The Plan of Correction is submitted as required under State and Federal law. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity determination is correct.

F 280
Patient #119 had been previously discharged from the center and as a result their care plan was unable to be reviewed and updated.

Overseen by the Regional Nurse all patient care plans were reviewed with Social Services and those patients with hypersexual behaviors and combattiveness care plans were reviewed and updated as necessary. This was completed on 07/22/13.

Social workers were in-serviced by the DON on including interventions for hypersexual behavior and combattiveness on patient care plans on 07/15/13.

Overseen by the Regional Nurse, beginning week of 07/22/13, Social Services will complete a quality assurance study assessing at a minimum 3 charts weekly x 4 weeks of patients with known behaviors or combattiveness ensuring interventions care plans are appropriate.

All Quality Assurance studies and monitors will be reported to the center's Quality Assurance committee which consists of the

Laboratory Directors or Provider/Supplier Representatives Signature

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 discloseable 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 discloseable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approval plan may affect the facility's ability to continued program participation.
**F 280 Continued From page 1**

The findings included:

Medical record review for Resident #119 documented an admission date of 12/28/12 with diagnoses of Alzheimer's Dementia, Anxiety, Anorexia, Hypertension, Pernicious Anemia, Insomnia, Psychosis, Tremor, Cognitive Communication Deficit, Abnormal Gait, Allergic Rhinitis, and Constipation.

Nurses' notes documented the following:

- a. 12/28/12 - "1a [AM] Pt. [patient] found wandering the hallways...
- b. 12/30/12 - "10p [PM] ...wandering hallways trying to go in other pts rooms...
- c. 1/1/13 - "10p Pt wandering the halls. redirect multiple times from pts rooms...
- d. 1/9/13 - "10:30p Pt. counts to wander hallways into other patient rooms slight agitation when redirected by staff...
- e. 1/17/13 - "2a Pt. wandering hallways into patient rooms, found attempting to remove a painting from the wall & almost dropping painting on himself & techs [technicians]... 1/17/13 - "7AM Pt. was flipping over dining room tables and chairs. Pt got stuck in one of the chair... Pt got combative Took 4 staff members to get Pt out of chair... Social service notified of pts agitation."
- f. 2/8/13 - "10p Pt. wanders into other pts rooms...
- g. 2/11/13 - "10:40P pt wandering and pacing halls multiple attempts to redirect also attempted to urinate on wall in hallway and going in other patient rooms...
- h. 2/12/13 - "7:30 Pt wandering into other pts room Inappropriate behavior noted, staff intervened. Social service notified...

administrator, DON, medical director, rehab
medical director, registered dietician, social
worker and health information manager.
Each study and monitor will continue as directed by the Quality Assurance Committee.
The 14 day Minimum Data Set (MDS) dated 1/8/13 and the 30 day MDS dated 1/25/13 documented the resident with severe impaired cognition with behaviors.

A Physician's facility follow-up dated 2/15/13 documented, "Assessment / Plan: Hypersexual behavior. He was put on Provera 10 mg [milligrams] q. [every] day..."

During an interview in the conference room on 7/11/13 at 8:00 AM, the Social Worker (SW) stated, "I monitor behaviors. On [named Resident #119] I called the caregiver..." The SW was asked about the inappropriate incident. The SW stated, "I called the Behavior Health Clinic to come and evaluate him... I would document what I did in social services notes. No, I can't find anything in chart..."

During an interview in the conference room on 7/11/13 at 8:25 AM, the Director of Nursing (DON) was asked about the inappropriate behavior situation. The DON stated, "Yes, it should have been documented. The social worker was brand new and we told her to document it... Yes, it should be in the notes. [Named Resident #119] was one that wandered worse at night... he would go in other resident rooms especially at night he had to be watched closely..."

The comprehensive care plan did not address hypersexual behavior or combativeness and did not include any interventions provided by the Social Worker.