STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155803	A. BUILDING 00 B. WING	09/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HAMILTON POINTE HEALTH AND REHAB	3800 ELI PLACE NEWBURGH, IN 47630

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00269951, IN00270558, IN00270980, IN00274438, IN00274547, and IN00274875. Complaint IN00269951 - Unsubstantiated due to lack of evidence. Complaint IN00270558 - Unsubstantiated due to lack of evidence. Complaint IN00270980, - Substantiated. Federal/state deficiencies related to the allegations are cited at F744 and F758 . Complaint IN00274438 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00274547 - Unsubstantiated due to lack of evidence. Complaint IN00274875 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: September 25 and 26, 2018 Facility number: 012966 Provider number: 155803 AIM number: 201110390 Census Bed Type: SNF/NF: 55 SNF: 39 Residential: 51 Total: 145 Census Payor Type:	F 0000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Medicare: 20 Medicaid: 42 Other: 32 Total: 94 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed October 1, 2018.			
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, interview, and record review, the facility failed to develop, revise, and implement an individualized plan to manage the behaviors of residents with dementia, and utilized medications to manage the behaviors without completely assessing the resident for reasons for the behaviors, resulting in 1 resident being transferred to the emergency room, for 3 of 3 residents reviewed for behavior management, in a sample of 9. (Residents C, G, and H) Findings include: 1. On 9/25/18 at 11:50 A.M., during an interview with LPN 2, she indicated Resident C exhibited behaviors at times. She indicated the resident could be very calm, and then become very agitated, mainly in the evenings. The clinical record of Resident C was reviewed on 9/26/18 at 10:20 A.M. The resident was admitted	F 0744	This Plan of Correction is the centers credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute 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 an/or executed solely because it is required by the provisions of federal and state law. It is the policy of The Villages at Hamilton Pointe to develop, revise, and implement an individualized plan to manage the behaviors of residents with dementia. Resident C's plan of care has been reviewed and updated as	10/18/2018

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	to the facility on 7/19/18. Diagnoses included, but were not limited to, fracture left femur and unspecified dementia with behavior disturbance. A quarterly Minimum Data Set (MDS) assessment, dated 8/12/18, indicated Resident C had a severe cognitive impairment, and did not exhibit any behavior symptoms in the previous 7 days. Nursing Progress Notes included the following notations: 8/11/18 at 5:03 A.M.: "Resident is very restless this morning and complains of hip hurting him. Given a Norco [pain medication] and then we tried to change him because he was wet and he became very combative, balling up fist and threatening to hit us." 8/11/18 at 5:36 A.M.: "Resident is still very combative and will not allow us to change him - his brief is very wet and his sheets are wet. He is not really consoled by his wife either. Resident left alone for a while [sic] to see if he will calm down a bit." 8/11/18 at 5:57 P.M.: "Gave resident Haldol 0.5 mg [an antipsychotic medication]...for behaviors, resident spit out med." A transfer form, dated 8/11/18 at 6:00 P.M., indicated, "Sent to: [Name of hospital]...Reason(s) for: Altered Mental Status." A Physician Communication form which accompanied the transfer form, undated, indicated: "The change in condition, symptoms, or signs observed and evaluated is/are: Altered mental status (e.g. agitation, psychosis). This		deemed appropriate based on current individualized assessment. Medications have been reviewed and adjusted by the Nurse Practitioner and are reflected in the residents current plan of care. A one time 100% review of current in-house residents has been completed to identify residents with a diagnosis of dementia. Identified residents have had plans of care reviewed to ensure that any identified behaviors have individualized non-pharmacological interventions in place. Social Service staff have been re-educated to the behavior management and psychoactive medication monitoring policy with emphasis on the development of individualized interventions for managing behaviors of dementia residents. Licensed Nurses have been re-educated to following individualized plans of care including the behavior management program. Residents with identified behaviors will be reviewed by the interdisciplinary team (IDT) Monday through Friday to ensure plans of care and/or behavior management program based on current resident assessment remains appropriate and that medications are not utilized prior to assessing for the cause of the behaviors	

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	started on: 8/11/18. Since this started it has gotten: [Left blank]. Things that make the condition or symptom worse are: [Left blank]. Things that make the condition or symptom better are: [Left blank]. This condition, symptom, or sign has occurred before: [Left blank]. Treatment for last episode: [Left blank]...Other pertinent history: Dementia...New or worsened delusions or hallucinations...Verbal aggression, Physical aggression...Appearance: [Left blank], Review and Notify: [Name of physician], 8/11/18, 12:00 AM. Recommendations of Primary Clinicians: ER...." A hospital note, dated 8/11/18 at 7:55 P.M., included: "BSW [social worker] contacted facility...She stated she would have the on call RN call. Awaiting call. Notified...that she had received a call back from [name of facility]. The pt's [patient's] RN...said pt became aggressive after his wife has been admitted to the hospital. He was reportedly hitting staff. Per pt's RN, they tried giving Haldol po [by mouth] but pt would spit out the medication. They did not have Haldol IM [intramuscularly] to give to pt...also questioned if they had anything else, such as Ativan, to give pt to calm him down if the need arises and his RN stated they do...Per MD, a report has been made to [name], Ombudsman, due to possible lack of knowledge on the patient's care plan as well as staff seemed to be unsure who was in charge of the pt's care at the facility...." An emergency room physician note, dated 8/11/18, indicated, "Social worker recruited to facilitate evaluation of current status, living conditions, availability to provide care, and disposition planning. Final Impression: 1. Dementia." ER orders indicated: "Resume prior orders. Monday - schedule a team meeting with the following - Facility manager, Social Worker,		Social Services Director (SSD) will complete an audit of residents with identified behaviors to ensure plans of care and/r behavior management program based on current resident assessment remains appropriate and that medications are not utilized prior to assessing for the cause of the behaviors 5 times weekly X 2 weeks, 2 times weekly X 2 weeks and then weekly for 5 months. Identified non-compliance will result in 1:1 re-education with progressive discipline for continued non-compliance. Results of audits will be forwarded to the Quality Assurance Committee (QA) monthly X 6 months for further review and recommendations as deemed appropriate.	

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Family, Doctor, Nurse, to develop a comprehensive treatment plan."

Nursing Progress Notes continued:

8/11/18 at 11:27 P.M.: "Resident returned from the ER...awake and alert to place...He is calm now...."

8/13/18 at 1:31 P.M.: "Social Service...SW [social worker] notified that resident spouse was in the hospital and is not here daily. Resident has had a change in mood/behavior over weekend and has been agitated with staff and refusing meds. He was sent to [name of hospital] ER...Physician was contacted today and NP [nurse practitioner] reviewed meds, orders and gave an order for UA [urinalysis] and prn [as needed] Haldol, he also has routine Haldol ordered now. He has dx [diagnosis] of dementia with behaviors...."

A Physician's order, dated 8/13/18, indicated, "Haldol 0.5 mg. Give 1 tablet by mouth every 12 hours as needed for behavior." An additional order, indicated, "Haldol 0.5 mg. Give 1 tablet in the afternoon for behaviors."

The resident was transferred from the rehab unit to the skilled unit on 8/13/18.

Nursing Progress Notes continued:

8/16/18 at 2:37 A.M.: "Haloperidol [Haldol]...for behaviors."

8/24/18 at 9:45 A.M.: "Social Service Behavior: Resident has a behavior sheet for 8/23/18 indicating he was having repetitive verbalizations and hollering out at others. Resident asking for wife over and over. Intervention: Resident was approached in a calm manner, staff identified

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	themselves...Staff sat with resident 1:1 till calm. Outcome and Prevention: Resident had staff sitting with him 1:1 till he calmed." 8/25/18 at 2:21 A.M.: "Haloperidol...given for behaviors." 8/27/18 at 1:35 A.M.: "Haloperidol [given] for behaviors." 9/1/18 at 9:13 A.M.: "Haloperidol [given]...Resident restless, yelling in the main sitting area and dining room during breakfast. Resident looking for a way out of facility. Offered refreshments, toileting and activity - refused. Family aware of behaviors." 9/4/18 at 3:09 P.M.: "Social Service Behavior: Resident noted on 8/31/18, to be yelling at staff and accused staff of lying to him regarding a meal, he attempted to swing and grab at staff and twist nurse fingers. Intervention:...called family, family came into facility to sit with resident and he calmed." 9/6/18 at 12:50 P.M.: "Social Service. Resident noted to have UTI [urinary tract infection]...SW spoke with [name] from [geriatric psychiatric unit] as she stated he will need a few days of ATB [antibiotic] and SW to call her the first of next week for update...." 9/6/18 at 3:15 P.M.: "Resident agitated, talking very loud, has been hitting staff today, received x 1 order for Lorazepam [anti-anxiety medication] 2 mg IM." 9/10/18 at 2:39 P.M.: "Haldol solution, Inject 5 mg intramuscularly one time only for behaviors for 1 day Gave by day shift rn [sic]."			

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9/11/18 at 5:56 A.M.: "Haloperidol...Given for agitation/behaviors."

9/11/18 at 10:50 A.M.: "Social Service Behavior. Resident was noted on 9/10/18, to be yelling and wandering up and down the hall and stopping staff to ask questions, going in and out of staff offices and nurses station and grabbing at tables in dining room. Intervention: staff removed from situation, took him for a walk, did not argue. Outcome and Prevention: resident continued to become agitated with staff and received prn Haldol with no change in behaviors."

9/11/18 at 6:23 P.M.: "Haloperidol [given]...for behaviors."

The notes indicated the SW called different geriatric psychiatric units on 9/11, 9/12, and 9/13 regarding Resident C.

Nursing Progress Notes continued:

9/15/18 at 3:15 P.M.: "Gave Haldol 1 mg IM for behaviors."

9/15/18 at 11:04 P.M.: "Spoke w [with] [name of physician's nurse] discussed resident's behaviors, received order for haldol 0.5 mg BID [twice daily]."

9/16/18 at 3:32 P.M.: "Haloperidol [given]...for behavior."

9/17/18 at 4:49 A.M.: "Haloperidol [given]...anxious."

9/18/18 at 12:50 A.M.: "Haloperidol [given]... agiated [sic]."

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	9/18/18 at 6:34 P.M.: "Was agitated at start of shift. Had had prn haldol injection at 1400 [2:00 P.M.] per day nurse. Coaxed him to follow nurse down hall a bit from nurse station where would be a little quieter...He ate very poorly but was cooperative at that time...." 9/21/18 at 5:42 P.M.: "Haloperidol tablet [given]...Turned table over, resist [sic] to care." 9/21/18 at 7:00 A.M.: "Social Service Behavior...Behavior sheet for the resident for 9/18/18. Resident was noted to be crying and tearful, hitting others. Intervention: Staff established eye contact with resident, staff talked with the resident, resident was removed from the situation. Residents [sic] behavior was unchanged. Outcome and Prevention: Staff left resident alone and resident calm at times, he yells out at times." 9/21/18 at 5:16 P.M.: "Haldol tablet [given]...for behavior...." 9/23/18 at 5:23 A.M.: "Resident restless pulling at bedclothes unable to console. Ask if hurting 'Yes why the hell do you think I wouldn't be.' Norco administered." 9/23/18 at 3:50 P.M.: "Haloperidol tablet [given]...." 9/24/18 at 6:49 P.M.: "Spoke [with name of physician's nurse], resident escalating & refusing to take meds, advised son at bedside & trying to get resident to take meds, ok haldol 1 mg IM x 1 NOW, if resident does not take meds." 9/24/18 at 7:00 P.M.: "Haldol Solution...intramuscularly...d/t [due to] behaviors			

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escalating."

A "Behavior Management Team Review," dated 9/24/18, indicated: "Resident has a hx [history] of being up in his w/c [wheelchair] and wandering the halls, yelling, agitation, accuses of staff lying to him, delusions of being at war, became combative with staff during care. Number of occurrences in the past 30 days: Behavior sheets on 9/18/18, 9/10/18, 8/31/18. Medical Considerations of Behaviors: Dementia with behavior disturbance...Will review medications/prn...Team review on 9/24/18, resident has moved from rehab to long term placement as wife is not able to care for him, he likes going to small activities or being on one with activity staff, he has a hx of becoming agitated and yelling at staff as he has hx of delusions regarding felling like he is in past and military."

Nursing Progress Notes continued:

9/25/18 at 5:29 P.M.: "Haloperidol tablet [given]...."

9/25/18 at 5:45 P.M.: "Spoke [with name of physician's nurse] advised resident is beginning to escalate & have given haldol 1 mg po approx 15 min ago [with] no relief...OK to give another 1 mg Haldol IM."

A Care Plan, dated 7/24/18 and revised on 9/7/18, indicated, "I have behavioral symptoms such as being restless/resistive to care and I will yell at staff and become agitated towards staff r/t [related to] dementia with behaviors." The Interventions indicated: "Allow me to express my feelings. Explain to me that my behavior is not appropriate. If am choosing not to have care, come back at a later time and re-approach me. Medications as

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	ordered. When I become agitated allow me time to calm and reapproach at a later time. You will redirect my behavior when choosing not to have care." There were no new interventions dated after 8/13/18. An additional Care Plan, dated 9/7/18 and revised on 9/18/18, indicated, "I am risk for elopement as evidenced by delusions, wandering as I am looking for family. Dx of dementia. I talk about being in the military/war." The Interventions included: "Offer me preferred snacks/drinks and conversation. Provide me with one-to-one conversation and attention. You will offer me diversional activities when I am attempting to or voicing a desire to leave...." The resident's Medication Administration Record (MAR) for August and September 2018 indicated the following: 7/20/18- 8/13/18; 8/14/18- 8/28/18; 8/28-9/10; 9-10-9/15: Haloperidol .5 mg in the afternoon routinely for behaviors. On 9/6 Lorazepam 2 gm IM given x 1. On 9/16/18 Haldol increased to 0.5 mg two times a day. Haldol 0.5 mg tablet given as a prn on 8/11, 8/16, 8/25, 8/26, 9/1, 9/15 Haldol 0.5 mg IM given as a prn on 9/10, 9/19, 9/24, and 9/25. Haldol 1 mg by mouth given twice on 9/11.			

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	On 9/15/18, Haldol 1 mg every 12 hours as needed for behavior po or IM. IM x 3 days only. Given 9/16, 9/17, 9/18, twice on 9/21, 9/23, and 9/25. On 9/15/18-9/26/18, Risperdal .25 mg [an anti-psychotic medication], 1 tablet at bedtime for behaviors On 9/26/18 Risperdal increased to .25 mg two times a day. On 9/26/18 at 2:40 P.M., Social Service (SS) Staff 1 was interviewed. She indicated a meeting had been held on 9/25/18, and Resident C had been started on Behavior Management at that time. She indicated that meant his care plans were printed on paper and put at the Nurses Station for easier access for everyone. She indicated she had been trying to get him into a psychiatric unit. She indicated the NP had recently increased his medications, and started him on Risperdal at bedtime. SS 1 indicated the resident "was hard to reason with" when he was delusional. 2. On 9/25/18 at 11:45 A.M., LPN 1 indicated Resident H occasionally had behavior symptoms. She indicated the main behavior was tearfulness, but that her medications had been adjusted and she was much better. On 9/26/18 at 10:55 A.M., CNA 1 and LPN 1 were observed to provide care for Resident H. Resident H appeared very sleepy, and did not open her eyes while being turned and checked for incontinence. The clinical record of Resident H was reviewed on 9/26/18 at 3:20 P.M. Diagnoses included, but were not limited to, unspecified dementia.			

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	A quarterly MDS assessment, dated 8/31/18, indicated Resident H was severely cognitively impaired, and had exhibited no behavior symptoms in the previous 7 days. Nursing Progress Notes included the following notations: 9/11/18 at 2:05 P.M.: "Resident experiencing increased tearful episodes. NP in house this day and new orders received to obtain UA [urinalysis]." The next Progress Note, dated 9/13/18 at 3:04 P.M., indicated, "Received new orders for Depakote [a medication used to stabilize mood] 250 mg bid and ativan 0.25 mg [an anti-anxiety medication] q [every] 8 hrs prn [as needed] - family notified of new orders." A Social Service Note, dated 9/14/18 at 9:50 A.M., indicated, "...resident has been tearful at times and easily reassured with staff redirection/verbal assurance, resident has a hx of agitation with caregivers during care and has been noted to be more restless, she was noted to have GDR [gradual dose reductions] within the past year, labs were completed, physician notified of above behaviors and received new orders for Depakote as resident has been on this med in past, Ativan prn was ordered. Will cont. to observe." A "Behavior Sheet, dated 9/15/18 at 1:15 A.M., indicated: "Behavior Symptoms: Wandering (without purpose), Yelling/screaming, Interventions: Removed from situation, Behavior unchanged, Offer fluids...Offered a snack, Behavior unchanged...Resident refused to be changed for incontinence, yelling and screaming. Reapproach x 3 so far with same results.			

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	Wandering down halls and trying to go into other resident's [sic] rooms and screams when taken out...Very agitated." A "Behavior Sheet," dated 9/18/18 at 7:07 P.M., indicated: "Behavior Symptoms: Wandering (without purpose), Resistant to care, Yelling/screaming, Interventions: Approached in a calm manner, Behavior worsened, Identified self, Behavior unchanged, Removed from situation, Behavior worsened, Called resident by name...Used simple sentences...Tasks broken into small steps...Don't argue or confront...Talk with resident...Wandering up and down halls, into other resident's [sic] rooms, will not allow staff to move wheelchair, begins screaming when staff attempts to move resident...Refuses to allow staff to provide care, refusing all food/fluids offered. Refuses to allow staff to toilet or provide incontinence care." Progress Notes continued: 9/18/18 at 7:12 P.M.: "[Name of physician's] on call notified for need to return call re: resident's behavior...Resident is red in face but is not cognitively able to report pain or other problems...." 9/18/18 at 3:26 P.M.: "Social Service...Discussed resident behavior/intervention and past medication...nursing reported mood/behaviors today and he ordered Depakote level and new order for Risperdal. Will continue to observed mood/behaviors." A Care Plan, initially dated 7/19/17 and revised 9/17/18, indicated, "I have behavioral symptoms such as hallucinating and hx of seeing dead people. I have a hx of becoming physically			

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	aggressive with the staff and will refuse to eat, I will propel self around the hall and need redirection by staff." The Interventions included: "Allow me to express my feelings. If I am choosing not to have care, come back at a later time and re-approach me. When my behavior disrupts a social setting, remove if unable to redirect me. None of the Interventions were dated after 7/19/18. On 9/26/18 at 5:00 P.M., during an interview with the Administrator, Director of Nursing (DON), and SS 1, the Administrator and SS 1 indicated the resident had a dose reduction of her medications, and they needed to be restarted recently. SS 1 indicated the dose reduction was in November 2017, and she acknowledged the resident had done fairly well since then. The Administrator, DON, and SS 1 did not know why the resident was started on 3 psychotropic medications in the span of 1 week. 3. On 9/25/18 at 12:00 P.M., during an interview with LPN 3 and LPN 4, each indicated that Resident G exhibited behaviors at times. LPN 4 indicated, "She can pinch and hit." Resident G was observed at that time sitting in a wheelchair at the nurses station. The clinical record of Resident G was reviewed on 9/26/18 at 2:30 P.M. Diagnoses included, but were not limited to, fractured left femur and Alzheimer's disease. The resident was admitted on 8/23/18. An admission MDS assessment, dated 8/30/18, indicated Resident G had severely impaired cognition, and did not exhibit behavior symptoms in the previous 7 days.			

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Daily skilled charting documentation, dated 8/30/18-9/4/18, indicated no behaviors were observed.

Nursing Progress Notes included the following notations:

9/4/18 at 12:43 P.M.: "...resident continually scratching self...Asked resident if she was itching and resident stated yes. MD notified...."

9/4/18 at 11:56 A.M.: "New orders to hold Xanax [an anti-anxiety medication] at this time...."

A Physician's order, dated 9/4/18, indicated, "Risperdal 0.25 mg at bedtime for dementia with behaviors."

A Social Service note, dated 9/5/18 at 10:24 A.M., indicated, "Resident noted on 9/4/18, to be restless and trying to climb out of bed and itching her skin and attempting to take off her clothes. Intervention: skin assessment done and doctor office notified...Outcome and Prevention: resident sits with nurses and calm."

Progress Notes continued:

9/18/18 at 3:13 P.M.: "New orders received from MD...to restart Xanax."

A Care Plan, dated 8/24/18, indicated, "I have Depression as r/t [related to] change in living environment and decline in health." The Interventions included: "Allow me to express my feelings. I will receive my medications as ordered."

An additional Care Plan, dated 9/5/18 and revised 9/18/18, indicated, "I have behavioral symptoms

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	such as being restless in bed and being agitated and resistive to caregivers during care, I have hx of Anxiety disorder, hx of Alzheimer's disease." The Interventions included: "Allow me to express my feelings. Medications as ordered. Reassure/comfort me when I need it to calm me down." On 9/26/18 at 5:00 P.M., during an interview with the Administrator, DON, and SS 1, the Administrator indicated he thinks the facility has attempted many interventions with Resident G that may have not been documented. On 9/26/18 at 4:35 P.M., the Director of Nursing provided the current facility policy, "Behavior Management and Psychoactive Medication Monitoring," revised 4/17. The policy included: "Policy: To ensure the resident receives treatment and intervention for behavior and mood symptoms...Procedure:...The nurse or social service [sic] will complete the Behavior Sheet upon being notified of or witnessing a behavior...Social Services will follow-up documentation of behaviors under progress notes. 5. Residents that are on Behavior Management Programs will have documentation of behavior symptoms completed every shift by the nursing staff...This will allow for accurate documentation and assessment of the resident's behaviors, and therefore appropriate follow-up by the Interdisciplinary team...A care plan will be initiated within 72 hours from the time the behavior occurs...." This Federal tag relates to Complaint IN00270980. 3.1-37(a)			

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F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be			

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	extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on interview, observation, and record review, the facility failed to ensure psychotropic medications were not used prior to implementing other interventions, and failed to monitor for side effects of the psychotropic medications, for 3 of 3 residents reviewed who received psychotropic medications, in a sample of 9. (Residents C, G, and H) Findings include: 1. On 9/25/18 at 11:50 A.M., during an interview with LPN 2, she indicated Resident C exhibited behaviors at times. She indicated the resident could be very calm, and then become very agitated, mainly in the evenings. The clinical record of Resident C was reviewed on 9/26/18 at 10:20 A.M. The resident was admitted to the facility on 7/19/18. Diagnoses included, but were not limited to, fracture left femur and unspecified dementia with behavior disturbance. A quarterly Minimum Data Set (MDS) assessment, dated 8/12/18, indicated Resident C had a severe cognitive impairment, and did not exhibit any behavior symptoms in the previous 7 days. Nursing Progress Notes included the following	F 0758	This Plan of Correction is the centers credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute 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 an/or executed solely because it is required by the provisions of federal and state law. Resident C's behavior plan of care and behavior monitoring program has been reviewed and updated to reflect individualized non-pharmacological interventions. Resident is being monitored for side effects as deemed appropriate. Resident H's behavior plan of care and behavior monitoring program has been reviewed and updated to reflect individualized non-pharmacological interventions. Resident is being monitored for side effects as deemed appropriate. Resident G no longer resides in the facility.	10/18/2018

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	notations: 8/11/18 at 5:03 A.M.: "Resident is very restless this morning and complains of hip hurting him. Given a Norco [pain medication] and then we tried to change him because he was wet and he became very combative, balling up fist and threatening to hit us." 8/11/18 at 5:36 A.M.: "Resident is still very combative and will not allow us to change him - his brief is very wet and his sheets are wet. He is not really consoled by his wife either. Resident left alone for a while [sic] to see if he will calm down a bit." 8/11/18 at 5:57 P.M.: "Gave resident Haldol 0.5 mg [an antipsychotic medication]...for behaviors, resident spit out med." A transfer form, dated 8/11/18 at 6:00 P.M., indicated, "Sent to: [Name of hospital]...Reason(s) for: Altered Mental Status." A Physician Communication form which accompanied the transfer form, undated, indicated: "The change in condition, symptoms, or signs observed and evaluated is/are: Altered mental status (e.g. agitation, psychosis). This started on: 8/11/18. Since this started it has gotten: [Left blank]. Things that make the condition or symptom worse are: [Left blank]. Things that make the condition or symptom better are: [Left blank]. This condition, symptom, or sign has occurred before: [Left blank]. Treatment for last episode: [Left blank]...Other pertinent history: Dementia...New or worsened delusions or hallucinations...Verbal aggression, Physical aggression...Appearance: [Left blank], Review and Notify: [Name of physician], 8/11/18, 12:00 AM.		A one time 100% review of current in-house residents has been completed to identify residents receiving psychoactive medications to ensure appropriate assessment, interventions and monitoring of side effects are in the plan of care and medication administration record (MAR) per policy. Re-education has been completed with social services staff and licensed nurses on facility policy for psychoactive medication and gradual dose reduction. Re-education included but was not limited to ensuring that non-pharmacological interventions per the resident's individualized plan of care or behavior management plan are utilized prior to administration of PRN psychoactive medications as well as ensuring that side effect monitoring is in place on the MAR. The IDT will review orders daily Monday through Friday to identify any new psychoactive medications and to ensure appropriate individualized plans of care with non-pharmacolgoical interventions and side effect monitoring are in place. The MAR will be reviewed to ensure side effect monitoring is in place per facility policy.	

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	Recommendations of Primary Clinicians: ER...." A hospital note, dated 8/11/18 at 7:55 P.M., included: "BSW [social worker] contacted facility...She stated she would have the on call RN call. Awaiting call. Notified...that she had received a call back from [name of facility]. The pt's [patient's] RN...said pt became aggressive after his wife has been admitted to the hospital. He was reportedly hitting staff. Per pt's RN, they tried giving Haldol po [by mouth] but pt would spit out the medication. They did not have Haldol IM [intramuscularly] to give to pt...also questioned if they had anything else, such as Ativan, to give pt to calm him down if the need arises and his RN stated they do...Per MD, a report has been made to [name], Ombudsman, due to possible lack of knowledge on the patient's care plan as well as staff seemed to be unsure who was in charge of the pt's care at the facility...." An emergency room physician note, dated 8/11/18, indicated, "Social worker recruited to facilitate evaluation of current status, living conditions, availability to provide care, and disposition planning. Final Impression: 1. Dementia." ER orders indicated: "Resume prior orders. Monday - schedule a team meeting with the following - Facility manager, Social Worker, Family, Doctor, Nurse, to develop a comprehensive treatment plan." Nursing Progress Notes continued: 8/11/18 at 11:27 P.M.: "Resident returned from the ER...awake and alert to place...He is calm now...." 8/13/18 at 1:31 P.M.: "Social Service...SW [social worker] notified that resident spouse was in the hospital and is not here daily. Resident has had a		The DON/designee will complete an audit of any new psychoactive medications and to ensure appropriate individualized plans of care with non-pharmacological interventions and side effect monitoring are in lace as well as reviewing the MAR to ensure side effect monitoring is in place per facility policy 5 times weekly X 2 weeks 2 times weekly X 2 weeks and then weekly X 5 months. Identified non-compliance will result in 1:1 re-education with progressive discipline for continued non-compliance. Results of audits will be forwarded to the Quality Assurance Committee (QA) monthly X 6 months for further review and recommendations as deemed appropriate.	

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	change in mood/behavior over weekend and has been agitated with staff and refusing meds. He was sent to [name of hospital] ER...Physician was contacted today and NP [nurse practitioner] reviewed meds, orders and gave an order for UA [urinalysis] and prn [as needed] Haldol, he also has routine Haldol ordered now. He has dx [diagnosis] of dementia with behaviors...." A Physician's order, dated 8/13/18, indicated, "Haldol 0.5 mg. Give 1 tablet by mouth every 12 hours as needed for behavior." An additional order, indicated, "Haldol 0.5 mg. Give 1 tablet in the afternoon for behaviors." Nursing Progress Notes continued: 8/16/18 at 2:37 A.M.: "Haloperidol [Haldol]...for behaviors." 8/24/18 at 9:45 A.M.: "Social Service Behavior: Resident has a behavior sheet for 8/23/18 indicating he was having repetitive verbalizations and hollering out at others. Resident asking for wife over and over. Intervention: Resident was approached in a calm manner, staff identified themselves...Staff sat with resident 1:1 till calm. Outcome and Prevention: Resident had staff sitting with him 1:1 till he calmed." 8/25/18 at 2:21 A.M.: "Haloperidol...given for behaviors." 8/27/18 at 1:35 A.M.: "Haloperidol [given] for behaviors." 9/1/18 at 9:13 A.M.: "Haloperidol [given]...Resident restless, yelling in the main sitting area and dining room during breakfast. Resident looking for a way out of facility. Offered			

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	refreshments, toileting and activity - refused. Family aware of behaviors." 9/4/18 at 3:09 P.M.: "Social Service Behavior: Resident noted on 8/31/18, to be yelling at staff and accused staff of lying to him regarding a meal, he attempted to swing and grab at staff and twist nurse fingers. Intervention:...called family, family came into facility to sit with resident and he calmed." 9/6/18 at 12:50 P.M.: "Social Service. Resident noted to have UTI [urinary tract infection]...SW spoke with [name] from [geriatric psychiatric unit] as she stated he will need a few days of ATB [antibiotic] and SW to call her the first of next week for update...." 9/6/18 at 3:15 P.M.: "Resident agitated, talking very loud, has been hitting staff today, received x 1 order for Lorazepam [anti-anxiety medication] 2 mg IM." 9/10/18 at 2:39 P.M.: "Haldol solution, Inject 5 mg intramuscularly one time only for behaviors for 1 day Gave by day shift rn [sic]." 9/11/18 at 5:56 A.M.: "Haloperidol...Given for agitation/behaviors." 9/11/18 at 10:50 A.M.: "Social Service Behavior. Resident was noted on 9/10/18, to be yelling and wandering up and down the hall and stopping staff to ask questions, going in and out of staff offices and nurses station and grabbing at tables in dining room. Intervention: staff removed from situation, took him for a walk, did not argue. Outcome and Prevention: resident continued to become agitated with staff and received prn Haldol with no change in behaviors."			

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9/11/18 at 6:23 P.M.: "Haloperidol [given]...for behaviors."

The notes indicated the SW called different geriatric psychiatric units on 9/11, 9/12, and 9/13 regarding Resident C.

Nursing Progress Notes continued:

9/15/18 at 3:15 P.M.: "Gave Haldol 1 mg IM for behaviors."

9/15/18 at 11:04 P.M.: "Spoke w [with] [name of physician's nurse] discussed resident's behaviors, received order for haldol 0.5 mg BID [twice daily]."

9/16/18 at 3:32 P.M.: "Haloperidol [given]...for behavior."

9/17/18 at 4:49 A.M.: "Haloperidol [given]...anxious."

9/18/18 at 12:50 A.M.: "Haloperidol [given]... agiated [sic]."

9/18/18 at 6:34 P.M.: "Was agitated at start of shift. Had had prn haldol injection at 1400 [2:00 P.M.] per day nurse. Coaxed him to follow nurse down hall a bit from nurse station where would be a little quieter...He ate very poorly but was cooperative at that time...."

9/21/18 at 5:42 P.M.: "Haloperidol tablet [given]...Turned table over, resist [sic] to care."

9/21/18 at 7:00 A.M.: "Social Service Behavior...Behavior sheet for the resident for 9/18/18. Resident was noted to be crying and tearful, hitting others. Intervention: Staff

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	established eye contact with resident, staff talked with the resident, resident was removed from the situation. Residents [sic] behavior was unchanged. Outcome and Prevention: Staff left resident alone and resident calm at times, he yells out at times." 9/21/18 at 5:16 P.M.: "Haldol tablet [given]...for behavior...." 9/23/18 at 5:23 A.M.: "Resident restless pulling at bedclothes unable to console. Ask if hurting 'Yes why the hell do you think I wouldn't be.' Norco administered." 9/23/18 at 3:50 P.M.: "Haloperidol tablet [given]...." 9/24/18 at 6:49 P.M.: "Spoke [with name of physician's nurse], resident escalating & refusing to take meds, advised son at bedside & trying to get resident to take meds, ok haldol 1 mg IM x 1 NOW, if resident does not take meds." 9/24/18 at 7:00 P.M.: "Haldol Solution...intramuscularly...d/t [due to] behaviors escalating." A "Behavior Management Team Review," dated 9/24/18, indicated: "Resident has a hx [history] of being up in his w/c [wheelchair] and wandering the halls, yelling, agitation, accuses of staff lying to him, delusions of being at war, became combative with staff during care. Number of occurrences in the past 30 days: Behavior sheets on 9/18/18, 9/10/18, 8/31/18. Medical Considerations of Behaviors: Dementia with behavior disturbance...Will review medications/prn...Team review on 9/24/18, resident has moved from rehab to long term			

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	placement as wife is not able to care for him, he likes going to small activities or being on one with activity staff, he has a hx of becoming agitated and yelling at staff as he has hx of delusions regarding felling like he is in past and military." Nursing Progress Notes continued: 9/25/18 at 5:29 P.M.: "Haloperidol tablet [given]...." 9/25/18 at 5:45 P.M.: "Spoke [with name of physician's nurse] advised resident is beginning to escalate & have given haldol 1 mg po approx 15 min ago [with] no relief...OK to give another 1 mg Haldol IM." A Care Plan, dated 7/24/18 and revised on 9/7/18, indicated, "I have behavioral symptoms such as being restless/resistive to care and I will yell at staff and become agitated towards staff r/t [related to] dementia with behaviors." The Interventions indicated: "Allow me to express my feelings. Explain to me that my behavior is not appropriate. If am choosing not to have care, come back at a later time and re-approach me. Medications as ordered. I will report and you will report side effects such as rigidity, persistent muscle spasms, restlessness, drowsiness, tremors, rapid heart beat and dizziness. When I become agitated allow me time to calm and reapproach at a later time. You will redirect my behavior when choosing not to have care." There were no new interventions dated after 8/13/18. An additional Care Plan, dated 9/7/18 and revised on 9/18/18, indicated, "I am risk for elopement as evidenced by delusions, wandering as I am			

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	155803	A. BUILDING 00 B. WING	09/26/2018

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	looking for family. Dx of dementia. I talk about being in the military/war." The Interventions included: "Offer me preferred snacks/drinks and conversation. Provide me with one-to-one conversation and attention. You will offer me diversional activities when I am attempting to or voicing a desire to leave...." The resident's Medication Administration Record (MAR) for August and September 2018 indicated the following: 7/20/18- 8/13/18; 8/14/18- 8/28/18; 8/28-9/10; 9-10-9/15: Haloperidol .5 mg in the afternoon routinely for behaviors. 9/6 Lorazepam 2 gm IM given x 1. 9/16/18 Haldol increased to 0.5 mg two times a day. Haldol 0.5 mg tablet given as a prn on 8/11, 8/16, 8/25, 8/26, 9/1, 9/15 Haldol 0.5 mg IM given as a prn on 9/10, 9/19, 9/24, and 9/25. Haldol 1 mg by mouth given twice on 9/11. 9/15/18, Haldol 1 mg every 12 hours as needed for behavior po or IM. IM x 3 days only. Given 9/16, 9/17, 9/18, twice on 9/21, 9/23, and 9/25. 9/15/18-9/26/18, Risperdal .25 mg [an anti-psychotic medication], 1 tablet at bedtime for behaviors 9/26/18 Risperdal increased to .25 mg two times a day.			

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	On 9/26/18 at 2:40 P.M., Social Service (SS) Staff 1 was interviewed. She indicated a meeting had been held on 9/25/18, and Resident C had been started on Behavior Management at that time. She indicated that meant his care plans were printed on paper and put at the Nurses Station for easier access for everyone. She indicated she had been trying to get him into a psychiatric unit. She indicated the NP had recently increased his medications, and started him on Risperdal at bedtime. SS 1 indicated the resident "was hard to reason with" when he was delusional. On 9/26/18 at 5:00 P.M., the Director of Nursing indicated a notation to monitor for side effects of the psychotropic medications would typically be on the MAR. She indicated she did not find that it had been documented on Resident C's MAR. 2. On 9/25/18 at 11:45 A.M., LPN 1 indicated Resident H occasionally had behavior symptoms. She indicated the main behavior was tearfulness, but that her medications had been adjusted and she was much better. On 9/26/18 at 10:55 A.M., CNA 1 and LPN 1 were observed to provide care for Resident H. Resident H appeared very sleepy, and did not open her eyes while being turned and checked for incontinence. The clinical record of Resident H was reviewed on 9/26/18 at 3:20 P.M. Diagnoses included, but were not limited to, unspecified dementia. A quarterly MDS assessment, dated 8/31/18, indicated Resident H was severely cognitively impaired, and had exhibited no behavior symptoms in the previous 7 days.			

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	Nursing Progress Notes included the following notations: 9/11/18 at 2:05 P.M.: "Resident experiencing increased tearful episodes. NP in house this day and new orders received to obtain UA [urinalysis]." The next Progress Note, dated 9/13/18 at 3:04 P.M., indicated, "Received new orders for Depakote [a medication used to stabilize mood] 250 mg bid and ativan 0.25 mg [an anti-anxiety medication] q [every] 8 hrs prn [as needed] - family notified of new orders." A Social Service Note, dated 9/14/18 at 9:50 A.M., indicated, "...resident has been tearful at times and easily reassured with staff redirection/verbal assurance, resident has a hx of agitation with caregivers during care and has been noted to be more restless, she was noted to have GDR [gradual dose reductions] within the past year, labs were completed, physician notified of above behaviors and received new orders for Depakote as resident has been on this med in past, Ativan prn was ordered. Will cont. to observe." A "Behavior Sheet, dated 9/15/18 at 1:15 A.M., indicated: "Behavior Symptoms: Wandering (without purpose), Yelling/screaming, Interventions: Removed from situation, Behavior unchanged, Offer fluids...Offered a snack, Behavior unchanged...Resident refused to be changed for incontinence, yelling and screaming. Reapproach x 3 so far with same results. Wandering down halls and trying to go into other resident's [sic] rooms and screams when taken out...Very agitated." A "Behavior Sheet," dated 9/18/18 at 7:07 P.M.,			

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	indicated: "Behavior Symptoms: Wandering (without purpose), Resistant to care, Yelling/screaming, Interventions: Approached in a calm manner, Behavior worsened, Identified self, Behavior unchanged, Removed from situation, Behavior worsened, Called resident by name...Used simple sentences...Tasks broken into small steps...Don't argue or confront...Talk with resident...Wandering up and down halls, into other resident's [sic] rooms, will not allow staff to move wheelchair, begins screaming when staff attempts to move resident...Refuses to allow staff to provide care, refusing all food/fluids offered. Refuses to allow staff to toilet or provide incontinence care." Progress Notes continued: 9/18/18 at 7:12 P.M.: "[Name of physician's] on call notified for need to return call re: resident's behavior...Resident is red in face but is not cognitively able to report pain or other problems...." 9/18/18 at 3:26 P.M.: "Social Service...Discussed resident behavior/intervention and past medication...nursing reported mood/behaviors today and he ordered Depakote level and new order for Risperdal. Will continue to observed mood/behaviors." A Care Plan, initially dated 7/19/17 and revised 9/17/18, indicated, "I have behavioral symptoms such as hallucinating and hx of seeing dead people. I have a hx of becoming physically aggressive with the staff and will refuse to eat, I will propel self around the hall and need redirection by staff." The Interventions included: "Allow me to express my feelings. If I am choosing not to have care, come back at a later			

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	time and re-approach me. When my behavior disrupts a social setting, remove if unable to redirect me." None of the Interventions were dated after 7/19/18. An additional Care Plan, dated 7/19/17 and revised 8/20/18, indicated, "I have potential for anxious verbalizations/expressions as r/t Change in environment...I have a dx of dementia." The Interventions included: "I will report and you will observe for signs and symptoms such as N/V [nausea/vomiting], dry mouth, weight gain/loss...." On 9/26/18 at 5:00 P.M., during an interview with the Administrator, Director of Nursing (DON), and SS 1, the Administrator and SS 1 indicated the resident had a dose reduction of her medications, and they needed to be restarted recently. SS 1 indicated the dose reduction was in November 2017, and she acknowledged the resident had done fairly well since then. The Administrator, DON, and SS 1 did not know why the resident was started on 3 psychotropic medications in the span of 1 week. 3. On 9/25/18 at 12:00 P.M., during an interview with LPN 3 and LPN 4, each indicated that Resident G exhibited behaviors at times. LPN 4 indicated, "She can pinch and hit." Resident G was observed at that time sitting in a wheelchair at the nurses station. The clinical record of Resident G was reviewed on 9/26/18 at 2:30 P.M. Diagnoses included, but were not limited to, fractured left femur and Alzheimer's disease. The resident was admitted on 8/23/18.			

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	An admission MDS assessment, dated 8/30/18, indicated Resident G had severely impaired cognition, and did not exhibit behavior symptoms in the previous 7 days. Nursing Progress Notes included the following notations: 9/4/18 at 12:43 P.M.: "...resident continually scratching self...Asked resident if she was itching and resident stated yes. MD notified...." 9/4/18 at 11:56 A.M.: "New orders to hold Xanax [an anti-anxiety medication] at this time...." A Physician's order, dated 9/4/18, indicated, "Risperdal 0.25 mg at bedtime for dementia with behaviors." A Social Service note, dated 9/5/18 at 10:24 A.M., indicated, "Resident noted on 9/4/18, to be restless and trying to climb out of bed and itching her skin and attempting to take off her clothes. Intervention: skin assessment done and doctor office notified...Outcome and Prevention: resident sits with nurses and calm." Progress Notes continued: 9/18/18 at 3:13 P.M.: "New orders received from MD...to restart Xanax." A Care Plan, dated 8/24/18, indicated, "I have Depression as r/t [related to] change in living environment and decline in health." The Interventions included: "Allow me to express my feelings. I will receive my medications as ordered." An additional Care Plan, dated 9/5/18 and revised 9/18/18, indicated, "I have behavioral symptoms			

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	such as being restless in bed and being agitated and resistive to caregivers during care, I have hx of Anxiety disorder, hx of Alzheimer's disease." The Interventions included: "Allow me to express my feelings. Medications as ordered. Reassure/comfort me when I need it to calm me down. I will report and you will report side effects such as rigidity, persistent muscle spasms, restlessness, drowsiness, tremors, rapid heart beat and dizziness." On 9/26/18 at 5:00 P.M., during an interview with the Administrator, DON, and SS 1, the Administrator indicated he thinks the facility had attempted many interventions with Resident G that may have not been documented. On 9/26/18 at 4:35 P.M., the DON provided the current facility policy, "Psychoactive Medications/Gradual Dose Reduction Policy," revised 4/17. The policy included: "It is the policy of this facility that a resident will receive psychoactive medications only when it is necessary to improve the resident's overall psychosocial health...Residents receiving psychoactive medications will have a care plan initiated that contains interventions regarding the target behaviors and possible adverse side effects of the medication(s). Nursing will observe for adverse side effects...every shift and document on the electronic MAR...Prior to the administration of a prn psychoactive medication, the nurse will attempt non-pharmacological interventions document the interventions attempted and outcomes of the interventions...." This Federal tag relates to Complaint IN00270980. 3.1-48(a)(3) 3.1-48(a)(4)			

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	3.1-48(b)(2)			