STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555136	A. BUILDING _____ B. WING _____	C 01/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWAY HEALTHCARE CENTER	15632 POMERADO ROAD POWAY, CA 92064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated standard survey in relation to an entity-reported incident. Complaint: CA00399052 Four deficiencies were identified through this investigation. The investigation was limited to the specific entity-reported incident and does not represent a full inspection of the facility. Representing the California Department of Public Health: Health Facilities Evaluator Nurse, 33922 and Health Facilities Evaluator Supervisor, 29509.	F 000	LICENSING [illegible] SAN DIEGO [illegible] STATION Preparation and/or execution of this Plan of Correction, inclusive of pages 1 through 18, does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by provisions of 42 CFR 483, et seq., and Health and Safety Code Section 1280. In response to the Department's findings we submit the following Plan of Correction which shall constitute Poway Healthcare Center's credible allegation of compliance by March 11, 2015.	
F 154 SS=D	483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that one sampled resident (Resident 1) was fully informed regarding an	F 154	**F154 INFORMED OF HEALTH STATUS, CARE & TREATMENTS** Resident 1 was discharged from the facility on 05.15.2014.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: LNHA, ADMINISTRATOR — (X6) DATE: 3/3/2015

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.

POC accepted 3/3/15 JMills HFEVA

3-5-15

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F 154	Continued From page 1 antipsychotic medication (medication used to control behavior) prior to the medication being administered. As a result, Resident 1 was not made aware of the name or potential side effects and adverse reactions of the medication administered. Findings: Resident 1 was admitted to the facility on 2/3/14 with diagnoses which included schizoaffective disorder (a mental condition which causes both a loss of contact with reality and mood problems). Resident 1 had a responsible party (RP) assigned to make decisions regarding Resident 1's care and treatment, per the Resident Admission Record. During an interview with Licensed Nurse (LN) 7 on 8/27/14 at 8 A.M., LN 7 stated, Resident 1 was knowledgeable about the medications she was taking and could identify each medication. LN 7 stated, Resident 1 "knew which medications did not work for her." LN 7 stated, Resident 1 had once refused a medication that had not worked in the past and requested the physician order a different medication in it's place. During an interview with LN 2 on 8/27/14 at 4:30 P.M., LN 2 stated, she was performing medication pass on the 3 P.M. -11 P.M. shift of 5/15/14, when another staff member came and asked her to "help calm" Resident 1 and tell Resident 1 she was being transferred to another facility. LN 2 stated, Resident 1 "liked her" and usually responded well to her. LN 2 stated, upon arriving to Resident 1's room, she heard Resident 1 yelling out she did not want to go to the hospital	F 154	Residents who receive medications have the potential to be affected. Nursing staff was in-serviced by the Director of Staff Development (DSD) on 02.24.2015 to the medication administration process of explaining medications to residents prior to the administration of a medication. Licensed Nurse 2 was coached and counseled on 02.27.2015 regarding explaining medications to residents prior to the administration of the medication. Any new nursing staff hired will by in-serviced by the DSD regarding the medication administration process of explaining medications to residents prior to the administration of a medication.	

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F 154	Continued From page 2 with the Emergency Medical Technicians (EMT) and wanted to stay at the facility. LN 2 stated, "another nurse" (she could not recall who) was attempting to administer an intramuscular (IM) injection of Haldol (medication used to control behavior) and Resident 1 had refused the medication. LN 2 stated, she entered Resident 1's room while the EMTs, Director of Nursing (DON), and Director of Staff Development (DSD) waited outside. LN 2 stated, Resident 1 stopped yelling and became calm when LN 2 was alone in the room with the resident. LN 2 further stated, she told Resident 1 the physician ordered "a shot" for her. LN 2 stated, Resident 1 asked "why?" LN 2 stated she replied "the doctor wants you to have it." LN 2 stated, Resident 1 remained calm and LN 2 then administered the IM Haldol. LN 2 further stated, after she administered the medication, Resident 1 asked, "what did you give me?" LN 2 stated she replied, "Haldol." LN 2 stated, Resident 1 became upset and said to her, "you didn't tell me it was Haldol!" LN 2 stated she replied, "You didn't ask." LN 2 further stated, Resident 1 was upset LN 2 did not tell her what medication she was going to administer. During an interview with LN 7 on 10/14/14 at 9:15 A.M., LN 7 stated, before giving a resident a medication, "I always tell the patient (resident) what they are getting." LN 7 stated, she was instructed, during her training from the facility and also in nursing school, to tell the resident the name of the medication and it's use. LN 7 further stated, if a resident refused medications, she would educate them on the risks and benefits of the medication. Then, if the resident still refused the medication, she would document in the	F 154	Weekly audits of five (5) random licensed nurses administering medications will be conducted by the Director of Staff Development (DSD) and/or designee for the next month and then monthly for the next two (2) months. Accurately completing eighty percent (4/5) of the medication pass observation will determine compliance. Any licensed nurse identified as not explaining medications to residents prior to administration will be in-serviced and counseled by the DSD. The DSD will monitor for explaining medications to residents prior to administration and overall compliance. Results and trends from the audits will be reported to the monthly Quality Assurance & Assessment Committee Meeting by the DSD for the next three (3) months.	

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F 154	Continued From page 3 clinical record and notify the physician. During an interview with LN 8 on 10/14/14 at 3:45 P.M., LN 8 stated, before giving a medication, "I tell the patient (resident) what I'm giving them because they have the right to know that they are taking." LN 8 further stated, if the resident refused a medication, she would notify the physician. During an interview with the Director of Staff Development (DSD) on 10/15/14 at 10 A.M., the DSD stated, the LNs should tell the resident what medications they are giving prior to administration and, if the resident refuses, the medication cannot be given. The DSD further stated, LN 2 should have told Resident 1 she was going to administer Haldol prior to giving Resident 1 the injection. According to the Medication Administration Flowsheet, LN 2 documented, "... Haldol 0.5 mg IM given on 5/15/14 at 10:45 P.M. for calling names..." According to the facility's undated document, Resident Rights... " Nursing home residents have the right... to full information, in advance, and participation in planning and making any changes in their care or treatment..."	F 154		
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.	F 250	**F250 PROVISION OF MEDICALLY RELATED SOCIAL SERVICE** Resident 1 was discharged from the facility on 05.15.2014. Residents who require medically related social services have the potential to be affected. Social Services staff and the IDT (Interdisciplinary Team) will be in-serviced by the Quality Services Nurse Consultant regarding IDT planning and updates, notification of responsible parties and discharge planning.	

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F 250	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure social services responded to the needs of one sampled resident (Resident 1) regarding IDT (Interdisciplinary Team) updates, notification of responsible party (RP), and discharge planning. As a result, Resident 1 continued to have aggressive behaviors that were not addressed in IDT meetings and was eventually transferred to another facility via 911 call. Findings: Resident 1 was admitted to the facility on 2/3/14, with diagnoses which included schizoaffective disorder (a mental condition that causes both a loss of contact with reality and mood problems). Resident 1 had a responsible party assigned to make decisions regarding care and treatment, per the Resident Admission Record. During an interview with the Social Service Designee (SW) on 7/23/14 at 2 P.M., SW stated "the goal was to get Resident 1 to a Behavioral Health Unit (BHU) because she was not appropriate for Skilled Nursing Facility (SNF)." SW further stated, the facility did not have an Interdisciplinary Team (IDT) meeting to discuss the plans for placing Resident 1 in a BHU. During an interview on 7/23/14 at 3:30 P.M., Licenced Nurse (LN 3) stated, Resident 1's behaviors had been escalating and MD 1 wrote an order on 5/12/14, to "transfer Resident 1 out." LN 3 stated, he referred the transfer order to SW to make arrangements.	F 250	Weekly audits of five (5) random clinical records for inter-disciplinary team (IDT) updates, notification of responsible parties and discharge planning will be conducted by the Social Services Director (SSD) and/or designee for the next month and then monthly for the next two (2) months. Accurately completing eighty percent (4/5) of the audits related to IDT updates, notification of responsible parties and discharge planning will determine compliance. Any staff identified as not completing IDT updates, notification of responsible parties and discharge planning will be in-serviced and counseled by the Administrator. The SSD will monitor for the completion of IDT updates, notification of responsible parties and discharge planning and overall compliance. Results and trends from the audits will be reported to the monthly Quality Assurance & Assessment Committee Meeting by the SSD for the next three (3) months.	

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F 250	Continued From page 5 During an interview with the Administrator on 7/23/14 at 3:40 P.M., the Administrator stated, the consulting physician (MD 2) was unable to come to the facility to assess Resident 1 between the dates of 5/12/14 and 5/15/14 and was unable to admit her to the BHU. The Administrator further stated, Resident 1's behaviors continued to escalate and she was eventually transferred to the hospital by ambulance on 5/15/14. On 8/26/14 at 2:05 P.M., Resident 1's clinical record was jointly reviewed with the Director of Nursing (DON) and the Social Services Designee (SW). Per the Resident Progress Notes, a Care Conference was held on 2/7/14 at 12:34 P.M. According to the notes, "... Resident 1 had "a behavior episode this morning with the roommate..." No Plan of Care which addressed Resident 1's behaviors was found in the clinical record. Per the Resident Progress Notes, a Care Conference was held on 2/27/14 at 2:25 P.M. According to the notes, "...resident with episodes of refusing medications, turning and repositioning, and weighing..." Per the Resident Progress Notes, a Care Conference was held on 3/13/14 at 1:35 P.M. According to the notes, "...resident with episodes of refusing medications, turning, and repositioning, and weighing..." No Plan of Care which addressed Resident 1's refusal of care was found in the clinical record. Resident 1's clinical record did not contain any	F 250		

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F 250	Continued From page 6 additional Care Conferences from 3/13/14 until her discharge date of 5/15/14. Additionally, Resident 1's clinical record contained no documentation Resident 1's RP was notified of the documented behavior episode or refusal of treatment. The DON confirmed, there was no documentation a Care Conference was held to address Resident 1's behaviors after 3/13/14, and no documentation that Resident 1's RP had been notified. According to the Resident Progress notes between the dates of 3/5/14 and 5/15/15, the Licensed Nurses documented multiple times Resident 1 was exhibiting behaviors which included yelling, cursing at staff, refusing care, and throwing things at staff. Resident 1's clinical record had no documentation that Resident 1's responsible party was notified of the above behaviors. SW verified there was no documentation that the RP was notified. SW further stated, "We don't call the RP every time Resident 1 acts out." According to the Resident Progress Notes, the IDT team met three times between the dates of 2/7/14 and 3/3/14. There were no documented IDT meetings after 3/5/14 when, according to the LN's documentation, Resident 1's behaviors escalated. On 8/26/14 at 3 P.M., SW confirmed, the IDT did not meet after 3/5/14, to discuss Resident 1's behaviors. During an joint interview on 8/26/14 at 3 P.M., with SW and the DON, the DON stated, "I think we called other facilities to try and place Resident	F 250		

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F 250	Continued From page 7 1 elsewhere when MD 2 was unable to admit Resident 1 to BHU." The DON stated she was unable to find any documentation in Resident 1's clinical record indicating the facility attempted to arrange placement at another facility. The DON further stated, the Administrator was trying to make arrangements. During the joint interview with SW on 8/26/14 at 3 P.M., SW stated, she did not attempt to find alternate placement for Resident 1 when MD 2 was unable to admit Resident 1 to BHU. According to the Physician's Orders written by MD 1, dated 5/12/14, "Discharge planning to behavioral facility when arrangements are made." According to the Physician's Progress Notes written by MD 1, dated 5/12/14, "agree pt (patient) is appropriate for Behavioral Unit setting for more aggressive treatment of psych issues." According to the facility's Policy Statement entitled, Change in a Resident's Condition or Status, revised April 2007, "...Our facility shall promptly notify the representative (RP) of any changes in the resident's medical/mental condition... when there is a significant change in the resident's physical , mental, or psychosocial status...when it is necessary to transfer the resident to a hospital/treatment facility..."	F 250		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282	**F282 SERVICES BY QUALIFIED PERSONS/PER CARE PLAN** Resident 1 was discharged from the facility on 05.15.2014.	

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F 282	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to administer medications as prescribed by the physician for one sampled resident (Resident 1). As a result, Resident 1 had the potential to suffer side effects related to medications not administered as prescribed. Findings: Resident 1 was admitted to the facility on 2/3/14, with diagnoses which included schizoaffective disorder (a mental condition that causes both a loss of contact with reality and mood problems). Resident 1 had a responsible party assigned to make decisions regarding care and treatment, per the Resident Admission Record. According to the Physician's Order dated, 5/2/14 at 1:20 A.M., Resident 1 was to receive, "...Risperdal (medication used to decrease verbal or physical aggression and agitation) 3 mg (milligrams) Q HS (every night at bedtime), Xanax (medication to decrease anxiety) 0.5 mg take 1 tab TID (three times daily) at 9, 1, and 5, and Trazodone (medication to help sleep) 100 mg Q HS ..." According to the document, Facility Verification of Resident Informed Consent- Psychotherapeutic Meds (medications that affect mood or sleep), Resident 1's physician obtained consent to administer the above medications from Resident 1's responsible party, and Licenced Nurse (LN 3) verified the consent was obtained.	F 282	Residents who receive medications have the potential to be affected. Review of residents' Medication Administration Records (MARs) was reviewed on 03.03.2015 by Medical Records Staff; any found errors will be corrected. Nursing staff was in-serviced by the Director of Staff Development (DSD) regarding the medication administration process, administering medications as ordered by the physician and the importance of proper MAR documentation on 02.24.2015. Any new licensed nursing staff hired will be in-serviced by the DSD regarding medication administration process, administering medications as ordered by the physician and the importance of proper MAR documentation.	

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F 282	Continued From page 9 On 7/23/14 at 12:30 P.M., Resident 1's Medication Administration Record (MAR) was reviewed: From 5/3/14 to 5/15/14, 28 of 39 scheduled doses of Xanax were initialed and circled on the MAR (indicating the dose was held by the LN). On the back of the MAR, Licensed Nurse (LN 1) documented the reason the Xanax was not given as, "no consent." From 5/3/14 to 5/15/14, 11 of 13 scheduled doses of Trazodone were initialed and circled on the MAR (indicating the dose was held by the LN). On the back of the MAR, LN 1 documented the reason as, "consent not signed." From 5/3/14 to 5/15/14, 4 of 13 scheduled doses of Risperdal were not documented as being given. There was no documentation on the back of the MAR regarding the reason the medication was not given. On 7/23/14 at 3:15 P.M., the Director of Nursing (DON) stated she was unaware Resident 1 was not receiving her medications as ordered by the physician. On 7/23/14 at 4:40 P.M., LN 1 stated she did not administer the medications as ordered by the physician. LN further stated, she did not notify Resident 1's physician that she had not been administering the medication. On 8/27/14 at 4:30 P.M., LN 2 stated, she did not administer Resident 1's scheduled medications per physician's order and should have notified the physician and DON that Resident 1 had not been receiving her medications as ordered.	F 282	Weekly audits of ten (10) random resident MARs will be conducted by the Medical Records Staff and/or designee for the next month and then monthly for the next two (2) months. Accurately completing eighty percent (8/10) of the MAR audit will determine compliance. Any licensed nurse identified as not administering medications as ordered and documenting on the MAR appropriately will be in-serviced and counseled by the DSD. The DSD will monitor for administering medications as ordered and the proper documentation on the MAR and overall compliance. Results and trends from the audits will be reported to the monthly Quality Assurance & Assessment Committee Meeting by the DSD for the next three (3) months.	

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F 282	Continued From page 10 On 7/30/14 at 4:10 P.M., Physician (MD 1) stated he did not recall the staff notifying him that Resident 1 was not receiving her scheduled medications as ordered. On 7/31/14 at 11:40 P.M., Physician (MD 2) stated, she expected staff to follow orders and Resident 1 should have received her medications as ordered. MD 2 further stated, she should have been notified Resident 1 did not receive the ordered medications. According to the facility's Policy Statement entitled, Administering Medications, "... Medications must be administered in accordance with the orders... if a drug is withheld or given at at time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided..."	F 282		
F 319 SS=D	483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to: 1. Thoroughly assess for appropriateness of admission of 1 sampled resident (Resident 1). 2. Ensure staff were trained to appropriately care	F 319	**F319 TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES** Resident 1 was discharged from the facility on 05.15.2014.	

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F 319	Continued From page 11 for Resident 1's psychiatric diagnoses and aggressive behaviors. 3. Develop and implement a plan of care with effective interventions for Resident 1 to manage behaviors. As a result, Resident 1 was transferred to another facility when staff were unable to effectively manage Resident 1's behaviors. Findings: Resident 1 was admitted to the facility on 2/3/14, with diagnoses which included schizoaffective disorder (a mental condition that causes both a loss of contact with reality and mood problems). Resident 1 had a responsible party assigned to make decisions regarding care and treatment, per the Resident Admission Record. 1. During an interview with Resident 1's Nurse Practitioner (NP) on 7/23/14 at 2 P. M., NP stated, Resident 1 was not at all appropriate for the facility. NP further stated, Resident 1 was physically and verbally abusive and refused care. During an interview with the Administrator on 7/23/14 at 3:40 P.M., the Administrator stated, she was not aware that Resident 1 had any history of physically violent behaviors, only verbal behaviors. The Administrator further stated, Resident 1 was initially screened as appropriate for admission. During an interview with the Clinical Liaison (LN 4) on 8/28/14 at 12:30 P.M., LN 4 stated, she received a referral to admit Resident 1 to the facility in January of 2014, from a Behavioral Health Unit (BHU) but did not accept Resident 1	F 319	Residents who display mental or psychosocial adjustment difficulties will receive appropriate services to correct the assessed problem. Clinical records for residents admitted with psychiatric diagnoses and aggressive behaviors was reviewed for appropriate plans of care on 03.03.2015 by Medical Records staff, any adjustment needed will be care planned. Admission staff, Social Services staff and the IDT (Interdisciplinary Team) will be in-serviced by the Quality Services Nurse Consultant regarding assessment for admitting residents to the facility. Staff are trained to appropriately care for residents with psychiatric diagnoses and aggressive behaviors and develop and implement a plan of care with effective interventions for residents to manage behaviors.	

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F 319	Continued From page 12 at that time because she was still "agitated." LN 4 further stated, she re-evaluated Resident 1, "about a month after that," when Resident 1 was on a medical unit at the same facility. LN 4 stated, at that time, staff on the medical unit reported to LN 4, Resident 1 had not had any combative behaviors while in their care. LN 4 stated, Resident 1, "seemed stable." LN 4 further stated that she met with the Administrator to discuss admitting Resident 1 to the facility and, although they did have concerns regarding Resident 1's history of behaviors, "they thought they could manage her" with the assistance of a consulting physician (MD 2). LN 4 stated, Resident 1's behaviors escalated over time. A record review was conducted of the facility's admission intake screening package on 8/27/14. According to the Physician Consultation Notes included in the facility's intake screening package, MD 2 documented on 1/21/14, "...the patient was admitted to the psychiatric unit on 12/10/13 for behavioral disturbance, agitation, hostility, and depression." According to the document, Medication Reconciliation Discharge Orders, dated 2/3/14, included in the facility's intake screening package, Resident 1 was to receive Haldol (medication to control behaviors) 5 mg (milligrams) IM (intramuscularly) PRN (as needed) for agitation while in the previous facility. The order was written on 1/29/14, and had a stop date of 2/28/14. According to the document, Discharge Summary dated 2/2/14, Resident 1 was admitted to the BHU on 12/10/14, and transferred from BHU to the Medical Unit on 1/18/14, due to respiratory	F 319	Weekly audits of five (5) random clinical records of residents who were admitted with psychiatric diagnoses or aggressive behaviors will be reviewed for the development and implementation of plans of care to manage behaviors. The audits will be conducted by the Director of Nursing (DON) or designee for the next month and then monthly for the next 2 months. Accurately completing eighty percent (4/5) of the audits will determine compliance. The Administrator or DON will monitor for newly admitted residents with psychiatric diagnoses or aggressive behaviors and that proper development and implementation of plans of care to manage behaviors were implemented. Results and trends from the audits will be reported to the monthly Quality Assurance & Assessment Committee Meeting by the Administrator or DON for the next 3 months.	

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F 319	Continued From page 13 distress (difficulty breathing). Per the document, Resident 1 "... was admitted to the GPU (geriatric psychiatric unit) with a behavior problem...During the interview with MD 2, she attempted to throw herself onto the floor, became very agitated, and verbally abusive to the staff... She slowly improved , however...She needs constant monitoring regarding her behaviors." According to the facility's Policy Statement, Admissions to the Facility, Revised December 2006, "... Our facility will admit only those residents whose medical and nursing care needs can be met..." 2. On 5/28/14 at 3:20 P.M., Licensed Nurse (LN 1) stated Resident 1 had "multiple combative issues," and she was afraid of her at times. LN 1 further stated that she did not receive any training on how to care for combative residents with psychiatric diagnoses such as Resident 1's. During a subsequent interview with LN 1 on 8/28/14 at 4:30 P.M., LN 1 stated, Resident 1 once said to her, "You don't know how to take care of a psych patient, do you?" On 5/28/14 at 3:30 P.M., Director of Staff Development (DSD) stated, she provided education on dementia, but no specific training on de-escalation or recognizing signs and symptoms of triggers for Resident's with psychiatric disorders. In a subsequent interview on 9/3/14 at 9 A.M., DSD stated the facility "never had a resident like Resident 1," and staff were trained to "leave Resident 1 alone until she calmed down" when Resident 1 exhibited aggressive behaviors. On 7/29/14 at 12:20 P.M., Licensed Nurse (LN 2) stated, the facility did not provide any training on	F 319		

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F 319	Continued From page 14 managing Resident 1's behaviors. LN 2 stated, Resident 1, "cursed and threw things." LN 2 further stated, Resident 1, "needs a person with specialty training to take care of her." On 8/28/14 at 9:30 A.M., Certified Nursing Assistant (CNA 3) stated, yelling at staff and throwing things was a common behavior for Resident 1. CNA 3 stated, she had no training on caring for residents with behaviors such as Resident 1. CNA 3 further stated, when Resident 1 became agitated, "she would walk away and come back later." On 8/28/14 at 3 P.M., Certified Nursing Assistant (CNA 1) stated, Resident 1 exhibited combative behaviors from the time she was admitted to the facility, and often kicked over her bedside table when upset. CNA 1 further stated she did not receive any training on caring for Resident 1's behaviors. On 9/2/14 at 1:35 P.M., Certified Nursing Assistant (CNA 2) stated, Resident 1 threw water pitchers at staff, called staff racist names, and tried to hit people. Because of this behavior, CNA 2 stated, "I always used 2 CNAs to go into the room together," and some staff were afraid of Resident 1. CNA 2 stated, when Resident 1 became aggressive, she would "just leave the room and come back later," or tell the licensed nurses. CNA 2 stated Resident 1 exhibited this behavior from the time she was admitted to the facility. CNA 2 stated the facility did not provide any training on de-escalating Resident 1. On 5/28/14 at 3:30 P.M., the facility's staff inservice/training log was reviewed with the DSD. The log did not contain documentation of staff	F 319		

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F 319	Continued From page 15 training in managing behaviors in residents with psychiatric diagnoses, recognizing triggers, or de-escalation of behaviors of residents with psychiatric disorders such as Resident 1. 3. During an interview on 8/28/14 at 4:30 P.M., LN 1 stated, on 5/15/14 at approximately 5 P.M., Resident 1 became agitated, began screaming, cursing, and threw a cup at her. LN 1 became emotional, cried during the interview, and stated, "It's hard for me to talk about it because I'm not used to being treated like that." LN 1 stated she did not want to go back into Resident 1's room because Resident 1 scared her. LN 1 stated, she did not go back to Resident 1's room that shift. A review of the clinical record was conducted on 8/27/14 at 2:05 P.M. According to the Resident Progress Note/Care Conference Note dated 2/7/14 at 12:34 P.M., "...Resident had a behavioral episode this morning with the roommate..." Care Conference Note dated 2/27/14 "... Resident with episodes of refusing medications, repositioning, and weighing..." Care Conference Note dated 3/13/14, "... Resident with episodes of refusing medications, repositioning, and weighing..." According to the Resident Progress notes between 3/5/14 and 5/14/14, the Licensed Nurses documented multiple entries detailing Resident 1's aggressive behavior including yelling, cursing at staff, calling staff names, and throwing things at staff. According to the Resident Progress Notes dated 5/15/14 from 5:43 P.M. to 11:35 P.M., the Licensed Nurses documented, Resident 1 was	F 319		

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F 319	Continued From page 16 exhibiting behaviors including yelling out, cursing at staff, refusing care, and throwing things at staff. At 10:59 P.M., DSD documented, Resident 1's physician was notified of Resident 1's behavior and the DSD received an order to send Resident 1 to BHU for evaluation. At 5/15/14 11:05 P.M., the DON documented, Resident 1 was sent to the hospital via ambulance. Resident 1's Care Plans were jointly reviewed with the DON and Social Work Designee (SW) on 8/26/14 at 3 P.M. According to the facility's document entitled, Care Plan History dated 5/15/14, a behavioral plan of care was initiated for Resident 1 on 5/15/14 (date Resident 1 was discharged). Behaviors included "...Verbal aggression (screaming and cursing) and Physical Aggression (kicks, grabs, throws items at staff)". There was no plan of care for Resident 1's behaviors prior to 5/15/14 in the clinical record. SW stated she did not initiate a behavioral plan of care for Resident 1. The DON stated, the behavioral plan of care initiated on 5/15/14 was the only behavioral plan of care for Resident 1. There was no plan of care for managing Resident 1's behaviors from admission on 2/3/14, until Resident 1 was discharged from the facility on 5/15/14. According to the Physician's Orders dated 2/3/14, Resident 1 was receiving 3 different psychotropic medications (medications to alter mood or behavior). According to the facility's Policy and Procedure entitled, Psychotherapeutic Drug Management Program, dated January 3013, "... Nursing Responsibilities:...Develop behavioral care	F 319		

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F 319	Continued From page 17 plans..." Social Work Responsibilities: "...develop behavioral care plans...".	F 319		