

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

PRINTED: 02/24/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175455	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/23/2016
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ESKRIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 505 N. MAIN ST. ESKRIDGE, KS 66423		
(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 280 SS=D	<p>The following citations represent the findings of a Health Resurvey and complaint investigations #KS00096689 and #KS00096149.</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: The facility identified a census of 59 residents. The sample included 17 residents. Based on observation, record review, and interview, the facility failed to revise the care plan for 1 resident (#37).</p> <p>Findings included:</p>	F 280			

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

TITLE

(X6) DATE

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

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F 280	<p>Continued From page 1</p> <p>- The signed Physician's Order Sheet dated 1/16/16 for resident #37 documented diagnoses of schizophrenia (a psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought) and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).</p> <p>The Significant Change Minimum Data Set (MDS) dated 1/25/16 noted a Brief Interview for Mental Status (BIMS) of 13 (12 to 15 indicated intact cognition) and was independent with transfers and walking in the halls.</p> <p>The Annual Minimum Data Set (MDS) dated 12/7/15 noted a BIMS of 14 and he/she was independent with transfers and walking in the halls.</p> <p>The Care Area Assessments (CAAs) dated 1/25/16 documented the resident was at risk for cognitive loss due to a decline in physical ability related to a recent heart attack (a sudden and sometimes fatal occurrence of a blood clot in the artery of the heart) and for falls.</p> <p>The care plan dated 12/23/15 noted the resident notified staff of any changes or increased dizziness or feelings of being lightheaded and staff observed the resident's gait for any signs of unsteadiness. The care plan lacked revision after the resident fell on 1/19/16 and 2/4/16.</p> <p>The nurse's note dated 1/19/16 documented staff found the resident sitting on the floor.</p> <p>The nurse's note dated 2/4/16 noted the resident</p>	F 280			

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F 280	<p>Continued From page 2 sat on a box in his/her room.</p> <p>The fall risk assessment dated 1/16/16 noted a score of 6 (greater than 10 indicated at risk for a fall).</p> <p>The fall investigation dated 1/19/16 noted the resident chose poor footwear for ambulating. Staff encouraged him/her to use the call light in order for staff to ambulate with the resident.</p> <p>The fall investigation dated 2/4/16 noted the resident had impaired judgement and decision making ability. Staff encouraged him/her to ask for staff for assistance when walking.</p> <p>An observation on 02/17/16 at 4:10 P.M. revealed the resident walked across the living area unassisted.</p> <p>During an observation on 02/18/16 at 8:53 A.M., the resident ambulated around the nurse's station unassisted.</p> <p>Interview on 02/22/16 at 11:18 A.M. direct care staff O stated he/she encouraged the resident to use the call light.</p> <p>Interview on 02/22/16 at 1:24 P.M. licensed nursing staff H stated he/she encouraged the resident to use the call light and licensed nursing staff updated the care plan.</p> <p>Interview on 02/22/16 at 3:52 P.M. administrative nursing staff D stated he/she expected the care plan to be updated when needed.</p> <p>The facility's policy "Fall Management Clinical Guidelines", revised January 2011, revealed the</p>	F 280			

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F 280	Continued From page 3 resident's care plan should be updated after a fall.	F 280			
F 311 SS=D	<p>The facility failed to update the care plan for this resident who fell on 1/19/16 and 2/4/16.</p> <p>483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS</p> <p>A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.</p> <p>This REQUIREMENT is not met as evidenced by: The facility identified a census of 59 residents. The sample included 17 residents. Based on observation, record review, and interview, the facility failed to ensure that one (#11) of three residents sampled for Activities of Daily Living (ADLs) received cueing and assistance with dressing.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - The Physician's Order sheet dated 1/13/2016 for resident #11 revealed the resident had diagnoses including schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), major depressive disorder (major mood disorder) with psychotic symptoms (mental disorder characterized by a gross impairment in reality testing), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), paranoid personality disorder (unrelenting mistrust and 	F 311			

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F 311	<p>Continued From page 4</p> <p>suspicion of others, even when there is no reason to be suspicious), and history of unspecified skin rashes.</p> <p>The Quarterly MDS (minimum data set) dated 11/30/2015, included a Staff Assessment for Mental Status (SAMS) revealed Moderately Impaired cognition with short term and long term memory problems, delirium signs of inattention and psychomotor retardation present and fluctuating, and delirium sign of disorganized thinking continuously present. Potential indicators of psychosis included hallucinations and delusions. Verbal behavioral symptoms directed towards others and other behavioral symptoms not directed towards others occurred on 1-3 days of the assessment period. All ADLs were performed independently. The resident was occasionally incontinent of bladder.</p> <p>The Annual MDS dated 9/18/2015 revealed the same information, except he/she had a BIMS score of 2, which indicated severe cognitive impairment, with disorganized thinking present and fluctuating.</p> <p>The 9/18/2015 Care Area Assessment (CAA) for Cognitive Loss/Dementia revealed the resident has a history of mental illness, violent aggression against others, and rejection of personal cares, bathing, changing of clothes, and taking medications.</p> <p>The 9/18/2015 CAA for Urinary Incontinence revealed the resident is occasionally incontinent of bladder, and needs cues from staff to change clothes and complete personal hygiene properly.</p> <p>The Care Plan dated 1/7/2016 revealed the</p>	F 311			

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F 311	<p>Continued From page 5</p> <p>resident needs to develop skills in interacting appropriately with others, and gain self-care skills including personal hygiene. The resident has potential risk for altered skin integrity, non-pressure related, and for staff to lay clothes out as a reminder to change. The resident prefers to shower once a week, although he/she may not use soap or shampoo.</p> <p>Observation on 2/17/2016 at 2:08 P.M. revealed the resident wearing a grey hooded sweatshirt, heavily soiled on the front with what appeared to be food stains; a blue and green striped shirt beneath it; and dark grey sweatpants. The resident had a musty, sour odor, noticeable when standing next to him/her.</p> <p>Record Review revealed the resident took a shower during the evening shift on 2/17/2016, as documented by Direct Care Staff R.</p> <p>Observation on 2/18/2016 at 9:09 A.M. revealed the resident wearing the same blue and green shirt, the same sweatshirt still covered in stains, and grey sweatpants that appeared to be the same from 2/17. Licensed nursing staff H asked the resident if he/she would like to have his/her sweatshirt washed, and resident responded, "No, it isn't ready yet."</p> <p>In an interview with the resident on 2/18/2016 at 9:25 A.M., he/she stated he/she did not want to wear different clothes and did not own another jacket. After asking the resident for permission to open his/her closet door, it revealed he/she owned multiple items of clothing including another hooded sweatshirt. When asked if he/she would consider wearing it, he/she stated "No, this one's fine."</p>	F 311			

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F 311	Continued From page 6 In an interview on 2/18/2016 at 9:33 A.M., Direct Care Staff Q stated he/she would "sometimes" lay clothes out on his bed, but "he usually refuses everything we try to do." In an interview on 2/18/2016, Direct Care Staff S stated he/she was assigned to the hall with the resident's room, but he/she had not laid out clothes to cue the resident to change. The staff member stated he/she had worked the day before on the same hall, but did not lay clothes out. He/She claimed the resident probably won't cooperate so he/she does not try to do it anymore. Observation on 2/22/2016 at 3:05 P.M. revealed the resident wearing the same blue and green shirt, and the sweatshirt still covered in stains, but blue sweatpants. In an interview on 2/22/2016 at 4:14 P.M., Direct Care Staff R stated he/she assisted the resident with a shower on 2/17, but ended his/her shift and went home before the resident had finished bathing. The staff member acknowledged the resident was wearing the same shirt and sweatshirt as the week before and it had not been laundered. He/She stated the resident will change clothes after showering, but claimed staff forgot to bring in new clothes after the shower on 2/17. The facility failed to provide the resident with assistance in dressing as specified in the care plan.	F 311			
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323			

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F 323	<p>Continued From page 7</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: The facility identified a census of 59 residents. The sample included 17 residents with 3 residents sampled for falls. Based on observation, record review, and interview, the facility failed to implement fall interventions for 1 resident (#37). The facility also failed to ensure 54 independently mobile residents remained free from potential hazards when staff left the therapy room unlocked with an unlocked hydrocollator (therapy device with hot water for hot packs) accessible to residents.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - The signed Physician's Order Sheet dated 1/16/16 for resident #37 documented diagnoses of schizophrenia (a psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought) and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). <p>The Significant Change Minimum Data Set (MDS) dated 1/25/16 noted a Brief Interview for Mental Status (BIMS) of 13 (12 to 15 indicated intact cognition) and was independent with transfers and walking in the halls.</p>	F 323			

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F 323	Continued From page 8 The Annual Minimum Data Set (MDS) dated 12/7/15 noted a BIMS of 14 and was independent with transfers and walking in the halls. The Care Area Assessments (CAAs) dated 1/25/16 documented the resident was at risk for cognitive loss due to a decline in physical ability related to a recent heart attack (a sudden and sometimes fatal occurrence of a blood clot in the artery of the heart) and for falls. The care plan dated 12/23/15 noted the resident notified staff of any changes or increased dizziness or feelings of being lightheaded and staff observed the resident's gait for any signs of unsteadiness. The care plan lacked revision with fall prevention strategies to prevent future falls after the resident fell on 1/19/16 and 2/4/16. The nurse's note dated 1/19/16 documented staff found the resident sitting on the floor. The nurse's note dated 2/4/16 noted the resident sat on a box in his/her room. The fall risk assessment dated 1/16/16 noted a score of 6 (greater than 10 indicated at risk for a fall). The fall investigation dated 1/19/16 noted the resident chose poor footwear for ambulating. Staff encouraged him/her to use the call light in order for staff to ambulate with the resident. The fall investigation dated 2/4/16 noted the resident had impaired judgement and decision making ability. Staff encouraged him/her to ask for staff for assistance when walking.	F 323			

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F 323	<p>Continued From page 9</p> <p>Observation on 02/17/16 at 4:10 P.M. the resident walked across the living area unassisted with plain socks on.</p> <p>Observation on 02/18/16 at 8:53 A.M. the resident ambulated around the nurse's station unassisted with plain socks on.</p> <p>Interview on 02/22/16 at 11:18 A.M. direct care staff O stated he/she encouraged the resident to use the call light.</p> <p>Interview on 02/22/16 at 1:24 P.M. licensed nursing staff H stated he/she encouraged the resident to use the call light for assistance with ambulating and to wear appropriate shoes and/or socks.</p> <p>Interview on 02/22/16 at 3:52 P.M. administrative nursing staff D stated he/she expected staff to encourage the resident to wear appropriate shoes and/or socks.</p> <p>The facility policy "Fall Management Clinical Guidelines", revised January 2011, revealed appropriate intervention should be implemented after a fall.</p> <p>The facility failed to implement fall prevention strategies to prevent future falls for this resident who fell on 1/19/16 and 2/4/16.</p> <p>- During an observation on 02/18/16 at 11:15 A.M. the rehab/therapy room door was open and the hydrocollator (therapy device with hot water for hot packs) was unlocked. The water temperature in the hydrocollator was 163.7 degrees Fahrenheit (F).</p>	F 323			

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F 323	Continued From page 10 An observation on 02/18/16 at 11:20 A.M. revealed resident #37 was in the rehab/therapy room alone while exercising with a restorator (pedal device for upper extremities). The hydrocollator remained unlocked. Interview on 02/18/16 at 11:21 A.M. therapy staff JJ stated the door was left open while he/she left the room to obtain linens. He/she stated there was a lock on the hydrocollator. During an interview on 2/18/16 at 4:45 P.M., administrative staff A stated the therapy room door should remain locked when staff are not in the room. The facility failed to ensure 54 independently mobile residents remained free from potential accidents when therapy staff left the therapy room door open with the hydrocollator unlocked and accessible to residents.	F 323			
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not	F 329			

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F 329	<p>Continued From page 11</p> <p>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 59 residents. The sample included 17 residents with 5 residents sampled for medication reviews. Based on observation, record review, and interview, the facility failed to ensure 1 of 5 sampled residents remained free from unnecessary medications (failure to offer non-pharmacological pain relief interventions and failure to include Black Box Warning information in the resident's care plan for Plavix, a blood thinning medication). (#37)</p> <p>Findings included:</p> <ul style="list-style-type: none"> - The signed Physician's Order Sheet (POS) dated 1/16/16 for resident #37 documented diagnoses of schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought) and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). <p>The Significant Change Minimum Data Set (MDS) dated 1/25/16 noted a Brief Interview for</p>	F 329			

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F 329	<p>Continued From page 12</p> <p>Mental Status (BIMS) of 13 (12 to 15 indicated intact cognition), was independent with all Activities of Daily Living (ADLs) and denied pain.</p> <p>The Care Area Assessments (CAAs) dated 1/25/16 documented the resident was at risk for cognitive loss due to a decline in physical ability related to a recent heart attack (a sudden and sometimes fatal occurrence of a blood clot in the artery of the heart) and for falls. The CAA for pain did not trigger.</p> <p>The care plan dated 2/15/16 noted staff encouraged the resident to voice feelings about his/her family. It lacked the black box warning for Plavix. The care plan also lacked non-medication interventions for pain and his/her pharmacological pain management interventions.</p> <p>A physician's order dated 8/7/13 noted an order for Tylenol 650 milligrams (mg) or 1000 mg every 4 hours as needed for pain.</p> <p>A physician's order dated 7/2/14 noted an order for Tramadol 50 mg every 8 hours as needed for pain.</p> <p>A physician's order dated 1/16/16 noted an order for Plavix 75 mg daily to prevent blood clots.</p> <p>The Medication Administration Records (MARs) for January 2016 and February 2016 documented the resident received Plavix every day since 1/16/16. The MAR also noted the resident received Tylenol on 1/10/16, 1/14/16, 1/22/16, 2/3/16, 2/4/16, 2/6/16, and 2/18/16. The resident also received Tramadol on 1/19/16, 1/26/16, 2/10/16, and 2/11/16. The resident received these medications for leg pain.</p>	F 329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175455	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/23/2016
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F 329	Continued From page 13 The clinical record failed to note evidence of non-medication interventions for pain attempted before staff administered pain medications. According to the Food and Drug Administration, the black boxed warning for Plavix directed health professionals to monitor patients for slow metabolism of the medication, decreasing the medication's effectiveness. Observation on 2/22/16 at 2:55 P.M. the resident asked for pain medication. Staff assessed the resident, but did not provide or suggest non-medication interventions before administering the pain medication. Interview on 02/22/16 at 11:27 A.M. direct care staff O was unsure what to watch for with Plavix and referred to the resident's care plan for this information. Interview on 02/22/16 at 1:31 P.M. licensed nursing staff H stated he/she encouraged the resident to put his/her legs up to relieve the pain before administering pain medications. Interview on 02/22/16 at 3:32 P.M. administrative nursing staff E stated staff encouraged the resident to lay down and rest, and to elevate his/her feet before administration of pain medications. Nurse E further stated the care plan should include these interventions. Interview on 02/22/16 at 3:54 P.M. administrative nursing staff D expected staff to attempt non-medication interventions for pain before administering the pain medications, and expected those interventions to be on the care plan. He/she	F 329			

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F 329	Continued From page 14 expected all black box warnings to be on the resident's care plan. The facility policy "Guidelines for Black Box Warning Medications", reviewed 10/26/11, revealed medications with a black box warning should be listed within the resident's chart. The facility policy "Pain Management Guideline", revised January 2011, documented non-drug interventions should be used to assist in pain management. The facility failed to ensure this resident was free from unnecessary medications when staff failed to offer non-pharmacological interventions for pain management prior to administration of pain medications. The facility also failed to include the Black Box Warning information for Plavix on resident #37's care plan.	F 329			
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: The facility identified a census of 59 residents.	F 428			

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OMB NO. 0938-0391

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F 428	<p>Continued From page 15</p> <p>The sample was 17 residents with 5 residents sampled for medication reviews. Based on observation, record review, and interview, the facility failed to ensure the consultant pharmacist identified irregularities (failure to offer non-pharmacological interventions for pain prior to administration of pain medications and failure to include Black Box Warning information on the resident's care plan) for 1 of 5 sampled residents. (#37)</p> <p>Findings included:</p> <ul style="list-style-type: none"> - The signed Physician's Order Sheet (POS) dated 1/16/16 for resident #37 documented diagnoses of schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought) and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). <p>The Significant Change Minimum Data Set (MDS) dated 1/25/16 noted a Brief Interview for Mental Status (BIMS) of 13 (12 to 15 indicated intact cognition), was independent with all Activities of Daily Living (ADLs) and denied pain.</p> <p>The Care Area Assessments (CAAs) dated 1/25/16 documented the resident was at risk for cognitive loss due to a decline in physical ability related to a recent heart attack (a sudden and sometimes fatal occurrence of a blood clot in the artery of the heart) and for falls. The CAA for pain did not trigger.</p> <p>The care plan dated 2/15/16 noted staff encouraged the resident to voice feelings about his/her family. It lacked the black box warning for Plavix and lacked non-medication interventions</p>	F 428			

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F 428	<p>Continued From page 16 for pain.</p> <p>A physician's order dated 8/7/13 noted an order for Tylenol 650 milligrams (mg) or 1000 mg every 4 hours as needed for pain.</p> <p>A physician's order dated 7/2/14 noted an order for Tramadol 50 mg every 8 hours as needed for pain.</p> <p>A physician's order dated 1/16/16 noted an order for Plavix 75 mg daily to prevent blood clots.</p> <p>The Medication Administration Records (MARs) for January 2016 and February 2016 documented the resident received Plavix every day since 1/16/16. They noted the resident received Tylenol on 1/10/16, 1/14/16, 1/22/16, 2/3/16, 2/4/16, 2/6/16, and 2/18/16, and received Tramadol on 1/19/16, 1/26/16, 2/10/16, and 2/11/16. The resident received these medications for leg pain.</p> <p>The clinical record failed to note evidence of non-medication interventions for pain attempted before the pain medication was administered.</p> <p>The pharmacy consultant medication reviews dated 1/31/15, 2/18/15, 3/20/15, 4/24/15, 5/20/15, 6/30/15, 7/22/15, 8/31/15, 9/29/15, 10/30/15, 11/29/15, 12/29/15, and 1/25/16 failed to address the need for non-medication interventions for pain or inclusion of the Black Box Warning information in the resident's care plan.</p> <p>According to the Food and Drug Administration, the black boxed warning for Plavix directed health professionals to monitor patients for slow metabolism of the medication, decreasing the medication's effectiveness.</p>	F 428			

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F 428	<p>Continued From page 17</p> <p>Observation on 2/22/16 at 2:55 P.M. the resident asked for pain medication. Staff assessed the resident, but did not suggest or provide non-medication interventions before administering the pain medication.</p> <p>Interview on 02/22/16 at 3:32 P.M. administrative nursing staff E stated staff encouraged the resident to lay down and rest, and to elevate his/her feet before administration of pain medications. Nurse E further stated the care plan should include these interventions.</p> <p>Interview on 02/22/16 at 3:54 P.M. administrative nursing staff D expected staff to attempt non-medication interventions for pain before administering the pain medications, and expected those interventions to be on the care plan. He/she expected all black box warnings to be on the resident's care plan.</p> <p>Interview on 02/23/16 at 11:01 A.M. pharmacy consultant KK stated he/she reviewed the resident's care plan for black box warnings and for non-medication interventions for pain if they were pertinent to the resident.</p> <p>The facility policy "Guidelines for Black Box Warning Medications", reviewed 10/26/11, revealed medications with a black box warning should be listed within the resident's chart.</p> <p>The facility policy "Pain Management Guideline", revised January 2011, documented non-drug interventions should be used to assist in pain management.</p> <p>The facility failed to ensure the consultant</p>	F 428			

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F 428	Continued From page 18	F 428			
F 441 SS=F	<p>pharmacist identified drug irregularities (failure to offer non-pharmacological pain interventions prior to administration of pain medications and failure to include Black Box Warning information for Plavix in the nursing care plan) for resident #37.</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(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.</p> <p>(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.</p>	F 441			

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F 441	<p>Continued From page 19</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: The facility identified a census of 59 residents. Based on observation, record review and staff interview, the facility failed to utilize precautions to minimize transmission of infection within the facility while distributing ice to residents.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Observation on 02/17/2016 at 2:12 PM direct care staff P passed ice to residents. The residents brought their cup from their room to staff to be filled with ice. He/she filled a resident's cup, setting the ice scoop on the edge of the cup, and pressed the ice down into the cup with the back of the ice scoop. Staff P then used the same scoop to obtain ice for the next resident after contaminating the scoop on the edge of the previous resident's cup. He/she stated he/she was taught to do it in that manner. <p>Observation on 02/18/2016 at 8:25 AM direct care staff Q passed ice to residents. He/she filled the ice in a resident's cup setting the ice scoop on the edge of the cup, and pressed the ice down with the back of the ice scoop in the same manner as the previous observation. Staff Q stated he/she didn't remember how he/she was taught to pass ice.</p> <p>Interview on 02/22/2016 at 1:51 PM nursing staff</p>	F 441			

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F 441	<p>Continued From page 20</p> <p>H stated staff should use the scoop to fill ice into the residents' glasses/cups without touching the glass/cup. Staff should not press the ice down with the scoop.</p> <p>Interview on 02/22/2016 at 3:57 PM administrative nursing staff D stated all staff received in-services about infection control throughout the year. He/she expected staff not to set the ice scoop on the edge of the residents' personal cups.</p> <p>The facility policy "Handling Ice" dated 2/12/15 noted ice should be handled in a manner to avoid cross contamination.</p> <p>The facility failed to pass the ice to the residents in a manner that prevented the spread of infection.</p>	F 441			