STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	17E294		C 06/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(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	F 000		
	The following citations represent the findings of a Health Resurvey and Complaint Investigation # 93702.			
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES	F 242		
	The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.			
	This REQUIREMENT is not met as evidenced by: The facility had a census of 28 residents. The sample included 12 residents of which 3 were reviewed for bathing choices. Based on observations, record review, and interviews, the facility failed to assess for and provide a tub bath based on resident preferences for 1 (#6) of the 3 sampled residents.			
	Findings included:			
	- Review of resident #6's annual Minimum Data Set (MDS) assessment dated 2/4/16 included the resident identified choosing a tub bath was very important to him/her.			
	Review of the quarterly MDS dated 5/5/16 did not include a preferences assessment.			
	The care plan updated 5/23/16 documented the resident required extensive assistance with			

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 242	Continued From page 1 bathing. The resident liked to take two showers a week in the mornings and needed assistance with showers. Observation on 5/25/16 at 11:15 AM staff S and O assisted the resident with incontinent care. Interview on 5/23/16 at 1:59 PM the resident stated he/she would rather have a tub bath, and had told the staff before. During another interview on 5/26/16 at 9:20 AM the resident confirmed that he/she would like a tub bath and stated it was very important to him/her. Interview on 5/24/16 at 4:40 PM direct care staff U, who worked with the resident for many years confirmed the facility had a tub (for resident bathing), and had a whirlpool in the past, but the facility removed both, he/she estimated more than a couple of years ago. Staff U gave the residents showers now, as that was only what the facility had to offer now. He/she stated staff used to give the resident whirlpool baths once a week, but do not do any longer since there is no whirlpool. Interview with administrative nursing staff D on 5/26/16 at 1:45 PM, revealed the shower frequency and time of day are honored and in the care plan. The assessment of preferences for bathing is with every care plan meeting, and at least quarterly. The facility failed to assess this long term residents bathing preferences and provide tub bathing prior to removal of the tub and whirlpool facilities when remodeling the resident common	F 242		

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F 242	Continued From page 2 bathrooms with only showers.	F 242		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: The facility identified a census of 28 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to complete a Significant Change Minimum Data Set for resident #23 when the resident began hospice services. Findings included: - The Physician's Order Sheet for resident #23 dated 4/6/16 included diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and	F 274		

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F 274	Continued From page 3 anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). The Annual Minimum Data Set (MDS) dated 1/21/16 documented a BIMS score of 0 (less than 7 indicated severely impaired cognition), and the resident did not receive hospice care. The Quarterly MDS dated 4/21/16 documented a Brief Interview for Mental Status (BIMS) score of 1. The resident received hospice care. The Care Area Assessments (CAAs) dated 1/21/16 revealed the resident suffered from cognitive loss and dementia (progressive mental disorder characterized by failing memory, confusion). The care plan dated 5/8/16 noted Hospice worked with the nursing staff to provide the maximum comfort for the resident. The physician's order dated 4/18/16 revealed the resident received a hospice evaluation. On 5/24/16 at 4:09 PM, the resident laid in a recliner with his/her eyes closed. On 5/26/16 at 11:28 AM, the resident stated he/she received hospice care. On 5/25/16 at 3:47 PM, direct care staff Q stated the resident received hospice care. On 5/26/16 at 10:14 AM, licensed nursing staff H stated the resident received hospice care. On 5/26/16 at 11:47 AM, administrative nursing	F 274		

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F 274	Continued From page 4 staff D stated when a resident started to receive hospice care, a Significant Change MDS should have been completed. He/she confirmed the resident's significant change MDS due to starting hospice services was not completed as indicated. The facility's policy "MDS", revised 5/25/16, instructed staff was to complete a Significant Change MDS when there was an overall deterioration of the resident's condition. The facility failed to complete a Significant Change MDS when required for this cognitively impaired resident, which could result in disrupting the continuity of care for this resident.	F 274		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual	F 278		

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F 278	Continued From page 5 to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: The facility identified a census of 28 residents. The sample included 12 residents. Based on observation, record review and interview, the facility failed to accurately assess1 (#25) of the 12 sampled residents, who was edentulous (without teeth). Findings included: - The May 2016 Physician's Order Sheet for resident #25 included diagnoses of cognitive deficits following cerebrovascular disease (a stroke) and unspecified dementia (progressive mental disorder characterized by failing memory, confusion) without behavioral disturbance. The physician's order included a regular diet as tolerated. The quarterly Minimum Data Set (MDS) dated 12/2/15 revealed the resident with a Brief Interview for Mental Status score of 0 (score 0 to 7 indicating the resident had severely impaired cognition). The resident had broken or loosely fitting dentures. The Annual MDS dated 3/22/16 revealed the resident with a BIMS score of 1, and with no oral or dental problems noted.	F 278		

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F 278	Continued From page 6 The Care Area Assessments (CAAs) dated 3/24/16 for dental did not trigger. The care plan dated 4/7/16 revealed the resident was able to eat independently, and directed staff to assist the resident with brushing teeth, cleaning gums with toothette (an oral sponge swab) and rinsing with mouthwash. On 05/25/2016 at 8:09 AM, the resident observed eating breakfast in the dining room. The resident did not have any natural teeth or dentures in his/her mouth. On05/25/2016 at 8:31 AM, there was not a set of dentures or a denture cup observed in the resident's bed room. On 05/25/2016 at 2:41 PM, direct care staff O stated the resident did not have natural teeth or dentures. On 05/26/2016 at 10:46 AM, direct care staff P stated he/she was not sure what to do for the resident regarding oral care. On 05/25/2016 at 4:25 PM, licensed nursing staff H stated he/she was not sure if the resident had natural teeth or dentures. On 05/26/2016 at 12:28 PM, administrative nursing staff D confirmed the error of the resident's dental status in the annual MDS dated 3/22/2016. The resident should have been identified as edentulous. The facility's MDS policy revised 5/25/16 documented all MDS's should be completed	F 278		

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F 278	Continued From page 7 accurately. The facility failed to assess the dental status and document accurately in the MDS for this cognitively impaired resident who was edentulous.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: The facility had a census of 28 residents. The sample included 12 residents. Based on observations, record review and staff interview, the facility failed to develop a comprehensive care plan to include nursing restorative services	F 279		

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F 279	Continued From page 8 for a decline in range of motion for one sampled resident (#29). Findings included: - Review of resident #29's signed physician orders dated May 2016 included these diagnoses: rheumatoid arthritis (chronic inflammatory disease that affected joints and other organ systems), chronic pain, major depression disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness) and insomnia (inability to sleep). Review of the signed physician orders dated May 2016 included these medications: Bio Freeze (a topical product applied to area of pain for pain relief) (started 5/4/16) apply to left shoulder Q8h (every 8 hours) and a Fentynal patch (a narcotic patch applied topically for chronic pain) 50 mcg (micrograms) changed every 72 hours, started 5/1/16 (7/2/15) The signed physician orders also included an order dated 1/19/16 for a fall on 12/31/15, included a left shoulder X-ray. The quarterly MDS (Minimum Data Set) dated 1/7/16 included the resident required limited assistance of one staff with transfers, supervision with locomotion in room and halls; no impairment of upper or lower extremities; balance unsteady, BIMS (Brief Interview for Mental Status) score of 8 (moderately impaired cognition), the resident did not receive restorative nursing services or exercises, and did not have a brace or splint device in place.	F 279		

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F 279	Continued From page 9 The MDS for annual assessment dated 4/8/16 included the resident required limited assistance of one with transfers, extensive physical assistance of one with dressing, had one sided upper extremity impairment; no impairment of lower extremities; used a walker for mobility; long and short term memory ok; and received scheduled pain medication. The care plan revised on 4/15/16 did not include restorative interventions for range of motion exercises. Review of the plan of care information the direct care staff document cares done for the resident included: right upper extremity therapy exercises with one pound weights for 6 times, and to repeat ten times, and do two sets or ten minutes with the arm bike. The affected area for the resident was the left shoulder, not the right shoulder. Observation on 5/24/16 at 2:10 PM included the resident was in his/her room seated in chair; she did not get exercises or wear a brace; observation of his/her included no brace or splint in place. Interview with Licensed Staff I, on 5/24/16 at 3:55 PM he/she stated some restorative nursing is done by the direct care staff U. Interview with direct care staff U on 5/24/16 at 3:56 PM, he/she stated no one gets restorative nursing anymore. Interview with direct care staff R, on 5/26/16 at 9:15 AM, he/she stated he/she knows this	F 279		

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F 279	Continued From page 10 resident, he/she usually works 2-10 PM shift, he/she doesn't do any exercises with resident except when assisting with dressing activities and that is just putting arms into clothing, not joint range of motion (ROM). Interview with administrative nursing staff D on 5/26/16 at 1:50 PM confirmed the resident did not receive ROM exercises through 5/26/16. He/she stated the resident should get ROM he/she confirmed an RN needs to be over the restorative program; and confirmed that also included monitoring that the ROM is done. Further interview on 5/26/16 at 1:50 PM with administrative nursing staff D confirmed ROM information should be in the care plan; he/she stated ROM not in the care plan and should be. He/she will add the ROM exercises to the care plan now. Review of the facility policy for comprehensive care plans are to ....aid in preventing or reducing decline in the level at which the resident functions, as well as enhancing the optimal level of functioning for the resident by focusing on rehabilitation programs... Review of the facility policy for Restorative Nursing was ...the facility has an active program of rehabilitative nursing which is developed and coordinated through the residents care plan ....The facility's rehabilitative nursing care program is designed to assist each resident to achieve and maintain an optimal level of self-care and independence... The facility failed to develop a comprehensive care plan to include the restorative nursing	F 279		

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F 279	Continued From page 11 exercises for the resident's left shoulder.	F 279		
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 participate in planning care and treatment or changes in care and treatment. 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. This REQUIREMENT is not met as evidenced by: The facility identified a census of 28 residents. The sample included 12 residents. Based on observation, record review and interview, the facility failed to revise the care plan to accurately reflect the needs of the resident for 2 of the 12 residents sampled, including dental for resident #25 and incontinence for resident #26. Findings included:	F 280		

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F 280	Continued From page 12 - The May 2016 Physician's Order Sheet for resident #25 included diagnoses of cognitive deficits following cerebrovascular disease (a stroke) and unspecified dementia (progressive mental disorder characterized by failing memory, confusion) without behavioral disturbance. The physician's order included a regular diet as tolerated. The quarterly Minimum Data Set (MDS) dated 12/2/15 revealed the resident with a Brief Interview for Mental Status score of 0 (score 0 to 7 indicating the resident had severely impaired cognition). The resident had broken or loosely fitting dentures. The Annual MDS dated 3/22/16 revealed the resident with a BIMS score of 1, and with no oral or dental problem noted. The Care Area Assessments (CAAs) dated 3/24/16 for dental status did not trigger. The care plan reviewed on 4/7/16 revealed the resident was able to eat independently, and direct care staff to assist the resident with brushing teeth, cleaning gums with toothette (an oral sponge swab) and rinsing with mouthwash. On 05/25/2016 at 8:09 AM, the resident observed having breakfast in the dining room. The resident did not have natural teeth or dentures in his/her mouth. On 05/25/2016 at 8:31 AM, there was not a set of dentures or a denture cup observed in the resident's room. On 05/25/2016 at 2:41 PM, direct care staff O	F 280		

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F 280	Continued From page 13 stated the resident did not have natural teeth or dentures. On 05/26/2016 at 10:46 AM, direct care staff P stated he/she was not sure what to do for the resident regarding oral care. On 05/25/2016 at 4:25 PM, licensed nursing staff H stated he/she was not sure if the resident had natural teeth or dentures. On 05/26/2016 at 12:25 PM, administrative nursing staff E confirmed the error of the dental care plan for the resident. The resident should have been identified as edentulous. The facility's Comprehensive Care Plan Policy, revised 12/31/2016, documented the care plan should reflect currently recognized standards of practice for problem areas and conditions. The facility failed to develop an accurate dental care plan for this cognitively impaired resident who was dentulous. - The May 2016 Physician Order Sheet for resident #26 listed a diagnosis of unspecified dementia without behavioral disturbance (progressive mental disorder characterized by failing memory, confusion). The admission Minimum Data Set (MDS) dated 12/24/15 revealed the resident with a Brief Interview for Mental Status (BIMS) of 2 (score 0 to 7 indicating the resident had severely impaired cognition). The resident required limited assistance with toilet use. The resident was always continent with bladder.	F 280		

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F 280	Continued From page 14 The significant MDS dated 3/22/16 revealed the resident with a BIMS of 9 (score 8 to 12 indicating the resident had moderately impaired cognition). The resident required limited assistance with toilet use. The resident was occasionally incontinent with bladder. The urinary incontinence Care Area Assessment dated 3/24/16 revealed the resident needed some assistance with his/her toileting needs. The care plan dated 3/30/16 revealed the resident was incontinent of bladder at times and staff to assist the resident with toileting every 2 hours and as needed. Review of Activity of Daily Livings (ADLs) record from January 2016 to May 2016, noted the resident was independent with toilet use. On 05/25/2016 at 10:39 AM, the resident sat in a wheelchair free of wetness and urine odor. On 05/25/2016 at 10:44 AM, the resident stated he/she transferred to the toilet independently but needed assistance with toilet use at times, especially with peri-care. The resident also stated he/she felt the urge to use the bathroom. On 05/25/2016 at 12:17 PM, direct care staff S stated the resident was rarely incontinent of bladder and used the toilet independently. Staff S also stated he/she was not aware of the instructions on the care plan to assist the resident with toileting every 2 hour. On 05/25/2016 at 2:50 PM, direct care staff O stated the resident was able to use the toilet	F 280		

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F 280	Continued From page 15 independently and used the call light for assistance as needed. On 05/25/2016 at 1:08 PM, licensed nursing staff H stated the resident was rarely incontinent with bladder and used the bathroom independently or needed assistance at times. Staff H also stated the care plan was not accurate about the assistance the resident required for toilet use. On 05/26/2016 at 11:27 AM, administrative nursing staff E stated the care plan was inaccurate and the resident did not require every 2 hour toileting with staff's assistance. The facility's Comprehensive Care Plan Policy revised 12/31/2015 documented the care plan should reflect currently recognized standards of practice for problem areas and conditions. The facility failed to develop an accurate care plan regarding the toileting assistance for this cognitively impaired resident.	F 280		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: The facility census included 28 residents, of	F 318		

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F 318	Continued From page 16 which 12 were included in the sample. Based on observations, record review, and interviews, the facility failed to provide restorative nursing services for 2 (#29 and #21) of 3 sampled residents reviewed for restorative nursing services. Findings included: - Review of resident #29's signed physician orders dated May 2016 included these diagnoses: rheumatoid arthritis (chronic inflammatory disease that affected joints and other organ systems), chronic pain, major depression disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness) and insomnia (inability to sleep). Review of the signed physician orders dated May 2016 included these medications: Bio Freeze (a topical product applied to area of pain for pain relief) (started 5/4/16) apply to left shoulder Q8h (every 8 hours) and a Fentanyl patch (a narcotic patch applied topically for chronic pain) 50 mcg (micrograms) changed every 72 hours. The quarterly MDS (Minimum Data Set) dated 1/7/16 included the resident required limited assistance of one staff with transfers, supervision with locomotion in room and halls; had no impairment of the upper or lower extremities; had an unsteady balance, had a BIMS (Brief Interview for Mental Status) score of 8 (8 to 12 indicated moderately impaired cognition). The resident did not receive restorative nursing services or exercises, and did not have a brace or splint device in place.	F 318		

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F 318	Continued From page 17 The MDS annual assessment dated 4/8/16 included the resident required limited assistance with transfers, and required extensive physical assistance with dressing. The resident had one-sided upper extremity impairment, but no impairment of the lower extremities. He/she used a walker for mobility and received scheduled pain medication. His/her long and short term memory was adequate. The care plan revised on 4/15/16 did not include restorative interventions for the range of motion exercises. A physician's order dated 1/19/16 noted the resident to have a left shoulder x-ray. Review of the restorative documentation record used by direct care staff for the resident included: right upper extremity therapy exercises with one pound weights for 6 repetitions, and repeat ten times. Then repeat for total of two sets of these exercises or ten minutes with the arm bike. The affected area for the resident was the left shoulder, per the pysician's x-ray order dated 1/19/16, not the right shoulder. Observation on 5/24/16 at 2:10 PM included the resident sat in a chair in his/her room. He/she stated she did not get exercises or wear a brace or splint. The resident lacked a brace on either shoulder. Interview on 5/24/16 at 2:11 PM included the resident stated he/she could get up on his/her own, but staff wanted him/her to wait for help. He/she stated he/she had fallen in the past.	F 318		

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F 318	Continued From page 18 Interview with direct care staff T, on 5/24/16 at 3:55 PM, stated the resident did get up on his/her own, and sometimes did not use the call light. Interview with licensed nursing staff I, on 5/24/16 at 3:55 PM, stated direct care staff U was responsible for providing restorative nursing. Interview with direct care staff U on 5/24/16 at 3:56 PM stated there are not any residents that receive restorative nursing. Interview with direct care staff R, on 5/26/16 at 9:15 AM, stated he/she did not perform any exercises with the resident, except when he/she assisted the resident with dressing. He/she confirmed the resident did not receive any range of motion exercises (ROM). Interview with administrative nursing staff D on 5/26/16 at 1:50 PM confirmed there was a lack of documentation the resident received ROM. Review of the facility's policy "Restorative Nursing" revised 5/25/15 noted staff was to ensure the residents who were admitted to a restorative program maintained functional status. The facility failed to provide range of motion exercises for this resident. - The physician's progress note dated 5/3/16 for resident #21 included diagnoses of congestive heart failure (CHF)(a condition with low heart output and the body becomes congested with fluid) and dementia (progressive mental disorder characterized by failing memory, confusion). The Significant Change Minimum Data Set (MDS) dated 5/20/16 noted a Brief Interview for	F 318		

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F 318	Continued From page 19 Mental Status (BIMS) score of 3 (less than 7 indicated severely impaired cognition). The resident required limited assistance with bed mobility, transfers, and locomotion on and off of the unit, and was unsteady with transfers. He/she required extensive assistance with toileting, and received physical and occupational therapy. The resident did not have any range of motion impairments. The Admission MDS dated 12/6/15 documented a BIMS score of 5. He/she required supervision with all Activities of Daily Living (ADLs), and was unsteady with transfers. The resident did not have any range of motion impairment (ROM), or receive physical, occupational, or restorative therapy. The Care Area Assessments (CAAs) dated 5/20/16 noted the resident had poor memory and needed prompting to remember details. He/she was not steady with transfers, and required assistance with all transfers. The resident received physical and occupational therapy for strengthening. The Activities of Daily Living (ADL) CAA did not trigger. The care plan dated 3/14/16 noted the resident needed supervision at times with decision making. He/she was able to ambulate independently with the use of his/her walker, and able to transfer independently. The resident's restorative nursing program included the following exercises to be performed with the resident: resident walked to and from the dining room 5 days a week, 15 knee/leg lifts with both the right and left legs, 10 cycling motions with right and left feet to maintain active ROM for 15 minutes three times weekly, and 15 repetitious circles for 10	F 318		

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F 318	Continued From page 20 minutes with his/her right and left arms to maintain active ROM three times weekly. Review of the occupational therapy evaluation dated 3/8/16 noted the resident needed restorative nursing therapy to maintain gains in independence, strength for increased safety in the facility, and to decrease fall risk. The Restorative documentation records for February 2016, March 2016, and April 2016 were blank. On 5/25/16 at 1:17 PM, the resident sat at a table in the therapy room, and exercised with the arm bike. On 5/25/16 at 4:09 PM, direct care staff Q stated the direct care staff performed restorative nursing therapy with the resident. On 5/26/16 at 11:22 AM, direct care staff O was unsure if the resident received restorative nursing therapy, or who performed it. On 5/25/16 at 3:06 PM, administrative nursing staff E stated every resident received a therapy evaluation upon admission. From there, it was determined whether or not the resident needed therapy or restorative nursing. If the resident needed restorative nursing, the direct care staff were informed. The direct care staff were expected to perform the restorative nursing exercises as directed with the resident. On 5/26/16 at 10:31 AM, licensed nursing staff H stated the resident received restorative nursing. On 5/26/16 at 12:00 PM, administrative nursing	F 318		

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F 318	Continued From page 21 staff D stated he/she expected the direct care staff to carry out the restorative nursing exercises with the resident as documented in the care plan. Staff D went further on to say the direct care staff were responsible for knowing which residents received restorative therapy. The facility's policy "Restorative Nursing", revised 5/25/15, noted the facility's rehabilitative nursing care program was designed to assist each resident to achieve and maintain an optimal level of self-care and independence. The facility failed to provide restorative nursing therapy as planned for this cognitively impaired resident who was at risk for a decline in his/her self-care ability.	F 318		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility identified a census of 28 residents. The sample included 12 residents, with 3 residents reviewed for accidents. The facility identified 18 cognitively impaired, independently mobile residents in the facility. Based on observation, record review, and interview, the facility failed to provide safe side rails for 2 of the	F 323		

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F 323	Continued From page 22 3 (#21 and #5) residents reviewed for accidents and failed to maintain an environment free of accident hazards with unsafe hot water temperatures in an area accessible to the 18 cognitively impaired, independently mobile residents of the facility Findings included: - The physician's progress note dated 5/3/16 for resident #21 included diagnoses of congestive heart failure (CHF)(a condition with low heart output and the body becomes congested with fluid) and dementia (progressive mental disorder characterized by failing memory, confusion). The Significant Change Minimum Data Set (MDS) dated 5/20/16 for resident #21 noted a Brief Interview for Mental Status (BIMS) score of 3 (less than 7 indicated severely impaired cognition). The resident required limited assistance with bed mobility, transfers, and locomotion on and off of unit, and was unsteady with transfers. He/she required extensive assistance with toileting, and received physical and occupational therapy. The resident did not have any range of motion impairments and had one minor injury fall. The Admission MDS dated 12/6/15 documented a BIMS score of 5. He/she required supervision with all Activities of Daily Living (ADLs), and was unsteady with transfers. The resident did not have any range of motion impairment (ROM), or receive physical, occupational, or restorative therapy. He/she had not had a fall. The Care Area Assessments (CAAs) dated 5/20/16 noted the resident had poor memory and	F 323		

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F 323	Continued From page 23 needed prompting to remember details. He/she was not steady with transfers, and required assistance with all transfers. The resident received physical and occupational therapy for strengthening. He/she had fallen once since reentry; this fall was a non-injury fall. The Activities of Daily Living (ADL) CAA did not trigger. The care plan dated 3/14/16 noted the resident needed supervision at times with decision making. He/she was able to ambulate independently with the use of his/her walker, and able to transfer independently. Hourly monitoring was increased to every 15 minutes for increased safety due to increased falls. Staff left the resident's light on at night, so he/she could see to use the bathroom and get out of bed safely on his/her own. The care plan lacked information about the side rail on the resident's bed. Review of the fall assessments dated 11/30/15, 1/20/16, 2/29/16, 4/8/16, 4/19/16, 5/9/16, and 5/17/16 noted the resident was at a high risk for falling. Review of the side rail assessment dated 2/17/16 noted the resident had visual defects, could get in and out of bed safely, used the rail for positioning, and was cognitive enough not to climb over the rail. On 5/23/16 at 4:42 PM, observation of the resident's room revealed a side rail on the resident's bed, on his/her right side. The side rail was not attached to the bed, as there were rails fitted between the mattress and the bed frame to hold the side rail on the bed. There was a 5 inch gap between the top of the rail and the first	F 323		

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F 323	Continued From page 24 horizontal rail. The rail was loose and wobbled when touched. When the bed was sat upon, the rail was still loose and wobbled when gripped. On 5/24/16 at 4:11 PM, the resident sat in a chair with his/her eyes closed. On 5/26/16 at 11:14 AM, the resident stated he/she had trouble with falls. On 5/23/16 at 3:19 PM, licensed nursing staff J confirmed the presence of a side rail on the resident's bed. On 5/26/16 at 1:20 PM, administrative nursing staff E the resident's family brought the side rail for the resident to use, so the facility put it on the resident's bed. The U.S. Food and Drug Administration's " Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment ", issued on 3/10/06, revealed any gap in a side rail should be less than 4.75 inches. The facility policy "Side Rail Use", revised 5/25/16, lacked information in regards to the required gap measurement and safe installation process. The facility failed to ensure the side rail was safe for this cognitively impaired resident who had a history of falls. - On 5/23/16 at 9:15 AM, the water temperature at the sink in the cafe (an open room accessible to any mobile resident and used for resident activities) measured 124.5 degrees Fahrenheit. A	F 323		

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F 323	Continued From page 25 second thermometer read 123 degrees Fahrenheit. On 5/26/16 at 12:29 PM, the same sink water temperature measured 122.7 degrees. Review of the water temperature weekly checks log for February 2016, March 2016, and April 2016 only noted the shower water temperatures. The log lacked documentation of water temperature measurements for the resident rooms and the cafe sink. On 5/26/16 at 11:39 AM, maintenance staff X stated he/she performed monthly water temperature checks. He/she said the checks for the cafe were periodic and not documented anywhere. He/she further stated the mixing valve was adjusted earlier in the week due to finding high water temperatures. He/she stated it would be adjusted this day. The facility's policy "Water Temperature Policy and Procedure", undated, noted maintenance staff checked water temperatures on a weekly basis, and the results were recorded. The facility failed to maintain an environment free of accident hazards by maintaining appropriate water temperatures for 18 cognitively impaired and independently mobile residents in the facility. - The May 2016 Physician's Order Sheet for resident #5 included diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) and malaise (vague uneasy feeling of body weakness, distress or discomfort). The admission Minimum Data Set (MDS) dated	F 323		

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F 323	Continued From page 26 4/19/16 revealed the resident with a Brief Interview for Mental Status (BIMS) score of 3, which indicated severely impaired cognition. The resident required assistance with bed mobility and transfers. The Care Area Assessments (CAAs) dated 4/21/16 for cognitive loss and dementia noted the resident was confused most of the time. The care plan dated 4/27/16 documented the resident repositioned himself/herself in bed. The care plan lacked information about side rail use. The side rail assessments dated 4/13/16 and 4/20/16 revealed the resident did not express desire to have side rails while in bed. The resident did not use the side rail for positioning and/or support. On 05/25/2016 at 3:51 PM, there were upper side rails on the resident's bed, and the left side of the bed was against the wall. The gap between the top of the side rail and the top of the mattress measured 7.5 inches, and the width between the side rail vertical bars measured 16 inches. According to U.S. Food and Drug Administration, "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment", issued on 3/10/06, the gaps within rails should be less than 4.75 inches to prevent head or body entrapment. On 05/25/2016 at 2:44 PM, direct care staff O stated the resident was confused and tried to transfer by himself/herself to the bed from the wheelchair.	F 323		

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F 323	Continued From page 27	F 323		

On 05/26/2016 at 7:39 AM direct care staff P and S transferred the resident from the bed to the wheelchair. The resident did not use the side rail.

On 05/26/2016 at 7:41 AM, direct care staff P stated the resident was able to use the side rails for positioning and transferring.

On 05/26/2016 at 10:01 AM, direct care staff R stated the resident used the side rail for positioning in bed.

On 05/25/2016 at 4:28 PM, licensed nursing staff H stated the resident used the side rails for repositioning in bed. Staff H was not aware who was responsible for conducting side rail assessments.

On 05/26/2016 at 9:49 AM, maintenance staff X stated he/she was unsure who installed the resident's side rails, and he/she was not aware of the required side rail measurements for safety.

On 05/26/2016 at 10:47 AM, administrative staff E stated he/she conducted side rail assessments, but he/she was not aware of the required side rail measurements for safety.

On 05/26/2016 at 10:49 AM, administrative staff D stated the resident used the side rails in bed, and he/she was not aware of the required side rail measurements for safety.

The facility's Side Rail Use Policy dated 5/25/16 lacked evidence of the side rail gap measurements for safety.

The facility failed to ensure the environment was free from potential side rail entrapment for this

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F 323	Continued From page 28 cognitively impaired resident whose side rail gap measurements exceed the recommended 4.75 inches. This unsafe practice could potentially cause entrapment for this resident.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: The facility identified a census of 28 residents. The sample included 12 residents, with 5 residents selected for medication review. Based	F 329		

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F 329	Continued From page 29 on observation, record review, and interview, the facility failed to monitor 2 residents (#23 and #21) for side effects of medications causing constipation, and failed to report high blood sugar readings for 1 resident (#13). Findings included: - The April 2016 Physician's Order Sheet (POS) for resident #23 dated 4/6/16 included a diagnosis of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure). The POS also included Carbidopa/Levodopa 25 milligrams (mg)/100 mg (a medication for tremors), Zyprexa 5 mg (a medication for behaviors), Cogentin 0.5 mg (a medication for involuntary muscle movements), Depakene 500 mg (a mood stabilizer), Namenda 10 mg (a medication to improve memory), Miralax 17 grams (a medication for constipation), Milk of Magnesia 30 milliliters (ml) as needed (a medication for constipation), and Dulcolax 10 mg as needed (a medication for constipation). The annual Minimum Data Set (MDS) dated 1/21/16 noted a Brief Interview for Mental Status (BIMS) score of 0 (less than 7 indicated severely impaired cognition). The resident required extensive assistance with toileting, and received antipsychotic medications. The quarterly (MDS) dated 4/21/16 noted a BIMS score of 1. The resident required extensive assistance with toileting, and received antipsychotic medications. The Care Area Assessments (CAAs) dated 1/21/16 revealed the resident suffered from cognitive loss and dementia (progressive mental	F 329		

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F 329	Continued From page 30 disorder characterized by failing memory, confusion). The care plan dated 5/8/16 noted staff to monitor the side effects of the resident's medications. The U.S. Food and Drug Administration's recommendations revealed the side effects of Carbidopa/Levodopa, Zyprexa, Cogentin, Depakene and Namenda included constipation. The Bowel monitoring records for February 2016, March 2016, and April 2016 noted the resident did not have a bowel movement from 2/12/16 until 2/17/15 (5 days), from 3/8/16 until 3/14/16 (6 days), from 3/14/16 until 3/20/16 (6 days), from 3/27/16 until 4/1/16 (5 days), and from 4/10/16 until 4/15/16 (5 days). The Medication Administration Record (MAR) lacked evidence of as needed laxatives administered on those dates mentioned above. On 5/24/16 at 4:09 PM, the resident rested in a recliner. On 5/25/16 at 3:49 PM, direct care staff Q stated direct care staff were to document the result in the electronic chart when a resident had a bowel movement. On 5/25/16 at 4:38 PM, licensed nursing staff H stated the nurses administered Milk of Magnesia according to the physician's order for those who had not had a bowel movement for 3 days. On 5/26/16 at 11:49 AM, administrative nursing staff D stated he/she expected the nurses to act upon and administered an as needed laxative if it	F 329		

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F 329	Continued From page 31 was ordered, or obtained an order for one for those residents not having a bowel movement in 3 days. The facility's policy "Bowel Monitoring Policy", revised 11/10/15, noted if a resident had not had a bowel movement in the last 3 days, he/she received Milk of Magnesia. The facility failed to monitor for the side effects of medications causing constipation for this cognitively impaired resident. - The physician's progress note dated 5/3/16 for resident #21 noted diagnoses of congestive heart failure (CHF)(a condition with low heart output and the body becomes congested with fluid) and dementia (progressive mental disorder characterized by failing memory, confusion). The Physician's Order Sheet (POS) for May 2016 documented orders for Namenda 5 milligrams (mg) twice daily (a medication for memory), Sertraline 75 mg daily (an antidepressant), Detrol 4 mg (a medication to strengthen the bladder), and Amlodipine 5 mg daily (a medication to strengthen the heart). The Significant Change Minimum Data Set (MDS) dated 5/20/16 noted a Brief Interview for Mental Status (BIMS) score of 3 (less than 7 indicated severely impaired cognition). The resident required extensive assistance with toileting. The Care Area Assessments (CAAs) dated 5/20/16 noted the resident had poor memory and needed prompting to remember details. The Activities of Daily Living (ADL) CAA did not	F 329		

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F 329	Continued From page 32 trigger. The care plan dated 3/14/16 noted staff monitored and documented side effects of the medications the resident received. Staff cued, reoriented and supervised the resident as needed. Bowel monitoring records for February 2016, March 2016, and April 2016 noted the resident did not have a bowel movement from 2/11/16 until 2/16/16 (5 days), from 3/31/16 until 4/5/16 (6 days), from 4/5/16 until 4/9/16 (4 days), and from 4/13/16 until 4/17/16 (4 days). The U.S. Food and Drug Administration's recommendations revealed the side effects of Namenda, Sertraline, Detrol, and Amlodipine included constipation. The Medication Administration Record (MAR) lacked evidence of as needed laxatives administered on those dates mentioned above. On 5/24/16 at 4:11 PM, the resident sat in a chair with his/her eyes closed. On 5/25/16 at 3:49 PM, direct care staff Q stated direct care staff were to document the result in the electronic chart when a resident had a bowel movement. On 5/25/16 at 4:38 PM, licensed nursing staff H stated the nurses administered Milk of Magnesia according to the physician's order for those who had not had a bowel movement for 3 days. On 5/26/16 at 11:49 AM, administrative nursing staff D stated he/she expected the nurses to act	F 329		

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F 329	Continued From page 33 upon and administered an as needed laxative if it was ordered, or obtained an order for one for those residents not having a bowel movement in 3 days. The facility's policy "Bowel Monitoring Policy", revised 11/10/15, noted if a resident had not had a bowel movement in the last 3 days, he/she received Milk of Magnesia. The facility failed to monitor for the side effects of medications causing constipation for this cognitively impaired resident. - The May 2016 Physician Order Sheet (POS) for resident #13 included diagnoses of type 2 diabetes mellitus and dementia. The POS also listed the resident received Lantus (an insulin to treat diabetes) 20 units twice a day, Novolog (an insulin to treat diabetes) 10 units before meals, fasting blood sugar checks before meals and at bedtime and to notify the physician when the blood sugar was <60 or >400. The annual Minimum Data Set (MDS) dated 11/22/15 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 01, which indicated severely impaired cognition. The resident received insulin injections. The quarterly MDS dated 5/19/16 revealed the resident a BIMS score of 1. The resident received insulin injections. The dementia Care Area Assessments (CAAs) dated 11/22/15 revealed the resident had a diagnosis of dementia and a behavior of refusal of care.	F 329		

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F 329	Continued From page 34 The care plan dated 5/23/16 revealed nursing staff was to administer medications as ordered and to monitor and document for side effects and effectiveness. The resident had fasting blood sugar checks before meals and at bed time according to physician's orders. If the blood sugars were not within parameters, nursing staff should contact the physician. Review of the Medication Administration Record (MAR) noted the following times the resident's blood glucose levels were greater than 400: 4 times in February 2016, 4 times in March 2016, and 6 times in May 2016. Review of the MAR noted the resident had refused Novolog 7 times in March 2016, 3 times in April 2016, and 9 times in May 2016; and refused Lantus once in March 2016, 3 times in April 2016 and 2 times in May 2016. Review of the clinical records from February 2016 to May 2016 revealed the facility failed to notify the physician when the blood glucose levels were greater than 400 as mentioned above or of the resident's refusal of the insulin injections as mentioned above. On 05/25/2016 at 11:06 AM, the resident rested in the wheelchair in the day room. On 05/25/2016 at 2:52 PM, direct care staff O stated the resident had a behavior of rejection of cares. On 05/26/2016 at 7:44 AM, direct care staff S stated the resident was drowsy and sleepy with high blood sugar.	F 329		

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F 329	Continued From page 35 On 05/25/2016 at 4:35 PM, licensed nursing staff H stated the resident often refused insulin and the resident ' s fasting blood glucose levels fluctuated. Staff H also stated nurses should notify the physician when the blood sugar level was out of parameters per the physician's order. On 05/26/2016 at 11:02 AM, administrative nursing staff D stated he/she expected the nurses to notify the physician with abnormal blood sugar levels and frequent refusal of the medications. The facility's Medication Administration policy, dated 12/9/2015, documented the charge nurse should notify the physician when the blood sugar was out of range per the physician's order. The facility failed to report to the physician of the resident's abnormal blood sugar levels as ordered and frequent refusal of medications, which could potentially result in excessively high or low blood sugar for this cognitively impaired resident who was an insulin dependent diabetic.	F 329		
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer	F 411		

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F 411	Continued From page 36 residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: The facility identified a census of 28 residents. The sample included 12 residents, with 3 residents reviewed for dental services. Based on observation, record review and interview, the facility failed to provide dental service for 1 of the 3 sampled residents, resident #25. Findings included: - The May 2016 Physician's Order Sheet for resident #25 included diagnoses of cognitive deficits following cerebrovascular disease (a stroke) and unspecified dementia (progressive mental disorder characterized by failing memory, confusion). The physician's order included a regular diet as tolerated. The quarterly Minimum Data Set (MDS) dated 12/2/15 revealed the resident with a Brief Interview for Mental Status score of 0 (score 0 to 7 indicating the resident had severely impaired cognition). The resident had broken or loosely fitting dentures. The Annual MDS dated 3/22/16 revealed the resident with a BIMS score of 1, and with no oral or dental problems noted. The Care Area Assessments (CAAs) dated 3/24/16 for dental did not trigger. The care plan reviewed on 4/7/16 revealed the resident was able to eat independently. He/she	F 411		

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F 411	Continued From page 37 required assistance of one staff member for personal hygiene. Staff was to assist the resident with brushing teeth, cleaning gums with toothette (oral sponge swab) and rinsing with mouthwash. On 05/25/2016 at 8:09 AM, the resident observed having breakfast in the dining room. The resident did not have any natural teeth or dentures in his/her mouth. On 05/25/2016 at 8:31 AM, there was not a set of dentures or a denture up observed in the resident's bed room. On 05/25/2016 at 2:41 PM, direct care staff O stated the resident did not have natural teeth or dentures. On 05/25/2016 at 4:25 PM, licensed nursing staff H stated he/she was not sure if the resident had natural teeth or dentures. On 05/26/2016 at 10:06 AM, administrative staff B stated he/she was not sure if the resident had natural teeth or dentures. Staff B also stated he/she could not locate any of the resident's dental visit or consultation documents. The facility's Dental Services Policy, dated 11/09/2015, documented the facility should ensure that routine and emergent dental service were available to meet the resident's oral health needs. The facility failed to provide dental service for this cognitively impaired resident who was edentulous.	F 411		
F 428	483.60(c) DRUG REGIMEN REVIEW, REPORT	F 428		

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F 428 SS=D	Continued From page 38 IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: The facility identified a census of 28 residents. The sample included 12 residents, with 5 residents selected for medication review. Based on observation, record review, and interview, the facility consultant staff failed to identify and report the facility's failure to adequately monitor 2 residents (#23 and #21) for side effects of medications causing and implementing medication administration to prevent constipation, and failure to report high blood sugar readings to the physician for 1 resident (#13). Findings included: - The April 2016 Physician's Order Sheet (POS) for resident #23 dated 4/6/16 included a diagnosis of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure). The POS also included Carbidopa/Levodopa 25 milligrams (mg)/100 mg (a medication for tremors), Zyprexa 5 mg (a medication for behaviors), Cogentin 0.5 mg (a medication for involuntary muscle movements), Depakene 500 mg (a mood stabilizer), Namenda	F 428		

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F 428	Continued From page 39 10 mg (a medication to improve memory), Miralax 17 grams (a medication for constipation), Milk of Magnesia 30 milliliters (ml) as needed (a medication for constipation), and Dulcolax 10 mg as needed (a medication for constipation). The annual Minimum Data Set (MDS) dated 1/21/16 noted a Brief Interview for Mental Status (BIMS) score of 0 (less than 7 indicated severely impaired cognition). The resident required extensive assistance with toileting, and received antipsychotic medications. The quarterly (MDS) dated 4/21/16 noted a BIMS score of 1. The resident required extensive assistance with toileting, and received antipsychotic medications. The Care Area Assessments (CAAs) dated 1/21/16 revealed the resident suffered from cognitive loss and dementia (progressive mental disorder characterized by failing memory, confusion). The care plan dated 5/8/16 noted staff to monitor the side effects of the resident's medications. The U.S. Food and Drug Administration's recommendations revealed the side effects of Carbidopa/Levodopa, Zyprexa, Cogentin, Depakene and Namenda included constipation. The Bowel monitoring records for February 2016, March 2016, and April 2016 noted the resident did not have a bowel movement from 2/12/16 until 2/17/15 (5 days), from 3/8/16 until 3/14/16 (6 days), from 3/14/16 until 3/20/16 (6 days), from 3/27/16 until 4/1/16 (5 days), and from 4/10/16 until 4/15/16 (5 days).	F 428		

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F 428	Continued From page 40 The Medication Administration Record (MAR) lacked evidence of as needed laxatives administered on those dates mentioned above. Review of the pharmacist's consultations on 5/31/15, 6/10/15, 7/20/15, 8/27/15, 9/14/15, 10/8/15, 11/25/15, 12/8/15, 1/12/16, 2/9/16, 3/31/16, and 4/12/16 revealed the pharmacist consultant failed to identify and report a need for closer bowel movement monitoring. On 5/24/16 at 4:09 PM, the resident rested in a recliner. On 5/25/16 at 3:49 PM, direct care staff Q stated direct care staff were to document the result in the electronic chart when a resident had a bowel movement. On 5/25/16 at 4:38 PM, licensed nursing staff H stated the nurses administered Milk of Magnesia according to the physician's order for those who had not had a bowel movement for 3 days. On 5/26/16 at 11:49 AM, administrative nursing staff D stated he/she expected the nurses to act upon and administered an as needed laxative if it was ordered, or obtained an order for one for those residents not having a bowel movement in 3 days. On 5/31/16 at 2:41 PM, pharmacy consultant KK stated he/she did not review the resident's bowel monitoring records. The facility's policy "Bowel Monitoring Policy", revised 11/10/15, noted if a resident had not had a bowel movement in the last 3 days, he/she	F 428		

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F 428	Continued From page 41 received Milk of Magnesia. The facility failed to provide a policy regarding the consultant pharmacist's expectations as requested. The facility consultant staff failed to identify and report the facility's failure to monitor for the side effects of medications causing constipation and failure to administer ordered medications to prevent constipation for this cognitively impaired resident. - The physician's progress note dated 5/3/16 for resident #21 noted diagnoses of congestive heart failure (CHF)(a condition with low heart output and the body becomes congested with fluid) and dementia (progressive mental disorder characterized by failing memory, confusion). The Physician's Order Sheet (POS) for May 2016 documented orders for Namenda 5 milligrams (mg) twice daily (a medication for memory), Sertraline 75 mg daily (an antidepressant), Detrol 4 mg (a medication to strengthen the bladder), and Amlodipine 5 mg daily (a medication to strengthen the heart). The Significant Change Minimum Data Set (MDS) dated 5/20/16 noted a Brief Interview for Mental Status (BIMS) score of 3 (less than 7 indicated severely impaired cognition). The resident required extensive assistance with toileting. The Care Area Assessments (CAAs) dated 5/20/16 noted the resident had poor memory and needed prompting to remember details. The Activities of Daily Living (ADL) CAA did not trigger.	F 428		

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F 428	Continued From page 42 The care plan dated 3/14/16 noted staff monitored and documented side effects of the medications the resident received. Staff cued, reoriented and supervised the resident as needed. Bowel monitoring records for February 2016, March 2016, and April 2016 noted the resident did not have a bowel movement from 2/11/16 until 2/16/16 (5 days), from 3/31/16 until 4/5/16 (6 days), from 4/5/16 until 4/9/16 (4 days), and from 4/13/16 until 4/17/16 (4 days). The U.S. Food and Drug Administration's recommendations revealed the side effects of Namenda, Sertraline, Detrol, and Amlodipine included constipation. The Medication Administration Record (MAR) lacked evidence of as needed laxatives administered on those dates mentioned above. Review of the pharmacist's consultations on 12/8/15, 1/12/16, 2/9/16, 3/31/16, and 4/12/16 failed to recommend closer bowel movement monitoring. On 5/24/16 at 4:11 PM, the resident sat in a chair with his/her eyes closed. On 5/25/16 at 3:49 PM, direct care staff Q stated direct care staff were to document the result in the electronic chart when a resident had a bowel movement. On 5/25/16 at 4:38 PM, licensed nursing staff H stated the nurses administered Milk of Magnesia according to the physician's order for those who had not had a bowel movement for 3 days.	F 428		

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F 428	Continued From page 43 On 5/26/16 at 11:49 AM, administrative nursing staff D stated he/she expected the nurses to act upon and administered an as needed laxative if it was ordered, or obtained an order for one for those residents not having a bowel movement in 3 days. On 5/31/16 at 2:41 PM, pharmacy consultant KK stated he/she did not review the resident's bowel monitoring records. The facility's policy "Bowel Monitoring Policy", revised 11/10/15, noted if a resident had not had a bowel movement in the last 3 days, he/she received Milk of Magnesia. The facility failed to provide a policy regarding the consultant pharmacist's expectations as requested. The facility consultant staff failed to identify and report the facility's failure to monitor for the side effects of medications causing constipation and failure to administer ordered medications to prevent constipation for this cognitively impaired resident. - The May 2016 Physician Order Sheet (POS) for resident #13 included diagnoses of type 2 diabetes mellitus (not enough insulin made or the body cannot respond to the insulin) and dementia (progressive mental disorder characterized by failing memory, confusion). The POS also listed the resident received Lantus (an insulin to treat diabetes) 20 units twice a day, Novolog (an insulin to treat diabetes) 10 units before meals, fasting blood sugar checks before meals and at bedtime and to notify the physician when the blood sugar was <60 or >400. The annual Minimum Data Set (MDS) dated	F 428		

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F 428	Continued From page 44 11/22/15 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 01, which indicated severely impaired cognition. The resident received insulin injections. The quarterly MDS dated 5/19/16 revealed the resident a BIMS score of 01. The resident received insulin injections. The dementia Care Area Assessments (CAAs) dated 11/22/15 revealed the resident had a diagnosis of dementia and a behavior of refusal of care. The care plan dated 5/23/16 revealed nursing staff was to administer medications as ordered and to monitor and document for side effects and effectiveness. The resident had fasting blood sugar checks before meals and at bed time according to physician's orders. If the blood sugars were not within parameters, nursing staff should contact the physician. Review of the Medication Administration Record (MAR) noted the following times the resident ' s blood glucose levels were greater than 400: 4 times in February 2016, 4 times in March 2016, and 6 times in May 2016. Review of the MAR noted the resident had refused Novolog 7 times in March 2016, 3 times in April 2016, and 9 times in May 2016; and refused Lantus once in March 2016, 3 times in April 2016 and 2 times in May 2016. Review of the clinical records from February 2016 to May 2016 revealed the facility failed to notify the physician when the blood glucose levels were greater than 400 as mentioned above or of the	F 428		

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F 428	Continued From page 45 resident ' s refusal of the insulin injections as mentioned above. Review of the pharmacist recommendation reports from February 2016 to May 2016 revealed the reports lacked evidence of recommendations to report to the physician of the high blood sugar levels and of the frequent refusal of the insulin. On 05/25/2016 at 11:06 AM, the resident rested in the wheelchair in the day room. On 05/25/2016 at 2:52 PM, direct care staff O stated the resident had a behavior of rejection of cares. On 05/26/2016 at 7:44 AM, direct care staff S stated the resident was drowsy and sleepy with high blood sugar. On 05/25/2016 at 4:35 PM, licensed nursing staff H stated the resident often refused insulin and the resident's fasting blood glucose levels fluctuated. Staff H also stated nurses should notify the physician when the blood sugar level was out of parameters per the physician's order. On 05/26/2016 at 11:02 AM, administrative nursing staff D stated he/she expected the nurses to notify the physician with abnormal blood sugar levels and the frequent refusal of the medications. On 05/31/2016 at 2:41 PM, pharmacist consultant KK stated he/she did not review the resident's daily fasting blood levels or review the MAR for compliance with medications. The facility failed to provide a policy regarding	F 428		

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F 428	Continued From page 46 consultant pharmacist's expectations as requested. The consultant staff failed to identify and report potentially ineffective medication management of diabetes for this resident with frequent blood sugar levels outside the physician recommendations and refusals of medications used to control the blood sugar.	F 428		
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 431		

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F 431	Continued From page 47 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: The facility identified a census of 28 residents and one medication cart. Based on observation and interview, the facility failed to properly date opened inhalers, and failed to discard expired medication. Findings included: - During the initial tour on 5/23/16 at 8:55 AM, observation of the medication cart included 2 opened Advair inhalers which were undated and a cassette containing Neurontin 100 milligrams (an oral medication for nerve pain) with an expiration date of 4/2016. On 5/23/16 at 09:00 AM, licensed nursing staff K stated staff were to date all inhalers when opened. On 5/26/16 at 10:50 AM, licensed nursing staff H stated medications came from the pharmacy in 2 week batches every Thursday. The facility received the Neurontin on 5/12/16. Staff were expected to check the expiration dates at the batch refill and before administering each medication to a resident. On 5/26/16 at 12:05 PM, administrative nursing staff D stated he/she expected staff to check the	F 431		

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F 431	Continued From page 48 expiration dates at the batch fill, and upon administration of the medication to the resident. On 5/31/16 at 9:45 AM, administrative nursing staff D expected staff to date inhalers when they were removed from the foil pouch. The facility's policy "Storage of Medication", revised 1/12/16, revealed opened medications that expired within a particular time frame would have an open dated clearly marked on the medication container. The facility shall not use outdated medications. The facility failed to date medications when warranted and discard expired medications.	F 431		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to	F 441		

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F 441	Continued From page 49 prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: The facility identified a census of 28 residents. The facility had three hallways with resident rooms. Based on observations, record review, and staff interview, the facility failed to implement an infection control program with a multidisciplinary approach, and failed to disinfect frequently used objects in resident rooms on 2 of 3 halls by failing to follow manufacturer labeled disinfecting recommendations. Findings included: - Observation on 5/25/16 at 8:55 AM housekeeping staff Z observed cleaning a resident's room. Staff Z stated he/she was doing the regular cleaning (as opposed to deep cleaning), and he/she was disinfecting the "touch points" in the resident's rooms. He/she applied a chemical from a labeled spray bottle onto a fresh	F 441		

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F 441	Continued From page 50 cloth, wiped the handles, door knobs, hand rails, call light, and the bed controls. He/she stated the chemical was called LD64. Review of the label revealed it was smudged. Housekeeping staff Z stated he/she did not know the contact time needed for the chemical to disinfect. Review of the Meyer Laboratory, Inc. form for LD64, the chemical housekeeping used when disinfecting included contact time "let solution remain on surface for a minimum of ten minutes." During an interview on 5/25/16 at 9:45 AM with housekeeping staff Y, he/she reviewed the MSDS sheet for the chemical LD64 and the sheet confirmed 10 minutes contact time was needed for disinfecting. The facility housekeeping staff failed to follow the manufacturers labeled instruction for disinfecting while performing resident room disinfecting. Observation on 5/26/16 at 8:40 AM included housekeeping staff Z, sprayed a chemical from a can into a cloth and wiped the surface of the handles in a residents room. He/she stated he/she was disinfecting touch points for a resident room; he/she displayed the chemical "Zip, Hospital Disinfectant", and stated he/she was both cleaning and disinfecting. Review of the label of the Zip product revealed the following: allow "ten minutes contact for disinfecting". Interview with administrative nursing staff E on 5/25/16 at 1:15 PM included he/she stated he/she does not communicate or coordinate activities related to infection control with the housekeeping department or staff.	F 441		

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F 441	Continued From page 51 Interview on 5/26/16 at 8:40 AM with Housekeeping staff Y, he/she confirmed the contact time according to the label, for the "Zip" chemical stated 10 minutes. Interview on 5/26/16 at 12:30 PM with Maintenance/housekeeping supervisor X revealed he/she would expect the touch points in the resident's rooms to be disinfected daily. He/she confirmed all of the disinfecting chemicals used by the facility need at least 10 minutes contact time to disinfect. The facility failed to implement an effective Infection Control program with an interdisciplinary approach and failed to appropriately disinfect resident rooms by not following the manufacturers recommended contact times for the disinfectant cleaning solutions used.	F 441		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require	F 520		

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F 520	Continued From page 52 disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: The facility identified a census of 28 residents. Based on record review and staff interview, the facility failed to ensure that the physician designated by the facility attended the Quality Assessment and Assurance (QAA) meetings at least quarterly. Findings included: The facility failed to provide the requested signature record of QAA meetings, which included the names, titles and signatures of those attending each meeting. On 05/26/2016 at 2:48 PM, administrative staff A stated there was not an attending roster with attendees' signatures for QAA meetings. Review of facility's Quality Assurance and Performance Improvement (QAPI) Program/Plan dated November 2012 documented the QAPI coordinators shall attend meetings of committees or departments as deemed appropriate or as directed by the Chief Executive Officer. The facility failed to ensure the physician designated by the facility attended the Quality	F 520		

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F 520	Continued From page 53 Assessment and Assurance (QAA) meetings at least quarterly by failing to document a record including names, titles and signatures of those in attendance in QAA meetings.	F 520		