

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

PRINTED: 03/30/2012
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185136 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 03/16/2012 |
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| NAME OF PROVIDER OR SUPPLIER WESLEY MANOR NURSING CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 5012 EAST MANSLICK RD LOUISVILLE, KY 40219 |
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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 |
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| F 000 | INITIAL COMMENTS An abbreviated survey was conducted 03/14/12 through 03/16/12 investigating KY18014. KY18014 was unsubstantiated with deficiencies cited. | F 000 | | |
| F 279 SS=D | 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, it was determined the facility failed to develop a comprehensive plan of care for one (1) of five (5) sampled residents, Resident #2, as it relates to Resident #2's aggressive | F 279 | <u>Corrective action to be accomplished for those resident(s) found to have been affected by the deficient practice:</u> Resident #2 had his care plan updated to match his current behavioral care needs. The care plan addresses both the resident's verbal and physical aggression and provides interventions for staff to follow to ensure safety for resident, resident's wife and staff. <u>How the facility will identify other residents having the potential to be affected by the same deficient practice will not recur:</u> 6 other residents have been identified as having behavioral symptoms requiring the initiation and/or revision of their comprehensive care plan addressing behavioral symptoms. Each of these residents' care plans were reviewed and updated to ensure that proper interventions were in place and to ensure safety of the resident, other residents and/or staff. <i>Continued on next page-</i> | 4/30/12 |

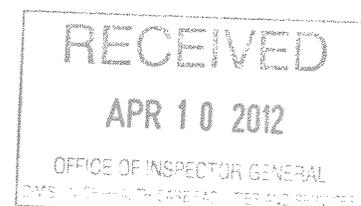
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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  | TITLE PRESIDENT/ADMINISTRATOR | (X6) DATE 4-9-12 |
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Any deficiency statement ending with an asterisk (*) denotes a deficiency 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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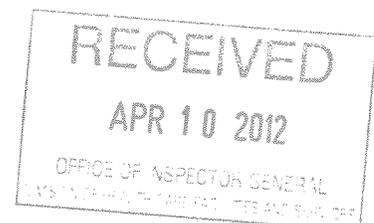
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| F 279 | Continued From page 1 behavior. The Findings include: Review of the Resident Care Plan Policy, revised 2/12, revealed that all residents would have an initial needs care plan upon admission and that their care plan would be reviewed and updated promptly for care changes. Review of the Assessment Package Documentation, revised 10/11, revealed an accurate assessment and documentation of a resident's condition on admission and at other times as indicated by condition status and federal requirements will be completed by the appropriate persons. Observation of Resident #2, on 03/15/12 at 8:15 AM, revealed Resident #2 being very confused and agitated. While staff was assisting the spouse (Resident #1) of Resident #2 out of bed, Resident #2 was looking through his/her closet. Staff encouraged Resident #2 to sit down for breakfast. He/She stated "NO", then proceeded to look through the closet. When asked what the resident was looking for in the closet, Resident #2 stated "I don't know". The Certified Nursing Assistant (CNA) placed an alarm in the chair and Resident #2 stated in an upset voice, I don't want this in my chair and asked the CNA who told the he/she needed this thing? The CNA replied the Doctor ordered it for safety. Resident #2 then stated well I need the name of this Doctor so I can tell him I don't need it. When the CNA placed the alarm into the chair, the resident smacked the CNA on the buttocks. The CNA stated to the resident that was inappropriate behavior. | F 279 | <u>Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur:</u> A new Resident Behavior Policy was developed (see attached). This policy provides guidance to staff on how to exam resident behavior, exploring solutions and responding. The policy also guides staff toward care planning interventions, resolution with follow-up charting, documentation and the CNA assignment sheets. A new binder is also being put into place for the nurses to have a template of nursing care plans that can be copied and then individualized for each resident. The Medical Director reviewed and approved the Resident Behavior Policy . The plan of care changes for resident #2 and the other residents identified were also reviewed and approved the Medical Director. <u>How the facility plans to monitor its performance to ensure that solutions are sustained:</u> A daily morning meeting will be held with the nursing department managers and social services to review the 24 hour report and any incident reports in the last 24 hours. If any behavior symptoms have been identified, the nursing notes, the care plan and the CNA assignment sheet will be reviewed. The resident will be assessed, the resident's attending physician and family will be notified and consulted to ensure the plan that is put into place is appropriate for the resident. Appropriate interventions will be immediately put into place to ensure the safety of the resident, other residents and/or staff. | |



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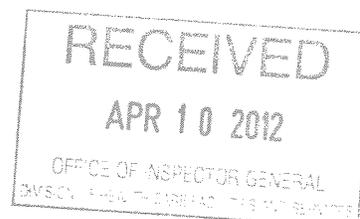
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| F 279 | Continued From page 2 Record review of Resident #2's record revealed Resident #2 was admitted on 01/23/12, with a diagnosis of Alzheimer, Dementia, Depression and a Left Frontal Sinus Mass. Record review of Resident #2's nursing notes revealed on 01/24/12 at 11:25 PM, Resident #2 had increased anxiety and would attempt to become aggressive with staff. On 01/25/12 at 12:00 AM, revealed Resident #2 becoming aggressive with staff and making the statement that he/she would hurt staff and enjoying it. Resident #2 also attempted to pull staff in the bed with him/her and was identified as very restless. On 01/26/12 at 6:00 PM and 9:28 PM, Resident #2 was noted to be agitated. On 01/27/12 at 10:40 PM, revealed Resident #2 was pushing and yelling at staff. Resident #2 was noted to push a wheelchair at a staff member and the wheelchair hit his/her spouse instead, with minimal injury's noted to the spouse. On 01/28/12 at 12:20 PM, revealed Resident #2 becoming combative with staff. Documentation on 01/29/12 at 10:00 PM, revealed Resident #2 was given Ativan for increased anxiety. Record review of Resident #2's Behavior care plan, initiated on 02/02/12, revealed the Problem Need Concern Strength or Issue section, identified behavioral symptoms of yelling at staff and threatening staff during care. Resident's behavior was easily altered with redirection. No aggression care plan outlined by Social Services could be obtained. Record Review of the Minimum Data Set (MDS) Admission Assessment, dated 01/29/12, revealed section E0200 Behavioral Symptoms- Presence and Frequency only identified verbal behavior | F 279 | This information will be taken to the monthly and quarterly quality assurance committee for tracking and trending and further recommendations. | |



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| F 279 | Continued From page 3 symptoms directed toward staff. Physical behavioral symptoms directed toward others was not identified by Social Services. Interview with Social Services, on 03/15/12 at 1:55 PM, revealed she was responsible for completing care plans for behavior and mood. When she conducts her behavior assessment, she talks to the resident, looks through the chart and nurses notes. Social Services further stated when she looks at the MDS Admission Assessment for Resident #2, she could see it was not an accurate account of the resident's behavior and needed to be changed from a zero (0) for no aggression to a one (1) for aggressive behaviors. Interview with the MDS Coordinator, on 03/16/12 at 1:30 PM, revealed she made the hard copies of the care plans identified upon admission. The MDS Coordinator stated when she does her seven day look back period (01/23/12 through 01/29/12) if she saw something that was not addressed by social services, she would call Social Services to tell her. The MDS Coordinator further stated she saw the nursing notes in the look back period and the care plans did not address aggression. Interview with the Director of Nursing (DON), on 03/16/12 at 3:05 PM, revealed the MDS Coordinator was responsible for the nursing care plans and to make sure the care plans were accurate. The need for an aggression care plan should have been caught by the MDS Coordinator. The DON further stated had there been a care plan identified, there would be interventions in place and noted on the Certified | F 279 | | | |



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F 279 Continued From page 4
Nursing Assistant (CNA) sheet. The DON further stated, she was ultimately responsible for the care plans and the accuracy of the care provided.

F 279

F 280 SS=D 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP

F 280

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 observation, interview, record review and policy review, it was determined the facility failed to revise a comprehensive plan of care for one (1) of five (5) sampled residents, Resident #2, as it relates to Resident #2's aggressive behavior.

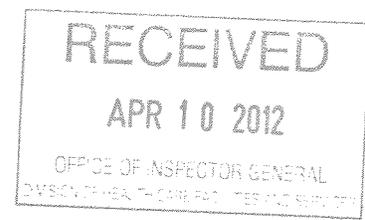
The Findings include:

Corrective action to be accomplished for those residents found to have been affected by the deficient practice:
Resident #2 had his care plan updated to match his current behavioral care needs. The care plan addresses both the resident's verbal and physical aggression and provides interventions for staff to follow to ensure safety for resident, resident's wife and staff.

4/30/12

How the facility will identify other residents having the potential to be affected by the same deficient practice will not recur:
Six other residents have been identified as having behavioral symptoms requiring the initiation and/or revision of their comprehensive care plan addressing behavioral symptoms. Each of these residents' care plans were reviewed and updated to ensure that proper interventions were in place and to ensure safety of the resident, other residents and/or staff.

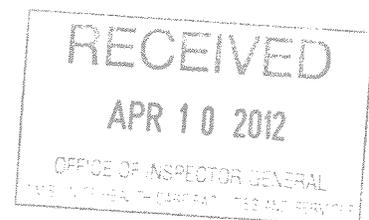
Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur:
A new **Resident Behavior Policy** was developed (see attached). This policy provides guidance to staff on how to exam resident behavior, exploring solutions and responding.



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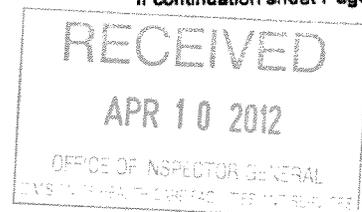
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| F 280 | Continued From page 5 Review of the Resident Care Plans Policy, revised 02/12, revealed to ensure that all residents have an initial needs care plan upon admission and that their care plan was reviewed and updated promptly for care changes. The changes may include but are not limited to the following: changes in resident behavior, refusal of medications, altercations or vocal outbursts. By day twenty-one (21) of the residents admission, the RAI Coordinator will have a completely typed Resident Care Plan in the resident's medical record under the care plan tab. Record review of Resident #2's record revealed Resident #2 was admitted on 01/23/12, with a diagnosis of Alzheimer, Dementia, Depression and a Left Frontal Sinus Mass. Record review of Resident #2's nursing notes revealed on 01/24/12 at 11:25 PM, Resident #2 had increased anxiety and would attempt to become aggressive with staff. On 01/25/12 at 12:00 AM, revealed Resident #2 becoming aggressive with staff and making the statement that he/she would hurt staff and enjoying it. Resident #2 also attempted to pull staff in the bed with him/her, very restless. On 01/26/12 at 6:00 PM and 9:28 PM, Resident #2 was noted to be agitated. On 01/27/12 at 10:40 PM, revealed Resident #2 was pushing and yelling at staff. Resident #2 was noted to push a wheelchair at a staff member and the wheelchair hit his/her spouse instead, with minimal injury's noted to the spouse. Interview with Registered Nurse (RN) #1, on 03/15/12 at 3:00 PM, revealed Resident #2 has become more aggressive, especially during times when providing care for spouse. Documentation on 01/28/12 at 12:20 PM, revealed Resident #2 becoming combative with | F 280 | The policy also guides staff toward care planning interventions, resolution with follow-up charting, documentation and the CNA assignment sheets. A new binder is also being put into place for the nurses to have a template of nursing care plans that can be copied and then individualized for each resident. The Medical Director reviewed and approved the <u>Resident Behavior Policy</u> . The plan of care changes for resident #2 and the other residents identified were also reviewed and approved the Medical Director. <u>How the facility plans to monitor its performance to ensure that solutions are sustained:</u> A daily morning meeting will be held with the nursing department managers and social services to review the 24 hour report and any incident reports in the last 24 hours. If any behavior symptoms have been identified, the nursing notes, the care plan and the CNA assignment sheet will be reviewed. The resident will be assessed, the resident's attending physician and family will be notified and consulted to ensure the plan that is put into place is appropriate for the resident. Appropriate interventions will be immediately put into place to ensure the safety of the resident, other residents and/or staff. This information will be taken to the monthly and quarterly quality assurance committee for tracking and trending and further recommendations. | | |



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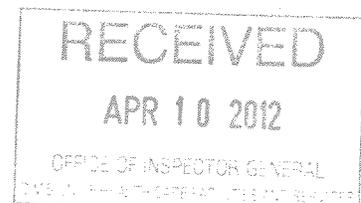
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| F 280 | Continued From page 6 staff. On 01/29/12 at 10:00 PM, revealed Resident #2 was given Ativan for increased anxiety. Observation of Resident #2, on 03/15/12 at 8:15 AM, revealed Resident #2 being very confused and agitated. While staff was assisting the spouse (Resident #1) of Resident #2 out of bed, Resident #2 was looking through his/her closet. Staff encouraged Resident #2 to sit down for breakfast. He/She stated "NO", then proceeded to look through the closet. When asked what the resident was looking for in the closet, Resident #2 stated "I don't know". The Certified Nursing Assistant (CNA) placed an alarm in the chair and Resident #2 stated in an upset voice, I don't want this in my chair and asked the CNA who told the he/she needed this thing? The CNA replied the Doctor ordered it for safety. Resident #2 then stated well I need the name of this Doctor so I can tell him I don't need it. When the CNA placed the alarm into the chair, the resident smacked the CNA on the buttocks. The CNA stated to the resident that was inappropriate behavior. Observation of Resident #2, on 03/15/12 at 8:20 PM, revealed Resident #2 complaining about the alarm and attempting to take it form underneath himself/herself on two occasions. The alarm sounded twice. Record review of Resident #2's Behavior care plan, initiated on 02/02/12, revealed the Problem Need Concern Strength or Issue section, identified behavioral symptoms of yelling at staff and threatening staff during care. Resident's behavior was easily altered with redirection. | F 280 | | |



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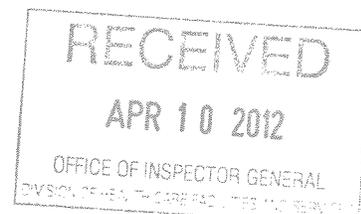
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| F 280 | Continued From page 7 Interview with Social Services, on 03/15/12 at 1:55 PM, revealed she was responsible for doing the behavior and mood care plans. When she conducts her behavior assessment, she talks to the resident, looks through the chart and nurses notes. She stated she generally receives her information from the resident, through interview, even if the resident was confused. When asked how reliable would the residents answer be? The Social Services stated in her training she was told to always interview the resident even if they were confused. Interview with Social Services, on 03/16/12 at 4:30 PM, revealed when asked if the care plan was accurate to the resident behavior and mood? Social Services responded "yes". Social Services stated she had read the nurses notes and this was the way she interpreted the care plan. Social Services further stated, she interpreted the behavior care plan to be accurate. Interview with the Minimum Data Set (MDS) Coordinator, on 03/15/12 at 2:20 PM, revealed when she looked at the MDS Assessment, she would pull information from the chart: telephone orders, daily twenty-four (24) hour report and nursing notes. The MDS Coordinator stated she would catch anything that was not documented on the care plan with the MDS review. She further stated nursing was responsible to update the care plans because it happens to them. The nurses were responsible for the patient. Interview with the Assistant Director of Nursing (ADON), on 03/16/12 at 2:05 PM, revealed based on the record review of the nursing notes the behavior care plan was not accurate. The nursing staff did not do a thorough job and no behaviors was added to the care plan as they should have | F 280 | | |



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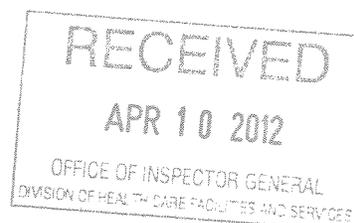
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| F 280 | Continued From page 8 been. The ADON stated she was the supervisor of the nursing staff and the Director of Nursing (DON) was responsible for the nursing staff. Interview with the DON, on 03/16/12 at 3.05 PM, revealed the Behavior Care Plan only addressed verbal issues. Social Services completes the behavior care plan. The DON further stated she was ultimately responsible for the care plans being accurate to the care provided. | 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 observation, interview and record review it was determined the facility failed to assist one (1) of five (5) residents, Resident #2 in reaching his/her highest level of mental and psychosocial functioning as related to Resident #2's lack of adjusting to a room change. The findings include: Record review of the Social Services Progress Notes, Problem/Need: Admission, dated 01/25/12, revealed Resident admitted from, Alzheimer Unit on 01/23/12. BIM score 5 (which revealed cognitively impaired). Significant cognitive loss. Mood symptoms as measured by PHQ-9 was one signifying little depression. | F 319 | <u>Corrective action to be accomplished for those residents found to have been affected by the deficient practice:</u> Resident #2 has continued to have difficulty with both verbal and physical aggression. On April 1, 2012 resident was placed with one-to-one companion 24-hours a day. Because of the residents aggression the companion was instructed to devoted most of their time to the wife while watching the resident and communicating with the resident. Most of the time this has worked well, with less outburst. We have also asked for no African-American male companions, as we feel this was one of the triggers on 4-1-12. Lab work has been done and medications have been adjusted. The facility has met with the family and discussed care with both the ARNP, Psych, and the Medical Director. Currently resident is on the waiting list for hospitalization at a psychiatric hospital if needed. | 4/30/12 | |



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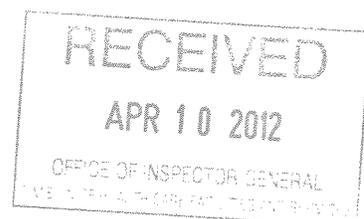
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| F 319 | Continued From page 9 Nursing notes 01/24/12 through 01/25/12 noted agitation and threats to hit staff, also grabbing at staff breasts. Behaviors fluctuate. Will allow resident time to adjust to new surroundings. Observation of Resident #2, on 03/15/12 at 8:15 AM, revealed Resident #2 being very confused and agitated. While staff was assisting the spouse (Resident #1) of Resident #2 out of bed, Resident #2 was looking through his/her closet. Staff encouraged Resident #2 to sit down for breakfast. He stated "NO". Then proceeded to look through the closet. When asked what are you looking for in the closet? Resident #2 stated "I don't know". The Certified Nursing Assistant (CNA) placed an alarm in the chair and Resident #2 stated in an upset voice, I don't want this in my chair. Who told you I needed this thing? The CNA replied the Doctor ordered it for your safety. Resident #2 then states well I need the name of this Doctor so I can tell him I don't need it. Observation of Resident #2, on 03/15/12 at 8:20 PM, revealed Resident #2 complaining about the alarm and attempting to take it form underneath himself/herself on two occasions. The alarm sounded twice. Record review of Resident #2's record revealed Resident #2 was admitted on 01/23/12, with a diagnosis of Alzheimer, Dementia, Depression and a Left Frontal Sinus Mass. Record review of Resident #2's nursing notes revealed on 01/24/12 at 11:25 PM, Resident #2 had increased anxiety and would attempt to become aggressive with staff. On 01/25/12 at 12:00 AM, revealed Resident #2 becoming aggressive with staff and making the statement that he/she would hurt staff | F 319 | <u>How the facility will identify other residents having the potential to be affected by the same deficient practice will not recur:</u> 5 residents were identified as new admission from 3-16-12 to present. All resident charts were reviewed and no other resident has been identified as displaying mental or psychosocial adjustment difficulty. <u>Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur:</u> <u>The Color Turn Dial for Event Charting Policy</u> (see attached) has been revised. The change in the policy is staff will now be charting every shift on a new admission for 14 days (instead of the previous 72 hours) and the turn dial will be turned to yellow during that time. This allows for staff to get a clearer picture on the residents adjustment to the facility. For a re-admission we will continue with a 72-hour charting schedule. Social Services will provide in the admission packet a Behavior Monitor (see attached) to be placed with the Medication Administration Records for additional documentation. This documentation will be completed for 14 days from the date of admission. During the first 14 days of admission in the daily morning meeting all new admission charts will be reviewed by the Director of Social Services, the VP of Nursing and Client Services or the Assistant Director of Nursing. Nursing Notes will be reviewed, the Behavior monitoring form will be reviewed as well as information on the 24-hour report and | |



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| F 319 | Continued From page 10 and enjoying it. Resident #2 also attempted to pull staff in the bed with him/her and identified as very restless. On 01/26/12 at 6:00 PM and 9:28 PM, Resident #2 was noted to be agitated. On 01/27/12 at 10:40 PM, revealed Resident #2 was pushing and yelling at staff. Resident #2 was noted to push a wheelchair at a staff member and the wheelchair hit his/her spouse instead, minimal injury's noted to spouse. On 01/28/12 at 12:20 PM, revealed Resident #2 becoming combative with staff. On 01/29/12 at 10:00 PM, revealed Resident #2 was given Ativan for increased anxiety. On 01/30/12 at 7:45 PM, revealed increased anxiety. On 01/31/12 at 10:05 PM, revealed increased agitation and resisting care. On 02/02/12 at 10 PM, revealed Resident #2 on knees trying to push the buttons on his/her television. Resident #2 stated "I'm trying to turn this damn thing off". On 02/03/12 at 3:00 PM, revealed Resident #2 extremely agitated this shift. Refused to be toileted and stated "we are leaving this hotel in the morning" while talking to spouse. Ativan given and was effective. On 02/03/12 at 7:18 PM, revealed Resident currently on Ativan 0.5 mg every four (4) hours as needed for agitation. Resident becomes increasingly agitated after taking the Ativan 0.5 mg, call placed to Advanced Register Nurse Practitioner (ARNP). On 02/03/12 at 7:45 PM, revealed Resident #2 seen by Psych for increased agitation and ordered Seroquel 12.5 mg PO every 12 hours as needed. On the same day at 11:00 PM, revealed the nurse and Certified Nursing Assistant (CNA) escorted resident to bathroom. Resident #2 then grabbed nurse by both arms and pushed the nurse out of bathroom. Resident then refused all assistance from the nurse and CNA. On 02/07/12 at 4:20 PM, CNA attempted to | F 319 | any incident reports that may have occurred. Identified difficulties shall be addressed immediately to ensure the resident receives appropriate treatment. <u>A New Resident Welcoming Program</u> has been initiated. This program helps to ensure that all new admission receive a visit from key personnel during their first 2 weeks of admission regardless of their cognitive functioning. The members of this committee include : The Director of Social Services, The President, The Vice President of Nursing and Client Services, The Assistant Director of Nursing, The Staff Development Coordinator, The Director of RAI, The Chaplain, The Director of Dietary and The Activities Director. The purpose of this program is for each member to touch base with the new resident , see how they are adjusting and see if there is anything we can do to help with their adjustment. Each member of the program will document on the <u>New Resident Welcoming Program form</u> , located in the social services section of the chart. Any concern or need voiced the program member shall work with other program members to find resolution. The New Program and changes in current resident care policies were reviewed and approved by the Medical Director. <u>How the facility plans to monitor its performance to ensure that solutions are sustained:</u> Each Month the Assistant Director of Nursing will audit all new admissions, reviewing the <u>New Resident Welcoming Program form</u> for |



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| F 319 | <p>Continued From page 11</p> <p>help Resident #2 change his/her pants and he/she refused. Nurse attempted to help and Resident #2 became agitated and verbally aggressive.</p> <p>Record review of Resident #2's Care Plan meeting, on 02/08/12, revealed Resident #2 was adjusting appropriately to new environment.</p> <p>Record review of Resident #2's Behavior care plan revealed no aggression care plan outlined by Social Services. No Psychosocial adjustment difficulties were addressed in care plan outlined by Social Services.</p> <p>Interview with Social Services, on 03/16/12 at 4:30 PM, revealed as a team (care plan team) they came up with the conclusion that Resident #2 adjusted appropriately to the new environment. Social Services stated Resident #2 had not been on unit that long and his/her behavior could be related to the staff approach.</p> <p>Interview with the MDS Coordinator, on 03/15/12 at 2:20 PM, revealed she attended the care plan meeting on 02/08/12. She stated the team talked about how the resident was adjusting well to the new unit. When asked how was this judgement called? The MDS Coordinator stated we made the decision together. She stated she reviewed nursing notes at the time the Minimum Data Set (MDS) was due, but not during the care plan meetings. The MDS Coordinator further stated nurses where to update and initiate care plans.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 03/16/12 at 2:05 PM, revealed she thought the care plan meeting team would review</p> | F 319 | <p>completion. The President will address any non-compliant member. This information will be taken to the monthly and quarterly quality assurance committee for tracking and trending and further recommendations.</p> | |



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| F 319 | Continued From page 12 the chart in the meetings. Interview with the Director of Nursing (DON), on 03/16/12 at 3:05 PM, revealed Resident #2 was having a difficult time adjusting to the environment. Resident #2 came back from the hospital and had been declining rapidly. The DON further stated, had there been a care plan there would be interventions in place. | F 319 | | |

