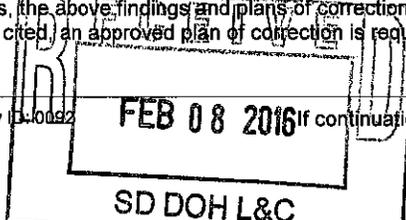


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F 000	<p><i>*Addendums noted with an asterisk per 2/10/16 per email with Surveyor: 32572 facility chief financial officer.</i></p> <p>A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 1/11/16 through 1/12/16. Areas surveyed included quality of care and staffing. Kadoka Nursing Home was found not in compliance with the following requirements: F224, F250, F280, and F514.</p>	F 000	F224 Prohibit mistreatment/neglect/misappropriation of resident property.  The DON and ADON will revise the Abuse and neglect policies currently used and make sure that all policies and procedures about mistreatment, neglect, and abuse of residents and misappropriation of resident property are covered.	3/2/16	
F 224 SS=D	<p><b>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN</b></p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on record review, interview, job description review, and policy review, the provider failed to identify and ensure one of five sampled residents (1) had appropriate preventative measures and interventions in place to protect him and others from abuse. Findings include:</p> <p>1. Review of resident 1's medical record revealed: *He had been admitted on 7/16/08. *A diagnoses of multiple myeloma (skin cancer) and depression. *Chemotherapy (cancer treatment) started on 12/16/15.</p>	F 224	<p>The DON and MDS will review and rewrite the monthly summary to ensure that MDS has the information needed for the MDS assessment period and retrain staff about the importance of using the tool correctly and accurately.</p> <p>ADON/SSD will work with <i>*LAIS DOH L&amp;C</i> our social work consultant to implement a behavior modification plan for resident 1 and all residents with mood and behaviors. DON will monitor behaviors for 4 weeks until 100% compliant and report to QI quarterly at QI meetings.</p> <p>The careplan interdisciplinary team consisting of COO, DON, ADON, MDS, CDM, Activities director, and RT staff will continue to seek a personalized activity specified for resident 1 and continue to care plans current and new activities for all residents. Care plan will be updated and specific to resident 1 and all residents. DON will monitor care plans quarterly until 100% compliant and report to QI quarterly at QI meetings.</p> <p>Medication was reassessed by MD for resident 1 and Zolofit was discontinued and Celexa 20 mg once daily was started on 1/14/16. Resident has</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: **ADMINISTRATOR** (X6) DATE: **2/7/16**

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



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F 224	Continued From page 1 *No mention of verbally abusive behaviors on the licensed nurses Monthly Summary notes for March, April, May, June, September, October, November, and December 2015. *Documentation on the Monthly Summary notes for July and August 2015 stated he had been verbally abusive to other residents. *In September, October, and November 2015 he had been resistive to care by refusing his bath. *Contract social worker notations in the Social Progress Notes for 2015 revealed only one notation of behaviors. On 11/12/15 she stated the resident became irritated with confused people in the dining room and made negative comments. Those same notes had not mentioned behavior management for the resident. *Social Progress Notes for 2015 revealed only one notation of behaviors. On 11/25/15 the social service designee documented the resident had a history of yelling at dietary staff and other residents while in the dining room. There had not been reference to behavior management for the resident. *Certified nurse aide notes stated: -On 7/17 (no year documented) "Resident poured water on other resident for opening his door. Nurse notified." -On 3/5 (no year documented) "Resident must have been angry when other resident was by door way. Unknown to him pushing other resident threw a pillow at the resident on the floor aid." -On 3/24 (no year documented) "Resident being rude to other residents that came in the dining room also to his table of friends. They just stood up & left unknown if they ate any of theyre [their] food." -On 8/18 (no year documented) "Resident was very rude to dietary [dietary] aide. Nurse was notified and resident was still very rude to nurse	F 224	excessive wax buildup and MD ordered Peroxide in each ear canal every other week. The ADON contacted Hearing aid specialist at Audibel Hearing Aid Center to reassess resident 1, test hearing, evaluate current hearing aids, and make changes as needed.  The ADON has attempted numerous times to locate and arrange for psychologist or psychiatrist services to come to the facility. She has been communicating with Deer Oaks behavioral health organization in San Antonio TX. Deer Oaks is currently looking for a provider to come to our facility. The ADON has also contacted Capital Area Counseling in Pierre and Behavioral Management Services in Rapid City. We will continue to pursue of psychologist or psychiatrist services to provide our residents in our facility. We have a meeting with Capital Area Counseling on Wednesday, February 3, 2016 to see if they can see the residents.  An In-service meeting will be held on February 4 at 1:30pm by State Ombudsman [REDACTED] concerning Abuse and Neglect, Resident Rights, and Confidentiality of Resident Rights. The ADON, DON, COO, CDM, RT and Activity Director met with [REDACTED] on 1/31/2016 to discuss resident rights, abuse and neglect when a *social services consultant LAISSDOHTEL		

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F 224	<p>Continued From page 2 and dietary [dietary] aide." *ADL Flow Sheet (activities of daily living) for October, November, and December 2015 revealed no behaviors had been documented. *Behaviors had not been identified as a problem on his care plan. *No behavior modification plan had been identified. *No personalized activity plan had been identified. *He had been taking the same dosage of Zoloft (antidepressant) for several years. *There had not been a referral made to a psychologist or psychiatrist.</p> <p>Interview on 1/12/16 at 10:20 a.m. with the certified dietary manager regarding resident 1 revealed he: *Came and went as he wanted from the dining room. *Sat at many different tables in the dining room. He had been moved, because he did not like who he was sitting with or where he was sitting. *Was short tempered. *Yelled and cursed at other residents in the dining room. *Yelled and cursed at dietary and other staff in the dining room. *Had always yelled and cursed at other residents and staff since he had been admitted. *Had shoved his table before.</p> <p>Interview on 1/12/16 at 1:45 p.m. with the chief operation officer revealed she had been aware resident 1 had behaviors of yelling and pushing his table. Those behaviors had been occurring since admission 7/16/08. There had not been a specific behavior management plan in place for him.</p>	F 224	<p>resident behaviors impede on other resident rights, and video taped meeting to play at in-service on February 4. <i>LA/SDDOTT/EL</i></p> <p><i>on behaviors, abuse and neglect.</i></p> <p>Documentation will be reviewed by DON and reteach the importance of accurate documentation to include behavioral issues. A behavior monitoring tool has been introduced to the ADL charting to ensure more accurate documentation. <i>*all</i></p> <p>documentation, QI for behavioral tool by DON <i>LA/SDDOTT/EL</i> will include review of tool weekly for 4 weeks, <i>LA/SDDOTT/EL</i> then once a month until 100% compliance. <i>*and reported to CI</i></p> <p><i>*by CNA's and nursing staff</i></p> <p><i>*Behavior monitoring tool was explained to all CNA's and nursing staff and other departments at the in-service on 2/4/16 by DON.</i></p> <p><i>LA/SDDOTT/EL</i></p>	

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

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FORM APPROVED  
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F 224	<p>Continued From page 3</p> <p>Interview on 1/12/16 at 2:10 p.m. with the social service designee revealed she:</p> <ul style="list-style-type: none"> <li>*Had worked with resident 1 on some of his personal goals.</li> <li>*Had been aware he had behaviors of yelling, cursing, and pushing tables in the dining room. Those behaviors had been present from the time of admission.</li> <li>*Had tried amplifiers for his hearing loss, and he had been seen by the consultant social worker</li> <li>*Did not know what else to do for him.</li> <li>*Agreed there had not been a specific behavior management plan for him.</li> </ul> <p>Interview on 1/12/16 at 2:45 p.m. with the director of nurses revealed she had been aware resident 1 had behaviors. She stated, "I can guarantee it." Had been aware he did not have a behavior management plan. She stated they had tried amplifiers for his hearing loss, and he had been seen by the consultant social worker.</p> <p>Review of the provider's undated SOCIAL SERVICE DESIGNEE policy revealed she was to:</p> <ul style="list-style-type: none"> <li>*Meet the medically related social and emotional needs of the residents.</li> <li>**Assess resident needs, problems, concerns, and strengths and complete care plan documentation as assigned."</li> <li>***Refer more difficult resident problems, needs, concerns to the social service consultant and administrator."</li> </ul> <p>Review of the provider's undated Specific Resident Rights policy revealed residents had the right to receive services with reasonable accommodation by the facility of individual needs and preferences. "The RAI [resident assessment instrument] process with the cooperation of all</p>	F 224			

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F 224	Continued From page 4 staff will be the responsibility of the professional staff for the assessment, care planning, and monitoring of resident with needs and behaviors which lead to conflict or neglect."	F 224	F250 Provision of medically related social service		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE  The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on record review, interview, and policy review, the provider failed to ensure one of five sampled residents (1) who exhibited disruptive behaviors with staff and residents had a behavior management plan. Findings include:  1. Review of resident 1's medical record revealed: *No behavior management plan. *His care plan was not current and accurate. *Incomplete behavior documentation.  Refer to F224. Refer to F280, finding 1. Refer to F514, finding 1.	F 250	The ADON/SSD and Ardith Sand SW consult will create a behavior management plan specific to resident 1.  * nurse LA/SDDO/H/EL The MDS will review and rewrite resident 1 care plan to be more accurate and complete. The DON will QI care plan for resident 1 and all residents on a quarterly basis until 100% compliant. *and report to quarterly QI LA/SDDO/H/EL  An In-service meeting to be held on February 4, 2016 at 1:30pm will include education for staff on charting ADL's and behavior charting.  *All resident care plans will be reviewed and put into the electronic documentation system by 3/2/16 and all issues of behaviors will be addressed. LA/SDDO/H/EL	3/2/16	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to	F 280			

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F 280	<p>Continued From page 5</p> <p>participate in planning care and treatment or changes in care and treatment.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on record review and interview, the provider failed to ensure care plans were current, updated, and personalized, for three of five sampled residents (1, 4, and 5). Findings include:</p> <p>1. Review of resident 1's care plan revealed: *It had been last updated on 8/27/15. *Problem areas had been identified on 8/27/15 for: -Falls -Depression and impaired communication, and history of chemotherapy. -Skin irritation and breakdown. *A care plan signature page on 11/24/15 had been signed by the Minimum Data Set assessment coordinator, director of nurses, social service designee, activity director, chief operating</p>	F 280	<p>F280 The resident has the right to- unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, participate in planning care and treatment or changes in care and treatment.</p> <p>ADON/SSD will work with [redacted] our social work consultant to create a behavior modification plan for resident 1 and for all residents with behavior issues.</p> <p>Care plan will be QI by DON for resident 1 and all residents quarterly until 100% compliant, *and reported quarterly to QI.</p> <p>*All resident care plans will be reviewed and put into electronic documentation system by 3/2/16, and all issues of behaviors will be addressed.</p>	<p>3/2/16</p> <p>4 and 5</p>	

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F 280	<p>Continued From page 6</p> <p>officer, and certified dietary manager.</p> <p>-There had been no changes or updates made to the resident's care plan that reflected that care plan review date.</p> <p>*There had not been a problem area or plan for behaviors.</p> <p>-On 11/12/15 the social service consultant had noted, "He becomes irritated with confused people in the dining room and makes negative comments."</p> <p>-On 11/25/16 the social service designee's progress note revealed the resident had a history of yelling at dietary staff and other residents in the dining room.</p> <p>*There had not been a problem area for the start of chemotherapy on 12/16/15.</p> <p>Surveyor: 32572</p> <p>2. Review of resident 4's 9/9/15 updated care plan revealed:</p> <p>*Problem area of "Risk for communication deficit and decline in cognitive status d/t [due to] dementia [decline in mental abilities] a/e/b [as evidenced by] confusion, especially at night and many attempts to leave the facility and agitation when being re-directed by staff."</p> <p>*Goals were:</p> <p>-"Resident will be re-directed or cued without agitation or abusive behaviors if needing assistance or attempting elopement from facility through 11/15."</p> <p>-"Resident will remain alert and oriented to facility through 11/15."</p> <p>*Evaluation completed on 8/27/15 stated:</p> <p>-"Refused cares X [times] four. Physical abuse occurred X two days and socially inappropriate one day. Wandering X five days. Cont. [continue] plan."</p>	F 280			

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F 280	<p>Continued From page 7</p> <p>3. Review of resident 5's 1/6/16 care plan revealed the following: *Problem area of "At risk for depression/social isolation and cognitive loss r/t [related to] recent admission from previous home environment and possible pain from compression fracture." *Goal of "Resident will show no signs/symptoms of depression through 1/16. Resident will be able to communicate needs and feelings effectively to staff through 1/16." *Interventions of: -"Orient to facility, room and call light." -"Staff to anticipate needs and provide cares and pleasant interactions with cares." -"Staff to provide safe environment." *The care plan did not mention her irritable behavior, wandering, and refusal of care that occurred and how to assist her during those times.</p> <p>4. Interview on 1/12/16 at 2:00 p.m. with the director of nursing confirmed the above residents' care plans were not current and did not reflect their current plan of care.</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 6th Ed., St. Louis, MO., 2005, p. 327, revealed: *"A written care plan is designed to direct clinical care and to decrease the risk of incomplete, incorrect, or inaccurate care." *The care plan can identify and coordinate resources used to deliver nursing care. *The care plan enhances the continuity of nursing care by listing specific nursing actions necessary to achieve the goals and outcomes of care."</p> <p>Review of the October 2015 Resident Assessment Instrument (RAI) manual revealed</p>	F 280			

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F 280	Continued From page 8 on p. 2-40 "Nursing homes should also evaluate the appropriateness of the care plan after each quarterly assessment and modify the care plan on an ongoing basis, if appropriate."	F 280		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on record review and interview, the provider failed to ensure three of five sampled residents (1, 4, and 5) had consistent documentation of monitoring resident moods and behaviors. Findings include:  1. Review of resident 1's medical record revealed: *Monthly Summary flow sheets that had been completed by the licensed nurses for the resident. -In September, October, and November 2015 his behaviors had been documented as calm and cooperative.	F 514	F514 Records complete/ accurate/ accessible/systematically organized  The DON, ADON, and MDS will re-educate staff at the in service on February 4, 2016, on appropriate documentation for ADL charting and nursing interventions. Behavior monitoring tool has also been added to 6 residents ADL charting* to ensure easier documentation of behaviors for residents that have frequent behaviors. The DON will QI and monitor documentation and check documentation weekly for 4 weeks, monthly until 100% compliant.  <i>*to include residents 1, 4, and 5. We will assess this for all residents with behaviors. LA/SDDOH/EL</i>  <i>*and reported quarterly to QI meeting. LA/SDDOH/EL</i>	3/2/16

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F 514	<p>Continued From page 9</p> <p>-In those same months he had been resistive to care by refusing his bath.</p> <p>*Interdisciplinary progress notes had no mention of behaviors for September, October, November, and December 2015.</p> <p>*Contract social worker notations in the Social Progress Notes for 2015 revealed only one notation of behaviors. On 11/12/15 she stated the resident became irritated with confused people in the dining room and made negative comments.</p> <p>*Social Progress Notes for 2015 revealed only one notation of behaviors. On 11/25/15 the social service designee wrote the resident had a history of yelling at dietary staff and other residents in the dining room.</p> <p>*Certified nurse aide notes stated:</p> <p>-On 7/17 (no year documented) "Resident poured water on other resident for opening his door. Nurse notified."</p> <p>-On 3/5 (no year documented) "Resident must have been angry when other resident was by door way. Unknown to him pushing other resident threw a pillow at the resident on the floor aid."</p> <p>-On 3/24 (no year documented) "Resident being rude to other residents that came in the dining room also to his table of friends. They just stood up &amp; left unknown if they ate any of theyre [their] food."</p> <p>-On 8/18 (no year documented) "Resident was very rude to diatary [dietary] aide. Nurse was notified and resident was still very rude to nurse and diatary [dietary] aide."</p> <p>*ADL Flow Sheet (activities of daily living) for October, November, and December 2015 revealed no behaviors had been documented.</p> <p>*Behaviors had not been identified as a problem on his care plan.</p> <p>Interview on 1/12/16 at 10:20 a.m. with the</p>	F 514			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>43A103</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/12/2016</b>
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F 514	<p>Continued From page 10</p> <p>certified dietary manager regarding resident 1 revealed he:</p> <ul style="list-style-type: none"> <li>*Came and went as he wanted from the dining room.</li> <li>*Had sat at many different tables in the dining room. He had been moved, because he did not like who he was sitting with or where he was sitting.</li> <li>*Was short tempered.</li> <li>*Had yelled and cursed at other residents in the dining room.</li> <li>*Had yelled and cursed at dietary and other staff in the dining room.</li> <li>*Had always yelled and cursed at other residents and staff since the time of his admission on 7/16/08.</li> </ul> <p>Surveyor: 32572</p> <p>2. Review of resident 4's medical record revealed:</p> <ul style="list-style-type: none"> <li>*Flow sheet nursing Monthly Summary documentation for July, August, September, October, November, and December 2015 revealed:</li> <li>-Mental status "Alert, lethargic, confused; oriented to person [knows who she is]."</li> <li>-Behaviors of "Calm, cooperative, combative, and resistive to cares."</li> </ul> <p>Review of the interdisciplinary nursing documentation revealed the following:</p> <ul style="list-style-type: none"> <li>*9/14/15 "Res. [resident] alert, confuse, ambulating hallways and sitting in lobby."</li> <li>*9/16/15 "Res. alert this eve [evening], confused, ambulating about the facility."</li> <li>*11/17/15 "CNA [certified nursing assistant] reported to this nurse that res hit another res (medical record number number) while in DR</li> </ul>	F 514			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 514	<p>Continued From page 11</p> <p>[dining room] waiting for lunch to be served. CNA stated this res got up from table and began wandering to kitchen. Res (number) began yelling at this res, 'Sit down! You can't do that!' This res began talking/rambling back to res (medical record number) as she walked over to her. This res then hit res (medical record number) in the face et R [right] arm."</p> <p>*11/22/15 "Res was sitting in recliner in room with soda bottle full of birdseed. Upon assessment res had eaten some of the birdseed. Res had multiple seeds in mouth et on chest."</p> <p>*12/14/15 "Resident and [another resident] were arguing in the dining room. Was only a verbal argument and no one was harmed."</p> <p>Review of the social service documentation revealed on 8/26/15 "Resident is confused. Res [resident] wanders about the facility et [and] has attempted to elope this past quarter...Res becomes angry/irritable at times of redirection et when staff assist with cares."</p> <p>Review of the CNA progress notes revealed on the following dates:</p> <p>*7/1/15 "Resident went up to another resident and I assume playfully made to punch him in the face. He laughed luckily. Also saw resident pushing another residents wheelchair after supper. Later this resident reported she was slapped in the face by her."</p> <p>*7/11/15 "Resident smacked me on the side three times and elbow me in the mouth."</p> <p>*7/13/15 "Resident hit me in the mouth three times with an open hand and when I told her that was not ok, she said 'oh its not that hard' and did it again."</p> <p>*7/13/15 "Found resident in another residents doorway with her pants and underpants down</p>	F 514			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 514	<p>Continued From page 12</p> <p>taking off her pad. Got door shut so I could pull up her pants but was a little resistant. Got to her room and she refused the toilet but did get clean pants and pad on. Just a little bit later when taking her a snack found resident in bathroom with pants off again and a wet bed and wet floor in the bathroom. Was resistant but did manage to get dry clothes on again."</p> <p>*8/20/15 "Res was assisted to restroom by aide and nurse. Refused offer to change into night clothes times three."</p> <p>*9/13/15 "Resident was walking around room in the a.m. She agreed to go to the bathroom, then when in the bathroom refused, started hitting! BM [bowel movement; stool] all over her tried to clean it up much as possible. Still covered in feces [stool]."</p> <p>*10/20/15 "Resident used a Kleenex box to hit [resident's name] and grabbed her arm and told her to 'shut up!'"</p> <p>*10/22/15 "Resident refuses to let CNA help her with ADL's. She is hitting and kicking at CNA."</p> <p>*10/22/15 "Resident had bowel movement on the floor, and the bed and all over herself and bathroom."</p> <p>Review of CNA activities of daily living (ADL; dressing, toileting, bathing, transferring) and mood and behavior flow sheet documentation sheets for the above documented dates revealed on:</p> <p>*7/1/15 resident was "irritable, angry, and confused with resistive to cares and physically abusive" behaviors.</p> <p>*7/11/15 resident was "happy and confused with resistive to cares and physically abusive" behaviors.</p> <p>*7/13/15 resident was "happy, angry, and confused with resistive to cares, physically</p>	F 514			

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F 514	<p>Continued From page 13</p> <p>abusive, verbally abusive, and socially inappropriate" behaviors.</p> <p>*8/26/15 resident was "happy and confused with no behaviors."</p> <p>*8/20/15 resident was "irritable, angry, and confused with resistive to cares and physically abusive" behaviors.</p> <p>*9/13/15 no documentation.</p> <p>*9/14/15 resident was "happy with resists/refuse care."</p> <p>*9/16/15 resident was "happy with no behaviors."</p> <p>*10/20/15 resident was "happy and confused with no behaviors."</p> <p>*10/22/15 resident was "irritable, restless, angry, and lethargic with resistive to cares, physically abusive, verbally abusive, socially inappropriate, and repetitive hollering behaviors."</p> <p>*11/17/15 resident was "confused with no behaviors."</p> <p>*11/22/15 resident was "happy and confused with no behaviors."</p> <p>*12/14/15 resident was "happy and confused with no behaviors."</p> <p>3. Review of resident 5's medical record revealed: *Flow sheet nursing Monthly Summary documentation for October, November, and December 2015 and January 2016 revealed: -Mental status "Alert and confused; oriented to person." -Behaviors of "Calm and cooperative."</p> <p>Review of the interdisciplinary nursing documentation revealed on 11/29/15 "Res had verbal disagreement with another res c/o [complains of] R [right] arm hurting after res 'touched it." Ten minutes later res forgot about arm pain. No injury noted to RUE [right upper</p>	F 514			

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F 514	<p>Continued From page 14 extremity]."</p> <p>Review of the social service documentation during the above time frame revealed on: *7/8/15 "Res is alert and oriented to self et room. Res has ST [short term; recent] et LT [long term; past] memory loss...Res is noted to correct other residents when she thinks they are wrong. Res denies mood issues and states she is very proud of all she has done in her life." *10/7/15 "Res is A/O [alert and oriented] to self et room. Res has ST et LT memory loss. Res gets irritable at times of doing dressing change et at times with other residents when she thinks they are incorrect. Res did refuse cares once during this assessment period et was also noted to wander once."</p> <p>Review of the CNA progress notes revealed no documentation of care issues.</p> <p>Review of CNAADL and mood and behavior flow sheet documentation sheets for the following dates revealed: *September 2015 had fourteen shift entries blank. *October 2015 had twenty-five shift entries blank. -10/7/15 resident was "happy and irritable with no behaviors" documented. *November 2015 had twenty-three shift entries blank. *December 2015 had twenty-three shift entries blank.</p> <p>4. Interview on 1/12/15 at 2:00 p.m. with the director of nursing confirmed: *She was aware of the inconsistent charting that occurred with the monitoring of residents' mood and behaviors. *She and the Minimum Data Set assessment</p>	F 514			

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F 514	Continued From page 15 nurse were monitoring and educating staff. *She felt staff had normalized residents' behaviors causing them not to chart the abnormal behaviors.  Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 6th Ed., St. Louis, MO., 2005, p.477, revealed: *Nursing documentation must be accurate, comprehensive, and flexible enough to retrieve critical data, maintain continuity of care, track outcomes, and reflect current standards of nursing practice. *Information in the record provides a detailed account of the level of quality of care delivered. *Effective documentation ensures continuation of care, saves time, and minimizes the risk of errors."	F 514			