

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

PRINTED: 02/25/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/25/2016
NAME OF PROVIDER OR SUPPLIER GRISELL MEMORIAL HOSPITAL LTCU			STREET ADDRESS, CITY, STATE, ZIP CODE 210 S VERMONT RANSOM, KS 67572		
(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 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p>	F 157			

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 157	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: The facility had a census of 22 residents. The sample included 8 residents, of which 3 residents were reviewed for accidents/falls. Based on observation, record review and interview the facility failed to notify the physician for 1 of 3 sampled residents, who had an injury with pain and scheduled pain medications not available. (#27)</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident #27's admission (MDS) Minimum Data Set assessment, dated 02/10/16, indicated the resident understands, usually understood, and had moderately impaired cognition. The MDS also indicated the resident required extensive assistance with transfers, functional limitation of (ROM) range of motion for both upper and lower extremities, and impaired balance that required human assistance to stabilize. The MDS further indicated the resident received oxygen therapy and had shortness of breath with exertion or while sitting at rest. <p>The 02/01/16 admission care plan indicated the resident was alert and oriented and able to make his/her needs known. The care plan also indicated the resident was a fall risk related to unsteady gait, weakness and history of falls at home. The care plan directed 2 staff to assist the resident with transfers.</p> <p>The 02/01/16 admission physician orders for pain medications included the following: Fentanyl Patch (narcotic pain medication used to manage chronic moderate to severe pain) 100</p>	F 157			

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F 157	<p>Continued From page 2</p> <p>(mcg) micrograms an hour, change every 48 hours for pain.</p> <p>Oxycodone (narcotic pain medication for moderate to severe pain) 5/325 (mg) milligram every 6 hours prn for pain.</p> <p>The 02/01/16 at 1:45 PM, nurse's note indicated the resident arrived at the facility with a family member and staff would perform a complete skin assessment tomorrow, when the resident showers.</p> <p>The facility's 02/01/16 admission skin assessment indicated the resident had a 4 (cm) centimeter purple, red and brownish bruise on his/her right hip. Continued review of the resident's skin assessment revealed no documentation of other bruises.</p> <p>The facility's 02/01/16 Physician's Admission History and Assessment indicated the resident had bilateral lower leg edema and was not able to walk due to arthritis in both knees. The assessment also indicated the resident had an abrasion and bruising on his/her left hand. Continued review of the physician's assessment revealed no documentation the resident had other skin issues.</p> <p>The 02/01/16 at 6:50 PM, nurse's note indicated staff found the resident seated on the floor near his/her bed with the call light next to the resident's hand. The nurse's note indicated the resident was unable to raise his/her arms and complained of left shoulder pain.</p> <p>The facility's 02/01/16 Physical Assessment Following Fall Form indicated staff assessed the resident had limited ROM of his/her left shoulder</p>	F 157			

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F 157	<p>Continued From page 3 and complained of left shoulder pain.</p> <p>The 02/02/16 at 4:45 PM, nurse's note indicated staff assessed a large, deep purple bruise on the resident's left upper arm and the resident complained of left arm pain. The nurse's note indicated the resident's family had not brought the resident's Fentanyl patches, when the resident was admitted.</p> <p>The 02/02/16 at 8:28 PM, nurse's note indicated the resident kept his/her eyes closed and refused to respond when staff asked the resident about pain from the fall.</p> <p>The 02/03/16 at 6:10 PM, nurse's note indicated the resident complained of left shoulder pain and staff reported the large purple bruise on the resident's left upper arm was not present when the resident was admitted. The note also indicated the family delivered the resident's Fentanyl patches.</p> <p>Review of the resident's medical record revealed no documentation the staff notified the physician of the resident's complaints of pain and decreased arm and shoulder range of motion</p> <p>The 02/04/16 at 8:56 AM, nurse's note indicated staff received a verbal physician's order to x-ray the resident's left arm due to acute pain (approximately 62 hours after the resident's fall).</p> <p>The 02/04/16 at 8:56 AM, physician's order directed staff to get a STAT (immediate) x-ray of the resident's left humerus due to left upper arm pain.</p> <p>The 02/04/16 radiology report indicated staff</p>	F 157			

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F 157	<p>Continued From page 4</p> <p>x-rayed the resident's left upper arm due to increased pain and bruising and the x-ray diagnosed a comminuted humeral neck fracture.</p> <p>The 02/04/16 at 11:35 AM, nurse's note indicated staff assessed large, dark purple bruising on the resident's left upper arm and left upper torso.</p> <p>The 02/04/16 Physician Progress Note indicated the resident had a fall a couple days ago and was seen today for left upper arm pain and bruising. The note indicated the resident had an impacted, comminuted fracture of the left humeral head. The note also indicated the physician ordered a sling placed on the resident's left arm to immobilize and treat the fracture. The note further indicated the resident used Fentanyl patches every 48 hours for pain.</p> <p>Review of the February 2016 (MAR) Medication Administration Record revealed the resident's Fentanyl patch was not available on 02/01/16, 02/02/16, 02/03/16 and not administered until 02/05/16 (4 days after the fall). The MAR also indicated staff administered Oxycodone 5/325 (mg) milligrams, every 6 hours as needed for pain, to the resident 1 time on 02/02/16, 3 times on 02/03/16 and 4 times on 02/04/16.</p> <p>On 02/18/16 at 10:52 AM, observation revealed the resident, seated in a wheelchair, in his/her room with oxygen in place per nasal cannula (nose piece) and left arm in a sling. Continued observation revealed Medication Aide G administered a scheduled breathing treatment. Continued observation revealed the resident had facial grimaces and complained of left shoulder pain.</p>	F 157			

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F 157	<p>Continued From page 5</p> <p>On 02/22/16 at 10:06 AM, Nurse Aide B stated the resident had a fall shortly after admission, had large, dark purple bruises on his/her left upper arm and shoulder and frequently complained of left arm and shoulder pain, especially with movement. Nurse Aide H also stated the resident now has a sling to immobilize his/her left arm and continued to complain of pain daily.</p> <p>On 02/22/16 at 2:02 PM. Nurse E stated the resident had a fall in his/her room several hours after he/she was admitted and staff assessed the resident with pain and limited range of motion in his/her left arm. Nurse E stated staff reported the resident had large bruises on his/her left upper arm and continued to have left arm and shoulder pain. Nurse E stated staff notified the physician concerning the resident's arm pain and bruising, several days after the fall and the physician ordered an x-ray. Nurse E stated the physician ordered a sling to immobilize the resident's arm, after he/she was diagnosed with left humerus fracture. Nurse E further stated the resident's Fentanyl patch for pain was not available for 3 days after the fall and staff had not notified the physician.</p> <p>On 02/23/16 at 8:45 AM, Physician J stated staff reported the resident had a fall several hours after admission and the resident had no injuries that required medical attention. Physician J stated, several days after the fall, staff reported the resident had significant arm and shoulder pain, and he/she ordered an x-ray. Physician J stated the resident was diagnosed with a comminuted humerus fracture, a sling was ordered to immobilize the arm and the resident had scheduled and (prn) as needed pain medications. Physician J further stated staff had</p>	F 157			

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F 157	Continued From page 6 not notified him/her the resident's Fentanyl patch was not available, for several days after the resident's fall. On 02/23/16 at 2:17 PM, Nurse F stated staff should have reported the resident's large bruises and arm pain to the physician sooner and notified the physician, when the resident's pain medications were not available. The facility's October 2015 Post Injury Policy and Procedure directed staff to assess and document the resident's injuries and notify the physician promptly for orders to care for the resident. The policy also directed the staff to notify the physician, if the resident had changes or worsening of the injuries or pain. The facility failed to notify the physician of Resident #27's injury with pain and scheduled medications not available for pain control.	F 157			
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility had a census of 22 residents. The sample included 8 residents, of which 3 residents were reviewed for accidents/falls. Based on	F 323			

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F 323	<p>Continued From page 7</p> <p>observation, record review and interview the facility failed to develop and implement timely and effective interventions to prevent falls for 2 of 3 residents sampled for falls. Resident #27 fell within hours of admission to the facility and sustained, a comminuted (a break or splinter of the bone into two or more fragments, fractures of this degree occur after high impact trauma) fracture of the left humeral head (bone of the upper arm). Resident #11 fell from a toilet and sustained head injury that required stitches, when staff failed to provide adequate supervision and support.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - The 02/01/16 Physician's Order Sheet indicated Resident #27 had the following diagnoses: chronic pain (persistent or constant pain), depression (abnormal emotional state characterized by exaggerated feelings of sadness and hopelessness) and anxiety (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) <p>Resident #27's admission (MDS) Minimum Data Set assessment, dated 02/10/16, indicated the resident had moderately impaired cognition. The MDS also indicated the resident required extensive assistance with transfers, functional limitation of (ROM) range of motion for both upper and lower extremities, and impaired balance that required human assistance to stabilize.</p> <p>The 02/01/16 admission care plan indicated the resident was alert and oriented and able to make his/her needs known. The care plan also indicated the resident was a fall risk related to</p>	F 323			

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F 323	<p>Continued From page 8</p> <p>unsteady gait, weakness and history of falls at home. The care plan directed 2 staff to assist the resident with transfers. The care plan lacked interventions to prevent falls for this newly admitted resident.</p> <p>The 02/01/16 at 1:45 PM, nurse's note indicated the resident arrived at the facility with a family member.</p> <p>The facility's 02/01/16 Physician's Admission History and Assessment indicated the resident was not able to walk due to arthritis in both knees.</p> <p>The 02/01/16 at 6:50 PM, nurse's note indicated staff found the resident seated on the floor near his/her bed with the call light next to the resident's hand. The nurse's note indicated the resident was unable to raise his/her arms and complained of left shoulder pain.</p> <p>The facility's 02/01/16 Physical Assessment Following Fall Form indicated staff assessed the resident had limited ROM of his/her left shoulder and complained of left shoulder pain.</p> <p>The 02/02/16 at 4:45 PM, nurse's note indicated staff assessed a large, deep purple bruise on the resident's left upper arm and the resident complained of left arm pain.</p> <p>The 02/03/16 at 6:10 PM, nurse's note indicated the resident complained of left shoulder pain and staff reported the large purple bruise on the resident's left upper arm was not present when the resident was admitted.</p> <p>Review of the resident's medical record revealed</p>	F 323			

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F 323	<p>Continued From page 9</p> <p>no documentation the staff notified the physician of the resident's complaints of pain and decreased arm and shoulder range of motion</p> <p>The 02/04/16 at 8:56 AM, nurse's note indicated staff received a verbal physician's order to x-ray the resident's left arm due to acute pain (approximately 62 hours after the resident's fall).</p> <p>The 02/04/16 at 8:56 AM, physician's order directed staff to get a STAT (immediate) x-ray of the resident's left humerus due to left upper arm pain.</p> <p>The 02/04/16 radiology report diagnosed a comminuted humeral neck fracture.</p> <p>The 02/04/16 Physician Progress Note indicated the resident had a fall a couple days ago and was seen today for left upper arm pain and bruising. The note indicated the resident had an impacted, comminuted fracture of the left humeral head. The note also indicated the physician ordered a sling placed on the resident's left arm to immobilize and treat the fracture.</p> <p>On 02/18/16 at 10:52 AM, observation revealed the resident, seated in a wheelchair, with his/her left arm in a sling. Continued observation revealed the resident had facial grimaces and complained of left shoulder pain.</p> <p>On 02/22/16 at 10:06 AM, Nurse Aide B stated the resident had a fall shortly after admission, had large, dark purple bruises on his/her left upper arm and shoulder and frequently complained of left arm and shoulder pain, especially with movement. Nurse Aide H also stated the resident now had a sling to immobilize his/her left arm and</p>	F 323			

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F 323	<p>Continued From page 10 continued to complain of pain daily.</p> <p>On 02/22/16 at 2:02 PM. Nurse E stated the resident had a fall in his/her room several hours after he/she admitted and staff assessed the resident with pain and limited range of motion in his/her left arm. Nurse E stated staff reported the resident had large bruises on his/her left upper arm and continued to have left arm and shoulder pain. Nurse E stated staff notified the physician concerning the resident's arm pain and bruising, several days after the fall and the physician ordered an x-ray. Nurse E stated the physician ordered a sling to immobilize the resident's arm, after he/she was diagnosed with left humerus fracture.</p> <p>On 02/23/16 at 8:45 AM, Physician J stated staff reported the resident had a fall several hours after admission and the resident had no injuries that required medical attention. Physician J stated, several days after the fall, staff reported the resident had significant arm and shoulder pain, and he/she ordered an x-ray. Physician J stated the resident had a comminuted humerus fracture. Physician J stated he/she ordered, a sling to immobilize the arm and the resident had scheduled and (prn) as needed pain medications.</p> <p>On 02/23/16 at 2:17 PM, Nurse F stated staff was aware the resident had a history of falls at home and was agitated and unhappy about admission to the facility. Nurse F stated staff should not have left the resident unsupervised in his/her room, hours after admission, without adequate safety interventions.</p> <p>The facility's October 2015 Post Injury Policy and Procedure directed staff to assess and document</p>	F 323			

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F 323	<p>Continued From page 11</p> <p>the resident's injuries and notify the physician promptly for orders to care for the resident. The policy also directed the staff to notify the physician, if the resident had changes or worsening of the injuries or pain.</p> <p>The facility failed to develop and implement timely and appropriate interventions to prevent falls for Resident #27, who fell and sustained a comminuted fracture of the left humeral head.</p> <p>- Resident #11's (POS) Physician Order Sheet, dated 2/1/16, indicated diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), arthritis (inflammation of a joint characterized by pain, swelling, heat, redness and limitation of movement), and general pain.</p> <p>The quarterly (MDS) Minimum Data Set assessment, dated 9/23/15, indicated the resident rarely understood, had short/long term memory loss, inattention, disorganized thinking, altered level of consciousness, psychomotor retardation (involves a slowing-down of thought and a reduction of physical movements in an individual), and severe cognitive impairment. The MDS indicated the resident required extensive assistance of 2 staff with transfers, and total assistance with eating, personal hygiene, bathing, bed mobility, dressing and toileting. The MDS indicated the resident's balance was unsteady, unable to stabilize without assistance, had (ROM) Range of Motion impairment in all extremities and used a wheelchair for mobility. The MDS indicated the resident was frequently incontinent of urine, occasionally incontinent of bowel, and</p>	F 323			

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F 323	<p>Continued From page 12 had no falls.</p> <p>The annual MDS, dated 12/2/15, indicated the same.</p> <p>The 12/10/15 care plan indicated the resident had Alzheimer's disease, spoke few words, was rarely understood, had eyes closed most of the time and difficulty staying awake. The care plan stated the resident's posture was poor, held his/her head downward, and used a Geri chair (specialized recliner with wheels) for mobility and positioning. The care plan directed staff to toilet the resident upon rising and every 2 hours, provide extensive assistance of 2 staff with gait belt for pivot transfers to bed.</p> <p>The 1/20/16 care plan update directed staff to ensure 2 staff were with the resident at all times when he/she was in the bathroom.</p> <p>The 2/4/16 care plan update directed staff to toilet the resident when alert, may check and change the resident if lethargic (drowsy).</p> <p>The 1/18/15 Bowel and Bladder assessment stated the resident was incontinent of bowel and bladder, required extensive to total staff assistance with transfers and toileting, due to poor balance and coordination related to Alzheimer's disease. Recommendations included staff to place the resident on the toilet upon rising and every 2 hours during the day.</p> <p>The 1/20/16 fall assessment form indicated, on 1/20/16 at 11:00 AM, the resident had a witnessed fall. The form stated Nurse Aide A, during incontinence care for the resident, who was on the toilet, reached for more moistened wipes and the resident slid off the toilet, hitting his/her head on the floor. Injuries from the fall</p>	F 323			

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F 323	<p>Continued From page 13</p> <p>included knocking out a tooth, and a 4.5 cm by 2.5 (cm) centimeter laceration to his/her right forehead. The form stated the staff notified the physician and the physician gave orders to transfer the resident to the (ER) emergency room. The form indicated the post fall intervention directed staff to ensure 2 staff were with the resident while in the bathroom.</p> <p>The 1/20/16 physician's progress note stated the resident had a fall with head laceration (a deep cut or tear in skin or flesh), which required 7 stitches.</p> <p>The 1/21/16 Risk Management tool stated one staff had the resident leaning forward during incontinence care, and the resident fell forward off the toilet, when the staff reached for more wipes. The notes indicated a second staff member had left the room shortly before, to get clean clothes for the resident. The form indicated the standard of care was not met, with injury.</p> <p>The 1/13/16 at 11:50 AM monthly nursing summary stated the resident required extensive assistance with all (ADL) activities of daily living, 2 staff assistance for pivot transfers, on a toileting schedule, and the resident usually keeps his/her eyes closed.</p> <p>The 1/20/16 at 11:00 AM nurse's note stated staff called the nurse to the east hall bathroom where the resident was lying on his/her right side, on the floor, in front of the sink/toilet. The note stated there was blood and (BM) bowel movement on the floor and the nurse aide was holding the resident's right forehead/brow area. The note stated staff cleaned the resident and assisted him/her onto the gurney for transport to the ER.</p>	F 323			

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F 323	<p>Continued From page 14</p> <p>On 2/18/16 at 9:10 AM, observation revealed the resident seated in a Geri chair, near the nurse's station. The resident did not respond to verbal stimulus.</p> <p>On 2/18/16 at 11:05 AM, observation revealed Nurse Aides B and C checked the resident for incontinence. Further observation revealed the aides assisted the resident to sit up at the edge of the bed and applied a gait belt. Staff transported the resident to the hall bathroom, assisted him/her to stand/pivot onto the toilet, and remained in the bathroom with the resident. Staff provided support/balance to the resident, as needed. During the observation, the resident did not respond verbally, made no attempt to participate in care, and did not open his/her eyes. After toileting, 2 staff assisted the resident to transfer from the toilet to the Geri chair.</p> <p>On 2/18/16 at 10:20 AM, Nurse Aide D stated the resident required extensive to total staff assistance with all ADLs and 2 staff assistance with gait belt for transfers. He/she stated the resident was unable to support him/her when sitting, most of the time due to lethargy and upper body weakness. Nurse Aide D stated staff check the resident throughout the day for incontinence and toilet as needed. Nurse Aide D stated 2 staff transfer the resident while another staff person moves the Geri chair. Nurse Aide D stated 2 staff provide toileting related to the resident's impaired cognition and mobility, fall risk and unsafe without support during cares.</p> <p>On 2/18/16 at 11:05 AM, Nurse Aide B and Nurse Aide C stated the resident required extensive to total staff assistance with all ADLs, 2 staff</p>	F 323			

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F 323	<p>Continued From page 15</p> <p>assistance with transfers. Nurse Aide B and Nurse Aide C stated the resident did not participate in cares and was unable to sit up without support at times due to lethargy and upper body weakness. Nurse Aide B and Nurse Aide C stated 2 staff remain in the bathroom to support the resident while toileting and providing incontinence care.</p> <p>On 2/23/16 at 9:35 AM, Nurse Aide A stated he/she and another nurse aide transported the resident to the hall bathroom to toilet the resident. Nurse Aide A stated the resident was incontinent of a large loose BM and the other nurse aide left the bathroom to get more wipes and a change of clothing for the resident. Nurse Aide A stated he/she continued to clean the resident with one hand, while placing the other hand on the resident 's shoulder to support him/her. Nurse Aide A stated the resident was leaning forward to access and clean the resident's lower back and buttocks, when he/she removed his/her hand from the resident's shoulder to grab more wipes. Nurse Aide A stated the resident fell forward, off the toilet and hit the floor with his/her head. Nurse Aide A stated currently staff always transfer the resident with 2 staff due to the resident does not participate in care and staff must position/move his/her extremities.</p> <p>On 2/23/16 at 10:12 AM, Nurse E verified the resident required extensive to total staff assistance with all ADLs, 2 staff for transfers. Nurse E stated staff provide scheduled toileting every 2-3 hours.</p> <p>On 2/23/16 at 2:02 PM, Administrative Nurse F stated the resident did not participate in cares, and required extensive to total staff assistance</p>	F 323			

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

PRINTED: 02/25/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/25/2016
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F 323	Continued From page 16 with all ADLs. Administrative Nurse F stated the resident was not able to support him/herself while on the toilet without staff assistance. Administrative Nurse F verified the resident fell off a toilet and sustained a head injury. The facility did not provide a fall policy. The facility failed to provide adequate supervision and support, as planned, to prevent a fall for Resident #11, who leaned forward on the toilet, without staff support, fell to the floor, and required emergency services and stitches for a head injury.	F 323			
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425			

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F 425	<p>Continued From page 17</p> <p>This REQUIREMENT is not met as evidenced by: The facility had a census of 22 residents. The sample included 8 residents, of which 5 residents were reviewed for medications. Based on observation, record review and interview the facility failed to provide scheduled medications as ordered by the physician for 1 of 5 sampled residents. (#27)</p> <p>Findings Included:</p> <ul style="list-style-type: none"> - Resident #27's admission (MDS) Minimum Data Set assessment, dated 02/10/16, indicated the resident understands and usually understood, and had moderately impaired cognition. The MDS indicated the resident received scheduled and (prn) as needed pain medications for almost constant severe pain. The MDS also indicated the resident received oxygen therapy, had shortness of breath with exertion or while sitting at rest. The MDS further indicated the resident received antidepressant and anti-anxiety medications 7 days a week. <p>The 02/01/16 admission care plan indicated the resident had chronic knee and back pain and directed staff to provide routine pain assessments and administer pain medications as ordered by the physician. The care plan also indicated the resident had (SOB) shortness of breath with activity and received continuous oxygen and breathing treatments.</p> <p>The 02/01/16 admission physician orders for medications included the following: Fentanyl Patch (narcotic pain medication used to manage chronic moderate to severe pain), 100</p>	F 425			

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F 425	<p>Continued From page 18</p> <p>(mcg) micrograms an hour, change every 48 hours for chronic pain</p> <p>Metoprolol (blood pressure medication), 37.5 (mg) milligrams. twice a day for high blood pressures</p> <p>Nortriptyline (antidepressant medication), 25 mg, twice a day for anxiety</p> <p>Duoneb breathing treatment (obstructive airway medication) 0.5/2.5 mg every 4 hours while awake for (COPD) Chronic Obstructive Pulmonary Disease</p> <p>The 02/02/16 at 4:45 PM, nurse's note indicated the resident's family had not brought the resident's scheduled Fentanyl patch, Metoprolol, Nortriptyline and Duoneb breathing treatment, when the resident was admitted.</p> <p>Review of the resident's medical record revealed no documentation staff notified the physician concerning scheduled medications not available to the resident.</p> <p>The 02/02/16 at 8:00 PM, nurse's note indicated staff reported the resident had agitated behaviors and anxiety, that hopefully will decrease when family brings in medications tomorrow.</p> <p>The 02/03/16 at 6:10 PM, nurse's note indicated the resident's family brought in the resident's medications and staff was hopeful the resident's mood would improve, when medication regimen was back to routine.</p> <p>Review of the February 2016 (MAR) Medication Administration Record revealed the following: 02/01/16 to 02/03/16 - Metoprolol (5 missed doses) 02/01/16 to 02/03/16 - Nortriptyline (5 missed</p>	F 425			

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F 425	<p>Continued From page 19 doses) 02/01/16 to 02/03/16 - Duoneb breathing treatment (10 missed doses) 02/01/16 to 02/03/16 - Fentanyl Patch (administered 02/05/16, missed 2 doses)</p> <p>On 02/18/16 at 10:52 AM, observation revealed the resident, seated in a wheelchair, in his/her room with oxygen in place per nasal cannula (nose piece) and left arm in a sling. Continued observation revealed Medication Aide G administered a scheduled breathing treatment. Continued observation revealed the resident had facial grimaces and complained of left shoulder pain.</p> <p>On 02/23/16 at 8:45 AM, Physician J stated staff had not notified him/her concerning the resident not having scheduled medications available for 3 days or he could have taken care of the situation. Physician J stated the facility policy directed staff to notify the physician if medications were not available.</p> <p>On 02/23/16 at 2:17 PM, Nurse J stated staff should have notified the physician concerning 4 of the resident's scheduled medications not available.</p> <p>The facility failed to provide scheduled medications as ordered by the physician for Resident #27.</p>	F 425			