STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106088	A. BUILDING _____ B. WING _____	**07/07/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CLYDE E LASSEN STATE VETERANS NURSING HOME	**4650 STATE RD 16 SAINT AUGUSTINE, FL 32092**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to protect the resident's right to be free from abuse for three (Resident #2, Resident #3, Resident #4) of three residents reviewed for abuse. The findings include: A record review for Resident #1 revealed an admission date of [DATE] with a primary medical [DIAGNOSES REDACTED]. The resident required extensive assistance with activities of daily living and his cognition was impaired. A record review for Resident #2 revealed an admission date of [DATE] with a primary medical [DIAGNOSES REDACTED]. The resident required extensive assistance with activities of daily living and his cognition was impaired. A record review for Resident #3 revealed an admission date of [DATE] with a primary medical [DIAGNOSES REDACTED]. Secondary [DIAGNOSES REDACTED]. The resident required extensive assistance with activities of daily living and his cognition was impaired. A record review for Resident #4 revealed an admission date of [DATE] with a primary medical [DIAGNOSES REDACTED]. Secondary [DIAGNOSES REDACTED]. The resident required supervision to limited assistance with activities of daily living and his cognition was impaired. A review of the facility's federal reports was conducted on 7/7/20. An incident occurring on 5/12/20 indicated that the alleged perpetrator (Resident #1) took a cane belonging to Resident #3 and struck Resident #3 repeatedly on his head, left arm and left side before staff intervened. An interview was conducted with the Interim Administrator and the facility Risk Manager on 7/7/20 at 1:20 PM regarding this incident. The Interim Administrator, referencing the facility's investigation file, explained that Resident #1 and Resident #3 were eventually separated and that all remaining residents were removed from the unit due to safety concerns. She further explained that the resident was transferred to the hospital under the Baker Act. The Interim Administrator confirmed that, upon return from the hospital, Resident #1 was not placed under direct supervision until a determination could be made as to whether he was a continuing risk to others. Continued review of the facility's federal reports revealed an incident occurring on 6/6/20 indicating that Resident #1 struck Resident #3 on the head with a wash cloth. The facility indicated that a review of each resident's care plan was conducted and that the care plans were found to accurately reflect the needs of each resident. This event was discussed with the Interim Administrator and the facility Risk Manager during the interview conducted on 7/7/20 at 1:20 PM. The Interim Administrator, again referencing the facility's investigation file, explained that all residents were again removed from the unit due to safety concerns. She confirmed that Resident #1 was not placed under direct supervision despite the resident's now repetitive physical aggression toward other residents. An incident occurring on 6/9/20 indicated that Resident #1, during a period of increased agitation, threw a spoon which hit Resident #4's middle finger causing an injury. The facility indicated that direct supervision would be provided as needed. This event was discussed with the Interim Administrator and the facility Risk Manager during the interview conducted on 7/7/20 at 1:20 PM. The Interim Administrator explained that the facility continued close supervision following the incident but confirmed that Resident #1 was not placed under direct supervision despite a pattern of physical aggression toward other residents. An incident occurring on 6/24/20 indicated that Resident #1 approached Resident #2 and grabbed Resident #2's groin while he was asleep in a reclining chart. As a result, Resident #2 suffered redness and swelling to the area. Resident #1 was again transferred to the hospital under the Baker Act. This event was discussed with the Interim Administrator and the facility Risk Manager during the interview conducted on 7/7/20 at 1:20 PM. The Administrator acknowledged the concern about Resident #1's repeated episodes of physical aggression and the facility's lack of appropriate interventions to prevent resident to resident altercations. The Administrator explained that she hadn't yet taken over the administrative role during the first three incidents but acknowledged that, given the resident's aggressive history, it would have been appropriate to have Resident #1 supervised directly. A review of the resident's nursing progress notes revealed a significant and repeating history of behaviors and aggression. The resident's care plans did not include interventions that were effective in ensuring the safety of the resident or others. -A note dated 4/26/20 at 4:50 PM indicated Resident #1 entered the room of another resident and laid down in the resident's bed. -A note dated 4/27/20 at 10:13 PM indicated Resident #1 was walking into other resident's rooms and waking them up. -A note dated 5/2/20 at 10:00 PM indicated Resident #1 was again walking into other resident's rooms and waking them up. -A note dated 5/8/20 at 10:19 PM indicated Resident #1 became aggressive when trying to redirect him away from another resident he was attempting to push. -A note dated 5/21/20 at 9:40 PM indicated Resident #1 was unable to be redirected and was displaying aggressive behavior when staff were attempting to assist him to bed. -A note dated 5/28/20 at 2:26 PM indicated Resident #1 walked into another resident's room and sat on the resident's bed refusing to get up. Once the resident was out of the room he became agitated and kicked a certified nursing assistant (CNA). -A note dated 5/30/20 at 10:24 PM indicated Resident #1 entered another resident's room and the staff were not able to redirect him. -A note dated 6/5/20 at 6:43 AM indicated Resident #1 was agitated and was swinging a dustpan at staff. -A note dated 6/9/20 at 6:35 AM indicated Resident #1 chased a CNA around the nurse's station and tore a door off it's hinges. -A note dated 6/13/20 at 3:14 AM indicated Resident #1 came out of his room and overturned a table. -A note dated 6/14/20 at 4:47 AM indicated Resident #1 was wandering around and trying to get into other resident's rooms. A review of Residident #1's care plans revealed a behavior care plan with a revision date of 7/7/20 at 2:38 PM. The goal was that behaviors would be controlled by staff approach and redirection through the next review date on 8/19/20. Interventions included the following: Maintain other residents at a safe distance - start date: 9/27/19 Do not crowd resident - start date: 9/18/19 Do not touch until attention is focused on you - start date: 9/18/19 May need to remove resident to quieter surroundings - start date: 9/18/19 A review of the facility's abuse policy titled Abuse, Neglect, and Exploitation/Misappropriation of Resident Property revealed in the section titled Protection, If the abuse involves another resident, the accused resident' representative and attending physician will be informed of the alleged abuse incident and there may be closer supervision and/or restrictions on the accused resident's interactions with other residents. .
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and facility record reviews and staff interviews, the facility failed to ensure residents

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

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 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) who received [MEDICAL CONDITION] drugs received appropriate behavioral interventions and clinical monitoring for three (Residents #1, #3 and #4) of four residents reviewed who received [MEDICAL CONDITION] medications, from a total of nine residents in the sample. The findings include: 1. An observation of Resident #1 was conducted in the locked unit on 7/7/20 at 10:20 a.m. Resident #1 was closely followed by Certified Nursing Assistant (CNA) A, and walked about slowly with a shuffling gait and forward-bent posture. An attempted greeting was met with refusal to visually engage or verbally respond. An interview was conducted with CNA B on 7/7/20 at 10:34 a.m. She stated Resident #1 exhibited many behaviors including resistance to care and fighting with residents and staff. He recently had a big problem, so now someone had to be near him around the clock. An interview was conducted with CNA A on 7/7/20 at 10:45 a.m. She explained she was assigned to provide 1:1 supervision today for Resident #1. CNA A stated the biggest trigger of Resident #1's unwanted behavior was when staff attempted to change his brief. Resident #1 did not like that at all and did not like to be touched. A record review for Resident #1 found he was admitted to the facility on [DATE] and was [AGE] years old. Resident #1 was recently discharged to a psychiatric hospital under a Baker Act on 6/24/20 and returned to the facility on [DATE]. A Discharge Return Anticipated Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/24/20, noted Resident #1 had an unplanned discharge to a psychiatric hospital the same day. He had memory problems and moderately impaired cognitive skills for daily decision making. Inattention and disorganized thought fluctuated. He exhibited physical and verbal behaviors directed toward others, rejection of care and wandering behavior during 1-3 days over the assessment period. He ambulated independently and required limited assistance with activities of daily living. Resident #1 was frequently incontinent. His [DIAGNOSES REDACTED]. He also experienced hallucinations. Resident #1 was care planned on 6/26/20 for periods of negative behavior that potentially result in injury to self and others, which included hitting staff, resisting care, urinating in others rooms, picking up random objects, hallucinations, and running to chase his target. A review of the physician's order history revealed that on 6/23/20, Resident #1 began treatment with [MEDICATION NAME] ([MEDICATION NAME], an antipsychotic medication), one 5 milligram (mg) tablet twice daily. The dose was increased to three times daily on 6/26/20. A single-dose order was also obtained on 6/26/20 for 1 mg of [MEDICATION NAME] intramuscularly (injection). On 6/27/20 the physician again increased the dose and changed the medication to [MEDICATION NAME] liquid concentrate 2 mg/milliliter (ml), give 2.5 ml three times daily and 5 ml at bedtime. On 7/2/20 the dose was reduced to 2.5 mg twice daily. A history and physical examination [REDACTED]. He had been sent out under Baker Acts three times since May. Resident #1 was described with known behavior of sudden changes of personality and character, a strong tendency to get hostile, and the ability to physically assault other patients or staff. His medications were adjusted and appropriate. [DIAGNOSES REDACTED]. A subsequent visit on 6/29/20 noted that due to violent weekend behavior, Resident #1 received intramuscular (IM) [MEDICATION NAME] and an increase to three times daily. Sleepiness was noted, as was poor appetite due to increased sleep. On 7/2/20 the physician again noted increased sleepiness and readjusted Resident #1's [MEDICATION NAME] back to twice daily. The physician expressed concern over poor nutrition should the sedation linger. Further review of the clinical and medication administration records found there was no monitoring in place for the use of [MEDICATION NAME] for the treatment of [REDACTED]. There was no indication as to what associated behaviors should be monitored, no specific side effects or special instructions for monitoring those side-effects, and no intervention codes to note what non-pharmacological interventions were attempted when behavioral outbursts occurred. 2. A record review for Resident #3 revealed he was admitted to the facility on [DATE] and was [AGE] years old. His quarterly MDS assessment with an ARD of 4/16/20, noted he was sometimes able to make himself understood and sometimes understood others. He had a brief interview for mental status (BIMS) score of 3, indicating severely impaired cognition. Inattention and disorganized thought fluctuated. Resident #3 required extensive assistance with walking, dressing, and activities of daily living. [DIAGNOSES REDACTED]. Resident #3 was care planned on 4/22/20 for elopement behaviors (attempting to leave facility unaccompanied and without authorization) and for his cognition and communication deficits. He was care planned for resisting care during periods of paranoid beliefs related to his [MEDICAL CONDITION] and for delusional behaviors related to the use of his personal vehicle. There was no mention of aggressive behaviors in the care plan. Resident #3 was last seen by a psychiatrist on 11/22/19, who noted a [DIAGNOSES REDACTED]. He recommended the resident continue with his use of [MEDICATION NAME] ([MEDICATION NAME] - an antipsychotic medication) and [MEDICATION NAME] ([MEDICATION NAME] - an antianxiety medication). He was last seen by the Advanced Registered Nurse Practitioner (ARNP) on 6/5/20 for review of his medications. Resident #3 had a physician's order for [MEDICATION NAME] ([MEDICATION NAME] - an antipsychotic medication) 0.25 mg twice daily. Behavioral monitoring was in place for the use of this medication and associated behaviors of yelling, swinging his cane at staff and his inability to be redirected. Further review of the clinical and medication administration records found no care plan for the aggressive behaviors being monitored in relation to the use of [MEDICATION NAME]. There were no instructions for how to intervene when these behaviors occurred, and no non-pharmacological interventions to redirect aggressive or resistive behaviors. 3. A record review for Resident #4 revealed he was admitted to the facility on [DATE] and was [AGE] years old. A quarterly MDS assessment with an ARD of 5/11/20 revealed the resident was sometimes able to understand others and to make himself understood. He had a BIMS score of 4, indicating severe cognitive impairment, with fluctuating inattention and disorganized thought. He required supervision with mobility and limited assistance with activities of daily living. [DIAGNOSES REDACTED]. Resident #4 had a physician's order for [MEDICATION NAME] (an antipsychotic medication) 50 mg every night at bedtime, with instructions to monitor for aggressive behavior related to the indication for use of [MEDICATION NAME]. Resident #4 was care planned on 5/13/20 for occasional confusion, disorientation and urinating in a trash can due to his slowly advancing dementia. He was also care planned for a history of delusions, suspiciousness and paranoia, and for frequent requests to call his wife. Further review found no care plan for aggressive behaviors that were ordered to be monitored in relation to the [MEDICATION NAME]. 4. An interview was conducted with the Interim Administrator at 3:00 p.m. on 7/7/20. She confirmed there should be care plans to address resident behavior and [MEDICAL CONDITION] medication use. She confirmed behavioral symptoms, side-effects and interventions should be monitored for all residents on [MEDICAL CONDITION] medication. She and the Consulting Nurse searched for care plans for Residents #3 and #4 and [MEDICATION NAME] monitoring for Resident #1, but found none. 5. A review of the facility policy and procedure [MEDICAL CONDITION] Medication Clinical Guidelines effective 4/30/17 and revised 10/6/17, found under section 1 (Standard): Residents who use [MEDICAL CONDITION] drugs should receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Section II. Procedures specified: Nursing 1. Daily monitoring of the resident for presence of target behaviors and any adverse effects of the medication (charting behavior/adverse effects when present) . .3. (Nursing) assists in the development of behavioral care plans . Social Services: .2. Coordinates the development of behavioral care plans. Photocopy was obtained. The Informed Consent for Antipsychotic Medications form included with the policy, listed multiple medications including [MEDICATION NAME] and the following possible side effects: Sedation, lethargy, dry mouth, constipation, enlarged breast, disturbed gait, blurred vision, weight gain, movement disorders, [MEDICAL CONDITIONS], tremors, [MEDICAL CONDITIONS], cardiovascular events, increased risk for [MEDICAL CONDITION]. stroke, drooling and skin reactions. .