercation with
	to the State Survey Agency on 11	that she had killed Resident #2. In an investigation a 1/17/2014 as a follow-up report to the ERII, the fact	ility documented that on 11/13/2014,
		rged with felony murder and aggravated assault. Re to have been involved in the incident of 11/11/2014	
		ve) revealed an Admission Minimum Data Set (MD	
	of 09/10/2014 which documented	the resident's admission Entry Date of 09/03/2014	I. Section I - Active [DIAGNOSES
	REDACTED].#1 had [DIAGNOS Interview for	SES REDACTED]. Section C - Cognitive Patterns	documented that Resident #1 had a Brief
		Score of 8, indicating that the resident had moderal hibited physical behavioral symptoms toward other	
	look-back period. A Daily Skilled	d Nurses Notes (DSNN) entry of 09/03/2014 timed acility from an Intensive Treatment Board center. T	at 4:10 p.m. for Resident #1 documented the
	Resident #1 had [DIAGNOSES F	REDACTED]. This DSNN entry further documented	ed that upon admission, Resident #1 was placed
		ion physician's orders [REDACTED].#1 specified of tion Risperidone two (2) milligrams (mgs) by mout	
		by mouth every six $(6)$ hours as needed for agitation y six $(6)$ hours as needed for agitation if unable to	
	09/06/2014 timed at 5:30 a.m. for	r Resident #1 documented that the nurse had gone i ut the resident sat up in the the bed, hit the nurse ac	into the resident's room to ask the
	and stated I am not doing anythin	ng and get out. This DSNN further documented that	Resident #1 refused to take any of her
	status of the resident and began to	9/07/2014 timed at 8:00 a.m. for Resident #1 docur o ask the resident questions, but the resident closed	her eyes, pulled the cover over
		se, and refused her medications. A Behavior Mana resident was placed in the facility's Behavior Mana	
	Management Program Policy rev	ealed that all residents would be evaluated upon ad , for placement in the Behavior Management Progr	mission/readmission, and with new behaviors
	Care Plan and additional interven	tions if necessary, to eliminate or reduce behaviors	s. This Policy further indicated that
		Management Program would be evaluated by the B ses which included brainstorming/assessing for pot	
		ated, and reassessing and revising the behavior red resident in the Behavior Management Program woo	
	behavior-free for 30 days or until	deemed appropriate to discontinue by the Behavio m of 09/09/2014 referenced above for Resident #1	r Management Committee. The Behavior
	#1 in the Behavior Management	Program was based on the resident's physically agg	ressive behaviors. A Behavioral Symptom
		completed on 09/10/2014 upon the resident's inclu- of Manic Depression, Dementia with Behavioral I	
	Type, and also documented a hist	tory of the resident being physically aggressive tow pocketing (cheeking) medications. The 09/09/2014	vards staff, refusing medications,
	for Resident #1, as referenced ab	ove, documented that once enrolled in the Behavior	ral Management Program on that date, the
	Management Policy, on the dates	iewed the resident's behavior and behavioral intervest of 09/16/2014, 09/23/2014, 09/30/2014, 10/07/2014	14, and 10/14/2014. Further review of
		aled DSNN entries of 09/14/2014 timed at 10:30 a. ications, and a DSNN entry of 09/16/2014 timed at	
	had balled up her fist and swung	at the nurse, then grabbed at another staff member. dent continued refusing care, and documented that	A 09/18/2014, 7:00 a.m. DSNN entry for
	the physician ordered for the resid	dent to receive Risperidone one (1) mg each morning	ng (in addition to the nightly
	7:14 a.m. for Resident #1 then do	eady being administered at bedtime, as indicated ab ocumented the resident was still uncooperative and	struck out and hit a certified nursing
	assistant (CNA). Resident #1's Se	eptember 2014 Medication Record (MR) and Nurse 0/2014, Resident #1 had refused medications, inclu	e's Medication Notes documented, per licensed
	ordered and scheduled at 8:00 p.r	n. This September MR further documented, per lic 23/2014, Resident #1 refused all of her medications	ensed nursing staff entries, that on
	dose ordered and scheduled at 8:0	00 a.m. A DSNN entry of 09/28/2014 timed at 1:40	p.m. for Resident #1 documented that
	Resident #1 had received a 0.5 m	g dose of intramuscular Ativan for increased agitat	ion arter naving stapped starr and
	1		

ENTERS FOR MEDICARE	& MEDICAID SERVICES		FORM APPROVED OMB NO. 0938-0391
ATEMENT OF EFICIENCIES ND PLAN OF DRRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/21/2014
KRECTION	115385		
ME OF PROVIDER OF SU		STREET ADD	RESS, CITY, STATE, ZIP
UITTHEALTH - CRESTV	VOOD	415 PENDLE VALDOSTA,	
information on the nursing	home's plan to correct this deficient	cy, please contact the nursing home or the state s	
(4) ID PREFIX TAG		DEFICIENCIES (EACH DEFICIENCY MUST B	E PRECEDED BY FULL REGULATORY
0323	OR LSC IDENTIFYING INFORM (continued from page 7)	MATION)	
Level of harm - Immediate	pulled staffs' hair out as they were	e attempting to assist the resident to dress and am #1 signed by the attending physician documente	
eopardy	that date. In this 09/29/2014 Phys	ician's Progress Notes entry, the physician docun	nented that Resident #1 was combative and
Jeopardy Residents Affected - Few	that the resident was not taking he behavioral issues and refusal to ta entries of 10/03/2014 timed at 9:0 medications. Subsequent DSNN of Daily Nurse's Note's (SDNN) ent refuse to take her oral medication licensed nursing staff documented at 8:00 a.m. daily, on eight (8) of 10/05/2014, 10/17/2014, 10/19/2 documented that the resident refu at 8:00 p.m., on five (5) of thirty- 10/19/2014, and 10/21/2014. How the month of October 2014, as do Resident #1's clinical record reve: to refuse her ordered medication n escalating behaviors, during the n being aware of the resident's refui in which the physician document October MR entries from 10/03/2 multiple occasions during Octobe p.m., 10/02/14 at 7:00 a.m., 10/03/2 multiple occasions during Octobe p.m., 10/02/14 at 7:00 a.m., 10/06/ 2014 at 7:00 a.m., 10/06/2014 at and 7:00 p.m., 10/09/2014 at 2:35 5:00 p.m., 10/12/2014 at 2:14 a.m an., 10/15/2014 at 2:30 a.m., 10/20/14 been noted/reported for Resident #1 was calm, with no behaviors a entry on Resident #1's Behavior M for Resident #1 documented the r that Resident #1 documented in fac revealed a SDNN of 10/24/2014 for that Resident #2 (who, in addition to I 11/11/2014, as documented in fac revealed a SDNN of 10/24/2014 for resident #2 who fin 0/24/2014 for that Resident #1 further documented the for Resident #1 further documented that her Schizophrenia and Deme revealed a Nurse's Notes (NN) en SDNN referenced above documented that her Schizophrenia and Deme revealed a Nurse's Notes (NN) en SDNN referenced above documented that her Schizophrenia and Deme revealed a nurse's Notes (NN) en SDNN referenced above documented that her Schizophrenia and Deme revealed a nurse's Notes (NN) en SDNN referenced above documented that PA schiden #1 was sisted Resi 12:20 p.m., the Administrator ide Resident #2 on 11/02/2014. Durin was working on the Secured Unit a member. The IS documented that female resident #1 who slapped the Resident #1 was sisted Resi 12:20 p.m., the Administrator ide her, I am going to ge ther. This IS referri	ician's Progress Notes entry, the physician' docun er medications. Rue documenting the physician's ke medications. Review of Resident #1's Octobe 00 p.m. and 10/17/2014 timed at 9:00 p.m. and 10/1 ry of 10/19/2014 timed at 5:55 p.m. for Resident s on occasion. More specifically, review of Resis 0 the resident refused the Risperidone 1 mg dose, thirty-one (31) days during the month of October 104, 10/23/2013, 10/24/2014, 10/28/2014 and 10/ wever, even though Resident #1 continued to refu cumented in the resident's October MR and DSN aled no evidence to indicate that Resident #1's ph therapy, including the Risperidone medication th nonth of October 2014. The last documented evic as of medications was the 09/29/2014 Physician' ed awareness of the resident's medication refusal. 10/14 through 10/21/2014 referenced above docum r of 2014, daily DSNN/SDNN entries for Reside 5/2014 at 2:50 a.m. and 7:00 a.m., 10/04/14 at 3:60 7:00 a.m. and 8:00 p.m., 10/07/2014 at 7:00 a.m. a .m. and 7:00 a.m., 10/10/2014 at 7:00 a.m. and a.m. and 7:00 p.m., 10/13/2014 at 2:40 a.m. and 7:10 a a.m. and 7:00 p.m., 10/13/2014 at 2:40 a.m. and 7:00 9:00 p.m., 10/13/2014 at 2:40 a.m. and 7:10/3/2014 at 2:30 a.m. and 7:00 p.m. and 10/21/2014 at 2:42 as 0.m. and 7:00 p.m., and 10/21/2014 at 2:41 at 2:50 a.m. and 7:00 p.m., and 10/21/2014 at 2:42 as 0.m. and 7:00 p.m., and 10/21/2014 at 2:42 as 0.m. and 7:00 p.m., and 10/21/2014 at 2:42 as 0.m. and 7:00 p.m., and 10/21/2014 at 2:51 at 1:10 a.m. documenting this resident head 10/2/21/ 4 anagement Program on that date. A subsequent esident #1 wor reported by the facility to have 1 aility ERII Number GA 575 referenced above). R at 1:10 a.m. documenting this resident medication on 2 m. Admission MDS assessment having an Assess [DIAGNOSES REDACTED]. Section C - Cogn of 4, indicating severe cognitive impairment, and strance with walking. Continued review of the cli 20 a.m. (the day after Resident #2's facility admissi in Resident #1 and the resident facility simest and necident #1 state 11/02/2014, a	awareness on that date of the resident's r 2014 nursing notes entries revealed DSNN documented the resident again refused 8/2014 timed at 7:30 p.m., and a Skilled #1 documented the resident continued to lent #1's October 2014 MR revealed ordered and scheduled to be administered and scheduled to be administered at bedtime 03/2014, 10/17/2014, 10/18/2014, sed medications on multiple occasions during N/SDNN entries referenced above, review of ysician was notified of her continuing rrapy prescribed in response to her lence of Resident #1's ustending physician s Progress Notes entry referenced above Even though Resident #1's DSNN/SDNN and ented that Resident #1's DSNN/SDNN and ented that Resident #1's 00 a.m. and 8:00 00 a.m. and 8:00 p.m., 10/05/14 at 2:00 0.m., 10/14/14 at 2:03 a.m. and 8:00 10 p.m., 10/14/14 at 2:00 a.m. and 0.p.m., 10/18/14 at 8:00 a.m., and 0.p.m., 10/18/14 at 9:00 a.m. and 0.p.m., 10/18/14 at 9:00 a.m., and 0.p.m., 10/18/14 at 8:00 a.m., e1 0/24/2014, 7:00 a.m. SDNN documented that Resident #1 was SDNN entry of 10/24/2014 tim cal 2:00 a.m. e1 0/24/2014, 7:00 a.m. SDNN documented records revealed a clinical record for been involved in the incident of eview of Resident #2's clinical record at the facility for admission on that Resident #2' was placed in resident room 260B 00A, as referenced above). Further record ment Reference Date of 10/31/2014 which tive Patterns of this MDS documented that Section G - Functional Status documented that that time. This SDNN further indicated ician's Progress Notes entry of resident mmate, and one week after Resident #1's on and placement in Resident #1's the Behavior Management Documentation Fon e. This Physician's Progress Notes entry in relation to her Bipolar Disorder, and view of Resident #1's clinical record the family picture in the face of incetted. This facility IS documented that far the 10/25/2014, &t:00 a.m. 5 days after the 10/25/

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE			PRINTED:6/30/2015 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/21/2014
NAME OF PROVIDER OF SU	115385		ESS, CITY, STATE, ZIP
RUITTHEALTH - CRESTV		415 PENDLET	
		VALDOSTA, G	A 31602
(X4) ID PREFIX TAG	· · ·	cy, please contact the nursing home or the state sur DEFICIENCIES (EACH DEFICIENCY MUST BE	
	OR LSC IDENTIFYING INFOR		
F 0323 Level of harm - Immediate jeopardy	#2, to allow the nurse to go make toward other residents before this	s CNA to watch Resident #1 to make sure Resident a telephone call. CNA EE stated that she had not a 11/02/2014 incident. In a written statement provid at approximately 11:00 a.m., Resident #1 was walki	bserved Resident #1 to be aggressive ed by LPN DD dated 11/14/2014, LPN DD
F 0406	family picture in the face of Resid #1 was being redirected, Residen documented that she and the CN/ her, I am going to get her. LPN D staff, and after refusing to take a' Ativan. LPN DD and the DON cond during which Resident #1 threate that Resident #1 had been given a #1 threatening another resident an DD stated she reported this behav not at work on 11/02/2014 (Sund regarding Resident #1. The DON involving Resident #1 threatening #1 vas calm at that time. During #2 later in the day of 11/02/2014 awareness, as she documented in am going to get you, I am going t if she had been made aware of the made aware of Resident #1's sect that time. However, despite LPN witnessed and overheard Residen the 11/18/2014, 12:45 p.m. interv resident's verbal threats against R Additionally, record review for R additional interventions, monitori verbal threats and aggression aga ensure the supervision and monit addition, further review of the fa a new behavior or change in exist resident sor Management Program incidents of 11/02/2014 during w The facility's failure to place Resi 10/21/2014, as documented on B #1's Behavior Management Docu behaviors as the reason for her in that Resident #1 had subsequent] This was also despite the fact tha resident identified to have a new involving Resident #1's verbal threats resident #1 and subsequent] This was also despite the fact tha resident #1 and subsequent] This was also despite the fact tha resident #2, which were a chang involving Resident #1 so real threats the Administrator conducted on I facility to place Resident #1 on a Resident #2, which were a chang involving Resident #1's verbal thr management program Policy (ref placement on Behavior Manageen Policy that way. When questionec change in behavior involving her any further interventions to preve	It approximately 11:00 a.m., Resident #1 was walki dent #2, at which time the residents were redirected t #1 pointed at Resident #2 and stated I am going to A encouraged Resident #1 to not say that, but that F D documented that Resident #1 then approached a dose of Ativan by mouth, was escorted to her room inted that she then reported the incident to the Direc ucted on 11/18/2014 at 12:45 p.m., LPN DD ackno ned Resident #2 and held a family picture in the far an IM dose of Ativan after this incident, and stated do getting upset about the picture on 11/02/2014 w. vior involving Resident #1 to the DON. The DON s ay), but rather was at church when she received the stated she returned the call later in the day of 11/0 g Resident #2 and of the actions staff had taken to i this interview, LPN DD asserted she was not awar (after the earlier 11:00 a.m. incident of 11/02/2014 her written statement referenced above, when Resi o get you, and stating If you don't get her, I am goi e second threat, she would have called the DON ag mot threat toward Resident #2, she would have had DD's acknowledgement, per her 11/14/2014 writte t #1 making verbal threats toward Resident #1's behavior c for the resident, and despite the DON's acknowledg she was made aware on 11/02/2014 of Resident #1's plexident #2, or of the resident's 11/02/2014 aggressi tesident #1 revealed no evidence to indicate that the ing or supervision on ar after 11/02/2014, after Re- inst Resident #2, to address Resident #1's newly ex oring of Resident #1 related to this behavior and to cility's Behavior Management Program the behavior, to include an event of even one (1) a s, would be placed on a Behavior Management Program the behavior Management Program Policy referenced ab tient/Resident #1 exhibited the new behavior for or ident #1 back on a Behavior Management Program the behavior Management Program Molicy man ehavior Management Program Molicy man the behavior or change in existing behavior, to include balthreats, would be placed on the Behavior Management Pr	I. LPN DD documented that as Resident per you, I am going to get you. LPN DD Resident #I then stated If you don't get nother resident but was redirected by and was administered an IM dose of tor of Nursing (DON). During an interview owledged awareness of the 11/02/2014 incident ce of Resident #2. LPN DD acknowledged that this behavior regarding Resident as a new behavior for Resident #1. LPN tated, during this interview, that she was telephone call from the nursing facility 2/2014, was told about the incident netrvene, and was told that Resident e that Resident #1 and threatened Resident of which LPN DD did acknowledge dent #1 pointed at Resident #2, stated I ng to get her.). LPN DD stated that ain. The DON stated that if she had been Resident #1 transferred to the hospital at n statement referenced above, that she had 1/02/2014, despite LPN DD stating during of threatening another resident on hysician was notified of the ve behavior toward residents. e facility developed and implemented sident #1's new behavior, to both ensure the safety of Resident #2. In ove revealed the Policy to specify, in 10/21/2014, as referenced above, how how thereation involving gram. This Behavior Management Policy ade due to events which resulted in injury, h. However, review of Resident #1's n, or was considered for placement on, 10/02/2014, as referenced above) after the cing verbal threats against Resident #2. (after her discharged from the Program on ced above) was despite the fact that Resident documented only physically aggressive m on 09/09/2014, and despite the fact eatening Resident #2 on 11/02/2014). reed above specifically indicated that any an event of even on (1) altercation gement Program. During an interview with estioned regarding the failure of the s 11/02/2014 verbal threats toward ated that the 11/02/2014 incident norming meeting involving facility ator conducted on 11/19/2014 at 1:40 p.m., esident #1's new behavior Management Men asked about the Behavior ith injury were not the only criteria for en just one (
Level of harm - Immediate	care. **NOTE- TERMS IN BRACKET	IS HAVE BEEN EDITED TO PROTECT CONFI	DENTIALITY**
jeopardy <b>Residents Affected -</b> Few	Based on clinical record review, 1 Preadmission Screening and Resi review, PASRR Review Outcomm review, and staff interview, the fa consultation/evaluation, for one ( had a history of [REDACTED].#	facility investigation summary review, Behavior M dent Review (PASRR) Level I Application - Resid e Notification form review, PASRR Psychiatric an cility failed to provide specialized services, related 1) resident (Resident #1) as recommended by the P 2). The total survey sample was eleven (11) resider IOSES REDACTED]. Resident #1's PASRR Psych	anagement Documentation Form review, ent Identification Screening Instrument Form I MR/RC Evaluation and Medical History form to a psychiatric ASRR Assessment, even though Resident #1 nts. Resident #1 was admitted to the
	recommended a psychiatric const aggressive behaviors toward staff indicate that the facility provided the need for this psychiatric const threats on 11/02/2014 against Re- don't get her, I am going to get he the floor and was not breathing, I stating to facility staff that she ha murder and aggravated assault. T participation caused, or had the li facility's Administrator and Corp The noncompliance related to the #1 was documented as stating she pulse, and with an electric cord at	altation/evaluation by a psychiatrist. After facility a f, including hitting staff and pulling staffs' hair. The Resident #1 with a psychiatric consultation/evaluation, evaluation/evaluation, even after Resident #1 was rep sident #2. Resident #1's verbal threats toward Resid er, and I'm going to get that bh. Then, on 11/1/12 and no pulse, and had an electric bed cord around h d killed Resident #2, and Resident #1 was later arm his resulted in a situation in which the facility's nor kelihood to cause, serious harm, injury, impairmen orate Consultant were informed of the immediate je immediate jeopardy was identified to have existed e killed her roommate. Resident #2, after Resident # round her neck, and nine (9) days after November 2 o Resident #1's verbal threats against Resident #2. T	re was no evidence, however, to tion, or assessed the resident for orted by facility staff to make verbal lent #2 were reported to include If you 014, Resident #2 was discovered on er neck. Resident #1 was documented as ested and charged with felony compliance with the requirements of t or death to residents. The zopardy on November 19, 2014 at 3:36 p.m. on November 11, 2014, the date Resident #2 was found to have no respirations, no 2, 2014, when the facility failed to
FORM CMS-2567(02-99)	Event ID: YL1011	Facility ID: 115385	If continuation sheet

	& MEDICAID SERVICES		FORM APPROVED OMB NO. 0938-0391
TATEMENT OF EFICIENCIES ND PLAN OF ORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/21/2014
	115385		
ME OF PROVIDER OF SU UITTHEALTH - CRESTW		STREET ADD 415 PENDLET	RESS, CITY, STATE, ZIP FON PLACE
		VALDOSTA,	GA 31602
X4) ID PREFIX TAG	· ·	cy, please contact the nursing home or the state su DEFICIENCIES (EACH DEFICIENCY MUST B	
E 0406	OR LSC IDENTIFYING INFOR	MATION)	
F 0406 <b>Level of harm -</b> Immediate jeopardy	removal related to the immediate 11/19/2014 at 2:05 p.m. and the I	was removed on November 21, 2014. The facilit jeopardy on November 20, 2014. During intervie Director of Nursing (DON) on 11/19/2014, at 2:45	ws with the Administrator conducted on 5 p.m., these facility staff provided no
	removal related to the immediate 11/19/2014 at 2:05 p.m. and the I information to indicate that Resid recommendation. An allegation of had been developed and impleme immediacy of the deficient practi- compliance at a lower scope and monitoring of resident behaviors, resident Care Plan updating and i behavioral changes, in accordance Interviews were conducted with s resident monitoring and the repor resident safety. Resident records: current status of residents, includ Findings include: Resident #1's A Section I - Active [DIAGNOSES toward others 1 to 3 days during the look Resident #1's facility admission f Admission physician's orders [RF mouth at bedtime and the antianxiety drug intramuscularly (IM), every six (6) hours as needed for Resident Review (PASRR) Level physician and dated 09/03/2014, 4 documented, in Section 2, that Re 1) diagnosis, and Section 3 of this REDACTED]. A related PASRR PASRR review found Resident #1 to meet services according to a plan of ca form further indicated that a copy enclosed. Review of this attached Section X(1.1) documented appre Section XI, Service Planning Rec consultation/evaluation by a psyc medications and an extensive hist PASRR Review Outcome Notific facility's receipt of these document Resident #1's medical record reve MR/RC Evaluation and Medical1 consultation/evaluation by a psyc mychiatrist, or assessed for the nn During an interview with the Diro process by which resident PASRI she would inquire as to this proce conducted on 11/19/2014 at 3:00 packet documents were sent by fs stated that the admission packet do give orders for treatment. Howey that Resident #1's admission docc consultation/evaluation) should h admission, record review revealed for the need for, a psychiatric consult and Medical placetory. A 09/18/ behaviors of slapping staff and pt referenced above, specified that F PASRR Review Outcome Notific consultation/evaluation) accordin review for Resident #1 revealed a made verbal threats against anoth received an IM dose of [MEDIC/ after Resident #1's doc	jeopardy on November 20, 2014. During intervie	ws with the Administrator conducted on 5 p.m., these facility staff provided no aluation, as per the PASRR 0, 2014. Based on the corrective plans which pardy removal on November 20, 2014, the ember 21, 2014. The facility remained out of ment level staff oversight of staffs' r Management Program as indicated, physician notification of resident materials and records were reviewed. tility policies and procedures governing s and the physician, to therefore ensure s and Care Plans accurately reflected the ventions to address aggressive behaviors. immented an admission date of [DATE], and Resident #1 had physical behavioral symptoms tiled Nurses Notes (DSNN) entry documented ted additional [DIAGNOSES REDACTED]. CATION NAME] two (2) milligrams (mgs) by <i>ME</i> ]) one (1) mg, either by mouth or revealed a Preadmission Screening and Instrument Form which was signed by a on. This PASRR Level 1 Application ONDITION] - Residual Type as a primary (Ax t did not have an Axis II [DIAGNOSES 2012 documented that Resident #1's Level II to receive additional specialized uis PASRR Review Outcome Notification in cluded treatment recommendations, was Medical History form for Resident #1 revealed tentai illness and specialized services. mented a recommendation for a psychiatric nanagement of [MEDICAL CONDITION] 09/03/2014 was stamped at the top of the 1 Medical History forms, thus documenting the Imission. However, further review of <i>view</i> Outcome Notification and Psychiatric and that Resident #1 receive a psychiatric sident #1 had been evaluated by a r her 09/03/2014 (Acility admission, 14 at 2:45 p.m., the DON was asked about the nt's sadmission to the facility. The DON stated ring a subsequent interview with the DON further tents, which the physician when Resident #1 was d that on 09/09/2014, approximately one (1) t Program. A related Behavioral Disturbances, and vads staff, refusing medications, and pocketing nt #1's physician had bee notified of continued AME] one (1) mg each morning. A 09/20/2014, ite the fact that, as documented in

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YL1011

Facility ID: 115385

If continuation sheet Page 10 of 18

EPARTMENT OF HEALTH ENTERS FOR MEDICARE			PRINTED:6/30/2015 FORM APPROVED OMB NO. 0938-0391	
FATEMENT OF EFICIENCIES ND PLAN OF ORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 115385	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/21/2014	
ME OF PROVIDER OF SU		STREET ADDRESS, CIT		
UITTHEALTH - CRESTV	VOOD	415 PENDLETON PLA VALDOSTA, GA 31602	CE	
r information on the nursing X4) ID PREFIX TAG	1 1	cy, please contact the nursing home or the state survey agen- DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEI MATION)	•	
F 0406	(continued from page 10)			
Level of harm - Immediate jeopardy Residents Affected - Few	Nursing (DON) conducted on 11/ #1 as recommended on the reside psychiatric consultation/evaluatio death revealed the IS to documen autopsy report concluded Resider facility IS documented that Resid Resident #1 had been arrested on Resident #1's [DIAGNOSES REI facility on [DATE] having a PASRR reco to exhibit aggressive behaviors, to	obtained, per the PASRR recommendation. During a subsect (19/2014 at 2:45 p.m., when asked about a psychiatric consu- nt's PASRR Assessment, the DON provided no evidence of on. Further review of the facility's IS referenced above relate t that, based on verbal reports from sources close to the poli- it #2's trachea was crushed, with a determination that Reside ent #1 told a nurse consultant that she killed Resident #2, an 11/13/2014 and charged with felony murder and aggravated DACTED]. Resident #1 received [MEDICAL CONDITION commendation for a psychiatric evaluation/consultation. How to include hitting staff and verbally threatening Resident #2, Resident (evaluation for Resident #1. Then, on 11/1/2014. Resident	Itation/recommendation for Resident Resident #1 having received a d Resident #2's 11/11/2014 ce department, Resident #2's nt #1 used her hands. This d further documented that assault. Based on the above, ] medications and was admitted to th ever, despite Resident #1 continuing the facility failed to	
	to exhibit aggressive behaviors, to provide a psychiatric consultation her room with an electric cord art staff that she had killed Resident to F323 for more information reg on 11/20/2014, and it was determ implemented the following interv immediately placed on one-to-om the facility's Interdisciplinary Tea and Social Services Director) con resident behavior screening had be monitoring of these residents and have a behavior screen done upor behavior. 3. On 11/3/2014, the f Care Plans of all residents having needed, based on these reviews. F condition, and with any new beha record, making no recommendati Team would screen and review al admissions, and no resident woulf for aggressive or physical behavid Admission Audit Tool, which dou Notes/MR notation; any Consulta implemented a new procedure by Resident Behavioral Symptom Sc accuracy and completion of these the Behavior Management Docur this Form. This Form (a previous) Management Program, the trackin newly developed interventions. In the Behavior Management Log F ensure accuracy and completion cor- domistive behaviors, per day and Administrator dating and signing procedure by which a designated Support Unit on the hallways and Form allows for the documentatic Nurse and the identity of the staff Nurse and the identity of the staff were i observations of resident abuse. TI addressed how to identify abuse to patterns of behaviors. Staff were i batterns of behaviors. Staff were i patterns of behaviors. Staff were i patterns of behaviors. Staff were i undersistered Nurses; seven (7) of ss Partner, and MDS Nurse) that did Director, Financial Counselor, M. CNA staff, one (1) LPN staff, two Registered Nurses; seven (7) of ss Partner, and MDS Nurse) that did Director, Financial Counselor, M. CNA staff, one (1) LPN staff, two Registered Nurse win had not be their return to work, and will not employem svill receive training u resident neglect, the the procedur 11/		the facility failed to #2 was found on the floor in #1 later stated to facility ggravated assault. Cross refer on of jeopardy removal (CAJR) [4] att which time the facility had nt of that date, Resident #1 was acility. 2. On 11/13/2014, ons Personnel, LPN Supervisor, lity resident. This process of is process and identified as Monitoring Program, to ensure the sary. All residents will tutus, and with any new begun on 11/12/2014, of the ese Care Plans were revised as th a significant change in weed Resident #1's medical by which the Interdisciplinary ply to all new resident condition and the potential be documented on the ical; PASRR Level II; Nurse' 20/2014, the facility a minimum of 10 percent of the vioral management, to ensure the accuracy and completion of sidents in the Behavior and the documented or be documented by the 4, the facility implemented a n, continuous rounds in the Memory for. This Behavior Monitoring ehavior(s) to the Charge e of verification. If, during its staff member was to intervene e Nurse. This monitoring was mory Support Unit to begin the ess of reviewing resident space that is in-service training also ing signs of being afraid, or ould be protected from any te s. Staff were advised of who would then report the so provided regarding fication verification. As of training. This number included (9) of eleven (11) kers; Supervisor, Senior Care Worker, Maintenance Supervisor, Senior Care Worker, Maintenance Supervisor, Senior Care Worker, Maintenance Supervisor, Senior Care IWorker, Maintenance Supervisor, shirteen eatilabe due to being off allow workers, and one (1) is in-service training upon 1/1 /202014, the facility's eas. In-service training upon 1/1 /202014, the low on the son provided regarding for the objer of	

CENTERS FOR MEDICARE	I AND HUMAN SERVICES & MEDICAID SERVICES	PRINTED:6/30/2015 FORM APPROVED OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 115385	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/21/2014
JAME OF PROVIDER OF SU PRUITTHEALTH - CREST		STREET ADDRES. 415 PENDLETON VALDOSTA, GA 3	
For information on the nursing	home's plan to correct this deficien	cy, please contact the nursing home or the state survey	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF I OR LSC IDENTIFYING INFOR	DEFICIENCIES (EACH DEFICIENCY MUST BE PR MATION)	ECEDED BY FULL REGULATORY
	SUMMARY STATEMENT OF I OR LSC IDENTIFYING INFORI (continued from page 11) weeks, then monthly by the Adm monitor staff compliance with the aggressive behaviors which could facility's QA Committee quarterly policies and procedures related to notification, and resident monitor actions implemented by the facilit review of facility investigative do one-to-one observation on 11/11/ Step #1 of the CAJR referenced a which had been ongoing through screenings on residents for the pu- indicated in Step #2 of the CAJR which had been ongoing through which had been ongoing through reviewed and updated by the Inte accordance with Step #3 of the C that the Medical Director had rev the facility on [DATE]. This was a a.m., a telephone call had been pl interview with the Administrator resident admissions, with no resia aggressive behaviors can be asses the Administrator, DON, ADON, accordance with Step #5 of the C Administrator confirmed that the Screening forms, the Behavior M for resident requiring behavior M for resident requiring behavior M for resident requiring behavior M for resident requiring behavior M for nesident requiring behavior M for congoing and continuous rounds ff documented on the Behavior M process of ongoing, continuous rounds ff documented on the Behavior M for resident teolowe On 11/21/201 survey, was completed and verifi Director, and the Admissions Cov yet completed this in-service train of the CAJR referenced above 4 Inservice Report Sign-In Sheet F- specific for licensed nursing staff, Director, and the Admissions Cov yet completed this in-service train of the CAJR referenced above 4 Inservice Report Sign-In Sheet F- specific for licensed nursing staff, Director, and the Admissions Cov yet completed this in-service train of the CAJR referenced above 4 Inservice Report Sign-In Sheet F- specific for licensed nursing staff resident behaviors. All staff havin work. This was in accordance wi in-service documentation, to inclic conducted additional staff in-servic physician for changes in cond	DEFICIENCIES (EACH DEFICIENCY MUST BE PR	keceDeD BY FULL REGULATORY will allow the QA Sub-Committee to having verbal and/or physically ults will also be presented to the staff conformance with facility of resident behaviors, physician Agency reviewed the corrective dings as follow: - On 11/21/2014, a ident #1 was immediately placed on tt #1 and Resident #2, as indicated in records completed on that date, but plinary Team had conducted behavioral e Behavioral Monitoring Program, as of multiple resident records, but d that resident Care Plans had been ggressive behaviors. This was in cility investigative documents confirmed tritten summary of this information to bove. (Of note, on 11/21/2014, m will screen and review all new dical condition and potential for sion Audit Tool. This Team will include ocial Services Director. This was in ment review and interview with the te Resident Behavioral Symptom ggement Log Forms, and resident Care Plans ep #6 of the CAJR referenced above an assigned staff member to conduct behaviors. These rounds were ew with the Administrator that this cordance with Step #7 of the CAJR en ongoing throughout the abbreviated sident PASRR Level II Assessments, is action was also confirmed during rdance with Step #8 of the CAJR include facility Inservice Report ing for staff, including (but not Records staff, the Maintenance fanagement POICy. All staff having not its was in accordance with Step #9 mentation, to include facility diditional staff in-service training, tent policies and the documentation of ve training upon their return to /2014, review of facility staff w, revealed that the facility had ing the notification of the completed this in-service training f the CAJR referenced above On of all audits, as referenced in the ning of care, and provision of care to le ongoing QA Committee oversight of in these corrective actions which had
F 0490 Level of harm - Immediate jeopardy Residents Affected - Few	plans could not be fully assessed <b>Be administered in an acceptabl</b> **NOTE- TERMS IN BRACKET Based on clinical record review, i intervention and supervision in re toward another resident (Residen to the facility on [DATE] with [E Program on 10/21/2014, and the physician [MEDICAL CONDITION] Dison physician of the resident's ongoin an incident of 11/02/2014 when F threats against Resident #2. The f failed to place Resident #1 in the incident. The facility also failed t 11/11/2014, Resident #2 was diss Resident #1 stated to facility staff felony murder and aggravated ass requirements of participation cau residents. The facility's Administ 2014 at 3:36 p.m. The noncompli the date Resident #1 was docume respirations, no pulse, and with an facility failed to enact interventio jeopardy continued through Nove allegation of jeopardy removal ref 11/19/2014 at 12:20 p.m., the Add toward Resident #2, and stated th meeting on 11/03/2014. However interventions were developed and An allegation of jeopardy removal and implemented by the facility v deficient practice was determinec lower scope and severity of D wh resident behaviors, resident scree updating and implementation reg accordance with facility policies	ce had been removed on 11/21/2014; however, the efficto ensure ongoing application and completion. On 11/ le way that maintains the well-being of each residen TS HAVE BEEN EDITED TO PROTECT CONFIDE facility document review, and staff interview, facility a sponse to verbal threats and aggression exhibited by o (#2), on the total survey sample of eleven (11) residen DIAGNOSES REDACTED]. Resident #1 was then disc documented in a 10/28/2014 Physician's Progress Not rder, and [MEDICAL CONDITION] were stable. How g refusal of drug therapy during October of 2014, and Resident #1 experienced a change in behavior and was acility failed to put measures into place to ensure closs Behavior Management Program, as specified by facili o evaluate Resident #1 regarding the need for a psychi- covered not breathing, having no pulse, and having an i that she had killed Resident #2, and Resident #1 was stall. This resulted in a situation in which the facility's sed, or had the likelihood to cause, serious harm, injur- rator and Corporate Consultant were informed of the i ance related to the immediate jeopardy was identified need as stating she killed her roommate, Resident #2, 20 an electric cord around her neck, and nine (9) days after ns in response to Resident #1/2 verbal threats against F ember 20, 2014, and was removed on November 21, 20 lated to the immediate jeopardy vas disentified ind as stating she killed her roommate, Resident #2, 20 lated to the immediate jeopardy on November 21, 20 lated to the immediate jeopardy on November 21, 20 lated to the immediate jeopardy as oldent iffed in placement of norsponse to Resident #1's verbal threat accelidet #1's verbally threatening behavior was diss ;, during a later 11/19/2014, 2:30 p.m. interview, the A implemented in response to Resident #1's verbal threat in actend behavior Management Prog arding resident behaviors, and physician notification o and procedures. In-service materials and records were swledgeable about facility policies and procedures gov hanges to supervisors and	19/2014, the facility implemented <b>nt</b> . NTIALITY** administration failed to ensure one (1) resident (Resident #1) tts. Resident #1, who was admitted continued from the Behavior Management tes entry that the resident's mood, vever, the facility failed to notify Resident #1' failed to notify the physician of reported to have made multiple verbal e monitoring of Resident #1 and ty Policy, after this 11/02/2014 tatric consultation. On electric cord around her neck. later arrested and charged with noncompliance with the y, impairment or death to mmediate jeopardy on November 19, to have existed on November 11, 2014, after Resident #2 was found to have no r November 2, 2014, when the Resident #2. The immediate D14. The facility implemented a credible 4. During an interview conducted on olving Resident #1's verbal threat cussed in the facility's morning udministrator acknowledged that no new ats against Resident #2 on 11/02/2014. sorrective plans which had been developed nher 20, 2014, the immediacy of the cility remained out of compliance at a sight of staff's monitoring of rean as indicated, resident Care Plan of resident behavioral changes, in reviewed. Interviews were conducted verning resident monitoring and the

ENTERS FOR MEDICARE &			OMB NO. 0938-0391
ATEMENT OF	(X1) PROVIDER / SUPPLIER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
EFICIENCIES ND PLAN OF	/ CLIA IDENNTIFICATION	A. BUILDING B. WING	11/21/2014
RRECTION	NUMBER		
ME OF PROVIDER OF SU	115385 PPLIER	STREET ADDR	ESS, CITY, STATE, ZIP
JITTHEALTH - CRESTW		415 PENDLET	
information on the surging	home's plan to correct this deficien	VALDOSTA, G	
(4) ID PREFIX TAG	· ·	cy, please contact the nursing home or the state sur DEFICIENCIES (EACH DEFICIENCY MUST BE	
	OR LSC IDENTIFYING INFOR	MATION)	
0490		hat resident assessments and Care Plans accurately	
Level of harm - Immediate eopardy		ent and implementation of interventions to address nical record review, facility document review, facil	
Residents Affected - Few		by b	
	of eleven (11) residents. Resident	#1, who had [DIAGNOSÉS REDACTED]. Évide 10/01/2014 through 10/21/2014, and was disconti	nce indicated that Resident #1 had no
	11/02/2014, Resident #1 was repo	orted to make verbal threats against Resident #2 (R	esident #1's roommate), including If you
	implement interventions for moni	r, and I'm going to get that bh; however, the faci itoring of Resident #1 related to her verbally threate	ening behavior, failed to place
	Resident #1 in the Behavior Man change in behavior for Resident #	agement Program per Policy, and failed to notify R 1. On 11/11/2014, facility staff discovered Resider	esident #1's physician regarding this of #2 not breathing having no pulse
	and with an electric cord around l	her neck. Resident #1 stated to facility staff that she	had killed Resident #2, and
	conducted on 11/19/2014 at 12:20	rged with felony murder and aggravated assault. Do p.m., the 11/02/2014 incident during which Resid	ent #1 made verbal threats against
		ionally, the Administrator was asked about the 11/ ident #2 was discovered having no respiration and h	
	stated to facility staff that she had	I killed Resident #2. In relation to the 11/02/2014 in the Administrator acknowledged awareness the ind	ncident involving Resident #1's
	been discussed in the morning sta	ff meeting of 11/03/2014, which she had attended.	During a subsequent interview with the
	Administrator conducted on 11/19 when Resident #1 expressed verb	9/2014 at 2:30 p.m., the Administrator was again q al threats toward Resident #2, and was asked about	what specific action or actions were
		nt to address Resident #1's verbal threats against Re reatened Resident #2 on 11/02/2014, facility staff st	
	[MEDICATION NAME] to Resid	dent #1, and also redirected the residents. However medication [MEDICATION NAME] to Resident #	, the Administrator acknowledged that the
	interventions which had been in p	place prior to the 11/02/2014 incident. The Administ	strator further acknowledged that no new
		, or actions taken, after Resident #1 verbally threat vidence of any new interventions that she had put i	
		014 threatening behavior toward Resident #2, even meeting of 11/03/2014. Subsequent to the 11/02/20	
	threatening Resident #2, and to th	e 11/03/2014 morning staff meeting during which	this incident was discussed, Resident #2
	acknowledged to facility staff she	no pulse, and with an electric cord around her neck had killed Resident #2, and was arrested and charge	ged with felony murder and aggravated
	assault. The facility presented a c the immediate jeopardy was remo	redible allegation of jeopardy removal (CAJR) on two on $11/21/2014$ , at which time the facility had it	11/20/2014, and it was determined that mplemented the following interventions:
	1. On 11/11/2014, upon the disco	very of the incident of that date, Resident #1 was in insferred out of the facility. 2. On 11/13/2014, the f	nmediately placed on one-to-one staff
	(consisting of the Administrator,	DON, ADON, Admissions Personnel, LPN Superv	isor, and Social Services Director) completed
	initiated on 11/12/2014. All resid	Forms on every facility resident. This process of res ents screened during this process and identified as 1	having had physical or verbal
		were placed on the Behavior Monitoring Program, vioral interventions were necessary. All residents v	
	facility admission, quarterly, upor	n significant change in status, and with any new be	havior. 3. On 11/13/2014, the
	having any physical or verbal beh	completed a review, initially begun on 11/12/2014, avoirs in the previous month. These Care Plans we	re revised as needed, based on these
		be reviewed quarterly, annually, with a significant acility's Medical Director reviewed Resident #1's n	
		014, the facility implemented a procedure by which ssions. This screening process would apply to all no	
	would be admitted until a detailed	d review of the resident's mental condition and the	potential for aggressive or physical
		esident screening and review will be documented o s name; the History and Physical; PASRR Level II	
		ignature of the reviewer. 6. On 11/20/2014, the fac onduct a monthly audit of a minimum of 10 percen	
	Screening forms and resident Car	e Plans for residents in behavioral management, to	ensure the accuracy and completion of
	Documentation Form for resident	tor will conduct a monthly audit of a minimum of s in behavioral management, to ensure the accuracy	y and completion of this Form. This Form (a
	of the effectiveness of existing be	for the weekly documentation of residents in the Be havioral interventions, and the documentation of a	ehavior Management Program, the tracking ny newly developed interventions. In
	addition, the Administrator will c	onduct a monthly audit of a minimum of 10 percen esidents in a Behavior Management Program, to er	t of the Behavior Management Log Forms (a
	Form. This Form serves to docum	referenced above will be documented by the Admin	combative behaviors, per day and per
	each of the referenced forms. 7. C	In 11/20/2014, the facility implemented a procedur	e by which a designated CNA was to
		onitoring Form, continuous rounds in the Memory s we resident behavior. This Behavior Monitoring For	
	resident behaviors, interventions,	the reporting of the behavior(s) to the Charge Nurs nd a signature of the nurse of verification. If, durin	se and the identity of the staff
	on the Memory Support Unit, beh	naviors were observed, this staff member was to int	ervene as necessary to de-escalate the
	11/11/2014, when the staff memb	sident behavior to the Charge Nurse. This monitor are was immediately assigned to the Memory Suppo	ort Unit to begin the continuous rounds. 8. Or
		ciplinary Team continued the process of reviewing II Assessments. This review revealed three (3) res	
	with a recommendation for a psyc	chiatric consultation. One (1) of these residents was on $11/20/2014$ for the remaining two (2) residents, i	s seen by a psychiatrist on a regular
	psychiatric consultation, to have a	a consultation with a psychiatrist. On 11/20/2014, t	he facility implemented a procedure
		cial Service Director will make a copy of each resi he resident's medical record. 9. On 11/20/2014, the	
	continued to provide staff in-serv	ice training related to a number of areas. In-service	training was provided to staff to
	abuse. This included both physica	abuse, including behaviors what to report, and to wal and verbal resident behaviors. This in-service tra	ining also addressed how to identify
	Staff were informed that any resid	having suspicious bruising, showing signs of being dent suspected of any alleged abuse would be prote	cted from any further abuse by the
	removal of the alleged perpetrator	r from the facility, as deemed appropriate. Staff we visor, leading up to the Administrator, who would the	re advised of reporting any alleged
	the appropriate State and corpora	te agencies. In-service training was also provided re-	egarding employment screening, via
	of one-hundred-and-two (102) sta	rence checks, and licensure/certification verificatio off had received this in-service training. This number	er included thirty-three (33) of
		een (13) of fourteen (14) LPN staff; nine (9) of elev	
		en (17) of twenty (20) dietary workers; seven (7) of	

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE			PRINTED:6/30/2015 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY Completed 11/21/2014
AME OF PROVIDER OF SU	115385 PPLIER	STREET AD	DRESS, CITY, STATE, ZIP
RUITTHEALTH - CRESTV	VOOD		ETON PLACE
or information on the nursing	home's plan to correct this deficien	VALDOSTA cy, please contact the nursing home or the state	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF I	DEFICIENCIES (EACH DEFICIENCY MUST	
F 0490	OR LSC IDENTIFYING INFORM (continued from page 13)	MATION)	
Level of harm - Immediate jeopardy	Medical Records, Admissions Co two (2) housekeepers, one (1) lau available due to being off duty or	ndry worker, three (3) dietary workers, and one on leave will receive this in-service training up	oon their return to work, and will not
Residents Affected - Few	hire during the orientation proces which to deal with residents havi to conduct additional staff in-service thaviors. As of 11/20/2014, sixt thirty-one (31) of thirty-seven (37 Nurses, one (1) LPN, and six (6) in-service training upon their retur- ly 11/20/2014, staff in-service traini- and of new resident behaviors. A: Registered Nurses had received th been available due to being off dn not be allowed to work until in-set the results of Administrator and/c Behavior Management Documen PASRR Assessment reviews would be pro- radministrator or Director of Hea- the facility's policies and procedu have the potential to lead to resid for the Committee's review and o management of resident behavior During this abbreviated survey, fu- reflected in the CAJR referenced documents, including the facility 11/11/2014 immediately after the referenced above On 11/21/201 throughout the abbreviated survey residents for the purpose of ensur Step #2 of the CAJR referenced a ongoing throughout the abbreviat updated by the Interdisciplinary 7 Step #3 of the CAJR referenced a dedical Director had reviewed R facility on [DATE]. This was in a a.m., a telephone call had been p1 interview with the Administrator resident admissions, with no resis aggressive behaviors can be asset aggressive behaviors. All staff havin work confirmed that the Screening forms, the Behavior Mo process of ongoing, continuous rounds fd documented on the Behavior Mo process of ongoing, continuous rounds fd documented on the Behavior Mo process of ongoing, continuous rounds fd documented on the Behavior Mo process of ongoing, continuous rounds fd documented on the Behavior Mo process of ongoing, continuous rounds fd documented on the Behavior Mo process of ongoing, continuous rounds fd documented on the Behavior Mo process of ongoing, continuous rounds fd documented on the Behavior Mo process of ongoing, continuous rounds fi documented on the Behavior Mo proceduce Albitonial staff in-service trainity inplemented an very rece continuous rounds in the memory thi	Admissions Personnel, an LPN Supervisor, and AJR referenced above On 11/21/2014, facility Administrator will be conducting monthly audi	ent neglect, and the procedures by 014, the Interdisciplinary Team continued specifically intended for licensed s and the documentation of resident of fourteen (14) LPN staff, and g. The remaining two (2) Registered eing off duty or neave will receive this it in-service is completed. 11. On the physician of a change in condition PN staff and seven (7) of eight (8) and one (1) Registered Nurse who had not ing upon their return to work, and will lity implemented a new procedure by which on Audit Tool, Behavior Monitoring Form, m, Management Log Form, and Care Plan and or four (4) weeks, then monthly by the b-Committee to monitor staff compliance with ysically aggressive behaviors which could o the facility's QA Committee quarterly ity policies and procedures related to the n notification, and resident monitoring. a citons implemented by the facility, as 4, a review of facility investigative y placed on one-to-one observation on 2, as indicated in Step #1 of the CAJR tet on that date, but which had been noging conducted behavioral screenings on vioral Monitoring Program, as indicated in ultiple resident records, but which had been dent Care Plans had been reviewed and we behaviors. This was in accordance with tigative documents confirmed that the titren summary of this information to the d above. (Of note, on 11/20/2014 at 11:12 an declined interview.) - On 11/21/2014, ry Team will screen and review all new rit's medical condition and potential for Admission Audit Tool. This Team will include d the Social Services Director. This was in y document review and interview with the tis of the Resident Behavioral Symptom r Management Log Forms, and resident Care Plans with Step #6 of the CAJR referenced above nece of an assigned staff member to conduct pressive behaviors. These rounds were interview with the Administrator that this is in accordance with Step #7 of the CAJR had been ongoing throughout the abbreviated 1 all resident PASRR Level II Assessments, see This a

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE			PRINTED:6/30/2015 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/21/2014
NAME OF PROVIDER OF SU	115385 IPPL IER	STREET	ADDRESS, CITY, STATE, ZIP
			NDLETON PLACE
For information on the nursing	home's plan to correct this deficien	cy, please contact the nursing home or the	STA, GA 31602 state survey agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF D	EFICIENCIES (EACH DEFICIENCY M	UST BE PRECEDED BY FULL REGULATORY
F 0490	OR LSC IDENTIFYING INFORM (continued from page 14)	MATION)	
Level of harm - Immediate jeopardy	laundry worker, three (3) dietary on leave will receive this in-servi	ce training upon their return to work. On 1	o had not been available due to being off duty or 1/20/2014, the Interdisciplinary Team staff and CNA staff regarding the resident
Residents Affected - Few	behavior management policies an Nurses, thirteen (13) of fourteen ( in-service training. The remaining in-service training upon their retu notification of the physician of a staff and seven (7) of eight (8) Ré receive this in-service training up yet remaining to receive in-servic not be assessed at the time of sur- future evaluation and assessment assessment, supervision, and mor training regarding these issues, th	d the documentation of resident behaviors. 14) LPN staff, and thirty-one (31) of thirty g two (2) Registered Nurses, one (1) LPN, rn to work. Also, on 11/20/2014, staff in-s- shange in condition and of new resident be gistered Nurses, but the remaining three (2) on their return to work. Therefore, due to 1 e training at the time of survey exit, their c rey exit, and will need to be evaluated at a of the facility's ongoing compliance with 1 itoring of residents having aggressive beha	As of 11/20/2014, six (6) of eight (8) Registered -seven (37) CNA staff had received this and six (6) CNA staff will need to receive this ervice training was conducted regarding the haviors for eleven (11) of fourteen (14) LPN 8) LPN staff and one (1) Registered Nurse will nultiple licensed and certified staff members completion of this required training could future time. Therefore, due to the need for newly-implemented procedures regarding the
F 0520	D level.	ment and assurance group to review qu	ality deficiencies
Level of harm - Immediate jeopardy	quarterly, and develop correcti **NOTE- TERMS IN BRACKET Based on clinical record review, f	ve plans of action. S HAVE BEEN EDITED TO PROTECT acility document review, and staff intervie	CONFIDENTIALITY** w, the facility failed to ensure the
Residents Affected - Few	involvement of the Quality Assur to 11/02/2014 and 11/11/2014 att However, the facility failed to no change in behavior by making the Resident #1 and failed to place R also failed to evaluate Resident # not breathing, having no pulse, ar facility staff that she hak killed R aggravated assault. This resulted participation caused, or had the li facility's Administrator and Corp The noncompliance related to the #1 was documented as stating she no pulse, and with an electric cor enact interventions in response to through November 20, 2014, and removal (CAIR) related to the im a.m., the Administrator stated tha 11/11/2014 incidents involving R these incidents. However, the Ad discuss these identified quality de Committee had reviewed and app abbreviated survey, and provided CAJR. An allegation of jeopardy developed and implemented by tf of the deficient practice was detei at a lower scope and severity of L resident behaviors, resident scree updating and implementation reg accordance with facility policies i with staff to ensure they were kno reporting of resident behavioral c records were reviewed to ensure 1 residents, including the developm Cross refer to F323. Based on rec facility failed to supervise one (I] Resident #1 had made verbal thre REDACTED]. Nursing documen 10/21/2014, and she was disconti Resident #2 on 11/02/2014, inclu the facility developed and implen place Resident #1 in the Behavior physician of this change in behav electric cord around her neck. Re with felony murder and aggravata a.m., the Administrator was quest interview, the Administrator was quest interview, the Administrator was guest interview, the Administrator was guest interview, the Administrator was quest interview, the Adminis	ance (QA) Committee in the development recations between Resident #1 and Resider ify Resident #1's physician of this 11/02/2 se verbal threats against Resident #2. The sident #1 in the Behavior Management Pr I for the need for a psychiatric consultation d having an electric cord around her neck. seident #2, and Resident #1 was later arres in a situation in which the facility's noncor kelihood to cause, serious harm, injury, im orate Consultant were informed of the imm immediate jeopardy was identified to have had killed her roommate, Resident #2, aft around her neck, and nine (9) days after 1 Resident #1's verbal threats against Resid was removed on November 20, 2014. The mediate jeopardy on November 20, 2014. t a QA Sub-Committee had met to discuss esident #1 and Resident #2, and to discuss ministrator acknowledged that a formal Q/ ficiencies. The Administrator further ackn roved the CAIR, this review was not comp no evidence to indicate that the QA Comm removal was received on November 20, 20 e facility via a credible allegation of jeopa mined to have been removed on November 0 while the facility continued management ting and placement in the Behavior Manag arding resident behaviors, and physician nd end procedures. In-service materials and re wheldgeable about facility policies and pro hanges to supervisors and the physician, to hat resident assessments and Care Plans at ent and implementation of interventions to roth review, facility document review, facil resident Resident #1 had no observ nued from Behavior Management. Resider diassult. During an interview with the Ac ioned about the facility 's Quality Assurant asked if the facility had identified a proble ror to the 11/11/2014, Resident #2 was found ident #1 stated to staff that she had killed d assault. During an interview with the Ac ioned about the facility 's Quality Assurant asked if the facility had identified a proble ror to the 11/1/2014 altercation between Re deficiencies related to resident-to-resident 0 unittee to meet the first week of Decem	of a corrective action plan formulated in response nt #2. Resident #1 had [DIAGNOSES REDACTED].# 014 incident when Resident #1 experienced a facility failed to ensure close monitoring of ogram per facility Policy after this incident, and n. On 11/1/2014, Resident #2 was discovered Resident #1 was documented as reporting to ted and charged with felony murder and mpliance with the requirements of pairment or death to residents. The ediate jeopardy on November 19, 2014 at 3:36 p.m. e existed on November 11, 2014, the date Resident er Resident #2 was found to have no respirations, November 2, 2014, when the facility failed to ent #2. The immediate jeopardy continued facility implemented a credible allegation of jeopardy During an interview conducted on 11/21/2014 at 11:20 the issues involved in the 11/02/2014 and the corrective action plan formulated related to A Committee meeting had not been held to review and owledged that, while all members of the QA bleted until 11/21/2014, the exit date of this nittee had been involved in the formulation of this 114. Based on the corrective plans which had been rdy removal on November 20, 2014, the immediacy rr 21, 2014. The facility remained out of compliance level staff oversight of staffs' monitoring of gement Program as indicated, resident Care Plan stification of resident behavioral changes, in cords were reviewed. Interviews were conducted cedures governing resident monitoring and the therefore ensure resident safety. Resident currately reflected the current status of o address aggressive behaviors. Findings include: Ity Policy review, and staff interview, the y of her roommate (Resident #2), toward whom 1) residents. Resident #1 had [DIAGNOSES ed/reported behaviors from 10/01/2014 through tt #1 was then reported to make verbal threats against her, and I'm going to get that bh. However, ident #1 and Resident #2, the facility had incidents or related to the facility's we referenced above, the Administrator was also Resident #1 and Resident #2. During this interview, w

EPARTMENT OF HEALTH ENTERS FOR MEDICARE &			PRINTED:6/30/2015 FORM APPROVED OMB NO. 0938-0391
FATEMENT OF EFICIENCIES ND PLAN OF	(X1) PROVIDER / SUPPLIER / CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
RRECTION	IDENNTIFICATION NUMBER 115385	B. WING	11/21/2014
ME OF PROVIDER OF SU		STREET ADDR	ESS, CITY, STATE, ZIP
JITTHEALTH - CRESTW	VOOD	415 PENDLET( VALDOSTA, G	
information on the nursing	home's plan to correct this deficien	cy, please contact the nursing home or the state sur-	
(4) ID PREFIX TAG	SUMMARY STATEMENT OF I OR LSC IDENTIFYING INFOR	DEFICIENCIES (EACH DEFICIENCY MUST BE	PRECEDED BY FULL REGULATORY
0520	(continued from page 15)		
evel of harm - Immediate copardy	11/21/2/14, reviewed and approvential to approve 11/11/2014 incidents, no evidence this CAJR. This was despite facility	ed the CAJR formulated in response to the immedia e was presented to indicate that the QA Committee ity staff having developed and implemented, as doc	had been involved in the formulation of cumented in the CAJR, corrective actions
esidents Affected - Few	11/13/2014 Care Plan review of a revision; the 11/20/2014 initiation	behavioral screenings of all residents for inclusion in all residents having physical/verbal behaviors in the n of a process involving a 10 percent minimum more	past month to determine to need for hthly audit by the Administrator of
	Form; and the completion, by 11/ the CAJR) regarding dealing with	for Management Documentation Forms, and Care P 20/2014, of in-service training of the majority of the residents having behavior, the reporting of resident	e facility's staff (as documented in at altercations, and physician
	indicate that the QA Committee h	on and new resident behaviors. In addition, the facilitation and evaluated and analyzed the facility's systems (w	hich had been in effect prior to the
		ents referenced above) regarding resident monitorin y, facility response to significant changes in resider	
	having been identified regarding	f response to resident-to-resident incidents. This was the 11/02/2014 incident when Resident #1 verbally	threatened Resident #2, related to the
	safety; ensure the referral and inc	mediate interventions to ensure resident monitoring lusion of residents in a Behavior Monitoring Progra	am, per facility policy; ensure
	11/11/2014, when Resident #2 wa	nt changes in status, including behavior changes. The as found with no respirations or pulse, after which H	Resident #1 was documented as admitting
		the above, on 11/02/2014, Resident #1 verbally three to implement immediate interventions to ensure r	
	#2; and failed to refer Resident #	with the physician regarding Resident #1's verbally 1 to the Behavior Monitoring Program, per facility	policy. Then, on 11/11/2014, Resident
	#2 was found with no respiration: had killed Resident #2. In response	s or pulse and with an electric cord around her neck se to Resident #2's 11/11/2014 death, the facility ide	a, and Resident #1 stated to staff she entified quality deficiencies and
		procedures, reflected on a corrective action plan, w Behavior Monitoring Program; Care Plan review and	
	However, even though these new	procedures were developed and implemented, and	even though the facility conducted staff
	in-service training, beginning on	11/14/2014, there was no evidence to indicate that the eloped in response to the 11/11/2014 incident result	the QA Committee had been involved in
	also no evidence of QA Committ	ee evaluation and analysis of facility systems in effo pervision, response to significant changes in behavior	ect prior to the 11/11/2014 incident
	referral, and response to resident-	to-resident altercations. The facility presented a CA opardy was removed on $11/21/2014$ , at which time	AJR on 11/20/2014, and it was
	interventions: 1. On 11/11/2014,	upon the discovery of the incident of that date, Resi she was later transferred out of the facility. 2. On I	ident #1 was immediately placed on
	Interdisciplinary Team (consistin	g of the Administrator, DON, ADON, Admissions havioral Symptom Screening Forms on every facilit	Personnel, LPN Supervisor, and Social
	behavior screening had been initi	ated on 11/12/2014. All residents screened during the	his process and identified as having
	monitoring of these residents and	in the previous month were placed on the Behavior to ensure that no further behavioral interventions v	vere necessary. All residents will
	behavior. 3. On 11/13/2014, the f	n facility admission, quarterly, upon significant char acility's Interdisciplinary Team completed a review	, initially begun on 11/12/2014, of the
	needed, based on these reviews. I	any physical or verbal behaviors in the previous m Resident Care Plans will be reviewed quarterly, ann	ually, with a significant change in
	record, making no recommendati	avior. 4. On $11/14/2014$ , the facility's Medical Directions. 5. On $11/19/2014$ , the facility implemented a p	procedure by which the Interdisciplinary
	admissions, and no resident woul	Il new resident admissions. This screening process d be admitted until a detailed review of the resident	s mental condition and the potential
	Admission Audit Tool, which do	ors can be assessed. This resident screening and rev cuments: the date; the resident's name; the History a	and Physical; PASRR Level II; Nurse'
		tion Information; and a signature of the reviewer. 6 which the Administrator would conduct a monthly	
	accuracy and completion of these the Behavior Management Docur	creening forms and resident Care Plans for residents documents. The Administrator will conduct a mon nentation Form for residents in behavioral manager	thly audit of a minimum of 10 percent of nent, to ensure the accuracy and completion
	Management Program, the tracking	ly existing form) allows for the weekly documentat ng of the effectiveness of existing behavioral interv	entions, and the documentation of any
	the Behavior Management Log F	n addition, the Administrator will conduct a monthl orms (a previously existing form) for all residents i	n a Behavior Management Program, to
	combative behaviors, per day and	of this Form. This Form serves to document any obs l per shift. These monthly form audits referenced at	pove will be documented by the
	procedure by which a designated	the review of each of the referenced forms. 7. On 1 CNA was to document, using the Behavior Monito	ring Form, continuous rounds in the Memory
		resident areas to monitor for any aggressive reside on of resident behaviors, interventions, the reporting	
		f member reporting the behavior, and a signature of ed on the Memory Support Unit, behaviors were ob-	
		havior, and also to report the resident behavior to the when the staff member was immediately assigned to	
	continuous rounds. 8. On 11/20/2	014, the facility's Interdisciplinary Team continued dent Review (PASRR) Level II Assessments. This	the process of reviewing resident
	PASRR Level II assessments with	h a recommendation for a psychiatric consultation. pointments were made on $11/20/2014$ for the rema	One (1) of these residents was seen by a
	recommendations for a psychiatri	c consultation, to have a consultation with a psychi ch the Administrator or Social Service Director will	atrist. On 11/20/2014, the facility
	and initial and date that copy, wh	ich will then be kept in the resident's medical record to provide staff in-service training related to a num	d. 9. On 11/20/2014, the facility's
	provided to staff to educate them	in ways to prevent abuse, including behaviors what his included both physical and verbal resident behaviors	t to report, and to whom to report
	addressed how to identify abuse b	by observation of residents having suspicious bruisi	ng, showing signs of being afraid, or
	further abuse by the removal of the	informed that any resident suspected of any alleged ne alleged perpetrator from the facility, as deemed a paintable to their supervisor leading up to the Administration	appropriate. Staff were advised of
	allegation of abuse to the appropr	ediately to their supervisor, leading up to the Admir iate State and corporate agencies. In-service trainin	g was also provided regarding
	11/20/2014, eighty-nine (89) of o	nal background checks, reference checks, and licens ne-hundred-and-two (102) staff had received this in	n-service training. This number included
	housekeepers; four (4) of five (5)	37) CNA staff; thirteen (13) of fourteen (14) LPN st laundry workers; seventeen (17) of twenty (20) die	etary workers; seven (7) of eight (8)
	Partner, and MDS Nurse) that did	even (7) department heads (not including the DON, I not include nurses, including the Activities Director	or, Social Worker, Maintenance
	Director, Financial Counselor, M	edical Records, Admissions Coordinator, and Hous	ekeeping Supervisor. The remaining four (4)

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE &			PRINTED:6/30/2015 FORM APPROVED OMB NO. 0938-0391
TATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/21/2014
AME OF PROVIDER OF SU	115385	STREET AD	DRESS, CITY, STATE, ZIP
RUITTHEALTH - CRESTW			ETON PLACE
		VALDOSTA	A, GA 31602
(X4) ID PREFIX TAG	1 1	cy, please contact the nursing home or the state DEFICIENCIES (EACH DEFICIENCY MUST	
	OR LSC IDENTIFYING INFORM		
F 0520 Level of harm - Immediate jeopardy	Registered Nurse who had not be their return to work, and will not	o (2) housekeepers, one (1) laundry worker, thre en available due to being off duty or on leave w be allowed to work until in-service is completed pon bire during the orientation process and qua	ill receive this in-service training upon d. Additionally, going forward, all
Residents Affected - Few	resident neglect, and the procedur 11/20/2014, the Interdisciplinary 11/14/20/2014, specifically intended policies and the documentation of (13) of fourteen (14) LPN staff, a The remaining two (2) Registered duty or on leave will receive this in-service is completed. 11. On 1 physician of a change in conditio and seven (7) of eight (8) Registe Registered Nurse who had not be their return to work, and will not implemented a new procedure by Audit Tool, Behavior Monitoring Management Log Form, and Care Plan and PA weeks, then monthly by the Adm monitor staff compliance with the aggressive behaviors which could facility's QA Committee quarterly policies and procedures related to notification, and resident monitor actions implemented by the facili review of facility investigative dc one-to-one observation on 11/11/ Step #1 of the CAJR referenced a which had been ongoing through screenings on residents for the pu- indicated in Step #2 of the CAJR which had been ongoing through reviewed and updated by the Inte accordance with Step #3 of the C that the Medical Director had rev the facility on [DATE]. This was a.m., a telephone call had been pi- interview with the Administrator resident admissions, with no resid aggressive behaviors can be asses the Administrator DON, ADON, accordance with Step #5 of the C Administrator confirmed that the Screening forms, the Behavior Mo process of ongoing, continuous rounds fd documented on the Behavior Mo process of ongoing, continuous rounds fd documented on the Behavior Mo process of ongoing, continuous rounds fd documented on the Behavior Mo process of ongoing, continuous rounds fd documented on the Behavior Mo process of ongoing, continuous rounds fd documented on the Behavior Mo process of ongoing, continuous rounds fd documented on the Behavior Mo process of ongoing, continuous rounds fd documented on the Behavior Mo process of ongoing, continuous rounds fd documented on the Behavior Mo proceduce by which the Interdisci admitted uplicensed nursing staff, Director, and the Admis	inistrator or Director of Health Services. This pr e facility's policies and procedures regarding res have the potential to lead to resident abuse. Au y for the Committee's review and oversight of fa the management of resident behaviors, the scre- ing. During this abbreviated survey, the State St ty, as reflected in the CAJR referenced above, w cuments, including the facility IS, confirmed th 2014 immediately after the incident involving R ubove On 11/21/2014, a sampled review of res but the abbreviated survey, revealed that the Inte referenced above On 11/21/2014, a sampled rout wisciplinary Team, as related to physically/verb AJR referenced above On 11/21/2014, review iewed Resident #1's medical record and submitt in accordance with Step #4 of the CAJR referer aced to Resident #1's physician, but the physicia at 11:20 a.m. confirmed that the Interdisciplinar lent being admitted until a review of the residen AJR referenced above On 11/21/2014, review iewed Resident #1's physician, but the physici at 11:20 a.m. confirmed that the Interdisciplinar lent being admitted until a review of the residen AJR referenced above On 11/21/2014, facility Administrator will be conducting monthly audit	<ul> <li>d or physical behaviors. 10. On ervice training, originally initiated on ling the resident behavior management of eight (8) Registered Nurses, thirteen ff had received this in-service training. The had not been available due to being off d will not be allowed to work until ed regarding the notification of the D14, eleven (11) of fourteen (14) LPN staff ining three (3) LPN staff and one (1) ill receive this in-service training upon 4. 12. On 11/20/2014, the facility al service Director audits of the Admission Form, Behavior Symptom Screening Form, or the QA Sub-Committee each week for four (4) to coess will allow the QA Sub-Committee to idents having verbal and/or physically dit results will also be presented to the acility staff conformance with facility ening of resident behaviors, physician urvey Agency reviewed the corrective with findings as follow: - On 11/21/2014, a tat Resident #1 was immediately placed on tesident #1 and Resident #2, as indicated in ident records completed on that date, but verified that resident Care Plans had been bally aggressive behaviors. This was in of facility investigative documents confirmed ed a written summary of this information to need above. (Of note, on 11/21/2014, at Medical Condition and potential for Admission Audit Tool. This Team will include the Social Services Director. This was in y document review and interview with the ts of the Resident Behavioral Spreyeim will step #6 of the CAJR referenced above nee of an assigned staff member to conduct ressive behaviors. These rounds were interview with the Step #6 of the CAJR referenced above On seed above. For the CAJR referenced above So the cod staff, including (but not edical Records staff, the Maintenance twivior Management Log Forms, and resident Grap Hans will not the staff. Including (but not edical Records staff, the Maintenance to the there the Steve Staff, the Maintenance to the the Steve Staff, the Maintenance the the staff. Including (but not edical Records staff, the Maintenance to the there</li></ul>

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 115385	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/21/2014
VAME OF PROVIDER OF SU		STREET ADD	DRESS, CITY, STATE, ZIP
RUITTHEALTH - CRESTV	VOOD	415 PENDLE VALDOSTA,	TON PLACE GA 31602
		cy, please contact the nursing home or the state s DEFICIENCIES (EACH DEFICIENCY MUST B	
(X4) ID PREFIX TAG	OR LSC IDENTIFYING INFORM		BE PRECEDED BT FULL REGULATOR I
F 0520 Level of harm - Immediate jeopardy	continued to conduct additional s behavior management policies an	ce training upon their return to work. On 11/20/2 taff in-service training for licensed nursing staff a d the documentation of resident behaviors. As of (14) LPN staff and thirty-one (31) of thirty-sever	and CNA staff regarding the resident 11/20/2014, six (6) of eight (8) Registered
Residents Affected - Few	Nurses, thirteen (13) of fourteen ( in-service training. The remaining in-service training upon their retu- notification of the physician of a staff and seven (7) of eight (8) Re- receive this in-service training up	(14) LPN staff, and thirty-one (31) of thirty-sever g two (2) Registered Nurses, one (1) LPN, and si: rn to work. Also, on 11/20/2014, staff in-service change in condition and of new resident behavior sgistered Nurses, but the remaining three (3) LPN on their return to work. Therefore, due to multipl e training at the time of survey exit, their comple	n (37) CNA staff had received this x (6) CNA staff will need to receive this training was conducted regarding the rs for eleven (11) of fourteen (14) LPN s taff and one (1) Registered Nurse will le licensed and certified staff members