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PINE HILLS HEALTH AND REHABILITATION, LLC	**900 MAGNOLIA RD CAMDEN, AR 71701**

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F 000	INITIAL COMMENTS	F 000		
	Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately.			
	Complaint #20354 (AR00018459) was substantiated (all or in part) with deficiencies cited at F282, F309, F314, F332, F441, and F498.			
	Complaint #20362 (AR00018472) was unsubstantiated.			
	Complaint #20365 (AR00018476) substantiated with deficiencies cited at F157, F224, and F323.			
F 157 SS=K	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)	F 157		
	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment			

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

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

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significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Complaint #20365 (AR00018476) substantiated, all or in part, in these findings:

Based on record review and interview, the facility failed to ensure immediate consultation with physician and Adult Protective Services regarding frequent agitated, aggressive, and/or intrusive behaviors that increased risk of being injured or injuring others due to his behaviors for 1 (Resident #7) of 4 (Resident #7, #12, #13 and #14) case mix residents who were was admitted to the Certified Alzheimer Care Unit in the past 6 months. This failed practice resulted in Immediate Jeopardy which caused or could have caused serious injury, harm or possible death for Resident #8 who sustained an orbital and

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maxillary fracture and had the potential to affect 19 residents who resided on the Certified Alzheimer's Unit as of 7/21/15. The Immediate Jeopardy was removed by the facility on 7/21/15 at 7:00 a.m. and the scope/severity reduced to "H" when the facility identified the issue and initiated corrective action however the facility did not correct the underlying deficient practice at the time of the survey. The facility was informed of the Immediate Jeopardy removed on 7/24/15 at 5:15 p.m. The findings are:

1. Resident #7 was admitted to the facility on 4/6/15 with diagnoses of Dementia with Behavioral Disturbance, Schizophrenia, Anxiety and Insomnia.

The History and Physical Report from the geri-psych unit dated 3/13/15 documented, " ...Admit Date: 03/13/2015...He apparently was in a psych unit in Little Rock and he was aggressive and/or taking food from other people's trays? Concern was expressed that he might be harmed on an acute unit and was sent to Geri unit. At this facility, he has been noted to lay on other people beds and take their clothing. Any other history is absolutely unavailable to this physician at this time ..." The Discharge Summary dated 4/6/15 documented, "Principle Diagnosis: Dementia with behavioral disturbances Secondary Diagnoses Schizophrenia. The Reason for Hospitalization: Patient arrived as a referral from [Hospital] due to confusion and inability to care for himself as well as a tendency to be so intrusive with other clients at that Psychiatric facility that staff there felt he was at risk for being beaten as most of the clients at that facility were younger than the client. Hospital Course: Patient was admitted to our unit and continued to evidence confusion,

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intrusiveness, and ease of agitation as well as a tendency to not take his medication despite prompting... Despite increasing doses of Haldol the patient remained, he is easily agitated and intrusive and difficult to redirect and eventually began to have tolerability issues with the Haldol in terms of side effects..."

The Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) 7/13/15 documented the resident scored 3 (0-7 indicates severely impaired) on the Brief Interview for Mental Status (BIMS); had a mood score of 0; had wandering behaviors that occurred daily; required limited assistance of 1 person for bed mobility, transfers, ambulation in room or corridor and personal hygiene; was occasionally incontinent of bowel and bladder; had no pain; was 75 inches (6 foot 2 1/2 inches) in height; and received Antipsychotic, Antidepressant and Antianxiety medication 7 of the past 7 days. The responsible party was APS (Adult Protective Service) worker #1.

a. Departmental Notes dated 4/7/15 at 1:12 a.m. documented, "On 4/6/15 10 p.m. Resident admitted to [facility name] secured Alzheimer's Unit LTC [long term care] bed ... He is ambulatory independently in corridors with slow and steady gait."

b. Departmental Notes from 4/7/15-4/30/15 (23 days) documented the resident had 11 episodes of increased agitation, aggression, and/or intrusiveness that required PRN (as needed) medication. The Departmental Notes did not document consultation with physician and APS regarding resident increased risk of being injured or injuring others due to his behaviors:

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1) Departmental Notes dated 4/7/15 at 1:47 p.m. documented, "Resident pacing and going to exit doors. Resident entering other residents' rooms and disturbing them and their visitors. Resident redirected and diverted with activities and food and drinks. Diversions lasting only a few minutes ... pacing and exit seeking. Haldol 5 mg [milligrams] IM [intramuscular] given."

2) Departmental Notes dated 4/9/15 at 2:17 a.m. documented, "On 4/8/15 at 3:00 p.m. ...Resident is becoming verbally aggressive with staff and other residents. He states, 'If you say anything else I will hold you in contempt of court and you will be put in jail for no less than 9 days.' He points at a female resident states 'Sit down and don't say a word or I will put you in jail.' Resident medicated with Haldol 5 mg IM. At 7:15 p.m. awake wandering around in dining room takes a soda from a female resident she asks him to put it down and he uses profanity."

3) Departmental Notes dated 4/10/15 at 12:26 a.m. documented, "On 4/9/15 ... at 6:00 p.m. resident is up wandering around the dining room and telling female resident to sit down and do not say anything. Attempts to redirect resident to his seat and he states ' Stop talking ' .... staff let resident wander with close supervision until he seated himself at table ... 6:30 p.m. ... Haldol 5 mg IM right deltoid."

Departmental Notes dated 4/10/15 at 3:06 p.m. documented, "...New orders received from [Physician] derease [decrease] Trazadone to 150 mg at hs [hour of sleep], dc [discontinue] Zyprexa, give Seroquel 25 mg. q [every] a.m. and 50 mg at hs. ... APS [Adult Protective Services]

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notified ..."

4) Departmental Notes dated 4/11/15 at 1:01 a.m. documented, "On 4/10/15... at 4:45 p.m. Resident went to stand over female resident seated in her w/c [wheelchair] and asks her 'Why did you get my chair' resident daughter remains present and states, 'No that her w/c.' resident turns to resident daughter and states, "You are a lie." Staff redirects across the hall for privacy Haldol 5 mg IM for increased agitation/aggressiveness. 7:30 p.m. Resident is in a female room and refuses to leave room. He was redirected by staff after 15 minutes spent with redirection ..."

5) Departmental Notes dated 4/13/15 at 10:28 p.m. at 7:30 p.m. documented, "...resident pushed the west exit door open to the courtyard causing the alarm to sound. Resident redirected ... Haldol 5 mg IM."

6) Departmental Notes dated 4/19/15 at 10:44 p.m. documented, "Resident up pacing hallway ... verbally abusive to residents and staff. Administered Lorazepam 2 mg IM in left hip at 2130 [9:30 p.m.] ..."

7) Departmental Notes dated 4/20/15 at 12:39 p.m. documented, "Resident observed pacing in hallways and other resident's rooms picking up various objects and putting them in his pocket. Resident got hold of housekeepers cart and started pushing it down the hallway staff x [times] 3 attempted to get cart away from him and he became combative, hitting at staff and saying we had better get away from him. Eventually walked away from cart continue to pick up and pocket other resident belongings becoming more

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agitated and verbally and physically aggressive. 1200 Lorazepam 1 mg IM given x 3 staff with much difficulty."

8) Departmental Notes dated 4/23/15 at 4:14 p.m. documented, "4/22/15 at 8:30 p.m. Resident turned to water on in the sink in his bathroom placed a trash can in the sink causing the water to fill the sink overflowing the bathroom and room [number] bedroom which then flowed out into the corridor. He is wandering into other residents room removing their walkers, trash cans, and other items ... he then was served alternate meal... He refused to eat became verbally aggressive with staff. He was medicated with Haldol 5 mg IM right deltoid."

Departmental Notes dated 4/23/15 at 2:54 p.m. documented, "Resident followed staff out of exit door this morning, agitated and slightly combative when staff attempted to redirect him back ... [Physician] notified, new order received for Lorazepam 1 mg po [by mouth] q [every] 4 hrs [hours] prn agitation ..." Departmental Notes at 3:34 p.m. documented the physician would be at facility on 4/30/15 and make medication adjustments.

9) Departmental Notes dated 4/26/15 at 1:39 p.m. at 11:00 a.m. documented, "Resident became agitated and started to ambulate in hallway by eye wash station. Hit window with his right hand knocking out a pane of plexi-glass. No injury. Resident medicated with Lorazepam 1 mg IM r [right] arm for agitation."

10) Departmental Notes dated 4/29/15 at 12:37 p.m. documented, "12:34 p.m. R [Resident] pacing the hallway back and forth. Agitstion

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[agitation] noted to be increased at this time. R refuses to go into dining room and eat, stating 'there's bad people in there.' Lorazepam 1 mg given po at this time ..."

11) Departmental Notes dated 4/30/15 at 2:18 a.m. documented, "1:00 a.m. Resident up pacing back and forth in hallways not easily redirected increase agitation when redirecting resident. Ativan [Lorazepam] 2 mg/ml carpuject inject 0.5 ml (1 mg) IM given..."

c. Departmental Notes and the May 2015 Medication Administration Record (MAR) from 5/1/15 - 5/31/15 (31 days) documented the resident had 24 episodes of increased agitation, aggression, and/or intrusiveness that required PRN medication. The Departmental Notes and Physician Progress Notes did not document consultation with the physician and APS regarding resident increased risk of being injured or injuring others due to his behaviors

1) Departmental Notes dated 5/2/15 at 10:59 p.m. documented, "At 10:00 a.m. resident pacing back and forth in hallway, very anger, balling fist and trying to hit staff and residents. Lorazepam 2 mg administered. At 1700 [5:00 p.m.] Resident pacing back and forth in hallway, very anger [angry] balling fist and trying to hit staff and residents. Lorazepam 2 mg administer[ed] ..."

2) Departmental Notes dated 5/2/15 at 10:59 p.m. documented, "...at 1700 [5:00 p.m.] resident pacing back and forth in hallway, very anger [angry], balling fist and trying to hit staff and residents. Lorazepam 2 mg administer[ed] ..."

3) The back of the May 2015 MAR documented

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the resident was administered Lorazepam 1 mg p.o. for increased agitation on 5/4/15 at 6:15 p.m.

4) The back of the May 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation on 5/5/15 at 1030.

5) Departmental Notes dated 5/6/15 at 3:54 a.m. documented, "2:45 p.m. Resident up wandering hallways not easily redirected easily agitated. Ativan 1 mg 1 tab po given ..."

6) Departmental Notes dated 5/7/15 at 6:28 a.m. documented, "5:30 a.m. Resident is up attempting to wander throughout halls. Not easily redirected... Increased agitation Ativan 1 mg po given."

7) Departmental Notes dated 5/7/15 at 1:02 p.m. documented, "0915 [9:15 a.m.] R is noted to have extreme agitation at this time. Housekeeper state he will not leave things on her cart alone. R [Resident] noted trying to move the doghouse on the unit as another R was leaning on it as he does daily. R noncompliant with redirection. Lorazepam 2 mg/ml carpuject inject 0.5 ml (1 mg) IM given at this time for agitation ..."

Departmental Notes dated 5/7/15 at 1:16 p.m., "1100 [11:00 a.m.]-R is noted across the hall from his room in another R room without pants or brief on. R in other resident's bathroom running the water to the point of almost overflowing. R taken back to his room ..."

8) Departmental Notes dated 5/8/15 at 12:08 a.m. documented, "Resident up wandering up and down hallways. Inattention fidgeting with door knobs trying to open doors. Moving the dog

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house trying to pick it up. Not easily redirected increase in agitation Ativan 1 mg 1 tablet given po ..."

9) Departmental Notes dated 5/8/15 at 6:02 a.m. documented, "Resident wandering in dining room getting into drawers and anything that is on the counter. Resident will not put on clothing and not easily redirected to his room. Increased agitation when trying to dress him or redirect. Ativan 1 mg 1 tab po given ...."

10) Departmental Notes Addendum dated 5/8/15 at 11:59 a.m. documented, "Resident in and out of resident's rooms going in bathrooms and turning water on not easily redirected. Resident noted to be incontinent of bowel, when staff approached him for toileting and peri-care he's very resistive and became slightly combative. Male staff arrived and peri-care given per 3 staff. 12:30[p.m.] Ativan 1 mg po given. ..."

11) The back of the May 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation at 7:00 p.m. on 5/8/15.

12) Departmental Notes dated 5/8/15 at 4:44 a.m. documented, "11:30 [p.m.] Resident up wandering halls with diaper on head and no pants. Not easily redirected increase in agitation when trying to get resident go back to room. Ativan 1 mg 1 tablet given po ..."

13) Departmental Notes dated 5/9/15 at 6:05 a.m. documented, "Residnet [resident] taking clothes off and on in room. Resident as [has] clothing all over room. Has diaper on head and shirt on wrong way. Resident urinating outside door. Not easily redirected. Ativan 1 mg po given ..."

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14) The back of the May 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation at 7:00 p.m. on 5/12/15.

15) Departmental Notes dated 5/13/15 documented, "7 p.m. Resident is up wandering from table to table in the dining room, turning on the water at the sink, becoming loud with staff and other residents. He is redirected with fluids and food but continues with behavior escalation. He is medicated with Ativan 1 mg 2 po ..."

16) The back of the May 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation on 5/16/15 at 1940 (7:40 p. m.).

17) The back of the May 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation on 5/17/15 at 1610 (4:10 p.m.).

18) Departmental Notes dated 5/21/15 at 4:04 p.m. documented, "1000 [10 a.m.] Resident observed standing at window in kitchen looking out at parking lot, he said he see his car out there and needs to go get it, he attempted to open window, multiple attempts per staff to divert him away from window before he complied, then he became severely agitated with staff and verbally aggressive. At 10:30 a.m. attempted to give Lorazepam 0.5 ml 1 mg IM per assist x 3 staff, resident became extremely agitated and resistive and unable to give complete dose ... Lorezpam 1 mg po given and taken without incident ..."

19) Departmental Notes dated 5/21/15 at 11:42

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p.m. documented, "...7:00 p.m. He is medicated with Ativan 1 mg 1 po for increased agitation when staff attempts to assist with changing of his clothes."

20) Departmental Notes dated 5/22/15 at 6:43 a.m. documented, "1:10 a.m. gave bruse [?] 0.5mg im [IM] for being vety [very] aggitated [agitated] and trying to take things in other resident froom [room]." The May 2015 Medication Administration Record (MAR) documented Lorazepam 1 mg IM was administered.

21) Departmental Notes dated 5/22/15 at 11:18 a.m. documented, "1045 Resident observed at window in dining room pulling up on window and trying to open it, not easily diverted. Resident left dining room and began pacing in hallways and pounding on door and window of Nursing Station. Lorezepan 1 mg po given..."

22) Departmental Notes dated 5/25/15 at 1:46 p.m. documented, "Since out of bed this morning resident has been pacing, going in other residents rooms and getting their belongings, he became agitated with staff when redirected. Lorezepam 1 mg po given at 11:30 a.m...."

23) Departmental Notes dated 5/25/15 at 11:35 p.m. documented, "6:40 p.m. Resident up and pacing in the corridors. He has behavior of wandering in other residents rooms. Resident in [room #33] states he doesn't want this resident [Resident #7] back in his room. ADON [Assistant Director of Nurses] was notified of the resident in [room #33] concerns of this resident coming into his room. At 7:00 p.m. Resident has wandered into room #34 when redirecting him he became

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agitated states, 'Just leave me alone' , staff gave resident sandwich and sweet tea and medicated him with Ativan 1 mg po. Staff remains in room 34 with resident [#7] until he agrees to go to his room..."

Departmental Notes dated 5/27/15 at 3:44 p.m. documented, "Resident pacing hallways and going into other residents rooms pilfering in closets and drawers. Attempts to redirect with activities/food/fluids. Resident becomes increasingly agitated towards staff. Call placed to [Physician] with new orders received to increase Seroquel to 50 mg in am and 100 mg hs. [APS] notified of new orders..."

Departmental Notes dated 5/28/15 at 4:34 p.m. documented, "[Physician] here to examine resident with no new orders received."

Physician Progress Notes dated 5/28/15 documented, "HPI [history and physical information]/Social History: ...He was transferred to psych facility for APS related issue. He was aggressively taking food from other patient's trays. Because of his aggressive behavior, it was felt that there might be some issues with him being placed in acute care unit, so he was admitted to the Geriatric Unit at this facility. It had been reported that he was found on occasion on other peoples' beds removing their clothes. Beyond that, I can't get much else ...Plan: He seems to have done better with the dose reduction on the medications he came in here taking. At this point we'll sit tight and see how he responds with the switch from Abilify to Seroquel bid [twice daily]..."

24) Departmental Notes dated 5/31/15 at 4:10

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p.m. documented, "At 4:15 p.m. administered Lorazepam 2 mg IM right hip for agiation [agitation]."
d. Departmental Notes and the June 2015 Medication Administration Record (MAR) from 6/1/15 - 6/30/15 (30 days) documented the resident had 13 episodes of increased agitation, aggression, and/or intrusiveness that required PRN medication. The Departmental Notes did not document consultation with physician and APS regarding resident increased risk of being injured or injuring others due to his behaviors:

1) Departmental Notes dated 6/1/15 4:10 p.m. documented, "At 1430 [2:30 p.m.] Resident went in eyewash room, had BM [bowel movement] smeared it on cabinets and is clothing. He refused to change his clothes or allow staff to assist him, he became verbally and physically threatening. Lorazepam 1 mg IM given."

2) The back of the June 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation on 6/5/15 at 9:30 a.m.

3) The back of the June 2015 MAR documented the resident was administered Lorazepam 1 mg IM for behavior on 6/7/15 at 1830 (6:30 p.m.).

4) The back of the June 2015 MAR documented the resident was administered Lorazepam 1 mg IM for behavior agitation on 6/8/15 at 0400 (4:00 a.m.).

5) The back of the June 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation on 6/16/15 at 4:30 p.m.

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F 157	Continued From page 14 6) The back of the June 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation on 6/17/15 at 10:45 a.m. 7) The back of the June 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation on 6/19/15 at 4:30 p.m. 8) The back of the June 2015 MAR documented the resident was administered Lorazepam 1 mg IM for behavior agitation on 6/21/15 at 2202 (10:02 p.m.). 9) The back of the June 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation on 6/23/15 at 10:45 a.m. 10) The back of the June 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation on 6/23/15 at 3:30 p.m. 11) The back of the June 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation on 6/26/15 at 9:30 a.m. 12) Departmental Notes dated 6/26/15 11:52 p.m. documented, "4:20 p.m. Resident was walking pass staff he caught her left arm holding tightly around her left wrist, verbal cueing from staff to resident to released staff arm then redirected to dining room for food and fluid. Resident continues to be verbal aggressive to staff and other residents. He is medicated with Ativan 1 mg po. "	F 157		

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13) The back of the June 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation on 6/27/15 at 11:40 a.m.

e. Departmental Notes and the July 2015 Medication Administration Record (MAR) from 7/1/15 - 7/16/15 (16 days) documented the resident had 6 episodes of increased agitation, aggression, and/or intrusiveness that required PRN medication. The Departmental Notes did not document consultation with physician and APS regarding resident increased risk of being injured or injuring others due to his behaviors:

1) The back of the July 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation on 7/01/15 at 3:00 a.m.

2) Departmental Notes dated 7/2/15 10:32 a.m. documented, "10:30 a.m. Ativan 1 mg po given, resident observed over past hour pacing in hallways, going in male residents room and bothering them. Resident talking non-stop in manic like mode with speech becoming threatening towards some staff. All attempts to divert his attention with activities snacks, 1-1 have been futile ... "

3) The back of the July 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation on 7/4/15 at 9:15 a.m.

4) The back of the July 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation on 7/5/15 at 9:00 a.m.

5) The back of the July 2015 MAR documented

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the resident was administered Lorazepam 1 mg p.o. for increased agitation on 7/8/15 at 11:30 a.m.

6) Departmental Notes dated 7/16/15 at 3:19 p.m. documented, "10:45 a.m. Resident woke up this morning in agitated mood, pacing with angry of tone of voice when staff cues him for redirections and to dining room for breakfast. Resident made attempt to hit staff but did not make contact. Ativan 1 mg po given ... "

f. Departmental Notes dated 7/21/15 at 7:30 a.m. documented, "6:30 a.m. Resident came to Nurse at Nurse's station stated, ' Someone attacked me. ' this nurse followed resident to room and found [Resident #8] sitting on bed with blood coming from nose and hematoma with quarter sized swelling to right eye. This [Resident #8] could not state what happened. Resident [Resident #7] stated, ' She attacked me. ' I asked did resident hit her, he [Resident #7] stated, ' I kicked her in the face. ' When asked Resident did this resident [Resident #8] hit him he stated, "No." This Nurse separated the resident into Nurses Station. Resident [Resident #7] denies any pain 0 on pain scale 1-10. Full ROM [range of motion] in UE [upper extremities] and LE [lower extremities] No noted blood on resident. Resident was given Ativan 2 mg/ml 0.5 ml [IM] given to right gluteus medius... Called on call MD ... notified of incident ... 6:55 a.m. Attempted to notify [APS worker #1] and only answering machine. " A Continuous Monitoring 1:1 form dated 7/21/15 documented the facility began continuous 1 on 1 monitoring of resident at 6:30 a.m. which continued until discharge.

Resident #8, a 102 year old female, had

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F 157	Continued From page 17 diagnosis of Alzheimer's disease. Departmental Notes dated 7/21/15 at 7:27 a.m. documented the resident was sent to the hospital emergency room (ER). Departmental Notes date 7/21/15 at 11:24 a.m. documented, "Discharge dx [diagnosis] from ER facial fracture. Right orbital and right maxillary fracture..." g. Departmental Notes dated 7/23/15 at 3:14 p.m. and signed Alzheimer ' s Care Unit Director (ACUD) documented, "At approximately 1:30 p.m. this Nurse took over the 1:1 continuous monitoring to relieve CNA for lunch. [Resident #7] was ambulating up and down hallway. Resident went into the room of two female residents and I had difficulty redirecting him to leave the room. He was exhibiting sternness and reverting to "cop lingo" when speaking to me. I attempted to hold open the door he was trying to shut and he grabbed my wrist stating. ' I will murder you and they will find you hanging in the trees. ' Once redirected and back into hallway, resident became increasingly agitated and inconsolable. He opened the door to another resident ' s room, entered and I was unable to redirect him out of the room. [Resident #7] reached down to grab a shoe belonging to the resident of the room he entered and the two resident became verbally aggressive towards one another and I had to call for help to redirect [Resident #7]. The [Name] ADON and [Name] DON entered the room. The [DON] was able to get [Resident #7] attention and walk him out the room. [Resident #7] became increasingly agitated, would not take the oral Ativan 1 mg that the LPN was offering. [Resident #7] became increasingly verbally threatening to staff and several staff members stated they were "scared" of him at this point. He was not able to be redirected and I sought guidance from the	F 157		

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DON and ADON. I was told to call ambulance and send him to ER. The ER was contacted and the ambulance was dispatched to the facility. It took several staff members to get [Resident #7] to calm down and get onto the stretcher. [Resident #7] was given Ativan 1 mg IM in right deltoid muscle. Phone [APS Worker #1] and left message. ER call and stated they were sending [Resident#7] back to the facility. I spoke with [APS Worker #1] and will seek placement at geri-psych. facility with her approval of facility .... "

Departmental Notes dated 7/23/15 documented the resident was transferred out of facility at 7:00 p.m.

h. On 7/24/15 licensed nurses were interviewed:

At 9:40 a.m., Licensed Practical Nurse (LPN) #5 was asked if she worked on the Certified Alzheimer Unit. The LPN stated, "Yes for 3 1/2 years. " The LPN was asked what was Resident #7 behaviors. The LPN stated, "He would wander in and out of other residents' rooms, he had trouble finding the bathroom. He had behaviors, but I was able to control him better than other people. He got agitated, he would pace, pilfer and pick up things. " The LPN was asked if Resident #7 ' s behaviors got to a point that he had to have medications. The LPN stated, "Yes, there were periods that he would have to be medicated. Then all of a sudden his behaviors escalated, they had been random. " The LPN was asked if she had talked to anyone. The LPN stated the CNAs reported to her his behaviors. The LPN was asked if she had reported to anyone else regarding the increased episodes of the resident ' s behaviors. The LPN stated, "Yes, I spoke with then Alzheimer Care Unit Director." The LPN was

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asked what was the criteria for giving residents the PRN [as needed] medications. The LPN stated, "We try redirection, activities, food, 1-to-1 with him before we give the medications. " The LPN was asked, " Did you call the physician when the resident received PRN medication for several days and the resident's behaviors of agitation had increased and was the responsible party notified. " The LPN stated, "No."

At 10:55 a.m., LPN #4 was asked if she worked on the Certified Alzheimer Unit. The LPN stated for 1 year. The LPN was asked what was Resident #7's behaviors. The LPN stated, "At times he can become verbally abusive and you have to redirect him. " The LPN was asked what kind of behaviors did he exhibit. The LPN stated, "Verbal threats that he was going to do something to you. Sometimes he would calm down and sometimes he required medication to calm him down. " The LPN was asked what kind of threats did the resident make, did the resident threaten to hit. The LPN was shown documentation that she documented on 5/2/15. The LPN stated, " Yes he did ball up his fist and threaten to hit staff and residents. " The LPN was asked if she had reported this incident to anyone. The LPN stated, "I can't remember." The LPN was asked if she had called the Physician or the responsible party regarding the increased behaviors. The LPN stated, "I can't remember." The LPN was asked, " Do you feel that the resident ' s aggressive behaviors should have been reported? " The LPN stated, "I probably called the Supervisor on call. " The LPN was asked where this was documented. The LPN stated, "It's not documented." The LPN was asked if the other residents were at risk. The LPN stated, "Not at that time, we redirected him and gave him

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F 157	Continued From page 20 medication. " The LPN was asked should a resident be admitted to the Certified Alzheimer Unit with a Psychiatric Diagnosis. The LPN stated, "No." The LPN was asked why. The LPN stated, "No, that would be a potential danger." At 1:35 p.m., LPN #2 was asked if she worked on the Certified Alzheimer Unit. The LPN stated, "Yes on the 11-7 shift. The LPN was asked if there were any issues related to behaviors or aggressive residents on the Alzheimer Unit. The LPN stated, " Yes with [Resident #7] that was the only issue. He was doing fine, then he had periods of agitation and not easily redirected. " The LPN was asked what the resident's behaviors were. The LPN stated, "He knocked out a window, no major problems until the other day. " The LPN was asked what happened. The LPN stated, "I was at the Nursing station, [Resident #7] came to the Nursing Station and stated that somebody had attacked him. I followed him back to his room and I saw [Resident #8] sitting on the bed with blood all over her. I got [Resident #7] out of the room. I got [Resident #8] out of the room, I got her sent to the ER [Emergency Room]. When [Resident #7] came to the Nursing Station he was not showing any signs or symptoms of aggression. I asked [Resident #7] what happened. [Resident #7] stated ' I kicked her in the face ' . " The LPN was asked when did this happen. The LPN stated, "It occurred at about 6:30 a.m. on 7/21/15. " The LPN was asked if there had been any aggressive behaviors problems. The LPN stated no resident to resident contact, but he had aggressive behavior that wasn't easily redirected. The LPN stated, "I was at the Nursing Station. " The LPN was asked if she could see down the hall. The LPN stated, "Not the front hall where	F 157		

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[Resident #7 and #8] were located. " The LPN was asked if [Resident #8] had any behaviors. The LPN stated, "She generally didn't wander, once in a blue moon did she get up at night. " The LPN was asked if Resident #7 had any behaviors at night. The LPN stated, "He did wander at night, he had started sleeping, but that morning he was getting up. "

i. On 7/23/15 at 7:00 p.m., the Director of Nursing (DON) was asked, after reviewing the documentation regarding Resident #7, if this resident was appropriate for the Certified Alzheimer's Unit. The DON stated, "I was not aware of his history. I didn't read the documentation at that time of admission. " The DON was asked if she was aware of the resident's aggressive behaviors that were documented in the resident ' s clinical record. The DON stated, "I was aware of his pacing and going in other resident rooms. I was not aware of his aggressive behaviors towards staff and other residents. " The DON was shown the documentation on 5/2/15 that the resident had balled up his fist and was threatening the staff and other residents. The DON stated, "I was not aware." The DON was asked if the resident's increased incidents of aggressive behaviors were reported to her. The DON stated, "No." The DON was asked if a resident was having increased episodes of aggressive behaviors shouldn't this be reported to the Physician and responsible party. The DON stated, "Yes." The DON was asked if the increased episodes of aggressive behaviors would put the other residents on the Alzheimer's unit at risk. The DON stated, "Yes."

j. On 7/24/15 at 2:15 p.m., the Alzheimer Care Unit Director (ACUD) was asked if the staff

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F 157	Continued From page 22 reported any aggressive behaviors or increased behaviors regarding Resident #7. The ACUD stated, "No." The ACUD was asked if a resident had increased behaviors that required to be medicated who should they report to. The ACUD stated that they should report to the Nurse and notify the ACUD. The ACUD was asked if the Physician and responsible party should be notified. The ACUD stated, "Yes. I thought they had been notified when the incident occurred on 7/21/15." The ACUD was asked was the Physician and responsible party notified when Resident #7 had increased behaviors. The ACUD stated that she had not notified the responsible party [APS worker #1] until 7/23/15. The ACUD was asked, "What is the importance of notifying the Physician of the resident increased behaviors?" The ACUD stated, "For the benefit of the resident." The ACUD stated that this was an oversight on her part. The ACUD stated, "I was trying to transfer the resident out. " The ACUD was asked if she had called the Physician or the responsible party when she was trying to transfer the resident. The ACUD stated, "No, I should have called for guidance." The ACUD was asked if a resident with Psychiatric diagnosis, Schizophrenia, be admitted to the Certified Alzheimer Unit. The ACUD stated, "I would say we are not equipped to deal with them. " k. On 7/27/15 at 4:30 p.m., the Administrator was asked regarding the documentation on a letter dated July 21, 2015, signed by the Administrator, and attached to the OLTC (Office of Long Term Care) Incident and Accident Report (I&A) form dated 7/21/15. The Administrator stated that they had contacted [Physician #1] to place a referral for [Resident #7]. The documentation stated that the resident had not displayed any s/s (signs or	F 157		

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symptoms) of aggressive behavior at this time and that he was very remorseful for the events that took place and has repeatedly asked staff, "How is she? Is she ok? " The letter stated [Physician #1] has agreed to review this information in attempt to prevent resident from being placed outside the facility in geri-psych admission. The Administrator was asked if the resident's attending Physician had given orders for the referral. The Administrator stated, "No." The Administrator was asked if the staff had reported to her the frequently documented incidents in the resident ' s clinical record of aggressive behaviors. The Administrator stated, "No."

l. On 7/27/15 at 6:35 p.m., the attending physician [Physician #2] was asked if he was made aware of Resident #7's incident on 7/21/15 and the physician stated, "On vacation last week. Typically adjust med." The physician was asked if he would expect the facility to notify the physician when a resident has had behavior changes and the physician stated, "Yes..."

m. On 7/24/15 at 3:40 p.m., APS Caseworker #1 was asked if Resident #7 was in APS custody and the Caseworker stated, "Yes." The APS Caseworker was asked if had was notifed on 7/21/15 of any resident to resident altercation that involved Resident #7 and the Caseworker stated, "No. I was advised 7/23/15 by Emergency Room hospital staff after I received a call from them. I was advised by [Alzheimer's Care Unit] Director then afterwards. Only received call after the hospital called ... By the way on Tuesday [7/21/15] he kicked a 102 year old resident [Resident #8] I found that out after he went to the Emergency Room ...I did an order to transport.

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F 157	Continued From page 24 Judge signed. [County] Sheriff office transport. Started process for transport as soon as found out Thursday." The APS Caseworker was asked if aware of other behavior incidents could any measures have been taken with Resident #7 and the APS Caseworker #1 stated, "Talked to doctor about meds and we could have addressed the behaviors sooner." The APS Caseworker was asked if notified of the resident's increased behaviors that included hitting window and hitting female resident. The APS Caseworker stated, "I have not been notified about him getting aggressive or hitting objects. Found out about the incident yesterday when I was called by staff nurse [Emergency Room]. If I had known about that incident sooner I could have initiated arrangements to send out sooner. Not notified of any aggressive behavior."	F 157		
F 224 SS=K	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Complaint #20365 (AR00018476) substantiated, all or in part, in these findings: Based on observation, record review and interview, the facility failed to fully operationalize written policies and procedures related to the	F 224		

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certified Alzheimer Care Unit to prevent neglect as evidenced by the facilities failures to ensure adequate pre-screening for appropriateness of placement prior to admission, to ensure risk factors due to behaviors were identified with interventions promptly developed and consistently implemented and assessed for effectiveness; to ensure physician, Adult Protective Services (resident guardian), and facility management involved in developing interventions to ensure safety of resident as well as the other residents that was in close contact; to ensure sufficient staffing to monitor resident to prevent resident injury for 1 (Resident #7) of 4 (Resident #7, #12, #13 and #14) case mix residents who were admitted to the Certified Alzheimer Care Unit in the past 6 months. This failed practice resulted in Immediate Jeopardy which caused or could have caused serious injury, harm or possible death for Resident #8 who sustained an orbital and maxillary fracture and had the potential to affect 19 residents that resided on the Certified Alzheimer's Unit as of 7/21/15. The Immediate Jeopardy was removed by the facility on 7/21/15 at 7:00 a.m. and the scope/severity reduced to " H " when the facility identified the issue and initiated corrective action however the facility did not correct the underlying deficient practice at the time of the survey. The facility was informed of the Immediate Jeopardy removed on 7/24/15 at 5:15 p.m. The findings are:

1. On 7/27/15 at 11:30 a.m., the Administrator provided the Admission/Discharge Criteria for the Alzheimer Care Unit. The criteria was documented as follows:

"I. The primary diagnosis of Alzheimer's or other related cognitive disorder was

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established.

II. The cognitive loss is not a result of head injury, mental illness or mental retardation. (Persons with traumatic brain injury, mental illness and mental retardation have different needs). Look for age appropriateness as well as former lifestyle.

III. The resident must not be harmful to self (self-injurious) or other residents... "This is to certify that (Facility Name) Alzheimer Special Care Unit capacity is 40 beds is hereby recognized in compliance with the Office of Long Term Care's rules and regulation for Alzheimer's Special Care Units and is authorized to advertise or otherwise hold itself out as offering a specialized unit for the residents with Alzheimer's or related dementia."

2. The Department of Human Services Division of Human Services Regulation Memo-Promulgation of Alzheimer's Special Care Unit Regulation for Nursing Homes documented, "The Office of Long Term Care has promulgated regulations for Alzheimer's Special Care Units (ASCU'S) For Nursing Homes. The regulations became effective October 1, 2003. A copy of the regulations is attached to this memorandum.

Definitions ... Alzheimer's Special Care Unit. A separate and distinct unit within a Long Term Care Facility that segregates and provides a special program for residents with a diagnosis of probable Alzheimer's Disease or related Dementia and that advertises or otherwise hold itself out as having one (1) or more special units for residents with diagnosis of probable Alzheimer's Disease or related Dementia.

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Direct Care Staff. An individual who is an employee of the facility or who is an employee of temporary agency assigned to work in the facility and who has received or will receive in accordance with this regulation specialized; training regarding Alzheimer's or related Dementia and is responsible for providing direct, hands-on care or services to resident in the ASCU.

3. The ACU [Alzheimer Care Unit] Book containing policies, procedures, and other documentation for the specialized Alzheimer unit was received from the Alzheimer Care Unit Director (ACUD) on 7/25/15 at 5:55 p.m. The ACUD was asked if this was the policy and procedures that were put in place when the ACU unit was approved by Department of Human Services as an accredited Alzheimer's Care Unit. The ACUD stated that she was hired approximately 3 weeks ago and was still in training. The ACUD stated, "The Beacon book was their advertising, but also had policies."

The Policy and Procedures were reviewed for the Admission Policy documented "...2. The assessment process begins prior to admission with the inquiry and pre-admission screening ... 9. The initial assessment for pre-admission/admission should... Ascertain the validity of the diagnosis by noting the comprehensiveness and skill which the diagnostic evaluations were conducted... Even with a diagnosis of Alzheimer's disease established, other accompanying dementia's or treatable cause of increased confusion should be rigorously evaluated and diagnosed... Assess the social needs, preferences, behaviors and medical needs of the individual to maintain a balance of

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social needs and personalities among the existing participants in the program."

The Policy and Procedures in the Alzheimer's Care Unit book documented,
Department Dedicated Alzheimer's Care Unit
Subject: Staffing Policy documented, "There will be sufficient consistent and qualified staff dedicated to carry out the mission policies and the care plan of the dementia care services."

"Department Heads, All facility department heads retain accountability for assessing planning and documenting the delivery of services on the unit as well as clinical oversight including, acting as a resource to the unit. Evaluating referral regarding nutritional, medical, social, and recreational needs when a resident experiences a significant change or evidences a need that cannot be met through unit staff intervention. Provide clinical oversight on the unit ...

Resident with cognitive impairment require a more constant staff presence for the implementation of the structured daily plan for each resident in their assignment. Consistent assignments are the basis of the primary care aide system in which CNA [Certified Nursing Assistant] leads his/her assigned residents through successful activities of daily living, meals and recreation. Each unit will have established staff to resident ratio ...

... Staffing Ratio ------ primary caregivers case load should not exceed.
Day/shift staffing ration 1 BACS [Beverly Alzheimer's Care Specialist] to 8 residents.
Evening Shift staffing ratio 1 BACS to 10 residents and Night Shift staffing ratio of 1 BACS

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to 10 residents."

4. The Beacon Place Program Binder Admission Criteria received from the Alzheimer Care Unit Director (ACUD) on 7/23/15 documented, "Policy Skilled Nursing Facilities that have a secure or Memory Care model will provide specialized services to meet the needs of individuals with diagnosis of dementia.

65 years of age
moderate to severe Dementia.
Benefit from a secure environment
with or without behaviors

Procedure
Clinical team will evaluate incoming residents to verify a diagnosis similar or the same as outlined below. Team will utilize the following admission criteria in addition to the current admissions guidelines to determine if the resident is appropriate for the community. If a prospective resident has a diagnosis other that listed below, the DON or similar position will contact the Regional Clinical Manger for approval prior to admission.

Admitting Diagnosis (included but not limited to)
Dementia Alzheimer Type
Frontal Temporal Dementia
Vascular Dementia
Parkinson's related Dementia
Lewy Body Dementia
Dementia's secondary to brain injury.

Basic Admission Criteria:
65 and younger (younger individuals will be considered on a case by case basis)
Experiencing symptoms related to dementia that

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are unmanageable in current community setting benefit from secure therapeutic environment."

5. Resident #7 was admitted to the facility on 4/6/15 with diagnoses of Dementia with Behavioral Disturbance, Schizophrenia, Anxiety and Insomnia.

The History and Physical Report from the geri-psych unit dated 3/13/15 documented, "...Admit Date: 03/13/2015...He apparently was in a psych unit in Little Rock and he was aggressive and /or taking food from other people's trays? Concern was expressed that he might be harmed on an acute unit and was sent to Geri unit. At this facility, he has been noted to lay on other people beds and take their clothing. Any other history is absolutely unavailable to this physician at this time ..." The Discharge Summary dated 4/6/15 documented, "Principle Diagnosis: Dementia with behavioral disturbances Secondary Diagnoses Schizophrenia. The Reason for Hospitalization: Patient arrived as a referral from (Hospital Name) due to confusion and inability to care for himself as well as a tendency to be so intrusive with other clients at that Psychiatric facility that staff there felt he was at risk for being beaten as most of the clients at that facility were younger than the client. Hospital Course: Patient was admitted to our unit and continued to evidence confusion, intrusiveness, and ease of agitation as well as a tendency to not take his medication despite prompting...Despite increasing doses of Haldol the patient remained, he is easily agitated and intrusive and difficult to redirect and eventually began to have tolerability issues with the Haldol in terms of side effects..."

The Quarterly Minimum Data Set (MDS) with

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Assessment Reference Date (ARD) 7/13/15 documented the resident scored 3 (a score of 0-7 indicates severely impaired) on the Brief Interview for Mental Status (BIMS); had a mood score of 0; had wandering behaviors that occurred daily; required limited assistance of 1 person for bed mobility, transfers, ambulation in room or corridor and personal hygiene; was occasionally incontinent of bowel and bladder; had no pain; was 75 inches (6 foot 2 1/2 inches) in height; and received Antipsychotic, Antidepressant and Antianxiety medication 7 of the past 7 days. The responsible party was APS (Adult Protective Service) worker #1.

a. Departmental Notes dated 4/7/15 at 1:12 a.m. documented, "On 4/6/15 10 p.m. Resident admitted to [facility name] secured Alzheimer's Unit LTC [long term care] bed ...He is ambulatory independently in corridors with slow and steady gait."

b. Departmental Notes from 4/7/15-4/30/15 (23 days) documented the resident had 11 episodes of increased agitation, aggression, and/or intrusiveness that required PRN medication. The Departmental Notes did not document consultation with physician, APS, or facility management regarding resident increased risk of being injured or injuring others due to his behaviors:

1) Departmental Notes dated 4/7/15 at 1:47 p.m. documented, "Resident pacing and going to exit doors. Resident entering other residents rooms and disturbing them and their visitors. Resident redirected and diverted with activities and food and drinks. Diversions lasting only a few minutes ... pacing and exit seeking. Haldol 5 mg

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[milligrams] IM [intramuscular] given."

2) Departmental Notes dated 4/9/15 at 2:17 a.m. documented, "On 4/8/15 at 3:00 p.m. ...Resident is becoming verbally aggressive with staff and other residents. He states, 'If you say anything else I will hold you in contempt of court and you will be put in jail for no less than 9 days.' He points at a female resident states 'Sit down and don't say a word or I will put you in jail.' Resident medicated with Haldol 5 mg IM. At 7:15 p.m. awake wandering around in dining room takes a soda from a female resident she asks him to put it down and he uses profanity."

3) Departmental Notes dated 4/10/15 at 12:26 a.m. documented, "On 4/9/15 ... at 6:00 p.m. resident is up wandering around the dining room and telling female resident to sit down and do not say anything. Attempts to redirect resident to his seat and he states 'Stop talking' .... staff let resident wander with close supervision until he seated himself at table ... 6:30 p.m. ...Haldol 5 mg IM right deltoid."

Departmental Notes dated 4/10/15 at 3:06 p.m. documented, "...New orders received from [Physician] derease [decrease] Trazadone to 150 mg at hs [hour of sleep], dc [discontinue] Zyprexa, give Seroquel 25 mg. q [every] a.m. and 50 mg at hs. ... APS [Adult Protective Services] notified ..."

4) Departmental Notes dated 4/11/15 at 1:01 a.m. documented, "On 4/10/15... at 4:45 p.m. Resident went to stand over female resident seated in her w/c [wheelchair] and asks her 'Why did you get my chair' resident daughter remains present and states, 'No that her w/c.' resident turns to

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F 224	Continued From page 33 resident daughter and states, "You are a lie." Staff redirects across the hall for privacy Haldol 5 mg IM for increased agitation/aggressiveness. 7:30 p.m. Resident is in a female room and refuses to leave room. He was redirected by staff after 15 minutes spent with redirection ..." 5) Departmental Notes dated 4/13/15 at 10:28 p.m. at 7:30 p.m. documented, " ...resident pushed the west exit door open to the courtyard causing the alarm to sound. Resident redirected ...Haldol 5 mg IM." 6) Departmental Notes dated 4/19/15 at 10:44 p.m. documented, "Resident up pacing hallway ... verbally abusive to residents and staff. Administered Lorazepam 2 mg IM in left hip at 2130 [9"30 p.m.] ..." 7) Departmental Notes dated 4/20/15 at 12:39 p.m. documented, "Resident observed pacing in hallways and other resident's rooms picking up various objects and putting them in his pocket. Resident got hold of housekeepers cart and started pushing it down the hallway staff x 3 attempted to get cart away from him and he became combative, hitting at staff and saying we had better get away from him. Eventually walked away from cart continue to pick up and pocket other resident belongings becoming more agitated and verbally and physically aggressive. 1200 Lorazepam 1 mg IM given x 3 staff with much difficulty." 8) Departmental Notes dated 4/23/15 at 4:14 p.m. documented, "4/22/15 at 8:30 p.m. Resident turned to water on in the sink in his bathroom placed a trash can in the sink causing the water to fill the sink overflowing the bathroom and room	F 224		

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[number] bedroom which then flowed out into the corridor. He is wandering into other residents room removing their walkers, trash cans, and other items ....he then was served alternate meal...He refused to eat became verbally aggressive with staff. He was medicated with Haldol 5 mg IM right deltoid."

Departmental Notes dated 4/23/15 at 2:54 p.m. documented, "Resident followed staff out of exit door this morning, agitated and slightly combative when staff attempted to redirect him back ... [Physician] notified, new order received for Lorazepam 1 mg po [by mouth] q [every] 4 hrs [hours] prn agitation ..." Departmental Notes at 3:34 p.m. documented the physician would be at facility on 4/30/15 and make medication adjustments.

9) Departmental Notes dated 4/26/15 at 1:39 p.m. at 11:00 a.m. documented, "Resident became agitated and started to ambulate in hallway by eye wash station. Hit window with his right hand knocking out a pane of plexi-glass. No injury. Resident medicated with Lorazepam 1 mg IM r [right] arm for agitation."

10) Departmental Notes dated 4/29/15 at 12:37 p.m. documented, "12:34 p.m. R [Resident] pacing the hallway back and forth. Agitstion [agitation] noted to be increased at this time. R refuses to go into dining room and eat, stating ' there ' s bad people in there.' Lorazepam 1 mg given po at this time ..."

11) Departmental Notes dated 4/30/15 at 2:18 a.m. documented, 1:00 a.m. Resident up pacing back and forth in hallways not easily redirected increase agitation when redirecting resident.

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Ativan [Lorazepam] 2 mg/ml carpuject inject 0.5 ml (1 mg) IM given .... "

c. Departmental Notes and the May 2015 Medication Administration Record (MAR) from 5/1/15 - 5/31/15 (31 days) documented the resident had 24 episodes of increased agitation, aggression, and/or intrusiveness that required PRN medication. The Departmental Notes did not document consultation with physician, APS, or facility management regarding resident increased risk of being injured or injuring others due to his behaviors

1) Departmental Notes dated 5/2/15 at 10:59 p.m. documented, "At 10:00 a.m. resident pacing back and forth in hallway, very anger, balling fist and trying to hit staff and residents. Lorazepam 2 mg administered. At 1700 [5:00 p.m.] Resident pacing back and forth in hallway, very anger [angry] balling fist and trying to hit staff and residents. Lorazepam 2 mg administer[ed] ..."

2) Departmental Notes dated 5/2/15 at 10:59 p.m. documented, "...at 1700 [5:00 p.m.] resident pacing back and forth in hallway, very anger [angry], balling fist and trying to hit staff and residents. Lorazepam 2 mg administer[ed] ..."

3) The back of the May 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation on 5/4/15 at 6:15 p.m.

4) The back of the May 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation on 5/5/15 at 1030.

5) Departmental Notes dated 5/6/15 at 3:54 a.m. documented, "2:45 p.m. Resident up wandering

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hallways not easily redirected easily agitated. Ativan 1 mg 1 tab po given ..."

6) Departmental Notes dated 5/7/15 at 6:28 a.m. documented, "5:30 a.m. Resident is up attempting to wander throughout halls. Not easily redirected... Increased agitation Ativan 1 mg po given."

7) Departmental Notes dated 5/7/15 at 1:02 p.m. documented, "0915 R is noted to have extreme agitation at this time. Housekeeper state he will not leave things on her cart alone. R [Resident] noted trying to move the doghouse on the unit as another R was leaning on it as he does daily. R noncompliant with redirection. Lorazepam 2 mg/ml carpuject inject 0.5 ml (1 mg) IM given at this time for agitation ..."

Departmental Notes dated 5/7/15 at 1:16 p.m., "1100-R is noted across the hall from his room in another R room without pants or brief on. R in other residents bathroom running the water to the point of almost overflowing. R taken back to his room ..."

8) Departmental Notes dated 5/8/15 at 12:08 a.m. documented, "Resident up wandering up and down hallways. Inattention fidgeting with door knobs trying to open doors. Moving the dog house trying to pick it up. Not easily redirected increase in agitation Ativan 1 mg 1 tablet given po..."

9) Departmental Notes dated 5/8/15 at 6:02 a.m. documented, "Resident wandering in dining room getting into drawers and anything that is on the counter. Resident will not put on clothing and not easily redirected to his room. Increased agitation

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when trying to dress him or redirect. Ativan 1 mg 1 tab po given ...."

10) Departmental Notes Addendum dated 5/8/15 at 11:59 a.m. documented, "Resident in and out of resident's rooms going in bathrooms and turning water on not easily redirected. Resident noted to be incontinent of bowel, when staff approached him for toileting and peri-care he's very resistive and became slightly combative. Male staff arrived and peri-care given per 3 staff. 12:30 Ativan 1 mg po given. ..."

11) The back of the May 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation at 7:00 p.m. on 5/8/15.

12) Departmental Notes dated 5/8/15 at 4:44 a.m. documented, "11:30 [p.m.] Resident up wandering halls with diaper on head and no pants. Not easily redirected increase in agitation when trying to get resident go back to room. Ativan 1 mg 1 tablet given po ..."

13) Departmental Notes dated 5/9/15 at 6:05 a.m. documented, "Residnet [resident] taking clothes off and on in room. Resident as [has] clothing all over room. Has diaper on head and shirt on wrong way. Resident urinating outside door. Not easily redirected. Ativan 1 mg po given ..."

14) The back of the May 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation at 7:00 p.m. on 5/12/15.

15) Departmental Notes dated 5/13/15 documented, "7 p.m. Resident is up wandering from table to table in the dining room, turning on

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the water at the sink, becoming loud with staff and other residents. He is redirected with fluids and food but continues with behavior escalation. He is medicated with Ativan 1 mg 2 po ..."

16) The back of the May 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation on 5/16/15 at 1940 (7:40 p. m.).

17) The back of the May 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation on 5/17/15 at 1610 (4:10 p.m.).

18) Departmental Notes dated 5/21/15 at 4:04 p.m. documented, "1000 [10 a.m.] Resident observed standing at window in kitchen looking out at parking lot, he said he see his car out there and needs to go get it, he attempted to open window, multiple attempts per staff to divert him away from window before he complied, then he became severely agitated with staff and verbally aggressive. At 10:30 a.m. attempted to give Lorazepam 0.5 ml 1 mg IM per assist x 3 staff, resident became extremely agitated and resistive and unable to give complete dose ... Lorazepam 1 mg po given and taken without incident ..."

19) Departmental Notes dated 5/21/15 at 11:42 p.m. documented, "...7:00 p.m. He is medicated with Ativan 1 mg 1 po for increased agitation when staff attempts to assist with changing of his clothes. "

20) Departmental Notes dated 5/22/15 at 6:43 a.m. documented, "1:10 a.m. gave bruse [?] 0.5mg im [IM]for being vety [very] aggitated [agitated] and trying to take things in other

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resident froom [room]." The May 2015 Medication Administration Record (MAR) documented Lorazepam 1 mg IM was administered.

21) Departmental Notes dated 5/22/15 at 11:18 a.m. documented, "1045 Resident observed at window in dining room pulling up on window and trying to open it, not easily diverted. Resident left dining room and began pacing in hallways and pounding on door and window of Nursing Station. Lorezepan 1 mg po given ..."

22) Departmental Notes dated 5/25/15 at 1:46 p.m. documented, "Since out of bed this morning resident has been pacing, going in other residents rooms and getting their belongings, he became agitated with staff when redirected. Lorezepam 1 mg po given at 11:30 a.m. ..."

23) Departmental Notes dated 5/25/15 at 11:35 p.m. documented, "6:40 p.m. Resident up and pacing in the corridors. He has behavior of wandering in other residents rooms. Resident in [room #33] states he doesn't want this resident [Resident #7] back in his room. ADON [Assistant Director of Nurses] was notified of the resident in [room #33] concerns of this resident coming into his room. At 7:00 p.m. Resident has wandered into room #34 when redirecting him he became agitated states, ' Just leave me alone ' , staff gave resident sandwich and sweet tea and medicated him with Ativan 1 mg po. Staff remains in room 34 with resident [#7] until he agrees to go to his room ..."

Departmental Notes dated 5/27/15 at 3:44 p.m. documented, "Resident pacing hallways and going into other residents rooms pilfering in

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closets and drawers. Attempts to redirect with activities/food/fluids. Resident becomes increasingly agitated towards staff. Call placed to [Physician] with new orders received to increase Seroquel to 50 mg in am and 100 mg hs. [APS] notified of new orders ..."

Departmental Notes dated 5/28/15 at 4:34 p.m. documented, "[Physician] here to examine resident with no new orders received. "

Physician Progress Notes dated 5/28/15 documented, "HPI [history and physical information]/Social History: ...He was transferred to psych facility for APS related issue. He was aggressively taking food from other patient's trays. Because of his aggressive behavior, it was felt that there might be some issues with him being placed in acute care unit, so he was admitted to the Geriatric Unit at this facility. It had been reported that he was found on occasion on other peoples' beds removing their clothes. Beyond that, I can't get much else ...Plan: He seems to have done better with the dose reduction on the medications he came in here taking. At this point we 'll sit tight and see how he responds with the switch from Abilify to Seroquel bid [twice daily] ..."

24) Departmental Notes dated 5/31/15 at 4:10 p.m. documented, "At 4:15 p.m. administered Lorazepam 2 mg IM right hip for agiation [agitation]."
d. Departmental Notes and the June 2015 Medication Administration Record (MAR) from 6/1/15 - 6/30/15 (30 days) documented the resident had 13 episodes of increased agitation, aggression, and/or intrusiveness that required PRN medication. The Departmental Notes did not

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document consultation with physician, APS, or facility management regarding resident increased risk of being injured or injuring others due to his behaviors:

1) Departmental Notes dated 6/1/15 4:10 p.m. documented, "At 1430 [2:30 p.m.] Resident went in eyewash room, had BM [bowel movement] smeared it on cabinets and is clothing. He refused to change his clothes or allow staff to assist him, he became verbally and physically threatening. Lorazepam 1 mg IM given."

2) The back of the June 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation on 6/5/15 at 9:30 a.m.

3) The back of the June 2015 MAR documented the resident was administered Lorazepam 1 mg IM for behavior on 6/7/15 at 1830 (6:30 p.m.).

4) The back of the June 2015 MAR documented the resident was administered Lorazepam 1 mg IM for behavior agitation on 6/8/15 at 0400 (4:00 a.m.).

5) The back of the June 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation on 6/16/15 at 4:30 p.m.

6) The back of the June 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation on 6/17/15 at 10:45 a.m.

7) The back of the June 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation on 6/19/15 at 4:30

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p.m.

8) The back of the June 2015 MAR documented the resident was administered Lorazepam 1 mg IM for behavior agitation on 6/21/15 at 2202 (10:02 p.m.).

9) The back of the June 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation on 6/23/15 at 10:45 a.m.

10) The back of the June 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation on 6/23/15 at 3:30 p.m.

11) The back of the June 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation on 6/26/15 at 9:30 a.m.

12) Departmental Notes dated 6/26/15 11:52 p.m. documented, "4:20 p.m. Resident was walking pass staff he caught her left arm holding tightly around her left wrist, verbal cueing from staff to resident to released staff arm then redirected to dining room for food and fluid. Resident continues to be verbal aggressive to staff and other residents. He is medicated with Ativan 1 mg po."

13) The back of the June 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation on 6/27/15 at 11:40 a.m.

e. Departmental Notes and the July 2015 Medication Administration Record (MAR) from 7/1/15 - 7/16/15 (16 days) documented the

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resident had 6 episodes of increased agitation, aggression, and/or intrusiveness that required PRN medication. The Departmental Notes did not document consultation with physician, APS, facility management regarding resident increased risk of being injured or injuring others due to his behaviors:

1) The back of the July 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation on 7/01/15 at 3:00 a.m.

2) Departmental Notes dated 7/2/15 10:32 a.m. documented, "10:30 a.m. Ativan 1 mg po given, resident observed over past hour pacing in hallways, going in male residents room and bothering them. Resident talking non-stop in manic like mode with speech becoming threatening towards some staff. All attempts to divert his attention with activities snacks, 1-1 have been futile ... "

3) The back of the July 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation on 7/4/15 at 9:15 a.m.

4) The back of the July 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation on 7/5/15 at 9:00 a.m.

5) The back of the July 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation on 7/8/15 at 11:30 a.m.

6) Departmental Notes dated 7/16/15 at 3:19 p.m. documented, "10:45 a.m. Resident woke up this morning in agitated mood, pacing with angry of

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F 224	Continued From page 44 tone of voice when staff cues him for redirections and to dining room for breakfast. Resident made attempt to hit staff but did not make contact. Ativan 1 mg po given ..." f. The Resident's Comprehensive Care Plan with review date of 7/14/15 cpoc (continue plan of care) documented: "Problem Onset 04/14/15 ... I display verbally aggressive behaviors. Goal ...I will decrease my episodes of verbally aggressive behaviors by 50%. Approaches ... Activities staff to visit with me and provide diversion activities. Observe and document my behaviors .... " A handwritten note dated 4/26/15 documented, "Broke window out on secured unit, with no injuries. Secured windows. Nursing staff in-serviced to administer p.m. [as needed] med before behaviors becomes escalated." "Problem Onset 04/14/15 ...Resident has Mood & [and]/or Behavior concerns - Has orders for Psychotropic medication(s). Goal ...-Resident will remain free of injury/adverse effects related to Psychotropic medication(s) for the next 30 days ... Approach ...Monitor for Behaviors and intervene as needed ... Remove to a private areas when behaviors are disrupting to others ..." A handwritten note dated 4/10/15 documented, "[increased] verbal aggression towards staff/residents ...D/C [discontinue] Zyprexa 10 mg hs [decrease] Trazodone 150 mg hs Seroquel 25 mg am [and] 50 mg pm" The care plan did not address resident's risk of being injured or injuring others due to his intrusive and aggressive behaviors. The care plan had no new interventions after 4/26/15 for	F 224		

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F 224	Continued From page 45 mood/behaviors. g. Departmental Notes dated 7/21/15 at 7:30 a.m. documented, "6:30 a.m. Resident came to Nurse at Nurse's station stated, 'Someone attacked me.' this nurse followed resident to room and found [Resident #8] sitting on bed with blood coming from nose and hematoma with quarter sized swelling to right eye. This [Resident #8] could not state what happened. Resident [Resident #7] stated, 'She attacked me.' I asked did resident hit her, he [Resident #7] stated, 'I kicked her in the face.' When asked Resident did this resident [Resident #8] hit him he stated, "No." This Nurse separated the resident into Nurses Station. Resident [Resident #7] denies any pain 0 on pain scale 1-10. Full ROM [range of motion] in UE [upper extremities] and LE [lower extremities] No noted blood on resident. Resident was given Ativan 2 mg/ml 0.5 ml [IM] given to right gluteus medius... Called on call MD ...notified of incident ...6:55 a.m. Attempted to notify [APS worker #1] and only answering machine." A Continuous Monitoring 1:1 form dated 7/21/15 documented the facility began continuous 1 on 1 monitoring of resident at 6:30 a.m. which continued until discharge. Resident #8, a 102 year old female, had diagnosis of Alzheimer's disease. Departmental Notes dated 7/21/15 at 7:27 a.m. documented the resident was sent to the hospital emergency room (ER). Departmental Notes date 7/21/15 at 11:24 a.m. documented, "Discharge dx [diagnosis] from ER facial fracture. Right orbital and right maxillary fracture ..." On 7/21/15 at 11:28 a.m. during initial rounds of the facility, the resident's right eye was swollen shut and there was extensive dark purple bruising, and bruising to the	F 224		

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left cheek area. There was dried blood on both nares and a trickle of bright red blood from the right nare.

The OLTC (Office of Long Term Care) Incident and Accident Report (I&A) dated 7/21/15 documented the type of abuse Physical. Steps taken to prevent continued Abuse or neglect during the investigation: "An investigation was initiated immediately. Family, Local Law Enforcement and Administrator were notified. [Resident #7] was removed from room taken to Nurse Station for evaluation and placed 1:1 for safety. First Aid was provided to Resident [#8] by Registered Nurse (RN) #1 and [Resident #8] was then immediately transported to [hospital emergency room (ER)] for evaluation. Investigation is ongoing at this time."

g. Departmental Notes dated 7/23/15 at 3:14 p.m. and signed Alzheimer's Care Unit Director (ACUD) documented, "At approximately 1:30 p.m. this Nurse took over the 1:1 continuous monitoring to relieve CNA for lunch. [Resident #7] was ambulating up and down hallway. Resident went into the room of two female residents and I had difficulty redirecting him to leave the room. He was exhibiting sternness and reverting to "cop lingo" when speaking to me. I attempted to hold open the door he was trying to shut and he grabbed my wrist stating. 'I will murder you and they will find you hanging in the trees ' Once redirected and back into hallway, resident became increasingly agitated and inconsolable. He opened the door to another resident's room, entered and I was unable to redirect him out of the room. [Resident #7] reached down to grab a shoe belonging to the resident of the room he entered and the two resident became verbally

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aggressive towards one another and I had to call for help to redirect [Resident #7]. The [Name] ADON and [Name] DON entered the room. The [DON] was able to get [Resident #7] attention and walk him out the room. [Resident #7] became increasingly agitated, would not take the oral Ativan 1 mg that the LPN was offering. [Resident #7] became increasingly verbally threatening to staff and several staff members stated they were "scared" of him at this point. He was not able to be redirected and I sought guidance from the DON and ADON. I was told to call ambulance and send him to ER. The ER was contacted and the ambulance was dispatched to the facility. It took several staff members to get [Resident #7] to calm down and get onto the stretcher. [Resident #7] was given Ativan 1 mg IM in right deltoid muscle. Phone [APS Worker #1] and left message. ER call and stated they were sending [Resident#7] back to the facility. I spoke with [APS Worker #1] and will seek placement at geri-psych. facility with her approval of facility ...."

Departmental Notes dated 7/23/15 documented the resident was transferred out of facility at 7:00 p.m.

h. On 7/24/15 licensed nurses were interviewed:

At 9:40 a.m., Licensed Practical Nurse (LPN) #5 was asked if she worked on the Certified Alzheimer Unit. The LPN stated, "Yes for 3 1/2 years." The LPN was asked if she had had training for the Alzheimer Unit. The LPN stated, "Yes." The LPN was asked what qualified a resident to be admitted to the Certified Alzheimer Unit. The LPN stated, "They have to be ambulatory, if in a wheelchair must be able to self propel the wheelchair and they should be

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F 224	Continued From page 48 continent. They shouldn't have GT [gastronomy tube], catheter or wounds. The should have a diagnosis of Dementia and shouldn't have psychiatric diagnosis. The LPN was asked what was Resident #7 behaviors. The LPN stated, "He would wander in and out of other residents rooms, he had trouble finding the bathroom. He had behaviors, but I was able to control him better than other people. He got agitated, he would pace, pilfer and pick up things." The LPN was asked if Resident #7's behaviors got to a point that he had to have medications. The LPN stated, "Yes, there were periods that he would have to be medicated. Then all of a sudden his behaviors escalated, they had been random." The LPN was asked if she had talked to anyone. The LPN stated the CNAs reported to her his behaviors. The LPN was asked if she had reported to anyone else regarding the increased episodes of the resident's behaviors. The LPN stated, "Yes, I spoke with then Alzheimer Care Unit Director." The LPN was asked what was the criteria for giving residents the PRN [as needed] medications. The LPN stated, "We try redirection, activities, food, 1 to 1 with him before we give the medications." The LPN was asked, "Did you call the physician when the resident received PRN medication for several days and the resident's behaviors of agitation had increased and was the responsible party notified." The LPN stated, "No." At 10:55 a.m., LPN #4 was asked if she worked on the Certified Alzheimer Unit. The LPN stated for 1 year. The LPN was asked regarding the training for the Certified Alzheimer Unit. The LPN stated that she had specialized training and hand-outs that the former Alzheimer Unit Director would hand out and tests were given on the handouts. The LPN was asked regarding	F 224		

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PINE HILLS HEALTH AND REHABILITATION, LLC	**900 MAGNOLIA RD CAMDEN, AR 71701**

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Resident #7 behaviors. The LPN was asked what Resident #7 ' s behaviors were. The LPN stated, "At times he can become verbally abusive and you have to redirect him." The LPN was asked what kind of behaviors the resident exhibited. The LPN stated, "Verbal threats that he was going to do something to you. Sometimes he would calm down and sometimes he required medication to calm him down." The LPN was asked what kind of threats did the resident make, did the resident threaten to hit. The LPN was shown documentation that she documented on 5/2/15. The LPN stated, "Yes he did ball up his fist and threaten to hit staff and residents." The LPN was asked if she had reported this incident to anyone. The LPN stated, "I can't remember." The LPN was asked if she had called the Physician or the responsibility party regarding the increased behaviors. The LPN stated, "I can't remember." The LPN was asked, "Do you feel that the resident ' s aggressive behaviors should have been reported?" The LPN stated, "I probably called the Supervisor on call." The LPN was asked where this was documented. The LPN stated, "It's not documented." The LPN was asked if the other residents were at risk. The LPN stated, "Not at that time, we redirected him and gave him medication." The LPN was asked should a resident be admitted to the Certified Alzheimer Unit with a Psychiatric Diagnosis. The LPN stated, "No." The LPN was asked why. The LPN stated, "No, that would be a potential danger."

At 1:35 p.m., LPN #2 was asked if she worked on the Certified Alzheimer Unit. The LPN stated, "Yes on the 11-7 shift. The LPN was asked if she had training for the Certified Alzheimer Unit. The LPN stated, "Yes, by the former ACUD that gave

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F 224	Continued From page 50 in-services." The LPN was asked if she had been trained on dealing with aggressive resident. The LPN stated, "Not at this facility, but elsewhere." The LPN was asked if there were any issues related to behaviors or aggressive residents on the Alzheimer Unit. The LPN stated, "Yes with [Resident #7] that was the only issue. He was doing fine, then he had periods of agitation and not easily redirected." The LPN was asked what the resident's behaviors were. The LPN stated, "He knocked out a window, no major problems until the other day." The LPN was asked what happened. The LPN stated, "I was at the Nursing station, [Resident #7] came to the Nursing Station and stated that somebody had attacked him. I followed him back to his room and I saw [Resident #8] sitting on the bed with blood all over her. I got [Resident #7] out of the room. I got [Resident #8] out of the room, I got her sent to the ER [Emergency Room]. When [Resident #7] came to the Nursing Station he was not showing any signs or symptoms of aggression. I asked [Resident #7] what happened. [Resident #7] stated ' I kicked her in the face. '" The LPN was asked when did this happen. The LPN stated, "It occurred at about 6:30 a.m. on 7/21/15." The LPN was asked if there had been any aggressive behaviors problems. The LPN stated no resident to resident contact, but he had aggressive behavior that wasn't easily redirected. The LPN was asked where was a Certified Nursing Assistant (CNA) when this incident occurred. The LPN stated, "The CNA was on the back unit helping the other CNA with a resident. The LPN was asked how the unit was staffed. The LPN stated, "They have 2 CNA'S. There is one CNA on the front and one CNA on the back. The CNA was off the unit." The LPN stated, "I was at the Nursing Station." The LPN was asked if she	F 224		

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F 224	Continued From page 51 could see down the hall. The LPN stated, "Not the front hall where [Resident #7 and #8] were located." The LPN was asked if [Resident #8] had any behaviors. The LPN stated, "She generally didn't wander, once in a blue moon did she get up at night." The LPN was asked if Resident #7 had any behaviors at night. The LPN stated, "He did wander at night, he had started sleeping, but that morning he was getting up." The LPN was asked regarding the staffing, the unit only has 1 CNA at night, for 18 residents on the front hall and 1 CNA on the back unit for 9 residents. The LPN stated, "Yes." i. On 7/23/15, Certified Nursing Assistants were interviewed: At 7:50 p.m., Certified Nursing Assistant (CNA) #1 was asked if she worked on the Certified Alzheimer Unit. The CNA stated, "Yes." The CNA stated, "I started to work in April 2015." The CNA was asked if she had received special training for the Certified Alzheimer Unit. The CNA stated, "Yes." The CNA was asked if she had cared for Resident #7. The CNA stated, "Yes." The CNA was asked what the resident's behaviors were. The CNA stated, "At first he was calm, later he got more aggressive. If we tried to assist him he didn't like us touching him. He began peeing elsewhere beside the bathroom. His attitude was different. He was aggressive toward staff." The CNA was asked if he was aggressive towards other residents. The CNA stated, "He would get agitated. He would ball up his fist, grab at them. If we touched him he would yell, get away from me. His attitude was up and down." The CNA was asked if he tried to hit the staff. The CNA stated, "Yes, plenty of times but he didn't make contact. I got to a point, I was afraid of him at times, then I	F 224		

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would get someone else. He would yell at us." When asked about her fear of resident, the CNA stated, "Yes, at times he was aggressive and he did try to hit me, but he was more threatening." The CNA was asked since you stated you were afraid of him and he would become more aggressive do you feel that he could have hit another resident. The CNA stated, "If it came down to it." The CNA was asked if she had reported the incidents of the resident being aggressive. The CNA stated, "Yes, to the Nurse." The CNA was asked if she had reported that she was afraid of the resident at times. The CNA stated, "No."

At 7:58 p.m., CNA #2 was asked if she worked on the Certified Alzheimer Unit. The CNA stated, "Yes." The CNA was asked if she had received training for the Certified Alzheimer Unit. The CNA stated, "I worked here about 1 1/2 months, and I've not started the training yet." The CNA was asked if she had cared for Resident #7. The CNA stated, "Yes, together with the other CNA's." The CNA was asked about the resident's behaviors. The CNA stated, "His behaviors had slipped, he got real agitated. He didn't like people bothering him. He would talk like a cop. He wouldn't let us give him care. He was in a mind that he was working. He would walk all the time. We had to watch him, he would go in and out of other resident's room. He would get aggressive towards staff." The CNA was asked if the resident tried to hit staff. The CNA stated, "Yes." When asked if the resident got aggressive towards residents, the CNA stated, "No."

j. On 7/23/15 at 7:00 p.m., the Director of Nursing (DON) was asked after reviewing the documentation regarding Resident #7 if this

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resident was appropriate for the Certified Alzheimer's Unit. The DON stated, "I was not aware of his history. I didn't read the documentation at that time of admission." The DON was asked if she was aware of the resident's aggressive behaviors documented in the resident's clinical record. The DON stated, "I was aware of his pacing and going in other resident room. I was not aware of his aggressive behaviors towards staff and other residents." The DON was shown the documentation on 5/2/15 that the resident had balled up his fist and was threatening the staff and other residents. The DON stated, "I was not aware." The DON was asked if the resident's increased incidents of aggressive behaviors were reported to her. The DON stated, "No." The DON was asked if a resident is having increased episodes of aggressive behaviors shouldn't this be reported to Physician and the responsible party. The DON stated, "Yes." The DON was asked if the increased episodes of aggressive behaviors would put the other residents on the Alzheimer's unit at risk. The DON stated, "Yes."

k. On 7/24/15 at 2:15 p.m., the Alzheimer Care Unit Director (ACUD) was asked regarding the criteria for admission to the Certified Alzheimer Unit. The ACUD stated, they have to be a certain age, diagnosis of Alzheimer's or Dementia, have a certain level of functioning and self-mobile or ambulating. The advanced unit has residents that are more advanced in the disease process and require more supervision. The ACUD was asked, " How do you staff?" The ACUD stated that on days they have 2 or 3 on the front and 1 on the back and evening they have 2 on the front and 1 on the back on 11-7 they have 1 on the front and 1 on the back, with 1 Nurse for the front and back

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F 224	Continued From page 54 Alzheimer Unit. The ACUD was asked if the staff reported any aggressive behaviors or increased behaviors regarding Resident #7. The ACUD stated, "No." The ACUD was asked if a resident had increased behaviors that required to be medicated who should they report to. The ACUD stated that they should report to the Nurse and notify the ACUD. The ACUD was asked if the Physician and responsible party should be notified. The ACUD stated, "Yes. I thought they had been notified when the incident occurred on 7/21/15. The ACUD was asked was the Physician and responsible party notified when Resident #7 had increased behaviors. The ACUD stated that she had not notified the responsible party [APS worker #1] until 7/23/15. The ACUD was asked what was the importance of notifying the Physician of the resident increased behaviors. The ACUD stated, "For the benefit of the resident." The ACUD stated that this was an oversight on her part. The ACUD stated, "I was trying to transfer the resident out." The ACUD was asked if she had called the Physician or the responsible party when she was trying to transfer the resident. The ACUD stated, "No, I should have called for guidance." The ACUD was asked if a resident with Psychiatric diagnosis, Schizophrenia be admitted to the Certified Alzheimer Unit. The ACUD stated, "I would say we are not equipped to deal with them." l. On 7/27/15 at 4:30 p.m., the Administrator was asked regarding the documentation on a letter dated July 21, 2015, signed by the Administrator, and attached to the OLTC (Office of Long Term Care) Incident and Accident Report (I&A) form dated 7/21/15. The Administrator stated that they had contacted [Physician #1] to place a referral for [Resident #7]. The documentation stated that	F 224		

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the resident had not displayed any s/s of aggressive behavior at this time and that he was very remorseful for the events that took place and has repeatedly asked staff, "How is she? Is she ok?" The letter stated [Physician #1] has agreed to review this information in attempt to prevent resident from being placed outside the facility in geri-psych admission. The Administrator was asked if the Resident's attending Physician had given orders for the referral. The Administrator stated, "No." The Administrator was asked if the staff had reported to her the frequently documented incident in the resident's clinical record of aggressive behaviors. The Administrator stated, "No." The Administrator was asked regarding the documentation in the letter referring to the resident having the diagnosis of Alzheimer's Disease and if [Resident #7] had diagnosis of Alzheimer's Disease. The Administrator stated, "No." The Administrator was asked if she had reviewed the resident's Nurses Notes or if the staff had reported to her regarding the documented incident in the resident clinical record of aggressive behavior. The Administrator stated, "No."

m. On 7/27/15 at 6:35 p.m., the attending physician [Physician #2] was asked if made aware of Resident #7's incident 7/21/15 and the physician stated, "On vacation last week. Typically adjust med." The physician was asked if he would expect the facility to notify the physician when a resident has had behavior changes and the physician stated, "Yes..."

n. On 7/24/15 at 3:40 p.m., Adult Protective Services (APS) Caseworker #1 was asked if Resident #7 was in APS custody and the Caseworker stated, "Yes." The APS Caseworker

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was asked if had was notifed on 7/21/15 of any resident to resident altercation that involved Resident #7 and the Caseworker stated, "No. I was advised 7/23/15 by Emergency Room hospital staff after I received a call from them. I was advised by [Alzheimer's Care Unit] Director then afterwards. Only received call after the hospital called... By the way on Tuesday [7/21/15] he kicked a 102 year old resident [Resident #8] I found that out after he went to the Emergency Room ...I did an order to transport. Judge signed. [County] Sheriff office transport. Started process for transport as soon as found out Thursday." The APS Caseworker was asked if aware of other behavior incidents could any measures have been taken with Resident #7 and the APS Caseworker #1 stated, "Talked to doctor about meds and we could have addressed the behaviors sooner." The APS Caseworker was asked if notified of the resident's increased behaviors that included hitting window and hitting female resident. The APS Caseworker stated, "I have not been notified about him getting aggressive or hitting objects. Found out about the incident yesterday when I was called by staff nurse [Emergency Room]. If I had known about that incident sooner I could have initiated arrangements to send out sooner. Not notified of any aggressive behavior."

o. On 7/24/15 4:37 p.m., the Assistant Director of Nurses (ADON) was asked, "How do you determine the staff to resident ratio for the Alzheimer Care Unit?" The ADON stated that unit was staffed according to the state minimum staffing ratio. The ADON was shown the documentation in the Alzheimer Unit Care Book with the ratios for the primary care givers as 1 staff to 8 residents on the day shift and the

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F 224	Continued From page 57 evening and night ratio is 1 staff to 10 residents. The ADON stated, "I've never seen that before." p. On 7/27/15 at 4:30 p.m., the Administrator was asked what the admission criteria was for the Certified Alzheimer Unit. The Administrator stated, "The IDT [Interdisciplinary] team meets as a group to see if the Residents needs can be met." The Administrator was asked if they had documentation of this meeting. The Administrator stated, "We don't keep this documentation, Regarding [Resident #7] I do believe that the IDT did have a meeting prior to the admission." The Surveyor stated in staff interviews staff stated they do not recall having a meeting regarding [Resident #7]. The Administrator stated, "I don't recall if the former ACUD went to meet with him prior to admission, but he had the diagnosis of Dementia." The Administrator was asked what about the resident age. The Administrator stated that the age is case by case. The Administrator was asked about the Policy and Procedure for admission to the Certified Alzheimer Unit for pre-screening, IDT meetings and the staffing for the Certified Alzheimer Unit. The Administrator stated, "The facility had been sold and resold since that time." The Administrator was reminded the requirements from the regulation for the Certified Alzheimer Unit would not have changed. The Administrator stated, "I will have to check with corporate." As of 7/30/15 at 11:15 a.m. no additional information has been received.	F 224		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of	F 282		

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F 282	Continued From page 58 care. This REQUIREMENT is not met as evidenced by: Complaint 20354 (AR 00018459) was substantiated, all or in part, in these findings. Based on observation, record review, and interview, the facility failed to ensure medications were administered as ordered to appropriately treat an infection and prevent a significant medication error for 1 (Resident #4) of 3 (Resident #2, #4 and #7) case mix residents who had an order for an antibiotic medication and medication was administered as ordered on 1 of 2 halls to prevent a significant medication error for 1 (Resident #4) of 9 (Resident #1, #2, #3, #4, #6, #8, #9, #10 and #11) case mix residents who received medications on the East Hall. This failed practice had the potential to affect 3 residents who had an order for an antibiotic according to the Resident Census and Conditions of Residents received on 7/21/15 and 32 residents who received medications on the East Hall, according to the list received from the Director of Nurses (DON) on 7/23/15. The findings are. Resident #4 had diagnoses of Schizophrenia and Depression. The Quarterly Minimum Data Set with an Assessment Reference Date of 4/29/15 documented the resident scored 0 (0-7 indicates severely impaired) on the Brief Interview for Mental Status, required limited assistance of one person for bed mobility and transfers, extensive assistance of 1 person for personal hygiene, was frequently incontinent of bladder, occasionally incontinent of bowel, and was at risk for developing pressure ulcers.	F 282		

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a. Nurses Notes dated for 5/25/15 documented the resident returned from the emergency room with a physician order for Keflex 500 mg (milligrams) capsule po (by mouth) q (every) 12 hours x (times) 10 days.

1) The lab results dated for 5/27/15 documented, "Culture Urine Gram negative bacilli < [less than]10,000 cfu/ml [colony forming units per milliliter]." Handwritten on the lab report was Keflex 500 mg capsule by mouth q 12 (hours) x 10 d (days).

2) The May 2015 Medication Administration Record (MAR) documented, Keflex 500 mg was started on 5/26/15 and was administered, per nurses initials, from 5/26/15, -5/31/15 at 6:00 a.m. and 6:00 p.m., 6 days.

3) The June 2015 MAR documented Keflex 500 mg was administered, per nurses initials, on 6/1/15 and 6/2/15 at 8:00 a.m. and 8:00 p.m., 2 days. The Keflex was adminisntered for 8 days instead of 10 days as ordered.

b. Nurses Notes dated 5/30/15 documented, "...Orders to decrease Haldol from 10 mg to 5 mg and Benztropine MES 2 mg from BID [two times daily] to HS [at bedtime]..."

A Physician Order dated 5/29/15 documented, "Start Date 5/29/15 Benztropine Mes [Mesylate] 2 mg - give one tablet by mouth evening. For diagnosis Schizophrenia."

1) The May 2015 MAR documented a handwritten order for, "Benztropine tablet 1 po Q [every evening]" and the medication was

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documented as started on 5/29/15.

2) The June 2015 MAR documented, "Benztropine MES 2 mg tablet one tablet by mouth twice a day at 8 a.m. and 4:00 p.m., Order Date 5/12/15, Start Date - 5/13/15." The order to reduce the Benztropine Mesylate to once daily was not transcribed to the June 2015 MAR. The Benztropine MES was documented, by nurses's initials, as being administered at 8:00 a.m. from 6/1/15-6/30/15 and 4:00 p.m. on 6/1/15- 6/3/15 and 6/9/15 - 6/30/15. The 4:00 p.m. time was circled as not given from 6/4/15 - 6/8/15 and documented on the back of the MAR:

"6/4/15 Benztropine 2 mg unavailable. Need to reorder through [Pharmacy]" This entry was initialed by Licensed Practical Nurse (LPN) #3.

"6/5/15 Benztropine 2 mg unavailable Re-ordered through [Pharmacy] but not received." This entry was initialed by LPN #3.

"6/6/15 Benztropine unavailable again RO [reorder again]."

"6/7/15 Benztropine unavailable."

3) As of 7/24/15 there was no documentation on the MAR that the physician was consulted when the medication was not available.

4) The June 2015 MAR documented Benztropine 2 mg was administered at 8:00 a.m. from 6/4 - 6/7 when no Benztropine 2 mg was available in the facility.

c. On 7/24/15 at 8:50 a.m., Licensed Practical Nurse (LPN) #4 was asked if a medication was

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F 282	Continued From page 61 not available, "what do you do?" The LPN stated, "If med [medication] is not available call the pharmacy to get it and if we have to after hours call [local pharmacy]. If it's a routine med you can reorder the med and if it doesn't arrive you call [local pharmacy]." The LPN was asked should all doses of the antibiotic be administered. The LPN stated, "Yes, so that it will kill the infection and, if not given, the infection could come back." d. On 7/24/15 at 7:21 p.m., the Director of Nurses was asked, "How did you perform the end of the month change-out for the medications in the med cart and the Medication Administration Records?" The DON stated, "We do a match back with the Physician Orders and the MARs and the medication cart." The DON was asked, "Do you check the Physician Orders with the MAR's?" The DON stated, "Yes." The DON was asked if the facility did 24-hour chart checks. The DON stated, "No."	F 282		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Complaint #20354 (AR00018459) and Complaint #20365 (AR00018476) substantiated, all or in part, in these findings.	F 309		

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Based on record review and interview, the facility failed to ensure the physician was consulted regarding non-therapeutic lab levels 1 (Resident #2) of 2 (Resident #2 and #10) case mix residents in the facility who had Physician Orders for Dilantin levels. The facility also failed to ensure the physician was consulted regarding the withholding of scheduled insulin for 1 (Resident #9) of 2 (Residents #9 and #11) case mix residents who had scheduled insulin doses. This failed practice had the potential to affect 3 residents who received Dilantin and had Physician Orders for Dilantin Levels according to a list received from the Director of Nurses (DON) on 7/24/15 and had the potential to affect 6 residents on the East Wing who had insulin ordered as documented on a list provided by the DON on 7/27/15. The findings are:

1. Resident #2 had diagnoses of Presenile Dementia and Convulsions. The Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) 7/14/15 documented the resident scored 5 (0-7 indicates severely impaired) on the Brief Interview for Mental Status, required extensive assistance of 1 person for personal hygiene, and was always incontinent of bowel and bladder.

a. The July 2015 Physician Orders documented, "Dilantin 100 mg [milligram] capsule one capsule po [by mouth] daily at 0800 a.m. and Dilantin Level Q [every] 3 months (April, July, October, January)."

b. The Lab results for the Phenytion [Dilantin] Level Reference range (10-20)
were as follows:

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F 309	Continued From page 63 1) 7/29/14 Level 2.5 L [low] 2) 10/22/14 Level 2.1 L [low] 3) 1/6/15 Level 1.7 L [low] 4) 4/22/15 Level 2.4 L [low] c. The Nurses Notes dated 5/11/15 at 4:10 p.m. documented, "Summoned to room at 3:00 p.m. on arrival resident having seizure, airway patent. Seizure activity lasted approximately 6 minutes. Resident alert able to answer simple questions..." d. The Nurses Notes dated 5/11/15 at 4:19 p.m. documented, "3:30 p.m. Called back to residents room, upon entering room resident having seizure with right sided facial twitching. Seizure lasted approximately 8 minutes, but has r [right] arm weakness and r [right] leg weakness. [Physician] office notified and order to send to ER [Emergency Room] for evaluation. e. The Hospital Physician Documentation dated 5/11/15 at 4:15 p.m. documented, " This patient presents with history of multiple seizures an unknown number. Character of seizure(s): Motor activity; generalized shaking all over. Seizure onset just prior to arrival... The patient did not suffer any apparent associated injury ...The Phenytoin/Dilantin Level was 2.4 below low normal -range (10-20) ...The Resident received Dilantin 1 gram IVPB [intravenous piggy back] and Rocephin 1 gram IM [intramuscular].The Resident was discharged with diagnoses of Bronchitis and Adult Seizure, Recurrent (Adult). " f. On 7/24/15 at 7:15 p.m., the DON was asked	F 309		

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who was responsible for reviewing the lab results. The DON stated, "The ADON [Assistant Director of Nurses]." The DON was asked what could happen when the resident Dilantin Level is below the therapeutic range for several months. The DON stated, "It could cause resident to have seizures."

g. On 7/24/15 at 7:18 p.m. the ADON stated, "I look at the lab when it is received." The ADON was asked, "If a resident has a Dilantin Level that is consistently below the therapeutic range should the Physician be notified?" The DON stated, "Yes."

2. Resident #9 had diagnoses of Type 2 Diabetes Mellitus Uncontrolled, Alzheimer's Disease, Cerebrovascular Accident (CVA), and Vascular Dementia. The Quarterly MDS with an ARD of 7/21/15 documented the resident scored 4 (0-7 indicates severely impaired) on the BIMS, had Diabetes Mellitus, and had received insulin injections.

a. The Care Plan dated 6/25/15 documented, "...administer my ordered medications ...as per my Physician's orders... 6/4/15 Novolin 70-30 (insulin) give 60 units sq [subcutaneous] BID [twice a day]... Give me verbal cues/reminders when I cannot remember... 25% may be uneaten at some meals, ...Staff to assist me... observe for needed assistance..."

b. The July 2015 Physician Orders documented an order originally dated 6/4/15 "Novolin 70-30 100 unit/ml (unit/milliter) vial Give 60 units subcutaneous twice a day..."

c. On 7/21/15 at 4:35 p.m., Licensed Practical

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F 309	Continued From page 65 Nurse (LPN) #3 performed a finger-stick blood sugar check on the resident and stated the blood sugar level was 115. The LPN stated, "I'm not going to give. I don't feel comfortable giving it but I don't want her to get 60 units Novolin 70/30 without snack and bottoming out so I'll get her a cookie." At 4:36 p.m., the LPN left the resident's room, went to the nurse's station, picked up a package that contained a soft cream filled oatmeal cookie and returned to the resident's bedside. The LPN laid the cookie down on the bedside tablet then promptly left the resident's room without having waited to ensure the resident ate the cookie or any other food with the medication. d. The Medication Administration Record (MAR) dated July 2015 documented "Novolin 70-30 100 unit/ml vial Give 60 units subcutaneous twice a day 6:00 a.m." on 7/21/15 "Result 66 Units [none given]" and "4:00 p.m." the nurse's initial's [LPN #3] Result 115" The amount of units and site had a diagonal slash mark across each of the areas. e. On 7/22/15 at 4:30 p.m., the Departmental Notes were reviewed and there was an entry by nursing dated 7/14/15 at 9:27 p.m. and the next entry was dated 7/22/15 at 11:26 a.m. by Social Services. There was no documentation by nursing that indicated that the physician was notified that the scheduled insulin doses were held nor were there any telephone orders that indicated that the physician was consulted and given instructions regarding the insulin. f. On 7/22/15 at 5:15 p.m., LPN #3 was asked when scheduled insulin doses are withheld, should the physician be notified and the LPN stated, "Yes and [Attending Physician #3] has	F 309		

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F 309	Continued From page 66 been notified in the past." The LPN was asked if the physician was notified when the insulin was withheld on 7/21/15 and the LPN stated, "No." The LPN was asked if the physician should be notified each time scheduled insulin doses are withheld and the LPN stated, "Yes." g. On 7/27/15 at 4:30 p.m., the DON was asked if the physician should be notified if scheduled insulin doses are withheld and the DON stated, "Yes."	F 309		
F 314 SS=E	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Complaint #20354 (AR 00018459) substantiated, all or in part, in these findings. Based on observation, record review, and interview, the facility failed to ensure a turning and repositioning program was implemented and incontinence checks were completed at least every 2 hours, all skin areas were cleaned of urine and feces, and plain water was no used during incontinent care to prevent the development of pressure ulcers for 2 (Resident	F 314		

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#2 and #4) of 6 (Resident #1, 2, #3, #4, #6 and #9) case mix resident who were dependent on staff for incontinent care on the East Wing and failed to apply skin barrier cream per the plan of care to prevent skin irritation and potential development of pressure ulcers for 1 of 1 (Resident #2) case mix resident that was care planned for barrier cream. This failed practice had the potential to affect 27 residents who were incontinent and 9 residents who were at risk for developing pressure ulcers and resided on the East Wing according to a list provided by the Assistant Director of Nursing (ADON) on 8/10/15. The findings are:

1. Resident #2 had diagnosis of Pre-senile Dementia and Convulsions. The Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 7/14/15 documented the resident scored 5 (0-7 indicates severely impaired) on the Brief Interview for Mental Status, resident required extensive assistance of 1 person for personal hygiene, was always incontinent of bowel and bladder, was at risk for developing pressure ulcers, and had no pressure ulcers.

a. The Comprehensive Care Plan dated 10/13/14 documented, "Problem/Need, I require extensive assistance with bed mobility, transfers, dressing, toileting, personal hygiene, bathing, and locomotion. Goal I will continue to have all my cares met by staff ongoing. Approaches, If I am incont. [incontinent] of B&B [bowel and bladder] please give me incont. care and if I wear a brief and or pull up please change... Please turn and reposition me q [every] 2 hours and PRN [as needed]..."

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"Problem/need At risk for altered skin integrity r/t [related to] impaired mobility and incontinent of B&B. Goal I will not experience any skin conditions r/t incontinence. Approaches... Toilet me Q 2 H [hours] and PRN, with peri-care and barrier cream application after each toileting and PRN as needed..."

b. The Braden Risk Assessment Report dated 7/16/15 documented a Risk Score of 15, which indicated a Risk Level of Mild.

c. On 7/22/15 at 8:15 a.m., the resident was sitting up in the wheelchair in her room.

d. On 7/22/15 at 8:20 a.m., 8:30 a.m., and 9:15 the resident was sitting up in the wheelchair in her room. The resident was kept in this Surveyor's line of sight.

e. On 7/22/15 at 9:30 a.m., Certified Nursing Assistant (CNA) #8 entered the resident's room. The CNA washed the resident's face and changed her shirt. The CNA did not reposition or check the resident for incontinence.

f. On 7/22/15 at 9:35 a.m. the resident wheeled her self down the hall and entered the dining room area for activities.

g. On 7/22/15 from 9:35 a.m. until 11:03 a.m., this Surveyor observed the resident in dining room playing bingo.

h. On 7/22/15 at 11:03 a.m., the resident wheeled her self down the hall and then turned around and went back to the dining room.

i. On 7/22/15 from 11:17 a.m. through 12:25

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p.m., the resident remained in the wheelchair in the dining room, in constant observation of this Surveyor.

j. On 7/22/15 at 12:25 p.m., the resident was propelling self in the wheelchair down the hall. CNA #8 was asked how often are the residents to be checked for incontinence and repositioned. The CNA stated, "Every 2 hours." The CNA was asked when was the last time you checked this resident. The CNA stated she had checked the resident before she went to lunch. The CNA was asked, "What time did you go to lunch?" The CNA stated, 10:30 a.m. The CNA asked, "You were in the resident's room at 9:30 a.m. and you washed her face and changed her shirt. Did you check her [for incontinence] at that time?" The CNA stated, "I didn't check her." The resident was sitting in the wheelchair from 8:15 until 12:25 p.m. approximately 4 hours and 15 minutes and was not checked for incontinence.

At 12:38 p.m., CNA #8 took the resident to her room then went to get the mechanical lift. The CNA returned with the sit to stand lift and then left again and returned with the Marisa Mechanical Lift. The resident was transferred to the bed and CNA #8 and #3 provided incontinent care. The resident's pants were pulled down and the crotch of the pants was wet with urine. The incontinent brief was saturated with urine. CNA #3 performed incontinent care. The CNA cleansed the front perineal area with water only. The CNA wiped with the same surface of the cloth across the labia area and groin area. The CNAs turned the resident on her right side and CNA #3 continued to perform incontinent care. The CNA wiped with the same surface of the cloth across the rectum 2 times. When CNA #3 wiped the rectum, the cloth

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F 314	Continued From page 70 had a darkish substance on the cloth. Wearing the same soiled gloves, the CNAs then applied a clean incontinent brief. The CNAs were asked if they were finished with the incontinent care and stated, "Yes." The CNAs were asked if they could wipe the rectal area again. CNA #3 wiped the rectal area and a darkish substance soiled the cloth. The resident was wiped 3 more times before the cloth returned free of feces. 2. Resident #4 had diagnoses of Schizophrenia and Depression. The Quarterly MDS with an ARD of 4/29/15 documented the resident scored 0 (0-7 indicates severely impaired) on the BIMS, required limited assistance of one person for bed mobility and transfers, extensive assistance of 1 person for personal hygiene, was incontinent of bladder and bowel and at risk for developing pressure ulcers. a. The Resident's Comprehensive Care Plan dated 6/5/15 documented, "Problem need, I require limited assistance with bed mobility, transfers, locomotion, dressing, toileting, personal hygiene and bathing. Goal, I will not have further decline with my ADL [Activity Daily Living] function. Approaches, If I am incont. of B&B please give me incont. care and if I wear a brief and or pull up please change. Please assist with turning and repositioning and encourage me to assist q 2 hours and PRN." Problem Need, I am at risk for pressure ulcers r/t incontinent of B&B impaired mobility. Goal, I will not have any skin breakdown. Approaches, Reposition me Q 2 H. Provide peri-care Q 2 H and PRN." b. On 7/22/15 at 8:18 a.m., the resident was self propelling the wheelchair down the East hall. At 8:20 a.m., CNA #8 entered the resident's room	F 314		

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F 314	Continued From page 71 and washed the resident's face and brushed the resident's hair. The resident was not repositioned in the wheelchair. The resident wheeled himself out of the room. c. On 7/22/15 at 8:38 a.m., the resident was in the wheelchair propelling himself down the hallway. The resident was observed by this Surveyor at all times. d. On 7/22/15 at 8:40 a.m., 9:30 a.m., 9:33 a.m., the resident was sitting in the wheelchair without being repositioned or checked for incontinence. e. On 7/22/15 at 9:33 a.m., the resident wheeled himself to the dining room for activities. f. On 7/22/15 from 9:33 a.m. through 11:00 a.m., the resident was in the dining room at an activity of bingo. g. On 7/22/15 from 11:00 a.m. through 12:15 a.m., the resident was in the wheelchair in the dining room without being repositioned and checked for incontinence. h. On 7/22/15 at 12:45 p.m., the resident was self propelling himself in a wheelchair down the hall. i. On 7/22/15 at 1:42 p.m., the resident was sitting in the wheelchair in the hallway and CNA #8 pushed the resident down the hall to his room. The CNA stated that she was waiting for the key to get clean linen to change the resident. At 1:45 p.m., the resident was taken to the resident's bathroom. The resident was in the wheelchair from 8:20 a.m. until 1:45 p.m. without being changed or repositioned, approximately 5 hours	F 314		

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F 314	Continued From page 72 and 25 minutes. The resident was able to stand with limited assistance. The resident's incontinent brief was removed and saturated with urine. CNA #8 provided the incontinent care with peri-wash. The CNA wiped across the top of the penis 2 times with the same surface of the cloth in a back and forth motion. The CNA did not cleanse the resident's buttocks or inner thighs. 3. On 7/23/15 at 2:40 p.m., CNA #8 was asked if Resident #2 and #4 were checked for incontinence and were the residents repositioned in the wheelchair the morning of 7/22/15. The CNA stated, "No." The CNA was asked how often should the resident be checked for incontinence and their position be changed while up in the wheelchair. The CNA stated, "Every 2 hours." The CNA was asked the importance of ensuring that the residents were checked for incontinence and being repositioned. The CNA stated, "Skin breakdown." The CNA was asked, "What is the problem when all skin surfaces were not cleansed of urine and/or feces?" The CNA stated, "Skin breakdown." The CNA was asked if the resident's skin should be cleansed with plain water. The CNA stated, "No." The CNA was asked, "What is the problem with cleansing with only plain water?" The CNA stated, "Not getting the skin clean and skin breakdown."	F 314		
F 323 SS=K	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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This REQUIREMENT is not met as evidenced by:
Complaint #20365 (AR00018476) substantiated, all or in part. in these findings:

A. Based on observation, record review and interview, the facility failed to ensure risk factors due to behaviors were identified with interventions promptly developed and consistently implemented and assessed for effectiveness; to ensure physician, Adult Protective Services (resident guardian), and facility management involved in developing interventions to ensure safety of resident as well as the other residents that were in close contact; to ensure sufficient staffing to monitor resident to prevent resident injury for 1 (Resident #7) of 4 (Resident #7, #12, #13 and #14) case mix residents who were admitted to the Certified Alzheimer Care Unit in the past 6 months. This failed practice resulted in Immediate Jeopardy which caused or could have caused serious injury, harm or possible death for Resident #8 who sustained an orbital and maxillary fracture and had the potential to affect 19 residents that resided on the Certified Alzheimer's Unit as of 7/21/15. The Immediate Jeopardy was removed by the facility on 7/21/15 at 7:00 a.m. and the scope/severity reduced to "H" when the facility identified the issue and initiated corrective action however the facility did not correct the underlying deficient practice at the time of the survey. The facility was informed of the Immediate Jeopardy removed on 7/24/15 at 5:15 p.m. The findings are:

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1. Resident #7 was admitted to the facility on 4/6/15 with diagnoses of Dementia with Behavioral Disturbance, Schizophrenia, Anxiety and Insomnia.

The History and Physical Report from the geri-psych unit dated 3/13/15 documented, "...Admit Date: 03/13/2015...He apparently was in a psych unit in Little Rock and he was aggressive and /or taking food from other people's trays? Concern was expressed that he might be harmed on an acute unit and was sent to Geri unit. At this facility, he has been noted to lay on other people beds and take their clothing. Any other history is absolutely unavailable to this physician at this time ..." The Discharge Summary dated 4/6/15 documented, "Principle Diagnosis: Dementia with behavioral disturbances Secondary Diagnoses Schizophrenia. The Reason for Hospitalization: Patient arrived as a referral from (Hospital Name) due to confusion and inability to care for himself as well as a tendency to be so intrusive with other clients at that Psychiatric facility that staff there felt he was at risk for being beaten as most of the clients at that facility were younger than the client. Hospital Course: Patient was admitted to our unit and continued to evidence confusion, intrusiveness, and ease of agitation as well as a tendency to not take his medication despite prompting... Despite increasing doses of Haldol the patient remained, he is easily agitated and intrusive and difficult to redirect and eventually began to have tolerability issues with the Haldol in terms of side effects..."

The Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) 7/13/15 documented the resident scored 3 (a score of 0-7 indicates severely impaired) on the Brief Interview

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for Mental Status (BIMS); had a mood score of 0; had wandering behaviors that occurred daily; required limited assistance of 1 person for bed mobility, transfers, ambulation in room or corridor and personal hygiene; was occasionally incontinent of bowel and bladder; had no pain; was 75 inches (6 foot 2 1/2 inches) in height; and received Antipsychotic, Antidepressant and Antianxiety medication 7 of the past 7 days. The responsible party was APS (Adult Protective Service) worker #1.

a. Departmental Notes dated 4/7/15 at 1:12 a.m. documented, "On 4/6/15 10 p.m. Resident admitted to [facility name] secured Alzheimer's Unit LTC [long term care] bed ...He is ambulatory independently in corridors with slow and steady gait."

b. Departmental Notes from 4/7/15-4/30/15 (23 days) documented the resident had 11 episodes of increased agitation, aggression, and/or intrusiveness that required PRN (as needed) medication. The Departmental Notes did not document consultation with physician, APS, or facility management regarding resident increased risk of being injured or injuring others due to his behaviors:

1) Departmental Notes dated 4/7/15 at 1:47 p.m. documented, "Resident pacing and going to exit doors. Resident entering other residents' rooms and disturbing them and their visitors. Resident redirected and diverted with activities and food and drinks. Diversions lasting only a few minutes ... pacing and exit seeking. Haldol 5 mg [milligrams] IM [intramuscular] given."

2) Departmental Notes dated 4/9/15 at 2:17 a.m.

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documented, "On 4/8/15 at 3:00 p.m. ...Resident is becoming verbally aggressive with staff and other residents. He states, 'If you say anything else I will hold you in contempt of court and you will be put in jail for no less than 9 days.' He points at a female resident states 'Sit down and don't say a word or I will put you in jail.' Resident medicated with Haldol 5 mg IM. At 7:15 p.m. awake wandering around in dining room takes a soda from a female resident she asks him to put it down and he uses profanity."

3) Departmental Notes dated 4/10/15 at 12:26 a.m. documented, "On 4/9/15 ... at 6:00 p.m. resident is up wandering around the dining room and telling female resident to sit down and do not say anything. Attempts to redirect resident to his seat and he states ' Stop talking' .... staff let resident wander with close supervision until he seated himself at table ... 6:30 p.m. ...Haldol 5 mg IM right deltoid."

Departmental Notes dated 4/10/15 at 3:06 p.m. documented, "...New orders received from [Physician] derease [decrease] Trazadone to 150 mg at hs [hour of sleep], dc [discontinue] Zyprexa, give Seroquel 25 mg. q a.m. and 50 mg at hs. ... APS [Adult Protective Services] notified ..."

4) Departmental Notes dated 4/11/15 at 1:01 a.m. documented, "On 4/10/15... at 4:45 p.m. Resident went to stand over female resident seated in her w/c [wheelchair] and asks her 'Why did you get my chair' resident daughter remains present and states, 'No that her w/c.' resident turns to resident daughter and states, "You are a lie." Staff redirects across the hall for privacy Haldol 5 mg IM for increased

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agitation/aggressiveness. 7:30 p.m. Resident is in a female room and refuses to leave room. He was redirected by staff after 15 minutes spent with redirection ..."

5) Departmental Notes dated 4/13/15 at 10:28 p.m. at 7:30 p.m. documented, "...resident pushed the west exit door open to the courtyard causing the alarm to sound. Resident redirected ...Haldol 5 mg IM."

6) Departmental Notes dated 4/19/15 at 10:44 p.m. documented, "Resident up pacing hallway ... verbally abusive to residents and staff. Administered Lorazepam 2 mg IM in left hip at 2130 [9:30 p.m.] ..."

7) Departmental Notes dated 4/20/15 at 12:39 p.m. documented, "Resident observed pacing in hallways and other resident's rooms picking up various objects and putting them in his pocket. Resident got hold of housekeepers cart and started pushing it down the hallway staff x 3 attempted to get cart away from him and he became combative, hitting at staff and saying we had better get away from him. Eventually walked away from cart continue to pick up and pocket other resident belongings becoming more agitated and verbally and physically aggressive. 1200 Lorazepam 1 mg IM given x 3 staff with much difficulty."

8) Departmental Notes dated 4/23/15 at 4:14 p.m. documented, "4/22/15 at 8:30 p.m. Resident turned to water on in the sink in his bathroom placed a trash can in the sink causing the water to fill the sink overflowing the bathroom and room [number] bedroom which then flowed out into the corridor. He is wandering into other residents

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room removing their walkers, trash cans, and other items ....he then was served alternate meal...He refused to eat became verbally aggressive with staff. He was medicated with Haldol 5 mg IM right deltoid."

Departmental Notes dated 4/23/15 at 2:54 p.m. documented, "Resident followed staff out of exit door this morning, agitated and slightly combative when staff attempted to redirect him back ... [Physician] notified, new order received for Lorazepam 1 mg po [by mouth] q [every] 4 hrs [hours] prn agitation ..." Departmental Notes at 3:34 p.m. documented the physician would be at facility on 4/30/15 and make medication adjustments.

9) Departmental Notes dated 4/26/15 at 1:39 p.m. at 11:00 a.m. documented, "Resident became agitated and started to ambulate in hallway by eye wash station. Hit window with his right hand knocking out a pane of plexi-glass. No injury. Resident medicated with Lorazepam 1 mg IM r [right] arm for agitation."

10) Departmental Notes dated 4/29/15 at 12:37 p.m. documented, "12:34 p.m. R [Resident] pacing the hallway back and forth. Agitstion [agitation] noted to be increased at this time. R refuses to go into dining room and eat, stating 'there's bad people in there.' Lorazepam 1 mg given po at this time ..."

11) Departmental Notes dated 4/30/15 at 2:18 a.m. documented, "1:00 a.m. Resident up pacing back and forth in hallways not easily redirected increase agitation when redirecting resident. Ativan [Lorazepam] 2 mg/ml carpuject inject 0.5 ml (1 mg) IM given ..."

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c. Departmental Notes and the May 2015 Medication Administration Record (MAR) from 5/1/15 - 5/31/15 (31 days) documented the resident had 24 episodes of increased agitation, aggression, and/or intrusiveness that required PRN medication. The Departmental Notes did not document consultation with physician, APS, or facility management regarding resident increased risk of being injured or injuring others due to his behaviors:

1) Departmental Notes dated 5/2/15 at 10:59 p.m. documented, "At 10:00 a.m. resident pacing back and forth in hallway, very anger, balling fist and trying to hit staff and residents. Lorazepam 2 mg administered. At 1700 [5:00 p.m.] Resident pacing back and forth in hallway, very anger [angry] balling fist and trying to hit staff and residents. Lorazepam 2 mg administer[ed] ..."

2) Departmental Notes dated 5/2/15 at 10:59 p.m. documented, "...at 1700 [5:00 p.m.] resident pacing back and forth in hallway, very anger [angry], balling fist and trying to hit staff and residents. Lorazepam 2 mg administer[ed] ..."

3) The back of the May 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation on 5/4/15 at 6:15 p.m.

4) The back of the May 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation on 5/5/15 at 1030.

5) Departmental Notes dated 5/6/15 at 3:54 a.m. documented, "2:45 p.m. Resident up wandering hallways not easily redirected easily agitated. Ativan 1 mg 1 tab po given ..."

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6) Departmental Notes dated 5/7/15 at 6:28 a.m. documented, "5:30 a.m. Resident is up attempting to wander throughout halls. Not easily redirected... Increased agitation Ativan 1 mg po given."

7) Departmental Notes dated 5/7/15 at 1:02 p.m. documented, "0915 R is noted to have extreme agitation at this time. Housekeeper state he will not leave things on her cart alone. R [Resident] noted trying to move the doghouse on the unit as another R was leaning on it as he does daily. R noncompliant with redirection. Lorazepam 2 mg/ml carpuject inject 0.5 ml (1 mg) IM given at this time for agitation ..."

Departmental Notes dated 5/7/15 at 1:16 p.m., "1100 [11:00 a.m.]-R is noted across the hall from his room in another R room without pants or brief on. R in other resident's bathroom running the water to the point of almost overflowing. R taken back to his room ..."

8) Departmental Notes dated 5/8/15 at 12:08 a.m. documented, "Resident up wandering up and down hallways. Inattention fidgeting with door knobs trying to open doors. Moving the dog house trying to pick it up. Not easily redirected increase in agitation Ativan 1 mg 1 tablet given po ..."

9) Departmental Notes dated 5/8/15 at 6:02 a.m. documented, "Resident wandering in dining room getting into drawers and anything that is on the counter. Resident will not put on clothing and not easily redirected to his room. Increased agitation when trying to dress him or redirect. Ativan 1 mg 1 tab po given ..."

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10) Departmental Notes Addendum dated 5/8/15 at 11:59 a.m. documented, "Resident in and out of resident's rooms going in bathrooms and turning water on not easily redirected. Resident noted to be incontinent of bowel, when staff approached him for toileting and peri-care he's very resistive and became slightly combative. Male staff arrived and peri-care given per 3 staff. 12:30 Ativan 1 mg po given. ..."

11) The back of the May 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation at 7:00 p.m. on 5/8/15.

12) Departmental Notes dated 5/8/15 at 4:44 a.m. documented, "11:30 [p.m.] Resident up wandering halls with diaper on head and no pants. Not easily redirected increase in agitation when trying to get resident go back to room. Ativan 1 mg 1 tablet given po ..."

13) Departmental Notes dated 5/9/15 at 6:05 a.m. documented, "Residnet [resident] taking clothes off and on in room. Resident as [has] clothing all over room. Has diaper on head and shirt on wrong way. Resident urinating outside door. Not easily redirected. Ativan 1 mg po given ..."

14) The back of the May 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation at 7:00 p.m. on 5/12/15.

15) Departmental Notes dated 5/13/15 documented, "7 p.m. Resident is up wandering from table to table in the dining room, turning on the water at the sink, becoming loud with staff and other residents. He is redirected with fluids

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and food but continues with behavior escalation. He is medicated with Ativan 1 mg 2 po ..."

16) The back of the May 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation on 5/16/15 at 1940 (7:40 p. m.).

17) The back of the May 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation on 5/17/15 at 1610 (4:10 p.m.).

18) Departmental Notes dated 5/21/15 at 4:04 p.m. documented, "1000 [10 a.m.] Resident observed standing at window in kitchen looking out at parking lot, he said he see his car out there and needs to go get it, he attempted to open window, multiple attempts per staff to divert him away from window before he complied, then he became severely agitated with staff and verbally aggressive. At 10:30 a.m. attempted to give Lorazepam 0.5 ml 1 mg IM per assist x 3 staff, resident became extremely agitated and resistive and unable to give complete dose ... Lorezpam 1 mg po given and taken without incident ..."

19) Departmental Notes dated 5/21/15 at 11:42 p.m. documented, "...7:00 p.m. He is medicated with Ativan 1 mg 1 po for increased agitation when staff attempts to assist with changing of his clothes."

20) Departmental Notes dated 5/22/15 at 6:43 a.m. documented, "1:10 a.m. gave bruse [?] 0.5mg im [IM]for being vety [very] aggitated [agitated] and trying to take things in other resident froom [room]. " The May 2015 Medication Administration Record (MAR)

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documented Lorazepam 1 mg IM was administered.

21) Departmental Notes dated 5/22/15 at 11:18 a.m. documented, "1045 [10:45 a.m.] Resident observed at window in dining room pulling up on window and trying to open it, not easily diverted. Resident left dining room and began pacing in hallways and pounding on door and window of Nursing Station. Lorezepan 1 mg po given ..."

22) Departmental Notes dated 5/25/15 at 1:46 p.m. documented, "Since out of bed this morning resident has been pacing, going in other residents rooms and getting their belongings, he became agitated with staff when redirected. Lorazepam 1 mg po given at 11:30 a.m. ..."

23) Departmental Notes dated 5/25/15 at 11:35 p.m. documented, "6:40 p.m. Resident up and pacing in the corridors. He has behavior of wandering in other residents rooms. Resident in [room #33] states he doesn't want this resident [Resident #7] back in his room. ADON [Assistant Director of Nurses] was notified of the resident in [room #33] concerns of this resident coming into his room. At 7:00 p.m. Resident has wandered into room #34 when redirecting him he became agitated states, 'Just leave me alone' , staff gave resident sandwich and sweet tea and medicated him with Ativan 1 mg po. Staff remains in room 34 with resident [#7] until he agrees to go to his room ..."

Departmental Notes dated 5/27/15 at 3:44 p.m. documented, "Resident pacing hallways and going into other residents rooms pilfering in closets and drawers. Attempts to redirect with activities/food/fluids. Resident becomes

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increasingly agitated towards staff. Call placed to [Physician] with new orders received to increase Seroquel to 50 mg in am and 100 mg hs. [APS] notified of new orders ..."

Departmental Notes dated 5/28/15 at 4:34 p.m. documented, "[Physician] here to examine resident with no new orders received."

Physician Progress Notes dated 5/28/15 documented, "HPI [history and physical information]/Social History: ...He was transferred to psych facility for APS related issue. He was aggressively taking food from other patient's trays. Because of his aggressive behavior, it was felt that there might be some issues with him being placed in acute care unit, so he was admitted to the Geriatric Unit at this facility. It had been reported that he was found on occasion on other peoples' beds removing their clothes. Beyond that, I can't get much else ... Plan: He seems to have done better with the dose reduction on the medications he came in here taking. At this point we'll sit tight and see how he responds with the switch from Abilify to Seroquel bid [twice daily] ..."

24) Departmental Notes dated 5/31/15 at 4:10 p.m. documented, "At 4:15 p.m. administered Lorazepam 2 mg IM right hip for agiation [agitation]."
d. Departmental Notes and the June 2015 Medication Administration Record (MAR) from 6/1/15 - 6/30/15 (30 days) documented the resident had 13 episodes of increased agitation, aggression, and/or intrusiveness that required PRN medication. The Departmental Notes did not document consultation with physician, APS, or facility management regarding resident increased

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risk of being injured or injuring others due to his behaviors:

1) Departmental Notes dated 6/1/15 4:10 p.m. documented, "At 1430 [2:30 p.m.] Resident went in eyewash room, had BM [bowel movement] smeared it on cabinets and is clothing. He refused to change his clothes or allow staff to assist him, he became verbally and physically threatening. Lorazepam 1 mg IM given."

2) The back of the June 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation on 6/5/15 at 9:30 a.m.

3) The back of the June 2015 MAR documented the resident was administered Lorazepam 1 mg IM for behavior on 6/7/15 at 1830 (6:30 p.m.).

4) The back of the June 2015 MAR documented the resident was administered Lorazepam 1 mg IM for behavior agitation on 6/8/15 at 0400 (4:00 a.m.).

5) The back of the June 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation on 6/16/15 at 4:30 p.m.

6) The back of the June 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation on 6/17/15 at 10:45 a.m.

7) The back of the June 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation on 6/19/15 at 4:30 p.m.

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F 323	Continued From page 86 8) The back of the June 2015 MAR documented the resident was administered Lorazepam 1 mg IM for behavior agitation on 6/21/15 at 2202 (10:02 p.m.). 9) The back of the June 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation on 6/23/15 at 10:45 a.m. 10) The back of the June 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation on 6/23/15 at 3:30 p.m. 11) The back of the June 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation on 6/26/15 at 9:30 a.m. 12) Departmental Notes dated 6/26/15 11:52 p.m. documented, "4:20 p.m. Resident was walking pass staff he caught her left arm holding tightly around her left wrist, verbal cueing from staff to resident to released staff arm then redirected to dining room for food and fluid. Resident continues to be verbal aggressive to staff and other residents. He is medicated with Ativan 1 mg po." 13) The back of the June 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation on 6/27/15 at 11:40 a.m. e. Departmental Notes and the July 2015 Medication Administration Record (MAR) from 7/1/15 - 7/16/15 (16 days) documented the resident had 6 episodes of increased agitation, aggression, and/or intrusiveness that required	F 323		

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PRN medication. The Departmental Notes did not document consultation with physician, APS, facility management regarding resident increased risk of being injured or injuring others due to his behaviors:

1) The back of the July 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation on 7/01/15 at 3:00 a.m.

2) Departmental Notes dated 7/2/15 10:32 a.m. documented, "10:30 a.m. Ativan 1 mg po given, resident observed over past hour pacing in hallways, going in male residents room and bothering them. Resident talking non-stop in manic like mode with speech becoming threatening towards some staff. All attempts to divert his attention with activities snacks, 1-1 have been futile ..."

3) The back of the July 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation on 7/4/15 at 9:15 a.m.

4) The back of the July 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation on 7/5/15 at 9:00 a.m.

5) The back of the July 2015 MAR documented the resident was administered Lorazepam 1 mg p.o. for increased agitation on 7/8/15 at 11:30 a.m.

6) Departmental Notes dated 7/16/15 at 3:19 p.m. documented, "10:45 a.m. Resident woke up this morning in agitated mood, pacing with angry of tone of voice when staff cues him for redirections and to dining room for breakfast. Resident made

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attempt to hit staff but did not make contact. Ativan 1 mg po given ..."

f. The Resident's Comprehensive Care Plan with review date of 7/14/15 cpoc (continue plan of care) documented:

"Problem Onset 04/14/15 ... I display verbally aggressive behaviors. Goal ...I will decrease my episodes of verbally aggressive behaviors by 50%. Approaches ... Activities staff to visit with me and provide diversion activities. Observe and document my behaviors ..." A handwritten note dated 4/26/15 documented, "Broke window out on secured unit, with no injuries. Secured windows. Nursing staff in-serviced to administer p.m. [as needed] med before behaviors becomes escalated."

"Problem Onset 04/14/15 ...Resident has Mood & [and]/or Behavior concerns - Has orders for Psychotropic medication(s). Goal ...-Resident will remain free of injury/adverse effects related to Psychotropic medication(s) for the next 30 days ... Approach ...Monitor for Behaviors and intervene as needed ...-Remove to a private areas when behaviors are disrupting to others ... " A handwritten note dated 4/10/15 documented, " [increased] verbal aggression towards staff/residents ... D/C [discontinue] Zyprexa 10 mg hs [decrease] Trazodone 150 mg hs Seroquel 25 mg am [and] 50 mg pm"

The care plan did not address resident's risk of being injured or injuring others due to his intrusive and aggressive behaviors. The care plan had no new interventions after 4/26/15 for mood/behaviors.

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F 323	Continued From page 89 g. Departmental Notes dated 7/21/15 at 7:30 a.m. documented, "6:30 a.m. Resident came to Nurse at Nurse's station stated, 'Someone attacked me.' this nurse followed resident to room and found [Resident #8] sitting on bed with blood coming from nose and hematoma with quarter sized swelling to right eye. This [Resident #8] could not state what happened. Resident [Resident #7] stated, 'She attacked me.' I asked did resident hit her, he [Resident #7] stated, 'I kicked her in the face.' When asked Resident did this resident [Resident #8] hit him he stated, "No." This Nurse separated the resident into Nurses Station. Resident [Resident #7] denies any pain 0 on pain scale 1-10. Full ROM [range of motion] in UE [upper extremities] and LE [lower extremities] No noted blood on resident. Resident was given Ativan 2 mg/ml 0.5 ml [IM] given to right gluteus medius...Called on call MD ...notified of incident ...6:55 a.m. Attempted to notify [APS worker #1] and only answering machine. " A Continuous Monitoring 1:1 form dated 7/21/15 documented the facility began continuous 1 on 1 monitoring of resident at 6:30 a.m. which continued until discharge. Resident #8, a 102 year old female, had diagnosis of Alzheimer's disease. Departmental Notes dated 7/21/15 at 7:27 a.m. documented the resident was sent to the hospital emergency room (ER). Departmental Notes date 7/21/15 at 11:24 a.m. documented, "Discharge dx [diagnosis] from ER facial fracture. Right orbital and right maxillary fracture ..." On 7/21/15 at 11:28 a.m. during initial rounds of the facility, the resident ' s right eye was swollen shut and there was extensive dark purple bruising, and bruising to the left cheek area. There was dried blood on both nares and a trickle of bright red blood from the	F 323		

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right nare.

The OLTC (Office of Long Term Care) Incident and Accident Report (I&A) dated 7/21/15 documented the type of abuse Physical. Steps taken to prevent continued Abuse or neglect during the investigation: "An investigation was initiated immediately. Family, Local Law Enforcement and Administrator were notified. [Resident #7] was removed from room taken to Nurse Station for evaluation and placed 1:1 for safety. First Aid was provided to Resident [#8] by Registered Nurse (RN) #1 and [Resident #8] was then immediately transported to Ouachita County Medical Center ER for evaluation. Investigation is ongoing at this time."

g. Departmental Notes dated 7/23/15 at 3:14 p.m. and signed Alzheimer's Care Unit Director (ACUD) documented, "At approximately 1:30 p.m. this Nurse took over the 1:1 continuous monitoring to relieve CNA for lunch. [Resident #7] was ambulating up and down hallway. Resident went into the room of two female residents and I had difficulty redirecting him to leave the room. He was exhibiting sternness and reverting to "cop lingo" when speaking to me. I attempted to hold open the door he was trying to shut and he grabbed my wrist stating. 'I will murder you and they will find you hanging in the trees.' Once redirected and back into hallway, resident became increasingly agitated and inconsolable. He opened the door to another resident's room, entered and I was unable to redirect him out of the room. [Resident #7] reached down to grab a shoe belonging to the resident of the room he entered and the two resident became verbally aggressive towards one another and I had to call for help to redirect [Resident #7]. The [Name]

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ADON and [Name] DON entered the room. The [DON] was able to get [Resident #7] attention and walk him out the room. [Resident #7] became increasingly agitated, would not take the oral Ativan 1 mg that the LPN was offering. [Resident #7] became increasingly verbally threatening to staff and several staff members stated they were "scared" of him at this point. He was not able to be redirected and I sought guidance from the DON and ADON. I was told to call ambulance and send him to ER. The ER was contacted and the ambulance was dispatched to the facility. It took several staff members to get [Resident #7] to calm down and get onto the stretcher. [Resident #7] was given Ativan 1 mg IM in right deltoid muscle. Phone [APS Worker #1] and left message. ER call and stated they were sending [Resident#7] back to the facility. I spoke with [APS Worker #1] and will seek placement at geri-psych. facility with her approval of facility ...."

Departmental Notes dated 7/23/15 documented the resident was transferred out of facility at 7:00 p.m.

h. On 7/24/15 licensed nurses were interviewed:

At 9:40 a.m., Licensed Practical Nurse (LPN) #5 was asked if she worked on the Certified Alzheimer Unit. The LPN stated, "Yes for 3 1/2 years." The LPN was asked what was Resident #7 behaviors. The LPN stated, "He would wander in and out of other residents rooms, he had trouble finding the bathroom. He had behaviors, but I was able to control him better than other people. He got agitated, he would pace, pilfer and pick up things." The LPN was asked if Resident #7's behaviors got to a point that he had to have medications. The LPN stated, "Yes, there were

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F 323	Continued From page 92 periods that he would have to be medicated. Then all of a sudden his behaviors escalated, they had been random." The LPN was asked if she had talked to anyone. The LPN stated the CNAs reported to her his behaviors. The LPN was asked if she had reported to anyone else regarding the increased episodes of the resident ' s behaviors. The LPN stated, "Yes, I spoke with then Alzheimer Care Unit Director." The LPN was asked what was the criteria for giving residents the PRN [as needed] medications. The LPN stated, "We try redirection, activities, food, 1 to 1 with him before we give the medications." The LPN was asked, "Did you call the physician when the resident received PRN medication for several days and the resident's behaviors of agitation had increased and was the responsible party notified." The LPN stated, "No." At 10:55 a.m., LPN #4 was asked if she worked on the Certified Alzheimer Unit. The LPN stated for 1 year. The LPN was asked what Resident #7 ' s behaviors were. The LPN stated, "At times he can become verbally abusive and you have to redirect him." The LPN was asked what kind of behaviors the resident exhibited. The LPN stated, "Verbal threats that he was going to do something to you. Sometimes he would calm down and sometimes he required medication to calm him down." The LPN was asked what kind of threats did the resident make, did the resident threaten to hit. The LPN was shown documentation that she documented on 5/2/15. The LPN stated, "Yes he did ball up his fist and threaten to hit staff and residents." The LPN was asked if she had reported this incident to anyone. The LPN stated, "I can't remember." The LPN was asked if she had called the Physician or the responsibility party regarding the increased behaviors. The LPN	F 323		

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F 323	Continued From page 93 stated, "I can't remember." The LPN was asked, "Do you feel that the resident's aggressive behaviors should have been reported?" The LPN stated, "I probably called the Supervisor on call." The LPN was asked where this was documented. The LPN stated, "It's not documented." The LPN was asked if the other residents were at risk. The LPN stated, "Not at that time, we redirected him and gave him medication." The LPN was asked should a resident be admitted to the Certified Alzheimer Unit with a Psychiatric Diagnosis. The LPN stated, "No." The LPN was asked why. The LPN stated, "No, that would be a potential danger." At 1:35 p.m., LPN #2 was asked if she worked on the Certified Alzheimer Unit. The LPN stated, "Yes on the 11-7 shift. The LPN was asked if she had training for the Certified Alzheimer Unit. The LPN stated, "Yes, by the former ACUD that gave in-services." The LPN was asked if she had been trained on dealing with aggressive resident. The LPN stated, "Not at this facility, but elsewhere." The LPN was asked if there were any issues related to behaviors or aggressive residents on the Alzheimer Unit. The LPN stated, "Yes with [Resident #7] that was the only issue. He was doing fine, then he had periods of agitation and not easily redirected." The LPN was asked what the resident's behaviors were. The LPN stated, "He knocked out a window, no major problems until the other day." The LPN was asked what happened. The LPN stated, "I was at the Nursing station, [Resident #7] came to the Nursing Station and stated that somebody had attacked him. I followed him back to his room and I saw [Resident #8] sitting on the bed with blood all over her. I got [Resident #7] out of the room. I got [Resident #8] out of the room, I got her sent to the	F 323		

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ER [Emergency Room]. When [Resident #7] came to the Nursing Station he was not showing any signs or symptoms of aggression. I asked [Resident #7] what happened. [Resident #7] stated ' I kicked her in the face.'" The LPN was asked when did this happen. The LPN stated, "It occurred at about 6:30 a.m. on 7/21/15." The LPN was asked if there had been any aggressive behaviors problems. The LPN stated no resident to resident contact, but he had aggressive behavior that wasn't easily redirected. The LPN was asked where was a Certified Nursing Assistant (CNA) when this incident occurred. The LPN stated, "The CNA was on the back unit helping the other CNA with a resident. The LPN was asked how the unit was staffed. The LPN stated, "They have 2 CNA's. There is one CNA on the front and one CNA on the back. The CNA was off the unit." The LPN stated, "I was at the Nursing Station." The LPN was asked if she could see down the hall. The LPN stated, "Not the front hall where [Resident #7 and #8] were located." The LPN was asked if [Resident #8] had any behaviors. The LPN stated, "She generally didn't wander, once in a blue moon did she get up at night." The LPN was asked if Resident #7 had any behaviors at night. The LPN stated, "He did wander at night, he had started sleeping, but that morning he was getting up." The LPN was asked regarding the staffing, the unit only has 1 CNA at night, for 18 residents on the front hall and 1 CNA on the back unit for 9 residents. The LPN stated, "Yes."

i. On 7/23/15, Certified Nursing Assistants were interviewed:

At 7:50 p.m., CNA#1 was asked if she worked on the Certified Alzheimer Unit. The CNA stated,

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F 323	Continued From page 95 "Yes." The CNA stated, "I started to work in April 2015." The CNA was asked if she had received special training for the Certified Alzheimer Unit. The CNA stated, "Yes." The CNA was asked if she had cared for Resident #7. The CNA stated, "Yes." The CNA was asked what the resident's behaviors were. The CNA stated, "At first he was calm, later he got more aggressive. If we tried to assist him he didn't like us touching him. He began peeing elsewhere beside the bathroom. His attitude was different. He was aggressive toward staff." The CNA was asked if he was aggressive towards other residents. The CNA stated, "He would get agitated. He would ball up his fist, grab at them. If we touched him he would yell, get away from me. His attitude was up and down." The CNA was asked if he tried to hit the staff. The CNA stated, "Yes, plenty of times but he didn't make contact. I got to a point, I was afraid of him at times, then I would get someone else. He would yell at us." When asked about her fear of resident, the CNA stated, "Yes, at times he was aggressive and he did try to hit me, but he was more threatening." The CNA was asked since you stated you were afraid of him and he would become more aggressive do you feel that he could have hit another resident. The CNA stated, "If it came down to it." The CNA was asked if she had reported the incidents of the resident being aggressive. The CNA stated, "Yes, to the Nurse." The CNA was asked if she had reported that she was afraid of the resident at times. The CNA stated, "No." At 7:58 p.m., CNA #2 was asked if she worked on the Certified Alzheimer Unit. The CNA stated, "Yes." The CNA was asked if she had received training for the Certified Alzheimer Unit. The CNA stated, "I worked here about 1 1/2 months, and	F 323		

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I've not started the training yet." The CNA was asked if she had cared for Resident #7. The CNA stated, "Yes, together with the other CNA's." The CNA was asked about the resident's behaviors. The CNA stated, "His behaviors had slipped, he got real agitated. He didn't like people bothering him. He would talk like a cop. He wouldn't let us give him care. He was in a mind that he was working. He would walk all the time. We had to watch him, he would go in and out of other resident's room. He would get aggressive towards staff." The CNA was asked if the resident triedy to hit staff. The CNA stated, "Yes." When asked if the resident got aggressive towards residents, the CNA stated, "No."

j. On 7/23/15 at 7:00 p.m., the Director of Nursing (DON) was asked after reviewing the documentation regarding Resident #7 if this resident was appropriate for the Certified Alzheimer's Unit. The DON stated, "I was not aware of his history. I didn't read the documentation at that time of admission." The DON was asked if she was aware of the resident's aggressive behaviors documented in the resident's clinical record. The DON stated, "I was aware of his pacing and going in other resident room. I was not aware of his aggressive behaviors towards staff and other residents." The DON was shown the documentation on 5/2/15 that the resident had balled up his fist and was threatening the staff and other residents. The DON stated, "I was not aware." The DON was asked if the resident's increased incidents of aggressive behaviors were reported to her. The DON stated, "No." The DON was asked if a resident is having increased episodes of aggressive behaviors shouldn't this be reported to Physician and the responsible party. The DON

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F 323	Continued From page 97 stated, "Yes." The DON was asked if the increased episodes of aggressive behaviors would put the other residents on the Alzheimer's unit at risk. The DON stated, "Yes." k. On 7/24/15 at 2:15 p.m., the Alzheimer Care Unit Director (ACUD) if the staff reported any aggressive behaviors or increased behaviors regarding Resident #7. The ACUD stated, "No." The ACUD was asked if a resident had increased behaviors that required to be medicated who should they report to. The ACUD stated that they should report to the Nurse and notify the ACUD. The ACUD was asked if the Physician and responsible party should be notified. The ACUD stated, "Yes. I thought they had been notified when the incident occurred on 7/21/15. The ACUD was asked was the Physician and responsible party notified when Resident #7 had increased behaviors. The ACUD stated that she had not notified the responsible party [APS worker #1] until 7/23/15. The ACUD was asked what was the importance of notifying the Physician of the resident increased behaviors. The ACUD stated, "For the benefit of the resident." The ACUD stated that this was an oversight on her part. The ACUD stated, "I was trying to transfer the resident out." The ACUD was asked if she had called the Physician or the responsible party when she was trying to transfer the resident. The ACUD stated, "No, I should have called for guidance." The ACUD was asked if a resident with Psychiatric diagnosis, Schizophrenia be admitted to the Certified Alzheimer Unit. The ACUD stated, "I would say we are not equipped to deal with them. " l. On 7/27/15 at 4:30 p.m., the Administrator was asked regarding the documentation on a letter	F 323		

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PINE HILLS HEALTH AND REHABILITATION, LLC	**900 MAGNOLIA RD CAMDEN, AR 71701**

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dated July 21, 2015, signed by the Administrator, and attached to the OLTC (Office of Long Term Care) Incident and Accident Report (I&A) form dated 7/21/15. The Administrator stated that they had contacted [Physician #1] to place a referral for [Resident #7]. The documentation stated that the resident had not displayed any s/s of aggressive behavior at this time and that he was very remorseful for the events that took place and has repeatedly asked staff, "How is she? Is she ok?" The letter stated [Physician #1] has agreed to review this information in attempt to prevent resident from being placed outside the facility in geri-psych admission. The Administrator was asked if the Resident's attending Physician had given orders for the referral. The Administrator stated, "No." The Administrator was asked if the staff had reported to her the frequently documented incident in the resident's clinical record of aggressive behaviors. The Administrator stated, "No." The Administrator was asked regarding the documentation in the letter referring to the resident having the diagnosis of Alzheimer's Disease and if [Resident #7] had diagnosis of Alzheimer's Disease. The Administrator stated, "No." The Administrator was asked if she had reviewed the resident's Nurses Notes or if the staff had reported to her regarding the documented incident in the resident clinical record of aggressive behavior. The Administrator stated, "No."

m. On 7/27/15 at 6:35 p.m., the attending physician [Physician #2] was asked if made aware of Resident #7's incident 7/21/15 and the physician stated, "On vacation last week. Typically adjust med." The physician was asked if he would expect the facility to notify the physician when a resident has had behavior changes and

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the physician stated, "Yes..."

n. On 7/24/15 at 3:40 p.m., Adult Protective Services (APS) Caseworker #1 was asked if Resident #7 was in APS custody and the Caseworker stated, "Yes." The APS Caseworker was asked if had was notified on 7/21/15 of any resident to resident altercation that involved Resident #7 and the Caseworker stated, "No. I was advised 7/23/15 by Emergency Room hospital staff after I received a call from them. I was advised by [Alzheimer's Care Unit] Director then afterwards. Only received call after the hospital called ... By the way on Tuesday [7/21/15] he kicked a 102 year old resident [Resident #8] I found that out after he went to the Emergency Room ... I did an order to transport. Judge signed. [County] Sheriff office transport. Started process for transport as soon as found out Thursday." The APS Caseworker was asked if aware of other behavior incidents could any measures have been taken with Resident #7 and the APS Caseworker #1 stated, "Talked to doctor about meds and we could have addressed the behaviors sooner." The APS Caseworker was asked if notified of the resident's increased behaviors that included hitting window and hitting female resident. The APS Caseworker stated, "I have not been notified about him getting aggressive or hitting objects. Found out about the incident yesterday when I was called by staff nurse [Emergency Room]. If I had known about that incident sooner I could have initiated arrangements to send out sooner. Not notified of any aggressive behavior."

o. On 7/24/15 4:37 p.m., the Assistant Director of Nurses (ADON) was asked, "How do you determine the staff to resident ratio for the

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F 323	Continued From page 100 Alzheimer Care Unit?" The ADON stated that unit was staffed according to the state minimum staffing ratio. The ADON was shown the documentation in the Alzheimer Unit Care Book with the ratios for the primary care givers as 1 staff to 8 residents on the day shift and the evening and night ratio is 1 staff to 10 residents. The ADON stated, "I've never seen that before." Complaint #20365 (AR00018476) substantiated with these findings: B. Based on observation, record review, and interview, the facility failed to ensure residents were not lifted and repositioned underneath the axillae during transfer and repositioning in a wheelchair for 1 (Resident #6) of 3 (Residents #3, #4, and #6) case-mix residents who required gait belt transfer and 9 (Resident #1, #2, #3, #4, #6, #8, #9, #10, and #11) case mix residents who required assistance with repositioning in a wheelchair. The failed practice had the potential to affect 7 residents who were gait belt assisted transfers on the East Wing as documented on a list provided on 7/24/15 by the Director of Nursing (DON) and 14 residents who were wheelchair dependent on the East Wing per the Initial Rounds of 7/21/15. The findings are: Resident #6 had diagnoses of Huntington's Chorea, Type 2 Diabetes Mellitus, Hypertension, Anemia, and Anxiety State. The Annual Minimum Data (MDS) with an assessment reference date of 6/12/15 documented the resident scored 0 (0-7 indicates severely impaired) on a Brief Interview for Mental Status (BIMS); required extensive physical assistance from staff for transfer; was not steady with balance moving from seated to standing position, with walking, surface-to-surface	F 323		

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transfer; used a wheelchair; and had 2 or more falls.

a. The Care Plan dated 6/15/15 documented, "I am at risk for falls r/t [related to] uncontrollable sudden movements r/t Huntington's Chorea... Skid sock..." There was no documentation that indicated the type of assistance the resident required for transfer.

b. The Lift/Mobility Assessment for type of lift dated 6/9/14 and signed by Licensed Practical Nurse (LPN) #9, documented, "Reason for Lift/Transfer Assessment: quarterly... Can Resident stand, pivot, & [and] walk with no assistance or with limited assistance from staff with no risk of falling or injury to staff? [marked] Yes... Comments/summary: gait belt. " The section "Partial Lift Assessment " with yes or no response was not completed and was blank. The questions listed in that section were documented, "Is Resident able to bear at least 50% weight on at least 1 leg? Can Resident sit upright without Physical Assistance? Is Resident able to follow simple directions? Resident has upper extremity strength with ability to grip with at least one hand? Is Resident able to tolerate moderate pressure mid to lower back? Check if answers to "all" 5 questions are YES-Potential Candidate for Sit to Stand Lift ...Total Lift Assessment Can Resident tolerate being in a semi-reclined position?" These areas were not marked for either the Yes or the No response that indicated the assessment was completed.

c. On 7/23/15 at 11:10 a.m., after receiving pericare, the resident sat up on the bedside with LPN #4 on the resident's right side. LPN #4 placed her arm underneath the resident's right

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axilla. LPN #9 was at the resident's left side and placed her hand around the resident's upper left arm. The LPNs physically lifted the barefoot resident up from sitting position to stand at the bedside then took a few steps to the wheelchair to sit down. The resident had spastic movements of all extremities. LPN #4 pushed the resident's wheelchair from the room down the hallway. At 11:15 a.m., the resident slid down to the edge of the wheelchair seat. The LPN stopped the wheelchair in the hallway and Certified Nursing Assistant (CNA) #7 was on the right side of the wheelchair and CNA #8 joined her on the left side. CNA #7 lifted underneath the resident's right arm and grasped the resident's pants over the hip area. CNA #8 placed an arm underneath the resident's axilla and lifted upwards to pull the resident up in the wheelchair to reposition the resident upright in the wheelchair. LPN #4 pushed the wheelchair into the Business Office at 11:18 a.m. At 11:20 a.m., the resident slid down to the edge of the wheelchair with his buttocks on the edge of the wheelchair seat. LPN #4 stood facing the resident on the resident's left side and placed her left arm underneath the resident's left axilla. The Business Office Manager (BOM) went to the resident's right side of the wheelchair and with her right arm underneath the resident's right axilla, the 2 staff members lifted the resident upward to reposition him upright in the wheelchair. At 11:23 a.m., LPN #4 stated, "You're fixin' to slide out again." LPN #4 went to the resident's left side and the BOM went to the resident's right side and each put their arm underneath each of the resident's axillae and lifted up on the shoulders to resposition the resident in the wheelchair.

d. On 7/23/15 at 2:05 p.m., LPN #4 was asked

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what type of transfer does the resident require and the LPN stated, "He's a 2 person assist." The LPN was asked if the resident needed a gait belt for transfer and the LPN stated, "He really won't let us use the gait belt on him." The LPN was asked if the resident should have a gait belt used for transfer and the LPN stated, "He helps, he has full use of his legs so we're not pulling on him just guiding him." The LPN was asked if that was appropriate and the LPN stated, "He's a different case."

e. On 7/23/15 at 4:03 p.m., LPN #9 was asked what type of transfer did the resident require and the LPN stated, "Gait belt." The LPN was asked if a gait belt had been used when the resident was transferred to the wheelchair and the LPN stated, "No." LPN #9 was asked how she had transferred the resident and the LPN stated, "I held his hand." The LPN was asked if a gait belt should have been used and the LPN stated, "Probably." The LPN was asked who assessed the resident for transfer and the LPN stated, "Me." After review of the Transfer Assessment the LPN was shown the assessment and asked at 4:58 p.m. if there was a completed assessment for the transfer/lift and the LPN stated, "No that's it."

f. On 7/27/15 at 4:30 p.m., the Director of Nursing (DON) was asked if residents who were gait belt transfers should be lifted under the axillae and the DON stated, "No." The DON was asked what could occur from this and the DON stated, "You can cause bruising and shoulder dislocation."

g. On 7/27/15 at 8:55 p.m., the DON was asked if non-nursing staff should lift and reposition residents in the wheelchair and the DON stated,

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F 323	Continued From page 104 "No." The DON was asked why non-nursing staff should not lift or reposition residents and the DON stated, "Not trained to position them correctly and they could cause injury."	F 323		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Complaint #20354 (AR00018459) substantiated (all or in part) on these findings: Based on observation of the 4:00 p.m. medication pass on 7/21/15 and the 8:00 a.m. medication pass on 7/22/15, record review and interview, the facility failed to ensure the medication error rate was less than 5% to prevent potential complications for 3 (Residents #4, #9, and #10) of 8 residents observed during the medication passes resulting in medication errors. Medication errors were made by 2 Licensed Practical Nurses (LPN), (LPN #3 and #4), of 2 licensed nurses observed administering medications in the facility. The failed practice had the potential to affect 32 residents who resided on the East Hall and received medications administered from these Nurses according to a list provided by the Director of Nursing (DON) on 7/23/15. The medication error rate was 8.16% based on administration of 49 medications with 4 errors observed. The findings are: 1. Resident #9 had diagnoses of Type 2 Diabetes	F 332		

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F 332	Continued From page 105 Mellitus Uncontrolled, Alzheimer's Disease, and Cerebrovascular Accident (CVA). a. A physician order dated 1/13/14 documented, "Metformin Hcl [hydrochloride]1000 mg [milligrams] tablet 1 PO [by mouth] with food (crush)." b. On 7/21/15 at 4:34 p.m., LPN #3 crushed the Metformin 1000 mg tablet and mixed it in approximately one-half teaspoon of jelly, then administered it to the resident with a small amount of water. There was no other food on the bedside table. At 4:36 p.m., LPN #3 went to the nurses station, got a package of a soft oatmeal cookie with cream filling, returned to the resident's bedside and laid the cookie on the bedside table and instructed the resident to eat the cookie. The LPN promptly left the resident's room and did not wait to see if the resident ate the food provided. The dietary department meal trays did not begin to be served until 5:15 p.m. for the evening meal. c. On 7/22/15 at 5:15 p.m., LPN #3 was asked if the resident had eaten food with the medication, the LPN stated, "No but I took her a cookie and she always eats it." The LPN was asked if she had stayed and observed that the resident had eaten the cookie and the LPN stated, "No, I see what you mean." 2. Resident #4 had diagnoses of Closed Skull Fracture, Subdural Hemorrhage, Vitamin Deficiency, and Schizophrenia. a. A physician order dated 4/12/13 documented, "Calcium 600 [plus] Vit [vitamin] D 200 tablet 1 tab PO BID [twice a day] with food."	F 332		

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b. On 7/22/15 at 4:47 p.m., LPN #3 administered Calcium 600 with Vitamin D with approximately 2 ounces of water and no food. The evening meal service did not begin until 5:15 p.m.

3. Resident #10 had diagnoses of Peripheral Vascular Disease, Convulsions, General Muscle Weakness, and Alcohol Dementia.

a. A physician order dated 9/27/13 documented, "Folic Acid 1 mg tablet give 1 tab PO QD [every day]."

On 7/22/15 at 7:55 a.m., LPN #4 administered the 8:00 a.m. medications, but did not administer the Folic Acid tablet, which was scheduled with the 8:00 a.m. medication pass. At 3:55 p.m., the medication card for Folic Acid 1 mg had a tablet remaining in the medication card for the 22nd.

b. A Physician Order dated 9/27/13 documented, "Mag [Magnesium] Delay 64 mg tablet 1 tablet PO QD Do Not Crush."

On 7/22/15 at 7:55 a.m., LPN #4 administered Magnesium Oxide 400 mg tablet to the resident instead of Mag Delay 64 mg as ordered. At 3:00 p.m., LPN #4 was asked what medication was ordered and the LPN stated, "Mag 64 one tablet." The LPN was asked what was given, after the LPN looked at the bottle, stated, "I gave him Mag Oxide 400."

F 441 SS=F 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS — F 441

The facility must establish and maintain an Infection Control Program designed to provide a

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safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

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

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

This REQUIREMENT is not met as evidenced by:
Complaint #20354 (AR00018459) was substantiated (all or in part) in these findings:

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F 441	Continued From page 108 Based on observation, record review and interview, the facility failed to ensure staff washed their hands between dirty and clean tasks to prevent the potential spread of infection for 6 (Residents #1, #2, #4, #6, #9, and #11) of 12 (Residents #1 thru #4 and #6 thru #13) case mix residents who required assistance with activities of daily living. The facility failed to ensure staff donned gloves and gowns before entering an isolation room and followed contact isolation precaution procedures to prevent potential spread of infection to other residents for 1 of 1 (Resident #1) case mix resident who required contact isolation precautions and universal precautions to prevent potential spread of infection for 4 (Resident #1, #6, #9, and #11) of 12 (Residents #1 thru #4 and #6 thru #13) case mix residents who received ice water from the facility thermos and the medication cart water pitcher. The facility failed to ensure staff avoided touching residents' medication containers with contaminated hands to prevent potential infection or illness for 3 of 3 (Residents #1, #9, and #11) case mix residents who received medications from Licensed Practical Nurse (LPN) #3. The facility failed to ensure a blood glucose monitor was sanitized after use to prevent potential spread of infection for 1 (Resident #9) of 2 (Residents #9 and #11) case mix residents who had blood glucose monitor checks. These failed practices had the potential to affect 32 residents on the East Wing who were dependent for activities of daily living per the	F 441		

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Licensed Practical Nurse (LPN) on Initial Rounds 7/21/15, 8 residents who had glucose monitors used, as documented on a list provided by the Director of Nursing (DON); 1 resident who required isolation, per Initial Rounds on 7/21/15; and 27 residents who resided on the East Wing and had ice water served according to a list provided by the Assistant Director of Nursing (ADON) on 8/10/15.

The findings are:

1. The facility policy titled Housekeeping Routine Handwashing received from the DON on 7/22/15 at 11:10 a.m. and the facility policy titled Routine Handwashing received at 11:25 a.m. on 7/22/15, documented, "Handwashing is the single most important means of preventing the spread of infection. ...Handwashing indications (Patient care) ...2. Before contact with particularly susceptible patients. 3. After contact with a source that is likely to be contaminated with virulent microorganisms or hospital pathogens, such as infected patient or an object or device contaminated with secretions or excretions of patients. 4. Between patients. ...6. Hand antisepsis is required before... leaving the room of patients on contact precautions. ..."

2. The Infection Control policy and procedure received at 10:50 a.m. on 7/22/15 documented, "Policy To provide guidance for isolation precautions when residents have or are suspected to have an infectious or communicable disease. The facility is committed to providing a safe and healthy environment for residents and to minimize or prevent the spread of infections. Procedure 1. 1. The charge nurse notifies the Infection Control Nurse or designee and the

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resident's attending physician for appropriate isolation instructions when there is reason to believe that a resident has an infectious or communicable disease. 2. The charge nurse obtains a physician's order for isolation; the Infection Control Nurse or designee can approve implementing isolation in the vent of physician response delay. 3. Isolation Precautions are initiated: ...Explain to the ...staff the reason(s), for the isolation precautions. Maintain isolation precautions until no longer indicated. General Information Isolation precautions are required for certain infected residents to prevent the spread of disease to other residents, employees, and visitors."

3. A procedure titled Infection Control received from he DON at 10:53 a.m. on 7/22/15 documented, "Multiple-resistant organisms: MRSA, VRE [Vancomycin Resistant Enterococci]; other bacteria resistant to penicillin... Mask No, Gown yes, soiling is likely; Gloves Yes for touching infective material; Infective Material ...urine and possible feces, infected area, pus, secretions, and possibly feces; Duration Until antimicrobials culture is negative; Until antimicrobials culture is negative, colonized, or contained..."

4. A procedure titled Contaminated Isolation Room Cleaning received at 7:20 p.m. on 7/24/15 from the DON documented, "Before entering the room 1) Scrub hands and arms for 3 minutes with disinfectant soap. 2) Dress in isolation clothes: 1st-Booties 2nd-Cap 3rd-Mask 4th-Gown 5th-Gloves Enter the Isolation Room 3) Pick up and place in an isolation bag all personal property... Additional information Isolation is the separating of one patient or group of patients

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from the rest of the facility because they have some type of communicable illness. The purpose is to prevent the spread of this disease. Isolation cleaning-refer to the efforts made to keep all bacteria at a low level and within one designated area. Use a systematic routing while working. To protect the facility from the patient, every effort is made to keep the bacteria in the room. ..."

5. Resident #1 had diagnoses of Methicillin-Resistant Staphylococcus Aureus (MRSA), Peripheral Vascular Disease, Stage 4 Pressure Ulcer, Gangrene, Amputation Below Knee, and Amputation Above Knee. The Admission Minimum Data Set (MDS) with an Assessment Reference Date of 7/16/15 documented the resident had scored 11 (8-12 indicates moderately impaired) on the Brief Interview for Mental Status (BIMS), had extensive to total dependence on staff for activities of daily living, and had MRSA infection.

a. The Care Plan dated 7/21/15 documented, "I require isolation due to an MRSA. ...Educate ...about the isolation requirements..."

b. On 7/21/15 at 11:10 a.m., during the initial rounds, the resident had a sign on the room door that identified the room as isolation and there was a small cart located outside the room in the hallway that had supplies that included yellow paper gowns, red bags, and gloves on the cart. Licensed Practical Nurse (LPN) #10 stated, "Contact isolation for MRSA wound."

c. On 7/21/15 at 11:46 a.m., the door was wide open to the resident's room, and LPN #8 stood at the resident's bedside in the isolation room and was not gowned nor gloved. At 11:47 a.m., the

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LPN touched the nebulizer mask that was on the resident's face with ungloved fingers as she leaned her scrub top and pants against the resident's bed railing, then folded her arms across her chest. At 11:50 a.m., LPN #8 touched the nebulizer mask again with ungloved fingers of the left hand then folded her arms. At 11:55 a.m., the LPN left the resident's room without washing or sanitizing her hands then pushed a cart down the hallway.

d. On 7/21/15 at 11:50 a.m., Housekeeper #1 put a gown, mask, and gloves on and entered the resident's room. At 11:52 a.m., the Housekeeper came out of the isolation room carrying a clear plastic trash bag with trash, went to the housekeeping cart, and dropped the small plastic bag into the large clear plastic trash bag. The Housekeeper removed the mask, gown, and gloves and dropped the isolation items into the large clear plastic trash bag that was on the Housekeeping cart. The Housekeeper then pushed the housekeeping cart down the hall and stopped outside of Resident Room #5 without washing or sanitizing hands, then picked up a mop to go into Resident Room #5.

e. On 7/21/15 at 11:55 a.m., LPN #4 went into the isolation room with plastic gloves in her hand and without donning a gown. The LPN went to the bedside, gloved her hands, and leaned her scrub top against the resident's bed with the scrub suit touching against the bed. LPN #4 removed the nebulizer from the resident's face, then went into the bathroom and washed her hands. The LPN did not wear a gown while in the resident's room and at the resident's bedside.

f. On 7/21/15 at 4:58 p.m., the door was opened

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F 441	Continued From page 113 wide, and LPN #3 went into the isolation room during medication pass without donning an isolation gown or gloves. The LPN leaned against the bed rail and her scrub top touched the bed rail. The LPN administered the resident's medication. At 5:01 p.m., the LPN left the bedside without washing or sanitizing her hands, then went to the medication cart in the doorway, opened the Medication Administration Record (MAR) and controlled narcotic books, then wrote in the books. The LPN removed the medication cart keys from her scrub top pocket, unlocked the medication cart drawer and narcotic lock box, touched the medication cards, then removed a medication card from the drawer and dispensed a tablet. The LPN locked the narcotic lock box and placed the keys in the top pocket of her scrub top. At 5:04 p.m., LPN #3 went back inside the isolation room to the bedside, without donning an isolation gown and gloves, back to the medication cart, picked up the large water pitcher, poured water into a cup and moved the glucose monitor to another area on top of the cart. The LPN administered pain medication to the resident. At 5:05 p.m., the LPN left the bedside, exited the room, and pushed the medication cart down the hallway to the door of Resident Room #21 without washing her hands. g. On 7/22/15 at 8:10 a.m., Certified Nursing Assistant (CNA) #7 entered the isolation room without donning a gown or gloves, removed the meal tray out of the isolation room, and returned the tray to the metal food cart in the hallway, opening the door without washing or sanitizing her hands. At 8:19 a.m., CNA #7 entered the isolation room without donning a gown or gloves, went to the bedside table, picked up the water thermos, and went to the ice chest on a cart in	F 441		

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F 441	Continued From page 114 the hallway. The CNA held the thermos over the opened ice chest, filled the thermos with ice, and returned it to the bedside to place the water thermos on the table. The CNA then left the bedside, came out to the hallway, and pushed the cart with the ice chest down the hall. h. On 7/22/15 at 12:27 p.m., CNA #10 entered the resident's isolation room without donning a gown or gloves, leaned against the bedrail, placed the overbed table from the side of the bed to over the bed in front of the resident. The CNA went out to the food cart, opened the door of the metal cart, removed a meal tray, and returned to the isolation room. The CNA leaned against the bed with her scrubs touching the bedside, and moved the table. The CNA leaned against the overbed table, touched the plastic glass with the ungloved hand, and left the room. CNA #10 then went to the metal food cart in the hallway, pushed the cart down the hallway to outside Resident Room #5 without washing or sanitizing her hands and removed another resident's food tray from the cart at 12:30 p.m. i. On 7/23/15 at 7:58 a.m., CNA #8 was in the resident's room and wore gloves but no gown while assisting the resident with his breakfast. Her uniform touched the side rails and the resident's bed linens. The CNA removed her gloves, did not wash her hands, left the room, and walked down the hall to the dining room and returned with a straw. The CNA re-entered the resident's room, put on gloves and moved items on the overbed table, with her uniform touching the side rails and resident's bed linens. The CNA then removed her gloves and left the resident's room without washing her hands. The CNA went to the clean linen room and got a pair of socks	F 441		

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and handed them to another staff member. The CNA had an incontinent brief and placed it in a plastic bag. The CNA re-entered the resident's room and without donning gloves or a gown laid the plastic bag in the geri-chair. The CNA touched the linens at the head of the bed, the side rail with her uniform, and the bed linens. The CNA touched the control on the side rails with her bare hands, then left the room without washing her hands. The CNA went into Resident #2's room and touched the resident on the shoulder, then went down the hall to Resident Room #11, knocked on the door, and touched the door handle. The CNA went down the hall to the Nurses Station, touching the door knob, got a gait belt, and placed the gait belt around her waist, then went out the back door touching the control panel and door and got 2 barrels and returned the barrels to the bio-hazard room. At 8:12 a.m., the DON told the CNA to wash her hands

j. On 7/27/15 at 4:30 p.m., the Director of Nursing (DON) was asked why the resident was on isolation and the DON stated, "He had MRSA in the wound." The DON was asked who determined the resident should be on isolation when a physician order was not located in the resident record. The DON stated, "If someone has MRSA, it is protocol." The DON was asked if isolation protocols should be adhered to, such as gowning and gloving before contact with an isolation resident. The DON stated, "Yes."

k. On 7/27/15 at 5:35 p.m., LPN #8 was asked why the resident was on contact isolation and stated, "MRSA, past." The LPN was asked, when staff go in an isolation room and have contact with the resident, should they be gowned and gloved? The LPN stated, "Yes." The LPN was

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F 441	Continued From page 116 asked if there should be handwashing after contact with a resident in isolation and stated, "Yes." 6. Resident #6 had diagnoses of Huntington's Chorea, Type 2 Diabetes Mellitus, Hypertension, Anemia and Anxiety State. The Annual MDS with an ARD of 6/12/15 documented the resident scored 0 (0-7 indicates severely impaired) on the BIMS and required extensive physical assistance from staff for transfer. a. On 7/21/15 at 11:52 a.m., Housekeeper #1 had just exited an isolation room wearing the paper gown, gloves, and mask that was worn inside the isolation room. The Housekeeper removed a small clear plastic bag of trash and placed it inside a large clear plastic bag on the housekeeping cart, then removed the gown, mask, and gloves, dropped the items into the large clear plastic bag, and pushed the cart to outside of Resident #6's room. The Housekeeper did not wash or sanitize her hands prior to touching the mop to remove it from the cart, then took the mop and went into Resident #6's room. b. On 7/22/15 at 12:30 p.m., CNA #11 left the room of Resident #1, who was on contact isolation precautions, and without washing/sanitizing hands or donning a gown or gloves, the CNA pushed a metal food cart down the hallway to outside Resident #6's room. The CNA removed Resident #6's food tray, entered the room, sat the tray down on a table, then went into the bathroom and washed her hands. c. On 7/23/15 at 11:07 a.m., LPN #4 was at the bedside and removed a rolled up brief with feces, placed it inside a clear plastic bag, removed her	F 441		

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F 441	Continued From page 117 gloves and put the gloves into the bag then pulled the resident's pants up without washing or sanitizing her hands. The LPN then touched the resident to assist the resident in transferring before the LPN washed her hands. 7. Resident #9 had diagnoses of Type 2 Diabetes Mellitus Uncontrolled, Alzheimer's Disease, Cerebrovascular Accident (CVA), and Vascular Dementia. The Quarterly MDS with an ARD of 7/21/15 documented the resident scored 4 (0-7 indicates severely impaired) on the BIMS and had Diabetes Mellitus. On 7/21/15 at 4:35 p.m., LPN #3 performed a glucose monitor test for the blood sugar level for the resident. After the glucose check was finished, the LPN brought the monitor out of the resident's room and placed it on top of a small notebook on top of the medication cart without disinfecting the monitor with any type of sanitizer. 8. Resident #11 had diagnoses of Hereditary Progressive Muscular Dystrophy, Type 2 Diabetes Mellitus, Depressive Disorder, Chronic Frontal Sinusitis, and Acute Pancreatitis. The Quarterly MDS with an ARD of 5/20/15 documented the resident scored 15 (13-15 indicates cognitively intact) on the BIMS and required extensive to total dependence on staff for activities of daily living. On 7/21/15 at 5:05 p.m., LPN #4 pushed the medication cart to outside the resident's room without washing or sanitizing her hands after exiting an isolation room. The LPN went into the resident's room then returned to the medication cart. At the cart the LPN opened a drawer, pulled medication cards out of the drawer, then began	F 441		

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putting the medications into a plastic cup. A pharmacy delivery person arrived at the cart and gave the LPN a large white paper sack with the pharmacy logo. The LPN opened the sack, removed the medication cards from the sack, signed an invoice, replaced some of the medication cards back into the sack, placed medication cards into the cart drawer, then stated to the delivery person, "You'll go to her side. Get her to sign for those." LPN #4 then handed the delivery person the sack and the delivery person went down the hall to the secured unit. The LPN then finished dispensing medications for the resident into a plastic cup. The LPN was asked how many medications the resident got and stated, "6 in cup, 7 total, 2 same." At 5:15 p.m., LPN #4 picked up the large water pitcher and poured a cup of water, then went into the resident's room and handed the resident the cup of water and the cup of medications without washing or sanitizing her hands. At 5:17 p.m., the LPN returned to the medication cart, and without washing or sanitizing her hands moved the glucose meter to the side of the medication cart.

9. On 7/22/15 at 5:15 p.m., LPN #3 was asked if the glucometer should be cleaned and sanitized after each resident use and the LPN stated, "Yes. Usually we have sanitizer wipes." The LPN was asked if she had sanitized the glucometer and the LPN stated, "No." The LPN was asked if her hands should be washed or sanitized between each resident's care and the LPN stated "Yes." The LPN was asked if she should wash her hands after leaving an isolation resident's bedside and the LPN stated, "Yes."

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10. Resident #3 had diagnosis of Vascular Dementia and Convulsions. The Annual MDS with an ARD date of 5/4/15 documented the resident scored 6 (0-7 indicates severely impaired) on the BIMS, required extensive assistance of 1 person for bed mobility, transfers, dressing and personal hygiene, extensive assistance of 2 person for toilet use, and was incontinent of bladder and bowel.

a. On 7/22/15 at 9:12 a.m., CNA #3 was in the resident's bathroom with the resident, who had been incontinent. The resident was standing, facing the commode. On the right side of the sink, there was as white towel with a yellow tint and a soiled incontinent brief laying on the sink. The CNA placed the soiled towel and the soiled incontinent brief in plastic bags. The CNA had completed the incontinent care, then left the room without washing her hands. The CNA touched the door knob to the biohazard room, went down the hall touching a resident in a merry walker, and pushed the resident down the hall before washing her hands. The CNA did not clean the sink in the resident's room that was contaminated with the soiled towel and soiled incontinent brief.

11. Resident #2 had diagnoses of Presenile Dementia and Convulsions. The Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 7/14/15 documented the resident scored 5 (0-7 indicates severely impaired) on the Brief Interview for Mental Status, resident required extensive assistance of 1 person for personal hygiene, was always incontinent of bowel and bladder, at risk for developing pressure ulcers, and had no pressure ulcers.

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On 7/22/15 at 12:38 p.m., CNA #8 and #3 provided incontinent care. The resident's pants were pulled down and the crotch of the pants was wet with urine. The incontinent brief was saturated with urine. CNA #3 performed incontinent care. The CNA cleansed the front perineal area with water only. The CNA wiped with the same surface of the cloth across the labia area and groin area. The CNAs turned the resident on her right side and CNA #3 continued to perform the incontinent care. The CNA wiped with the same surface of the cloth across the rectum 2 times. When CNA #3 wiped the rectum, the cloth had a darkish substance on the cloth. Wearing the same soiled gloves, CNA #3 wiped the rectal area and a darkish substance soiled the cloth. The resident was wiped 3 more times before the cloth returned free of feces. With the same soiled gloves the CNA touched the resident's clean incontinent brief and the resident's clean pants, and placed the lift pad under the resident before changing gloves.

12. Resident #4 had diagnoses of Schizophrenia and Depression. The Quarterly MDS with an ARD of 4/29/15 documented the resident scored 0 (0-7 indicates severely impaired) on the BIMS, required limited assistance of one person for bed mobility and transfers, extensive assistance of 1 person for personal hygiene, was incontinent of bladder and bowel and at risk for developing pressure ulcers.

On 7/22/15 at 1:42 p.m., the resident was sitting in the wheelchair in the hallway and CNA #8 pushed the resident down the hall to his room. At 1:45 p.m., the resident was taken to the resident's bathroom. The resident was able to stand with limited assistance. The CNA stated the bathroom

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F 441	Continued From page 121 floor was wet because the resident next door had gone to the bathroom and urinated in the floor. The Resident was in sock feet, and the CNA placed a towel under his feet. The resident's incontinent brief was removed and saturated with urine. CNA #8 provided the incontinent care with peri-wash. The CNA wiped across the top of the penis 2 times with the same surface of the cloth in a back and forth motion. With the same gloves worn for incontinent care, the CNA placed a clean brief on the resident, pulled up his pants, and did not change the resident's socks that had came in-contact with the urine.	F 441		
F 498 SS=F	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Complaint #20354 (AR00018459) substantiated (all or in part) in these findings: Based on observation, record review and interview, the facility failed to ensure Certified Nursing Assistants (CNAs) were proficient in necessary skills and techniques for providing incontinent care to promote good personal hygiene and prevent odors and turning and repositioning procedures to prevent the potential for development of pressure ulcers for 2 (Resident #2 and #4) of 6 (Resident #1, 2, #3, #4, #6 and #9) case mix residents who were	F 498		

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dependent on staff for incontinent care and 2 (Resident #1 and 9) who were at risk for developing pressure ulcers, and resided on the East Hall; isolation protocols to prevent the potential for spread of infections for 1 of 1 (Resident #1) case mix resident who was in contact isolation and universal precautions for 2 (Resident #1 and #6) of 12 (Residents #1 thru #4 and #6 thru #13) case mix residents who received ice water from thermos and the medication cart water pitcher; conducting transfers using a gait belt to prevent the potential for injuries for 1 (Resident #6) of 3 (Residents #3, #4, and #6) case mix residents who required gait belt transfer and required assistance of 2 staff persons; and utilized proper handwashing / glove changing protocols between dirty and clean tasks to prevent the spread of infection for 6 (Residents #1, #2, #4, and #6) of 12 (Residents #1 thru #4 and #6 thru #13) case mix residents who required assistance with activities of daily living.

These failed practices had the potential to affect:

19 residents who resided on the East Wings and who were incontinent according to a list provided by Licensed Practical Nurse (LPN) #10 on 7/24/15.

9 residents who resided on the East wing and were at risk for developing pressure ulcers, according to a list provided by the Assistant Director of Nursing (ADON) on 8/10/15;

1 resident in contact isolation, according to Business Office Manager on 7/24/15;

23 residents who were dependent on staff for activities of daily living and 32 residents who

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received ice and water from the pitcher on the medication cart and resided on the East Wing, according to a list provided by the ADON on 8/10/15;

7 residents on the East Wing who required the assistance of 2 persons and the use of a gait belt for transfers, as documented on a list provided on 7/24/15 by the Director of Nursing (DON).

The findings are:

1. The job description titled Certified Nursing Assistant received at 9:00 a.m. on 7/27/15 from the Business Office Manager documented, "Provide quality nursing care to residents; implement specific procedures and programs; ...report pertinent information to the immediate supervisor... Essential Job Duties and Responsibilities... 3. Attend to the individual needs of residents which may include assistance with ...incontinent care, toileting, ...transferring, ...or other needs in keeping with the individual's care requirements, and scope of practice. ...9. Provide care that maintains each resident's skin integrity to prevent pressure ulcers, ...and other damage by changing incontinent residents, turning, repositioning immobile residents and applying moisturizers to fragile skin, etc. ...13. Lift, move, and transport residents, using proper body mechanics or lifting devices for accident prevention. ...18. Perform all job responsibilities in accordance with prescribed safety and infection control procedures including thorough hand washing, use of disposable gloves where indicated, and proper disposal of soiled materials. ..."

2. Resident #1 had diagnoses of

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Methicillin-Resistant Staphylococcus Aureus (MRSA), Peripheral Vascular Disease, Stage 4 Pressure Ulcer, Gangrene, Amputation Below Knee, and Amputation Above Knee. The Admission Minimum Data Set (MDS) with an Assessment Reference Date of 7/16/15 documented the resident scored 11 (8-12 indicates moderately impaired) on the Brief Interview for Mental Status (BIMS), required extensive to total assistance of staff for activities of daily living, and had MRSA infection.

a. The Care Plan dated 7/21/15 documented, "I require isolation due to MRSA. ...Educate ...about the isolation requirements..."

b. On 7/22/15 at 8:10 a.m., Certified Nursing Assistant (CNA) #7 entered the isolation room without donning a gown or gloves, removed the meal tray out of the isolation room, and returned the tray to the metal food cart in the hallway, opening the door without washing or sanitizing her hands. At 8:19 a.m., CNA #7 entered the isolation room without donning a gown or gloves, went to the bedside table, picked up the water thermos, and went to the ice chest on a cart in the hallway. The CNA held the thermos over the opened ice chest, filled the thermos with ice, and returned it to the bedside to place the water thermos on the table. The CNA then left the bedside, came out to the hallway, and pushed the cart with the ice chest down the hall.

c. On 7/22/15 at 12:27 p.m., CNA #10 entered the resident's isolation room without donning a gown or gloves, leaned against the bedrail, placed the overbed table from the side of the bed to over the bed in front of the resident. The CNA went out to the food cart, opened the door of the

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metal cart, removed a meal tray, and returned to the isolation room. The CNA leaned against the bed with her scrubs touching the bedside, and moved the table. The CNA leaned against the overbed table, touched the plastic glass with the ungloved hand, and left the room. CNA #10 then went to the metal food cart in the hallway, pushed the cart down the hallway to outside Resident Room #5 without washing or sanitizing her hands and removed another resident's food tray from the cart at 12:30 p.m.

2. Resident #6 had diagnoses of Huntington's Chorea, Type 2 Diabetes Mellitus, Hypertension, Anemia, and Anxiety State. The Annual MDS with an ARD of 6/12/15 documented the resident scored 0 (0-7 indicates severely impaired) on the BIMS and required extensive physical assistance from staff for transfer.

On 7/22/15 at 12:30 p.m., CNA #11 left Resident #1's room, who was in isolation, without being gloved and gowned, and pushed the metal food cart down the hallway to outside Resident #6's room without having washed or sanitized her hands. The CNA removed Resident #6's food tray, entered the room, sat the tray down on a table, then went into the bathroom and washed her hands.

d. On 7/23/15 at 11:15 a.m., the resident was in a wheelchair in the hallway and had slid down to the edge of the wheelchair seat. The LPN stopped the wheelchair in the hallway and CNA #7 was on the right side of the wheelchair and CNA #8 joined her on the left side. CNA #7 lifted underneath the resident's right arm and grasped the resident's pants over the hip area. CNA #8 placed an arm underneath the resident's axilla

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and lifted upwards to pull the resident up in the wheelchair to reposition the resident upright in the wheelchair. LPN #4 pushed the wheelchair into the Business Office at 11:18 a.m.

3. Resident #2 had diagnosis of Presenile Dementia and Convulsions. The Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 7/14/15 documented the resident scored 5 (0-7 indicates severely impaired) on the Brief Interview for Mental Status, resident required extensive assistance of 1 person for personal hygiene, was always incontinent of bowel and bladder, at risk for developing pressure ulcer and had no pressure ulcers.

a. The Comprehensive Care Plan dated for 10/13/14 documented, "Problem/Need, I require extensive assistance with bed mobility, transfers, dressing, toileting, personal hygiene, bathing, and locomotion. Goal I will continue to have all my cares met by staff ongoing. Approaches, If I am incont. [incontinent] of B&B [bowel and bladder] please give me incont. care and if I wear a brief and or pull up please change... Please turn and reposition me q [every] 2 hours and PRN [as needed]..."

"Problem/need At risk for altered skin integrity r/t [related to] impaired mobility and incontinent of B&B. Goal I will not experience any skin conditions r/t incontinence. Approaches... Toilet me Q 2 H [hours] and PRN, with peri-care and barrier cream application after each toileting and PRN as needed..."

b. The Braden Risk Assessment Report dated

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F 498	Continued From page 127 7/16/15 documented a Risk Score of 15, which indicated a Risk Level of Mild. c. On 7/22/15 at 8:15 a.m., the resident was sitting up in the wheelchair in her room. d. On 7/22/15 at 8:20 a.m., 8:30 a.m., and 9:15 the resident was sitting up in the wheelchair in her room. The resident was kept in this Surveyor's line of sight. e. On 7/22/15 at 9:30 a.m., Certified Nursing Assistant (CNA) #8 entered the resident's room. The CNA washed the resident's face and changed her shirt. The CNA did not reposition or check the resident for incontinence. f. On 7/22/15 at 9:35 a.m. the resident wheeled her self down the hall and entered the dining room area for activities. g. On 7/22/15 from 9:35 a.m. until 11:03 a.m., this Surveyor observed the resident in dining room playing bingo. h. On 7/22/15 at 11:03 a.m., the resident wheeled her self down the hall and then turned around and went back to the dining room. i. On 7/22/15 from 11:17 a.m. through 12:25 p.m., the resident remained in the wheelchair in the dining room, in constant observation of this Surveyor. j. On 7/22/15 at 12:25 p.m., the resident was propelling self in the wheelchair down the hall. CNA #8 was asked how often are the residents to be checked for incontinence and repositioned. The CNA stated, "Every 2 hours." The CNA was	F 498		

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F 498	Continued From page 128 asked when was the last time you checked this resident. The CNA stated she had checked the resident before she went to lunch. The CNA was asked, "What time did you go to lunch?" The CNA stated, 10:30 a.m. The CNA asked, "You were in the resident's room at 9:30 a.m. and you washed her face and changed her shirt. Did you check her [for incontinence] at that time?" The CNA stated, "I didn't check her." The resident was sitting in the wheelchair from 8:15 until 12:25 p.m. approximately 4 hours and 15 minutes and was not checked for incontinence. k. On 7/22/15 at 12:38 p.m., CNA #8 took the resident to her room and left to get the mechanical lift. The CNA returned with the sit to stand lift and then left the 2nd time and returned with the Marisa Mechanical Lift. The resident was transferred to the bed and CNA #8 and #3 provided the incontinent care. The resident's pants were pulled down and the crouch of the pants were wet with urine. The incontinent brief was saturated with urine. CNA #3 performed incontinent care. The CNA cleansed the front perineal area with water only. The CNA wiped with the same surface of the cloth across the labia area and groin area. The CNA's turned the resident on her right side and CNA #3 continued to perform the incontinent care. The CNA wiped with the same surface of the cloth across the rectum 2 times. When CNA #3 wiped the rectum, the cloth had a darkish substance on the cloth. Wearing the same soiled gloves the CNA's applied the clean incontinent brief. The CNA's were asked if they were finished with the incontinent care and the CNA's stated, "Yes." The CNA's were asked if they could wipe the rectal area again. CNA #3 wiped the rectal area and darkish substance was on the cloth. The resident	F 498		

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was wiped 3 more times before the resident's skin was cleansed of feces. With the same soiled gloves the CNA touched the resident's clean incontinent brief, the resident's clean pants, and placed the lift pad under the resident before changing gloves.

4. Resident #4 had diagnoses of Schizophrenia and Depression. The Quarterly MDS with an ARD of 4/29/15 documented the resident scored 0 (0-7 indicates severely impaired) on the BIMS, required limited assistance of one person for bed mobility and transfers, extensive assistance of 1 person for personal hygiene, was incontinent of bladder and bowel and at risk for developing pressure ulcers.

a. The Resident's Comprehensive Care Plan dated 6/5/15 documented, "Problem need, I require limited assistance with bed mobility, transfers, locomotion, dressing, toileting, personal hygiene and bathing. Goal, I will not have further decline with my ADL [Activity Daily Living] function. Approaches, If I am incont. of B&B please give me incont. care and if I wear a brief and or pull up please change. Please assist with turning and repositioning and encourage me to assist q 2 hours and PRN." Problem Need, I am at risk for pressure ulcers r/t incontinent of B&B impaired mobility. Goal, I will not have any skin breakdown. Approaches, Reposition me Q 2 H. Provide peri-care Q 2 H and PRN."

b. On 7/22/15 at 8:18 a.m., the resident was self propelling the wheelchair down the East hall. At 8:20 a.m., CNA #8 entered the resident's room and washed the resident's face and brushed the resident's hair. The resident was not repositioned in the wheelchair. The resident wheeled himself

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out of the room.

c. On 7/22/15 at 8:38 a.m., the resident was in the wheelchair propelling himself down the hallway. The resident was observed by this Surveyor at all times.

d. On 7/22/15 at 8:40 a.m., 9:30 a.m., 9:33 a.m., the resident was sitting in the wheelchair without being repositioned or checked for incontinence.

e. On 7/22/15 at 9:33 a.m., the resident wheeled himself to the dining room for activities.

f. On 7/22/15 from 9:33 a.m. through 11:00 a.m., the resident was in the dining room at an activity of bingo.

g. On 7/22/15 from 11:00 a.m. through 12:15 a.m., the resident was in the wheelchair in the dining room without being repositioned and checked for incontinence.

h. On 7/22/15 at 12:45 p.m., the resident was self propelling himself in a wheelchair down the hall.

i. On 7/22/15 at 1:42 p.m., the resident was sitting in the wheelchair in the hallway and CNA #8 pushed the resident down the hall to his room. The CNA stated that she was waiting for the key to get clean linen to change the resident. At 1:45 p.m., the resident was taken to the resident's bathroom. The resident was in the wheelchair from 8:20 a.m. until 1:45 p.m. without being changed or repositioned, approximately 5 hours and 25 minutes. The resident was able to stand with limited assistance. The CNA stated the bathroom floor was wet the resident next door

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F 498	Continued From page 131 had gone to the bathroom and urinated in the floor. The Resident was in sock feet, the CNA placed a towel under his feet. The resident's incontinent brief was removed and saturated with urine. CNA #8 provided the incontinent care with peri-wash. The CNA wiped across the top of the penis 2 times with the same surface of the cloth in a back and forth motion. The CNA did not cleanse the resident's buttocks or inner thighs. With the same gloves worn for incontinent care, the CNA placed a clean brief on the resident and pulled up his pants, and did not change the resident's socks that had came in-contact with the urine. 5. On 7/23/15 at 2:40 p.m., CNA #8 was asked if Residents #2 and #4 were checked for incontinence and were the residents repositioned in the wheelchair the morning of 7/22/15. The CNA stated, "No." The CNA was asked how often should the resident be checked for incontinence and their position be changed while up in the wheelchair. The CNA stated, "Every 2 hours." The CNA was asked the importance of ensuring that the residents were checked for incontinence and being repositioned. The CNA stated, "Skin breakdown." The CNA was asked, "What is the problem when all skin surfaces were not cleansed of urine and/or feces?" The CNA stated, "Skin breakdown." The CNA was asked if the resident's skin should be cleansed with plain water. The CNA stated, "No." The CNA was asked, "What is the problem with cleansing with only plain water?" The CNA stated, "Not getting the skin clean and skin breakdown." 6. On 7/27/15 at 3:05 p.m., the DON was asked who does the training for the CNAs regarding incontinent care. The DON stated, "The DEQ	F 498		

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[Director of Education and Quality], that would be [LPN #10]."

7. On 7/27/15 at 5:10 p.m., LPN #10 was asked her job duties. The LPN stated, "I'm the Director of Education and Quality." The LPN was asked who does the training for incontinent care and the LPN stated, "The training is done by AIPP [Arkansas Initiative Performance Program]." The LPN was asked how often the CNAs were checked off on incontinent care. The LPN stated, "Every 3 months." The LPN was asked, when CNAs are hired, who does the training? The LPN stated, "The company has a new program, a 3-day program, that is going to be implemented. As of now, they shadow a CNA and they check the CNA off on incontinent care and 1 of the trainer CNAs - there are 2 trainer [CNA's #8] and [#9] - the trainers are trained by AIPP." The LPN was asked if, during incontinent care, all surfaces of the skin should be cleansed of urine and why. The LPN stated "Yes, to prevent skin breakdown." The LPN was asked if the incontinent care should be performed with plain water and stated, "No."

8. On 7/27/15 at 6:55 p.m., LPN #10 was asked how often CNAs were checked for proficiency of skills such as transfer, infection control, and handwashing. The LPN stated, "I'm not sure." The LPN was asked if there were annual evaluations for these skills and stated, "I'm not sure; I just recently started."