

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

PRINTED: 09/09/2010
FORM APPROVED
OMB NO. 0938-0391

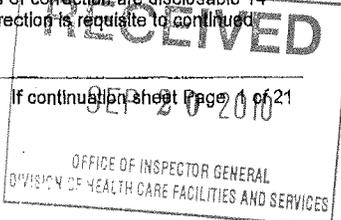
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185358	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/25/2010
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF TRIMBLE COUNTY	STREET ADDRESS, CITY, STATE, ZIP CODE 50 SHEPHERD LANE BEDFORD, KY 40006
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A standard health survey was conducted on 08/17/10 through 08/19/10 and a Life Safety Code survey was conducted on 08/25/10. Deficiencies were cited with the highest scope and severity of an "E" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition. KY14768 and KY15132 were investigated and substantiated with deficiencies cited at 483.10 Resident Rights, F157 at a Scope and Severity (S/S) of a "D" and F164 at a Scope and Severity (S/S) of an "E"; and 483.15 Quality of Life, F241 at a Scope and Severity (S/S) of an "E".	F 000	Signature HealthCARE of Trimble County Inc., dba Signature HealthCARE of Trimble County does not believe and does not admit that any deficiencies existed either before, during or after the survey. The facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered a waiver of any potential applicable Peer Review. Quality assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations of compliance and plan of correction as part of its efforts to provide quality of care to its residents.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). 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	F 157		9/28/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Francis C. Stutz</i>	TITLE <i>Administrator</i>	(X6) DATE <i>9/17/10</i>
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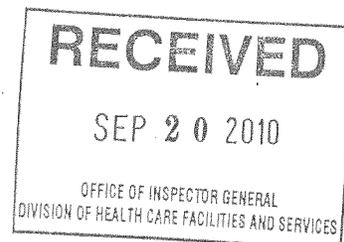
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 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 44 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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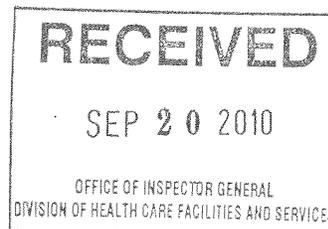
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F 157	<p>Continued From page 1</p> <p>specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined the facility failed to immediately inform and consult with one of fourteen (14) sampled residents (#13), physician/Advanced Registered Nurse Practitioner (ARNP); and notify the resident's family member when there was an accident that had the potential for requiring physician intervention or 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). Resident #13 sustained a fall on 02/19/10 at 2:30am with a red raised area on the head and at the 7:15am assessment revealed a neurological/cognitive change which was not relayed to the ARNP until 8:00am and the family member at 8:30am.</p> <p>The findings include:</p> <p>Record review revealed Resident #13 was admitted on 10/18/07 with the diagnoses of Alzheimer's, Chronic Ischemic Heart Disease, Primary Cardiomyopathy, Atrial Fibrillation, Congestive Heart Failure, Traumatic Subdural Hematoma, Cardiovascular Accident, and Arthritis. The Minimum Data Set (MDS) for</p>	F 157	<p>F 157</p> <ol style="list-style-type: none"> 1. Resident # 13 is no longer in the facility. The Assistant Director of Nurses educated the facility's registered nurses and licenses practical nurses on the policy and procedure on notifying physicians, advanced registered nurse practitioners and the family, when there was an accident that had potential for requiring physician intervention or a significant change in the residents physical, mental or psychosocial status. 2. The Assistant Director of Nursing will complete an audit on all incidents and accidents in the past 30 days to evaluate the need for resident's family or physician to be notified if there is an accident involving a resident which results in injury and has the potential for requiring physician intervention; the appropriate notification will be completed as needed by the Assistant Director of Nursing. 3. The Director of Nursing will educate the nursing department on 9/17/10 regarding the appropriate standards on when to notify the resident's family and physician; when an incident or accident has occurred or potential for physician 	



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F 157	<p>Continued From page 2</p> <p>Resident #13 was assessed on 01/07/10 and revealed a cognition for decision-making at a zero (0), the memory score for short term and long term memory at a score of zero (0), and scored for his/her ability to be understood and to understand at a zero (0), which indicated the resident was not impaired in these areas identified. Resident #13 sustained a fall on 02/19/10 at 2:30am with a red raised area on his/her head and at the 7:15am assessment revealed a cognitive change. The nurse's notes dated 02/21/10 at 8:00am revealed the ARNP was notified of the resident's fall and change of condition. The nurse's notes dated 02/21/10 at 8:30am revealed the family member/power of attorney was notified of the fall and the change of condition.</p> <p>Interview on 08/25/10 at 6:45pm with Licensed Practical Nurse (LPN) #5 revealed everything should be in the chart regarding Resident #13. The LPN reported neurological (neuro) checks were completed on the resident and there were no changes during the shift. The LPN reported the neuro changes were identified at shift change and the information regarding this resident was documented in the chart, and his/her memory would not be accurate.</p> <p>Interview on 08/25/10 at 7:00pm with Director of Nursing (DON) revealed everything should be in the chart regarding Resident #13 and an investigation of the fall was completed. The DON reported she was notified of the fall and the initial assessment was within normal limits. She reported neurological (neuro) checks were implemented on the resident and there were no neuro changes identified during the shift. The DON reported the neuro changes were identified</p>	F 157	<p>intervention. The family physician will be notified in the appropriate time frame when an incident or accident occurs or the potential of requiring physician intervention.</p> <p>4. The Director of Nursing/ Assistant Director of Nursing will monitor the incident and accident report daily in clinical meeting to determine that families and physicians were contacted at appropriate times when an accident or incident occurs or the potential for requiring physician. All results will be forwarded to the quarterly QA meeting for three months. All results will be reviewed for recommendation and further follow up as indicated.</p>		



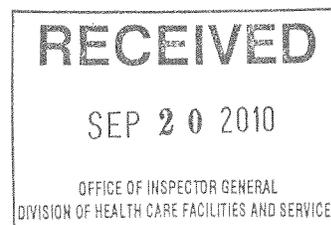
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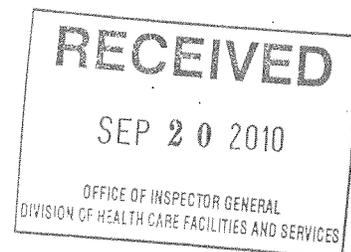
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F 157	Continued From page 3 at shift change and that is when the ARNP was notified and the family. She reported the facility sometimes waits a little later into the morning, closer to 7:00am to 8:00am.	F 157		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to promote care for one (1) of fourteen (14) sampled residents (#1) in a manner and environment that enhanced each resident's dignity and respect in full recognition of his/her individuality. The facility failed to provide toileting for Resident #1 when requested. In addition, the facility failed to provide dignity and respect by showering residents while the bathroom door was ajar during personal care. The findings include: Observation of Resident #1 on 08/23/10 at 11:30am revealed that Resident #1 told staff that she needed to go "poopoo". Observation at 11:40am revealed two Certified Nurse Aides (CNAs) walked Resident #1 back to the room and placed the resident in front of a television, and did not take the resident to the bathroom. Interview on 08/23/10 at 11:42am with CNA's #3 and #4 revealed that no nurse approached them	F 241	F 241 1. Resident #1 was toileted upon notification to clinical staff. The clinical staff was educated regarding Resident Rights, dignity and respect in full recognition of his/her individuality The shower room door will remain closed while residents are being bathed. 2. The Director of Nursing audited interviewable residents to ensure residents toileting request are met timely. The Director of Nursing audited the shower room door daily to ensure the shower room door is closed while residents are being bathed. The maintenance director evaluated the vent to ensure the vent is in working order. 3. The Director of Nursing educated the nursing staff on 9/10/10 regarding on the manner and environment that enhances each residents dignity and respect in full recognition of his/her individuality, by toileting a resident upon request, and that the facility must provide dignity and respect by keeping the	9/28/10



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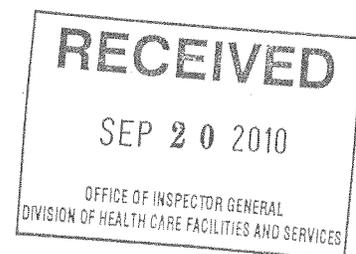
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F 241	<p>Continued From page 4</p> <p>with anything having to do with Resident #1 needing to be toileted or have a brief change.</p> <p>Interview on 08/23/10 at 11:44am with Licensed Practical Nurse (LPN) #2 revealed that she was under the impression that someone else checked Resident #1 and toileted or changed the resident's brief this morning. LPN #2 was unable to say who she told to change Resident #1's brief.</p> <p>Interview with the Director of Nursing (DON), on 08/25/10 at 4:40pm, revealed Resident #1 will say a bathroom visit is needed; however, when the DON would go with him/her to change his/her brief, Resident #1 would not be wet.</p> <p>Observation on 08/25/10 at 10:09am revealed the shower curtains did not meet the floor and that residents' feet were visible even when the shower curtain was pulled. Further observation revealed the vent system was powered by a dial that turned side to side which was next to the light switch.</p> <p>Interview on 08/25/10 at 5:20pm with Certified Nurse Aide (CNA) #1 revealed she had observed the shower door open while residents were being showered in the shower room and that, at least, once a week the shower room door was open related to the air conditioning not working effectively. CNA #1 further stated that the shower curtain was always pulled and the Maintenance Director was aware that the air conditioning unit was broken.</p> <p>Interview on 08/25/10 at 5:44pm with CNA #2 revealed that she witnessed the shower room doors open while residents received showers and the curtains were pulled to provide privacy. CNA</p>	F 241	<p>shower room door closed, when a resident is being bathed. A monitoring tool has been put into place to ensure that all residents are cared for in a manner that enhances each resident's dignity and respect. The maintenance director will evaluate the ventilation system in the shower room weekly, to ensure it is working appropriately. The maintenance director in-serviced the facility staff on the maintenance request process.</p> <p>4. The Director of Nursing/ ADON will monitor the process weekly to ensure that all residents are treated with dignity and respect of their individuality and will forward the results for review at the quarterly QA meeting for six months; for recommendations and further follow up as indicated.</p>	



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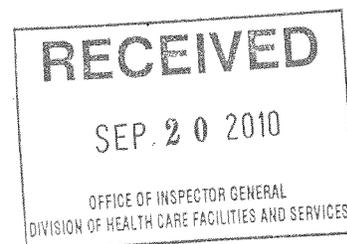
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F 241	Continued From page 5 #2 further stated that the Maintenance Director was aware. Interview with the Assistant Director of Nursing (ADON) on 08/25/10 at 4:36pm revealed that under normal circumstances the shower room door stays shut and there is a shower curtain for privacy. The ADON further stated the vent was powered by the ceiling vent. Interview with the Director of Nursing (DON) on 08/25/10 at 4:36pm revealed that during emergencies, for example, the vent or air conditioning unit shuts down, and the staff open the door to the shower room for ventilation. The DON further stated the vent was powered by the light switch. Interview with the Maintenance Director on 08/25/10 at 4:04pm revealed that staff were encouraged to write down on a clipboard concerns and staff were aware of how to turn on the vent in shower room.	F 241		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to	F 246	F 246 1. Resident #1 was assessed on 9/17/10 by the Assistant Director of Nurses and the Rehabilitation Services Manager, for the use of bilateral hand splints and the ability for resident # 1 to use the call system. An appropriate call system was put into place to ensure Resident # 1 had the ability to summon help from staff. 2. An assessment will be completed by the Assistant Director of Nursing on 9/17/10 on all residents with bilateral hand splints, to ensure the proper call system is in place to make certain that the resident has the ability to call for assistance from staff when needed. 3. An in-service was conducted on 9/24/10 by the Director of Nursing for the facility staff regarding the appropriate call systems to be used for residents that are unable to use the "standard call light" system. Those residents which receive an order for splints will be evaluated for	9/27/10



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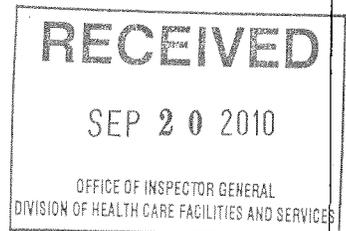
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F 246	<p>Continued From page 6</p> <p>ensure residents had the right to reside and receive services in the facility with reasonable accommodations of the individuals needs and preferences as evidenced by failing to provide a device (call system) for one (1) of fourteen (14) sampled residents (#1). Resident #1 was not able to use the standard call light related to the use of bilateral hand splints and the facility failed to modify the system to allow Resident #1 to summon help from staff.</p> <p>The findings include:</p> <p>Interview with Resident #1, on 08/24/10 at 2:56pm, revealed Resident #1 asked the surveyor if they could turn him/her to their right side. The resident was asked if he/she could use the call light and Resident #1 stated "no".</p> <p>Observation on 08/24/10 at 2:56pm revealed Resident #1 had splints applied to both hands and the call light was a push button call system.</p> <p>Interview with Certified Nurse Aide (CNA) #3, on 08/24/10 at 2:56pm, revealed that Resident #1 usually called out to his/her parent, who is a resident of the facility in the next bed, and the parent pushes the call light for the resident.</p> <p>Interview with the Occupational Therapist, on 08/25/10 at 3:50pm, revealed that no one brought to her attention that Resident #1 could not use the call light. The protocol included staff filling out a picture form, circling on the form what is needed, or write on the back of the picture form exactly what is needed for residents. The Occupational Therapist further stated that she was not aware Resident #1 asked his/her parent to push the call light.</p>	F 246	<p>call light system appropriateness and the appropriate call light system will be put into place as needed; to ensure the residents have the ability to summon staff for help.</p> <p>4. The Director of Nursing/ADON will audit all residents monthly and report to the safety committee for follow up and recommendations of determining the appropriate call system for residents with splints. All results and will be forward to the quarterly QA meeting for six months; for recommendations and further follow up as indicated.</p>	



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F 246	Continued From page 7 Interview with the Housekeeping Manager, on 08/25/10 at 4:19pm, revealed she was the one who ordered the call system inventory. Recently no one asked her to order a pressure call light or a TP call light. Interview with the Assistant Director of Nursing (ADON), on 08/25/10 at 4:40pm, revealed that Resident #1 yells out when he/she needs something. Resident #1 is able to make needs known by yelling. The DON further stated that she has not tried to use a different type of call system and thinks it would be difficult for Resident #1 to hit his/her call light with splints on both hands.	F 246			
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to provide the services necessary to maintain an orderly and comfortable environment; no light cords were present for five (5) over bed lights. Two (2) air condition (AC) units had sharp edges; one (1) air condition unit was missing a sealer around the AC unit. A faucet in the shower area was running continuously and tiles in the shower room were missing with the potential to be a trip hazard. Three (3) air condition units had outside broken grills and two (2) closet doors were broken.	F 253	F 253 1. The facility was evaluated to ensure a sanitary, orderly and comfortable interior. The outside air conditioning unit grills, with holes in them, have been replaced with new grills. The light cords in rooms 129A, 119A, 121A, 123B, and 125B have been replaced. The broken closet doors in rooms 114 and 116 have been repaired. The air conditioning units in rooms 121A and 123B have been repaired and secured appropriately with out exposed sharp edges. The air conditioning unit in room 117 was resealed and securely fastened against the wall. The faucet in the shower room has been evaluated and repaired. The missing tiles in the shower room floor have been repaired to ensure there is no trip hazard. 2. An environmental audit will be completed by the Maintenance Director and/or Environmental Service Director on 9/15/10 in all resident rooms to ensure that all light cords to resident's light are at the proper length for the residents to be able to use, an audit of all closet doors in resident rooms will be	9/28/10	



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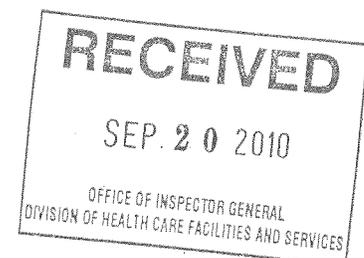
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F 253	Continued From page 8 The findings include: Observations made on 08/23/10, revealed three (3) air conditioning unit grills that were located to the outside of the building, had visible holes in them. Observations made on 08/25/10 revealed rooms 129A, 119A, 121A, 123B, 125B had no cords for residents to use to turn the lights on. Rooms 114 and 116 had broken closet doors. Rooms 121A and 123B revealed that the face of the air condition units were not secured correctly and exposed sharp edges. Room 117 revealed the air condition unit had no seal and looked as if it were coming away from the wall. Observation of the shower room revealed the tub's faucet had running water which ran continuously into the tub and tiles were missing from the shower floor creating a potential trip hazard. Observation of the Housekeeping Manager, on 08/25/10 at 10:09am, revealed she was unsuccessful at turning off the faucet in the tub. Interview with the Maintenance Director on 08/25/10 at 10:09am revealed the Maintenance Director was not allowed to leave the facility to retrieve tile to fix the shower floor because the Administrator did not like the Maintenance Director leaving the facility. The Maintenance Director was aware the tile needed to be fixed about a week prior to the survey. Fixing the tile would mean that the Maintenance Director would have to go to Louisville to pick up supplies and that he could not leave now because he was needed in the building. The Maintenance Director further stated that a possible skin tear could occur if the face of the air conditioning unit was not on correctly. The Maintenance Director voiced that	F 253	conducted to ensure that all doors are functioning appropriately, an audit of all the air conditioning units will be completed to ensure that the face of the air units are secured correctly and do not expose sharp edges and are properly sealed to the wall. The facility's Plant Operations Director will review the shower room for possible leaks and broken tiles on 9/17/10 to ensure that a trip hazard does not exist. If a concern is identified the appropriate maintenance request will be initiated immediately and forward to the plant operations director for evaluation and repair. 3. The Administrator educated the Maintenance Director and the Environmental Service director on 9/16/10 on the appropriate standards for proper routine maintenance on the air conditioning units, residents' closets, the shower room, and cords for resident's lights. The facility has implemented a process of weekly maintenance and environmental rounds for the identification of housekeeping and maintenance services needs.	
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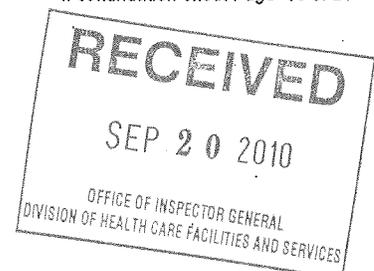
PRINTED: 09/09/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185358	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/25/2010
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF TRIMBLE COUNTY	STREET ADDRESS, CITY, STATE, ZIP CODE 50 SHEPHERD LANE BEDFORD, KY 40006
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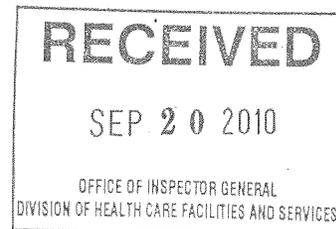
F 253	Continued From page 9 the caulking was replaced as needed to the smaller air conditioning units, that's why the caulking looks so bad. The Maintenance Director further stated that he did not see any issues with the holes in the grills to the outside air conditioning units. Interview with the Administrator, on 08/25/10 at 10:09am, revealed he did not know the air units had holes in the grill. These units should have no openings and there is no guarantee that rodents/insects cannot pass through the grill. The Administrator also revealed that he did not remember the Maintenance Director mentioning the tiles in the shower room needed to be fixed.	F 253	The Administrator will review the maintenance request log weekly in the morning meeting for completion 4. The Maintenance Director will perform environmental rounds weekly, of determining and identifying housekeeping and maintenance services needs. Appropriate maintenance request will be logged and will forward results for review to the monthly safety meeting. Results of the safety meeting will be forwarded to the monthly QA meeting for nine months for recommendations and further follow up as indicated.	
F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions;	F 272	F 272 1. Residents # 2, #3, and #4 were assessed by the MDS Coordinator on 9/22/10 and a Resident Assessment Protocol was modified for residents #2, #3, and #4 for antipsychotic medications and specific behaviors to show an accurate, standardized reproducible assessment of the resident's functional capacity which includes mood and behavior patterns. 2. A Resident Assessment audit will be completed, by the MDSC, on 9/22/10; on all residents receiving antipsychotics, to evaluate the	9/28/10



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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF TRIMBLE COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 50 SHEPHERD LANE BEDFORD, KY 40006		
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F 272	<p>Continued From page 10</p> <p>Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to conduct periodically a comprehensive, accurate, standardized reproducible assessment of the resident's functional capacity which included mood and behavior patterns and the efficacy of the antipsychotic medications for three (3) of fifteen (15) sampled residents (#2, #3 and #4). Resident #2, #3, and #4 received antipsychotic medication for behaviors; however, there was no evidence behaviors were assessed using the Resident Assessment Protocol for Antipsychotics (RAP).</p> <p>The findings include:</p> <p>The facility used the Resident Assessment Instrument (RAI) Manual 2.0 as their policy for MDS assessments. The policy revealed the RAPs were to be used to guide the interdisciplinary team through a structured comprehensive assessment of the resident's functional status. The RAPs provide further assessment of the triggered areas.</p> <p>The facility policy for Psychotropic Drug Use, dated 2002, revealed the facility would quantify</p>	F 272	<p>appropriateness for a Resident Assessment Protocol for accuracy, mood and behavior and the resident's functional capacity. Antipsychotics for the Resident Assessment Protocol will be modified to include a specific comprehensive accurate assessment for mood and behavior patterns and the efficacy of the antipsychotic medications for all identified resident.</p> <p>3. The Regional MDS Nurse Consultant will educate the DON, ADON, MDSC and Social Service Director on the guidelines that constitutes a Resident Assessment Protocol for Antipsychotics on 9/21/10. A process, of reviewing residents per the MDS process for antipsychotic triggers, behaviors and necessary drug use, a tracking system has been put in place to track and monitor specific resident behaviors. This process has been put into place for the identification and triggering of a Resident Assessment Protocol for antipsychotics and specific behaviors.</p> <p>4. The Director of Nursing/ ADON will audit the periodic comprehensive assessments weekly determining and identifying</p>		



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F 272	Continued From page 11 and objectively document specific behaviors for residents receiving antipsychotics. Symptoms resulting from anxiety and managed with anti-anxiety drugs will be quantitatively and objectively documented. The interdisciplinary team will assess and document therapeutic interventions, permanence of symptoms, the relationship of symptoms to life events and potential environmental and medical causes. 1. Observations of Resident #2 on 08/23/10 at 11:15am, 12:30pm, 2:30pm, and 3:00pm, and on 08/24/10 at 8:30am, 9:15am, 19:30am, 11:20am, and 2:30pm, revealed the resident was awake and quiet. No behaviors were observed. Review of the clinical record for Resident #2 revealed the resident was admitted with diagnoses of Head Injury, Dementia with Behaviors, and Personality Disorder. The facility completed an annual Mlnimum Data Set (MDS) assessment on 06/03/10 which revealed the resident had a severe Impairment in the ability to make daily care decisions. The resident was not able to communicate care needs and required total assistance of two for mobility, dressing and hygiene. The resident received an anti-anxiety medication twice a day. There was no evidence the medication or what specific behaviors being treated were assessed using the MDS Resident Assessment Protocol (RAP) for Antipsychotics to support clinical decisions. 2. Observation of Resident #3 on 08/23/10 at 11:15am, 11:40am, 12:30pm, 2:30pm and 3:15pm, and on 08/24/10 at 8:40am, 9:40am, 10:30am, 11:30am, 2:30pm and 4:00pm revealed the resident was alert and calm and sat or reclined in bed motionlessly. No behaviors were	F 272	residents that trigger for a Resident Assessment Protocol for Antipsychotics. The audit results will be forward to weekly At Risk meeting for review and follow up. Results and recommendations will be forwarded to the quarterly QA meeting for six months; for recommendations and further follow up as indicated.	

