

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

PRINTED: 12/11/2015
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 11/30/2015
NAME OF PROVIDER OR SUPPLIER ALMA MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 234 MANOR CIRCLE ALMA, KS 66401	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 244 SS=E	<p>483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION</p> <p>When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: The facility had a census of 28 residents. Based upon observation, record review and interview the facility failed to act upon the grievances voiced by the resident council that affected resident care life in the facility.</p> <p>Findings Included:</p> <ul style="list-style-type: none"> - Review of the resident's council meeting minutes from 9/30/14 to 10/27/15 revealed the following: <p>9/30/14: The residents would like for the business office door to be open more often. If the office was closed for staff to please place a sign on the door with a return time. Residents bed linens were not being changed after the residents received his/her baths.</p>	F 244		12/23/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

12/09/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 244	Continued From page 1 10/28/14: Residents stated bathroom were not being cleaned. 12/31/14: A staff member was not scheduling physician's appointments or notifying residents of appointments like the staff member stated he/she was and the office door was closed too much. 1/27/15: Staff did not give the resident's money upon resident's request, the office doors were always shut, residents felt like there was no longer an open door policy. There was no follow through for example, "I'll handle that today, come back in 30 minutes". Appointments were not scheduled on time. 2/27/15: The office door was open more but still closed the majority of the days. Dirty towels were not removed from resident's rooms. The shower room was not cleaned between resident showers. 3/31/15: The office door was still closed most of the day. Residents stated they were told "we are busy", "come back later" when they went to the office and needed something. Shower rooms need to be deep cleaned. The shower rooms were not cleaned between showers. Resident's rooms were not cleaned and the trash was not taken out of the rooms and residents stated they were having to take out their own trash. Resident's clothes had bleach on them. 4/28/15: Southside shower rooms still were not cleaned in between resident's showers. Resident's felt there was a certified nurse aide shortage, beds were still not changed on shower days. The office door was opened more but usually not until after 1:00 P.M.	F 244			

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F 244	Continued From page 2 5/26/15: There had not been a weekend housekeeper and rooms/halls were very dirty on Monday because of it. Dirty towels were not picked up. Direct care staff had been rude to several residents lately. 6/30/15: The large and small dining rooms were not fully swept/mopped after meals. Bleach was on resident's clothes and residents felt his/her clothes should be replaced by the facility since the bleach was ruining their clothes. Residents would like to create a separate office for the business manager so that residents could have more access to the office when other staff was in meetings. 7/28/15: Residents state staff was rarely in the office to give them their money. Staff used cellular telephones when they were not on break and told residents "hold on, I'm busy" and residents were frustrated an activity director had not been hired. 8/25/15: There was not enough food items on the snack cart. The meal portion sizes especially the supper meal were too small and residents were still hungry after eating their meals. Nurses and certified nurse aides still carried his/her cellular telephones and told residents they were busy because they were on the phone. Beds were not made daily and residents had to make his/her own beds, and staff was not changing bed linens on resident's bath/shower days. The office door was open more but was still closed most of the day and residents were able to get their money upon request. Residents stated there was no follow through when they ask for something to be done.	F 244			

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F 244	Continued From page 3 9/14/15. Resident stated the office door was open more but was still shut most of the day and resident were not able to get his/her money upon request. A Resident Council Complaint/Grievance Request Response Form dated and signed 9/30/15 documented last month's grievances were not resolved, the office door was still shut the majority of the day and residents could not access his/her money. Staff educated residents that after 5:00 P.M. and on weekends he/she could access his/her money by going to the charge nurse. 10/1/15: Rooms were not fully cleaned on a daily basis, staff ate the good snacks off the snack cart and the majority of activities on the activity calendar were not taking place. Certified nurse aide still carried his/her cellular phone and told resident he/she was busy because he/she was on his/her phones. Bed were not made on a daily basis and residents had to make his/her own bed, staff were not changing bedding on bath/shower days and the office door was still closed the majority of the day. 10/27/15: Nursing staff still carried their cellular telephones, played games and loud music on the phones on the 2 to 10 and 10 to 6 shift. During Stage 1 of the survey residents expressed concerns regarding rooms were not cleaned on a daily basis, hallways of the facility were unclean, residents had to arrange his/her transportation to/from physician appointments and funds were not not readily accessible in the evenings and/or weekends.	F 244			

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F 244	<p>Continued From page 4</p> <p>On 11/23/15 at 9:30 A.M. observation revealed a resident that resided on the south side of the facility 2 trash cans overflowed with trash and a dirty incontinent brief was on the floor. The alert and oriented resident stated staff did not clean his/her room on a daily basis and often times there was not a housekeeper on the weekends.</p> <p>On 11/19/15 at 11:15 A.M. social service staff GG stated he/she assisted with the resident council meetings. He/she stated during the month of October 2014 the facility had a change in administrators and during the month of January 2015 the facility had a change in Director of Nursing as well as a turn over in the nursing staff. Social service staff GG stated he/she relayed resident council concerns to department heads after each meeting and the previous administrator (the administrator hired in 10/14) responded back to him/her as to corrective actions the facility was to make regarding the resident council concerns. He/she stated he/she did not know if the administrator relayed the corrective actions to the department heads which might have contributed to the recurring resident council member concerns. Social service staff GG stated residents had expressed concerns regarding access to personal funds accounts during the day and until recently the facility kept \$100.00 in the medication room after business hours during the week and on weekends in the case residents requested money. He/she stated a couple of months ago corporate administration decided the nursing staff should not have to deal with resident's funds as well as nursing duties so the facility implemented a telephone call tree if residents requested money after hours and on weekends. Social service staff GG stated himself/herself whom lived about 30 minutes from</p>	F 244			

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F 244	Continued From page 5 the facility, the newly hired administrator whom lived about an hour away from the facility and the corporate nurse whom lived a couple of hours away from the facility were the staff nursing staff contacted if residents requested monies after business hours and on weekends. Social service staff GG stated the former Activity Director retired sometime during the summer and an employee resumed the Activity Director duties about a month ago. On 11/23/15 at 8:49 A.M. an alert and oriented resident stated administrative staff tell residents how the facility will implement changes relating to resident council concerns but the facility does not follow through so the concerns kept reoccurring. On 11/23/15 at approximately administrative staff A stated the facility implement a telephone call tree regarding resident's fund after hours and or weekends. He/she stated the nursing staff was to contact social service staff GG or the newly hired administrator if residents requested money after business hours Monday through Friday and on weekends and social service staff GG and/or the newly hired administrator would contact administrative nursing staff D to come to the facility and give the resident the money as requested. The facility's undated Resident Grievance Policy and Procedure included residents had a right to prompt efforts by the facility to resolve grievances. The facility failed to act upon the resident council grievances in a prompt and timely manner.	F 244			
F 248	483.15(f)(1) ACTIVITIES MEET	F 248		12/23/15	

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F 248 SS=D	<p>Continued From page 6</p> <p>INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: The facility reported a census of 28 residents, and the sample size was 15. Based on observation, record review, and interview the facility failed to provide activities for 2 of 2 (#4 and #18) sampled residents who required individualized activities.</p> <p>Findings included: - Review of resident #4's unsigned physician order sheet dated November 2015 documented the following diagnoses: muscle weakness and Clostridium difficile (contagious bacteria characterized by foul smelling frequent bowel movements).</p> <p>Review of a significant change in status MDS (Minimum Data Set) dated 10/23/2015 documented the resident reentered the facility from the hospital on 10/23/2015 and had a BIMS (Brief Interview for Mental Status) score of 0, which indicated severe cognitive impairment. The resident required extensive assistance of 2 staff with bed mobility and personal hygiene; dependent on two or more staff with transfers, dressing, toileting, and bathing; did not walk, left unit only once or twice; and required extensive assistance of one staff with eating. He/she used a wheelchair for mobility and did not reject cares. The resident was frequently incontinent of urine, always incontinent of bowel, and had no toileting</p>	F 248			

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F 248	<p>Continued From page 7</p> <p>program. The resident denied pain during the 5 day observation period and received no pain management interventions. The resident reported it was very important to him/her to have books, newspapers, and magazines to read, listen to music, and participate in religious services or practices.</p> <p>Review of a quarterly/5 day MDS dated 9/23/2015 documented the resident reentered the facility on 9/16/2015. The resident had short term memory problems and had difficulty with decision making in new situations. The resident was dependent on 2 or more staff with transfers, dressing, and toileting; extensive assistance of 2 or more staff with bed mobility; dependent on one staff with locomotion on and off the unit, personal hygiene, and bathing; and extensive assistance of one staff with eating. He/she used a wheelchair for mobility and did not reject cares. The resident was always incontinent of urine and bowel and was not on a toileting program. The resident reported severe frequent pain, rated a 10, which did not limit his/her daily activities or interfere with sleep at night. He/she received as needed and non-medication interventions to manage pain.</p> <p>Review of the Cognitive Loss CAA (Care Area Assessment) dated 11/6/2015 documented the resident had difficulty communicating due to a cognitive deficit. The speaker needed to speak loudly for best understanding, and sometimes if given a few moments the resident could answer questions. Progression of loss led to comfort measures for end of life.</p> <p>Review of the ADL (Activities of Daily Living) CAA did not trigger.</p> <p>Review of the Activities CAA dated 11/6/2015 documented the resident was on contact isolation precautions due to Clostridium difficile (C. Diff) and had active loose stools that required the</p>	F 248			

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F 248	Continued From page 8 resident to remain in his/her room. Staff encouraged the resident to have his/her television (TV) on and blinds open so he/she could have visual stimuli to look at. The resident slept more and had music available if he/she liked to listen. Some of his/her interests included football, baseball, and reading the Bible. The staff was to encourage interactions, as tolerated. Review of the care plan dated 10/28/2015 documented the resident liked to be involved in most activities so he/she was with others. The care plan documented the resident liked ice cream socials, holiday parties, and events. He/she liked to watch, but did not always participate. The resident liked to color, do ceramics, sew, paint, work with houseplants, but not gardening, and enjoyed putting puzzles together, Bingo, Sorry, Monopoly, Rummy, trivia, hangman, Wheel of Fortune, and Scrabble. The resident enjoyed soft/calming music when trying to rest and relax, grew up listening to Nat King Cole, liked Country and Christian music, George Strait, and Amazing Grace. The resident liked nonviolent and nonscary movies, liked Batman, Everybody Loves Raymond, pawn shop shows, Dick Van Dyke, liked reading the Bible in his/her room, and liked stories about Sherlock Holmes. The record lacked an activities assessment in the medical record since return from the hospital 10/28/2015. The unsigned Activity Assessment documented the resident liked Rummy, Bingo, football and baseball on TV, all music, the Bible, outings, sitting outdoors, visiting/conversation, and dogs. The Activity Record dated July 2015 documented no activity attendance and had not been feeling well since arriving. Isolation Precautions for C. Diff, 10/23/2015. Discontinued on 11/17/2015.	F 248			

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F 248	<p>Continued From page 9</p> <p>During an observation on 11/17/2015 at 8:05 A.M. the resident sat in his/her Broda chair on a cushion with facial grimacing and moaning. The TV was not on and staff were not present.</p> <p>During an observation on 11/17/2015 at 9:22 A.M. the resident was in bed with his/her eyes closed, television off, and blinds closed. There was no visible Bible, books, magazines, or music in the resident's room.</p> <p>During an observation on 11/17/2015 at 2:22 P.M. the resident laid in bed with his/her eyes closed, window blinds closed, and television off. There was no visible Bible, books, magazines, or music in the resident's room.</p> <p>During an interview on 11/17/2015 at 12:55 P.M. the resident said he/she liked to read the Bible, sew, and watch TV. The resident stated he/she was not bored, and had "too much pain to be bored". The resident said he/she had no difficulty with reading.</p> <p>During an interview on 11/17/2015 at 3:21 P.M. direct care staff S stated the resident loved to get his/her nails done and he/she loved to sing. He/she was not aware if the resident enjoyed reading the Bible, and was not aware if the resident received painted nails today. He/she informed the activity director would usually say something and the staff, who have been there longer, would give information on residents preferred activities. He/she had not witnessed the resident participating in activities, and before isolation precautions the resident would come out and listen to the piano, get his/her nails done, and attend church. He/she stated preferred activities were not part of the resident worksheet.</p> <p>During an interview on 11/18/2015 at 11:53 A.M. direct care staff P stated activities are done daily. Residents are informed of activities on the board and if there was an impromptu activity, staff</p>	F 248			

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F 248	<p>Continued From page 10</p> <p>would let each resident know. If a resident was cognitively impaired staff would take them out, if able, for kickball. If a resident was isolated in a room he/she was not sure how a resident was kept involved in activities. He/she was not aware of any activities the resident liked and stated he/she was not aware of the resident receiving activities in his/her room since being on isolation after return from the hospital. The resident liked to sit up front and watch the big screen TV, listen to the birds, and watch others.</p> <p>During an interview on 11/23/2015 at 7:19 A.M. activity staff EE said he/she spent one on one time with the resident since his/her return from the hospital and had not documented the encounters. He/she was aware the resident was religious, but was not aware the resident enjoyed reading the Bible. He/she was not sure if the resident had cable hooked up in his/her room to watch television.</p> <p>During an interview on 11/23/2015 at 8:47 A.M. licensed staff J said the resident did not like stimulation or to watch television. He/she stated the resident liked music, kickball with the beach ball, and sometimes liked to watch the birds. The resident basically wanted to sleep or converse during meal intake. He/she was not sure if the resident had a Bible or reading materials available to him/her.</p> <p>During an interview on 11/23/2015 at 9:24 A.M. administrative nursing staff D stated the facility had struggled with activities and was working on them to make sure residents get stimulation through activities, and even if on isolation precautions.</p> <p>The facility lacked a policy on providing activities to residents.</p> <p>The facility failed to provide activities to the resident according to his/her interests and needs.</p>	F 248			

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F 248	<p>Continued From page 11</p> <p>-Resident #18's quarterly Minimum Data Set (MDS) dated 10/7/15 identified the resident had severely impaired cognition, had no behaviors, was totally dependent upon staff for bed mobility, transfers, locomotion on/off the unit, dressing, toilet use and personal hygiene, and required extensive staff assistance with eating, and the activity of walking in the room/corridor occurred once or twice.</p> <p>The resident's annual MDS dated 7/5/15 identified had short and long term memory impairment, moderately impaired cognition, had no behaviors, was totally dependent upon staff for bed mobility, transfers, locomotion on/off the unit, dressing, toilet use and personal hygiene, and eating, and the activity of walking in the room/corridor did not occur. The MDS recorded it was very important to the resident to have books, newspapers, and magazines, to go outside to get fresh air when the weather permitted, participate in religious services or practices, it was somewhat important to the resident to keep up with the news and to do things with groups of people.</p> <p>The resident's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 7/17/15 included the resident had dementia, received hospice services, did not verbally communicate, made verbal sounds and grimaced and occasionally said yes or no.</p> <p>The resident's Activity CAA did not trigger.</p> <p>The resident's care plan reviewed/revised 10/23/15 included the resident required staff</p>	F 248			

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F 248	<p>Continued From page 12</p> <p>assistance to get him/her to organized activities, to make sure he/she spent quality time with his/her family. The resident no longer participated in activities which required a great deal of physical exertion, but the resident still enjoyed watching activities.</p> <p>Review of the resident's activity logs from January 2015 to July 2015 revealed the resident attended group exercises 2 to 3 times a month, received one on one visits 5 to 13 times each month and sensory stimulation which included staff applied lotion to the resident's arms and hands at least 7 times a month in a month. Notations on the logs documented the resident received hospice services, did not feel up to most group activities but enjoyed 1 to 1 visitors, watching television in the dayroom and in his/her room, watching kickball, sitting outdoors as weather permitted, sensory stimulation such as having lotion gently rubbed on his/her hands and arms.</p> <p>The resident's clinical record lacked evidence to support the resident had participated in activities since 7/2015.</p> <p>The Resident's Council Minutes dated 7/28/15 included residents were frustrated the facility had not hired an Activity Director.</p> <p>On 11/17/15 at 9:50 A.M. residents attended an exercise group which included kicking a beach ball and the resident was not in attendance.</p> <p>On 11/17/15 at 11:00 A.M. residents attended a finger nail painting activity and the resident was not in attendance.</p>	F 248			

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F 248	Continued From page 13 On 11/17/15 at 1:45 P.M. residents attended a music activity in and the resident was not in attendance. On 11/18/15 at 7:40 A.M. observation revealed the resident did not have a television in his/her room. On 11/17/15 at 7:45 A.M. activity staff EE confirmed the resident ' s clinical record lacked evidence to support the resident had participated in activities since 7/2015. He/she stated the former activity director retired some months ago and he/she had only held the position for 4 weeks. On 11/19/15 at 12:01 P.M. licensed nurse J stated staff tried to ensure the resident went to music and church activities and the resident was a passive participant in the beach ball activity. On 11/19/15 at 4:09 P.M. direct care staff U stated staff assisted the resident to music activities when the resident was awake. The facility did not provide an Activity Policy and Procedure. The facility failed to provide this severely cognitively resident an ongoing program of activities in accordance with the resident's comprehensive assessment and interests.	F 248			
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.	F 253		12/23/15	

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F 253	Continued From page 14 This REQUIREMENT is not met as evidenced by: The facility identified a census of 28 residents. Based upon observation, record review, and interview, the facility failed to provide services to maintain a sanitary and comfortable interior of the facility for four of six days of onsite survey and for three of three halls where residents resided. Findings included: Observations noted during the survey starting on 11/12/15 at 8:00 A.M. and through 11/19/15 and during the environmental tour on 11/19/15 at 10:00 A.M. with maintenance supervisor X revealed the following: In 4 resident rooms on the walls were unpainted patches in which holes had been repaired, but not painted. There was a window blind which needed installed in one resident room, and there was a gray substance on the floor of the bathroom. The bathroom door in one resident room dragged on the floor when opened or closed, and the door handle was covered with duct tape. There were 2 brown stains in the toilet bowl in one resident's room. The door to one resident room was difficult to open from the inside. Interview on 11/19/2015 at 10:10 A.M. maintenance supervisor X stated he/she was	F 253			

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F 253	<p>Continued From page 15</p> <p>aware there were some resident rooms in need of painting, aware of the bathroom door dragging and the duct tape on the door handle, and aware the door was difficult to open. He/she stated he/she was not aware the blind was not installed. He/she stated the gray substance on the floor was tile glue that needed scrapped up and was not aware it was there. He/she said the brown stain was a hard water stain.</p> <p>The facility failed to provide a policy about maintenance responsibilities.</p> <p>The facility failed to maintain a comfortable interior environment.</p> <p>- Observations noted during the survey starting on 11/12/15 at 8:00 A.M. and through 11/19/15 and during the environmental tour on 11/19/15 at 10:20 A.M. with administrative nursing staff D revealed the following:</p> <p>There were toilet risers (a device attached to the toilet to raise the height of the toilet seat) stored on the bathroom floor of two resident rooms.</p> <p>Interview on 11/19/2015 at 10:25 A.M. administrative nursing staff said he/she was unaware the toilet risers had been stored in this manner and would take care of them.</p> <p>The facility failed to provide a policy about maintenance responsibilities.</p> <p>The facility failed to maintain a sanitary environment.</p>	F 253			
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS	F 272		12/23/15	

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F 272	Continued From page 16 The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. 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 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.	F 272			

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F 272	<p>Continued From page 17</p> <p>This REQUIREMENT is not met as evidenced by: The facility reported a census of 28 residents. There were 15 residents in the sample. Based on interview, and record review the facility failed to complete an accurate and comprehensive MDS (Minimum Data Set) assessment for 1 of 15 residents reviewed for MDS'.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of resident #28's unsigned physician order sheet dated November 2015 documented the following diagnosis: pressure ulcer (localized injury to the skin and tissues). <p>Review of the admission MDS (Minimum Data Set) dated 4/6/2015 documented a BIMS (Brief Interview for Mental Status) score of 10, which indicated moderate cognitive impairment. The resident required physical assistance with ADL (Activities of Daily Living). The resident reported frequent moderate pain, rated a 5 on a scale of 0-10 (0 was no pain and 10 was the worst pain imagined), which limited his/her day to day activities and did not interfere with sleep at night. The resident had a risk for skin breakdown, admitted with a stage 2 pressure ulcer (superficial skin/tissue loss), had an open lesion to the foot.</p> <p>Review of the quarterly MDS dated 9/15/2015 documented a BIMS score of 15, which indicated intact cognition. The resident required staff assistance with ADL. The resident reported very severe, horrible pain, rated a 10, which limited his/her day to day activities, did not interfere with sleep at night, and he/she received as needed and non-medication interventions to manage</p>	F 272			

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F 272	<p>Continued From page 18</p> <p>pain. The resident had a risk for development of pressure ulcers and had one stage 2 pressure ulcer.</p> <p>Review of the Cognitive Loss, Pain, and Pressure Ulcer CAA (Care Area Assessment) dated 4/8/2015 lacked an analysis of findings and documented the resident had been admitted to the hospital.</p> <p>Review of a wound and skin progress dated 9/9/2015 documented the resident had 100% (percent) non blanching redness with light blue discoloration and yellow scabs.</p> <p>During an interview on 11/18/2015 at 11:09 A.M. with administrative nursing staff E he/she stated the resident did not have a completed comprehensive assessment and staff should have completed one when the resident returned from the hospital on 4/18/2015. Staff E confirmed not all CAA's were completed and the resident's wound to his/her right heel was miscoded and staff should have coded as a suspected deep tissue injury and not a stage 2.</p> <p>The facility's non dated MDS policy documented the facility conducted a comprehensive assessment according to Federal regulations and Medicare guidelines.</p> <p>MDS 3.0 required comprehensive assessments to include CAA's be completed by day 14 of the resident's stay.</p> <p>The facility failed to provide an accurate assessment stage of the resident's pressure ulcer and failed to complete all triggered CAA's to include Pressure Ulcer, Cognition, Nutritional</p>	F 272			

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F 272	Continued From page 19 Status, and Dehydration.	F 272			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: The facility reported a census of 28 residents. There were 15 resident sampled. Based on observation, interview, and record review the facility failed to timely review and revise resident #4's care plan to include the use of heel boots and management of pain during ADL and wound cares. Findings included:	F 280	12/23/15		

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F 280	<p>Continued From page 20</p> <p>- Review of resident #4's unsigned physician order sheet dated November 2015 documented the following diagnoses: muscle weakness. Review of a quarterly MDS (Minimum Data Set) dated 9/23/2015 documented the resident reentered the facility from the hospital on 9/16/2015 and had short term memory problems. The resident required staff assistance with ADL (Activities of Daily Living) and did not reject cares. The resident reported severe frequent pain, rated a 10 on a scale of 0-10 (zero being no pain and 10 the worst pain imaged), which did not limit his/her day to activities or interfere with his/her sleep at night. He/she received as needed medications and non-medication interventions to manage pain.</p> <p>Review of a significant change in status MDS dated 10/23/2015 documented the resident reentered the facility from the hospital on 10/23/2015 and had a BIMS score of 0, which indicated severe cognitive impairment. The resident required staff assistance with all ADL and did not reject cares. The resident denied pain during the 5 day observation period and received no pain management interventions.</p> <p>Review of the Cognitive Loss CAA (Care Area Assessment) dated 11/6/2015 documented the resident had communication difficulty due to cognitive loss.</p> <p>The Pain CAA did not trigger and the Pressure Ulcer CAA did not address pain.</p> <p>Review of the care plan dated 10/28/2015 documented the resident wished to remain comfortable, received palliative services (focus was on providing pain relief) and reported an</p>	F 280			

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F 280	<p>Continued From page 21</p> <p>acceptable level of pain was a 3 on a scale of 01-0 (zero was no pain and 10 the worst pain imagined). The care plan directed staff to administer pain medications as ordered, notify the doctor if he/she remained uncomfortable after pain medications received, assess pain four times daily using a 0-10 scale or other nonverbal signs of pain, and stop cares if the resident had pain during cares and tell the nurse. The care plan directed staff to attempt other non-pharmacological interventions to include; repositioning, turn down the lights, and provide extra pillows.</p> <p>Review of wound and skin assessments documented the resident had a stage 2 pressure ulcer present on admission, which worsened to an unstageable wound on 11/4/2015 and he/she developed an unstageable pressure ulcer on his/her right heel and a stage 1 pressure ulcer on his/her left heel on 11/17/2015.</p> <p>During an observation on 11/17/2015 at 7:27 A.M. direct care staff O and P transferred the resident from the bed to his/her wheelchair. The resident groaned when staff turned him/her side to side, said "ow" and stated he/she hurt during the transfer. Staff O replied, "I know, we just need to get you up." The resident's face grimaced throughout cares. Following cares direct care staff O asked the resident if he/she wanted pain medications and the resident said "yes" and made a crying sound. At 8:05 A.M., 8:20 A.M. and 8:35 A.M. the resident remained seated in his/her wheelchair and continued with facial grimacing and moaning. At 8:40 A.M. licensed nursing staff I entered the resident's room and administered pain medication. He/she asked the resident to rate his/her pain and the resident said</p>	F 280			

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F 280	<p>Continued From page 22</p> <p>his/her tail hurt and rated pain a 9.</p> <p>During an observation on 11/17/2015 at 8:54 A.M. direct care staff O and Q assisted the resident to bed using a Hoyer lift. The resident moaned during the transfer and cried "Oh my God". The resident continued to scream loudly during cares.</p> <p>During an observation on 11/17/2015 at 10:04 A.M. direct care staff O and licensed nursing staff H entered the resident's room. Staff O said I'm back to torture you, I'm so sorry". The resident moaned as staff assisted the resident with repositioning and incontinence care. The resident cried when staff turned him/her to his/her back and stated "my tailbone hurts". Staff H told the resident he/she had pain medication 45 minutes ago. Review of the medication administration record documented Morphine was administered at 8:32 A.M. (1 hour and 32 minutes prior).</p> <p>During an observation on 11/18/2015 at 8:28 A.M. licensed nursing staff I entered the resident's room and administered "Morphine" to the resident. Staff I said he/she did not assess the resident's pain level because "it's just for wound care". Administrative nursing staff D and licensed nursing staff I began wound assessment and wound care at 8:31 A.M. (3 minutes after medication administered). The resident yelled "ouch" when staff D lifted his/her right and left legs. Staff D told the resident he/she was "sorry" and continued the assessment. The resident continued to cry out and yell "ouch, it burns" during wound care to his/her coccyx. Administrative nursing staff D asked the resident to rate his/her pain after wound care completion and the resident replied "7".</p>	F 280			

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F 280	Continued From page 23 During an interview on 11/17/2015 at 7:50 A.M. the resident stated he/she "hurt real bad" and "had a cut on [his/her butt]", which he/she had for a month or two. The resident rated his/her pain "a 25" on a scale of 0-10. The resident said "it's so hard to sit on my butt, but they keep doing it and doing it and doing it." The resident moaned loudly during the interview. 12:55 P.M. the resident said staff did not give him/her pain medications prior to getting him/her up in the mornings and said he/she would like pain medication before staff move him/her. The resident said he/she did not think staff gave him/her pain medications before wound care because "it hurt bad". The resident said pain does not consume his/her life, "but it's pretty bad". During an interview on 11/17/2015 at 7:33 A.M. direct care staff O said he/she did not know if the resident received pain medication prior to cares and let the nurse know after cares if the resident had pain. Staff O stated the resident had too much pain if turned side to side, moaned and groaned during repositioning, and had the most pain when staff performed wound care to the coccyx.. During an interview on 11/17/2015 at 3:26 P.M. direct care staff S said the resident had pain to a sore on his/her coccyx and the resident moaned, groaned, sometimes screamed, had facial grimacing, and would tell staff when he/she had pain. Staff S said the resident had pain daily when staff got him/her up, repositioned, provided incontinence care, and anytime staff did anything with him/her.	F 280			

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F 280	<p>Continued From page 24</p> <p>During an interview on 11/18/2015 at 12:04 P.M. direct care staff P said the resident had pain whenever staff touched his/her legs, when turned side to side, and when staff completed wound care.</p> <p>During an interview on 11/18/2015 at 2:13 P.M. licensed nursing staff I said the resident received Morphine every hour as needed for pain. Staff I said he/she waited 15-20 minutes for the pain medication to work before completing wound care and confirmed wound care was started 3 minutes after he/she administered pain medication this morning. Staff I confirmed today was the first day he/she gave the resident pain medication prior to completing wound care.</p> <p>During an interview on 11/23/2015 at 8:51 A.M. licensed nursing staff J said the resident received Morphine for pain management and the Morphine took 20-30 for effectiveness. Staff J said he/she routinely gave the resident pain medication before he/she changed the resident's dressing to the coccyx. After review of the treatment administration record staff J confirmed he/she completed dressing changes to the resident's coccyx on 11/10 at 10:57 A.M., 11/11 at 1:14 P.M., 11/14 at 8:53 A.M. and on 11/15/15 at 9:52 A.M. Staff J also confirmed he/she did not give the resident pain medication prior to the dressing changes on those dates.</p> <p>During an observation on 11/23/2015 at 9:28 A.M. administrative nursing staff D said he/she expected staff to stop care if a resident had pain and let the nurse know. He/she said Morphine took about 15 minutes to work and staff should wait at least that long to continue cares. Staff D said he/she expected staff to address pain</p>	F 280			

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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 11/30/2015
NAME OF PROVIDER OR SUPPLIER ALMA MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 234 MANOR CIRCLE ALMA, KS 66401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 280	Continued From page 25 management during cares and wound cares. Review of the facility's undated Comprehensive Care Plan policy documented the resident's care plan was individualized, reviewed, and revised as indicated. The facility failed to review and revise the care plan this cognitively impaired and dependent resident who had an unstageable coccyx wound and experienced pain during wound care.	F 280			
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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. This REQUIREMENT is not met as evidenced by: The facility reported a census of 28 residents. There were 15 residents in the sample. Based on observation, interview, and record review the facility failed to timely assess and treat pain for 1 of 1 resident reviewed for pain (#4) who had a painful unstageable pressure ulcer (a full thickness tissue loss in which the actual depth of the ulcer is covered by slough) (dead tissue) to his/her coccyx (tailbone) and right heel and failed to timely assess, intervene, and notify the physician of a decline in medical condition for 1 of 1 resident reviewed for emergency care. (#1)	F 309		12/23/15	

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F 309	<p>Continued From page 26</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of the resident #4's unsigned physician order sheet dated November 2015 documented the following diagnoses: osteoporosis (an abnormal loss of bone density and bone tissue) and muscle weakness. <p>Review of a quarterly MDS (Minimum Data Set) dated 9/23/2015 documented the resident reentered the facility from the hospital on 9/16/2015 and had short term memory problems. The resident required staff assistance with ADL and did not reject cares. The resident reported severe frequent pain, rated a 10 on a scale of 0-10 (zero being no pain and 10 the worst pain imaged), which did not limit his/her day to activities or interfere with his/her sleep at night. He/she received as needed pain medications and non-medication interventions to manage pain. The resident had one stage 1 pressure ulcer (red skin, which did not resolve with pressure relief).</p> <p>Review of a significant change in status MDS dated 10/23/2015 documented the resident reentered the facility from the hospital on 10/23/2015 and had a BIMS score of 0, which indicated severe cognitive impairment. The resident required staff assistance with all ADL and did not reject cares. The resident denied pain during the 5 day observation period and received no pain management interventions. He/she had a stage 2 pressure (superficial loss of skin) ulcer.</p> <p>Review of the Cognitive Loss CAA (Care Area Assessment) dated 11/6/2015 documented the resident had communication difficulty due to cognitive loss.</p> <p>The Pressure Ulcer CAA dated 11/6/2015 did not</p>	F 309			

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F 309	<p>Continued From page 27 address pain.</p> <p>The Pain CAA did not trigger.</p> <p>Review of the care plan dated 10/28/2015 documented the resident wished to remain comfortable, received palliative services (focus was on providing pain relief) and reported an acceptable level of pain was a 3 on a scale of 01-0 (zero was no pain and 10 the worst pain imagined). The care plan directed staff to administer pain medications as ordered, notify the doctor if he/she remained uncomfortable after pain medications received, assess pain four times daily using a 0-10 scale or other nonverbal signs of pain, and stop cares if the resident had pain during cares and tell the nurse. The care plan directed staff to attempt other non-pharmacological interventions to include; repositioning, turn down the lights, and provide extra pillows.</p> <p>Review of wound and skin assessments documented the resident had a stage 2 pressure ulcer present on admission, which worsened to an unstageable wound on 11/4/2015 and he/she developed an unstageable pressure ulcer on his/her right heel and a stage 1 pressure ulcer on his/her left heel on 11/17/2015.</p> <p>Review of physician orders included the following: Monitor pain four times a day using a 0-10 scale or FLACC scale (method used to assess pain of face, legs, activity, crying, and in-consolability scale), effective 10/23/2015 Morphine Sulfate (a medication to treat pain) 20 mg/5 ml (milligrams/milliliters), give 0.25 ml buccal (in the tissue of the mouth) every hour as needed for pain, effective 10/28/2015.</p>	F 309			

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F 309	<p>Continued From page 28</p> <p>Review of pain monitoring four times daily documented the resident reported pain greater than a 3 on the following dates: On 11/2/2015- he/she rated his/her pain a 10 on 2-6 P.M. shift and no pain medication given and an 8 on 6 P.M. midnight shift and no pain medication given. On 11/5/2015- he/she rated his/her pain a 5 on 6-10 A.M. shift and no pain medication given. 11/6/15- he/she rated his/her pain a 6 on 10 A.M.-2 P.M. shift and no medication give, a 5 on 2-6 P.M. shift and no pain medication given, and a 4 on 6 P.M.-midnight shift and no pain medication given. 11/7/15- he/she rated his/her pain a 7 on 10 A.M. to 2 P.M. shift and no pain medication given. 11/8 /15- he/she rated his/her pain a 7 on 6-10 A.M. and no pain medication given. 11/13/15- he/she rated his/her pain a 4 on 6 P.M.-midnight shift and no pain medication administered. 11/18/15- he/she rated his/her pain a 4 on 10 A.M.-6 P.M. shift and no pain medication given.</p> <p>During an observation on 11/17/2015 at 7:27 A.M. direct care staff O and P transferred the resident from the bed to his/her wheelchair. The resident groaned when staff turned him/her side to side, said "ow" and stated he/she hurt during the transfer. Staff O replied, "I know, we just need to get you up." The resident's face grimaced throughout cares. Following cares direct care staff O asked the resident if he/she wanted pain medications and the resident said "yes" and made a crying sound. At 8:05 A.M., 8:20 A.M. and 8:35 A.M. the resident remained seated in his/her wheelchair and continued with facial grimacing and moaning. At 8:40 A.M. licensed nursing staff</p>	F 309			

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F 309	<p>Continued From page 29</p> <p>I entered the resident's room and administered pain medication. He/she asked the resident to rate his/her pain and the resident said his/her tail (bone area) hurt and he/she rated his/her pain a 9.</p> <p>During an observation on 11/17/2015 at 8:54 A.M. direct care staff O and Q assisted the resident to bed using a Hoyer lift. The resident moaned during the transfer and cried "Oh my God". The resident continued to scream loudly during cares.</p> <p>During an observation on 11/17/2015 at 10:04 A.M. direct care staff O and licensed nursing staff H entered the resident's room. Staff O said "I'm back to torture you, I'm so sorry". The resident moaned as staff assisted the resident with repositioning and incontinence care. The resident cried when staff turned him/her to his/her back and stated "my tailbone hurts". Staff H told the resident he/she had pain medication 45 minutes ago. Review of the medication administration record documented Morphine was administered at 8:32 A.M. (1 hour and 32 minutes prior).</p> <p>During an observation on 11/18/2015 at 8:28 A.M. licensed nursing staff I entered the resident's room and administered "Morphine" to the resident. Staff I said he/she did not assess the resident's pain level because "it's just for wound care". Administrative nursing staff D and licensed nursing staff I began wound assessment and wound care at 8:31 A.M. (3 minutes after medication administered). The resident yelled "ouch" when staff D lifted his/her right and left legs. Staff D told the resident he/she was "sorry" and continued the assessment. The resident continued to cry out and yell "ouch, it burns" during wound care to his/her coccyx.</p>	F 309			

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F 309	<p>Continued From page 30</p> <p>Administrative nursing staff D asked the resident to rate his/her pain after wound care completion and the resident replied "7".</p> <p>During an interview on 11/17/2015 at 7:50 A.M. the resident stated he/she "hurt real bad" and "had a cut on [his/her butt]", which he/she had for a month or two. The resident rated his/her pain "a 25" on a scale of 0-10. The resident said "it's so hard to sit on my butt, but they keep doing it and doing it and doing it." The resident moaned loudly during the interview. 12:55 P.M. the resident said staff did not give him/her pain medications prior to getting him/her up in the mornings and said he/she would like pain medication before staff move him/her. The resident said he/she did not think staff gave him/her pain medications before wound care because "it hurt bad". The resident said pain does not consume his/her life, "but it's pretty bad".</p> <p>During an interview on 11/17/2015 at 12:55 P.M. the resident said he/she liked to read the Bible, sew, and watch television. The resident said he/she was not bored, because he/she had "too much pain to be bored". The resident said he/she had no reading difficulty and enjoyed reading the Bible.</p> <p>During an interview on 11/17/2015 at 7:33 A.M. direct care staff O said he/she did not know if the resident received pain medication prior to cares and let the nurse know after cares if the resident had pain. Staff O stated the resident had too much pain if turned side to side, moaned and groaned during repositioning, and had the most pain when staff performed wound care to the coccyx.</p>	F 309			

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F 309	Continued From page 31 During an interview on 11/17/2015 at 3:26 P.M. direct care staff S said the resident had pain to a sore on his/her coccyx and the resident moaned, groaned, sometimes screamed, had facial grimacing, and would tell staff when he/she had pain. Staff S said the resident had pain daily when staff got him/her up, repositioned, provided incontinence care, and anytime staff did anything with him/her. During an interview on 11/18/2015 at 12:04 P.M. direct care staff P said the resident had pain whenever staff touched his/her legs, when turned side to side, and when staff completed wound care. During an interview on 11/18/2015 at 2:13 P.M. licensed nursing staff I said the resident received Morphine 0.25 milliliters every 1 hours as needed for pain. Staff I said he/she waited 15-20 minutes for the pain medication to work before completing wound care and confirmed wound care was started 3 minutes after he/she administered pain medication this morning. Staff I confirmed today was the first day he/she gave the resident pain medication prior to completing wound care. During an interview on 11/23/2015 at 8:51 A.M. licensed nursing staff J said the resident received Morphine for pain management and the Morphine took 20-30 minutes for effectiveness. Staff J said he/she routinely gave the resident pain medication before he/she changed the resident's dressing to the coccyx. After review of the treatment administration record staff J confirmed he/she completed dressing changes to the resident's coccyx on 11/10 at 10:57 A.M., 11/11 at 1:14 P.M., 11/14 at 8:53 A.M. and on 11/15/15 at	F 309			

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F 309	<p>Continued From page 32</p> <p>9:52 A.M. Staff J also confirmed he/she did not give the resident pain medication prior to the dressing changes on those dates.</p> <p>During an interview on 11/23/2015 at 9:28 A.M. administrative nursing staff D said he/she expected staff to stop care if a resident had pain and let the nurse know. He/she said Morphine took about 15 minutes to work and staff should wait at least that long to continue cares.</p> <p>During an interview on 11/24/2015 at 9:40 A.M. physician consultant JJ said he/she expected staff to assess the resident's pain level prior to providing cares and prior to completing dressing changes to his/her unstageable wound on his/her coccyx.</p> <p>Review of the facility's undated Pain policy documented every resident was assessed for pain and provided comfort through an individualized pain control plan, and if pain was unrelieved with non-pharmacological interventions, staff reassessed and gave further pain medication as ordered by the physician or contacted the physician.</p> <p>The facility failed to identify, treat, and manage pain for this cognitively impaired, dependent resident who experienced unrelieved pain and would accept medication to relieve pain.</p> <p>- The electronic record for resident #1 noted diagnoses of epilepsy (a brain disorder characterized by repeated seizures), hypertension (high blood pressure), chronic</p>	F 309			

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F 309	<p>Continued From page 33</p> <p>obstructive pulmonary disease ((COPD) - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin). It documented and order for Geodon 20 milligrams (mg) intramuscularly (in the muscle) twice a day as needed.</p> <p>The Admission Minimum Data Set (MDS) dated 7/15/15 revealed a Brief Interview for Mental Status (BIMS) score of 6 (less than 7 indicated severely impaired cognition). It documented the resident was administered an antipsychotic medication.</p> <p>The Care Area Assessment (CAA) dated 7/15/15 for cognition noted the resident had increased agitation when staff attempted to assist and was resistive to cares/showers and rehab. The CAA for psychotropic medication revealed the resident received Geodon for increased agitation and aggression.</p> <p>The care plan dated 7/8/15 documented staff were to keep the resident's environment calm and relaxed and assess for constipation and pain.</p> <p>Nurse's note dated 10/1/15 at 9:17 P.M. documented the resident was on the floor in his room.</p> <p>Nurse's note dated 10/5/2015 at 5:07 A.M. the resident awakened to verbal and tactile stimulation, but did not make eye contact with staff or acknowledge staff. The resident did not answer questions, and would not accept food or drink.</p> <p>Nurse's note dated 10/5/2015 at 10:08 A.M. the resident let fluid run back out of his/her mouth, was lethargic, and did not open his/her eyes when spoken to.</p>	F 309			

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F 309	Continued From page 34 Interview on 11/19/2015 at 1:08 P.M. direct care staff T stated he/she notified the nurse if a resident had a decline. He/she reported a decrease in appetite, a change in cognition, and a change in sleep pattern. Interview on 11/23/2015 at 10:19 A.M. licensed nursing staff J stated the resident was alert and a good eater. Interview on 11/23/2015 at 3:40 P.M. administrative nursing staff D stated it was the nurse's judgement as to whether the resident was transported by the ambulance or facility vehicle. He/she expected prompt physician notification. Interview on 11/24/15 at 9:45 A.M. physician JJ stated he/she expected staff to notify him/her promptly of a resident's decline. The facility failed to provide a policy about physician notification and timely nursing assessments. The facility failed to promptly notify the physician when there was a change in status for this cognitively impaired resident.	F 309			
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced	F 312		12/23/15	

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F 312	Continued From page 35 by: The facility reported a census of 28, and the sample size was 15. Based on observation, record review, and interview, the facility failed to provide urinary incontinence care for 1 of 1 (#4's) reviewed for urinary incontinence. Findings included: - Review of resident #4's unsigned physician order sheet dated November 2015 documented the following diagnoses: stress incontinence (a condition in which there is involuntary emission of urine when pressure within the abdomen increases suddenly). Review of the significant change in status MDS (Minimum Data Set) dated 10/23/2015 documented the resident reentered the facility from the hospital on 10/23/2015 and had a BIMS (Brief Interview for Mental Status) score of 0, which indicated severe cognitive impairment. The resident required extensive assistance of 2 staff with bed mobility and personal hygiene; dependent on two or more staff with transfers, dressing, toileting, and bathing; did not walk, left unit only once or twice; and required extensive assistance of one staff with eating. He/she used a wheelchair for mobility and did not reject cares. The resident was frequently incontinent of urine, always incontinent of bowel, and had no toileting program. Review of a quarterly/5day MDS dated 9/23/2015 documented the resident reentered the facility on 9/16/2015. The resident had short term memory problems and had difficulty with decision making in new situations. The resident was dependent on 2 or more staff with transfers, dressing, and toileting; extensive assistance of 2 or more staff with bed mobility; dependent on one staff with locomotion on and off the unit, personal hygiene, and bathing; and extensive assistance of one	F 312			

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F 312	<p>Continued From page 36</p> <p>staff with eating. He/she used a wheelchair for mobility and did not reject cares. The resident was always incontinent of urine and bowel and was not on a toileting program.</p> <p>Review of the Cognitive Loss CAA dated 11/6/2015 documented the resident had difficulty communicating due to a cognitive deficit. The speaker needed to speak loudly for best understanding, and sometimes if given a few moments the resident could answer questions. Progression of loss led to comfort measures for end of life.</p> <p>Review of the Activities of Daily Living (ADL) CAA did not trigger.</p> <p>Review of the Urinary Incontinence CAA dated 11/5/2015 documented the resident had an indwelling catheter, which was discontinued on 10/27/2015. The resident was incontinent of urine, had no urge or indication of need to urinate, wore briefs, and required frequent checks to assist with maintaining skin integrity. The resident was continued on Lasix (a medication to treat fluid retention) which increased the risk for incontinence.</p> <p>Review of the care plan dated 10/28/2015 documented the resident had problems with his/her memory due to delusions from paranoid schizophrenia and he/she did not always remember what his/her personal needs were or when to take care of his/her needs. The care plan directed staff to provide assistance with bathing and personal hygiene. He/she required 2 person assistance with repositioning, every 2 hours, from the left, right, and back side. The staff were directed to check every 2 hours for incontinence and provide pericare.</p> <p>During an observation on 11/17/2015 at 7:27 A.M. direct care staff O and P provided pericare to the resident. Staff removed a saturated and soiled</p>	F 312			

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F 312	Continued From page 37 brief. During an observation on 11/7/2015 at 10:04 A.M. direct care staff O and licensed nursing staff H entered the resident's room and provided incontinence care. The resident's brief was soiled with urine, and it was 2 hours and 37 minutes between brief check and change. During an interview on 11/17/2015 at 12:55 P.M. the resident said staff helped him/her out of bed for meals and brushed his/her hair and teeth. The resident was not sure how often his/her brief was changed by staff. During an interview on 11/18/2015 at 11:58 A.M. direct care staff P stated the resident was dependent on staff with personal grooming, and the resident did not refuse hair brushing. He/she does not like the use of a toothbrush, but allowed staff to use toothettes in mouthwash. During an interview on 11/17/2015 at 2:46 P.M. direct care staff R stated the resident was incontinent of bowel and urine and staff checked every 2 hours for incontinence and changed his/her brief. During an interview on 11/23/2015 at 8:51 A.M. licensed staff J stated the resident was dependent on staff for incontinence care and the resident should be checked and changed at least every 2 hours. During an interview on 11/23/2015 at 9:44 A.M. administrative nursing staff D stated the resident should be checked and changed at least every 2 hours. The policy on incontinence care was not provided by the facility. The facility failed to provide incontinence care every 2 hours to this dependent resident as outlined in the care plan.	F 312			
F 314	483.25(c) TREATMENT/SVCS TO	F 314		12/23/15	

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F 314 SS=G	Continued From page 38 PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: The facility reported a census of 28 residents. There were 15 residents in the sample. Based on observation, interview, and record review the facility failed to develop and implement timely interventions to promote wound healing to a stage 2 (partial thickness skin loss) coccyx (tailbone) wound, prevent the coccyx wound from worsening to an unstageable wound (full thickness tissue loss in which the actual depth of the ulcer is covered by slough) (dead tissue) and prevent the development of an suspected deep tissue injury wound (purple/maroon skin) to the resident's right heel and a stage 1 pressure wound (redness that remained after pressure was relieved) to the resident's left heel for 1 of 2 residents (#4). The facility also failed to correctly implement care plan interventions for heel boots to promote healing of an unstageable wound to the resident's right heel and prevent the development of a stage 1 pressure wound to his/her left heel. (#28) Findings included:	F 314			

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F 314	<p>Continued From page 39</p> <p>- Review of resident #4's unsigned physician order sheet dated November 2015 documented the following diagnosis: muscle weakness.</p> <p>Review of a quarterly MDS (Minimum Data Set) dated 9/23/2015 documented the resident reentered the facility on 9/16/2015. The resident had short term memory problems. He/she was dependent on 2 or more staff with transfers and toileting and required extensive assistance of 2 or more staff with bed mobility. The resident did not reject cares. The resident had a risk for the development of pressure ulcers and had one stage 1 pressure ulcer. The resident had a pressure reducing device for his/her chair and bed, a turning/repositioning program, pressure ulcer care, and staff applied a nonsurgical dressing and ointment/medications to an area other than the resident's feet.</p> <p>Review of a significant change in status MDS dated 10/23/2015 documented the resident reentered the facility from the hospital on 10/23/2015 and had a BIMS score of 0, which indicated severe cognitive impairment. The resident required extensive assistance of 2 or more staff with bed mobility and was dependent on 2 or more staff with transfers and toileting. The resident did not reject cares. The resident had a risk for the development of pressure ulcers, had one stage 2 pressure ulcer, a pressure reducing device on his/her chair and bed, a turning/repositioning program, and he/she received pressure ulcer care.</p> <p>Review of the Cognitive Loss CAA (Care Area Assessment) dated 11/6/2015 documented the resident had difficulty communicating due to cognitive loss.</p>	F 314			

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F 314	<p>Continued From page 40</p> <p>Review of the Pressure Ulcer CAA dated 11/5/2015 documented the resident admitted with a stage 2 pressure ulcer to his/her coccyx (tail bone), required staff assistance with repositioning every 2 hours, and had dressing changes daily and as needed.</p> <p>Review of a Braden Skin Risk Assessment dated 10/26/2015 documented a score of 14, which indicated the resident was at risk for the development of pressure ulcers.</p> <p>Review of the care plan dated 10/28/2015 documented the resident had multiple factors which resulted in an open area. The care plan directed staff to complete weekly skin assessments, remind and assist the resident with repositioning in bed and in wheelchair frequently, if an open area developed notify the dietitian, remind the resident to drink fluids, provide treatments to the coccyx as ordered, and to use of a low air loss mattress and a Broda chair to prevent pressure to his/her skin when out of bed. The care plan was revised on 11/17/2015 and documented the use of heel boots.</p> <p>Review of a resident admission assessment dated 10/23/2015 documented the resident had redness and rawness to his/her buttock.</p> <p>Review of Wound and Skin Assessments documented the following: On 10/27/2015- a stage 2 pressure ulcer, which measured 3.7 cm (centimeters) x (by) 2.3 cm. On 10/28/2015- coccyx wound was 100% red and excoriated, which measured 3.6 cm x 2.3 cm with epithelial tissue. On 11/4/15- coccyx wound was 98% slough,</p>	F 314			

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F 314	<p>Continued From page 41</p> <p>which measured 5 cm x 6.8 cm.</p> <p>On 11/11/15- coccyx wound had slough tissue, which measured 5.2 cm x 7 cm.</p> <p>On 11/17/15- stage 1 left heel wound was 100% dark pink, which measured 0.9 cm x 0.9 cm.</p> <p>On 11/17/15- unstageable right heel wound was 100% dark red/purple in color, which measured 1.2 cm x 1 cm.</p> <p>On 11/18/15- coccyx wound was 3.3 cm x 5.6 cm x 0.4 cm with a new area tailing off the coccyx wound at 7 o'clock (a means of determining location of wounds using the face of a clock) with a yellow center. The coccyx wound had inward rolled edges from 1-3 o'clock and at 6 o'clock, was 100% slough and had heavy yellow drainage and small greenish purulent drainage.</p> <p>Review of a dietitian assessment dated 11/18/2015 documented the resident was readmitted to the facility and received wound treatment to his/her coccyx.</p> <p>Review of physician orders documented the following: Cleanse the wound to the left buttock/coccyx area with wound cleanser and pat dry. Apply skin prep to peri-wound and allow to dry. Place silver alginate in wound bed, cover with non-adhesive optifoam and secure with mexix. Change daily and as needed when loose or soiled, effective 11/4/2015</p> <p>During an observation on 11/17/2015 at 7:27 A.M. direct care staff O and P assisted the resident out of bed using a mechanical Hoyer lift. The resident had a low air loss mattress and wore open heel boots to both feet. The resident's heels were not positioned in the open area of the boot. At 8:05 A.M. the resident remained in his/her wheelchair</p>	F 314			

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F 314	Continued From page 42 with the Hoyer sling placed between the resident and the pressure reducing cushion in his/her wheelchair. At 8:20 A.M. the resident remained in his/her wheelchair and both of his/her heel boots had slid off the resident's feet. At 8:54 A.M. direct care staff O and Q assisted the resident back to bed using a Hoyer lift. Staff positioned one flat unrolled pillow under the resident's right hip with pressure to his/her coccyx unrelieved. At 10:04 A.M. direct care staff O and licensed nursing staff H entered the resident's room and provided wound care, repositioning, and incontinence care. Staff O and H confirmed the flat pillow did not provide pressure relief to the coccyx area and staff H confirmed the resident's heels were not positioned properly in the heel boots. A surveyor requested skin check revealed the resident had a dime sized dark red/purple area to the right heel, which measured 1.2 cm x 1 cm and a nickel sized red area to the left heel, which measured 0.9 cm x 0.9 cm. Staff H removed the coccyx dressing and a small amount of bloody drainage was observed on the dressing. The coccyx wound measured 3.3 cm x 4.6 cm x 0.6 and an area located on the left side of the wound measured 2.0 cm x .4 cm x 0.1 cm. with 90% slough and a pinpoint dark spot in the center of the wound bed. The area left of the buttock had scant slough and a red wound bed. Staff H cleansed the wound with wound cleanser, applied skin prep around the wound bed, allowed the skin prep to dry, applied silver alginate (a medication dressing) to the wound bed, covered with non-adherent dressing, and secured with medfix (tape). Staff O and H repositioned the resident on his/her left side and relieved pressure to the resident's coccyx. Staff failed to provide sufficient repositioning to relieve pressure from the resident's coccyx for 2 hours	F 314			

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F 314	<p>Continued From page 43 and 37 minutes.</p> <p>During an observation on 11/18/2015 at 7:35 A.M. the resident laid in bed, eyes opened, and body covered with a sheet and blanket. Direct care staff P entered the room and uncovered the resident. The resident's feet were observed positioned flat against the mattress and a pillow laid next to the resident's feet on his/her bed.</p> <p>During an interview on 11/17/2015 at 7:50 A.M. the resident stated he/she "had a cut on [his/her] butt and it "hurt real bad". The resident said he/she had the wound for a month or two. The resident said "it's so hard to sit on my butt, but they keep doing it and doing it and doing it."</p> <p>During an interview on 11/17/2015 at 7:33 A.M. direct care staff P said the resident required total assistance for ADL, was checked and changed every 2 hours, and staff used a Hoyer lift with full sling for transfers. Staff P said the resident was assisted out of bed for each meal and when requested by the resident. He/she said the resident had a wound on his/her bottom and staff turned/repositioned the resident and he/she wore heel boots. Staff said the resident had not refused cares.</p> <p>During an interview on 11/17/2015 at 1:15 P.M. direct care staff Q said staff turned and repositioned the resident every 2 hours and beginning today the resident's heels were offloaded on pillows.</p> <p>During an interview on 11/17/2015 at 2:46 P.M. direct care staff R said staff repositioned the resident every 1-2 hours and the resident had a bed sore to his/her coccyx and had red heels.</p>	F 314			

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F 314	Continued From page 44 During an interview on 11/18/2015 at 12:00 P.M. direct care staff P said the resident had a wound on his/her bottom, some areas on his/her heels, and came back from the hospital with the heel boots. Staff P said he/she received no training on how to position heel boots and said the resident's boots frequently slid down his/her feet. Staff P said staff repositioned the resident every 1-2 hours and the resident did not refuse the use of the boots or repositioning. During an interview on 11/18/2015 at 2:07 P.M. licensed nursing staff I said the resident had a pressure ulcer on his/her coccyx. He/she said the wound was red, raw, and open with no slough when he/she returned from the hospital on 10/23/2015. Staff I said staff turned and repositioned the resident at least every 2 hours, wore boots on his/her feet, and did not refuse cares. Staff I said staff began offloading the resident's heels on 11/17/2015 after discovering pressure ulcers to his/her right and left heels. During an interview on 11/23/2015 at 9:32 A.M. administrative nursing staff D said all nursing staff were trained on the correct application of heel boots and he/she had no documentation of the training. Staff D said he/she expected staff to properly offload the resident's coccyx, properly position the heel boots, and let the nurse know if the resident was not able to repositioned due to pain. Staff D said he/she expected the dietitian to assess the resident within a week when he/she returned from the hospital on 10/23/2015 and confirmed the dietitian completed his/her assessment on 11/18/2015. Staff D said with early interventions from the dietitian, repositioning/turning every 2 hours, and proper	F 314			

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F 314	<p>Continued From page 45</p> <p>positioning of the heel boots, the wound to the coccyx may not have worsened and the heel wound may have been prevented.</p> <p>During an interview on 11/23/2015 at 12:24 P.M. dietary consultant DD said he/she planned to assess the resident on 11/19/2015 during a planned visit, but received a request from the facility to assess the resident on 11/16/2015. Staff DD said he/she preferred to see the resident sooner for assessment and recommendations and planned on recommendation for a prealbumin level.</p> <p>During an interview on 11/24/2015 at 9:40 A.M. physician consultant JJ said he/she last assessed the resident's coccyx wound 2 weeks ago and the wound was open, small, and healing. Staff JJ said the facility contacted him/her on 11/18/2015 and informed him/her the resident had a yellow substance over the wound bed. Staff JJ said he/she expected staff to be trained on the proper application of heel boots and for the resident to be repositioned and turned as care planned. Staff JJ said it was possible for the wound to the coccyx to improve and heal with appropriate implementation of interventions and it was possible to prevent the development of heel wounds with the proper application of the heel boots.</p> <p>Review of the facility's undated Wound Assessment, Prevention, and Treatment policy documented a resident who entered the facility with a pressure ulcer would receive the necessary treatment and services to promote healing and prevent new wounds from developing, heels would be floated when in bed.</p> <p>The facility failed to develop and implement interventions to prevent a stage 2 pressure ulcer from worsening to an unstageable pressure ulcer and failed to properly implement interventions to</p>	F 314			

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F 314	<p>Continued From page 46</p> <p>avoid the development of an unstageable pressure ulcer to the resident's right heel and a stage 1 pressure ulcer to his/her left heel.</p> <p>- Review of resident #28's unsigned physician order sheet dated November 2015 documented the following diagnoses: muscle weakness, diabetes (a condition when the body cannot use glucose /sugar), make enough insulin, or respond to insulin), and pressure ulcer (localized injury to the skin).</p> <p>Review of the admission MDS (Minimum Data Set) dated 4/6/2015 documented a BIMS (Brief Interview for Mental Status) score of 10, which indicated moderate cognitive impairment. The resident was dependent on 2 or more staff for bed mobility, transfers, and toileting and he/she did not reject cares. The resident had a risk for skin breakdown, admitted with a stage 2 pressure ulcer, had an open lesion to the foot, and received a pressure device for his/her bed and chair, turning/repositioning program, nutrition/hydration to manage skin problems, pressure ulcer care, and staff applied dressings to his/her feet.</p> <p>Review of the quarterly MDS dated 9/15/2015 documented a BIMS score of 15, which indicated intact cognition. The resident required extensive assistance of 2 staff with bed mobility and toileting; extensive assistance of one staff with transfers, and he/she did not reject cares. The resident had a risk for the development of pressure ulcers, had one stage 2 pressure ulcer, had a pressure reducing device for his/her chair and bed, turning/repositioning program, nutrition/hydration to manage skin, pressure ulcer care, and staff applied dressings to his/her feet.</p>	F 314			

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F 314	<p>Continued From page 47</p> <p>Review of the ADL (Activities of Daily Living) CAA (Care Area Assessment) dated 4/8/2015 documented the resident needed strengthening, preferred to stay in his/her recliner and slept in his/her recliner. The resident required extensive assistance and encouragement of at least 2 staff for ADL to include repositioning.</p> <p>Review of the Pressure Ulcer CAA dated 4/8/2015 lacked an analysis of findings and documented the resident had been admitted to the hospital on 4/6/2015.</p> <p>Review of a Braden Skin Risk Assessment dated 9/8/2015 documented the resident scored a 16 which indicated a risk for the development of pressure ulcers.</p> <p>Review of the care plan dated 10/26/2015 documented the resident needed assistance with ADL, had a history of pressure ulcers, and had a pressure ulcer to his/her right heel. The care plan directed staff to assist the resident the resident with repositioning at least every 2 hours, complete treatments as ordered, educate the resident to keep his/her heels floated when in bed and recliner The care plan documented the resident did not always like to float his/her right heel and agreed to wear a boot to his/her right heel. The facility revised the care plan on 11/17/2015 and directed staff to provide heel boot for the resident's left foot.</p> <p>Review of a wound and skin progress reports documented the following: On 9/9/2015 the right heel had non blanching redness (remained red after pressure relief) with scattered light blue discoloration and yellow scabs areas, which measured 0.8 cm</p>	F 314			

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F 314	<p>Continued From page 48</p> <p>(centimeters) x (by) 2 cm. and current interventions included; use a pressure reducing device on his/her bed and chair and float the resident's heels. The assessment lacked staging of the wound.</p> <p>On 11/17/2015- the right heel was 100% (percent) scabbed and measured 1.0 cm x 0.3 cm. Interventions included; float heels/boots</p> <p>On 11/17/2015 the left heel was 100% pink, non blanchable, and measured 0.3 cm x 0.4 cm.</p> <p>The record lacked evidence a dietitian assessment was completed since the resident returned from the hospital on 9/8/2015.</p> <p>During an observation on 11/17/2015 at 8:12 A.M. the resident laid flat and supine in bed on a low air loss mattress with open heel boots on both feet positioned on top of pillows. The heels were not positioned in the open area of the boot. At 8:33 A.M. direct care staff P removed the pillow under the resident's legs, removed heel boots, provided pericare, and returned the resident to a flat supine position in the bed. Staff P put the heel boots back on the resident's feet, which remained improperly positioned in the boots. A dime size reddened area was observed to the resident's left heel during pericare. Staff positioned 2 pillows under each of the residents legs. The resident's right and left heels remained positioned on pillows with no pressure relief. At 10:53 A.M. staff P and Q transferred the resident out of bed to his/her bedside commode, and to recliner. The resident had no significant change in position and his/her boots were improperly positioned for a total of 2 hours and 41 minutes.</p>	F 314			

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F 314	<p>Continued From page 49</p> <p>During an observation on 11/17/2015 at 11:58 A.M. the resident sat in his/her recliner, wore heel boots, and legs were elevated. Administrative nursing staff D removed the dressing to the resident's right heel wound. The right heel wound measured 1 cm x 0.3 cm and had a dark scabbed covering. During the assessment the resident told administrative nursing D he/she had pain to his/her left heel. Staff D assessed the area and documented a red, nonblanchable area to the left heel, which measured 0.4 cm x 0.3 cm. The resident told the DON he/she informed licensed nursing staff I about the pain to the area 1-2 weeks ago and staff I gave him/her a heel boot to wear. Staff D said he/she was not informed of the left heel area until today.</p> <p>During an observation on 11/18/2015 at 7:28 A.M. the resident laid in bed, wore heel boots to both feet, had pillows under his/her legs, and feet rested on top of the pillows. Direct care staff Q confirmed the resident's feet should be elevated off the pillows and not rested on the pillows.</p> <p>During an interview on 11/17/2015 at 8:12 A.M. the resident said he/she had a wound on his/her right heel, which was almost healed. The resident said he/she wore boots to both feet because the left heel felt funny last week and staff told him/her the left heel was mushy. The resident said staff do not offer to assist him/her with repositioning or check heel boot placement and he/she was not able to put on or take off the boots or make sure his/her heels were proper positioning.</p> <p>During an interview on 11/17/2015 at 8:45 A.M. direct care staff P said staff assisted the resident with bed mobility, repositioning in bed, and</p>	F 314			

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F 314	<p>Continued From page 50</p> <p>incontinence care. Staff P said the resident had a wound on his/her right heel, a soft left heel, and was not sure of the cause. Staff P said he/she noticed staff were floating the resident's heels as of the other day and was not told why.</p> <p>During an interview on 11/17/2015 at 3:06 P.M. direct care staff R said the resident had a bandage to his/her right heel and some redness to his/her left heel for a couple of day. Staff R said the resident wore a heel boot to the right foot for quite a while and a heel boot to the left foot for less than a week. Staff R said the resident did not refused use of the boots.</p> <p>During an interview on 11/18/2015 at 11:43 A.M. direct care staff S said the resident had a wound to his/her right heel and the resident's left foot started to break down over the past one to two weeks, which was why staff applied a boot to his/her left foot. Staff S said he/she had not been trained how to position the boots and the resident did not refused the use of the boots or the pillows.</p> <p>During an interview on 11/17/2015 at 12:23 P.M. licensed nursing staff I said the resident reported pain to his//her left heel last week, she did not observe any skin breakdown, and gave the resident a heel boot to wear. Staff I said he/she did not document the resident's concern, intervention, and did not report to administrative nursing staff.</p> <p>During an interview on 11/18/2015 at 1:59 P.M. licensed nursing staff I said the resident had a purple scabbed area on his/her right heel and current interventions included; heel boots, offloaded heels, and repositioning every 2 hours</p>	F 314			

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F 314	<p>Continued From page 51</p> <p>and as needed when in bed and in his/her chair. Staff I said the resident had not refused interventions since his/her return from the hospital on 9/8/2015.</p> <p>During an interview on 11/23/2015 at 8:13 A.M. administrative nursing staff E said when the resident returned from the hospital on 9/8/2015 the resident had a right heel SDTI (suspected deep tissue injury) and the MDS was coded inaccurately.</p> <p>During an interview on 11/23/2015 at 9:10 A.M. administrative nursing staff D said he/she expected inaccurate MDS's to be modified by staff. Staff D said staff should make sure heels are positioned properly in the heel boots and heels should be offloaded on pillows and should not touch the mattress. Staff D said all nursing staff were trained on proper application of heel boots and he/she did not have documentation. He/she expected staff to check for proper placement of boots and offloading of heels during repositioning.</p> <p>The facility's undated Wound Assessment, Prevention, and Treatment policy documented the resident's total skin wound be assessed, heels wound be floated, and staff would reposition at least every 2 hours.</p> <p>The facility failed to ensure staff applied heel boots properly, floated heels properly, and repositioned timely for this dependent resident who entered the facility with a suspected deep tissue injury and developed a stage 1 pressure wound to his/her left heel.</p>	F 314			
F 318	483.25(e)(2) INCREASE/PREVENT DECREASE	F 318		12/23/15	

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F 318 SS=D	<p>Continued From page 52 IN RANGE OF MOTION</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>This REQUIREMENT is not met as evidenced by: The facility had a census of 28 residents. The sample included 15 residents. Based upon observation, record review and interview the facility failed to performed restorative nursing services/range of motion exercises for 1 (#8) of 3 residents sampled for range of motion to maintain/attain the residents range of motion.</p> <p>Findings included:</p> <p>-Resident #8 ' s electronic medical record identified the resident had diagnoses that included contracture of the knee.</p> <p>The resident ' s Quarterly Minimum Data Set (MDS) dated 10/14/15 identified the resident scored 11 (moderately impaired cognition) on the Brief Interview for Mental Status (BIMS), had no behaviors, was totally dependent upon staff for bed mobility and transfers, the activity of walking in the room/corridor did not occur, required extensive staff assistance with locomotion on/off the unit, dressing, toilet use and personal hygiene. The MDS recorded the resident had a functional limitation in range of motion on both sides of his/her lower extremities, the resident ' s</p>	F 318			

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F 318	<p>Continued From page 53</p> <p>upper extremities did not have a functional limitation in range of motion, the resident utilized a wheelchair and did not receive therapy, or restorative nursing services during the 7 day assessment period.</p> <p>The resident ' s admission MDS dated 7/15/15 identified the resident scored 12 on the BIMS, had no behaviors, required extensive staff assistance with bed mobility, transfers, toilet use, personal hygiene, and locomotion on/off the unit, and the activity of walking in the room/corridor did not occur and the resident was totally dependent upon staff for dressing. The MDS recorded the resident had a functional limitation in range of motion on both sides of his/her lower extremities, the resident ' s upper extremities did not have a functional limitation in range of motion, the resident utilized a wheelchair and did not receive therapy, or restorative nursing services during the 7 day assessment period.</p> <p>The resident ' s Activity of Daily Living (ADL) Care Area Assessment dated 7/17/15 included the resident was non-ambulatory and staff propelled his/her wheelchair. The resident had an old stroke and had bilateral lower extremities contractures. The resident required extensive to total assistance of 1 to 2 staff.</p> <p>The resident ' s Fall CAA dated 7/17/15 documented the resident stated he/she did not fall prior to admission and had not fallen since admission. The resident was non-ambulatory, staff propelled his/her wheelchair and the resident ' s bilateral lower extremities were contracted at the knees.</p> <p>The resident ' s care plan dated 10/14/15</p>	F 318			

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F 318	<p>Continued From page 54</p> <p>included the resident did not like to lie in bed for long amounts of time because it was not comfortable due to his/her contractures. The resident had rolled himself/herself out of bed trying to get more comfortable and did not like to sleep in bed because it was hard for him/her to get comfortable due to his/her contractures and staff assisted him/her into his/her recliner to sleep if the resident requested.</p> <p>The resident ' s care plan did not include the resident refused restorative nursing services and/or the facility spoke with the resident regarding the adverse effects of not receiving restorative nursing services.</p> <p>On 11/12/15 administrative nursing staff E provided the surveyors with a list of residents that received restorative nursing services/range of motion exercises. Further review revealed the resident ' s name was not on the list.</p> <p>A nurse ' s note dated 7/15/15 and timed 1:46 P.M. documented the resident utilized a wheelchair for mobility and required assistance of 2 staff for transfers due to the resident ' s arms and legs had contractures.</p> <p>A nurse ' s note dated 7/28/15 and timed 9:58 included the resident ' s arms and legs were contracted.</p> <p>A nurse ' s note dated 8/28/15 and timed 12:40 P.M. documented the resident had 3 falls in one night. The resident reported he/she rolled out of bed onto the floor because he/she was not comfortable in his/her bed.</p>	F 318			

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F 318	<p>Continued From page 55</p> <p>On 11/16/15 at 2:45 A.M. the resident sat in his/her wheelchair and observation revealed the resident ' s legs bilaterally were contracted at the knees.</p> <p>On 11/17/15 at 9:45 A.M. the resident sat in his/her wheelchair and observation revealed the resident was a passive participant during the exercise group.</p> <p>On 11/19/15 at 7:30 .A.M.. staff propelled the resident ' s wheelchair. Observation revealed the resident ' s legs were contracted at the knees and the left knee more pronounced than the right.</p> <p>On 11/19/15 at 12:17 P.M. licensed nurse J stated the resident ' s arms and legs were contracted and the resident did not receive restorative nursing services/range of motion exercises. He/she stated due to the contractures the resident was unable to hit or kick the ball during group exercises.</p> <p>On 11/19/15 at 4:16 P.M. direct care staff U stated the resident was not on a restorative nursing program and staff performed range of motion exercise to the resident ' s legs when the resident asked staff to straightened his/her legs.</p> <p>The facility did not provide a Restorative Nursing Services policy and procedure.</p> <p>The facility failed to provide evidence to support the facility offered this resident with contractures restorative nursing services to maintain/attain his/her functional limitation in range of motion.</p>	F 318			
F 323	483.25(h) FREE OF ACCIDENT	F 323		12/23/15	

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F 323 SS=J	Continued From page 56 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 had a census of 27 residents. The sample included 15 residents. The facility identified 3 residents at risk for elopement and all 3 residents wore a Wanderguard device (a device that alerts staff when a resident attempts to exit the building without staff assistance). Based upon observation, record review and interview the facility failed to ensure that 1 (#30) of 3 residents sampled for accidents received adequate supervision to prevent an elopement which placed resident #30 in immediate jeopardy. Findings included: - Resident #30 ' s electronic health record identified the resident had diagnoses that included anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), Schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), psychosis (any major mental disorder characterized by a gross impairment in reality testing) and dementia (progressive mental disorder characterized by failing memory, confusion).	F 323			

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F 323	<p>Continued From page 57</p> <p>The resident ' s quarterly Minimum Data Set (MDS) dated 10/21/15 identified the resident scored 6 (severely impaired cognition) on the Brief Interview for Mental Status (BIMS), had no behaviors including wandering, was independent with bed mobility and transfers, required staff supervision with walking in the room/corridor and locomotion on/off the unit, limited staff assistance with dressing, staff supervision with toilet use and extensive staff assistance with personal hygiene . The resident's gait was steady when going from a seated to a standing position, walking, turning around and facing the opposite direction while walking, moving on/off the toilet and surface to surface transfers and had not fallen since the last assessment. The resident was occasionally incontinent of urine, and received an antipsychotic and an anti-anxiety medication 7 of the 7 days during the 7 day assessment period.</p> <p>The residen's annual MDS dated 7/22/15 identified the resident scored 6 (severely impaired cognition) on the BIMS, had wandering tendencies on a daily basis which placed the resident at significant risk of getting to a potentially dangerous place, was independent with bed mobility, transfers and walking in the room, required staff supervision with walking in the corridor and locomotion on the unit, required limited staff assistance with dressing, toilet use and personal hygiene, and received an antipsychotic and an anti-anxiety medication 7 of the 7 days during the 7 day assessment period. The resident's gait was steady when going from a seated to a standing position, walking, turning around and facing the opposite direction while walking, moving on/off the toilet and surface to surface transfers and had not fallen since the prior assessment.</p>	F 323			

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F 323	<p>Continued From page 58</p> <p>The resident's Cognitive Loss Dementia Care Area Assessment (CAA) dated 7/24/15 included the resident had a diagnosis of dementia.</p> <p>The resident's Activity of Daily Living (ADL) CAA dated 7/24/15 documented the resident was independent with ambulation without assistive devices and required limited staff assistance/supervision with ADL's.</p> <p>The resident's Behavioral Symptom CAA dated 7/24/15 included the resident often wandered to the front living room and back to his/her room, the resident wanted to exit the facility and wore a Wanderguard device. The resident was easily redirected and required frequent redirection.</p> <p>The resident's Fall CAA dated 7/24/15 documented the resident scored 11 (a score of 10 or higher represented the resident was at high risk for falls) on his/her fall assessment, the resident had a slow but steady gait without the use of assistive devices. The resident received medications that increased his/her risk of falls.</p> <p>The resident's fall risk assessment dated 10/21/15 identified the resident scored 14. According to the legend a score of 10 or higher represented the resident was at high risk for falls.</p> <p>The resident's elopement risk assessment dated 10/21/15 identified the resident scored 67. According to the legend a score of 15 or higher represented the resident was at risk for elopement.</p> <p>The resident's care plan revised on 11/4/15 addressed the resident had a diagnosis of</p>	F 323			

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F 323	<p>Continued From page 59</p> <p>schizophrenia that caused him/her to have delusions. The resident believed he/she needed to leave the facility and that someone would pick him/her up to go the bank or to get on the "bus" or somewhere each day and the resident packed his/her clothes and waited for someone to come and get him/her. The resident wore a Wanderguard bracelet on his/her ankle so that he/she could not get out of the exit doors without someone being with him/her or without staff hearing an alarm. Staff checked the resident's bracelet every shift to make sure it was still on and checked it every day to make sure it properly worked. The resident tried to enter the codes into the doors but he/she did not know what the code was and could not open the door. The facility performed an elopement risk assessment every quarter and with a significant change of condition. The resident used to work in a nursing facility as a Certified Nurse Aide and sometimes when he/she walked about it was because he/she thought he/she was at work. At bedtime staff informed the resident someone relieved him/her and that it was alright for the resident to go to bed.</p> <p>A nurse ' s note (NN) dated 7/3/2015 and timed 3:55 P.M. documented the resident attempted multiple time to get out of the facility. At 3:30 P.M. the resident followed another resident's family member out of the door and staff stopped the resident.</p> <p>A NN dated 9/9/15 and timed 10:56 P.M. documented the resident ambulated independently, wandered from door to door, entered a code attempting to unlock the door.</p> <p>A NN dated 10/21/2015 and timed 11:35 P.M. included the resident was alert and oriented to person only. The resident constantly paced</p>	F 323			

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F 323	<p>Continued From page 60</p> <p>throughout the facility and attempted to open exit doors and had a Wanderguard bracelet on his/her ankle and it was difficult to redirect the resident away from the door.</p> <p>A NN dated 11/10/15 and timed 3:53 A.M. documented the resident was alert and oriented to person only, was up constantly during the night and roamed from door to door pressing on it attempting to get out and currently required one on one observation</p> <p>A NN dated 11/15/15 with an effective time of 12:30 A.M. and charted at 5:46 A.M. documented the resident exited the building via the south door. This was witnessed by another resident who followed the resident out, called the resident's name and the resident turned around and came back into the building.</p> <p>On 11/16/15 at 2:30 P.M. observation revealed the south door exit door had a Wanderguard monitor and a keypad to the side of the door. A note on the south exit door read if the handle on the door was pressed for 15 seconds the door would open. Administrative nursing staff D stated after an incident over the weekend maintenance staff changed the code on the south exit door and the door currently was not properly functioning and observation revealed maintenance staff worked on the door. Administrative nursing D stated over the weekend resident #30 pressed on the handle of the door, the door opened and alarmed and a male resident manually reset the alarm after resident #30 exited the door without staff knowledge. Administrative nursing staff D stated nursing staff was down the hall performing care, did not hear the alarm and therefore was not aware resident #30 exited the facility.</p>	F 323			

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F 323	<p>Continued From page 61</p> <p>On 11/16/15 at 3:15 P.M. observation resident #30 attended BINGO and observation revealed the resident had a Wanderguard device on his/her left ankle.</p> <p>On 11/16/15 at 3:30 P.M. administrative staff A stated the resident wore a Wanderguard device. He/she stated the South exit door automatically locked when a resident with a Wanderguard device was in close proximity of the door. He/she stated if a resident with a Wanderguard pressed on the handle of the south exit door for 15 seconds the door opened and an alarm sounded. Administrative staff A stated the door did not remain locked if a resident with a Wanderguard pressed on the handle after 15 seconds.</p> <p>On 11/17/15 at 7:30 A.M. observation revealed if the handle of the south exit door was held for 15 seconds the door opened and an alarm sounded. Further observation revealed an entryway and then a second door which led to a parking lot. Observation revealed no alarm sounded when one opened and exited the second door that exited to the parking lot.</p> <p>On 11/17/15 at 10:15 A.M. and 3:00 P.M. observation revealed the resident stood at the South exit door and staff redirected the resident.</p> <p>On 11/17/15 at 1:45 P.M. surveyors pressed the handle of the south exit door, the door opened and an alarm sounded. The surveyors exited the door, entered an entryway and exited a door that exited to a parking lot. Observation revealed no alarm sounded when the surveyors exited the second door. Further observation revealed the</p>	F 323			

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F 323	<p>Continued From page 62</p> <p>parking lot in the alley had a very uneven surface with potholes and the parking lot led to a city street.</p> <p>On 11/17/15 at 4:00 P.M. a surveyor drove from the south parking lot of the facility and observation revealed a heavily traveled 2 lane state highway was four-tenths of a mile from the south exit door of the facility with a speed limit of 65 miles per hour.</p> <p>On 11/17/15 at 5:30 P.M. a surveyor activated the south exit door alarm and another surveyor entered the resident's room where staff assisted a resident at the time of the incident, explained the purpose of the surveyor's presence and a resident stated, then you need to turn down the volume of the radio. The surveyor asked the resident if he/she had the radio on at night and he/she stated sometimes. The surveyor turned the volume of the radio down and the surveyor heard a faint sound. Another surveyor entered the room and he/she stated he/she could hear the alarm. The surveyor then stood by bed B (bed the resident was in when the incident occurred) and could only hear a faint sound. The surveyor turned the volume of the radio to where the resident stated it was at night and the surveyor could not hear the alarm.</p> <p>During Stage 1 of the survey resident #16, an alert and oriented resident stated during the early morning hours of 11/5/15 resident #30 exited the south exit door of the facility without staff knowledge.</p> <p>On 11/17/15 at 3:45 P.M. resident #16 related to 2 surveyors the incident regarding resident #30. The resident stated on 11/15/15 around 2:00 A.M.</p>	F 323			

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F 323	Continued From page 63 he/she heard the south exit door alarm go off more than 6 times and he/she went to the nurse's station and the nurse and aide were not there. He/she stated she saw resident #38 eating a sandwich around the corner of the nurse's station and resident #38 informed the resident that resident #30 had gone outside and resident #16 stated he/she immediately went out of the door and headed for the street to the right of the facility. The resident stated resident #38 turned the alarm off. Resident #16 stated he/she called for resident #30 and saw the resident in a three quarter length light blue nightgown and the resident had on shoes. Resident #16 stated he/she kept talking to resident #30 and the resident turned around and came toward him/her. Resident #16 stated he/she asked resident #30 where he/she was going and the resident said to the bathroom. Resident #16 stated he/she and the resident entered the facility and he/she asked resident #38 to bring him/her a " pull-up " and wipes. Resident #16 stated resident #38 brought him/her a towel, wash cloth and "pull-up" and he/she cleaned the resident up and changed the resident's brief, he/she took the resident to his/her room and helped the resident to bed. Resident #16 stated he/she went back to the nurse's station to wait for the nurse and after 15 minutes the certified nurse aide showed up and he/she told the certified nurse aide the resident had gotten outside and he/she brought the resident back in, changed the resident and put the resident to bed and the nurse aide said okay. The resident stated the licensed nurse came up in a couple of minutes and he/she told the nurse resident #30 " got loose again " and he/she told the nurse what happened. The licensed nurse checked on the resident and Resident #16 went to bed.	F 323			

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F 323	Continued From page 64 On 11/17/15 at 4:10 P.M. resident #38 related to 2 surveyors the incident regarding resident #30. The resident stated between 12:00 A.M. and 2:00 .A.M. 1 to 2 days ago he/she was coming back from the snack machine and he/she heard the alarm going off and he/she saw resident #30 going outside. He/she started to look around for the nurse and aide and they were not around. Resident #16 came out of his/her room and he/she informed the resident that resident #30 "got out again," and resident #16 stated he/she would go and get resident #30 and he/she went to look for the nurse and the aide. He/she then went outside to help resident #16 and about 10 minutes later resident #16 and resident #30 came in the facility. Resident #16 took resident #30 to the bathroom and he/she took a " pull-up, a warm towel and a hand towel to resident #16 so he/she could clean resident #30 up and afterwards resident #16 placed the resident in bed. He/she stated he/she and resident #16 told the nurse resident #30 got out and they brought the resident back in. He/she stated the resident was wearing a nightgown and a pair of house slippers. On 11/17/15 at 5:02 P.M. direct care staff CC stated he/she worked from 10:00 P.M. 11/14/15 to 6:00 A.M. He/she stated he/she and a licensed nurse were the only 2 staff on duty from 10:00 P.M. to 6:00 A.M. Direct care staff CC stated he/she and the licensed nurse assisted a resident and after the task was completed the licensed nurse asked him/her to go to the nurse ' s station to make sure everything was ok. He/she stated when he/she reached the nurse ' s station resident #16 informed him/her that resident #30 left the facility, and he/she (resident #16) assisted	F 323			

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F 323	<p>Continued From page 65</p> <p>the resident back in, and he/she relayed the information to the licensed nurse. Direct care staff CC stated the resident wore a Wanderguard device, had a history of exit seeking including going to the south exit door. He/she stated he/she did not hear the alarm.</p> <p>On 11/18/15 at 11:14 P.M. licensed nurse K state he/she worked from 6:00 P.M. on 11/14/15 until 6:00 A.M. on 11/15/15. Licensed nurse K stated he/she and direct care staff CC were the only 2 staff on duty from 10:00 P.M. to 6:00 A.M. Licensed nurse K stated at 11:50 P.M. he/she and direct care staff CC entered a resident's room to perform a dressing change and the dressing change required 2 people. He/she stated he/she and direct care staff CC was in the resident's room from 11:50 P.M. until 12:15 A.M. (duration of 25 minutes). Licensed nurse K stated due to the length of time he/she and direct care staff CC was in the resident ' s room, after they completed the task he/she asked direct care staff CC to go to the nurse ' s station to make sure everything was okay. He/she stated direct care staff CC related to him/her that resident #16 reported to him/her that resident #30 left the building and resident #16 and resident #38 brought the resident back in. Licensed nurse K stated he/she went to the resident ' s room and the resident was in bed. He/she stated normally he/she performed the dressing change earlier in his/her shift when more staff was available but a resident " crashed " which delayed the time he/she normally performed the dressing change. Licensed nurse K stated the resident wore a Wanderguard device, had a history of exit seeking including going to the south exit door. Licensed nurse K stated he/she did not hear the alarm.</p>	F 323			

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F 323	<p>Continued From page 66</p> <p>On 11/19/15 at 1:27 P.M. licensed nurse J stated the resident had a tendency to wander and wore a Wanderguard device. He/she stated residents who smoked independently had the code to the exit door and the code for the south and front exit doors were the same at the time the resident left the facility.</p> <p>On 11/19/15 at 4:17 P.M. direct care staff U stated at the time of the incident staff and families had the code for the south and front exit doors. He/she stated the resident had wandering tendencies and would go to the exit door and once he/she observed the resident push on the bar/handle of the exit door.</p> <p>The facility's undated Elopement Policy and Procedure included it was the policy to ensure that each resident received adequate supervision and assistive devices to prevent elopement.</p> <p>According to Weather Underground on 11/14/15 at 11:52 P.M. the temperature in Alma, Kansas was 50 degrees Fahrenheit with a wind speed of 9.2 miles per hour.</p> <p>The facility failed to ensure that this severely cognitively impaired resident with a history of exit seeking received adequate supervision to prevent an elopement which placed this resident in immediate jeopardy.</p> <p>The facility abated the immediate jeopardy on 11/18/2015 at 12:45 P.M. by initiating the following:</p> <p>Staff placed the Resident on 15 minute visual checks. A staff member was present at the</p>	F 323			

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F 323	Continued From page 67 nurses's station beginning at 7:00 P.M. 11/17/15 through 11/18/15 to monitor the resident and the entrance and exits. In-patient psych evaluation is being arranged pending availability of a bed on the geriatric psychiatric unit. The resident transferred from the facility the on 11/18/15 at 4:35 P.M. All door alarms and Wanderguards were checked for proper function at 7:30 am on 11/15/15. All were functioning correctly. The door alarm codes for the west and south entrances were changed at 8 am on 11/16/15 so residents were not aware of the codes. Volume of the door alarms is being adjusted to ensure they are audible to all staff from every door with the addition of another annunciator. Re-education of all staff regarding elopement risk, door alarm use and function, and actions to be taken when an elopement attempt is identified was completed on 11/18/15 at 12:45 P.M. Continued compliance will be monitored by continued door alarm and Wanderguard checks for function and volume. Any elopement attempts will be reviewed and evaluated by the administrator and/or DON (Director of Nursing). All findings will be sent to Quality Assurance (QA) for review. The deficiency remained at the scope and severity of a D.	F 323			
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		12/23/15	

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F 329	<p>Continued From page 68</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: The facility identified a census of 28 residents. The sample was 15 residents with 6 residents sampled for medication reviews. Based on record review, and interview, the facility failed to ensure residents were free from unnecessary medication for one (#1) resident. Findings included: - The electronic record for resident #1 noted diagnoses of epilepsy (a brain disorder characterized by repeated seizures),</p>	F 329			

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F 329	<p>Continued From page 69</p> <p>hypertension (high blood pressure), chronic obstructive pulmonary disease ((COPD) - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin). It documented an order for Geodon 20 milligrams (mg) intramuscularly (in the muscle) twice a day as needed.</p> <p>The Admission Minimum Data Set (MDS) dated 7/15/15 revealed a Brief Interview for Mental Status (BIMS) score of 6 (less than 7 indicated severely impaired cognition). It documented the resident was administered an antipsychotic medication and had verbal behaviors.</p> <p>The Care Area Assessment (CAA) for cognition noted the resident had increased agitation when staff attempted to assist and was resistive to cares/showers and rehab. The CAA for psychotropic medication revealed the resident received Geodon for increased agitation and aggression.</p> <p>The care plan dated 7/8/15 documented staff were to keep the resident's environment calm and relaxed, redirect the resident as needed and remove the resident from the public area when behavior was unacceptable.</p> <p>The Medication Administration Record (MAR) for July 2015, August 2015, September 2015, and October 2015 revealed the resident received Geodon 5 times. The MARs lacked documentation of interventions attempted before the medication was administered.</p> <p>The nurse's notes for July 2015, August 2015, September 2015, and October 2015 lacked documentation of interventions attempted before the medication was administered.</p>	F 329			

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F 329	Continued From page 70 Interview on 11/19/2015 at 1:08 P.M. direct care staff T stated this resident threw things at staff and try to hit staff. He/she was unsure about interventions to redirect behavior. Interview on 11/23/2015 at 10:19 A.M. licensed nursing staff J stated staff were to assure the resident did not have any unmet needs, and redirect to an activity before administering Geodon. The facility failed to provide a policy about unnecessary medications. The facility failed to support unnecessary medication use for this cognitively impaired resident.	F 329			
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.	F 353		12/23/15	

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F 353	<p>Continued From page 71</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by: The facility had a census of 28 residents. Based upon record review, observations and interview the facility failed to provide sufficient nursing staff to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of the facility's September 2015 nursing schedule revealed the facility's usual nursing staffing pattern for the day shift was (2) direct care staff from 6:00 A.M. until 2:00 P.M. and on occasion a direct care staff from 8:00 A.M. to 2:00 P.M.; (1) Certified Medication Aide (CMA) from 7:00 A.M. until 7:00 P.M., and a licensed nurse from 6:00 A.M. until 6:00 P.M. The facility's evening shift staff normal staffing pattern was (2) direct care staff , (1) CMA until 7:00 P.M. and a licensed nurse from 6:00 P.M. until 6:00 A.M. The facility's night shift staffing pattern was (1) direct care staff from 10:00 P.M. until 6:00 A.M. and a licensed nurse form 6:00 P.M. until 6:00 A.M. <p>Review of the facility's October 2015 nursing schedule revealed the facility's usual nursing staffing pattern for the day shift was 2 to 3 direct care staff from 6:00 A.M. until 2:00 P.M. and on occasion a direct care staff from 8:00 A.M. to</p>	F 353			

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F 353	<p>Continued From page 72</p> <p>2:00 P.M.; (1) Certified Medication Aide (CMA) from 7:00 A.M. until 7:00 P.M., and a licensed nurse from 6:00 A.M. until 6:00 P.M. The facility's evening shift staff normal staffing pattern was (2) direct care staff , (1) CMA until 7:00 P.M. and a licensed nurse from 6:00 P.M. until 6:00 A.M. The facility's night shift staffing pattern was (1) direct care staff from 10:00 P.M. until 6:00 A.M. and a licensed nurse form 6:00 P.M. until 6:00 A.M.</p> <p>Review of the facility's November 2015 nursing schedule revealed the facility's usual nursing staffing pattern for the day shift was 2 to 3 direct care staff from 6:00 A.M. until 2:00 P.M. and on occasion a direct care staff from 8:00 A.M. to 2:00 P.M.; (1) Certified Medication Aide (CMA) from 7:00 A.M. until 7:00 P.M., and a licensed nurse from 6:00 A.M. until 6:00 P.M. until 11/12/15 when another licensed nurse worked 8:30 A.M. until 4:30 P.M. Monday through Friday. The facility's evening shift staff normal staffing pattern was (2) direct care staff , (1) CMA until 7:00 P.M. and a licensed nurse from 6:00 P.M. until 6:00 A.M. The facility's night shift staffing pattern was (1) direct care staff from 10:00 P.M. until 6:00 A.M. and a licensed nurse form 6:00 P.M. until 6:00 A.M.</p> <p>Review of the resident's council members meetings from 9/30/14 through 10/27/15 revealed on 2/27/15 residents stated they wanted a CMA on the north side to work all shifts and stated the facility needed a call light system at the south nursing station for the north side of the facility. On 4/28/15 residents stated there was a shortage in Certified Nurse Aides.</p> <p>During Stage 1 of the survey several alert and</p>	F 353			

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F 353	<p>Continued From page 73</p> <p>oriented residents stated the facility did not have sufficient nursing staff.</p> <p>On 11/17/15 at 5:02 P.M. direct care staff CC stated he/she worked from from 10:00 P.M. until 6:00 A.M. Direct care staff CC stated night shift staff also performed task as needed for residents that resided in the residential health care unit of the facility as well as those in the nursing facility and he/she did not feel the facility was sufficiently staffed on the night shift.</p> <p>On 11/23/15 at 10:36 A.M. administrative nursing staff D stated the facility's normal nursing staffing pattern on day shift was (1) CMA, (2) CNA's and a third CNA at times, (1) licensed nurse from 6:00 A.M. until 6:00 P.M. and another licensed nurse from 8:30 A.M. until 4:30 P.M. He/she stated the facility started using the second licensed nurse from 8:30 A.M. until 4:30 P.M. about a month ago. Administrative nursing staff D stated the CMA worked 7:00 A.M. until 7:00 P.M. The evening shift normal staff pattern was at least (2) CNAs, the CMA was in the facility until 7:00 P.M., and a licensed nurse from 6:00 P.M. until 6:00 A.M. On the night shift there was (1) licensed nurse and (1) CNA. Administrative nursing staff D stated the night shift staff, the 1 licensed nurse and the CNA covered the nursing facility as well as the 8 residents that resided on the resident care unit. He/she stated night shift staff had expressed concern regarding staffing and had asked for another CNA because some residents were up all night and gave the nurse a "hard time".</p> <p>Based upon observation, record review and interview the facility failed to ensure that 1 of 3 residents sampled for accidents received</p>	F 353			

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F 353	<p>Continued From page 74</p> <p>adequate supervision to prevent an elopement which placed the resident in immediate jeopardy. The facility also failed to provide assistive devices to prevent falls for 1 resident. Please refer to F323 for more information.</p> <p>Based upon record review and interview the facility failed to offer bedtime snacks on a nightly basis. Please refer to F368 for more information.</p> <p>Based upon record review and interview during the extended survey the facility failed to ensure 4 of 5 residents were seen by a physician at least once every 30 days for the first 90 days after admission. Please refer to F387 for more information.</p> <p>Based upon observation, interview and record review the facility failed to provide Specialized Mental Health Rehabilitative Services for 1 of 1 residents sampled for Specialized Rehabilitative Services. Please refer to F406 for more information.</p> <p>Based on observation, record review, and staff interview, the facility failed to utilize precautions to minimize transmission of infection on 2 of 2 halls. Please refer to F441 for more information.</p> <p>Based on interview and record review the facility failed to complete a performance review at least every 12 months and failed to provide sufficient in-service training based on the outcome of the reviews for a minimum of 12 hours per year for 5 of 5 nurse aides reviewed. Please refer to F497 for more information.</p> <p>The facility failed to ensure the facility had</p>	F 353			

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F 353	Continued From page 75 sufficient nursing staff to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 353			
F 368 SS=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: The facility had a census of 28 residents. Based upon record review interview the facility failed to offer snacks at bedtime on a nightly basis. Findings included: - Review of resident council meeting minutes from 9/30/14 through 10/27/15 revealed on 7/28/15 dietary staff spoke to residents regarding the facility's dietary budget and rules.	F 368		12/23/15	

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F 368	<p>Continued From page 76</p> <p>On 8/25/15 residents expressed concerns that there were not enough items on the snack cart. Portion sizes for meals, especially the supper meal were too small and residents were still hungry after eating their meals.</p> <p>A Complaint/Grievance/Request Response Form dated and signed 8/26/15 by social service staff GG stated there were only 3 choice of snacks on a tray and there was not enough snacks for residents. Residents were aware of budget cuts and changes to the snack cart.</p> <p>On 11/17/15 at 3:45 P.M. direct care staff AA stated nursing staff offered residents snacks at 10:00 A.M. and 2:00 P.M. but did not offer residents bedtime snacks. He/she stated residents had to ask nursing staff for bedtime snacks.</p> <p>On 11/19/15 at 11:15 A.M. social service staff GG stated he/she arranged the resident council meetings and he/she attended the meetings. He/she stated residents had expressed concerns regarding the night time snacks. Social service staff GG stated there had been some dietary budget cuts and the surveyor needed to speak with dietary staff FF regarding the night time snacks.</p> <p>On 11/19/15 at 9:45 A.M. an alert and oriented resident stated the facility did not offer bedtime snacks. He/she stated residents had to go to the nursing staff and ask for night time snacks and often times there were no night time snacks available.</p> <p>On 11/19/15 at 10:00 A.M. an alert and oriented resident stated the facility did not offer bedtime</p>	F 368			

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F 368	<p>Continued From page 77</p> <p>snacks. He/she stated residents could go to the nurse's station and request night time snacks but night time snacks were not always available.</p> <p>On 11/19/15 at approximately 2:30 P.M. dietary staff FF stated dietary staff delivered snacks each evening around 7:00 P.M. to the nursing staff. He/she stated there were enough snacks for everyone but it was his/her understanding that some residents took more than 1 or 2 snacks off of the trays which did not leave enough snacks for all residents. Dietary staff FF stated he/she did not know how the process regarding if nursing staff offered each resident a snack at bed time or not. He/she stated for residents on a pureed diet the dietary staff delivered applesauce and ice cream each evening at 7:00 P.M.</p> <p>On 11/19/15 at 4:10 P.M. direct care staff U stated nursing staff offered snacks at 2:00 P.M. but did not offer bed time snacks.</p> <p>On 11/23/15 at 8:49 an alert and oriented resident stated staff did not offer bedtime snacks on a regular basis. He/she stated residents had to request bedtime snacks but often times there were not enough bedtime snacks available for all residents.</p> <p>On 11/23/15 at 10:36 A.M. administrative nursing staff D stated nursing staff should offer residents a bedtime snack each night.</p> <p>The facility's Dining Service Pattern and Schedule Policy and Procedure revised 7/14/15 included all resident would be offered a bedtime snack unless clinically contraindicated.</p> <p>The facility failed to offer residents a bedtime</p>	F 368			

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F 368	Continued From page 78 snack on a nightly basis.	F 368			
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: The facility had a census of 28 residents. Based upon record review and interview during the extended survey the facility failed to ensure 4 (#1, #27, #34, #38) of 5 residents were seen by a physician at least once every 30 days for the first 90 days after admission. Findings included: - Review of resident #34's electronic record revealed the resident was admitted to the facility on 8/29/15. Further review revealed a physician saw the resident on 9/23/15 and on 11/14/15 (duration greater than 30 days from 9/23/15 until 11/14/15). This represented a physician did not see the	F 387		12/23/15	

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F 387	<p>Continued From page 79</p> <p>resident at least once every 30 days for the first 90 days after admission.</p> <p>During interview with administrative nursing staff D on 11/23/15 at 3:30 P.M. he/she stated he/she would have to review the resident's record to see if a physician had seen the resident other than as noted above. At the time of the writing the facility had not provided evidence support the resident was seen by a physician at least every 30 days after admission for the first 90 days.</p> <p>The facility failed to ensure the resident was seen by a physician at least every 30 days after admission.</p> <p>- Review of resident's #1's electronic medical record revealed the resident was admitted to the facility on 7/8/15. Further review revealed the physician saw the resident on 9/16/15. There was no evidence to support a physician saw the resident after 9/16/15.</p> <p>During interview with administrative nursing staff D on 11/23/15 at 3:30 P.M. he/she stated he/she would have to review the resident's record to see if a physician had seen the resident other than as noted above. At the time of the writing the facility had not provided evidence support the resident was seen by a physician at least every 30 days after admission for the first 90 days.</p> <p>The facility failed to ensure the resident was seen by a physician at least every 30 days after admission.</p> <p>- Review of resident #27's electronic medical record revealed the resident was admitted to the facility on 9/21/15. Further review of the</p>	F 387			

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F 387	<p>Continued From page 80</p> <p>resident's record lacked evidence a physician had seen the resident once every 30 days after his/her admission to the facility.</p> <p>During interview with administrative nursing staff D on 11/23/15 at 3:30 P.M. he/she stated he/she would have to review the resident's record to see if a physician had seen the resident other than as noted above. At the time of the writing the facility had not provided evidence support the resident was seen by a physician at least every 30 days after admission for the first 90 days.</p> <p>The facility failed to ensure the resident was seen by a physician at least every 30 days after admission.</p> <p>- Review of resident's #38's electronic medical record revealed the resident was admitted to the facility on 7/17/15. Further review revealed the physician saw the resident on 9/16/15. There was no evidence to support a physician saw the between 7/17/15 and 9/16/15 and/or after 9/16/15.</p> <p>During interview with administrative nursing staff D on 11/23/15 at 3:30 P.M. he/she stated he/she would have to review the resident's record to see if a physician had seen the resident other than as noted above. At the time of the writing the facility had not provided evidence support the resident was seen by a physician at least every 30 days after admission for the first 90 days.</p> <p>The facility failed to ensure the resident was seen by a physician at least every 30 days after admission.</p>	F 387			
F 406	483.45(a) PROVIDE/OBTAIN SPECIALIZED	F 406		12/23/15	

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F 406 SS=D	Continued From page 81 REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: The facility had a census of 28 residents. The sample included 15 residents. Based upon observation, interview and record review the facility failed to provide Specialized Mental Health Rehabilitative Services for 1 (#8) of 1 residents sampled for Specialized Rehabilitative Services. Findings included: - Resident #8 ' s electronic health record identified the resident had diagnoses that included Schizoaffective Disorder (mental disorder characterized by abnormal thought processes and deregulated emotions), insomnia (difficulty sleeping), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) and major depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness). The resident ' s Quarterly Minimum Data Set (MDS) dated 10/14/15 identified the resident	F 406			

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F 406	<p>Continued From page 82</p> <p>scored 11 (moderately impaired cognition) on the Brief Interview or Mental Status (BIMS), had no behaviors, was totally dependent upon staff for bed mobility and transfers, the activity of walking in the room/corridor did not occur, required extensive staff assistance with locomotion on/off the unit, dressing, toilet use and personal hygiene. The MDS recorded the resident received an anti-anxiety, an antipsychotic and an anti-depressant medication 7 of the 7 days during the assessment period.</p> <p>The resident's admission MDS dated 7/15/15 identified the resident scored 12 on the BIMS, had no behaviors, required extensive staff assistance with bed mobility, transfers, toilet use, personal hygiene, and locomotion on/off the unit, and the activity of walking in the room/corridor did not occur and the resident was totally dependent upon staff for dressing. The MDS recorded the resident received an anti-anxiety, an antipsychotic and an anti-depressant medication 7 of the 7 days during the assessment period.</p> <p>The resident's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 7/17/15 included the resident had diagnoses that included Schizoaffective Disorder, Depression and Anxiety.</p> <p>The resident's Psychotropic CAA dated 7/17/15 included the resident had diagnoses of depression, anxiety and Schizoaffective Disorder and had used antipsychotic medications for a long time and staff monitored the resident for side effects related to the medications and thus far staff had not observed any adverse side effects.</p> <p>The resident's care plan dated 10/14/15 addressed the resident had mental health</p>	F 406			

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F 406	Continued From page 83 diagnosis with behavioral issues. Licensed staff educated the resident and the resident knew it was important for him/her to have labs drawn as physician ordered and when the resident had increased agitation he/she might not want to take the time to comply; staff reminded the resident why it was important for his/her health. The resident at times exchanged items with his/her peers without telling staff and if the resident felt the exchange was unequal the resident might become agitated. Staff encouraged the resident to use staff as a mediator, and staff helped the resident to resolve any interpersonal disputes that would otherwise increase the risk of the resident's behavioral symptoms. If the resident had conflict with particular peers, staff closely observed the resident for signs and symptoms of increased anxiety or agitation so the resident could be easily redirected. The resident's disease caused him/her to have delusions and the resident believed things about himself/herself self and circumstances that were not true. Staff consulted with appropriate medical personnel whenever these symptoms appeared to be worsening. Staff addressed the resident ' s concerns in a calm manner, and allowed him/her to express himself/herself as needed. When the resident was verbally aggressive staff offered the resident a quiet place to calm down and waited before approaching the resident again. The following interventions were added 11/10/15. Staff verified with the resident's physician and the resident's physician documented the benefits of the resident's psychoactive medications outweighed the risks if the resident's physician indicated dosage reduction should not be done. Staff contacted the resident's physician to reduce the amount of Risperdal (an antipsychotic medication) and Olanzapine (an antipsychotic	F 406			

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F 406	<p>Continued From page 84</p> <p>medication) the resident received every 6 months and Ativan (an antianxiety medication) every 4 months. If the resident experience no changes or worsening of behaviors, the facility looked at further dose reductions. The resident received Lithium (used to treat the manic episodes of manic depression) and Trileptal (an anticonvulsant and mood-stabilizing drug, which is also used to treat anxiety and mood disorders) to help control his/her behaviors and staff administered the medications as physician ordered. The resident often made sexual advances towards staff members and staff informed the resident it was not acceptable behavior and documented the resident ' s behaviors. Staff monitored the resident for delusions, agitation, hallucinations, negative thoughts and racing thoughts and monitored documented the side effects of the medications. The resident believed things that were untrue, the beliefs were usually related to old accounts with non-specific amounts of money the resident believed he/she had and was entitled to, despite evidence to the contrary. If the resident expressed those beliefs and it caused him/her agitation, staff redirected the resident's attention to something fun and engaging that had the potential to immerse him/her at the moment.</p> <p>Review of a letter from a state agency dated 1/29/07 informed the resident the letter was proof that a Level II PASRR (Pre-admission Screening and Resident Review) assessment was completed. The letter included based on the information from the assessment conducted it was important that mental health services monitored the resident's mental health needs, and a psychiatrist monitored the resident's mental illness and psychiatric medications in addition to</p>	F 406			

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F 406	<p>Continued From page 85</p> <p>the following recommendations. The resident benefited from entering into a 24-hour structured/supervised setting for continued stabilization of his/her mental health condition; nursing staff would be available and able to administer and observe for medication compliance, effectiveness and/or side effects and provided medication education. The facility should provide and encourage the resident to attend and participate in daily activities and therapeutic groups and/or treatments.</p> <p>Review of the resident's November 2015 Medication Administration Record revealed the resident received the following medications Oxcarbazepine (an anticonvulsant medication and also used as a mood-stabilizing drug) 300 milligrams (mg) BID (twice a day) for Schizoaffective Disorder, Risperdal (an antipsychotic medication) 2 mg BID for Schizoaffective disorder, Duloxetine 30 mg daily for major depressive disorder, Olanzapine 10 mg daily for Schizoaffective disorder, Lithium Carbonate 600 mg daily for Schizoaffective disorder, Ativan 0.5 mg BID for anxiety and Trazadone (an antidepressant medication) 100 mg as needed at hour of sleep for insomnia.</p> <p>Review of the resident's nurse's note from 8/2015 to 11/19/15 revealed the resident made sexually inappropriate comments to female staff multiple times.</p> <p>A nurse's note dated 11/13/15 and timed 9:13 documented the resident sat at the nurse's station this A.M. and the resident became verbal with another resident for looking at him. The resident asked other resident using profanity what he/she was looking at and told the resident</p>	F 406			

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F 406	Continued From page 86 he/she might have to beat his/her ...expletive word used. Review of the resident's clinical record lacked evidence to support a mental health service monitored the resident's mental health needs, or a psychiatrist monitored the resident's mental illness and psychiatric medications. On 11/17/15 at 9:45 A.M. the resident sat in his/her wheelchair and observation revealed the resident was a passive participant during the exercise group. On 11/23/15 at 9:30 A.M. social service staff GG stated the resident had seen a psychiatrist and received mental health services at the facility he/she previously resided but had not received these services since admission to the facility. He/she stated the facility was unable to find a psychiatrist willing to see the resident because the resident ' s payer source was Medicaid. He/she further stated he/she had not contacted the psychiatrist or the mental health service agency/psychiatrist that previously managed the resident's mental illness and psychiatric medications. Social service GG stated he/she was aware the resident needed a psychiatrist to manage his/her mental illness and psychiatric medications. The facility failed to ensure the resident's received specialized mental health rehabilitative services as recommended by the state agency in order to ensure the resident attained/maintained his/her psychological well-being.	F 406			
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		12/23/15	

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F 441	Continued From page 87 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441			

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F 441	<p>Continued From page 88</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>The facility identified a census of 28 residents. Based on observation, record review, and staff interview, the facility failed to utilize precautions to minimize transmission of infection on 2 of 2 halls.</p> <p>Finding included:</p> <ul style="list-style-type: none"> - During an observation on 11/17/2015 at 7:27 A.M. direct care staff O and direct care staff P entered a resident's with isolation precautions. They transferred a resident from his/her bed to his/her wheelchair using a Hoyer lift (total body lift used to transfer residents). Direct care staff P used a bottle of liquid solution with a hand written label of " Bleach 1:9 (one part bleach 9 parts water) " to clean the Hoyer lift. He/she sprayed the Hoyer lift with the 1:9 bleach solution and immediately wiped down the Hoyer lift after spraying. He/she stated the bleach product killed organisms in 20 seconds per the facility's policy. He/she confirmed he/she immediately wiped down the Hoyer lift. <p>During an interview on 11/23/2015 at 9:07 A.M. administrative nursing staff D stated staff were expected to use a 1:9 bleach solution to clean and disinfect the Hoyer lift. Staff were to spray the bleach product on the surface of the Hoyer lift to be cleaned, ensure the surface stayed wet for 5 minutes, then wipe down the surfaces. Staff could then remove the equipment from the resident ' s room.</p> <p>The facility ' s undated Infection Control Policy documented reusable equipment should not be used for another resident until it had been appropriately cleaned and reprocessed. The</p>	F 441			

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F 441	<p>Continued From page 89</p> <p>policy failed to document the time required to leave the bleach solution on before wiping down.</p> <p>The facility failed to utilize precautions to minimize transmission of infection.</p> <p>- During an observation on 11/17/2015 at 8:33 A.M. direct care staff preformed peri-care to a resident with gloved hands. With a soiled gloved hand he/she removed clean wipes from a package of hygiene wipes. Direct staff P said he/she was doing peri-care on the resident and did not remove his/her dirty gloves before he/she removed the clean wipes from the peri-care wipes package. He/she said he/she should have changed gloves before getting clean wipes from the package.</p> <p>During an interview on 11/23/2015 at 9:08 A.M. administrative nursing staff D said he/she expected staff to remove soiled gloves, wash hands, re-glove, and remove clean wipes from the peri-care wipes package.</p> <p>The facility failed to provide a policy on Handwashing as requested.</p> <p>The facility failed to change gloves to minimize transmission of infection.</p> <p>- On 11/19/15 from 10:00 A.M. to 10:15 A.M. housekeeping staff BB cleaned resident # room. The resident was in isolation due to C-Diff. Prior to cleaning the resident's room, observation revealed one of the resident's dresser drawers was opened. Further observation revealed housekeeping staff BB removed a laminated paper from his/her cleaning cart and placed the</p>	F 441			

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F 441	Continued From page 90 laminated item in the resident's open dresser drawer and in direct contact with a clothing item within the resident's drawer. During cleaning of the room, housekeeping staff BB used a feathered duster with an extended handle and dusted the overhead light above the resident's bed and well as the overhead light above the the empty bed within the resident's room. Housekeeping staff BB then placed the duster and the laminated paper back in the cleaning cart. After clearing the resident's room, housekeeping staff BB wheeled the cleaning cart with the duster in an upright position down the hall where the resident resided. During interview with nursing administrative staff D on 11/19/15 at 10:20 AM the staff stated he/she was not sure if housekeeping staff BB should have replaced the duster and the paper back into the cart after he/she cleaned the resident's room. He/she asked administrative staff A for clarification and responded housekeeping staff BB should have placed the items in the red trash barrels in the resident's room and should not have replaced the items back into the cleaning cart and wheeled them down the hall. On 11/19/15 housekeeping staff BB stated he/she had not been instructed not to remove the duster or laminated paper from the resident's room.	F 441			
F 469 SS=F	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility failed to prevent cross-contamination and transmission of an infectious disease. The facility must maintain an effective pest control program so that the facility is free of pests	F 469		12/23/15	

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F 469	<p>Continued From page 91 and rodents.</p> <p>This REQUIREMENT is not met as evidenced by: The facility identified a census of 28 residents, and the sample size was 15. Based on observation, record review, and interview, the facility failed to maintain an effective pest control program so the facility was free from pests and rodents.</p> <p>Findings Included:</p> <ul style="list-style-type: none"> - Review of the Service Slip/Invoice dated 6/15/15 documented fly strips used for treatment. <p>Review of the Service Slip/Invoice dated 7/27/15 documented fly bait used for treatment.</p> <p>During an observation on 11/12/2015 at 10:12 A.M. resident #31 ' s room had several flies.</p> <p>During an observation on 11/12/2015 at 10:32 A.M. resident #6 ' s room had several flies.</p> <p>During an observation on 11/16/2015 3:26 P.M. several flies were observed in the dining room.</p> <p>During an observation on 11/17/2015 at 9:29 A.M. a fly was observed in the hallway by the kitchen.</p> <p>During an observation on 11/17/2015 at 11:48 A.M. a few flies were observed in the kitchen.</p> <p>During an observation on 11/17/2015 at 12:36 P.M. two flies were observed in the dining room.</p>	F 469			

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F 469	Continued From page 92 During an interview on 11/23/2015 at 9:47 A.M. resident #31 stated there were always flies in the facility, and it does not bother him/her that they are there. During an interview on 11/23/2015 at 9:49 A.M. resident #8 stated there were flies in the facility and they bother him/her. During an interview on 11/23/2015 at 10:28 A.M. resident #34 stated there are flies in the facility, especially when the weather is warm. He/she said they come in the smoker's door, and they do not bother him. During an interview on 11/17/2015 at 12:08 P.M. dietary staff FF stated the exterminator sprayed once a month in the kitchen and hung glue traps by the lights to catch flies. During an interview on 11/19/2015 at 10:10 A.M. maintenance staff X stated the exterminator came once a month to spray for bugs. He/she contacted the exterminator several times about the flies and was told they would bring a different chemical to treat them. During an interview on 11/19/2015 at 11:57 A.M. maintenance staff X stated the exterminator was last here on 11/4/15 and left spray for the flies. He/she stated it was not effective. He/she informed the flies mostly come in the door the residents use for smoking. The facility failed to maintain an environment free from pests and rodents.	F 469			
F 490 SS=F	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING	F 490		12/23/15	

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F 490	<p>Continued From page 93</p> <p>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: The facility had a census of 28 residents. Based upon observation, record review and interview the facility failed to ensure the facility was administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Findings included:</p> <p>Based upon observation, record review and interview the facility failed to ensure that 1 of 3 residents sampled for accidents received adequate supervision to prevent an elopement which placed the resident in immediate jeopardy. The facility also failed to provide assistive devices to prevent falls for 1 resident. Please refer to F323 for more information.</p> <p>Based upon record review, observations and interview the facility failed to provide sufficient nursing staff to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. Please refer to F353 for more information.</p> <p>Based upon record review and interview the facility failed to offer bedtime snacks on a nightly</p>	F 490			

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F 490	<p>Continued From page 94 basis. Please refer to F368 for more information.</p> <p>Based upon record review and interview during the extended survey the facility failed to ensure 4 of 5 residents were seen by a physician at least once every 30 days for the first 90 days after admission. Please refer to F387 for more information.</p> <p>Based upon observation, interview and record review the facility failed to provide Specialized Mental Health Rehabilitative Services for 1 of 1 residents sampled for Specialized Rehabilitative Services. Please refer to F406 for more information.</p> <p>Based on observation, record review, and staff interview, the facility failed to utilize precautions to minimize transmission of infection on 2 of 2 halls. Please refer to F441 for more information.</p> <p>Based upon observation, record review and interview the facility failed to maintain an effective pest control program. Please refer to F469 for more information.</p> <p>Based on interview and record review the facility failed to complete a performance review at least every 12 months and failed to provide sufficient in-service training based on the outcome of the reviews for a minimum of 12 hours per year for 5 of 5 nurse aides reviewed. Please refer to F497 for more information.</p> <p>Based on observation, record review, and staff interview, the facility Quality Assessment and Assurance (QAA) committee failed to identify and remedy issues that required an action plan. Please refer to F520 for more information.</p>	F 490			

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F 490	Continued From page 95 The facility failed to ensure the facility was administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 490			
F 497 SS=C	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: The facility reported a census of 28 residents. There were 15 residents in the sample. Based on interview and record review the facility failed to complete a performance review at least every 12 months and failed to provide sufficient in-service training based on the outcome of the reviews for a minimum of 12 hours per year for 5 of 5 nurse aides reviewed. Findings Included: - A review of direct care staff U, V, W, Y, and Z's	F 497		12/23/15	

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F 497	Continued From page 96 personnel files lacked documentation of a performance review and lacked a minimum of 12 hours in-service training based on a performance review. During an interview on 11/23/2015 at 12:39 P.M. administrative nursing staff D said the facility provided in-service training on the computer and in person in the facility, however hours of in-service were not tracked. Staff D said he/she had not completed performance reviews since his/her employment. During an interview on 12/23/2015 at 5:30 P.M. administrative staff A said the facility used competency checklist as performance reviews and all staff completed the same in-service training. The facility failed to provide a policy on Performance Reviews and In-Service Training as requested. The facility failed to develop in-service training based on the results of the review for a minimum of 12 hours per year.	F 497			
F 520 SS=D	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	F 520		12/23/15	

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F 520	<p>Continued From page 97</p> <p>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.</p> <p>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 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 28 residents. The sample included 15 residents. Based on observation, record review, and staff interview, the facility Quality Assessment and Assurance (QAA) committee failed to identify and remedy issues that required an action plan.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - On 11/23/15 at P.M. administrative staff A stated the QAA committee met at least quarterly and reviewed pressure ulcers rates, weight loss, falls and other identified issues. He/she stated the facility had not identified a system problem with pressure ulcer because the facility had good success with healing pressure ulcers, it was difficult to employ nurses and the facility provided staff based upon resident acuity. Administrative staff A stated the facility identified issues by speaking with residents reviewing the facility's 	F 520			

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F 520	<p>Continued From page 98</p> <p>quality measure reports and reviewed resident's grievances. He/she stated once an issue was identified the facility developed a plan and performed an audit to determine if the plan was effective.</p> <p>Based upon observation, record review and interview the facility failed to ensure that 1 of 3 residents sampled for accidents received adequate supervision to prevent an elopement which placed the resident in immediate jeopardy. The facility also failed to provide assistive devices to prevent falls for 1 resident. Please refer to F323 for more information.</p> <p>Based upon record review, observations and interview the facility failed to provide sufficient nursing staff to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. Please refer to F353 for more information.</p> <p>Based upon record review and interview the facility failed to offer bedtime snacks on a nightly basis. Please refer to F368 for more information.</p> <p>Based upon record review and interview during the extended survey the facility failed to ensure 4 of 5 residents were seen by a physician at least once every 30 days for the first 90 days after admission. Please refer to F387 for more information.</p> <p>Based upon observation, interview and record review the facility failed to provide Specialized Mental Health Rehabilitative Services for 1 of 1 residents sampled for Specialized Rehabilitative Services. Please refer to F406 for more</p>	F 520			

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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 520	Continued From page 99 information. Based on observation, record review, and staff interview, the facility failed to utilize precautions to minimize transmission of infection on 2 of 2 halls. Please refer to F441 for more information. Based upon observation, record review and interview the facility failed to maintain an effective pest control program. Please refer to F469 for more information. Based on interview and record review the facility failed to complete a performance review at least every 12 months and failed to provide sufficient in-service training based on the outcome of the reviews for a minimum of 12 hours per year for 5 of 5 nurse aides reviewed. Please refer to F497 for more information.	F 520		