

Division of Licensing and Protection

HC 2 South, 280 State Drive

Waterbury, VT 05671-2060

<http://www.dail.vermont.gov>

Survey and Certification Voice/TTY (802) 241-0480

Survey and Certification Fax (802) 241-0343

Survey and Certification Reporting Line: (888) 700-5330

To Report Adult Abuse: (800) 564-1612

October 3, 2016

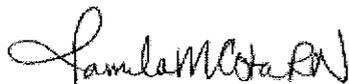
Ms. Wendy Beatty, Administrator
Crescent Manor Care Ctrs
312 Crescent Blvd
Bennington, VT 05201-0170

Dear Ms. Beatty:

Enclosed is a copy of your revised acceptable plans of correction for the survey conducted on **July 26, 2016**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,



Pamela M. Cota, RN
Licensing Chief

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

SEP 27 2016

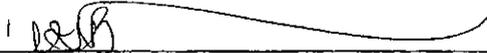
PRINTED: 09/08/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/26/2016
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NAME OF PROVIDER OR SUPPLIER CRESCENT MANOR CARE CTRS	STREET ADDRESS, CITY, STATE, ZIP CODE 312 CRESCENT BLVD BENNINGTON, VT 05201
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F 000	INITIAL COMMENTS An unannounced on-site entity reported incident and complaint investigation was conducted by the Division of Licensing and Protection on 7/25 and 7/26/16. Based on the investigation, the facility was found to have deficiencies which included findings of immediate jeopardy and substandard quality of care. At the time of exit on 7/26/16, the immediate jeopardy remained. During a subsequent visit on 8/2/16 & 8/3/16, it was determined that the immediate jeopardy was removed as of 7/29/16.	F 000		
F 222 SS=D	483.13(a) RIGHT TO BE FREE FROM CHEMICAL RESTRAINTS The resident has the right to be free from any chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to insure that 1 of 2 residents, Resident #2 was free from chemical restraints. Findings include: Resident #2 presents with diagnosis of dementia with behavioral disturbance, difficulty walking, adjustment disorder and depressed mood. Per staff interviews, the resident was often loud, verbal and demanding. His/her medication regimen included Seroquel (antipsychotic) 50 milligrams (mg) in the morning and Seroquel 75 mg at bedtime (HS), Haldol (antipsychotic) 0.5 mg daily as well as Haldol 2 mg (HS). S/he also had orders for Haldol 2 mg by mouth (po) every 3	F 222	F222 Resident #2 had no negative effects as a result of this alleged deficient practice. Resident #2 no longer resides in this facility. All residents with orders for antipsychotic IM administration without a supporting diagnosis have the potential to be effected. Staff have been educated on the proper usage of antipsychotic medications and the interventions necessary prior to usage. Chart audits will take place weekly x 4 and then monthly x4 with results reported through the QAPI process. Date of Correction: August 1, 2016. Responsible: DNS, Nurse Managers. <i>F222 POC accepted 10/31/16 pmetak</i>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE NHA	(X6) DATE 08/16/2016
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 222	Continued From page 1 (three) hours as needed (prn) and Haldol 5 mg via intramuscular (IM) injection every 3 hours prn. Per the medical record the resident received prn Haldol 2 mg po on 6 (six) separate occasions in June and 7 (seven) times in July. Medical record presents that the resident was administered Haldol 5 mg IM on the night shift 6/30/16 because of agitated behaviors and yelling out, there is no evidence that an attempt was made to administer the Haldol by mouth first. There also is no evidence at attempts of non-pharmaceutical interventions prior to administering the medication. Confirmed by the Registered Nurse Unit Manager on 7/26/16 at 10:15 AM that Resident #2 did not have a supporting diagnosis for the usage of the antipsychotics, there was no evidence that there were other interventions attempted prior to giving the Haldol 5 mg via IM injection, and there is no evidence that the resident agreed to have the injection.	F 222	F224 Resident #1 care plan was updated to reflect specific behaviors and safety checks. Resident #2 no longer resides in the facility. All residents who reside in the facility with behaviors that need interventions and implementation of safety checks have the potential to be affected. Staff have been educated on safety checks and new interventions. Safety checks are being audited daily x 4 weeks then weekly x 4 weeks. Resident #1 Care plan will be reviewed weekly and revised as needed x 4 months. Resident #1 has been referred to the monthly interdisciplinary team meeting for review. Date of Correction: July 29, 2016 Responsible: DNS, Nurse Managers.	
F 224 SS=J	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATE The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the facility failed to prevent abuse of 2 of 2 residents by failing to implement policies and procedures, to adequately develop intervention	F 224	First POC accepted 10/3/16 mncotarn	

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F 224	<p>Continued From page 2</p> <p>strategies, to monitor for changes and to reassess interventions for residents whose personal histories render them at risk for abusing other residents. (Resident #2 and #3). This deficiency is cited at the immediate jeopardy level. Findings include:</p> <p>Per record review, on 7/20/16, Resident #1 was in a verbal altercation with Resident #2 and was witnessed to chase Resident #2 (his/her roommate) out of the room. Per interview with the witness to the altercation, on 7/25/16 at 3:29 PM, the Licensed Nursing Assistant (LNA) Activity Aide intervened and redirected Resident #1 to his/her room and then retrieved Resident #2 and brought him/her back into the room. Resident #1 got off his/her bed, when the LNA and Resident #2 were a few feet into the room, and shoved Resident #2, which resulted in Resident #2 falling to the floor. The LNA stated that s/he probably shouldn't have taken Resident #2 back into the room because the two of them would fight sometimes and need to settle down. Resident #2 died after being transferred to the local hospital.</p> <p>Resident #1 was placed on 15 (fifteen) minute safety checks on 7/21/16, following the incident. Per interview with the Registered Nurse (RN) Unit Manager (UM), the facility policy is to put a resident on 15 minute checks if there is an incident or there is a behavior. Review of the safety checks for Resident #1 presents that the checks didn't start until the shift after the incident occurred and documentation is incomplete regarding the whereabouts of the resident between 4:00 and 5:45 AM on 7/21/16. There is no evidence that the checks were performed on 7/22/16, 7/23/16 or 7/24/16. The RN confirmed</p>	F 224		

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F 224	<p>Continued From page 3</p> <p>that the documentation was incomplete and missing on 7/26/16 at 2:30 PM.</p> <p>Despite knowledge of the resident to resident incident that occurred on 7/20/16, the facility failed to adequately supervise Resident #1 and on 7/25/16, Resident #1 assaulted another resident (Resident #3). Resident #1 is able to ambulate independently and was on 15 minute safety checks at the time of the second assault. There is no evidence that the facility added any new interventions after the second incident to prevent further assaults. The Registered Nurse (RN) confirmed on 7/26/16 at 2:30 PM that there were no other interventions after the second incident, other than the 15 minute safety checks.</p> <p>Per medical record review, Resident #1 was admitted to the facility from an acute care hospital in May 2016. Diagnoses include Dementia with behavioral disturbances and the hospital admission was secondary to presenting in the hospital four (4) times in two (2) months for aggressive behavior. Notes sent from the hospital presented that the resident was restless and agitated and tried to go in other resident rooms. A Physician progress note dated 7/5/16 indicated that Resident #1 was territorial of his/her room. The care plan dated 5/23/16 indicates that the resident has a potential to be physically aggressive related to dementia and his/her goals were that s/he would not harm self or others. Interventions were to intervene if became agitated, before agitation escalates and to guide away from source of distress. The Registered Nurse (RN) confirmed these findings on 7/26/16 at 2:30 PM and stated that the care plans don't reflect the specific behaviors of Resident #1.</p>	F 224		

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F 224	<p>Continued From page 4</p> <p>Per interview with the Registered Nurse (RN) at 11:40 AM on 7/25/16, Resident #2 didn't have a roommate prior to the admission of Resident #1 because s/he had problems with roommates in the past because of his/her verbal aggressive/abusive behaviors. S/he further stated that the staff would have to intervene between Resident #1 and #2 in the past and they had to be separated a "few times" after verbal altercations to keep them from "coming to blows".</p> <p>Per continuous observation on 7/26/16 from 9:45 AM to 10:30 AM, staff did not perform 15 minute safety checks on Resident #1, who was observed by the surveyor during that time to be in another resident's room. Review of the documentation presents that the 15 minute safety checks were not completed between 9:45 and 10:30 AM and the RN confirmed at 12:15 PM that there is no evidence that the checks were being done.</p> <p>F 241 SS=D 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, the facility failed to promote the dignity of 1 of 5 residents, Resident #4. Findings include: Per observation upon arrival to the facility on</p>	F 224	<p>F241</p> <p>Resident #4 has been provided a cover for his urinary drainage bag.</p> <p>All residents who reside in the facility and have urinary drainage bags have the potential to be affected.</p> <p>Education has been provided to resident #4 and staff regarding covering of urinary drainage bags.</p> <p>Audits will take place weekly x4 and reported to QAPI.</p> <p>Date of Compliance July 29, 2016.</p> <p><i>F241 POC accepted 10/31/16 pincotapn</i></p>

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F 241	Continued From page 5 7/25/16 at 10:15 AM, Resident #4 was seated in a wheelchair outside the front entrance. It was immediately obvious that s/he had a urinary drainage bag on the outside of his/her clothing. The administrator accompanied this surveyor at 10:20 AM to the resident, still seated outside, and confirmed that there was no urinary drainage bag cover and s/he asked the resident where the bag cover was and Resident #4 stated that s/he didn't know where it was and that s/he hasn't had it for a couple of days. The administrator stated that the resident knows better about keeping the bag covered. The Licensed Practical Nurse (LPN) on the unit where Resident #4 resides, told the administrator at 10:25 AM that the resident has had the cover for a couple of weeks. At 10:40 AM, the LPN stated that it is the responsibility of the staff to insure that the resident's bag is covered.	F 241			
F 250 SS=E	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide medically-related social services to maintain the highest practicable psychosocial well-being for 1 of 2 residents, Resident #1. Findings include: Per record review for Resident #1, a progress	F 250	F250 Resident #1 had no negative effects as a result of this alleged deficient practice. Resident #2 no longer resides in this facility. All residents who have aggressive behaviors and/or are the victim of physical aggression by another resident are identified as having the potential to be affected. Social Services will document follow-up provided for residents who have aggressive behaviors and/or are the victim of physical aggression by another resident. Audits of Social services follow-up documentation will take place weekly x 4 then monthly x4. Corrective action completed July 29, 2016. Responsible: Social Services <i>FASD POC accepted 10/3/16 Pmeotarn</i>		

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F 250	Continued From page 6 note dated 6/21/16 states that Resident #1 was standing next to his bed with a frightened look on his face and his/her roommate, Resident #2, was yelling that s/he was hit in the face by Resident #1. An additional 6/29/16 note presented that Resident #1 was alleging that s/he had been hit by another resident. There is no evidence to support that social services followed up with the resident following both instances. Per interview with social services on 7/26/16 at 9:45 AM, s/he stated that s/he would visit daily, but did not document the visits. S/he confirmed that there is no follow up documented for the 6/21 or 6/29/16 allegations.	F 250	F280 Resident #1 care plan was updated to reflect specific behaviors and safety checks. Resident #2 no longer resides in the facility. All residents who reside in the facility with behaviors that need interventions and implementation of safety checks have the potential to be affected.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	Staff have been educated on safety checks, new interventions and revision of care plans. Safety checks are being audited daily x 4 weeks then weekly x 4 weeks. Resident #1 Care plan will be reviewed weekly and revised as needed x 4 months. Resident #1 has been referred to the monthly interdisciplinary team meeting for review. Date of Correction: July 29, 2016 Responsible: DNS, Nurse Managers. <i>F280 POC accepted 10/21/16 pmeotaznd</i>	

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F 280	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to review and revise the comprehensive plan of care for 1 of 2 residents reviewed (Resident #1) to include parameters and objectives regarding aggressive behaviors. Findings include: Record review for Resident #1 presented that the resident was in an altercation with his/her roommate on 7/20/16. Resident #1 has a care plan that includes that the resident is/has potential to be physically aggressive related to dementia. The resident was involved in a verbal and physical altercation with his/her roommate on 7/20/16 in which the roommate was pushed and was transferred to the hospital, where s/he expired. The review of the care plan does not indicate that the care plan was reviewed or revised to include interventions to address the behaviors that were exhibited by Resident #1. On 7/25/16, there was another altercation involving Resident #1 and Resident #3, which was unprovoked, in which Resident #1 hit Resident #3 with a closed hand. Per interview on 7/26/16, at 2:30 PM, the Registered Nurse Unit Manager was unable to provide evidence that the care plan had been revised. S/he further stated that 15 (fifteen) minute safety checks were initiated for Resident #1 after the incident on 7/20/16, but the care plan was not revised until 7/26/16 at which time s/he added it to the care plan.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility	F 281		

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F 281	<p>Continued From page 8 must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to provide services that meet professional standards of quality, surrounding documentation process for 1 of 2 residents, Resident #1. Findings include:</p> <p>Resident #1 was placed on 15 (fifteen) minute safety checks on 7/21/16, following an incident in which s/he pushed another resident that entered the room they shared on 7/20/16. Per interview with the Registered Nurse (RN) Unit Manager (UM), the facility policy is to put a resident on 15 minute checks if there is an incident or there is a behavior. Per interviews with the RN and the Licensed Nursing Assistant(s) (LNA), on 7/26/16, there is no one person assigned to do the safety checks and it is the responsibility of all staff to do them. Per review of the Safety Checks policy of the facility, it states (under III. Procedure, letter D) 'the staff member should: 1. Identify the location of the resident/patient at the appropriate time intervals for each safety check'. It continues with number 2. ' Document the location on the form and initial after completing the check.' Review of the safety checks for Resident #1 presents that the checks didn't start until the shift after the incident occurred and documentation is incomplete regarding the whereabouts of the resident between 4:00 and 5:45 AM on 7/21/16. There is no evidence that the checks were performed on 7/22/16, 7/23/16 or 7/24/16. The RN confirmed that the documentation was incomplete and missing on 7/26/16 at 2:30 PM.</p>	F 281	<p>F281</p> <p>Resident #1 care plan was updated to reflect specific behaviors and safety checks. Resident #2 no longer resides in the facility.</p> <p>All residents who reside in the facility with behaviors that need interventions and implementation of safety checks have the potential to be affected.</p> <p>Staff have been educated on safety checks, new interventions and revision of care plans.</p> <p>Safety checks are being audited daily x 4 weeks then weekly x 4 weeks. Resident #1 Care plan will be reviewed weekly and revised as needed x 4 months. Resident #1 has been referred to the monthly interdisciplinary team meeting for review.</p> <p>Date of Correction: July 29, 2016</p> <p>Responsible: DNS, Nurse Managers.</p> <p><i>F281 POC accepted 10/3/16 mcastan</i></p>	

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F 281	Continued From page 9 Reference: Lippincott Manual of Nursing Practice Seventh Edition, 2001, Page 19.1. 'Failure to make prompt and accurate entries in a patient's medical record.'	F 281	F319		
F 319 SS=E	483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide the appropriate treatment and services to 2 of 2 residents in the sample, Resident #1 and #2. Findings include: Per record review, Resident #1 and #2 have documentation indicating that they have needs surrounding aggressive behaviors and both residents were receiving Seroquel (an antipsychotic) which has indicated use for psychosis and schizophrenia behaviors. Per review of Resident #1, the acute care hospital that s/he was admitted from had evaluated him/her and found them to be without psychoses, but does have dementia with behavioral disturbances. Resident #2 had a diagnosis of dementia with behavioral disturbances and adjustment disorder, but no indications of a diagnosis of psychosis or schizophrenia. Per interview with the Primary Care Physician (PCP) for both residents on 7/26/16 at 11:10 AM, s/he stated that Resident #1 was admitted on Seroquel and Resident #2 was someone that	F 319	Resident #1 guardian has granted permission for Deer Oaks services. Resident #2 no longer resides in the facility. All residents who are receiving Seroquel without a diagnosis of psychosis or schizophrenia have a potential to be affected. A request will be made for residents who receive Seroquel without a diagnosis of psychosis or schizophrenia to receive psychological services. Audits are ongoing to assure compliance. Results will be reported to the QAPI committee by social services for 3 months. Compliance Date: August 1, 2016. Responsible: Social Services, Nurse Managers.		

F319 POC accepted 10/3/16 Pincot RN

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NAME OF PROVIDER OR SUPPLIER CRESCENT MANOR CARE CTRS			STREET ADDRESS, CITY, STATE, ZIP CODE 312 CRESCENT BLVD BENNINGTON, VT 05201		
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F 319	Continued From page 10 s/he "inherited" from the former medical director of the facility. S/he stated that the medication was just continued and psychological services were not sought, stating that there is no psychiatrist in the area. Per the Licensed Practical Nurse (LPN) staff educator at 12:45 PM, on 7/26/16, Deer Oaks Psychology services are used by the facility and per the psychologist in house on 7/26/16, s/he said that visits with residents of the facility result in medication consult suggestions, but the changes are made through the PCP and there is no psychiatrist available. Per the LPN a consult has to be made by the PCP to request services and confirmed that no requests had been mad for either resident to receive psychological services. See also F329.	F 319	F323 Resident #3 had no negative effects as a result of this alleged deficient practice. Resident #1 care plan was updated to reflect specific behaviors and safety checks. Resident #2 no longer resides in the facility. All residents who reside in the facility with behaviors that need interventions and implementation of safety checks have the potential to be affected. Staff have been educated on safety checks and new interventions.		
F 323 SS=J	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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that 1 resident, Resident #1, receives adequate supervision to prevent/avoid accidents. This deficiency is cited at the immediate jeopardy level. Findings include:	F 323	Safety checks are being audited daily x 4 weeks then weekly x 4 weeks. Resident #1 Care plan will be reviewed weekly and revised as needed x 4 months. Resident #1 has been referred to the monthly interdisciplinary team meeting for review. Date of Correction: July 29, 2016 Responsible: DNS, Nurse Managers. <i>F323 POC accepted 10/3/16 [signature]</i>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	<p>Continued From page 11</p> <p>Per record review, on 7/20/16, Resident #1 was in a verbal altercation with Resident #2 and was witnessed to chase Resident #2 (his/her roommate) out of the room. Per interview with the witness to the altercation, on 7/25/16 at 3:29 PM, the Licensed Nursing Assistant (LNA) Activity Aide intervened and redirected Resident #1 to his/her room and then retrieved Resident #2 and brought him/her back into the room. Resident #1 got off his/her bed, when the LNA and Resident #2 were a few feet into the room, and shoved Resident #2, which resulted in Resident #2 falling to the floor. The LNA stated that s/he probably shouldn't have taken Resident #2 back into the room because the two of them would fight sometimes and need to settle down. Resident #2 died after being transferred to the local hospital.</p> <p>Resident #1 was placed on 15 (fifteen) minute safety checks on 7/21/16, following the incident. Per interview with the Registered Nurse (RN) Unit Manager (UM), the facility policy is to put a resident on 15 minute checks if there is an incident or there is a behavior. Review of the safety checks for Resident #1 presents that the checks didn't start until the shift after the incident occurred and documentation is incomplete regarding the whereabouts of the resident between 4:00 and 5:45 AM on 7/21/16. There is no evidence that the checks were performed on 7/22/16, 7/23/16 or 7/24/16. The RN confirmed that the documentation was incomplete and missing on 7/26/16 at 2:30 PM.</p> <p>Despite knowledge of the resident to resident incident that occurred on 7/20/16, the facility failed to adequately supervise Resident #1 and on 7/25/16, Resident #1 assaulted another</p>	F 323		

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F 323	<p>Continued From page 12</p> <p>resident (Resident #3). Resident #1 is able to ambulate independently and was on 15 minute safety checks at the time of the second assault. There is no evidence that the facility added any new interventions after the second incident to prevent further assaults. The Registered Nurse (RN) confirmed on 7/26/16 at 2:30 PM that there were no other interventions after the second incident, other than the 15 minute safety checks.</p> <p>Per medical record review, Resident #1 was admitted to the facility from an acute care hospital in May 2016. Diagnoses include Dementia with behavioral disturbances and the hospital admission was secondary to presenting in the hospital four (4) times in two (2) months for aggressive behavior. Notes sent from the hospital presented that the resident was restless and agitated and tried to go in other resident rooms. A Physician progress note dated 7/5/16 indicated that Resident #1 was territorial of his/her room. The care plan dated 5/23/16 indicates that the resident has a potential to be physically aggressive related to dementia and his/her goals were that s/he would not harm self or others. Interventions were to intervene if became agitated, before agitation escalates and to guide away from source of distress. The Registered Nurse (RN) confirmed these findings on 7/26/16 at 2:30 PM and stated that the care plans don't reflect the specific behaviors of Resident #1.</p> <p>Per interview with the Registered Nurse (RN) at 11:40 AM on 7/25/16, Resident #2 didn't have a roommate prior to the admission of Resident #1 because s/he had problems with roommates in the past because of his/her verbal aggressive/abusive behaviors. S/he further</p>	F 323		

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F 323	Continued From page 13 stated that the staff would have to intervene between Resident #1 and #2 in the past and they had to be separated a "few times" after verbal altercations to keep them from "coming to blows". Per continuous observation on 7/26/16 from 9:45 AM to 10:30 AM, staff did not perform 15 minute safety checks on Resident #1, who was observed by the surveyor during that time to be in another resident's room. Review of the documentation presents that the 15 minute safety checks were not completed between 9:45 and 10:30 AM and the RN confirmed at 12:15 PM that there is no evidence that the checks were being done.	F 323	F329 Resident #1 had no negative effects as a result of this alleged deficient practice. Resident #2 no longer resides in this facility. All residents with orders for antipsychotic IM or Seroquel administration without a supporting diagnosis have the potential to be effected. Staff have been educated on the proper usage of antipsychotic medications and the interventions necessary prior to usage. PCP ordered psychological consult for Resident #1 by both Deer Oaks and UCS to address further intervention. Chart audits will take place weekly x 4 and then monthly x4 with results reported through the QAPI process. Date of Correction: August 1, 2016. Responsible: DNS, Nurse Managers.	
F 329 SS=E	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	F329 POC accepted 10/3/16 pmcotARN	

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F 329	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to insure that 2 of 2 residents, Resident #1 and 2 had a drug regimen that was free from unnecessary drugs. Findings include: 1. Per record review, Resident #2 has diagnoses of dementia with behavioral disturbance, difficulty walking, adjustment disorder and depressed mood. His/her medication regimen included Seroquel (antipsychotic) 50 milligrams (mg) in the morning and Seroquel 75 mg at bedtime (HS), Haldol (antipsychotic) 0.5 mg daily as well as Haldol 2 mg (HS) and Zoloft (antidepressant) 100 mg daily as well as Zoloft 50 mg in the evening. S/he also had orders for Haldol 2 mg by mouth (po) every 3 (three) hours as needed (prn) and Haldol 5 mg intramuscularly (IM) every 3 hours prn. Per the medical record the resident received prn Haldol 2 mg po on 6 (six) separate occasions in June and 7 (seven) times in July. There is no supporting diagnosis for the usage of Haldol nor for Seroquel. Both medications are classified as antipsychotics used for psychosis or schizophrenia. Medical record presents that the resident was administered Haldol 5 mg IM on the night shift 6/30/16 and there is no evidence that an attempt was made to administer the Haldol po first. There also is no evidence at attempts of non-pharmaceutical interventions attempted prior to administering the medication. Confirmed by the Registered Nurse, Unit Manager on 7/26/16 at 10:15 AM that Resident #2 did not have a	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIDN	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/26/2016
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F 329	Continued From page 15 supporting diagnosis for the usage of the antipsychotics and that there was no evidence that there were other interventions prior to giving the Haldol 5 mg IM. See also F221. 2. Per record review, Resident #1 has diagnoses that include dementia with behavioral disturbances. S/he was admitted to the facility 5/3/16 from an acute care hospital, where he had been hospitalized secondary to abusive, physically aggressive behaviors. S/he was examined and evaluated prior to admission and was found to have no psychosis, but was on Seroquel (an antipsychotic that is used for schizophrenia and psychosis) without a supporting diagnosis. Interview with the Primary Care Physician (PCP) on 7/26/16 at 11:00 AM, s/he stated that the resident came to the facility on Seroquel and s/he just continued them and did not evaluate why it was used other than for behaviors.	F 329	F441 Residents #4, 5 and 6 had no negative effects from this alleged deficient practice. Masks were washed and placed in plastic bags. All residents who reside in the facility and receive nebulizer treatments have the potential to be affected by this alleged deficient practice. Staff have been educated on the policy and procedure for nebulizer treatments and maintenance. Audits of nebulizer treatments will take place weekly x 4 to assure compliance. Results will be reported to the QAPI committee by the Nurse manager for 3 months. Date of Correction: August 1, 2016. Responsible: DNS, Nurse Managers	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441	F441 POC accepted 10/3/16 Pmcoturn	

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F 441	<p>Continued From page 16</p> <p>should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and staff interview, the facility failed to provide a sanitary environment for 3 of 5 residents, Resident #4, 5 and 6, regarding nebulizer treatment equipment. Findings include:</p> <p>Upon arrival to the South Unit on 7/25/16 at 10:25 AM, to investigate a separate issue, it was observed that a nebulizer set up for Resident #4 was sitting on the night stand and the nebulizer mask was sitting on a pile of papers. The nebulizer mask cup that contains the medication still had particles or liquid in the container. Per</p>	F 441		

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F 441	Continued From page 17 review with the Licensed Practical Nurse at 10:30 AM, the resident has nebulizer treatments on a routine basis and when asked what the protocol for the nebulizer masks was, s/he stated that the oxygen tubing and nebulizer masks and tubing are changed weekly. S/he further stated that after a nebulizer treatment is completed, the mask is to be washed out and put in a plastic bag for protection against the spread of infection. The LPN told me of 2 other residents that have nebulizer treatments, Resident #5 and 6. Per observation, both resident #5 and 6 had nebulizer masks sitting on their night stands, neither were in a plastic bag and Resident #6's container had liquid particles in the cup of the nebulizer mask and Resident #5's was dry. Review of the medical records presented that Resident #4 and 6 had received treatments at 7:00 AM on 7/25/16 and the last documented treatment (it is as needed) for Resident # 5 was on 7/15/16 at 9:45 PM. The LPN confirmed at 10:35 AM that the nebulizer had not been properly maintained and the masks had not been placed in the protective bags.	F 441			

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 475033	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 7/26/2016
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 247	<p>483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE</p> <p>A resident has the right to receive notice before the resident's room or roommate in the facility is changed.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to provide notice to 1 of 1 resident, Resident #2, regarding a change in roommate status. Findings include:</p> <p>Per record review, there was no evidence that Resident #2 received notification that a s/he would be getting a roommate (Resident #1). Per interview with social services on 7/26/16 at 9:45 AM, s/he confirmed that there was no evidence of a written notice being given and no documentation that s/he had notified the resident or the resident's family.</p> <div style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <p style="text-align: center;">F247</p> <p>Resident #1 had no negative effects as a result of this alleged deficient practice. Resident #2 no longer resides in this facility.</p> <p>All residents with room changes and new roommates have the potential to be affected.</p> <p>Form has been revised and implemented to document roommates and room changes.</p> <p>Audits of notification will take place monthly x 4. Results will be reported to QAPI.</p> <p>Corrective action completed July 29, 2016.</p> <p>Responsible: Social Services</p> </div>

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

The above isolated deficiencies pose no actual harm to the residents