STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185268	A. BUILDING _____ B. WING _____	C 04/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN	3500 GOOD SAMARITAN WAY LOUISVILLE, KY 40229

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F 000	INITIAL COMMENTS An abbreviated survey was initiated on 04/06/2011 and concluded on 04/08/2011 investigating KY #16159. The Division of Health Care substantiated the allegation as verified by evidence. Federal deficiencies were cited. An abbreviated survey was initiated on 04/25/11 and concluded on 04/26/11 investigating KY00016305. KY00016305 was unsubstantiated with no deficiencies cited.	F 000		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 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 interview, review of the record and the Abuse and Neglect policy, it was determined the facility failed to implement written policies and procedures that related to the completion of incident reports and investigations for two (2) of the sixteen (16) sampled residents. Resident #8 had agressive behaviors toward Residents #3 and 4 that caused a skin tear and bruising. The findings include: Review of the facility's Abuse and Neglect Policy, dated November 1999 and revised October 2009, revealed the purpose was to ensure the center has in place an effective system that prevents	F 226	**Plan of Correction** Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual.	

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

X Beverly Miller Edwards — X Administrator — X 5/19/11

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

PRINTED: 05/11/2011
FORM APPROVED
OMB NO. 0938-0391

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F 226	Continued From page 1 mistreatment and abuse of residents; to ensure that residents are not subjected to abuse by anyone; to ensure that all identified incidents of alleged or suspected abuse/neglect are promptly investigated and reported; to identify and remedy any abusive situations; to prevent future injuries; to ensure that a complete review of existing incidents are documented. The Abuse and Neglect Policy stated if a staff member received an allegation of abuse, the staff member would immediately report this to a supervisor and complete sections A through D on the Incident Report. Review of the facility's Incident Report Procedure policy, dated February 1998 and revised January 2009, revealed the stated purpose was to document resident and visitor incidents, to conduct an investigation of each incident and to gather objective information and identify root causes to prevent similar occurrences from happening in the future. The Incident Report Procedure lists the following steps: 1. The Incident report is completed for each resident and/or visitor incident that occurs. 2. If the incident is a resident-to-resident incident, an incident report needs to be completed if any type of abuse occurred. 3. When an incident occurs, if a new intervention is put in place, ensure that it is placed on the care plan and resident care records, if applicable. 1. Review of the clinical record for Resident #8 revealed an admission date of 09/22/06 with diagnoses of Seizure Disorder, Muscle Weakness, Insulin Dependent Diabetes, Difficulty Walking and Dementia with Psychosis. Resident #8's Significant Change Minimum Data Set	F 226	F 226 1. Resident #8 was discharged from the facility on 4/30/11. 2. All resident concerns will be reviewed by the interdisciplinary Incident Report Committee to ensure that all residents involved in incidents have completed incident reports. Incidents involving staff members will also have completed employee incident reports. 3. All staff will be in-serviced on how and when to accurately complete incident reports. They will also be in-serviced on Behavioral Management Techniques and Abuse and Neglect. Training regarding the completion of Behavioral Management Techniques and incident reports began on 4/26/11 and 5/9/11 respectively. They were completed by our Staff Development Coordinator and Social Services Director and/or designee. Training regarding Abuse and Neglect will begin on 5/19/11 and will be completed by our Rehabilitation\Skilled Care Consultant, DNS and/or designee. All training will be completed by ~~6/10/11.~~ 5-27-11 Verification = Bev. Edwards DB	

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F 226	Continued From page 2 (MDS) assessment dated 06/08/10 revealed the facility assessed the resident as being moderately impaired related to cognition. The resident's behavior was assessed to include resisting care. The quarterly MDS dated 02/11/11 revealed the resident was assessed as moderately impaired in cognitive function. The resident's behavior included physical and verbal behavioral symptoms directed toward others. The resident was assessed as refusing care and wandering behavior. Record review for Resident #8 revealed a nurse's note dated 01/11/11 which indicated Resident #8 was noted to be exhibiting increased aggressive behaviors and pulled off another resident's glasses while the resident was seated in front of the nurse's station. The facility was unable to produce an incident report for this unusual occurrence as required by their policy. The nurse's note dated 02/05/11 revealed Resident #8 was frequently found in other resident's rooms. He/she often removed items such as glasses, or things the other residents may be holding. The Social Services note on 02/10/11 revealed Resident #8 had been hitting out and verbally abusing staff when they attempted daily care. He/She wandered in and out of residents rooms taking items. The nurse's note on 02/21/11 revealed the Director of Nursing (DON) reported Resident #8 went into another resident's room and hit a resident, there was no evidence the facility implemented their policy on reporting and investigating abuse. The record indicated Resident #8 was out of the building for an inpatient stay at a geriatric center for behavioral disorders from 02/22-02/28/11. No changes were implemented to the Behavior care plan dated	F 226	4. All incident reports will be reviewed daily, Monday through Friday by our interdisciplinary Incident Report Committee. The Nursing Weekend Supervisor or designee will review incident reports over the weekend and the Incident Report Committee will follow up on the incident during business hours the following week. The incident reports will be audited weekly x 12 weeks by the QA Coordinator or designee to ensure that all incident reports are complete and accurate. Findings will be reported to the QA Committee monthly for further recommendations.	6/10/11

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F 226	Continued From page 3 02/16/11, upon re-admission to the facility to reflect the increased need for staff supervision. The nurse's note dated 03/01/2011 revealed Resident #8 swung an arm at a CNA in the dining room. An Incident Report dated 03/05/11 indicated at 9:10am Resident #8 wandered into Resident #4's room and pinched Resident #4's arm. The pinch resulted in a bleeding skin tear measuring 0.5cm x 0.3cm which required a dressing. The incident report section titled Contributing Factors was blank. In addition, a second incident report dated 03/05/11 indicated Resident #8 pinched CNA #1 on the arm which resulted in a bleeding skin tear. The contributing factor marked was the Resident's behavior. The nurse's note dated 03/10/11 revealed Resident #8 became combative during medication pass. Resident #8 pinched the unit supervisor's left forearm leaving a whelp and redness. Observations of Resident #8 on 04/06/11 at 2:00pm and 2:40pm revealed the resident was in bed, wearing glasses, television was on and call light was in reach. On 04/07/11 Resident #8 was observed at 9:45am lying in bed, eyes were open and television was on. At 12:55pm Resident #8 was in a wheelchair, a CNA was taking resident to dining room for lunch. At 1:30pm a CNA was sitting next to Resident #8 in the dining room. At 2:30 and 2:55pm Resident #8 was observed in the activity area with a CNA sitting in chair next to the resident. On 04/08/11 at 10:40am and 11:55am Resident #8 was observed in bed with the television on. At 12:50pm Resident #8 was in dining room for lunch, CNA was in chair next to resident. No behaviors were observed for Resident #8.	F 226		

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F 226	Continued From page 4 2. Clinical record review on Resident #3 revealed the facility admitted the resident on 03/13/09 with the diagnoses of Acute Hypoxic Respiratory Failure and Chronic Obstructive Pulmonary Disease. The facility assessed Resident #3 as interviewable on 04/06/11. An Incident Report dated 02/19/11 stated Resident #3's family member had reported to the facility that Resident #8 hit Resident #3 twice, resulting in a bruise on Resident #3's right hand. The facility's incident report validated the presence of bruising The nurse's note dated 03/20/11 revealed Resident #3 reported to the nurse Resident #8 was in his/her room and he/she tried to get Resident #8 to leave. Resident #8 pulled at Resident #3's oxygen tubing and scratched him/her on the chin. There was no evidence the facility implemented their policy on reporting and preventing abuse. Interview with Resident #3 on 04/07/11 at 10:56am revealed Resident #8 had kicked him/her and hit his/her arm. He/She stated even when the door was closed Resident #8 would open the door and come into his/her room. Resident #3 reported Resident #8 had even eaten food off of his/her meal tray. Interview with Resident #3 on 04/08/11 at 11:00am revealed when he/she had reported Resident #8 for coming in to his/her room, he/she was told there was nothing the staff could do about it. Resident #3 stated one CNA told him/her when Resident #8 hit him/her, he/she should hit Resident #8 back. Interview with Resident #3's family member on 04/08/11 at 11:20am revealed Resident #8 had come into the room and eaten food off Resident #3's tray and pulled his/her oxygen tubing off.	F 226		

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F 226	Continued From page 5 Interview with CNA #3 on 04/08/11 at 12:55pm revealed Resident #8 did go in and out of other resident's rooms and picked up items from those rooms. She stated staff had told Resident #3 to put on the call light so staff could remove the resident from the room. CNA #3 reported she did tell Resident #3 to hit Resident #8 in retaliation. CNA #3 reported she was just kidding, but thought it might keep Resident #8 from entering Resident #3's room again. CNA #3 admitted there could be a potential problem it any resident took that advice seriously. 3. Record review for Resident #4 revealed the facility admitted the resident on 03/27/06 with the diagnoses of Myasthenia Gravis. The most recent quarterly Minimum Data Set (MDS) assessed cognition to be a 14, which indicates resident is cognitively intact. The facility assessed Resident #4 as interviewable on 04/06/11. Interview with Resident #4 on 04/06/11 at 1:50pm revealed Resident #8 came in his/her room about a month ago and pinched him/her so hard on his/her left arm that it drew blood. He/She stated Resident #8 had pinched him/her before but had never drawn blood. Resident #4 stated Resident #8 would come into his/her room and try to take his/her things and if he/she tried to stop Resident #8, the resident would try to pinch him/her. He/She stated Resident #8 had pinched several other residents and Resident #4 stated he/she felt pinching was abuse. Interview with the Charge Nurse (CN) on 04/07/11 at 11:46am revealed an incident report should be written any time there is a physical altercation. She stated once completed, the	F 226		

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F 226	Continued From page 6 incident reports are forwarded to the falls committee to decide if further action may be indicated. Any new interventions are then listed on the Care Plan and the CNA care plan if applicable. Interview with the DON on 04/08/11 at 2:40pm revealed Resident #8's behaviors had escalated in the last two to three months. She stated Resident #8's behavior is sporadic. The DON stated the house supervisor instructed staff to complete an incident report only if the incident was witnessed. Otherwise, chart the incident in the nursing notes. The DON stated the incident which caused the facility to issue a Notification of Transfer/Discharge should have had an incident report completed. The DON stated if staff wrote an incident report on everything that happened it would take up all the nurse's time. The DON asked where one draws the line on when to write an incident report and when not to. However, the DON could not verbalize if not completing incident reports was following the policy on Abuse investigations. Interview with the Administrator on 04/25/11 at 3:40pm revealed the Incident Report is a four page form. The original copy of the first two pages is placed in the resident's chart and the carbon of the first two pages and the original of the last two pages are kept in a file when the investigation is complete. Copies of the full report were requested for all incident reports related to Resident #8. The facility did not supply the full four page report on the identified incident reports. Interview with the Administrator on 4/26/11 at 10:55am revealed the incident report process	F 226		

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F 226	Continued From page 7 worked well for falls, but the system was not working for incidents related to behaviors. The Administrator stated if the Incident Report was not completely filled out, there was more work to be done.	F 226	F280	
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. This REQUIREMENT is not met as evidenced by: Based on interview, record review and policy review, it was determined the facility failed to update the Care Plan for one (1) of sixteen (16) sampled residents. Resident #8's Care Plan for altered mood and behavior was not revised to reflect changes in interventions which resulted in	F 280	1. Resident #8 was discharged from the facility on 4/30/11. 2. The care plans of all residents exhibiting behavioral concerns were reviewed and updated for accuracy, completion, and to ensure that all current interventions are effective 4/26/11. 3. All Staff were in-serviced on Behavioral Management Techniques by the Staff Development Coordinator, Social Services Director and designee beginning 4/ 26/11. All staff will be in-serviced on when and how to update the care plan when interventions are implemented to address behavioral concerns and other issues regarding the safety of all residents. The Rehabilitation\Skilled Care Consultant, DNS and/or designee will begin this training as well as training regarding Abuse and Neglect on 5/19/11. All resident care plans will be reviewed by the interdisciplinary team to ensure that they are accurate and current interventions are effective. All training will be completed by ~~6/10/11.~~ 5-27-11 Via phone c Bev. Edwards PB	

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F 280	Continued From page 8 continued behaviors by Resident #8. Resident #8 had documented incidents of aggressive behaviors toward Resident #3 and 4 and the facility failed to revise the care plan to reflect and prevent inappropriate behavior. The findings include: Review of facility Care Plan Policy revealed a qualified team of persons will review care plans at least quarterly. Care plans will also be reviewed, evaluated and updated when there is a significant change in the resident's condition and/or in accordance with stated guidelines. This plan of care will be modified to reflect the care currently required/provided for the resident. Review of the clinical record for Resident #8 revealed an admission date of 09/22/06 with diagnosis of Dementia with Psychosis. Resident #8's Minimum Data Set (MDS) assessment dated 06/08/10 revealed the facility assessed the resident as moderately impaired in cognitive abilities. The resident's behavior included resisting care, physical and verbal behavioral symptoms directed toward others, rejection of care and wandering. The mood/behavior care plan dated 11/24/10 had only been updated once, on 01/25/11, when Ativan 0.5mg had been prescribed for increased agitation. The entire Care Plan was updated 02/16/11, with no new interventions listed to address behaviors. All problems, goals and interventions on the Care Plan addressing behaviors were related to staff. There were no problems, goals or interventions on the Care Plan related to behavioral problems or aggression toward other residents.	F 280	4. Behavioral Management Committee will meet monthly and on an as needed basis to review residents exhibiting behaviors and to review and update their care plans as indicated. Care plans of residents exhibiting behaviors will be audited weekly x 4 weeks and monthly x 3 months by the Social Services Director or designee. When applicable, incident reports will be reviewed daily for residents exhibiting behavioral concerns and their care plans will be updated when necessary to determine if the current interventions are effective and if new interventions are needed. All audit findings will be reported to the QA Committee by the QA Coordinator or designee for further feedback and recommendations.	5-10-11 5-27-11

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F 280	Continued From page 9 Review of Resident #8's record revealed the resident was transferred to a local geriatric psychiatric center from 02/22/11 to 02/28/11 for increased behaviors. There was no evidence the facility revised the resident's care plan upon re-entry to the facility to address the increased agitation, altercations with other residents or wandering. A nurses note indicated on 03/01/11 Resident #8 swung an arm at a CNA in the dining room. In addition, an incident report dated 03/05/11 revealed at 9:10am Resident #8 wandered into Resident #4's room and pinched Resident #4's arm. The pinch resulted in a bleeding skin tear measuring 0.5cm x 0.3cm to which a dressing was applied. The nurse's note dated 03/05/11 revealed Resident #8 pinched CNA #1 on the arm which resulted in a bleeding skin tear. The nurse's note dated 03/10/11 revealed Resident #8 became combative during medication pass. Resident #8 pinched the unit supervisor's left forearm leaving a whelp and redness. Review of the care plan for Resident #8 revealed it was not revised, and no new interventions were put into place to address the behaviors, monitor or give direction to staff on how to manage the inappropriate behavior. Record review for Resident #3 revealed an Incident Report on 02/19/11 which stated Resident #3's family member had called and reported to the facility, Resident #8 hit Resident #3 twice, resulting in a bruise on Resident #3's right hand. The incident report indicated the bruise was confirmed during assessment by the nurse. There was no documented evidence the facility revised the plan of care to address this	F 280		

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F 280	Continued From page 10 behavior. Record review for Resident #4 revealed the facility admitted the resident on 03/27/06 with the diagnoses of Myasthenia Gravis. The most recent quarterly Minimum Data Set (MDS) assessed the resident as cognitively intact. Interview with Resident #4, on 04/06/11 at 1:50pm, revealed Resident #8 came in his/her room about a month ago and pinched him/her so hard on his/her left arm that it drew blood. He/She stated Resident #8 had pinched him/her before but had never drawn blood. Resident #4 stated Resident #8 would come into his/her room and try to take his/her things and if he/she tried to stop the resident, he/she would try to pinch him/her. He/She stated Resident #8 had pinched several other residents and Resident #4 stated he/she felt pinching was abuse. The resident made the facility aware however, the facility could not produce evidence Resident #8's plan of care was revised to address this behavior. An interview with the Director of Nursing (DON) on 04/07/11 at 4:15pm revealed the incident reports are reviewed every morning from the previous day. The interdisciplinary team reviews and discusses interventions and those interventions should be documented on the care plan. The DON could not provide evidence this residents behaviors were discussed in the morning meetings or any revisions to the mood and behavior care plan had been made by the facility. Continued interview with the DON on 04/26/11 at 10:15am revealed it is important to keep Care Plans up to date related to any changes in care, including behaviors. The DON stated it was especially important for new nurses	F 280		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN	3500 GOOD SAMARITAN WAY LOUISVILLE, KY 40229

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F 280	Continued From page 11 and PRN (as needed) nurses so they would know how to care for the residents. She reported CNA Care Plans are currently not being updated, due to problems with "Hand Helds", they had to go back to paper care plans and the updates to the CNA Care Plans were not current. An interview with the Charge Nurse (CN), on 04/08/11 at 2:14pm, revealed it is the responsibility of any nurse, charge nurse, MDS Coordinator or Social Service to update a resident's care plan. The CN stated other interventions had been put into place but were not documented on the Care Plan. The facility could not provide any evidence these interventions were monitored and evaluated to determine if changes were needed to the care plan. An interview with the Social Worker #2 (SW #2) on 04/25/11 at 2:55pm revealed in the morning meetings incident reports from the previous day are discussed and interventions and updates are put on the care plans by a representative from nursing. However the SW#2 could not provide evidence Resident #8 had been discussed in these meetings or provide evidence the resident's care plan had been revised to address the reoccurring behaviors towards other residents. Interview with the Charge Nurse (CN) on 04/25/11 at 1:45pm revealed Care Plans are updated as new MD orders come in, i.e. medication changes, a new intervention that came from an MD order, information from morning meetings and after reviewing incident reports. Interview with the Administrator on 04/26/11 at	F 280		

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F 280	Continued From page 12 10:55am revealed she heard about "things" through the Falls Committee (Morning Meeting). At that meeting, staff review incidents and decide what interventions are necessary. The Care Plan is then updated during the meeting. The Administrator stated she assumed that social services thought nursing should be updating the Care Plan and nursing thought social services should be updating the Care Plan. The Administrator revealed the system was not working for behaviors if the Care Plans are not updated. The Administrator could not provide evidence Resident #8's aggression towards other residents had been discussed in the morning meetings or any evidence that the facility revised the resident's care plan to implement new interventions, monitor those interventions and/or revisited the plan of care if the interventions were not working.	F 280		
F 319 SS=D	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 it was determined the facility failed to provide a behavior management program for aggressive behaviors for one (1) of sixteen (16) residents. Resident #8 displayed aggressive behaviors resulting in skin tears and bruises to two (2) residents.	F 319		

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OMB NO. 0938-0391

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F 319	Continued From page 13 The findings include: The facility could not produce a policy regarding a behavior management program. Clinical record review revealed the facility admitted Resident #8 on 09/22/06 with diagnosis of Dementia with Psychosis. Resident #8's Significant Change Minimum Data Set (MDS) assessment dated 06/08/10 revealed the facility assessed Resident #8 as having moderately impaired cognition and resisting care one to three times in the last seven days. The quarterly MDS dated 02/11/11 revealed the resident's behavior included physical and verbal behavioral symptoms directed toward others, rejection of care and wandering behaviors. The plan of care dated 11/24/10 revealed an alteration in mood and behavior disturbance, interventions for the nursing staff were to administer medications as ordered, observe for changes in behaviors, if resisting care notify the nurse, and if agitated - reapproach at a later time. The care plan dated 02/16/11 on altered mood and behavior revealed there were no problems, goals or interventions on the Care Plan related to behavioral problems or aggression toward other residents, only staff. There are no behavior management techniques listed as interventions to prevent aggression or abuse toward other residents. Review of the Mood and Behavior record printed 04/25/11 indicated the resident, since 12/21/10 had displayed an increase in wandering, being short tempered, easily annoyed and rejecting care. Resident #8 nurse's note dated 01/11/11 revealed Resident #8 pulled off another resident's	F 319	F 319 1 Resident #8 was discharged from the facility on 4/30/11. 2 The facility identified and reviewed and updated the care plans of all residents exhibiting behavioral concerns for accuracy, completion, and to ensure that all current interventions are effective 4/26/11. 3 All Staff were in-serviced on Behavioral Management Techniques by the Staff Development Coordinator, Social Services Director and designee beginning 4/ 26/11. All staff will be in-serviced on when and how to update the care plan when interventions are implemented to address behavioral concerns and other issues regarding the safety of all residents. The Rehabilitation\Skilled Care Consultant, DNS and/or designee will begin this training as well as training regarding Abuse and Neglect on 5/19/11. All training will be completed by ~~6/10/11.~~ 5-27-11 RB rec'd phone Ben Edwards	

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F 319	Continued From page 14 glasses while the resident was seated in front of the nurse's station. The nurse's note dated 02/05/11 revealed Resident #8 was frequently found in other resident's rooms. He/she often removed such items as glasses, or things the other residents may be holding. Although the nursing staff were aware of this change in behavior, the plan of care was not revised with new interventions for the staff to utilize. The Social Services note on 02/10/11 revealed Resident #8 had been wandering in and out of residents rooms taking items. The nurse's note on 02/21/11 revealed the Director of Nursing (DON) reported Resident #8 went into another resident's room and hit a resident. There was no evidence the facility made any changes to the plan of care. An Incident Report dated 03/05/11 revealed at 9:10am Resident #8 wandered into Resident #4's room and pinched Resident #4's arm. The pinch resulted in a bleeding skin tear measuring 0.5cm x 0.3cm which required a dressing. In addition, The nurse's note on 03/10/11 revealed Resident #8 became combative during medication pass. Resident #8 pinched the unit supervisor's left forearm leaving a whelp and redness. Again, the facility made no changes to the plan of care to address the behaviors directed toward other residents. Interview with Social Services #1 and #2 (SW) on 04/25/11 at 2:55pm revealed there was a Behavior Committee that meets monthly to discuss residents with behavioral issues that are currently on antipsychotic medications. SW #2 revealed Resident #8's behaviors were not discussed during those meetings due to him/her not being on antipsychotic medication. Although the physician's orders indicated the resident was receiving antipsychotic medications of Risperdal	F 319	4 All incident reports regarding behavioral management concerns will be reviewed daily, Monday through Friday when applicable by our interdisciplinary Incident Report Committee. The Nursing Weekend Supervisor or designee will review behavioral management incident reports over the weekend when applicable and the Incident Report Committee will follow up on the incident during business hours the following week. The incident reports regarding behavioral management concerns will be audited weekly x 12 weeks then monthly by the QA Coordinator or designee to ensure that all incident reports are complete and accurate. Implementation of care plan intervention for residents exhibiting behaviors will be audited weekly x 4 weeks and monthly x 3 months by the Social Services Director or designee. Findings will be reported to the QA Committee monthly for further recommendations.	6/16/11 5-27-11 pg Visi phone & BW [illegible]

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F 319	Continued From page 15 twice a day, Depakote three times a day and Ativan as needed. SW #1 states there was not a system (i.e. Behavioral Management Program) in place to address residents with behavioral problems using behavior modification, behavior reinforcement or contracts. SW #1 stated the Social Services Department was aware of the Resident's behaviors, as all staff were, and overlooked the resident's behaviors as this resident was a particular favorite and felt the other residents were instigating the situations.	F 319		

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