

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

PRINTED: 07/20/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175537	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/20/2016
NAME OF PROVIDER OR SUPPLIER HAYS MEDICAL CENTER LTCU			STREET ADDRESS, CITY, STATE, ZIP CODE 2220 SW CANTERBURY DRIVE HAYS, KS 67601		
(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 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: The facility reported a census of 5 residents, with 3 residents in the sample. Based on observation, interview and record review, the facility failed to develop an individualized comprehensive plan of care for 3 of 3 residents sampled. (#1, #2, #3)</p> <p>Findings included:</p>	F 279			

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 279	Continued From page 1 - Review of the medical record revealed the facility admitted Resident #1 on 5/28/16. The physician's orders for Resident #1 included the following medical diagnoses: lumbar burst fracture (a traumatic injury to the spine in which a vertebra breaks, with sharps of vertebra penetrating the surrounding tissue and/or the spinal canal), pneumocystis (a serious respiratory infection that often affects people with compromised immune systems), sepsis due to enterococcus (the presence of harmful bacteria - enterococcus and their toxins, usually found in a wound), candida stomatitis (yeast infection in the mouth), cutaneous abscess of the back (collection of pus in the skin), herpes viral keratitis (viral infection of the eye), rheumatoid arthritis (chronic inflammatory disease that affected joints and other organ systems, hypertension (elevated blood pressure, and insomnia (inability to sleep). The admission (MDS) Minimum Data Set assessment, dated 6/8/16, indicated the resident had intact cognition, required limited to extensive assistance of 1 for (ADLs) Activities of Daily Living and ambulation, on a pain management program, and received scheduled and as needed pain medications following surgery. The MDS further indicated the resident had a pressure reducing device in his/her chair, and received (PT) Physical Therapy and (TO) Occupational Therapy Services. The 6/7/16 (ADL) Activities of Daily Living (CAA)	F 279			

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F 279	<p>Continued From page 2</p> <p>Care Area Assessment stated the facility admitted the resident after a fall at home which resulted in a lumbar burst fracture. He/she required assistance with daily cares and mobility, due to weakness and pain from the fractures. The resident participates in therapy and continues to make progress.</p> <p>The 6/11/16 care plan provided basic information to staff, which included a problem for pain and stated as a goal, the resident would report pain at a tolerable level. The pain care plan lacked evidence of interventions to direct staff on basic cares and pain management.</p> <p>On 7/6/16 at 2:54 PM, Nurse Aide F stated the aides did not have an (ADL) Activities of Daily Living worksheet, which directed resident care. Nurse Aide F stated they receive report at the beginning of the shift and the nurse in charge provided the direct care information needed. Nurse Aide F stated, he/she initialed completion of tasks on the computer.</p> <p>On 7/6/16 at 4:23 PM, Nurse G verified the information stated by Nurse Aide F and provide the report sheet to view. The report sheet listed the resident with basic transfer information, but lacked information for complete care of the resident.</p> <p>On 7/6/16 at 5:10 PM, Nurse H verified the care plans lacked direct care interventions, and listed goals appropriate for post-operative care, not long term rehabilitative care.</p> <p>The facility's Care Plan policy and procedure, dated 8/27/13, stated a care plan addressing the</p>	F 279			

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F 279	<p>Continued From page 3</p> <p>needs of the residents will be developed to consider care involving nursing, social services, activities, therapy, and the physician. The nurse initiated the plan of care upon admission to the facility. The plan is initiated within 2 hours of admission.</p> <p>The facility failed to develop an individualized, comprehensive plan of care for immediate care with ADLs and rehabilitation following surgical repair of a lumbar burst fracture, placing the Resident #1 at risk for increased pain, infection, and decline in ADLs.</p> <p>- Resident #2's physician order sheet, dated 6/14/16 , indicated the following diagnoses: (MRSA) methicillin resistant staphylococcus aureus (drug resistant harmful bacteria) septicemia (invasion of harmful bacteria into the bloodstream), and in the sputum, rheumatoid arthritis (a chronic disease causing inflammation in the joints and results in painful deformity and immobility)of multiple sites, chronic systolic heart failure (the muscle on the left side of the heart is weak and enlarged), diabetes mellitus (disease associated with abnormally high levels of sugar glucose in the blood) and (COPD) chronic obstructive pulmonary disease (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing).</p> <p>The admission (MDS) Minimum Data Set assessment, dated 6/20/16, indicated the resident had intact cognition, required limited assistance of 1 for (ADLs) Activities of Daily Living and ambulation, had a stage 2 pressure ulcer (injury to the skin over a bony prominence) and a</p>	F 279			

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F 279	<p>Continued From page 4</p> <p>diabetic foot ulcer (injury to the skin related to the diabetes), with a pressure reducing device for his/her chair, and received an antibiotic for 6 days of the observation period.</p> <p>The 6/26/16 (ADL) Activities of Daily Living (CAA) Care Area Assessment stated the facility admitted the resident for therapy services and intravenous antibiotics following hospitalization for sepsis after a cardiac procedure, foot wounds, and he/she required assistance with daily cares and mobility.</p> <p>The 6/14/16 care plan provided basic information to staff which included the following problems, goals, and interventions:</p> <p>Impaired Mobility - goals listed, with non-specific interventions, which do not inform the aides on the level of help and equipment needed for completion of the resident's (ADLs) Activities of Daily Living,</p> <p>Altered urinary elimination - goals listed, with non-specific interventions, which direct the staff to establish a toileting schedule, evaluate the bladder for distention, institute a voiding schedule, and implement a urinary elimination program. No documentation of a toileting plan or urinary elimination program.</p> <p>Pain - goals listed, with interventions that did not specify specific instruction for pain management or monitoring for the side effects, or effectiveness of medications.</p> <p>Altered thought processes - goals listed, with non-specific interventions requiring a more</p>	F 279			

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F 279	<p>Continued From page 5</p> <p>specific direction, related to monitoring for side effects of medication and changes in mental status.</p> <p>High risk for falls - goals listed, with an intervention to keep call light within reach.</p> <p>Review of the care plan information revealed the information/tasks are mentioned as possible goals for the resident, and none of the problem areas provided specific care interventions based on the resident's assessment of needs such as: describing how to transfer the resident, providing scheduled toileting and/or incontinence care, skin care to provide and how often, pain management, possible medication side effects and monitoring the effectiveness of medication.</p> <p>On 7/6/16 at 2:54 PM, Nurse Aide F stated the aides did not have an (ADL) Activities of Daily Living worksheet, which directed resident care. Nurse Aide F stated they receive report at the beginning of the shift and the nurse in charge provided the direct care information needed. Nurse Aide F stated, he/she initialed completion of tasks on the computer.</p> <p>On 7/6/16 at 4:23 PM, Nurse G verified the information stated by Nurse Aide F and provide the report sheet to review. The report sheet listed the resident with basic transfer information, but lacked information for complete care of the resident.</p> <p>On 7/6/16 at 5:10 PM, Nurse H verified the care plans lacked direct care interventions, and listed goals appropriate for post-operative care, not long term rehabilitative care.</p>	F 279			

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F 279	<p>Continued From page 6</p> <p>The facility 's Care Plan policy and procedure, dated 8/27/13, stated a care plan addressing the needs of the residents will be developed to consider care involving nursing, social services, activities, therapy, and the physician. The nurse initiated the plan of care, within 2 hours of admission, to the facility.</p> <p>The facility failed to develop an individualized, comprehensive plan of care for immediate care with ADLs and rehabilitation following a major infection with a drug resistant bacteria, placing Resident #2 at risk for increased discomfort, re-infection, and decline in ADLs</p> <p>- Resident #3's (POS) Physician Order Sheet revealed the facility admitted the resident on 6/24/16, with diagnoses of: left hip fracture (a break in the upper quarter of the femur (thigh) bone, osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), and osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain) of left hip.</p> <p>The admission (MDS) Minimum Data Set assessment, was not completed at the time of the investigation.</p> <p>The 6/25/16 care plan provided basic information to staff which included the following problems, goals, and interventions:</p> <p>Impaired skin integrity: goals listed, intervention stated related to surgical repair of the hip, immediately following the surgery.</p>	F 279			

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F 279	Continued From page 7 Pain: goals listed, intervention included a patient controlled analgesic pump, and non-medication pain reducing techniques High risk for post-operative complications - goals listed, interventions included monitoring for signs of infection, post-operative vital signs, fluid balance, and signs of oxygen depletion. Activity intolerance - goals listed, with non-specific interventions to perform range of motion exercises. Impaired mobility - goals listed, stated resident could turn and reposition him/herself, and to encourage the resident to express his/her feelings, with no further individualization. Altered thought processes - goal listed, with non-specific interventions for behavioral assessment and to assess the level of consciousness. Review of the care plan information revealed the information/tasks are mentioned as possible goals for the resident, and none of the problem areas provided specific care interventions based on the resident's assessment of needs such as: describing how to transfer the resident, providing scheduled toileting and/or incontinence care, skin care to provide and how often, pain management, possible medication side effects and monitoring the effectiveness of medication. On 7/6/16 at 2:54 PM, Nurse Aide F stated the aides did not have an (ADL) Activities of Daily Living worksheet, which directed resident care.	F 279			

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F 279	Continued From page 8 Nurse Aide F stated they receive report at the beginning of the shift and the nurse in charge provided the direct care information needed. Nurse Aide F stated, he/she initialed completion of tasks on the computer. On 7/6/16 at 4:23 PM, Nurse G verified the information stated by Nurse Aide F and provide the report sheet to review. The report sheet listed the resident with basic transfer information, but lacked information for complete care of the resident. On 7/6/16 at 5:10 PM, Nurse H verified the care plans lacked direct care interventions, and listed goals appropriate for post-operative care, not long term rehabilitative care. The facility ' s Care Plan policy and procedure, dated 8/27/13, stated a care plan addressing the needs of the residents will be developed to consider care involving nursing, social services, activities, therapy, and the physician. The nurse initiated the plan of care, within 2 hours of admission to the facility. The facility failed to develop an individualized, comprehensive plan of care for immediate care with ADLs and rehabilitation following surgical repair of a left hip fracture, placing Resident #3 at risk for increased pain, infection, and decline in ADLs.	F 279			
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,	F 309			

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F 309	<p>Continued From page 9</p> <p>mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: The facility had a census of 5 residents. The sample included 3 residents reviewed for wound care. Based on observation, interview, and record review, the facility failed to provide necessary care and services for 1 of 3 residents with compromised skin, and implement effective pain management. The facility admitted Resident #1 from a regional hospital following back surgery and the resident developed, (VRE) Vancomycin Resistant Enterococcus(bacteria normally present in the human intestines that has developed resistance to many antibiotics),19 days after admitted to the long term care facility and uncontrolled pain. (#1)</p> <p>Findings included:</p> <p>- Review of the medical record revealed the facility admitted Resident #1 on 5/28/16. The physician's orders for Resident #1 included the following medical diagnoses: lumbar burst fracture [a traumatic injury to the spine in which a vertebra bone in the spinal column) breaks, with sharps of vertebra penetrating the surrounding tissue and/or the spinal canal], pneumocystis (a serious respiratory infection that often affects people with compromised immune systems),</p>	F 309			

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F 309	<p>Continued From page 10</p> <p>sepsis due to enterococcus [the presence of harmful bacteria - enterococcus and their toxins (poison), usually found in a wound], candida stomatitis (yeast infection in the mouth), cutaneous abscess of the back (collection of pus in the skin), herpes viral keratitis (viral infection of the eye), rheumatoid arthritis (chronic inflammatory disease that affected joints and other organ systems, hypertension (elevated blood pressure, and insomnia (inability to sleep).</p> <p>The admission (MDS) Minimum Data Set assessment, dated 6/8/16, indicated the resident had intact cognition, required limited to extensive assistance of 1 for (ADLs) Activities of Daily Living and ambulation, on a pain management program, and received scheduled and as needed pain medications following surgery. The MDS further indicated the resident had a pressure reducing device in his/her chair, and received (PT) Physical Therapy and (OT) Occupational Therapy Services.</p> <p>The 6/7/16 (ADL) Activities of Daily Living (CAA) Care Area Assessment stated the facility admitted the resident after a fall at home which resulted in a lumbar burst fracture and surgery. He/she required assistance with daily cares and mobility, due to weakness and pain from the fractures. The resident participates in therapy and continues to make progress.</p> <p>The Pain CAA, dated 6/7/16, stated the facility admitted the resident after a fall at home which resulted in a lumbar burst fracture. The resident</p>	F 309			

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F 309	<p>Continued From page 11</p> <p>continued to complain of pain and increased pain when performing therapy exercises. Staff control the resident's pain by administering Tylenol, Robaxin (muscle relaxant), and oxycodone IR (narcotic pain medication immediate release).</p> <p>The 6/11/16 care plan provided basic information to staff, which included a problem for pain and stated as a goal, the resident would report pain at a tolerable level. The pain care plan lacked evidence of interventions to direct staff on basic cares and pain management.</p> <p>Review of the June Medication Administration Record, revealed the resident received:</p> <p>Robaxin (muscle relaxant), 750 (mg), by mouth, scheduled every 6 hours each day, Gabapentin (nerve pain medication), 100 mg, by mouth, scheduled 3 times a day, Tylenol (pain reliever) 650 mg, by mouth, scheduled every 6 hours, Motrin/Ibuprofen (anti-inflammatory medication, 600 mg, by mouth, every 6 hours as needed for pain, Tramadol (narcotic pain medication), 50 mg, by mouth, every 6 hours as needed for pain, Oxycodone hydrochloride, (narcotic pain medication) 10-20 mg by mouth, every 4 hours, as needed, ordered 6/1/16 Oxycodone hydrochloride, (narcotic pain medication) 5 to 10 mg by mouth, every 4 hour, as needed for pain, ordered changed 6/1/16 Restoril (narcotic sleep medication), 30 mg by mouth at bedtime, from 6/6/16 to 6/18/16,</p>	F 309			

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F 309	<p>Continued From page 12</p> <p>Xanax 0.5 mg, by mouth every 8 hours for anxiety from 6/13/16 to 6/18/16, Xanax 0.25 mg, by mouth for anxiety, from 6/18/16 to 6/20/16.</p> <p>Staff assessed the resident for pain 1 to 3 times each day at different intervals, throughout the day to determine the level of pain the resident experienced. The results are based on a scale of 1 to 10, with 10 being the highest level of pain. The results of this monitor revealed the resident's pain level at the beginning of the June gradually increased to the point, the resident no longer tolerated his/her pain level and rated the pain as a 10.</p> <p>6/6/16 ---- 7, 2 6/7/16 ---- 5 6/8/16 ---- 7, 2 6/9/16 ---- 7, 8, 8, 10 (worst pain) 6/10/16 ---- 7, 8, 7 6/11/16 ---- 5, 7, 7 6/12/16 ---- 8, 8, 8 6/13/16 ---- 8, 5, 6 6/14/16 ---- 7, 5 6/15/16 ---- 8 6/16/16 ---- 9 6/17/16 ---- 8, 10, 10, (worst pain) 6/18/16 ---- 5, 0 6/19/16 ---- 8, 8 6/20/16 ---- 8, 8</p> <p>Review of the June (MAR) Medication Administration Record, from 6/3/16 to 6/20/16, revealed staff administered the following, as</p>	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175537	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/20/2016
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F 309	<p>Continued From page 13</p> <p>needed, narcotic pain medications for complaints of moderate to severe pain, in addition to the scheduled over the counter pain medications :</p> <p>Staff administered Oxycodone 84 times on an as needed basis,</p> <p>Staff administered Tramadol 18 times on an as needed basis,</p> <p>Further review of the MAR revealed staff did not consistently reassess the resident for effectiveness of the as needed pain medications, to determine if the resident's level of pain decreased following administration of the pain medication between 6/3/16 to 6/20/16:</p> <p>Staff reassessed the resident for pain relief following administration of Oxycodone, 17 out of 84 times.</p> <p>Staff failed to reassess the resident for pain relief following administration of the Tramadol.</p> <p>The physician notification, dated 6/6/16 at 10:20 PM, informed Physician B the resident continued to sleep poorly. The physician ordered Restoril (narcotic medication used to induce sleep) 30 mg, by mouth, at bedtime.</p> <p>The 6/10/16 at 3:34 PM, nurse's note stated the resident had difficulty getting comfortable, and experienced low back pain. The nurse administered 2 Oxycodone tablets and the scheduled Tylenol and Robaxin (muscle relaxant). Staff assisted the resident to change</p>	F 309			

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

PRINTED: 07/20/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175537	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/20/2016
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F 309	<p>Continued From page 14</p> <p>position frequently during the night, and he/she slept very little.</p> <p>The 6/10/16 at 11:20 PM, nurse's note revealed nursing staff notified Physician D of the resident's increased confusion, decreased oxygen saturation (the level of oxygen in the blood), a strong urine odor, and a temperature of 99 degrees Fahrenheit. Physician D instructed staff to obtain a urinalysis with a culture and sensitivity, obtain a complete blood count lab from the resident, and instructed staff to administer Tramadol (narcotic pain medication), 50 mg, by mouth as needed, for pain.</p> <p>The 6/10/16, complete blood count revealed the white blood cell count 14.7 high (normal readings 4 to 10), red blood cell count 3.17 low (normal readings 4.2 to 5.4), hemoglobin 9.9 low (normal readings 12.1 to 15.1), and the hematocrit of 30 (normal readings 36.1 to 44).</p> <p>On 6/11/16 at 00:55 AM, staff notified Physician D the resident had a temperature of 99 degrees. Physician D instructed staff to administer Tylenol (non-narcotic pain medication) 650 mg, by mouth every 6 hours routinely, and as needed for pain.</p> <p>The 6/11/16 at 8:01 AM, nurse's note described the resident's urine as cloudy, with a strong smell, with a white blood cell count of 14.7 microliters. The nurse initiated a sepsis alert (a life-threatening complication of an infection) and stated the surgical incision drained fluid, with no odor. The nurse notified Physician D and</p>	F 309			

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

PRINTED: 07/20/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175537	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/20/2016
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F 309	<p>Continued From page 15</p> <p>received an order to administer Vancomycin (an antibiotic).</p> <p>The 6/11/16 at 12:00 PM, urinalysis was negative for bacterial growth.</p> <p>The two blood culture tests, collected 6/11/16, revealed no growth on 6/16/16 for one culture and the 2nd culture, finalized on 6/25/16, in a corrected report, revealed (VRE) Vancomycin Resistant Enterococcus (drug resistant harmful bacteria), susceptible to Daptomycin (antibiotic), Gentamycin Synergy (antibiotic) and Linezolid (antibiotic).</p> <p>The 6/13/16 at 3:15 PM, Physician B's progress note described the incision as clean and dry, gaped open in a small area after the sutures were removed, and had no drainage. Physician B directed staff to administer Vancomycin, Rocephin (antibiotic), Levofloxacin (antibiotic) and Xanax (anti-anxiety) medications to the resident. The resident had completed a dosage of Bactrim (antibiotic).</p> <p>On 6/13/16 at 3:25 PM, the White Blood Cell Count result was 14.01/microliters.</p> <p>On 6/13/16 at 3:58 PM, Physician B instructed staff to administer Levofloxacin (antibiotic) and Xanax (anti-anxiety medication), Prednisone (steroid medication), and discontinued the Vancomycin (antibiotic) and Ceftriaxone</p>	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175537	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/20/2016
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F 309	<p>Continued From page 16 (antibiotic).The resident had completed a dosage of Bactrim (antibiotic).</p> <p>The 6/14/16 at 4:43 AM, nurse's note stated the resident was restless, and his/her pain poorly controlled. The nurse administered 2 Oxycodone tablets, Tramadol 50 mg, and the scheduled Tylenol and Robaxin. Staff assisted the resident to change position frequently and also administered Restoril for insomnia.</p> <p>The 6/15/16 at 3:21 AM, nurse's note stated the resident was restless, and his/her pain poorly controlled. The nurse administered 2 Oxycodone tablets, Tramadol 50 mg, and the scheduled Tylenol and Robaxin. Staff assisted the resident to change position frequently and also administered Restoril for insomnia.</p> <p>The 6/15/16 blood culture done at 9:20 AM and 1:08 PM result revealed gram positive cocci chains (bacteria that gives a positive result in the gram stain test), with VRE.</p> <p>The 6/15/16 at 10:30 AM, nurse's note stated the nurse from the surgeon's office called for an update on the resident. Nurse A reported the resident was on a sepsis alert and cultures revealed the resident with VRE. Nurse A reported the resident had a 1/4 inch gap in the surgical incision after removal of the sutures, the edges of the incision pink and had serous (clear, watery fluids in the body) drainage at the end of the incision. Nurse A stated the resident had increased pain and anxiety.</p>	F 309			

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

PRINTED: 07/20/2016
FORM APPROVED
OMB NO. 0938-0391

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F 309	Continued From page 17 Review of the medical record revealed the facility did not call the surgeon when the resident experienced uncontrolled pain. The surgeon's nurse contacted the facility on 6/15/16 for an update of the resident. The 6/15/16 at 5:56 PM, shift note revealed the resident began taking a new antibiotic and presented very irritable and anxious, and experienced back pain. The nurse administered oxycodone, with the scheduled Tylenol and Robaxin. The resident rested 1 hour after staff administered him/her Xanax. On 6/15/16 at 7:02 PM, the physician's order sheet revealed Physician B ordered 2 blood cultures and started Linezolid (antibiotic), to be administered intravenously for 14 days and discontinued the Levofloxacin at 12:48 PM. The 6/17/16 at 6:03 PM, nurse's note stated the resident rated his/her pain as 10 out of 10, with 10 being the most severe pain. The nurse stated he/she administered the Tylenol and Robaxin, and the as needed Oxycodone, Tylenol, the Tramadol, and the Xanax. Staff assisted the resident to transfer with a 1-2 person assist, use of the gait belt and walker. The 6/20/16 at 3:56 AM, nurse's note stated the resident's pain poorly controlled and the nurse administered 2 Oxycodone tablets, Tramadol 50 mg, and the scheduled Tylenol and Robaxin. Staff	F 309			

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

PRINTED: 07/20/2016
FORM APPROVED
OMB NO. 0938-0391

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F 309	<p>Continued From page 18</p> <p>assisted the resident to change position frequently and transferred the resident using a mechanical lift and 2 staff. The nurse added, at this time the resident rested quietly.</p> <p>The 6/20/16 at 7:50 PM, nurse's note revealed Physician E ordered 2 cultures and to dress the wound with gauze. The resident was now unable to move on his/her own, and staff used a mechanical lift to transfer the resident. The note revealed the physician ordered staff to transfer the resident to the spine center, where the initial surgery was done.</p> <p>The facility's Discharge Summary, dated 6/20/16, dictated by Physician C stated per nursing and rehabilitation staff, the resident experienced more pain despite increasing on analgesics, and had copious (abundant) drainage from the surgical site in the past 2 days, has become serosanguinous (a discharge with both blood and a serum, the liquid part of the blood). The orthopedic surgery team, from the local hospital, looked at the wound and stated the resident warranted having the wound surgically debrided (mechanical removal of dead tissue or infected tissue), and to have the resident return to the surgeon that performed the surgery. Physician C documented the resident had a functional decline and received inadequate pain control.</p> <p>On 6/20/16 at 10:51 PM, a regional hospital spine center admitted the resident as an inpatient with the primary diagnosis of back pain.</p>	F 309			

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

PRINTED: 07/20/2016
FORM APPROVED
OMB NO. 0938-0391

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F 309	<p>Continued From page 19</p> <p>The neurosurgery history and physical exam, dated 6/21/16, stated the resident previously met the sepsis criteria for the long term care facility and had blood cultures done around 6/16/16 and currently awaiting results. The resident noted the nurse there had concerns over the wound for the last 3 days with wound separation clearly noted.</p> <p>The trauma/critical care admission history and physical, dated 6/21/16, stated the resident was admitted for wound dehiscence (wound separation) from a lumbar fusion after a wound revision and washout with removal and replacement of hardware. The resident's mental status worsened, he/she had tremors, was combative, had tachycardia (rapid heart rate), some somnolence (drowsy, sleepy), and hypercapnia (excessive carbon dioxide in the blood stream). The resident was taken to the intensive care unit and intubated (a temporary tube inserted into the trachea - the tube that conveys air to the lungs) for airway protection. The plan for cardiovascular stated increasing fentanyl (narcotic medication to treat severe pain) and weaning of precede (drug induced sleep).</p> <p>The operation report, dated 6/21/16, revealed the surgeon washed out the wound and replaced the hardware. Two culture specimens were obtained, one from a pocket of fluid above the connecting tissue and the second from a fluid pocket beneath the hole in the connecting tissue.</p> <p>The 6/26/16 final aerobic culture, collected on 6/20/16 from the lower back surgical incision, revealed Vancomycin Resistant Enterococcus</p>	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175537	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/20/2016
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F 309	<p>Continued From page 20</p> <p>Faecium (drug resistant harmful bacteria).</p> <p>On 7/6/16 at 2:54 PM, Nurse Aide F stated the resident showed improvement in mobility after admission, but began to decline and complained of pain. Nurse Aide F stated the drainage from the resident's wound soaked through the dressing at times. He/she reported to the nurse who would then change the dressing. Nurse Aide F stated the pain medications initially helped, and then not much affected the resident pain level.</p> <p>On 7/6/16 at 4:23 PM, Nurse G stated the resident cried out a lot, screamed in pain, and the nurses in turn reported to the various physicians. Nurse G stated the resident's wound did not look good upon admission to the facility. On 6/20/16, when the resident transferred to another hospital, the incision had reddish, green/brown, slough (dead outer tissue), with a purulent (a yellow/white substance found in sores) discharge and became red when the staff transferred the resident from the facility to the original surgeon's care at the hospital. Nurse G stated staff administered the amount of medication for pain as allowed by the physician, then verified this did not address the level of pain the resident experienced.</p> <p>On 7/6/16 at 5:10 PM, Nurse H verified the resident had been treated by 4 or more physicians, and the first culture obtained approximately 2 weeks after admission. Nurse H verified the resident declined prior to the time of his/her transfer on 6/20/16 and verified the nurses</p>	F 309			

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

PRINTED: 07/20/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175537	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/20/2016
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F 309	<p>Continued From page 21</p> <p>administered the pain medication as ordered by the physician and notified the physician the medication regimen did not sufficiently decrease the resident's pain level. The spine center admitted the resident on 6/21/16, with a stay of 24 days.</p> <p>On 7/11/16 at 3:45 PM, Physician K stated he/she only saw the resident one time and was unfamiliar with the resident's health status. Physician K stated to call one of the other hospitalists (a physician that assumes the care of hospitalized patients in the place of patients' primary care physician) that may have treated the resident.</p> <p>On 7/12/16 at 3:45 PM, Physician B stated he/she only saw the resident one time. The resident presented very anxious and the wound did not have any drainage. Physician B stated staff informed him/her the wound pulled apart slightly when the staples were removed. The staff were directed to inform the surgeon the wound pulled apart, a sepsis (life-threatening complication of infection) alert was called previously, and the resident started on Levaquin (antibiotic). Physician B stated he/she changed some of the medication orders and had the cultures repeated. Physician B stated the resident was very anxious and had pain, but the level was not extreme, and he/she ordered an anxiety medication.</p> <p>On 7/12/16 at 4:09 PM, Physician L stated the local hospital transferred the resident to the regional hospital's spine center. Upon admission</p>	F 309			

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

PRINTED: 07/20/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175537	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/20/2016
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F 309	<p>Continued From page 22</p> <p>the resident had confusion, and delirium (sudden severe confusion, disorientation and restlessness). Physician L stated wound debridement (removal of dead tissue) was done, the resident was intubated, and a tracheostomy (opening though the neck into the trachea through which an indwelling tube may be inserted) placed. He/she stated the resident was very sick prior to repair of the lumbar fracture surgery. During the local hospital stay staff removed the staples, the wound pulled apart slightly, and signs of infection started.</p> <p>The facility's Wound Assessment and Reassessment policy and procedure, dated 8/11/2008, stated to observe for the presence of sepsis (life threatening complication of infection caused by a harmful bacteria), and swab the wound for culture and sensitivity after the wound is thoroughly cleaned and dried. The wound should be reassessed with dressing changes, when changes in the wound are observed, or if the wound has new purulent drainage.</p> <p>The facility did not provide a policy and procedure for physician involvement regarding a change in condition.</p> <p>The facility's Pain Management policy and procedure, dated 1/11/16, stated: All residents are screened for the presence or absence of pain, at a minimum of upon admission, discharge, change in condition, or treatment plan, and self-reporting pain or evidence of cues indicative of the presence of pain, and to identify and monitor the level of pain</p>	F 309			

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

PRINTED: 07/20/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175537	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/20/2016
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F 309	Continued From page 23 and effectiveness of treatment, until pain relief or control is achieved. Pain measurement is considered the 5th vital sign. The residents will be reassessed by nurses a minimum of every 4 hours. The nurse aide or primary care taker shall be responsible for measurement of the vital signs and inform the nurse assigned to the care of the resident of levels of pain. Medications or non-pharmacological interventions should be initiated when pain is rated at a higher level than the resident's self-reported comfort goal. Reassessment and documentation should be completed within 1 hour after an intramuscular, rectal, or oral analgesic administration. If the nurse has maximized administration of the ordered analgesic(s) and has implemented non-pharmacological interventions (ex. position change, massage, heat/cold, relaxation, distraction) and the resident continues to complain of pain, the attending physician will be notified. The facility failed to provide necessary care and services for Resident #1 who developed sepsis from a surgical wound, delirium, demonstrated a decline in his/her physical ability, and failed to provide effective pain management and seek physician involvement, from both the primary care physician and the surgeon, for Resident #1's uncontrolled pain.	F 309			
F 312	483.25(a)(3) ADL CARE PROVIDED FOR	F 312			

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

PRINTED: 07/20/2016
FORM APPROVED
OMB NO. 0938-0391

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F 312 SS=D	<p>Continued From page 24</p> <p>DEPENDENT RESIDENTS</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: The facility had a census of 5 residents. The sample included 3 residents reviewed for (ADLs) Activities of Daily Living. Based on observation, record review, and interview, the facility failed to provide necessary care and services to maintain the highest level of well-being for 2 of the 3 sampled residents. Resident #1 and #2 did not receive his/her scheduled showers.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident #1's admission (MDS) Minimum Data Set assessment, dated 6/8/16, indicated the resident had intact cognition, with a (BIMS) Brief Interview for Mental Status score of 13, and required extensive assistance of 1 staff with bed mobility, transfer, dressing, toilet use and bathing, and occasionally incontinent of urine. <p>The 6/11/16 care plan had no instruction to the staff on how to address the resident's (ADLs) Activities of Daily Living and frequency of bathing.</p> <p>The 5/29/16 at 3:53 PM nurse's note, stated the staff changed the resident's dressing to his/her back and noted a moderate amount of drainage.</p> <p>Review of Resident #1's medical record revealed</p>	F 312			

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

PRINTED: 07/20/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175537	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/20/2016
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F 312	<p>Continued From page 25</p> <p>the resident received a shower on the following dates: 5/30/16, 6/2/16, 6/5/16, (10 days without a shower), until 6/16/16 and 6/20/16.</p> <p>On 7/5/16 at 5:35 PM, Nurse Aide I stated the resident received a shower once a week in the evening.</p> <p>On 7/5/16 at 5:43 PM, Nurse J stated the resident had large amounts of drainage from his/her surgical site.</p> <p>On 7/6/16 at 2:54 PM, Nurse Aide F stated he/she assisted the resident with a shower before going to bed a couple of times and the resident did have drainage, from the surgical site, which soaked through the dressing.</p> <p>On 7/6/16 at 4:23 PM, Nurse G verified the resident was scheduled to receive 2 showers per week.</p> <p>On 7/6/16 at 4:36 PM, Administrative Nurse H verified the resident was scheduled to receive 2 showers per week and explained the facility did not have a policy and procedure for bathing, or specific schedules. Nurse H stated each resident should receive 2 baths per week, unless requested differently.</p> <p>Upon request, the facility did not provide a policy and procedure for ADL care, including bathing.</p> <p>The facility failed to provide the twice weekly scheduled showers for Resident #1, which placed the resident at risk for skin impairment.</p> <p>- Resident #2's 5 day (MDS) Minimum Data Set</p>	F 312			

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

PRINTED: 07/20/2016
FORM APPROVED
OMB NO. 0938-0391

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F 312	<p>Continued From page 26</p> <p>assessment, dated 6/20/16, indicated the resident had intact cognition with a (BIMS) Brief Interview for Mental Status score of 15, and required limited assistance of 1 staff with transfer, dressing and toilet use. The MDS further indicated the resident required extensive assistance of 1 staff with bed mobility, ambulation, hygiene and bathing. The MDS also indicated the resident had a stage II pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction), and a diabetic foot ulcer.</p> <p>The 6/14/16 care plan directed the staff to monitor for signs of compromised skin integrity with no instructions to staff regarding the resident's ADLs and frequency of bathing.</p> <p>Review of Resident #2's medical record revealed the resident received a shower on the following dates: 6/16/16, 6/20/16, 6/23/16, 6/25/16, (6 days without a shower), until 7/2/16, and 7/6/16.</p> <p>The 6/20/16 at 4:00 PM nurse's notes stated the diabetic ulcer on Resident #2's right outer side, near the ball of the foot, had a small amount of bloody drainage, the right outer side of the foot, by the small toe amputation (removal) had a small amount of yellow colored drainage and the coccyx, Stage 2 pressure ulcer had a small amount of drainage with some bleeding.</p> <p>On 7/5/16 at 4:54 PM, observation revealed Nurse Aide I assisted the resident from the commode to his/her bed.</p>	F 312			

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

PRINTED: 07/20/2016
FORM APPROVED
OMB NO. 0938-0391

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F 312	Continued From page 27 On 7/5/16 at 5:06 PM, Nurse Aide I stated the resident should receive 2 showers per week. On 7/6/16 at 3:10 PM, Nurse G changed the dressings on 3 open areas on Resident #2's right foot. Nurse G, with gown, gloves, and mask on, entered the resident's room and prepared to change the resident's dressings. Nurse G removed the soiled dressings and measured the wounds: 1 (cm) centimeter x 1 cm to the bottom of the right heel, 2 cm x 1.5 cm to the outer side of the right foot by the ball of the foot, and 3.5 cm x 5.1 cm to the outer side of the right foot near the amputated small toe. Nurse G stated there was a scant amount of yellow to red tinged drainage and the tissue surrounding the wounds was a light pink to a darker reddish purple. Nurse G rinsed the sores with wound cleanser, patted the area dry with gauze, applied a silver dressing, then wrapped the wound areas with kling (large roll of gauze). On 7/6/16 at 4:36 PM, Administrative Nurse H verified the staff attempt to provide 2 baths each week, unless the resident requested a different number of baths per week. Nurse H stated the facility does not have a specific policy and procedure for bathing, or use a specific weekly schedule. The facility failed to provide the twice weekly scheduled showers for Resident #2, who had 3 infected, open areas on his/her right foot, which placed the resident at risk for further skin impairment.	F 312			
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329			

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

PRINTED: 07/20/2016
FORM APPROVED
OMB NO. 0938-0391

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F 329	<p>Continued From page 28</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 reported a census of 5 residents with 1 sampled for unnecessary medications. Based on observation, interview, and record review, the facility failed to ensure that 1 of 1 resident did not receive unnecessary medications when staff failed to reassess the resident for effectiveness of the anxiety and pain medication.</p> <p>- Resident #1's admission (MDS) Minimum Data</p>	F 329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175537	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/20/2016
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F 329	<p>Continued From page 29</p> <p>Set assessment, dated 6/8/16, indicated the resident had intact cognition, required limited to extensive assistance of 1 for (ADL's) Activities of Daily Living and ambulation, had a pain management program, received scheduled and as needed medications, a surgical incision, pressure reducing device in his/her chair, and worked with (PT) Physical Therapy and (OT) Occupational Therapy.</p> <p>The 6/7/16 Pain (CAA) Care Area Assessment stated the facility admitted the resident after a fall at home which resulted in a lumbar burst fracture(a traumatic injury to the spine in which a vertebra breaks, with sharps of vertebra penetrating the surrounding tissue and/or the spinal canal). The resident continued to complain of pain and increased pain when performing therapy exercises. Staff control the resident pain by administering Tylenol, Robinin (muscle relaxant), and oxycodone IR (narcotic pain medication immediate release).</p> <p>The 6/11/16 care plan directed staff to provide pain management, with no specific interventions pharmacological and non-pharmacological interventions stated for direct resident care.</p> <p>On 6/1/16 at 12:43 PM, Physician K instructed staff to administer Oxycodone 5-10 mg, by mouth, every 4 hours as needed. At 2:01 PM, Physician K changed the order was changed to Oxycodone 10-20 mg, by mouth, every 4 hours</p>	F 329			

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F 329	<p>Continued From page 30 as needed for pain.</p> <p>Review of the June Medication Administration Record, revealed the resident received:</p> <p>Robaxin (muscle relaxant), 750 (mg), by mouth, scheduled every 6 hours each day, Gabapentin (nerve pain medication), 100 mg, by mouth, scheduled 3 times a day, Tylenol (pain reliever) 650 mg, by mouth, scheduled every 6 hours, Motrin/Ibuprofen (anti-inflammatory medication, 600 mg, by mouth, every 6 hours as needed for pain, Tramadol (narcotic pain medication), 50 mg, by mouth, every 6 hours as needed for pain, Oxycodone hydrochloride, (narcotic pain medication) 5-10 mg by mouth, every 4 hour, as needed for pain Restoril (narcotic sleep medication), 30 mg by mouth at bedtime, from 6/6/16 to 6/18/16, Xanax 0.5 mg, by mouth every 8 hours for anxiety from 6/13/16 to 6/18/16, Xanax 0.25 mg, by mouth for anxiety, from 6/18/16 to 6/20/16.</p> <p>Staff assessed the resident 1 to 3 times each day at different intervals, throughout the day to determine the level of pain the resident experienced. The results are based on a scale of 1 to 10, with 10 being the highest level of pain. The results of this monitor revealed the resident ' s pain level at the beginning of the June gradually increased to the point, the resident no longer tolerated his/her pain level and rated the pain as</p>	F 329			

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

PRINTED: 07/20/2016
FORM APPROVED
OMB NO. 0938-0391

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F 329	Continued From page 31 a 10. 6/6/16 ---- 7, 2 6/7/16 ---- 5 6/8/16 ---- 7, 2 6/9/16 ---- 7, 8, 8, 10 (worst pain) 6/10/16 ---- 7, 8, 7 6/11/16 ---- 5, 7, 7 6/12/16 ---- 8, 8, 8 6/13/16 ---- 8, 5, 6 6/14/16 ---- 7, 5 6/15/16 ---- 8 6/16/16 ---- 9 6/17/16 ---- 8, 10, 10, (worst pain) 6/18/16 ---- 5, 0 6/19/16 ---- 8, 8 6/20/16 ---- 8, 8 Review of the June (MAR) Medication Administration Record, from 6/3/16 to 6/20/16, revealed staff administered the following, as needed, narcotic pain medications for complaints of moderate to severe pain, in addition to the scheduled over the counter pain medications : Staff administered Oxycodone 84 times on an as needed basis, Staff administered Tramadol 18 times on an as needed basis, Further review of the MAR revealed staff did not consistently reassess the resident for effectiveness of the as needed pain medications, to determine if the resident ' s level of pain	F 329			

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

PRINTED: 07/20/2016
FORM APPROVED
OMB NO. 0938-0391

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F 329	<p>Continued From page 32</p> <p>decreased following administration of the pain medication between 6/3/16 to 6/20/16:</p> <p>Staff reassessed the resident for pain relief following administration of Oxycodone, 17 out of 84 times.</p> <p>Staff failed to reassess the resident for pain relief following administration of the Tramadol.</p> <p>The 6/10/16 at 3:34 PM, nurse's note stated the resident had difficulty getting comfortable, and experienced low back pain. The nurse administered 2 Oxycodone tablets and the scheduled Tylenol and Robaxin (muscle relaxant). Staff assisted the resident to change position frequently during the night, and he/she slept very little.</p> <p>On 6/10/16 at 11:22 PM, Physician D gave an order for Tramadol 50 mg, by mouth, every 6-8 hours as needed.</p> <p>On 6/11/16 at 11:18 PM, Physician D gave an order for Tylenol 650 mg, by mouth, scheduled every 6 hours as needed, Tylenol 650 mg, by mouth every 6 hours as needed, and Motrin 200 mg, by mouth, every 6 hours as needed,</p> <p>The 6/14/16 at 4:43 AM, nurse's note stated the resident was restless, and his/her pain poorly controlled. The nurse administered 2 Oxycodone tablets, Tramadol 50 mg, and the scheduled Tylenol and Robaxin. Staff assisted the resident to change position frequently and also administered Restoril for insomnia. The resident</p>	F 329			

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

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FORM APPROVED
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F 329	<p>Continued From page 33</p> <p>rested with his/her eyes closed at that time.</p> <p>The 6/15/16 at 3:21 AM, nurse's note stated the resident was restless, and his/her pain poorly controlled. The nurse administered 2 Oxycodone tablets, Tramadol 50 mg, and the scheduled Tylenol and Robaxin. Staff assisted the resident to change position frequently and also administered Restoril for insomnia. The resident rested with his/her eyes closed at that time.</p> <p>The 6/15/16 at 10:30 AM, nurse's note stated the nurse from the surgeon's office called for an update on the resident. Nurse A reported the resident was on a sepsis alert and had increased pain and anxiety.</p> <p>The 6/15/16 at 5:56 PM, shift note revealed the resident began taking a new antibiotic and presented very irritable and anxious, and experienced back pain. The nurse administered oxycodone, with the scheduled Tylenol and Robaxin. The resident rested 1 hour after staff administered him/her Xanax.</p> <p>The 6/17/16 at 6:03 PM, nurse's note stated the resident rated his/her pain as 10 out of 10, with 10 being the most severe pain. The nurse stated he/she administered the Tylenol and Robaxin, and the as needed Oxycodone, Tylenol, the Tramadol, and the Xanax. Staff assisted the resident to transfer with a 1-2 person assist, use</p>	F 329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175537	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/20/2016
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F 329	<p>Continued From page 34 of the gait belt and walker.</p> <p>On 6/18/16 at 1:26 PM, Physician C gave an order for Xanax 0.25 mg, by mouth, as needed, a Lidocaine 5% patch, Gabapentin 100 mg, by mouth, 4 x a day.</p> <p>The 6/20/16 at 3:56 AM, nurse's note stated the resident's pain poorly was controlled and the nurse administered 2 Oxycodone tablets, Tramadol 50 mg, and the scheduled Tylenol and Robaxin. Staff assisted the resident to change position frequently and transferred the resident using the Sara Lift and 2 staff. The nurse added, at this time the resident rested quietly.</p> <p>On 6/20/16 at 7:50 PM, the Nurse's Note stated Physician E ordered 2 cultures and to dress the wound with gauze. The resident was unable to move on his/her own. Staff used the Sara Steady, (a mechanical lift) to transfer the resident. An order was given to transfer the resident to the spine center, where the initial surgery was done.</p> <p>On 6/20/16 at 9:33 PM, Physician B ordered Morphine Sulfate, per intravenous injection, as needed,</p> <p>The facility's Discharge Summary, dated 6/20/16, dictated by Physician C stated per nursing and rehabilitation staff, the resident experienced more pain despite increasing on analgesics and had a functional decline and received inadequate pain control.</p>	F 329			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 329	Continued From page 35 On 7/6/16 at 2:54 PM, Nurse Aide F stated the resident showed improvement in mobility after admission, but began to decline and complained of pain. Nurse Aide F stated the pain medications initially helped, and then not much affected the resident pain level. On 7/6/16 at 4:23 PM, Nurse G stated the resident cried out a lot, screamed in pain, and the nurses in turn reported to the various physicians. Nurse G stated the resident's wound did not look good when first admitted to the facility and explained staff administered the amount of medication for pain as allowed by the physician, and then verified this did not address the level of pain the resident experienced. On 7/6/16 at 510 PM, Nurse H verified the nurses administered the pain medication as ordered by the physician and stated the physician was notified, the medication regimen did not sufficiently decrease the resident's pain level. The facility's Pain Management policy and procedure, dated 1/11/16, stated: All residents are screened for the presence or absence of pain, at a minimum of upon admission, discharge, change in condition, or treatment plan, and self-reporting pain or evidence of cues indicative of the presence of pain, and to identify and monitor the level of pain and effectiveness of treatment, until pain relief or control is achieved.	F 329			

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

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F 329	Continued From page 36 Pain measurement is considered the 5th vital sign. The residents will be reassessed by nurses a minimum of every 4 hours. The nurse aide or primary care taker shall be responsible for measurement of the vital signs and inform the nurse assigned to the care of the resident of levels of pain. Medications or non- pharmacological interventions should be initiated when pain is rated at a higher level than the resident's self-reported comfort goal. Reassessment and documentation should be completed within 1 hour after an intramuscular, rectal, or oral analgesic administration. If the nurse has maximized administration of the ordered analgesic(s) and has implemented non-pharmacological interventions (ex. Position change, massage, heat/cold, relaxation, distraction) and the resident continues to complain of pain, the attending physician will be notified. The facility failed to provide effective pain management, when staff failed to reassess Resident #1 for effectiveness of the anxiety and pain medication after administration. Increased pain placed the resident at risk for a decline in his/her ADL's and mobility.	F 329			