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	175218	A. BUILDING _____ B. WING _____	C 09/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW OF DERBY	**445 N WESTVIEW DR DERBY, KS 67037**

(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 The following citations represent the findings of complaint investigations KS00145380 and KS00145697. The 2567 was electronically sent to the facility on 09/24/19.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 609		

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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This REQUIREMENT is not met as evidenced by:
The facility had a census of 36 residents, with three residents selected for sample. Based on interview and record review, the facility failed to immediately report allegations of misappropriation of resident property, neglect and/or injuries of unknown origin involving two sampled residents to the State Survey Agency. The facility failed to thoroughly investigate the allegations and failed to submit the results of the investigations to the Survey Agency within five working days. (Residents (R) 1, R2)

Findings included:

- On 9/16/19 at 12:45 PM, Administrative Staff A confirmed an area pain clinic reported concerns in July of 2019 that Resident (R) 1 was not receiving his physician ordered pain medication, Oxycodone (an opioid medication used for treatment of moderate to severe pain), because a drug screen completed at the clinic came back negative for the presence of hydrocodone. According to Administrative Staff A, immediately upon learning of the concerns identified by the pain clinic, she and Administrative Nurse D reviewed the Medication Administration Records (MARs), and saw that staff initialed off the medications on the MARs to indicate the medication was administered. Administrative Nurse A reported they then knew R1 received his scheduled Oxycodone and determined the drug screen done at the clinic must have been inaccurate. Administrative Staff A could not verbalize other steps taken to investigate the possibility of misappropriation of property (a staff member diverting drugs) or neglect (staff failure to administer pain medication ordered by the

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F 609	Continued From page 2	F 609		

physician). Staff A reported she spoke with her "corporate team" and determined this allegation did not require filing a report with the State Survey Agency and therefore she did not report it.

During an interview on 09/16/19 at 01:00 PM, Administrative Nurse D reported she received a phone call "probably in July" from Mid-Level Practitioner JJ who was employed by the pain clinic R1 visited monthly. In that phone call, Practitioner JJ reported concerns the facility staff failed to administer R1's Oxycodone. Practitioner JJ reported evidence of failure to administer medications as R1's reported he did not receive the medication and due to the resident's uncontrolled pain levels. At that time, Practitioner JJ reported an oral swab drug screen completed at the pain clinic revealed an absence of opioids which indicated R1 did not receive the ordered Oxycodone.

Administrative Nurse D provided an undated timeline/document which noted each step taken in the allegation of staff failure to administer R1's Oxycodone. Investigative steps taken by the facility included review of MARs to ensure the resident received the medication daily as ordered, review of narcotic count sheets to ensure the counts were correct as related to Oxycodone, and obtaining witness statements from two certified medication aides (CMAs) who reported they administered the oxycodone as ordered. According to the timeline, Administrative Nurse D contacted a laboratory on 07/24/19 to review the results of R1's previously described oral swab drug screen and the doctor verbalized a belief the swab may have not been accurate due to the length of time since R1's dose of Oxycodone prior to obtaining the oral specimen. Administrative

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Nurse D reported she lacked further evidence of completion of a thorough investigation of the incident.

During an interview on 09/16/19 at 01:30 PM, Administrative Staff A reported the facility did not contact R1's physician to request a urine or blood drug screen once they learned the oral swab screen completed at the pain clinic may not have been accurate. Administrative Staff A also reported she never thought of this as a possible case of drug diversion and therefore did not investigate it from that standpoint.

The facility's "Abuse, Prevention and Prohibition Policy" with a revision date of 11/2018 defined neglect as "failure to provide goods and services necessary to avoid physical harm, pain, mental anguish or emotional distress." The policy defined misappropriation of resident property as "the deliberate misplacement, exploitation or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent." The policy directed staff to report allegations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property to the "mandated state agency and law enforcement" within 24 hours if the allegation did not involve abuse or serious bodily injury.

The facility failed to immediately report an allegation of misappropriation of resident property/ neglect involving R1 to the State Survey Agency, failed to thoroughly investigate the allegation and then failed to submit the results of the investigation to the Survey Agency within five working days.

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F 609	Continued From page 4	F 609		

- Resident (R) 2's clinical record included an 08/15/19 Quarterly Minimum Data Set (MDS) which identified the resident with severe cognitive impairment (Brief Interview for Mental Status score of 4).

"Progress Notes" included the following:

1) 07/30/19 at 02:40 AM: Described newly discovered "dark colored bruises" on both lower legs. The left lower leg bruises measured 8 centimeters (cm) by 2 cm and 2 cm by 0.5 cm. on the outer lower leg and 4.5 cm by 1 cm. on the lower inner leg. The bruise on the right outer lower leg measured 10 cm by 4 cm. According to the note, the resident did not know how the bruises occurred.

2) 07/31/19 at 03:33 PM: Described bruising on both lower legs as described in the 07/30/19 note and new bruising under the left knee.

The facility provided a copy of their "investigation" of R2's leg bruising. According to that document, the injury to the left lower outer leg was a "hematoma" (collection of blood trapped in the tissues of the skin or in an organ, resulting from trauma). The investigation lacked evidence of observations of care/transfers in an attempt to determine the cause of the injuries, interviews with staff who cared for the resident, or interview with other residents about abuse/neglect.

During an interview on 09/19/19 at 8:45 AM, Administrative Nurse D confirmed the facility did not report the bruising/injury to R2's lower legs to the State Survey Agency. Nurse D reported, "We talked about it and didn't think it needed reported so we didn't." Nurse D also confirmed the facility

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F 609	Continued From page 5 completed observations of transfers/care for R2 as part of the investigation into the incident but failed to document those observations. The facility's "Abuse, Prevention and Prohibition Policy" with a revision date of 11/2018 directed staff to report all allegations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source to the Administrator immediately and then to the mandated state agency within 24 hours if there is no evidence of abuse or serious bodily injury. The facility failed to immediately report injuries of unknown origin (extensive bruising of both lower legs with development of a hematoma) involving R2 to the State Survey Agency, failed to thoroughly investigate the allegation and then failed to submit the results of the investigation to the Survey Agency within five working days.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State	F 610		

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F 610	Continued From page 6	F 610		

Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:

The facility had a census of 36 residents, with three residents selected for sample. Based on interview and record review, the facility failed to thoroughly investigate allegations of misappropriation of resident property, neglect and/or injuries of unknown origin involving two sampled residents. (Residents (R) 1, R2)

Findings included:

- On 9/16/19 at 12:45 PM, Administrative Staff A confirmed an area pain clinic reported concerns in July of 2019 that Resident (R) 1 was not receiving his physician ordered pain medication, Oxycodone (an opioid medication used for treatment of moderate to severe pain), because a drug screen completed at the clinic came back negative for the presence of hydrocodone. According to Administrative Staff A, immediately upon learning of the concerns identified by the pain clinic, she and Administrative Nurse D reviewed the Medication Administration Records (MARs), and saw that staff initialed off the medications on the MARs to indicate the medication was administered. Administrative Nurse A reported they then knew R1 received his scheduled Oxycodone and determined the drug screen done at the clinic must have been inaccurate. Administrative Staff A could not verbalize other steps taken to investigate the possibility of misappropriation of property (a staff member diverting drugs) or neglect (staff failure to administer pain medication ordered by the physician).

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F 610	Continued From page 7	F 610		

During an interview on 09/16/19 at 01:00 PM, Administrative Nurse D reported she received a phone call "probably in July" from Mid-Level Practitioner JJ who was employed by the pain clinic R1 visited monthly. In that phone call, Practitioner JJ reported concerns the facility staff failed to administer R1's Oxycodone. Practitioner JJ reported evidence of failure to administer medications as R1's reported he did not receive the medication and due to the resident's uncontrolled pain levels. At that time, Practitioner JJ reported an oral swab drug screen completed at the pain clinic revealed an absence of opioids which indicated R1 did not receive the ordered Oxycodone.

Administrative Nurse D provided an undated timeline/document which noted each step taken in the allegation of staff failure to administer R1's Oxycodone. Investigative steps taken by the facility included review of MARs to ensure the resident received the medication daily as ordered, review of narcotic count sheets to ensure the counts were correct as related to Oxycodone, and obtaining witness statements from two certified medication aides (CMAs) who reported they administered the oxycodone as ordered. According to the timeline, Administrative Nurse D contacted a laboratory on 07/24/19 to review the results of R1's previously described oral swab drug screen and the doctor verbalized a belief the swab may have not been accurate due to the length of time since R1's dose of Oxycodone prior to obtaining the oral specimen. Administrative Nurse D reported she lacked further evidence of completion of a thorough investigation of the incident.

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F 610	Continued From page 8	F 610		

During an interview on 09/16/19 at 01:30 PM, Administrative Staff A reported the facility did not contact R1's physician to request a urine or blood drug screen once they learned the oral swab screen completed at the pain clinic may not have been accurate. Administrative Staff A also reported she never thought of this as a possible case of drug diversion and therefore did not investigate it from that standpoint.

The facility's "Abuse, Prevention and Prohibition Policy" with a revision date of 11/2018 defined neglect as "failure to provide goods and services necessary to avoid physical harm, pain, mental anguish or emotional distress." The policy defined misappropriation of resident property as "the deliberate misplacement, exploitation or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent."

The facility failed to thoroughly investigate the allegation of possible misappropriation of R1's pain medication.

- Resident (R) 2's clinical record included an 08/15/19 Quarterly Minimum Data Set (MDS) which identified the resident with severe cognitive impairment (Brief Interview for Mental Status score of 4).

"Progress Notes" included the following:

1) 07/30/19 at 02:40 AM: Described newly discovered "dark colored bruises" on both lower legs. The left lower leg bruises measured 8 centimeters (cm) by 2 cm and 2 cm by 0.5 cm. on the outer lower leg and 4.5 cm by 1 cm. on the lower inner leg. The bruise on the right outer

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F 610	Continued From page 9 lower leg measured 10 cm by 4 cm. According to the note, the resident did not know how the bruises occurred. 2) 07/31/19 at 03:33 PM: Described bruising on both lower legs as described in the 07/30/19 note and new bruising under the left knee. The facility provided a copy of their "investigation" of R2's leg bruising. According to that document, the injury to the left lower outer leg was a "hematoma" (collection of blood trapped in the tissues of the skin or in an organ, resulting from trauma). The investigation lacked evidence of observations of care/transfers in an attempt to determine the cause of the injuries, interviews with staff who cared for the resident, or interview with other residents about abuse/neglect. During an interview on 09/19/19 at 8:45 AM, Administrative Nurse D confirmed the facility completed observations of transfers/care for R2 as part of the investigation into the incident but failed to document those observations. The facility's "Abuse, Prevention and Prohibition Policy" with a revision date of 11/2018 directed staff to report all allegations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source to the Administrator immediately and then to the mandated state agency within 24 hours if there is no evidence of abuse or serious bodily injury. The facility failed to thoroughly investigate the bruises of unknown origin for R2.	F 610		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		

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§483.21(b) Comprehensive Care Plans
§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) 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 §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care

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plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 36 residents, with three residents selected for sample. Based on observation, interview and record review, the facility failed to develop and implement a comprehensive care plan for two of three sampled residents as related to pain management and bowel function/constipation (R1) and history of severe constipation (R2).

Findings included:

- Resident (R) 1's clinical record included a comprehensive diagnosis list which identified the resident with multiple medical diagnoses, including cerebral palsy (progressive disorder of movement, muscle tone or posture caused by injury or abnormal development in the immature brain, most often before birth), convulsions (involuntary series of contractions of a group of muscles), and osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain).

The 12/05/18 Significant Change "Minimum Data Set" (MDS) identified the resident with severe cognitive impairment (Brief Interview for Mental Status score of 5), use of scheduled and as needed (PRN) doses of pain medication, and R1 reported "almost constant" pain which affected his ability to sleep at night. R1 rated the worst pain he experienced within the previous five days as a "10" on a 1-10 pain scale in which 10 represented severe pain. According to the MDS, R1 received opioid medication (medication used

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to treat moderate to severe pain) daily during the seven day observation period.

The 06/18/19 Quarterly MDS identified R1 with moderate cognitive impairment (Brief Interview for Mental Status score of 9), use of routine and PRN pain medications, and reported "almost constant pain) which affected his sleep as well as day-to-day activities. According to the assessment, R1 rated his worst pain experienced within the previous five days as "10" on a 1-10 pain scale. The resident had total dependence on staff for toileting and experienced total bowel incontinence.

The 12/16/18 "Care Area Assessment" (CAA) for pain reported R1 often asked for pain medication "5-10 minutes" after staff administered pain medication. According to the CAA, R1 was not always cooperative with attempts to alleviate pain by repositioning or other non-pharmacological approaches.

The undated care plan included the "focus" of "The resident is on pain medication therapy related to disease process and cerebral palsy." The "goal" for the focus was "The resident will be free of any discomfort or adverse side effects from pain medication through the review date." The care plan lacked R1's goals related to pain management. According to the care plan, R1 had a tendency to "frequently report" he did not get his pain medication. On 07/31/19, staff added an intervention to administer medication in the presence of two staff members (the charge nurse and the certified medication aide (CMA)). The care plan also described R1's monthly visits to a pain clinic. The care plan lacked individualized, resident specific interventions to address R1's

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chronic pain issues. The care plan lacked measurable goals and resident specific interventions related to bowel incontinence and the bowel regimen followed to prevent constipation.

During an observation on 09/17/19 at 10:10 AM, Certified Nurse Aide (CNA) M and Certified Medication Aide (CMA) R repositioned R1 in his bed. The resident verbalized pain prior to and during movement. The resident had movement limitations of his lower extremities and wore an incontinence brief. During the observation, R1 had the ability to verbalize his needs.

During an interview on 09/16/19 at 01:00 PM, R1 reported he "always" has pain and sometimes it was so severe he could not stand it. R1 confirmed staff administered pain medication "a couple of times a day" and stated the medication helped but never really relieved the pain entirely. When asked specifically about his level of pain, R1 reported he could not remember a time when his pain was not at least a "5" on a 1-10 scale.

During an interview on 09/17/19 at 02:00 PM, Licensed Nurse (LN) G confirmed R1 "always" had pain in spite of the amount of medications he received.

On 09/18/19 at 09:30 AM, Administrative Nurse D confirmed the care plan lacked R1's goal for pain management.

The facility failed to develop and implement a comprehensive care plan for R1 as related to pain management, bowel incontinence, and bowel function/management of constipation.

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- Resident (R) 2's clinical record included an 08/15/19 Quarterly "Minimum Data Set" (MDS) which identified the resident with severe cognitive impairment (Brief Interview for Mental Status score of 4), total dependence on staff for toileting, and frequent bowel incontinence.

The 08/21/19 "Care Plan" lacked measurable goals and individualized interventions related to R2's bowel incontinence, history of severe constipation, and the bowel regimen followed to prevent a recurrence of constipation.

Review of the "Progress Notes" included the following:

1) 07/23/19 at 11:05 AM: Described R2's complaints of not feeling well. According to the note, the resident was "dry heaving" (repeated, involuntary retching) and felt as if she would vomit. The note described decreased bowel sounds (rumbling, growling or gurgling sounds noises produced by movement of contents through the stomach and bowel). The note also referenced the resident's lack of a bowel movement (BM) since 07/19/19, a time period of four days. The physician ordered a radiological exam of the kidney, ureter and bladder (KUB) due to R2's symptoms.

2) 07/23/19 at 12:11 PM: Described the results of the KUB which showed "severe constipation."

3) 07/23/19 at 05:06 PM: Described orders to increase laxatives and recheck the KUB on 07/24/19.

4) 07/24/19 at 10:03 AM: Described an order for

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F 656	Continued From page 15 an additional laxative. 5) 07/24/19 at 05:17 PM: Described the results of the KUB performed earlier that morning as "an improvement in constipation with no new abnormalities." During an observation on 09/17/19 at 11:30 AM, R2 was alert and could answer simple questions. The resident required assistance of two staff for transfers. During an interview on 09/18/19 at 09:00 AM, Administrative Nurse D reported an awareness R2 experienced severe constipation in July of 2019. The facility failed to develop and implement a comprehensive care plan for R2 as related to bowel incontinence and a history of severe constipation.	F 656		
F 690 SS=G	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the	F 690		

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resident's clinical condition demonstrates that catheterization was necessary;
(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and
(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 36 residents, with three residents selected for sample. Based on observation, interview, and record review the facility failed to provide the necessary care and services (monitoring of bowel movements and/or implementation of the physician ordered bowel program when the resident failed to have bowel movements) to maintain normal bowel function for two of three sampled residents. (Resident (R) 1, R2) R2 failed to have a bowel movement (BM) for four days and the facility failed to follow the physician prescribed regimen for treatment of constipation. After four days without a BM, R2 developed nausea and vomiting which warranted radiological evaluation via visualization of the kidneys, ureters and bowel (KUB). According to the KUB results, R2 experienced "severe

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constipation" as a result of failure to have a BM for four days.

Findings included:

- Resident (R) 2's Quarterly "Minimum Data Set" (MDS) dated 08/15/19 identified the resident with severe cognitive impairment (Brief Interview for Mental Status score of 4), total dependence on staff for toileting, and frequent bowel incontinence.

The 08/21/19 "Care Plan" lacked measurable goals and individualized interventions related to R2's bowel incontinence, history of severe constipation, and the bowel regimen followed to prevent a recurrence of constipation.

Physician's order included:

1) Milk of Magnesia (MOM), a medication used to treat constipation, 30 milliliters (ml) as needed for constipation. May administer one time if no bowel movement in 3 days. (01/29/19 order)

2) Docusate Sodium (laxative used to treat constipation) 100 milligrams (mg) - two capsules one time a day for constipation. (01/30/19 order)

3) Glycolax Powder (laxative) 17 grams (gm) daily for constipation (01/30/19 order)

Review of the bowel movement documentation and "Medication Administration Records (MARs) included:

1) July 2019:

a. There were no BMs recorded in the eight day

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time period from 07/07/19 - 07/15/19. According to the MARs, staff administered MOM 30 ml on July 10th and July 11th, 2019 with no results. The record lacked evidence staff implemented additional measures to relieve constipation when two doses of MOM failed to produce results. According to the MAR, staff administered an additional dose of MOM on 07/15/19 and obtained results.

b. There were no BMs recorded in the six day time period from 07/19/19 - 07/25/19. According to the MARs, staff failed to administer any medications to relieve constipation until 07/24/19, five days after the resident was known to have had a BM and one day after the resident experienced nausea and vomiting and was diagnosed with "severe constipation."

Review of the "Progress Notes" included the following:

07/23/19 at 11:05 AM: Described R2's complaints of not feeling well. According to the note, the resident was "dry heaving" (repeated, involuntary retching) and felt as if she would vomit. The note described decreased bowel sounds (rumbling, growling or gurgling sounds noises produced by movement of contents through the stomach and bowel). The note also referenced the resident's lack of a bowel movement (BM) since 07/19/19, a time period of four days. The physician ordered a radiological exam of the kidney, ureter and bladder (KUB) due to R2's symptoms.

07/23/19 at 12:11 PM: Described the results of the KUB which showed "severe constipation."

07/23/19 at 05:06 PM: Described orders to

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increase laxatives and recheck the KUB on 07/24/19.

07/24/19 at 10:03 AM: Described an order for an additional laxative.

07/24/19 at 05:17 PM: Described the results of the KUB performed earlier that morning as "an improvement in constipation with no new abnormalities."

2) August 2019:

a. There were no BMs recorded in the four day time period from 08/27/19 - 08/31/19. According to the MARs, staff failed to provide any medication to promote a bowel movement during that four day time period.

During an observation on 09/17/19 at 11:30 AM R2 was alert and could answer simple questions. The resident required assistance of two staff for transfers.

During an interview on 09/18/19 at 09:00 AM Administrative Nurse D reported "Our bowel program isn't working." According to Administrative Nurse D staff printed off BM records daily and gave those to the charge nurse. Administrative Nurse D said the charge nurse should then make sure the residents with no BMs in the past 3 days received medication to promote a BM and should also follow up to ensure the medication produced results. Administrative Nurse D confirmed awareness of R2's July 2019 diagnosis of "severe constipation" after no bowel movement for four days.

When asked to provide the facility's policy and/or

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bowel protocol, Administrative Staff A reported the facility did not have a policy.

The facility failed to provide the necessary care and services (monitoring of bowel movements and/or implementation of the physician ordered bowel program when the resident failed to have bowel movements) to maintain normal bowel function for R2. R2 failed to have a bowel movement (BM) for four days and the facility failed to follow the physician prescribed regimen for treatment of constipation. After four days without a BM, R2 developed nausea and vomiting which warranted radiological evaluation via visualization of the kidneys, ureters and bowel (KUB). According to the KUB results, R2 experienced "severe constipation" as a result of failure to have a BM for four days.

- Resident (R) 1's clinical record included a comprehensive diagnosis list which identified the resident with multiple medical diagnoses, including cerebral palsy (progressive disorder of movement, muscle tone or posture caused by injury or abnormal development in the immature brain, most often before birth).

The 06/18/19 Quarterly "Minimum Data Set" (MDS) identified R1 with moderate cognitive impairment (Brief Interview for Mental Status score of 9), total dependence on staff for assistance with toileting, and total bowel incontinence.

The undated "Care Plan" lacked measurable goals and resident specific interventions related to bowel incontinence and the bowel regimen followed to prevent constipation.

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Review of the "Physician's Orders" included:

1) An 01/29/19 order for Milk of Magnesia (MOM), a medication used to treat constipation, 30 milliliters (ml) as needed for constipation. May administer one time of no bowel movement in three days.

2) An 01/29/19 order for Bisacodyl (laxative medication) suppository inserted rectally as needed for constipation. Administer one time of no results from MOM.

Review of the bowel movement documentation and "Medication Administration Records (MARs) included:

1) July 2019: There were no BMs recorded in the six day time periods from 07/08/19 - 07/14/19 and again from 07/16/19 - 07/22/19. According to the MARs, staff failed to administer medications during those six day time periods to promote bowel movements and prevent constipation.

2) August 2019: There were no BMs recorded in the four day time period from 08/21/19 - 08/25/19. According to the MAR, staff failed to administer medications during that four day time period to promote a bowel movement. There were also no BMs recorded in the four day time period from 08/27/19 - 08/31/19. According to the MAR, staff administered MOM 30 ml on 08/30/19 at 09:15 AM and then failed to follow up when there were no results.

3) September 2019: There were no BMs recorded in the five day time period from 09/05/19 - 09/10/19. According to the MAR, staff failed to administer medications during that five day time

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F 690	Continued From page 22 period to promote a bowel movement and prevent constipation. During an observation on 09/17/19 at 10:10 AM, R1 required assistance of two staff for bed repositioning. The resident had severe physical limitations of the lower extremities and wore an incontinence brief. During an interview on 09/18/19 at 09:00 AM, Administrative Nurse D reported "Our bowel program isn't working." According to Administrative Nurse D the staff printed off BM records daily and gave those to the charge nurse. Administrative Nurse D said the charge nurse should then make sure the residents with no BMs in the past 3 days receive medication to promote a BM and should also follow up to ensure the medication produced results. When asked to provide the facility's policy and/or bowel protocol, Administrative Staff A reported the facility did not have a policy. The facility failed to provide the necessary care and services (monitoring of bowel movements and/or implementation of the physician ordered bowel program when the resident failed to have bowel movements) to maintain normal bowel function for R1.	F 690		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan,	F 697		

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and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 36 residents, with three residents selected for sample. Based on observation, interview and record review, the facility failed to develop/implement an effective pain management program for one of three sampled residents who experienced chronic pain. (Resident (R) 1)

Findings included:

- Resident (R) 1's clinical record included a comprehensive diagnosis list which identified the resident with multiple medical diagnoses, including cerebral palsy (progressive disorder of movement, muscle tone or posture caused by injury or abnormal development in the immature brain, most often before birth), convulsions (involuntary series of contractions of a group of muscles) and osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain).

The 12/05/18 Significant Change "Minimum Data Set" (MDS) identified the resident with severe cognitive impairment (Brief Interview for Mental Status score of 5), use of scheduled and as needed (PRN) doses of pain medication, and the resident reported "almost constant" pain which affected his ability to sleep at night. R1 rated the worst pain he experienced within the previous five days as a "10" on a 1-10 pain scale in which 10 represented severe pain. According to the MDS, R1 received opioid medication (medication used to treat moderate to severe pain) daily during the seven day observation period.

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The 06/18/19 Quarterly MDS identified R1 with moderate cognitive impairment (Brief Interview for Mental Status score of 9), use of routine and prn pain medications, and reports of "almost constant pain) which affected his sleep as well as day-to-day activities. According to the assessment, R1 rated his worst pain experienced within the previous five days as "10" on a 1-10 pain scale.

The 12/16/18 "Care Area Assessment" (CAA) for pain reported R1 often asked for pain medication "5-10 minutes" after staff administered pain medication. According to the CAA, R1 was not always cooperative with attempts to alleviate pain by repositioning or other non-pharmacological approaches.

The undated "Care Plan" noted R1s chronic pain issues and his tendency to "frequently report" he did not get his pain medication. On 07/31/19, staff added an intervention to administer medication in the presence of two staff members (the charge nurse and the certified medication aide (CMA)). The care plan also described R1's monthly visits to a pain clinic. The care plan lacked R1's goals related to pain management.

A "Nursing Quarterly and PRN Data Collection" tool dated 06/17/19 described R1 with chronic pain described as aching, burning, and dull that inhibited activities of daily living.

Review of the "Physician Orders" included the following:

1) An 09/13/19 order for Morphine 15 milligrams (mg) once daily. Morphine is an opioid medication used to treat moderate to severe pain.

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2) An 09/13/19 order for Morphine 7.5 mg daily.

3) A 03/26/19 order for Lyrica 100 mg three times daily for treatment of generalized pain. Lyrica decreases the nervous system's ability to send out pain signals.

The Medication Administration Records (MARs) directed staff to document the resident's pain level prior to or at the time of administration of pain medications. Review of the assessments of R1's pain on the MARs was as follows:

1) August 2019: Staff documented R1's pain level as "0" with administration of Morphine 7.5 mg at noon on 17 of 17 days staff administered the medication. Staff documented R1's pain level with administration of Morphine 15 mg as "0" 17 of 34 times, with an additional three doses administered without assessment of R1's pain level at all.

2) September 2019: Staff documented R1's pain level as "0" with administration of Morphine 7.5 mg at noon on four of four days staff administered the medication. Staff documented R1's pain level with administration of 15 mg of Morphine at 08:00 AM as "0" on five of five days.

During an observation on 09/17/19 at 10:10 AM, Certified Nurse Aide (CNA) M and Certified Medication Aide (CMA) R repositioned R1 in his bed. The resident verbalized pain prior to and during movement. During the observation, R1 had the ability to verbalize his needs.

During an interview on 09/16/19 at 01:00 PM, R1 reported he "always" had pain and sometimes it

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was so severe he could not stand it. R1 confirmed staff administered pain medication "a couple of times a day" and stated the medication helped but never really relieved the pain entirely. When asked specifically about his level of pain, R1 reported he could not remember a time when his pain was not at least a "5" on a 1-10 scale.

During an interview on 09/17/19 at 02:00 PM, Licensed Nurse G confirmed R1 "always" had pain in spite of the amount of medications he received.

On 09/18/19 at 09:30 AM, Administrative Nurse D reviewed R1's August 2019 and September 2019 MARs and confirmed most of the documentation related to the resident's pain level at the time of Morphine administration rated the pain level at "0." Administrative Nurse D reported R1 "always" had pain when asked about his pain level. According to Administrative Nurse D, staff recorded the resident's pain level on the MAR as what staff thought his pain was rather than asking the resident to rate his own pain level.

The facility reported they do not have a pain management policy.

The facility failed to develop/implement an effective pain management program for R1 when staff failed to ask the resident his level of pain prior to administration of scheduled pain medication.