

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

Printed: 05/06/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175346	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2013
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NAME OF PROVIDER OR SUPPLIER ALMA MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 234 MANOR CIRCLE ALMA, KS 66401
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F 000	<p>INITIAL COMMENTS</p> <p>The following citations represent the findings of a Health Resurvey.</p> <p>A revised copy of the 2567 was sent to the facility on 5/6/13.</p>	F 000		
F 242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>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.</p> <p>This Requirement is not met as evidenced by: The facility had a census of 26 residents. The sample included 17 residents.</p> <p>Based on observation, record review and interview, the facility failed to provide 1 of 1 resident sampled for choices regarding bathing. (#21)</p> <p>Finding included:</p> <ul style="list-style-type: none"> - Resident #21's annual (MDS) Minimum Data Set 3.0 assessment, dated 3/2/13, indicated the resident had a (BIMS) Brief Interview of Mental Status of 4 which indicated the resident had severe cognitive impairment. The assessment revealed the resident was independent with most (ADLs) Activities of Daily Living and required supervision and set up help for dressing and toilet use. The assessment further revealed the resident stated it was very important to choose between a tub, shower, or bed bath. 	F 242		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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	<p>Continued From page 1</p> <p>The (CAA) Care Area Assessment, dated 3/14/2013, stated the resident needs minimal assistance with dressing and toilet use and help in the shower with washing.</p> <p>The 4/2/2013 plan of care directed staff to provide the resident choices regarding what time to get up, when to go to bed, clothing choices as well as meal choices. The care plan further directed staff to set up the shower for the resident twice weekly and provide him/her with assistance as needed.</p> <p>On 4/23/2013 at 3:00 PM, observation revealed the resident ambulated independently in the hallway with a steady gait, using his/her quad cane.</p> <p>On 4/24/2013 at 11:40 AM, direct care staff G stated the residents are asked there preference for bathing but the whirlpool is broken and they can only take a shower.</p> <p>On 4/24/2013 at 2:50 PM, direct care staff H stated the staff offer the resident the choice of a whirlpool or shower, but the whirlpool is broken and is currently getting repaired.</p> <p>On 4/25/2013 at 10:00 AM, Activity Staff O stated the residents are given a choice for bathing but the whirlpool is not working right now and will be getting repaired.</p> <p>On 4/25/2013 at 10:30 AM, licensed staff D stated the staff ask the resident their preference for whirlpool or showers, but the whirlpool is broken and is needing to be repaired.</p> <p>On 4/25/2013 at 3:00 PM, Administrative Nurse B</p>	F 242			

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F 242	Continued From page 2 verified the whirlpool was not working and had not worked for approximately 6 months but would be getting fixed.	F 242		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This Requirement is not met as evidenced by: The facility had a census of 26 residents. The sample included 17 residents. Based on record review, observation, and interview the facility failed to provide medically-related social services related to dental for 1 of 1 resident sampled for social services. (#21) Findings included: - Resident #21's annual (MDS) Minimum Data Set 3.0 assessment, dated 3/2/2013, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 5, which indicated he/she had severe cognitive impairment. The assessment revealed the resident was independent with most (ADLs) Activities of Daily Living with limited assistance with one staff for dressing and toilet use. The MDS further revealed the resident had obvious or broken natural teeth. The 3/14/13 (CAA) Care Area Assessment for	F 250		

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F 250	<p>Continued From page 3</p> <p>dental triggered due to the resident had a tooth extracted on the lower left side. Staff offer him/her soft foods or ground meat as needed to help with eating meals. The summary indicated the resident had new dentures as of 2/14/12. The resident was to follow up with the dentist as needed.</p> <p>The quarterly MDS assessments, dated 3/14/13 and 9/5/12, both indicated the resident did not have any dental problems.</p> <p>The 2/3/12 care plan directed staff to assist the resident twice daily with oral care and to make an appointment with the dentist to have his/her teeth extracted.</p> <p>The un-timed 2/4/12 nurse's note stated the resident received new dentures which needed to be fitted.</p> <p>The 3/5/12 at 2:14 PM nurse's note stated the resident received a regular diet and at times had difficulty due to missing most of his/her bottom teeth. The staff offered the resident softer foods and ground meats as needed.</p> <p>The 3/21/12 Oral Assessment indicated the resident had broken lower partial dentures. He/she had discomfort and difficulty chewing. The assessment further indicated the resident had inflamed and bleeding gums on the lower left front of his/her mouth.</p> <p>The 4/5/12 at 12:30 PM, nurse's note stated the resident's lower left side mouth was sore. The resident was to rinse his/her mouth with warm salt water after meals as needed and be rechecked at the dentist in one month.</p>	F 250			

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F 250	<p>Continued From page 4</p> <p>The 5/3/12 at 2:00 PM, the dental consultation record indicated the resident is wearing a full top denture with out any complaints of pain.</p> <p>The 8/8/12 dental consultation record indicated the resident had a tooth broken at the gum line. The report further indicated the resident had an abscess (a cavity containing pus and surrounded by inflamed tissue) due to the broken tooth and the recommendation was to remove the tooth.</p> <p>The 8/27/12 at 11:30 AM, nurse's notes stated the resident had the broken tooth removed.</p> <p>The 8/28/12 at 11:00 AM, nurse's notes stated the dentist only removed the right tooth and did not take pictures of the left tooth.</p> <p>The 8/29/12 at 11:00 AM, nurse's notes stated the resident had increasing tenderness to left side of his/her mouth, jaw, cheek, and face. The note further revealed the staff requested the resident to have antibiotics for mouth edema and an appointment for dental examination and removal of the remaining lower tooth.</p> <p>Review of the medical recorded revealed no further dental follow up until April 2013.</p> <p>The 4/8/13 at 3:54 PM, nurse's note stated the resident was out for dental appointment for tooth extraction of his/her remaining tooth prior to lower denture impression being made.</p> <p>The 4/10/13 at 8:31 AM, nurse's note stated slight swelling at site of tooth extraction with resident denying pain and no facial grimacing.</p> <p>At 4/24/13 at 11:45 AM, observation revealed direct care staff G assisted the resident to his/her</p>	F 250		

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F 250	<p>Continued From page 5</p> <p>room and encouraged him/her to brush his/her teeth.</p> <p>At 4/24/13 at 12:00 PM, observation revealed the resident seated in the dining room eating lunch. The resident ate chicken spaghetti, carrots, bread, and applesauce without difficulty.</p> <p>At 4/23/13 at 11:52 AM, direct care staff G stated the resident brushed his/her own teeth with encouragement and the staff check to see if the resident has brushed his/her teeth and if he/she has not, they assist him/her.</p> <p>At 4/24/13 at 3:59 PM, Social Service Staff N stated he/she had not spoken with the resident's family about the resident getting dentures and further stated the dentures have not been a problem for very long, (although the medical record revealed the resident had his/her remaining teeth extracted in August 2012 approximately 7 months ago). He/she further stated he/she has not gotten involved with the resident's denture problem until this month. Social Service Staff N stated the resident now has an appointment for his/her new bottom dentures.</p> <p>At 4/25/13 at 10:43 AM, licensed staff D stated the resident had broken his/her bottom partial plate that had been anchored by two teeth. Licensed staff D further stated the partial plate could not be worn due to one of the bottom teeth breaking off. Licensed staff D stated the nursing staff could not reach the resident's family to assist with appointments, they told Social Services.</p> <p>At 4/25/13 at 3:00 PM, Administrative Nurse B stated the he/she knew the resident had broken his/her partial and needed further dental</p>	F 250		

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F 250	Continued From page 6 appointments and that the dental problems started at least 10 months ago. Nurse B further stated all dental appointments are referred to Social Services. The undated Facility Policy for Dental Services stated it is the policy to provide or obtain dental services to meet the needs of each resident. The policy further states Social Services or his/her designee will be responsible for assisting the resident in making dental appointments and transportation arrangements as necessary. The facility failed to provide medically-related social services regarding dental care for this cognitively impaired resident.	F 250		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This Requirement is not met as evidenced by: The facility reported a census of 26 residents. The facility had 2 hallways in which residents resided. Based on observation, interview, and record review, the facility failed to keep resident bathrooms, bedrooms, and bedroom fixtures clean and in orderly condition in multiple resident rooms in 1 of 2 hallways. Findings included: - Observations in multiple rooms on the 200 hallway on 4/22/13 from 8:00 a.m. - 3:20 p.m. and 4/23/13 from 7:53 a.m. to 9:20 a.m. revealed the	F 253		

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F 253	<p>Continued From page 7 following:</p> <ul style="list-style-type: none"> o Bent window blinds in 5 rooms o Stains on the bathroom floor in 2 rooms o Stained privacy curtains and/or window curtains in 7 rooms o A rusty heating unit in 1 room o Peeling wall paint in 3 rooms <p>Review of preventative maintenance records revealed no evidence staff noted the previously mentioned environmental issues or had a plan in place to address the issues in a timely manner.</p> <p>During an interview on 4-4-13 at 3:30 p.m., Administrative staff A stated he/she had an awareness of the conditions of the resident rooms. He/she also stated the facility newly hired the maintenance employee who repaired each room as it became available.</p> <p>The facility failed to maintain a sanitary and orderly interior in resident rooms on one of two nursing hallways.</p>	F 253			
F 272 SS=D	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at</p>	F 272			

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F 272	<p>Continued From page 8</p> <p>least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>This Requirement is not met as evidenced by: The facility identified a census of 26 residents. The sample included 17 residents.</p> <p>Based on record review, observation, and interview the facility failed to comprehensively assess 1 resident (#6) for falls.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - The admission Minimum Data Set 3.0 (MDS) 	F 272		

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F 272	<p>Continued From page 9</p> <p>dated 2/4/13 for resident #6 revealed a Brief Interview for Mental Status (BIMS) score of 4, indicating severe cognitive impairment. The resident required extensive assistance of 2 or more staff for bed mobility, transfers, locomotion on the unit, locomotion off the unit, dressing, toilet use, and personal hygiene. The resident was not steady and required human assistance when moving from a seated to standing position, walking, turning around and facing the opposite direction while walking, moving on and off the toilet, and surface-to-surface transfers.</p> <p>The Care Area Assessment (CAA) dated 3/12/13 for falls triggered and was not completed.</p> <p>The fall risk assessment dated 4/23/13 revealed a score of 17 (a score of 10 or higher indicated the resident was a high risk for falls). Analysis of the fall risk assessment revealed the resident had 4 non-injury falls in the past 90 days and is considered a high fall risk.</p> <p>Observation on 4/23/13 at 2:16 P.M. revealed the resident resting quietly in bed with his/her eyes closed. The call light was within reach, the bed was at a low level, his/her walker was within reach, a padded mat was at bedside, bed cane (positioning bar) was in place, and the resident was wearing non-skid socks.</p> <p>The undated policy regarding MDS provided by the facility revealed the facility would conduct a comprehensive assessment (MDS) according to federal regulations and medicare guidelines.</p> <p>Interview on 4/25/13 at 4:58 P.M. with administrative nursing staff B revealed he/she would expect that a CAA to be completed for each triggered area for each resident.</p>	F 272		

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F 272	Continued From page 10	F 272		
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This Requirement is not met as evidenced by: The facility identified a census of 26 residents. The sample included 17 residents.</p> <p>Based on observation, record review, and interview, the facility failed to revise the care plan for 2 (#1 and #21) of the sampled residents.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - The quarterly Minimum Data Set 3.0 (MDS) for 	F 280		

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F 280	<p>Continued From page 11</p> <p>resident #1 dated 4/2/13 revealed a Brief Interview for Mental Status (BIMS) was unable to be performed. Staff assessment for mental status revealed a short term memory problem, the resident was only able to recall staff names and faces and that he/she was in a nursing home. The resident had modified independence for cognitive skills for daily decision making, with some difficulty in new situations. The resident displayed disorganized thinking behavior and delusions. He/she received insulin injections (an animal-derived or synthetic form of this substance used to treat diabetes), an anti-anxiety medication (medication to treat anxiety, a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), an antidepressant medication (medication to treat depression, abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and a diuretic medication (medication to promote the formation and excretion of urine), during the seven day look back period.</p> <p>The Care Area Assessment (CAA) Summary dated 7/3/12 for psychotropic medication use revealed the resident took Citalopram (an antidepressant) for depression and Buspar (an anti-anxiety) for anxiety. The resident was monitored for resistance to care, yelling, and kicking.</p> <p>The care plan dated 2/6/13 for Black Box Warning (BBW) Medications listed the medications that the resident was taking that contained a black box warning but also included Compazine (an anti-emetic, effective against nausea and vomiting) and Evista (used to treat and prevent osteoporosis in postmenopausal women).</p>	F 280		

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F 280	<p>Continued From page 12</p> <p>The current Physician's Order Sheet (POS) dated 4/12/13 lacked documentation that the resident had active orders for Compazine and Evista.</p> <p>Observation on 4/24/13 at 9:10 A.M. revealed the resident sat in a high back wheelchair in the community television room, alert and watching television.</p> <p>Interview on 4/25/13 at 1:32 P.M. with licensed nursing staff D revealed the resident did not take Compazine or Evista anymore. He/she would expect the care plan for BBW medications to contain only the medications that the resident currently received. Staff D stated that care plans were developed by the MDS Coordinator, and then updated by the nursing staff.</p> <p>Interview on 4/25/13 at 3:26 P.M. with licensed nursing staff E revealed the MDS Coordinator developed the initial care plan for residents. Updating the care plan was a team effort by the nursing staff. He/she would expect care plans to be updated with BBW medication changes.</p> <p>Interview on 4/25/13 at 4:58 P.M. with administrative nursing staff B revealed care plans are developed by the MDS Coordinator, and the nursing staff wrote in updates as needed. He/she would expect care plans to be updated when BBW medications were discontinued.</p> <p>The un-dated policy regarding comprehensive care plans provided by the facility revealed the interdisciplinary team met weekly and reviewed problems, goals, and interventions and will revise the care plan as needed.</p> <p>The facility failed to revise the care plan for this</p>	F 280		

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F 280	<p>Continued From page 13 resident regarding BBW medications.</p> <p>- Resident #21's annual (MDS) Minimum Data Set 3.0 assessment, dated 3/2/13, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 5, which indicated he/she had severe cognitive impairment. The assessment revealed the resident was independent with most (ADLs) Activities of Daily Living and required supervision and set up help for dressing and toilet use. The MDS stated the resident was continent of bladder/bowel and had no falls since the prior MDS.</p> <p>The (CAA) Care Area Assessment, dated 3/14/2013, stated the resident ambulated with a quad cane (a cane adapted for increased stability by providing a four-legged rectangular base of support) and had a fairly steady gait. The CAA further stated he/she received an anti-anxiety medication (medication that calms and relaxes people with excessive anxiety). The CAA also stated the resident needed minimal assistance with dressing and toilet use.</p> <p>The 5/20/09, (last review date) on plan of care, directed staff to monitor for changes in ability to perform activities of daily living and report to the nurse. The care plan further indicated the resident required extensive verbal cues, especially for bathing and changing clothes.</p> <p>The most recent care plan, dated, 1/30/2013 stated the resident was at increased risk of falling due to his/her Dementia (progressive mental disorder characterized by failing memory, confusion). The care plan instructed staff to remind him/her to use the cane when he/she forgets.</p>	F 280			

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F 280	<p>Continued From page 14</p> <p>The 3/1/13 Urinary Incontinence Assessment indicated the resident was continent of bowel and bladder.</p> <p>The 12/15/2012 Fall Risk Assessment indicated the resident had a score of 9 which a score of 10 or more indicated a high risk for falls. The 1/15/2013 at 8:15 PM, nurse's note stated the resident's chair slipped out from under him/her in the dining room.</p> <p>The 3/1/2013 Fall Risk Assessment indicated the resident scored a 15 and a score of 10 or more indicates a high risk for falls.</p> <p>The 3/15/2013 at 1:30 PM, nurse's note stated the resident caught the edge of the pavement outside with his/her shoe and fell.</p> <p>An un-timed 4/3/13 nurses's note stated the resident had a decline and decreasing ability to perform simple activities of daily living tasks. The note further indicated the staff had been providing prompted toileting with limited success.</p> <p>The 4/10/2013 Physician Orders directed the staff to have Physical Therapy evaluate and treat the resident for gait changes.</p> <p>The un-timed 4/15/13 nurse's note indicated the resident was voiding in inappropriate places and unable to describe his/her wants and needs. The nurse's note further indicated the staff provided prompted voiding and toileting opportunities for the resident to encourage him/her to void or have a bowel movement. The nurse's note indicated the resident needed simple instructions to sit on the the toilet.</p>	F 280			

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F 280	<p>Continued From page 15</p> <p>The 4/19/2013 at 6:50 PM, nurse's note stated the resident slid to the floor from the edge of the recliner. The resident did not hit his/her head and had no injury from the fall.</p> <p>The 4/21/13 at 6:16 p.m. nurse's note indicated the resident needed assistance with toileting every 2 hours and as needed and the resident was continent of bladder and bowel, requiring frequent cueing with activities of daily living.</p> <p>On 4/23/2013 at 3:00 PM, observation revealed the resident ambulated in the hallway independently with a steady gait, using his/her quad cane.</p> <p>On 4/23/2013 at 12:14 PM, observation revealed the resident got up from the dining table and left without his/her quad cane and the staff retrieved the cane for the resident after he/she left the dining room.</p> <p>During an observation on 4/24/13 at 11:36 a.m. direct care staff G assisted the resident in his/her room, making sure his/her clothing was clean before lunch.</p> <p>On 4/23/13 at 11:40 a.m., direct care staff G stated the resident dressed him/herself and needed assistance with toileting.</p> <p>On 4/24/2013 at 2:30 PM, direct care staff H stated the resident walks around with his/her cane and had not had many falls.</p> <p>On 4/25/2013 at 2:34 PM, licensed staff E stated the resident had been outside with him/her when he/she had fallen and no fall interventions had been put into place. He/she further stated the resident was on a prompted toileting routine and</p>	F 280		

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F 280	<p>Continued From page 16</p> <p>staff toileted the resident before and after every meal. Licensed staff E further stated the resident had a decline in cognition and will, at times, urinated in the wrong places.</p> <p>On 4/25/2013 at 9:30 AM, Administrative Nurse B stated he/she had not updated the care plan after the resident's falls and the nursing staff are able to update the care plan after falls.</p> <p>On 4/25/2013 at 3:00 PM, Administrative Nurse C verified the care plan had not been updated after the resident's falls and all nurses are able to update the care plan.</p> <p>The Facility's un-dated Comprehensive Care Plan Policy indicated the facility shall review the care plan problems, goals, and interventions, and will revise the care plan as needed.</p> <p>The facility failed to revise the plan of care for Resident #21's falls and after staff initiated a prompted toileting plan in order to maintain the resident's continence.</p>	F 280			
F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This Requirement is not met as evidenced by: The facility had a census of 26 residents with 17 sampled for review.</p>	F 309			

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F 309	<p>Continued From page 17</p> <p>Based on observation, interview, and record review, the facility failed to ensure 1 of 17 sampled resident received the necessary care and services (neurological assessments following falls) to attain or maintain the resident's highest practicable physical well-being in accordance with the comprehensive assessment and plan of care. (#6)</p> <p>Findings included:</p> <ul style="list-style-type: none"> - The admission Minimum Data Set 3.0 (MDS) dated 2/4/13 for resident #6 revealed a Brief Interview for Mental Status (BIMS) score of 4, indicating severe cognitive impairment. Inattention behavior was present. The resident required extensive assistance of 2 or more staff for bed mobility, transfers, locomotion on and off the unit, dressing, toilet use, and personal hygiene. The resident was not steady and required human assistance when moving from a seated to standing position, walking, turning around and facing the opposite direction while walking, moving on and off the toilet, and surface-to-surface transfers. <p>The Care Area Assessment for Cognitive Loss dated 3/12/13 revealed the resident required extensive assistance with transfers and used a wheelchair. Staff anticipated his/her needs and offered frequent observation of the resident.</p> <p>Resident #6's nursing care plan for falls dated 3/25/13 revealed the resident was a fall risk due to not being able to remember safety needs and inability to stand or walk. Staff to ensure the call light was within reach even though the resident might not remember to use it. At times the resident may attempt to toilet him/herself without calling for help.</p>	F 309			

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F 309	Continued From page 18 The fall risk assessment dated 4/23/13 revealed a score of 17 (a score of 10 or higher indicated the resident was a high risk for falls). Analysis of the fall risk assessment revealed the resident had 4 non-injury falls in the past 90 days and is considered a high fall risk. The nursing note dated 3/20/13 at 8:10 P.M. stated resident #6's pad alarm had been activated. A certified nursing assistant (CNA) entered the resident's room and observed him/her sitting by the bed on the floor mat. Range of motion and vital signs were within normal limits. The fall investigation for 3/20/13 fall revealed the pad alarm was activated and the resident was observed sitting on the mat next to the bed. The bed was in the lowest position. The resident was unable to share why he/she wanted to get up. No injury was assessed. Staff to place gripper socks on the resident at bedtime, provide water and toileting at bedtime, keep the wheelchair near the bed, and call light within reach. The clinical record lacked documentation of a neurological assessment after the unwitnessed fall on 3/20/13. Observation on 4/23/13 at 2:16 P.M. revealed the resident rested quietly in bed with his/her eyes closed with the call light and walker within reach, bed at low level, padded mat at bedside, and bed cane in place. Interview on 4/25/13 at 1:32 P.M. with licensed staff D revealed a neurological assessment should be completed after all unwitnessed falls.	F 309			

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F 309	Continued From page 19 Interview on 4/25/13 at 3:26 P.M. with licensed nursing staff E revealed a neurological assessment should be completed after unwitnessed falls. The Neurological Assessment Policy with a revision date of March 2013 provided by the facility revealed a neurological assessment would be performed by a licensed nurse subsequent to any unwitnessed fall with indication head was struck after assessment or when indicated by a resident's condition, such as a significant change in mental status. The facility failed to neurologically assess this cognitively impaired resident after an unwitnessed fall.	F 309		
F 323 SS=G	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 reported a census of 26 residents. The sample included 17 residents, with 4 sampled for accidents. Based on observation, interview, and record review, the facility failed to develop and implement effective and/or appropriate interventions to prevent falls for 2 sampled residents who fell and sustained fractures (#32 who fell and sustained a hip fracture within 7	F 323		

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F 323	<p>Continued From page 20</p> <p>hours of admission, and #34 who fell and sustained a patella [knee cap] fracture). The facility also failed to implement appropriate and effective interventions to prevent falls for 1 sampled resident (#6) with multiple falls.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident # 32's diagnoses listed on the 1/25/13 Physician's Order Sheet included: Left hip fracture and dementia (a progressive mental disorder characterized by failing memory and confusion). <p>The clinical record revealed the resident fell on 1/3/13 at 11:20 P.M. and sustained a left hip fracture on the residential health care unit at the facility.</p> <p>The Admission Minimum Data Set (MDS) dated 1/25/13 (date of admission) recorded dashes (indicating it was not assessed) for cognition, the resident displayed inattention which fluctuated, had disorganized thinking which was continuously present and did not fluctuate, all Activities of Daily Living had dashes, and the resident was not steady and only able to stabilize with staff assist with walking and not steady but able to stabilize without staff assist with turning around; steady at all times when moving from seated to standing position, moving on and off toilet and surface to surface transfer, and no range of motion limitations. The MDS recorded the resident had a fall in the last month, a fall in the last 2-6 months and had a fracture related to a fall in the last 6 months.</p> <p>Resident #32's Care Area Assessment for falls and cognitive loss dated 2/15/13 recorded the resident had a fall and fracture of his/her left hip</p>	F 323			

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F 323	<p>Continued From page 21</p> <p>on 1/3/13. The resident had dementia and history of poor safety judgments. Due to the resident's dementia, a chair alarm was attached. At 6:40 P.M. on 1/25/13 the resident was observed on the floor with resident unable to move his/her right leg due to hip pain. The resident was admitted to the hospital with a right hip fracture.</p> <p>The Care Area Assessment for visual function dated 2/15/13 recorded the resident was alert and oriented to self, had a diagnosis of macular degeneration (progressive deterioration of the retina, affecting vision) and wore glasses.</p> <p>Resident #32's initial nursing care plan dated 1/25/13 identified the resident had a left hip fracture. The resident had anxiety/restlessness. The care plan identified the resident as a high risk for falls, and a need for physical therapy and occupational therapy to evaluate. The care plan also noted that the call light and personal articles should be easy to reach and a bed alarm and chair alarm should be in place at all times. The care plan further revealed the resident had a urinary tract infection (which can increase confusion) and received Macrobid (an antibiotic).</p> <p>The resident's fall risk assessment on 1/25/13 revealed a score of 15 which indicated a high risk for falls.</p> <p>Physician's orders dated 1/25/13 stated chair and bed alarm on at all times due to hip fracture.</p> <p>A resident admission assessment on 1/25/13 at 11 a.m. revealed resident #32 required extensive assistance of 1 staff for ambulation, transfers, bed mobility, and toileting. The resident required limited assistance of one staff for dressing, personal hygiene, and bathing. The assessment</p>	F 323		

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F 323	<p>Continued From page 22</p> <p>revealed the resident had a fall with fracture in the past 30 days, the resident was oriented to the facility but was forgetful and he/she had intermittent confusion. The assessment also revealed the resident had a change in gait pattern and dragged his/her foot, requiring assistance.</p> <p>Nurse's notes on 1/25/13 at 11:45 a.m. revealed the facility admitted the resident with a diagnosis of status post left hip fracture with continuation of physical and occupational therapy services for strengthening. He/she had a chair alarm placed with agreement of the resident's family member. A floor mat was placed next to resident's bed which also had a scoop mattress and the bed placed at lowest position. The nurses' notes revealed the resident walked with assist of 1 using a walker.</p> <p>Nurse's notes on 1/25/13 at 6:40 p.m. revealed staff found the resident on the floor in his/her room, unable to move his/her right leg, or roll and move torso related to right hip pain. Staff obtained a physician's order for an x-ray of the pelvis and 2 views of the right hip. Resident described his/her pain as a 7 on a scale of 1-10. Nurse's notes further revealed the facility called mobile medical to obtain an x-ray in the facility. The resident continued to rest on the floor with pillows under his/her knees and head for comfort.</p> <p>Nurse's note on 1/25/13 at 11:30 p.m., revealed the facility transferred the resident to the hospital via ambulance.</p> <p>The facility fall investigation dated 1/25/2013 revealed that at 6:30 p.m. the pad alarm sounded and the charge nurse responded to the resident's needs. A CNA (certified nurse assistant) also responded. Staff assisted the resident to the</p>	F 323		

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F 323	<p>Continued From page 23</p> <p>bathroom and back to his/her recliner with chair pad alarm in place. Items in his/her room were placed in order. Resident observed on floor at 6:40 p.m. without an alarm, or call light being activated. The walker was not utilized by the resident. The resident was fully clothed with shoes in place. Resident remained on floor due to right hip pain when attempting to move leg, roll, or move torso. The physician ordered an x-ray of pelvis and right hip.</p> <p>A witness statement by direct care staff H revealed on 1/25/13 at approximately 6:40 P.M., he/she was passing medications and heard a noise come from the resident's room, and he/she immediately notified the nurse.</p> <p>The facility's fall investigation conclusion and summary stated, After reviewing, a variety of fall precautions available to reduce the resident's risk of falling, all these Fall Risk Precautions were initiated prior to admission:</p> <ul style="list-style-type: none"> * Room near nurse's desk * Chair/ bed pad alarm in place (per interview, resident had a history of removing) * Call light in reach (cognitively impaired resident, per the care plan from the resident's previous admission, the resident may not always use the call light) * Walker in reach (resident was not using at the time of his/her fall) * Toileting schedule established * Resend staff education in regard to individual resident needs. * Bed in low position (not effective when resident is in chair) * Landing strip in place along length of bed (not effective when resident is in chair) * Bed cane in place to bed (positioning rail) (not 	F 323			

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F 323	<p>Continued From page 24 effective when resident is in chair)</p> <p>The decision to not admit the resident post right hip repair was determined after a review of his/her needs and dementia diagnosis. It was determined that the resident's needs would be better met at a home prepared to meet the needs of an individual with his/her level of dementia.</p> <p>During the dates of the survey on 4/22/13-4/25/13 resident #32 remained out of the facility.</p> <p>During an interview on 4/24/13 at 4:25 p.m., licensed staff F revealed that he/she was charge nurse the evening resident #32 was re-admitted to the facility. Licensed staff F further described the resident as disoriented and wandered. Licensed nurse F stated the facility admitted the resident to the first room closest to the nurses' station. Licensed staff F further stated staff toileted the resident prior to the fall and staff straightened his/her room of clutter. Licensed nurse F stated the resident sat in a recliner with an alarm applied, and the resident removed the alarm and took about 6 steps prior to falling. He/she further stated the resident was unable to move the lower right extremity.</p> <p>During an interview on 4/25/13 at 12:44 P.M., Licensed staff D stated the resident was alert with a busy habit; he/she was not safety conscious at all and liked to pick thru his/her drawers. The resident had alarms on to try to prevent falls, but he/she was also very good at disarming the alarms. The resident fell that evening he/she after re-admission to the facility. The resident would go looking for his/her family member before he/she fell and fractured his/her first hip. The resident's family member had left maybe 30 minutes before the resident fell and fractured his/her other hip.</p>	F 323			

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F 323	<p>Continued From page 25</p> <p>The hospital told us the resident had both a bed and pad alarms because the resident had been so good at disarming them. The resident did not have two alarms on here.</p> <p>Further interview on 4/25/13 at 1:15 p.m. with licensed staff D revealed the hospital staff reported the resident had crawled over the bed rails when he/she was at the hospital. Licensed staff D further stated hospital staff double alarmed the resident in the chair due to always trying to get up.</p> <p>The facility failed to ensure this cognitively impaired, dependent resident had effective interventions in place for fall prevention. The resident fell within 7 hours of admission and sustained his/her second hip fracture within 22 days.</p> <p>- Resident #34's significant change in status (MDS) Minimum Data Set 3.0 assessment, dated 4/25/2013, was in progress and not complete at this time. The resident had a decline since prior MDS, due to multiple falls, one which resulted in a fracture of the patella.</p> <p>The resident's quarterly MDS, dated 3/1/2013, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 7, which indicated he/she had severe cognitive impairment. The assessment revealed the resident was independent with most of his/her (ADLs) Activities of Daily Living with limited assistance with one staff for dressing and toilet use. The MDS further revealed the resident's balance was steady at all times and the resident had no impairment to upper and lower extremities. The MDS indicated the resident had</p>	F 323			

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F 323	<p>Continued From page 26 no falls since the prior MDS.</p> <p>The resident's Fall Risk Assessment, dated 11/27/2012, indicated the resident had a score of 13 which a score of 10 or more is a high risk for falls.</p> <p>The 2/8/2013 care plan stated the resident was at increased risk for falls because of his/her Schizophrenia (a psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought, perception and emotional reaction). The care plan stated the resident would continue to be independent without having any significant injuries from falls. The care plan indicated interventions were put into place after the resident had several falls on the following dates:</p> <ol style="list-style-type: none"> 1) 4/1/2013 fall - Resident has a brace to his/her knee but refused to wear 2) 4/7/2013 fall - 3 day voiding diary determined the resident was to be assisted with toileting 1 time during the night from midnight to 2 AM, upon rising from 6 to 7 AM, mid morning, after lunch, and before bed. 3) 4/12/2013 fall - Toileting plan per voiding diary and self locking wheelchair brakes. 4) 4/15/2013 fall - Personal alarm until neurosurgeon consultation, Physical and Occupational Therapy evaluation. <p>The 4/1/2013 at 1:10 AM, fall investigation stated the resident fell and the resident was independent with transfers and ambulation. Physician instructed staff to use an immobilizer.</p> <p>The 4/1/2013 at 9:05 AM, fall investigation stated the resident fell while transferring him/herself.</p>	F 323		

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F 323	<p>Continued From page 27</p> <p>The resident was instructed to request assistance when transferring. The MDS assessment revealed the resident had a severe cognitive impairment. The resident was diagnosed with a fractured patella.</p> <p>The 4/3/2013 at 5:30 PM, fall investigation stated the resident lowered him/herself to the floor. The resident was instructed to ask for assistance when transferring. The MDS assessment revealed the resident had a severe cognitive impairment and the resident refused to use the knee brace.</p> <p>The clinical record lacked evidence the facility implemented interventions to prevent future falls after this occurrence.</p> <p>The 4/5/2013 at 5:30 PM, fall investigation stated the resident lost his/her balance in the dining room and slid to the floor.</p> <p>The clinical record lacked evidence the facility implemented interventions to prevent future falls after this occurrence.</p> <p>The 4/7/2013 at 10:15 PM, fall investigation stated he/she fell when his/her knee buckled when he/she stood up from his/her wheelchair. The resident was encouraged to propel him/herself in the wheelchair for mobility unless a staff member was with him/her. Staff were directed to initiate a 3 day voiding diary. The resident continued to refuse to wear the knee brace for the fractured patella.</p> <p>The 4/12/2013 at 5:40 AM, fall investigation stated the resident was found on the floor. Staff were directed to initiate toileting plan.</p>	F 323			

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F 323	<p>Continued From page 28</p> <p>The 4/12/2013 at 5:10 PM, fall investigation stated the resident lost his/her balance while he/she walked to the bathroom independently. Staff were directed to apply self locking brakes to his/her wheelchair and to continue consistent observation.</p> <p>The 4/13/2013 at 5:30 PM, fall investigation stated the resident lowered him/herself to the floor. Staff were directed to continue consistent observation of the resident while attempting ambulation or transfer.</p> <p>The clinical record lacked evidence the facility implemented interventions to prevent future falls after this occurrence.</p> <p>The 4/13/2013 at 8:45 PM, fall investigation stated the resident was on the floor with blankets around his/her body. Staff were directed to continue consistent observation of the resident.</p> <p>The clinical record lacked evidence the facility implemented interventions to prevent future falls after this occurrence.</p> <p>The 4/14/2013 at 11:10 PM, fall investigation stated the resident fell in the bathroom. Staff were directed to continue consistent observation.</p> <p>The clinical record lacked evidence the facility implemented interventions to prevent future falls after this occurrence.</p> <p>The Physician order, dated 4/15/2013, directed the staff to have Physical Therapy evaluate and treat the resident. The order further directed the staff to check the resident's orthostatic blood pressures twice a day.</p>	F 323		

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F 323	<p>Continued From page 29</p> <p>On 4/23/2013 at 2:16 PM, observation revealed the resident seated in his/her wheelchair, personal alarm attached, outside smoking a cigarette with a staff member and no knee brace in place.</p> <p>On 4/24/2013 at 7:20 AM, observation revealed the resident lying in his/her bed with eyes closed and the bed alarm underneath him/her.</p> <p>On 4/24/2013 at 11:35 AM, direct care staff G stated the resident had numerous falls and the staff push him/her around the facility to keep him/her occupied. Direct care staff G stated, before the personal alarm, the staff would check on him/her.</p> <p>On 4/25/2013 at 2:30 PM, licensed staff E stated the resident has done well with the alarm and wheelchair brakes, and has not had any more falls since the alarm was put into place.</p> <p>On 4/25/2013 at 3:00 PM, Administrative Nurse B verified the alarm has been helpful to alert staff when the resident attempts to get up on his/her own. He/ She further verified the staff should have initiated the alarm sooner.</p> <p>The facility's un-dated Accidents and Occurrences policy indicated the facility will review the resident at the weekly Resident at Risk meeting to evaluate effectiveness of the interventions and to revise interventions if needed.</p> <p>The facility failed to develop and implement effective interventions to prevent falls for this cognitively impaired resident with multiple falls. Resident #34's nursing care plan failed to reflect</p>	F 323			

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F 323	<p>Continued From page 30</p> <p>interventions identified in the fall investigation reports and the resident continued to sustain falls.</p> <p>- The admission Minimum Data Set 3.0 (MDS) dated 2/4/13 for resident #6 revealed a Brief Interview for Mental Status (BIMS) score of 4, indicating severe cognitive impairment. Inattention behavior present. The resident required extensive assistance of 2 or more staff for bed mobility, transfers, locomotion on and off the unit, dressing, toilet use, and personal hygiene. The resident was not steady and required human assistance when moving from a seated to standing position, walking, turning around and facing the opposite direction while walking, moving on and off the toilet, and surface-to-surface transfers.</p> <p>The Care Area Assessment for Cognitive Loss dated 3/12/13 revealed the resident required extensive assistance with transfers and used a wheelchair. Staff anticipated his/her needs and offered frequent observation of the resident.</p> <p>Resident #6's nursing care plan for falls dated 3/25/13 revealed the resident was a fall risk due to not being able to remember safety needs and inability to stand or walk. Staff to ensure the call light was within reach even though the resident might not remember to use it. At times the resident may attempt to toilet him/herself without calling for help. Keep bed in low position and mat next to the bed. The resident required assistance from 2 staff members and a gait belt for transfers. The resident used a bed cane for bed mobility.</p> <p>Resident #6's fall risk assessment dated 4/23/13 revealed a score of 17 (a score of 10 or higher indicated the resident was a high risk for falls).</p>	F 323			

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F 323	<p>Continued From page 31</p> <p>Analysis of the fall risk assessment revealed the resident had 4 non-injury falls in the past 90 days and is considered a high fall risk.</p> <p>The nursing note dated 3/1/13 at 7:52 P.M. revealed the resident's pad alarm was activated, staff entered the room and observed the resident standing on the mat and then falling to the ground.</p> <p>The fall investigation dated 3/1/13 revealed the intervention(s) initiated post fall were as follows: Continue consistent observations of the resident to provide care and safety, encourage the resident to contact staff for assistance.</p> <p>The nursing note dated 3/20/13 at 8:10 P.M. revealed the resident was observed by staff on the floor.</p> <p>The fall investigation dated 3/20/13 revealed the intervention(s) initiated post fall were as follows: Continue consistent of the resident to provide care and safety, encourage the resident to contact staff for assistance.</p> <p>The nursing note dated 3/21/13 at 11:15 A.M. revealed resident #6 was observed by staff, falling out of a recliner in a common room.</p> <p>The fall investigation dated 3/21/13 revealed the intervention(s) initiated post fall were as follows: Utilize a heavier recliner that will not tip forward.</p> <p>The nursing note dated 4/1/13 at 8:05 P.M. revealed resident #6 was observed by staff on the floor.</p> <p>The fall investigation dated 4/1/13 revealed the intervention(s) initiated post fall were as follows:</p>	F 323		

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F 323	<p>Continued From page 32</p> <p>Keep resident's personal items within reach at bedside, and place wall clock in room or request a watch from durable power of attorney (DPOA).</p> <p>The nursing note dated 4/5/13 at 5:01 A.M. revealed the resident was observed by staff on the floor.</p> <p>The nursing note dated 4/5/13 at 1:00 P.M. revealed resident #6 was observed by staff on the floor.</p> <p>The fall investigation dated 4/5/13 revealed the intervention(s) initiated post fall were as follows: Resident encouraged to request assistance with transfers, continue consistent treatment observation and assist with the resident.</p> <p>Observation on 4/23/13 at 2:16 P.M. revealed the resident rested quietly in bed with his/her eyes closed with the call light and walker within reach, bed at low level, padded mat at bedside, and bed cane in place.</p> <p>Interview on 4/25/13 at 1:32 P.M. with licensed nursing staff D revealed a new intervention should be initiated with each fall.</p> <p>Interview on 4/25/13 at 3:26 P.M. with licensed nursing staff E revealed a new intervention should be initiated with each fall to prevent it from happening again.</p> <p>The un-dated Accidents and Occurrences Policy provided by the facility revealed the facility's policy was to ensure that each resident received adequate supervision and assistive devices to prevent occurrences. The director of nursing or designee was responsible for ensuring that relevant, individualized interventions were added</p>	F 323		

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F 323	Continued From page 33 to the care plan. The facility failed to complete fall investigations for and implement appropriate and effective interventions for fall prevention for this cognitively impaired, dependent resident.	F 323		
F 329 SS=E	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 had a census of 26 residents. The sample included 17 residents, with 10 residents reviewed for unnecessary medications.	F 329		

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F 329	<p>Continued From page 34</p> <p>Based on observation, interview and record review, the facility failed to ensure that 4 of 10 residents sampled for medications did not receive unnecessary medications, when staff failed to monitor for potential side effects and adverse reactions related to Black Box Warnings for resident #9. The facility also failed to monitor pulse and blood pressure levels on residents # 9, 7, and 21. The facility also failed to identify target behaviors for medications for resident #23.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident #9's 4/12/13 physician orders included renewed orders for: <ul style="list-style-type: none"> * Effexor, an anti-depressant, 100 mg (milligrams) 1 1/2 tabs every day * Cardizem CD, an anti-hypertensive, 120 mg every day * Norvasc, an anti-hypertensive, 10 mg every day * Catapres, an anti-hypertensive, 0.1 mg two times every day *Trandate, an anti-hypertensive, 200 mg 1 1/2 tabs every day <p>Resident #9's 3/1/13 Quarterly MDS (minimum data set) assessment revealed the resident had a BIMS (brief interview for mental status) score of 9 which indicated moderately impaired cognition and a mood score of 1 which indicated minimal depression.</p> <p>Resident #9's 9/1/12 CAA (care area assessment) summary triggered for psychosocial well-being, mood state and psychotropic drug use but lacked further assessment or analysis related to the resident's use of antidepressants.</p> <p>Resident #9's 2/26/13 revised nursing care plan lacked information related to potential side effects</p>	F 329			

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F 329	<p>Continued From page 35 and adverse reactions for the use of Effexor, with a black box warning.</p> <p>The FDA.gov website included the following boxed warning for Effexor: Patients of all ages who are started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber.</p> <p>Review of Resident #9's MAR (medication administration record) dated 3/15-4/14/13 revealed staff failed to document the resident's pulse rate on March 20th, 28th, April 13th and 14th with the administration of Cardizem. Staff also failed to document the pulse rate on March 28th and April 7th and 13th for the administration of Trandate.</p> <p>During and observation on 4/24/13 at 7:35 a.m., resident #9 sat in dining room and conversed with his/her table mates and did not exhibit any behavioral symptoms.</p> <p>During an interview on 4/25/13 at 1:10 p.m., licensed staff D stated the nurse who obtained the order for a new medication should note the black box warning to alert staff, then licensed staff C or B updated the care plans and CNA's (certified nurse assistant) care work sheets accordingly.</p> <p>During an interview on 4/25/13 2:00 p.m. Administrative staff B revealed that staff should obtain blood pressures and pulse and record them before the administration of the medication as ordered by the physician.</p>	F 329			

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F 329	<p>Continued From page 36</p> <p>The facility failed to adequately monitor for potential side effects and adverse reactions related to the Black box warning label on Effexor and obtaining blood pressure and pulse prior to medication administration.</p> <p>- Resident #7's medication order sheet included renewed orders for: * Tiazac (an anti-hypertensive) 120 mg everyday * Lanoxin (an anti-hypertensive) 0.25 mg everyday * Coreg (an anti-hypertensive) 6.2 mg everyday</p> <p>Resident #7's Admission MDS (minimum data set) assessment revealed the resident had a BIMS of 12 which indicated moderately impaired cognition.</p> <p>Resident #7's nursing care plan revised on 4/23/13 revealed a diagnosis for hypertension (elevated blood pressure) and to give medications as ordered. The care plan also directed staff to monitor blood pressure and pulse weekly, notify physician of a systolic blood pressure <90mmHg (millimeters of mercury) or >210mmHg or a diastolic blood pressure of <50mmHg or >115mmHg, and a pulse of <60 or >130 beats per minute.</p> <p>Review of the MAR (medication administration record) revealed that staff failed to obtain a pulse rate on 2/6, 2/8 and 2/9/13; and failed to obtain the resident's blood pressure and pulse on 3/18, 3/19, 3/21, 3/22, 3/24-3/26, 3/29, 3/31, 4/2, 4/5-4/9, and 4/13/13 for Tiazac.</p> <p>Staff also failed to obtain pulse on the 3/18, 3/19, 3/21, 3/22, 3/29-3/31/13, 4/2, 4-9/13; and 4/13/13 for the use of Lanoxin; and on the 3/19, 3/21,</p>	F 329			

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F 329	<p>Continued From page 37</p> <p>3/29, 3/31, 4/2, 4/6 and 4/13/13 for the use of Coreg.</p> <p>During an observation on 4/24/13 at 7:45 a.m., Resident #7 laid in bed with his/her eyes closed, head of bed elevated, and call bell in reach.</p> <p>During an interview on 4/24/13 at 4:20 p.m., licensed staff F revealed that nursing staff alerted CNA's (certified nurse assistants) of medications that required monitoring.</p> <p>During an interview on 4/25/13 2:00 p.m. Administrative staff B revealed that staff should obtain blood pressures and pulse and record them before the administration of the medication as ordered by the physician. Staff should also inform the charge nurse of any discrepancy from what they obtained and the parameters set up by the physician.</p> <p>The facility failed to obtain blood pressures and/or pulses prior to administering Tiazac, Lanoxin, and Coreg for this resident.</p> <p>- The quarterly Minimum Data Set 3.0 (MDS) dated 3/17/13 for resident #23 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. The resident received antipsychotic, anti-anxiety, antidepressant, and diuretic medication during the seven day look back period.</p> <p>The Care Area Assessment (CAA) for psychotropic medication use dated 10/10/12 stated the resident took Klonopin for the diagnosis of psychotic disorder (any major mental disorder characterized by a gross impairment in reality testing). The resident liked to keep to</p>	F 329		

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F 329	<p>Continued From page 38</p> <p>him/herself and will watch television most of the day. He/she would speak when spoken to but not initiate conversations.</p> <p>The physician's order sheet (POS) signed 4/12/13 revealed an order for Klonopin 0.25 milligrams (mg) by mouth at bedtime for the diagnosis of psychotic disorder.</p> <p>Resident #23's care plan for psychotropic medications dated 7/3/12 revealed staff was to monitor for behaviors of pacing, insomnia, and restlessness.</p> <p>Review of behavior monitoring sheets dated 2/15/13-3/14/13 revealed the behavior monitoring sheet for Klonopin lacked target behaviors and monitoring documentation.</p> <p>Interview on 4/25/13 at 4:58 P.M. with administrative nursing staff B revealed he/she would expect behavior monitoring sheets to list target behaviors and documentation of monitoring.</p> <p>The un-dated policy for behaviors provided by the facility revealed it was the facility's policy to monitor residents for behavioral issues and to provide the necessary treatment and interventions for the management of those behavioral issues.</p> <p>The facility failed to identify resident #23's target behaviors and monitor behaviors for Klonopin during the period of 2/15/13-3/14/13.</p> <p>- Resident #21's annual (MDS) Minimum Data Set 3.0 Assessment, dated 3/2/2013, indicated</p>	F 329		

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F 329	<p>Continued From page 39</p> <p>the resident had a (BIMS) Brief Interview for Mental Status of 5, which indicated severe cognitive impairment.</p> <p>The 12/22/2012 physician's order instructed the staff to administer Toprol XL (a medication for high blood pressure) 25(mg) milligrams, by mouth, 1/2 tablet daily, and the physician further instructed staff to monitor pulses prior to administration of the medication.</p> <p>The 1/31/2013 care plan directed staff to watch for any significant reactions for Toprol XL medication. The care plan further directed staff to notify the physician if the resident had any reactions from the medication.</p> <p>Review of the resident's Medication Administration Records (MARs) revealed the lack of documented pulses for Toprol XL medication as ordered by the physician on the following dates:</p> <ol style="list-style-type: none"> 1) January 2013 MAR on 1/22, 1/23, 1/28 2) February 2013 MAR on 2/2, 2/4 through 2/15. 3) March 2013 MAR on 3/21, and 3/23. 4) April 2013 MAR on 4/4 through 4/6, 4/11 through 4/14, and 4/21. <p>On 4/25/2013 at 10:33 AM, observation revealed the resident seated in the television room watching music videos.</p> <p>On 4/25/2013 at 3:00 PM, Administrative Nurse B verified staff should take and document resident's pulses prior to Toprol administration.</p>	F 329		

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F 329	Continued From page 40 The March 2011 Medication Administration Policy directed staff to obtain and record any vital signs as necessary prior to medication administration. The facility failed to monitor Resident #21's pulses prior to Toprol XL administration, as physician ordered.	F 329		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This Requirement is not met as evidenced by: The facility had a census of 26 residents. The facility had one kitchen/dining room and 2 residents that received nutrition via tube feedings. 24 residents ate meals served from the main kitchen. Based on observation, record review, and interview, the facility failed to prepare, store, and distribute food under sanitary conditions on 1/4 days of the survey by using inappropriate technique to wrap silverware for the 24 residents who ate meals served from the main kitchen in the facility. Findings included: - On 4/24/13, at 10:48 AM, observation revealed Dietary Staff M, with ungloved hands, wrapping	F 371		

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F 371	Continued From page 41 silverware, and touching the tops of the silverware that goes into the resident's mouth. Further observation revealed, Dietary Staff M texting on his/her phone while wrapping the silverware with no hand hygiene. On 4/24/13, at 10:48 AM, Dietary Staff M , verified he/she usually doesn't text on his/her cell phone when wrapping silverware. On 4/24/13, at 11:55 AM, Dietary Staff L verified the staff are only to be on cell phones at break time and he/she should not be handling silverware while texting on the phone. The undated Hand Hygiene and Glove Usage Policy states in accordance with the standard of practice, that proper hand washing, use of alcohol-based hand sanitizers, and gloves will reduce the transmission of infection. The facility failed to prepare, store, and distribute food under sanitary conditions for the 24 residents who ate meals served in the facility.	F 371		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This Requirement is not met as evidenced by:	F 412		

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F 412	<p>Continued From page 42</p> <p>The facility had a census of 26 residents. The sample included 17 residents.</p> <p>Based on observation, record review, and interview the facility failed to provide or obtain dental services to meet the needs of 1 of 1 resident sampled for dental.(#21)</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident #21's annual (MDS) Minimum Data Set 3.0 assessment, dated 3/2/2013, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 5, which indicated he/she had severe cognitive impairment. The assessment revealed the resident was independent with most (ADLs) Activities of Daily Living with limited assistance with one staff for dressing and toilet use. The MDS further revealed the resident had obvious or broken natural teeth with no weight loss. <p>The 3/14/2013 (CAA) Care Area Assessment for dental, triggered due to the resident had a tooth extracted on the lower left side. Staff offer him/her soft foods or ground meat as needed to help with eating meals. The summary indicated the resident had new dentures as of 2/14/2012. The resident was to follow up with the dentist as needed.</p> <p>Resident #21's quarterly MDS assessments, dated 3/14/13 and 9/5/2012, both indicated the resident did not have any dental problems.</p> <p>The 2/3/12 care plan directed staff to assist the resident twice daily with oral care and to make an appointment with the dentist to have his/her teeth extracted.</p>	F 412		

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F 412	<p>Continued From page 43</p> <p>The un-timed 2/4/2012 nurse's note stated resident #21 received new dentures which needed to be fitted.</p> <p>The 3/5/2012 at 2:14 PM, nurse's note stated the resident received a regular diet and at times had difficulty due to missing most of the his/her bottom teeth. The staff offered the resident softer foods and ground meats as needed.</p> <p>The 3/21/2012 Oral Assessment indicated the resident had broken lower partial dentures. He/she had discomfort and difficulty chewing. The assessment further indicated resident #21 had inflamed and bleeding gums on the lower left front of his/her mouth.</p> <p>The 4/5/2012 at 12:30 PM, nurse's note stated the resident's lower left side mouth was sore. The resident was to rinse his/her mouth with warm salt water after meals as needed and be rechecked at the dentist in one month.</p> <p>The 5/3/2012 at 2:00 PM dental consultation record indicated the resident is wearing a full top denture with out any complaints of pain.</p> <p>The 8/8/2012 dental consultation record indicated the resident had a tooth broken at the gum line. The report further indicated the resident had an abscess (a cavity containing pus and surrounded by inflamed tissue) due to the broken tooth and the recommendation was to remove the tooth.</p> <p>The 8/27/2012 at 11:30 AM nurse's notes stated resident #21 had the broken tooth removed.</p> <p>The 8/28/2012 at 11:00 AM, nurse's notes stated the dentist only removed the right tooth and did not take pictures of the left tooth.</p>	F 412		

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F 412	<p>Continued From page 44</p> <p>The 8/29/2012 at 11:00 AM nurse's notes stated the resident had increasing tenderness to the left side of his/her mouth, jaw, cheek, and face. The note further revealed the staff requested the resident to have antibiotics for mouth edema and an appointment for dental examination and removal of the remaining lower tooth.</p> <p>Review of the medical recorded revealed no further dental follow up until April 2013.</p> <p>The 4/8/2013 at 3:54 PM nurse's note stated resident #21 was out for dental appointment for tooth extraction of his/her remaining tooth prior to lower denture impression being made.</p> <p>The 4/10/2013 at 8:31 AM nurse's note stated slight swelling at site of tooth extraction with resident denying pain and no facial grimacing.</p> <p>At 4/24/2013 at 11:45 AM, observation revealed direct care staff G assisted resident #21 to his/her room and encouraged him/her to brush his/her teeth.</p> <p>At 4/24/2013 at 12:00 PM, observation revealed the resident seated in the dining room eating lunch. The resident ate chicken spaghetti, carrots, bread, and applesauce without difficulty.</p> <p>At 4/23/2013 at 11:52 AM, direct care staff G stated the resident brushed his/her own teeth with encouragement and the staff check to see if the resident has brushed his/her teeth and if he/she has not, they assist him/her.</p> <p>At 4/24/2013 at 3:59 PM, Social Service Staff N stated he/she had not spoken with resident #21's family about the resident getting dentures and</p>	F 412			

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F 412	<p>Continued From page 45</p> <p>further stated the dentures have not been a problem for very long, (although the medical record revealed the resident had his/her remaining teeth extracted in August 2012 approximately 7 months ago). He/she further stated he/she has not gotten involved with the resident's denture problem until this month. Social Service staff N stated the resident now has an appointment for his/her new bottom dentures.</p> <p>At 4/25/2013 at 10:43 AM, Nurse D stated the resident had broken his/her bottom partial plate that had been anchored by two teeth. Nurse D further stated the partial plate could not be worn due to one of the bottom teeth breaking off. Nurse D stated the nursing staff could not reach the resident's family to assist with appointments, they told Social Services.</p> <p>At 4/25/2013 at 3:00 PM, Administrative Nurse B stated he/she knew the resident had broken his/her partial and needed further dental appointments and that the dental problems started at least 10 months ago. Nurse B further stated all dental appointments are referred to Social Services.</p> <p>The un-dated Facility Dental Services Policy stated it is the policy to provide or obtain services to meet the needs of each resident.</p> <p>The facility failed to provide or obtain dental services to meet the needs of this cognitively impaired resident.</p>	F 412		
F 428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed</p>	F 428		

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F 428	<p>Continued From page 46 pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>This Requirement is not met as evidenced by: The facility had a census of 26 residents. The sample included 17 residents, with 10 residents reviewed for unnecessary medications.</p> <p>Based on observation, interview and record review, the facility failed to ensure the consultant pharmacist R identified drug irregularities and reported those irregularities to the attending physician and director of nursing for 2 of 10 sampled residents. (#9, #7)</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident #9's 4/12/13 physician orders included renewed orders for: <ul style="list-style-type: none"> * Effexor, an anti-depressant, 100 mg (milligrams) 1 1/2 tabs every day * Cardizem CD, an anti-hypertensive, 120 mg every day * Norvasc, an anti-hypertensive, 10 mg every day * Catapres, an anti-hypertensive, 0.1 mg two times every day * Trandate, an anti-hypertensive, 200 mg 1 1/2 tabs every day <p>Resident #9's 3/1/13 Quarterly MDS (minimum data set) assessment revealed the resident had a BIMS (brief interview for mental status) score of 9 which indicated moderately impaired cognition</p>	F 428			

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F 428	<p>Continued From page 47 and a mood score of 1 which indicated minimal depression.</p> <p>Resident #9's 9/1/12 CAA (care area assessment) summary triggered for psychosocial well-being, mood state and psychotropic drug use but lacked further assessment or analysis related to the resident's use of antidepressants.</p> <p>Resident #9's 2/26/13 revised nursing care plan lacked information related to potential side effects and adverse reactions for the use of Effexor, with a black box warning.</p> <p>The FDA.gov website included the following boxed warning for Effexor: Patients of all ages who are started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber.</p> <p>Resident #9's drug regimen review completed on 3/5/12, 4/21/12, 5/7/12, 6/4/12, 7/5/12, 8/9/12, 9/6/12, 10/4/12, 11/8/12, 12/6/12, 1/10/13, 2/8/13, 3/7/13 and 4/8/13 lacked concerns for a black box warning for use of Effexor or missing documentation of blood pressures and pulses for use of anti-hypertensive medications.</p> <p>Review of Resident #9's MAR (medication administration record) revealed staff failed to document the resident's pulse rate on 3/20, 3/28/13 and 4/13 and 4/14 with the administration of Cardizem. Staff also failed to document the pulse rate on March 28th and April 7th and 13th for the administration of Trandate.</p>	F 428		

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F 428	<p>Continued From page 48</p> <p>During and observation on 4/24/13 at 7:35 a.m., resident #9 sat in dining room and conversed with his/her table mates and did not exhibit any behavioral symptoms.</p> <p>During an interview on 4/25/13 at 1:10 p.m., licensed staff D stated the nurse who obtained the order for a new medication should note the black box warning to alert staff, then licensed staff C or B updated the care plans and CNAs (certified nurse assistant) care work sheets accordingly.</p> <p>During an interview on 4/29/13 at 10:47 a.m., Consultant staff R stated he/she reviewed charts, including MARs (medication administration record) and care plans for black box warning medications. He/she then gives the director of nursing a folder with "Executive Recommendations" if the concerns are global. He/she also reviews for vital signs monitoring and had knowledge the facility had inconsistent documentation of vital signs.</p> <p>The facility failed to ensure the consultant pharmacist reported drug irregularities to the attending physician and director of nursing for resident #9 related to Effexor which had a black box warning and documentation of vital signs prior to administration of anti-hypertensive medications.</p> <p>- Resident #7's medication order sheet included renewed orders for: * Tiazac (an anti-hypertensive) 120 mg everyday * Lanoxin (anti-dysrhythmic that slows the heart rate) 0.25 mg everyday * Coreg (an anti-hypertensive) 6.2 mg everyday</p>	F 428			

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F 428	<p>Continued From page 49</p> <p>Resident #7's 2/17/13 Admission MDS (minimum data set) assessment revealed the resident had a BIMS of 12 which indicated moderately impaired cognition.</p> <p>Resident #7's nursing care plan revised on 4/23/13 revealed a diagnosis for hypertension (elevated blood pressure) and to give medications as ordered. The care plan also directed staff to monitor blood pressure and pulse weekly, notify physician of a systolic blood pressure <90mmHg (millimeters of mercury) or >210mmHg or a diastolic blood pressure of <50mmHg or >115mmHg, and a pulse of <60 or >130 beats per minute.</p> <p>Resident #7's monthly medication review on 2/14/13, 3/12/13, and 4/11/13 lacked concern for missing documentation related to blood pressures and pulse monitoring prior to giving anti-hypertensive medications.</p> <p>Review of the MAR (medication administration record) revealed that from 2/4-2/14/13 staff failed to obtain a pulse rate on the 2/6, 2/8 and 2/9/13. The MAR revealed staff failed to take the blood pressure and pulse on 3/18, 3/19, 3/21, 3/22, 3/24-3/26, 3/29,3/31/13; 4/2,4/5-4/9 and 4/13/13 for Tiazac. Staff also failed to obtain pulses on the 3/18, 3/19, 3/21, 3/22, 3/29-3/31, 4/2, 4/5-9, and 4/13/13 for the use of Lanoxin; and on 3/19, 3/21, 3/29, 3/31, 4/2, 4/6 and 4/13/13 for the use of Coreg.</p> <p>During an observation on 4/24/13 at 7:45 a.m., Resident #7 laid in bed with his/her eyes closed.</p> <p>During an interview on 4/29/13 at 10:47 a.m., Consultant staff R stated he/she reviewed charts, including MARs (medication administration</p>	F 428			

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F 428	<p>Continued From page 50</p> <p>record) and care plans for black box warning medications. He/she then gives the director of nursing a folder with "Executive Recommendations" if the concerns are global. He/she also reviews for vital signs monitoring and had knowledge the facility had inconsistent documentation of vital signs.</p> <p>The facility failed to ensure the consultant pharmacist reported drug irregularities to the attending physician and director of nursing for this resident related to documentation of vital signs prior to administration of Tiazac, Lanoxin, and Coreg.</p> <p>- The quarterly Minimum Data Set 3.0 (MDS) dated 3/17/13 for resident #23 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. He/she required limited assistance with dressing, toilet use, and personal hygiene. The resident received antipsychotic, anti-anxiety, antidepressant, and diuretic medication during the seven day look back period.</p> <p>The Care Area Assessment (CAA) for psychotropic medication use dated 10/10/12 the resident took Klonopin for the diagnosis of psychotic disorder (any major mental disorder characterized by a gross impairment in reality testing). The resident liked to keep to himself and will watch television most of the day. He/she would speak when spoken to but not initiate conversations.</p> <p>Resident #23's physician order sheet signed 4/12/13 revealed an order for Klonopin 0.25 milligrams (mg) by mouth at bedtime for the diagnosis of psychotic disorder.</p>	F 428			

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F 428	<p>Continued From page 51</p> <p>Resident #23's nursing care plan for psychotropic medications dated 7/3/12 revealed staff was to monitor for behaviors of pacing, insomnia, and restlessness.</p> <p>Review of behavior monitoring sheets dated 2/15/13-3/14/13 revealed the behavior monitoring sheet for Klonopin lacked target behaviors and monitoring documentation.</p> <p>Interview on 4/25/13 at 4:58 P.M. with administrative nursing staff B revealed he/she would expect behavior monitoring sheets to list target behaviors and documentation of monitoring.</p> <p>Interview on 4/29/13 at 10:47 A.M. with consultant pharmacist R revealed the pharmacist reviews the Medication Administration Record (MAR), behavior monitoring sheets, care plans for BBW medications, labs, diagnosis appropriateness, physician's order sheet, gradual dose reduction appropriateness, Abnormal Involuntary Movements Scale (AIMS), and history & physical for new residents, monthly. When reviewing the behavior monitoring sheets for the previous month, staff R ensures that target behaviors were listed. For noted global concerns the pharmacist gave the director of nursing (DON) an executive recommendations form. Behavior monitoring had been a global concern during multiple months, including the pharmacist's most recent visit.</p> <p>The un-dated policy for behaviors provided by the facility revealed it was the facility's policy to monitor residents for behavioral issues and to provide the necessary treatment and interventions for the management of those behavioral issues.</p>	F 428		

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F 428	<p>Continued From page 52</p> <p>The 3/11 policy for Medication Regimen Review provided by the facility revealed the consultant pharmacist reviewed the medication regimen for each resident at least monthly (or more frequently depending upon resident's condition and/or risks) for adverse consequences related to current medications. Findings and recommendations are reported to the administrator, director of nursing, the attending physician, and the medical director, where appropriate.</p> <p>The facility failed to provide evidence that the pharmacy consultant identified and notified the facility that they failed to identify target behaviors and monitor behaviors for Klonopin for resident #23 during the period of 2/15/13-3/14/13.</p> <p>- Resident #21's annual (MDS) Minimum Data Set 3.0 Assessment, dated 3/2/2013, indicated the resident had a (BIMS) Brief Interview for Mental Status of 5, which indicated the resident has severe cognitive impairment. The MDS further indicated the resident was independent with most of his/her (ADL's) Activities of Daily Living and required supervision and set up for dressing and toilet use.</p> <p>The 1/31/2013 care plan directed staff to watch for any significant reactions for the Toprol XL medication. The care plan further directed staff to notify the physician if the resident had any reactions from the medication.</p> <p>Resident #21's 12/22/2012 physician order sheet instructed the staff to administer Toprol XL (a beta-blocker used to treat high blood pressure) 25(mg) milligrams, by mouth, 1/2 tablet daily, and the physician further instructed staff to monitor pulses prior to administration of the medication.</p>	F 428			

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F 428	<p>Continued From page 53</p> <p>The April 2013 (MAR) Medication Administration Record directed staff to administer Toprol XL 25 mg, by mouth 1/2 tablet daily and to monitor pulses prior to administration of the medication.</p> <p>Review of resident #21's MARs revealed the lack of documented pulses for the Toprol XL medication as ordered by the physician on the following dates:</p> <ol style="list-style-type: none"> 1) January 2013 MAR on 1/22, 1/23, 1/28 2) February 2013 MAR on 2/2, 2/4 through 2/15. 3) March 2013 MAR on 3/21 and 3/23. 4) April 2013 MAR on 4/4 through 4/6, 4/11 through 4/14, and 4/21. <p>Review of the Pharmacy Consultation Reports, dated 2/14/13, directed staff to check the resident's pulse prior to medication administration for Toprol XL. Further review of the pharmacy consultation reports for 3/13/13, and 4/11/13, did not address the lack of documenting regarding the resident's pulse.</p> <p>On 4/25/2013 at 10:33 AM, observation revealed the resident seated in the television room watching music videos.</p> <p>On 4/25/2013 at 3:00 PM, Administrative Nurse B verified staff should monitor and document the resident's pulses prior to the Toprol XL administration.</p> <p>During an interview on 4/29/13 at 10:47 a.m., Consultant staff R stated reviews for vital signs monitoring with the monthly review and had</p>	F 428		

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F 428	Continued From page 54 knowledge the facility had inconsistent documentation of vital signs. The March 2011 Medication Administration Policy directed staff to obtain and record any vital signs as necessary prior to medication administration. The facility's consulting pharmacist failed to report to the facility and physician the pulses not being documented on the MARs for Resident #21.	F 428		
F 456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This Requirement is not met as evidenced by: The facility had a census of 26 residents. Based on observation and interview the facility failed to maintain all essential mechanical, electrical and patient care equipment in safe operating condition, when staff failed to maintain the facility whirlpool in working use for resident use. Findings included: - During an observation on 4/24/13 at 3:30 p.m., the facility had one whirlpool for resident use. During an interview on 4/22/13 at 4:35 p.m., Resident #16 revealed that he/she preferred to be given a bath but the whirlpool had been broken and therefore had to shower. During an interview on 4/25/13 at 1:15 p.m.,	F 456		

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F 456	Continued From page 55 licensed staff D revealed that the whirlpool tub had not worked in over six months and that approximately 10 or more residents preferred a whirlpool bath. During an interview on 4/24/13 at 3:15 p.m., Administrative staff A and maintenance staff K revealed the whirlpool failed to drain properly and residents had to sit in the tub as the water drained slowly. The residents complained of feeling cold as they waited for the water to drain. Administrative staff A and maintenance staff K further confirmed the whirlpool had not been functioning correctly for over six months. The facility failed to maintain all essential mechanical, electrical and patient care equipment in safe operating condition, when staff failed to maintain the facility whirlpool in working order for resident use.	F 456		
F 469 SS=D	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This Requirement is not met as evidenced by: The facility reported a census of 26 residents. Based on observation, interview and record review, the facility failed to maintain an effective pest control program to ensure the facility remained free of pests (ants). Findings included: - During an observation on 4/23/13 at 11:20am	F 469		

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F 469	Continued From page 56 and 4/23/13 at 8:00 a.m. the room used for the facility for storage of resident's medical records, referred to as the "chart room" , had ants on the cupboards and counter top near the hand sink. Review of pest control records revealed a pest control company visited the facility monthly to spray for pests, with the last visit on 4/22/13. During an interview on 4/24/13 at 3:15 p.m., Administrative staff A reported a pest control company from another city services the facility monthly. Staff A further reported he/she was unaware of the ants in the chart room. The facility failed to maintain an effective pest control program as related to the presence of ants in the facility "chart room".	F 469		
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 disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the	F 520		

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F 520	<p>Continued From page 57 requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This Requirement is not met as evidenced by: The facility reported a census of 26 residents.</p> <p>Based on interview and record review, the facility failed to ensure the physician designee attended the Quality Assessment and Assurance Committee meetings on at least a quarterly basis and also failed to maintain a quality assessment and assurance committee that identified issues and developed/implemented appropriate plans of action to correct identified quality deficiencies.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - During an interview on 4/22/13 at 10:30 a.m., Administrative Staff A confirmed that the facility had a QA&A (Quality Assessment and Assurance) committee that met monthly with the facility's department heads and the committee met quarterly with the physician designee. <p>Review of the facility's monthly QA&A committee sign-in sheets between 2/29/12 and 3/13/13 revealed the physician failed to attend the QA&A meetings in 2 of the 4 quarters.</p> <p>During an interview on 4/25/13 at 2:15 p.m., Administrative Staff A verified the physician designee failed to attend the QA&A meetings on a quarterly basis.</p> <ul style="list-style-type: none"> - Based on observation, interview, and record review, the facility failed to offer choices in 	F 520		

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F 520	<p>Continued From page 58 bathing as cited at F242.</p> <ul style="list-style-type: none"> - Based on observation, interview, and record review, the facility failed to provide medically-related social services as cited at F250. - Based on observation, interview, and record review, the facility failed to maintain the resident environment in clean and orderly condition as cited at F253. - Based on observation, interview, and record review the facility failed to complete a comprehensive assessment of residents' needs as cited at F272. - Based on observation, interview, and record review, the facility failed to develop a comprehensive nursing care plan as cited at F279. - Based on observation, interview, and record review, the facility failed to update/revise residents' nursing care plans as cited at F280. - Based on observation, interview, and record review, the facility failed to provide necessary care and services (neurological assessment following falls) in order to attain or maintain the resident's highest practicable physical well being as cited at F309. - Based on observation, interview, and record review, the facility failed to provide adequate supervision (effective fall strategy interventions) and assistive devices to prevent accidents as cited at F323. - Based on observation, interview, and record review, the facility failed to ensure residents did 	F 520			

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F 520	<p>Continued From page 59</p> <p>not receive unnecessary medications as cited at F329.</p> <ul style="list-style-type: none"> - Based on observation, interview, and record review, the facility failed to ensure staff prepared, stored, and distributed food under sanitary conditions as cited at F371. - Based on observation, interview, and record review, the facility failed to provide or obtain dental services as cited at F412. - Based on observation, interview, and record review, the facility failed to ensure the consultant pharmacist identified drug irregularities and reported those irregularities to the attending physician and director of nursing as cited at F428. - Based on observation, interview, and record review, the facility failed to maintain all essential patient care equipment in safe operating condition as cited at F456. - Based on observation, interview, and record review, the facility failed to maintain an effective pest control program as cited at F469. <p>The facility failed to ensure the physician designee attended the QA&A Committee meetings on at least a quarterly basis. The facility also failed to maintain a quality assessment and assurance committee that identified issues and developed/implemented appropriate plans of action to correct identified quality deficiencies.</p>	F 520			