STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
DEC 17 2010	355093	A. BUILDING _____ B. WING DEC 8 2010	11/04/2010

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GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

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F 000	INITIAL COMMENTS For the Standard Medicare/Medicaid recertification survey started on November 1, 2010 and completed on November 4, 2010, the sample included four (4) residents for complete review, nine (9) residents for focused review, and two (2) closed records for review.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator | 12-7-10

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

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F 157	Continued From page 1 legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy and procedure, and staff interview, the facility failed to consult the physician and/or notify the resident's family members of a potential need for physician intervention for 3 of 3 sampled residents (Resident #1, #6, and #10) who experienced significant events requiring physician notification. Failure to notify the physicians limited their ability to consider changes in the residents' treatment programs, ensure the quality and appropriateness of care, resulted in Resident #6 experiencing untreated pain, did not allow Resident #10's family to make care decisions for the resident, and delayed care for the residents. Findings include: Review of the facility policy and procedure, Hypoglycemic Incidents, occurred on 11/04/10. This document, revised 01/09, stated "PURPOSE, To protect from complications of hypoglycemia. . . . PROCEDURE . . . 3. For blood glucose levels 45 [milligrams per milliliter (mg/ml)] or below as long as resident is able to swallow: . . . d. Notify physician immediately. If physician is not available, contact physician on-call for attending physician or the medical director; if not available contact the emergency room for further direction. . . . 4. If resident is unable to swallow . . . a. . . . physician notified per policy. . . ." - Observation of Resident #6 showed the following:	F 157	Since the survey, Resident #1 has died. Resident #6 was prescribed a Fentanyl Patch for pain as he was refusing to take oral medications. When Resident #10 saw the doctor on 07/02/10, the doctor charted "patient is to return to clinic if symptoms worsen, do not resolve, and PRN for problems." She has not had any instances of stool from vagina since 10/15/10. This occurance was one time, since she was seen on 07/13/10 by a Gynocologist, who found no fistula. The nursing staff is monitoring this. The physicians, who have residents that are diabetic, have been notified of our policy and to set low and high parameters. Telephone orders have been written to include low and high parameters and giving instructions to the nurses on how to proceed for hypoglycemic episodes. A list of diabetic residents has been made and orders have been written for all of them. The nurses will be inserviced on 12/08/10. The instructions from the physicians have been written up and put on the medication admininstration record. QA forms will be done by nursing staff daily for 2 weeks. Then QA coordinator and DON will do random checks of 3 residents monthly for 2 months. A list of residents taking PRN pain meds has been done. It also looks at the number of times it has been used. The QA coordinator and DON will discuss the findings, from the list, with the Unit Managers. If any changes are needed, the physician will be notified. The QA committee will discuss this issue every quarter.	

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F 157	Continued From page 2 * 11/02/10 at 10:15 a.m. - During toileting, when asked by a certified nursing assistant (CNA) if the resident's left leg hurt, the resident replied, "Oh you are [profanity] right it does." The resident grimaced during the transfer. Review of the as needed (PRN) Medication Administration Record (MAR) showed no pain medications were administered to Resident #6 at any time on 11/02/10. * 11/02/10 at 3:30 p.m. - After a staff member lifted Resident #6's left foot to place it back on the footpedal, the resident hollered out "[Profanity] that hurts so bad. My leg hurts so bad." The resident grimaced, became red in the face, and jerked his body back. When asked what part of his body hurt, he said his left leg and foot. Review of the resident's medical record showed the facility failed to provide any interventions to relieve the resident's pain. * 11/03/10 at 12:00 p.m. - The resident was refusing to eat dinner, yelling out, and swearing. A staff member asked the resident if he was in pain and he stated, "My leg hurts and my arm hurts all the time." The resident was then given 1000 milligrams (mg) of Extra Strength (ES) Tylenol. Observation of Resident #6 during the survey showed him periodically hollering out, swearing, self-propelling in the hallways (without apparent purpose), going into resident rooms, resisting prompts to eat/drink, and resisting cares. Untreated pain has the potential to cause an increase in agitation and restlessness. Review of Resident #6's medical record occurred on all days of survey. Diagnoses included insomnia, chronic back pain, history of a cerebrovascular accident (CVA) with left hemiplegia, anxiety, and depression. The record	F 157	The nurses will be inserviced on this issue on 12/08/10. A list of female residents, that get stool in their vagina, has been made. We found none. Nurses will be inserviced on 12/08/10 on the importance of informing physicians and families on occurances. We also discussed follow up charting. ADDENDUM: The doctor was notified of the stool in the vagina incident that happened on 10/15/10. All diabetic resident's sugar levels are being reviewed and their physician will be notified according to their instructions. A list will be made monthly for 3 months. The QA will be done monthly x3 and then quarterly.	12/14/10

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F 157	Continued From page 3 identified the resident showed increased confusion, mood/behavior, agitation, and restlessness, impacting his cares. The current significant change Minimum Data Set (MDS), dated 10/04/10, identified the resident understands others and is usually able to make his self understood, and showed the resident exhibited verbal behavioral symptoms directed toward others. During the pain interview, the MDS showed the resident stated he experienced almost constant pain in the last five days that made it hard for him to sleep at night and limited his day-to-day activities. Resident #6 rated the intensity of his worst pain over the last five days as a "3" indicating "severe." Review of the Resident Care Area Assessment for Delirium, dated 10/04/10, stated, " . . . He has increased in restlessness and becoming more agitationed [sic] in recent months . . . He does report having pain daily . . . Pain was referred to Unit Supervisor. . . ." Review of the Resident Care Area Assessment for Cognitive Loss/Dementia, dated 10/04/10, stated, " . . . Resident had more nights of poor sleep recorded than were good, during the assessment period. . . ." Review of the Resident Care Area Assessment for Pain, dated 10/04/10, stated, " . . . [Name of Resident] report having pain, which interupts [sic] his daily activity and sleep and is rated as moderate to severe which indicated a need for planning . . . [Name of Resident] indicates he has pain in rt [right] leg . . . he indicated it occurs everyday. He is not on a scheduled plain [sic] meed [sic] and has taken prrn [sic] ES Tylenol 17 [17 times] in September. He is confused with some inconsistent communication. He does verbalize. He also report [sic] difficulty sleeping at night and MD [medical doctor] is aware of this Med were reviewed [sic]	F 157		

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F 157	Continued From page 4 because of increased confusion . . . Unit supervisor was informed of comments regarding pain. . . ." Review of Resident #6's "Pain Management Review," dated 10/01/10 and completed in conjunction with his current significant change MDS, stated, "He admits to having pain daily. He states, "Yes all along the side and down the front of my leg" (indicates Rt leg). [sic] He points to severe on the verbal descriptor scale. He replies "Yes, I have it every day."He has used the PRN ES Tylenol 17 times in Sept [September] 2010 for various c/o [complaints of] - usually general discomfort. I reported the pain to his nurse who relates that he usually doesn't c/o the leg pain. He [Resident #6] related that the response to his c/o pain is usually "we will see what we can do." Will suggest asking physician for scheduled pain Rx [medication] or trial of PRN pain Rx used regularly as pain could be a contributing factor to his mood [and] behavior problems." The resident was last seen by his physician on 10/14/10. The resident's medical record and the progress note from the visit on 10/14/10 lacked evidence the facility notified the resident's physician on his constant, severe pain and the amount of PRN Tylenol used. Review of Resident #6's current medication regimen showed the only medication available for pain was as needed (PRN) ES Tylenol, 1000 mg every four to six hours. The resident's Medication Administration Record for the months of July 2010 - November 2010 showed the resident took PRN ES Tylenol 19 times in July, 25 times in August, 17 times in September, 24 times in October, and 1 time in November (November 3rd	F 157		

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F 157	Continued From page 5 at 12:00 p.m.). During an interview on 11/02/10 at 9:00 a.m., a nursing supervisor (#4) stated she doesn't recall Resident #6's physician being notified of the results and recommendations from the pain assessment completed on 10/01/10. During an interview on 11/04/10 at 10:45 a.m., an administrative nursing staff member (#3) agreed Resident #6's physician should have been notified in a timely matter regarding the resident's increased pain and excessive use of PRN Tylenol. The staff member (#3) agreed his uncontrolled pain could be contributing to his insomnia and increased agitation/restlessness. - Review of Resident #1's medical record occurred on November 01-04, 2010. The facility admitted the resident in 09/07. Current diagnoses included insulin dependent diabetes mellitus. Review of Resident #1's Diabetic Sheet (a facility form used to record blood glucose measurements and comments) showed blood glucose monitoring four times each day. For the period October 07-27, 2010, this form identified the following blood glucose measurements in mg/ml. The resident's Diabetic Sheet, Medication Administration Record (MAR), and the Interdisciplinary Progress Notes (IDPN) for these dates and times lacked evidence of physician notification. *10/07/10, 11:00 a.m. - 498; Comments - none. *10/12/10, 5:30 p.m. - 64; Comments "OJ [Orange Juice] given @ [at] 4:30 p.m.;" 8:30 p.m. - no measurement. *10/13/10, 5:00 a.m. - 53; Comments "OJ given @ 5:00 a.m.;"	F 157		

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F 157	Continued From page 6 *10/15/10, 5:00 a.m. - 55; Comments "Gave O [orange] juice." *10/17/10, 5:00 a.m. - 48; Comments "Gave milk. Re [check] 75." *10/21/10, 5:30 p.m. - 53; Comments - none *10/23/10, 5:00 a.m. - 50; Comments - none *10/26/10, 5:00 a.m. - 40; Comments "Gave (i) tube glucose gel.;" *10/27/10, 5:00 a.m. - 34; Comments "1 amp [ampule] D50 [Dextrose 50%]." *10/27/10, no time - 37; Comments "2 amp D50." *10/27/10, no time - 47; Comments - none" Review of Resident #1's medical record showed the facility staff failed to notify the resident's physician, the on-call physician, or the emergency room physician until 10/27/10. On that date the facility staff referred Resident #1 to the emergency room and the acute care facility admitted the resident. Failure to notify a physician regarding Resident #1's blood glucose levels, as identified in the facility's policy and procedure, prevented the resident's physician from considering treatment plan modifications that may have limited or prevented future hyperglycemic and hypoglycemic episodes. These episodes placed the resident at risk of complications of hypoglycemia, including convulsions and coma. - Review of Resident #10's medical record occurred on November 03-04, 2010. The facility admitted the resident in 05/08. Current diagnoses included delirium, dementia, and constipation. The resident's quarterly Minimum Data Set (MDS), dated 08/09/10, identified short and long term memory problems, severely impaired daily decision making ability, required extensive assistance of two or more persons for toileting and personal hygiene, and incontinent of bowel	F 157		

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F 157	Continued From page 7 and bladder multiple times each day. Resident #10's Interdisciplinary Progress Notes (IDPN) identified facility staff noted stool in the resident's vagina during perineal cares four times between 8:45 p.m. on 07/01/10 and 5:30 a.m. on 07/2/10. Facility staff contacted the resident's family members and referred Resident #10 to her local physician who referred the resident to a physician specialist. The medical record included the physician specialist's report, dated 07/13/10, which identified no problems and recommended referral to a surgical physician specialist if the problem recurred. Facility staff informed Resident #10's family of the findings and recommendation. Resident #10's IDPN, dated 10/15/10 at 8:30 p.m. and 10:15 p.m., identified facility staff again noted stool in the resident's vagina. The medical record lacked evidence facility staff consulted Resident #10's local physician and notified the resident's family regarding this recurrence. Failure to notify the physician and the family did not provide the physician or the family an opportunity to consider referral to a surgical physician specialist as previously recommended. During interview, on 11/04/10 at 9:30 a.m., an administrative nursing staff member (#3) reported she did not know why the facility staff failed to consult Resident #10's local physician and notify the resident's family of the recurrent stool in her vagina. This staff member reported she expected the facility staff to contact the physician and family members.	F 157		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written	F 226		

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F 226	Continued From page 8 policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy/procedure, and staff interview, the facility failed to follow their polices/procedures and investigate 2 of 2 sampled residents (Resident #10 and #11) with injuries. Failure to investigate accidents and incidents prevented the facility from identifying events, occurrences, patterns, and trends that may constitute abuse or neglect and determine any quality improvement measures that may be required to prevent future occurrences. Findings include: Review of the facility policy titled "Abuse and Neglect" occurred on 11/04/10. This policy, revised February 2005, stated, "PURPOSE * To ensure that the center has in place an effective system that regardless of the source prevents mistreatment, neglect and abuse of residents or misappropriation of their property . . . * To ensure that all identified incidents involving injuries of unknown origin are promptly investigated to determine probable cause of unknown origin injuries and are reported . . . * To prevent future injuries * To ensure that a complete review of existing incidents is documented * To identify events, such as suspicious bruising of residents, occurrences, patterns and trends that may constitute abuse and to determine the	F 226	Skin has been assessed on Resident #10 and #11 by DON and no bruises or skin tears were found. Residents have been, in the past and present, given a weekly skin assessment by nurses. This is usually done following the resident's bath. A form entitled "Skin Assessment Log" will be given to the nurses with instructions to fill out on any resident that presently has a bruise or skin tear. This form will be given to the DON who will see if an incident report was made. In the past, the nurses were writing incident reports on only unknown injuries. They have now been instructed to fill out an incident report on known and unknown injuries. From this incident report, an investigation will be done by the nurses and the DON. If there is a pattern noted, it will be brought to the attention of the Safety Committee, the QA Committee and the DON. The CNA's will also fill out a "Skin Assessment Log". They have been instructed to fill this out and to verbally report any skin abnormalities to the nurses. An inservice will be given 12/08/10 to the nurses and 12/09/10 and 12/10/10 to the CNA's. We will discuss the policy regarding 2 staff members needed to use a lift on a resident, the importance of reporting injuries of known and unknown injuries and the reason for filling out incident reports on known and unknown injuries. A QA will be done by the QA coordinator and DON on incident reports. This form will be filled out whenever a skin injury occurs and if there is a pattern noted. This will be done for 6 weeks.	12/14/10

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F 226	Continued From page 9 direction of the investigation . . . PROCEDURE 1. All staff are responsible for reporting any situation that is considered abuse or neglect along with injuries of unknown origin (including any suspicious bruising, skin tears, or other injuries), misappropriation of resident property, or involuntary seclusion by completing the center Resident/Visitor Incident Report . . . This completed incident report will be routed per center procedure . . . 3. When the cause can be identified through interviews of staff and residents, AND this is NOT a case of alleged or suspected abuse or neglect, these findings will be noted in the "Narrative of Incident" section of the Resident/Visitor Incident Report . . . 12. The center will record all incidents/accidents on the Incident Record Log . . . This should be done on a weekly basis and retained in the center. The Resident Incident Trending Chart . . . should be completed and forwarded to the Quality Assurance Committee. These forms are kept to assist staff in the identification of events, occurrences, patterns and trends that may constitute abuse; and to determine any quality improvement measures that may be required to prevent further occurrences. . . ." Review of the facility policy titled "Resident/Visitor Incident Report" occurred on 11/04/10. This policy, revised January 2009, stated, " . . . POLICY: All incidents/occurrences occurring within the center or affecting a resident/visitor will be documented, investigated and evaluated to determine contributing factors and to prevent recurrence whenever possible. . . ." Review of the facility procedure titled	F 226	ADDENDUM: The QA will be done weekly for 4 weeks and then monthly for 2 months.	

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F 226	Continued From page 10 "Resident/Visitor Incident Report" occurred on 11/04/10. This policy, revised January 2009, stated, "PURPOSE * To document resident and visitor incidents * To conduct an investigation of each incident * To gather objective information and identify root causes to prevent similar occurrences from happening in the future DEFINITION * Incident - an occurrence with or without injury, i.e., falls, elopement, etc., or a deviation from the standard of care that includes, but is not limited to, a physical injury; verbal, physical, mental or sexual abuse; failure to provide treatment; misappropriation of resident property, etc. PROCEDURE 1. The Resident/Visitor Incident Report . . . is completed for each resident and/or visitor incident that occurs . . . 20. All incidents and accidents are recorded on the Incident Record Log . . . This is done weekly. The Resident Trending Chart . . . is completed and forwarded to the Quality Assurance Committee. The Incident Record Log and Incident Trending Chart are completed in order to assist staff in the identification of events, occurrences, patterns and trends that may constitute abuse and to determine any quality improvement measures that may be required to prevent future occurrences . . . 21. Safety incidents will be reviewed by the Safety Committee each month to assess trends and take appropriate action. Results will be reported to the Quality Committee, using the Resident Incident Trending Chart. . . ."	F 226		

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GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

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F 226	Continued From page 11 During a confidential interview on 11/02/10, a certified nursing assistant (CNA) (#1) identified she/he had reported, to the nurse, a fellow CNA for transferring residents (Resident #10 and #11) without assistance using a full body mechanical lift. The CNA (#1) stated that in both instances the residents suffered a skin tear. The CNA (#1) identified the facility policy requires two staff members when transferring a resident with a full body mechanical lift. During a confidential interview on 11/03/10, a CNA (#2) confirmed facility policy requires two staff members with transfers when using a full body mechanical lift. - Review of Resident #11's record occurred on November 03-04, 2010. Diagnoses included advanced dementia and deconditioning. The current quarterly Minimum Data Set (MDS), dated 08/01/10, identified the resident with short and long term memory problems, severely impaired in daily decision making, and "rarely/never" for both making self understood and ability to understand others. The MDS identified the resident with no mood/behavior problems, showed the resident transferred with total assistance of two or more staff members, and required extensive assistance of two or more staff members for bed mobility. Resident #11's current care plan showed the resident transferred with a hoyer lift. Review of Resident #11's Interdisciplinary Progress Notes revealed the following: * 01/09/10 at 7:10 a.m. - "CNA brought [name of resident] to me - noted on rt [right] [upper] inner arm [and] inner elbow redness - CNA stated was there when she got [name of resident] up [and]	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	11/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

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F 226	Continued From page 12	F 226		

dressed - will monitor redness [every day] til [until] resolved." (The resident's Annual MDS, dated 11/01/09, identified the resident needed extensive assistance of two staff members for transfers.)

* 01/11/10 at 10:00 a.m. - "CNA requests using the mechanical lift for transfers due to resident inability to comprehend [and] assist in transfer . . ."

* 01/12/10 at 7:00 p.m. - "noted when [checking] rt [upper] inner arm [and] elbow area - scattered smaller purplish/red areas [with] yellowing around them."

* 04/17/10 at 7:15 p.m. - "CNA reported skin tear to (Lt) [left] elbow while transferring. Arm rubbed on mesh lift pad . . ."

* 08/09/10 at 1:00 a.m. - "N.A. [nurse aide] came to inform nurse that res [resident] (L) [left] arm bldg [bleeding]. (L) FA [forearm] has L shaped skin tear [and] has bled, sl. [slightly] clotted over, dried blood on res. hands/nail esp [especially] [right] hand . . ."

During an interview on 11/04/10 at 10:45 a.m., an administrative nursing staff member (#3) confirmed the facility failed to complete an incident report and investigate the incidents/accidents with Resident #11 on 01/09/10, 04/17/10, and 08/09/10. The staff member (#3) stated she expected staff to complete an incident report when injuries occur and to investigate the source of the injuries and the circumstances surrounding the incidents. The staff member (#3) confirmed the facility requires the assistance of two staff members for all transfers using mechanical lifts.

The facility failed to include the injuries occurring to Resident #11 on 01/09/10, 04/17/10, and 08/09/10 on the facility's Incident Log, as per their

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	11/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

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F 226	Continued From page 13	F 226		

policy. The resident experienced an unknown injury to her arm and elbow on 01/09/10, still visible on 01/12/10, with the circumstances unknown. Resident #11 experienced a skin tear from a mesh lift pad on 04/17/10 during a transfer, with unknown circumstances, such as the number of staff members assisting with the transfer. The events leading up to the resident experiencing a skin tear on 08/09/10 are also unknown. Failure to record the injuries on the facility's Incident Log and failure to investigate the circumstances involved with the injuries to Resident #11 prevented the facility from tracking and trending injuries and implementing corrective action, if deemed necessary.

- Review of Resident #10's medical record occurred on November 03-04, 2010. Current diagnoses included delirium and dementia. The resident's quarterly Minimum Data Set (MDS), dated 08/09/10, identified short and long term memory problems, severely impaired daily decision making, and required extensive assistance of two persons for transfers.

Resident #10's medical record identified she independently propels her wheelchair in the facility and identified "scattered petechiae" and "bruises" to her arms related to this activity. The medical record also included an Interdisciplinary Progress Note, dated 05/26/10 at 8:00 p.m., which stated "Skin tear on transfer to bed. Bumped grab bar. . . ." The progress note failed to identify the part of the resident's body affected by the skin tear or the events during the transfer.

Review of the facility's Incident Record Log, on 11/04/10, failed to identify Resident #10's skin tear of 05/26/10. During interview, on 11/04/10 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	11/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 226	Continued From page 14 9:30 a.m., with an administrative nursing staff member (#3), the surveyor requested information regarding whether the facility investigated Resident #10's skin tear of 05/26/10. During interview, on 11/04/10 at 1:30 p.m., this staff member reported the facility did not have an investigation of the skin tear. The facility identified Resident #10 experienced bruises to her arms as she propels her wheelchair in the facility. The resident experienced a skin tear during a transfer and the circumstances of the transfer are not known. Failure to investigate the circumstances resulting in the skin tear prevented the facility from implementing any corrective action and placed all facility residents requiring assistance with transfers at risk of injury. Failure to record the skin tear on the facility's Incident Record Log prevents the facility from tracking and trending skin tears and injuries and implementing corrective action if warranted.	F 226		
F 240 SS=D	483.15 CARE AND ENVIRONMENT PROMOTES QUALITY OF LIFE A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy/procedure, and staff interview, the facility failed to provide care in a manner that promoted and enhanced the quality of life for 1 of 3 sampled residents (Resident #6) who required	F 240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	11/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

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F 240	Continued From page 15 supervision with eating. Failure to assess Resident #6's dining skills and needs and provide him with necessary assistance and/or assistive devices did not create or maintain an environment that individualized and humanized his dining experience and negatively affected his quality of life. Findings include: Review of the facility policy/procedure titled "Assistive Devices" occurred on 11/04/10. This policy, revised March 2009, stated, "PURPOSE: To provide assistive devices to maintain or improve the resident's ability to eat independently. POLICY: The center will provide special eating equipment and utensils for residents who need these items. PROCEDURE: 1. The rehabilitation nurse or designee, in conjunction with the director of dietary services, may make recommendations regarding resident use of assistive devices. 2. Every effort will be made to assist a resident in attaining/maintaining independence in eating. 3. Residents who demonstrate inability to feed themselves independently will be evaluated regarding the continuing need for assistive devices. 4. Assistive devices will only be used with the approval of the resident. . . . 7. Use of these devices will be noted on the care plan and dietary card. 8. Effectiveness of devices will be evaluated initially and quarterly by dietary department. Staff will develop alternative recommendations as necessary . . ." - Review of Resident #6's medical record occurred on all days of survey. Medical diagnoses included history of a cerebrovascular accident (CVA) with left sided hemiplegia/hemiparesis (paralysis), diabetes mellitus type II, depression,	F 240	Resident #6 was given adaptive equipment to assist him in feeding self. His condition has worsened and now needs staff to feed him. DON will observe a meal to see if residents are using the correct equipment and receiving the help they need. From this observation, a list will be made of each resident with adaptive equipment. If a resident needs a change in adaptive equipment or needs adaptive equipment, it will be placed on the care plan. As assessment will be made on any new admissions regarding use of adaptive equipment, too. The Dietary Manager and DON will do a QA monthly for 2 months. From this QA, We will check the care plan to make sure the adaptive equipment is listed. ADDENDUM: If the DON and Dietary Manager can not figure out the best solution for adaptive equipment for a particular resident, an order will be obtained from the physician to have the occupational therapist assess and evaluate for different adaptive equipment in the dining room. Residents will be monitored on a regular basis by administrative staff and professional staff to ensure dignity of residents and provide assistance to the residents. The Dietary Manager and DON will do a QA weekly for 1 month and then monthly for 2 months. From this QA, OT will be notified if needed and any changes will be placed on the care plan. The nurses and CNA's were inserviced in December on the importance of notifying DON and Dietary Manager about any residents having difficulty feeding themselves.	12/14/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	11/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

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F 240	Continued From page 16	F 240		

and anxiety. The current significant change Minimum Data Set (MDS), dated 10/04/10, identified Resident #6 as usually being able to make himself understood and able to understand others. The MDS showed the resident exhibited mood and verbal behavioral symptoms and required supervision of one person to assist with eating. Review of Resident #6's care plan identified the resident with left sided weakness due to a CVA, requiring a neutral positioning brace to his left wrist during the day, and inability to use his left arm/hand. Resident #6's medical record and care plan lacked information regarding the resident needing staff assistance/assistive devices at meals.

Observation of Resident #6 during meals/snacks identified the following:

* 11/02/10 at 7:50 a.m. - Resident #6 was in his wheelchair at the dining room table eating his breakfast independently. Throughout the meal, the resident needed to fully extend his arm to reach his liquids placed near the middle of the table. The resident had to lean forward and reach to access each glass of liquid (for every drink). As Resident #6 ate his cereal, he reached for the bowl and slowly and carefully brought the spoon to his mouth. Milk and cereal dropped from his spoon and onto his clothing protector, lap, and floor. Facility staff failed to assist the resident with his meal by placing his bowl and fluids closer to him for easier access.

* 11/02/10 at 9:45 a.m. - Resident #6 remained in his wheelchair in the hallway. A staff member (#6) handed him his morning snack consisting of a milk product in a small plastic cup with a lid and a straw. Immediately after the staff member handed him the drink and walked away, Resident #6 was unable to get a good grasp on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	11/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 240	Continued From page 17	F 240		

the cup and spilled the glass of liquid. He hollered out "[Profanity] that is cold!" The resident became agitated and hollered out random statements for approximately twenty minutes until a staff member took the spilled glass from him. Multiple staff members walked by the resident and failed to assist him with the spilled snack in a timely manner. Facility staff failed to provide the resident with a new snack.

* 11/02/10 at 12:20 p.m. - Resident #6 was in his wheelchair at the dining room table for the noon meal. He independently ate his meal of bread, baked potato, turkey casserole, pickled beets, milk, cranberry juice, coffee, water, and pudding, on a standard plate and with standard silverware. Resident #6 reached for his glasses of liquids and plate throughout the meal, as they were positioned a distance from him. Resident #6 picked up the entire baked potato with his fork and took bites of the potato. Each time the resident attempted to scoop the turkey casserole onto his fork, it spilled over the edge of his plate onto the table. The resident began eating the turkey casserole directly off the table. This continued for the entire meal as he ate the turkey casserole. Food splatters covered his clothing protector, lap, and floor. Resident #6 picked up the plastic dish with pickled beets and lifted the cup to shake the beets into his mouth. The resident dropped the plastic cup of beets on the floor. The resident started to holler out, became agitated, and pushed himself away from the table. Staff sat near the resident to assist other residents with eating and often walked by the resident during the meal. Staff failed to place the resident's food/drinks within reach, cut up his potato, obtain a new cup of beets, encourage/cue the resident with eating, and failed to assist the resident or provide assistive devices to enhance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	11/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

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F 240	Continued From page 18 Resident #6's ability to eat independently and in a dignified manner. * 11/02/10 at 12:45 p.m. - A CNA (#7) came and pushed the resident's wheelchair back to the table, set his drinks in front of him, and encouraged him to drink. Resident #6 then drank the rest of his cranberry juice and water. During an interview on 11/03/10 at 3:45 p.m., a licensed occupational therapist (#9) stated nursing or dietary refer residents they identify as needing a meal evaluation. She stated she was never notified of Resident #6's difficulties with meals. After being informed of the observations of the resident eating during survey, she stated she would expect to be notified so she could conduct an assessment and possibly try some adaptive equipment. During an interview on 11/04/10 at 8:45 a.m., a dietary staff member (#10) stated she expected nursing and dietary staff members to help residents with meals when staff identify the need for assistance. The staff member (#10) stated when she receives notification of a resident needing increased assistance with eating, she attempts solutions herself, or she will make a referral to Occupational Therapy. She was unaware of Resident #6's current difficulties during snacks/meals and stated she observed him during breakfast on 10/03/10 and had no concerns at that time. During an interview on 11/04/10 at 10:45 a.m., an administrative nursing staff member (#3) stated she expected staff to meet the needs of Resident #6 and provide him with the level of assistance needed at each meal. She agreed the resident would benefit from having a meal/snack	F 240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	11/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 240	Continued From page 19 assessment completed. The facility failed to assess the resident for the use of assistive devices, failed to assist the resident with the placement of his meal items, failed to respond to his episodes of agitation/frustration, and failed to recognize and assist the resident as he ate his meal off of the table. These failures resulted in Resident #6 eating in an undignified manner and displaying increased agitation and negative behaviors, which could lead to an avoidable weight loss and/or the use of unnecessary medications.	F 240		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide an ongoing, meaningful activity program to meet the physical, mental, and psychosocial needs for 2 of 7 sampled residents (Resident #6 and #11) dependent on staff to attend activities. Failure to provide meaningful activities designed to reflect each resident's interests and lifestyle has the potential to negatively impact a resident's sense of self-worth and belonging. Lack of meaningful activities could have contributed to Resident #6's mood and behavior symptoms, resulting in increased restlessness and agitation.	F 248	1. Resident #6: Establish a 1:1 program to establish friendships, offer leisure activities of his past interest and adapt as needed. Resident #11: Offer 1:1 small group programs such as sensory activity. Provide in room activity such as music. Bring to center activities of her past interest. 2. Do a population analysis worksheet to establish a base line of residents who do not attend at least 3 group activities per week. This will be done to establish a list of residents who may benefit from 1:1 small group activities and to learn participation level of the resident population. Care plan for 1:1 small group. 3. Do a population analysis worksheet as needed to determine the changing needs of the residents. Provide a copy of the 1:1 small group policy procedure to activity staff. Train activity staff on programs and techniques to be used in 1:1 samll group. Remind all staff that it is eveyones responsibility to assist residents with leisure activities	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	11/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 248	Continued From page 20 Findings include: Review of the facility policy titled "Activity Services" occurred on 11/04/10. This policy, revised July 2005, stated, "PURPOSE: To ensure a structured and comprehensive service of recreation and leisure programs which facilitate a balanced life. POLICY: Activity services will focus on the cognitive, physical, spiritual, community, social, creative as well as any selected special needs of each individual resident. Creating, supporting, developing and restoring the resident's appropriate lifestyle through structured and spontaneous activity programming will enable the resident to participate in opportunities that will help to achieve his or her highest practicable level of functioning. The services of the activity department assist the resident to manage tasks of daily life. Since leisure/recreation are important components of daily life and an integral part of holistic care, therapeutic approaches to activities and programs will be implemented and offered to each resident." - Review of Resident #6's medical record occurred on all days of survey. Medical diagnoses included history of a cerebrovascular accident (CVA) with left sided hemiplegia/hemiparesis (paralysis/weakness), insomnia, chronic back pain, anxiety, and depression. The current significant change Minimum Data Set (MDS), dated 10/04/10, identified the resident with clear	F 248	of their interest. This will be presented to nursing staff at the inservices on 12/08/10, 12/09/10 and 12/10/10. 4. PUrchase new electronic equipment that may more accurately reflect resident participation and involvement. Do a QA daily for 1 week to see if the hand helds are accurately recording and sending data. Do a QA monthly for 3 months to monitor data being sent to National CAmpus and randomly. Thereafter to monitor on going data being sent. ADDENDUM: From the population analysis worksheet, a list of those needing 1:1 activities will be on paper. Those needing 1:1 activities will be scheduled throughout the week. The Activity Department will do a QA by randomly picking 3 residents weekly for 4 weeks and then monthly for 2 months. She will be checking to see if these residents are receiving 1:1 activities by staff throughout the week.	12/14/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	11/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 248	Continued From page 21 speech, usually able to make himself understood, and able to understand others. The MDS identified the resident with adequate hearing and able to see large print. The current MDS showed Resident #6 with mood and behavior symptoms present. The MDS also indicated the resident required limited assistance of one staff member for locomotion on the unit and extensive assistance of one staff member for locomotion off the unit. The MDS showed Resident #6 replied "very important" when asked how important it was to him to listen to music he likes, be around animals such as pets, to keep up with the news, to do things with groups of people, to do his favorite activities, and to participate in religious services or practices. When asked how important it was to the resident to go outside to get fresh air when the weather is good, the resident responded "somewhat important." Review of Resident #6's Resident Care Area Assessment for "Activities" from the 10/04/10 MDS stated, "He states he has little interest in doing things, has memory problems, periods of restlessness and a short attention span. He spends he [sic] awake time around othere [sic] will talk to other residents, staff and or family friends. He propells [sic] he [sic] w/c [wheelchair] around the center but is not sure where he is going. Has family friend contact . . . has not shown any interest in leisure activity other than spending time with others. He like [sic] to fidget with doors and other items. He feels he works here. He has a history of enjoying gardening, grand children, music and table games like cards but when given cards shows no interest. He has limited use on [sic] one arm and is in a wheel chair but is able to propell [sic] per self. When given cards and a card holder, taken to music,	F 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	11/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

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F 248	Continued From page 22 placed near a TV, offered magazines may look at for a short period of time and go on his way . . ." Review of the most recent activity assessment for Resident #6, dated 07/09/10, showed the following as his current interests: cards (rummy), baseball, dancing, football, walking, hunting/fishing, listening to music, fishing magazines, restaurants, rides, tending garden/plants, lawn work, baking, cooking, animals/pets, phone use, helping others, talking/conversing, TV, and senior citizens. The activity assessment stated, " . . . slow to respond but able to express himself . . . some vision loss . . . He is able to express himself [and] answer questions but fell [sic] asleep easily. States he wants to go home as soon as possible. Has good family contact. Will need encouragement to be at center activities." Resident #6's Interdisciplinary Assessments and Summary Reviews, dated 10/11/10, stated, " . . . Resident indicated little interest in leisure activities and exhibits the same. Resident has periods of restlessness and is easily distracted. Resident's goals are not met on previous care plan. Will monitor and encourage leisure activities as able . . ." Review of Resident #6's current care plan, dated 10/12/10, identified the concern of "I have limited interest in leisure activities, a short attention span, lack of motivation, memory problems and periods of restlessness." Approaches for this goal included "observe [and] record independent activities of watching TV, visiting [and] other activities of interest, invite to center activities of music, parties, men's group, social programs and other programs of interest, visit and encourage	F 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	11/04/2010

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GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 248	Continued From page 23 expressing self in a positive manner, enjoys teasing, provide center TV, to assist with independent activity, has a history of enjoying sports, assist with mail, e-mail, take on outings or home per family request as able . . ." The resident's care plan did not address one to one activities with staff. Observations of Resident #6 occurred throughout the survey and revealed the following: * 11/01/10 at 5:00 p.m.: Sitting in his wheelchair (w/c) in the commons area with eyes closed and head down * 11/02/10 at 7:50 a.m.: Eating breakfast in the dining room * 11/02/10 at 9:10 a.m.: In his w/c in the commons area, yelling out "Mike, come here! We need to take the tires to Minot, [profanity]!" * 11/02/10 at 9:25 a.m.: Activity staff reading aloud to other residents at a table in the commons area. Resident #6 sat in his w/c about 20 feet away from the activity with his head down and with his back facing the activity group. No one attempted to engage the resident or take him to the area of the activity. * 11/02/10 at 9:35 a.m.: Self-propelling in w/c in the hallway * 11/02/10 at 9:45 a.m.: Sitting in w/c in the commons area. An activity staff member gave the resident a cup of milk and walked away. Resident #6 spilled the milk immediately and became agitated/hollered out for approximately 15 minutes until assisted. Continued to sit in w/c in the hallway. * 11/02/10 at 10:15 a.m.: Toileted and then sat in his room in his w/c, eyes closed and head down * 11/02/10 at 12:20 p.m.: Eating lunch in the dining room * 11/02/10 at 12:55 p.m.: Toileted in the bathroom	F 248		

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F 248	Continued From page 24 adjoining his room * 11/02/10 at 1:00 p.m.: Sitting in his room in his w/c, head down and eyes closed, roommate's radio on at a low volume * 11/02/10 at 1:50 p.m.: Self propelling in the hallway * 11/02/10 at 3:10 p.m.: Still self propelling in the hallway * 11/02/10 at 3:30 p.m.: Sitting in his w/c in the hallway * 11/02/10 at 4:30 p.m.: Toileted and taken to commons area, self propelling and hollering out "Who the [profanity] shot those baby birds, [profanity]." * 11/02/10 at 5:45 p.m.: Sitting in w/c in the hallway, head down and eyes closed * 11/03/10 at 7:45 a.m.: In w/c in the commons area, head down and eyes closed * 11/03/10 at 8:25 a.m.: Declined breakfast, self propelling w/c in the hallway * 11/03/10 at 8:50 a.m.: Sitting in wheelchair in the middle of the hallway, eyes closed and head down * 11/03/10 at 11:45 a.m.: Agitated and swearing, self propelling into other residents' rooms, looking for his "apartment" * 11/03/10 at 11:50 a.m.: Agitated, declined lunch, sitting in w/c in the hallway * 11/03/10 at 12:00 p.m.: Swearing, toileted, taken to commons area/self propelling in hallway * 11/03/10 at 2:00 p.m.: Toileted, taken to commons area * 11/03/10 at 2:40 p.m.: Sitting in w/c in his room, room dark, roommate sleeping, roommate's radio on softly * 11/03/10 at 3:20 p.m.: Sitting in w/c by nurse's station, head down * 11/03/10 at 5:00 p.m.: Self propelling in hallway * 11/03/10 at 5:50 p.m.: In dining room for supper,	F 248		

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F 248	Continued From page 25 head down * 11/04/10 at 8:00 a.m.: In dining room, finished with breakfast, rocking back and forth in his w/c * 11/04/10 at 9:00 a.m.: Still in dining room, restless, hollering out Review of the Activity Logs for Resident #6 from July 2010 - October 2010 showed the resident most often participated in the following activities: visiting with family/friends/staff, watching TV, bird watching, activity rounds, parties/programs/music, and exercise. The Activity Logs for Resident #6 showed an activity staff member charted a one to one visit with the resident on 11/02/10. During an interview with the activity staff member (#8) on 11/03/10 at 12:45 p.m., when asked what the one to one activity she did with Resident #6 on 11/02/10 entailed, she stated she did not visit the resident that day, but said "hi" to him in the hallway. The staff member (#8) stated Resident #6 rarely participated in group activities and was more of a "one to one type of guy." During an interview on 11/04/10 at 9:00 a.m., an activity staff member (#6) stated one to one activities with Resident #6 can range anywhere from one minute to twenty minutes, depending on his mood. She stated "Activity Rounds" are short one to one interactions with the residents. The staff member (#6) stated she considered a good quality one to one activity to be five to ten minutes long. The staff member (#6) stated she recognized Resident #6 doesn't have many activities as she feels they have backed away due to his increased agitation. She agreed a more engaging and frequent activity program could be a proactive approach in dealing with Resident	F 248		

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F 248	Continued From page 26 #6's agitation and potentially decrease his mood/behavior symptoms overall. The activity staff member (#6) stated most of the activity staff members are certified nursing assistants (CNAs) and are pulled from activities to work on the floor if they are short CNAs, which ultimately affects the residents' time with activity staff. Activity staff members are also required to drive residents to clinic appointments, which also takes away from the amount of time they can spend doing activities with the residents. The activity staff member (#6) stated the majority of the activities are tailored for residents who are able to participate in large group settings. - Review of Resident #11's medical record occurred on November 03-04, 2010. Medical diagnoses included advanced dementia, depression, deconditioning, and anxiety. The current quarterly MDS, dated 08/01/10, identified the resident with short and long term memory problems, severely impaired in daily decision making, and "rarely/never" for both making self understood and ability to understand others. The MDS identified the resident needed total assistance of one staff member for locomotion on and off the unit. The "Activities" portion of the MDS showed Resident #11's preferred activities included cards/other games, crafts/arts, exercise/sports, music, reading/writing, spiritual/religious activities, trips/shopping, walking/wheeling outdoors, TV, gardening of plants, talking or conversing, and helping others; and Resident #11 spent less than 1/3 of her time involved in activities and preferred activities in the day/activity room. Review of Resident #11's Interdisciplinary Assessments and Summary Reviews, dated	F 248		

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F 248	Continued From page 27 11/02/10, stated, "Annual charting [sic] Activities . . . She is totally dependent on others for all her needs. She is hard to assess as to how much enjoyment she receives from spending time with others [and] or attending leisure activities. May or may not give eye contact [and] or smile rarely never speaks spends her awake time around others where she is encouraged to respond. Has a hx [history] of enjoying music, spiritual programs [and] or plants. She is provided 1-1 [one to one] small group activity where she is encouraged to respond. She has good family contact may attend activities with her when present. They encourage responses as well. She has a hx of enjoying TV programs especially family or animal type. She is brought to center activities of her past interest as able. She has memory problems [and] does not make decisions . . ." Review of Resident #11's current care plan, dated 08/10/10, identified the concern of "Altered leasure [sic] activity [and] communication R/T [related to] dementia M/B [manifested by] shows little interest in spendi [sic] [spending] time with others or attending activities, has good family contact, takes frequent naps, dependent on others for all her needs, rarely never speaks has difficulty understanding others." The care plan showed the long/short term goals of "will attend activities of my past interest I have a Hx of enjoying music, spiritual programs and social groups . . . will be encouraged to respond to others . . . will spend my awake time in the day areas where others can visit with me and I can observe center life . . ." The resident's care plan included the following approaches: "Encourage responses in 1-1 small group activity, provide lotion rubs, music, readings, w/c rides, and other	F 248		

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F 248	Continued From page 28 activities of interest, bring to vesper [service], hymn sing, morning service and other activities of interest. Provide doll or stuffed animal to hold as may find comfort in these items. Has difficulty expressing self. Needs simple direct communication. Make chaplain referals [sic], set hair, provide TV, assist with family contact. Anticipate needs . . ." Observation of Resident #11 occurred on November 03-04, 2010 and revealed the following: * 11/03/10 at 11:50 a.m.: In Horizon w/c at the dining room table for lunch, staff assisted with meal * 11/03/10 at 2:05 p.m.: Laying in bed, eyes open * 11/03/10 at 4:15 p.m.: Brief changed, transferred from the bed to her w/c, taken out to commons area by nurse's station * 11/03/10 at 4:45 p.m.: In Activity Room, Beverly Hills movie on, eyes closed * 11/04/10 at 8:00 a.m.: In dining room for breakfast, staff assisted with eating * 11/04/10 at 9:00 a.m.: In Horizon w/c in her room, eyes open, no radio or TV on (resident does not have a TV in her room) * 11/04/10 at 9:45 a.m.: Still in w/c in her room, not taken to any activities (exercise, devotions, and Bible study going on in the activity room all morning) * 11/04/10 at 10:20 a.m.: Still in w/c in room, no stimulation, not taken to coffee hour in activity room going on at this time Review of Resident #11's Activity Logs from August 2010 - October 2010 showed the resident most often participated in the following activities: visiting with family/friends/staff, religious services, watching TV, and parties/programs/music. The	F 248		

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F 248	Continued From page 29 Activity Logs showed the facility failed to provide activities for Resident #11 for 12 days in August, 14 days in September, and 18 days in October. The Activity Logs showed facility staff only performed two one to one activities with Resident #11 in the last 90 days. During an interview on 11/04/10 at 9:30 a.m., an activity staff member (#6) stated Resident #11 is usually in the activity room from 9:00 a.m. until 12:00 p.m. each day. She stated the resident observes activities going on at this time and people visit with her. The staff member (#6) stated staff bring her to coffee hour, place her in front of the window to look outside, and play Beverly Hillbillies and Danny O'Donnell on the TV for her. The activity staff member (#6) agreed staff take the resident to some activities that are not appropriate for her current status/needs. The staff member (#6) stated she realized they could do more one to one activities with the resident tailored to her level of functioning, including more sensory stimulating and engaging activities. The staff member (#6) explained the facility does not have an area to have small group activities for residents more dependent on staff for activities, as the large activity room is the only place to go and it is always in use with large group activities. The activity staff member (#6) agreed the majority of the activities at the facility are large group activities for more independent residents. The staff member (#6) agreed there is a need for more meaningful and frequent activities for residents who are lower functioning and more dependent on staff for activities. The facility failed to develop an ongoing, meaningful, and individualized activity program designed to meet the current physical, mental,	F 248		

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F 248	Continued From page 30 and psychosocial needs for Resident #6 and #11. The facility failed to consistently provide stimulating and engaging activities to these residents and failed to adapt their activity program to their changing needs. A well-developed and individualized activity program could potentially decrease behaviors and improve the residents' quality of life.	F 248		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: 1. Based on observation, record review, and staff interview, the facility failed to provide the necessary care and services to attain the highest practicable physical, mental, and psychosocial well-being for 1 of 1 sampled resident (Resident #6) with uncontrolled pain. Failure to address Resident #6's pain decreased his quality of life and well-being and contributed to his behaviors and insomnia. Findings include: - Observation of Resident #6 showed the following: * 11/02/10 at 10:15 a.m. - During toileting, when asked by a certified nursing assistant (CNA) if the resident's left leg hurt, the resident replied,	F 309	Resident #6 was started on Fentanyl Patch on 11/09/10. His behaviors have escalated and he was refusing to take oral meds. The psychiatrist saw him on 11/19/10 because Resident #6 was not cooperating with staff for his own safety and was not sleeping at all. A blood clot was found and he would not stay on bed rest. At this time, he is being medicated so he can get some bed rest and to thin his blood. Nurses will be in contact with the psychiatrist to reduce medications. They will then be incontact with the primary physician to increase the Fentanyl Patch. Staff is working hard to get pain and behaviors controlled. Since the survey, Resident #1 and #3 have died. A list of residents taking PRN meds have been done. It also looks at the number of times it has been used. The nurses, from this list, will use their nursing judgement and notify the physician if a PRN medication should be ordered routinely or if a new pain medication should be ordered. The QA coordinator and DON will get the list and discuss the findings with Unit Managers. If any changes are needed, the doctor will be notified. The QA committee will discuss this issue every quarter.	

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F 309	Continued From page 31 "Oh you are [profanity] right it does." The resident grimaced during the transfer. Review of the as needed (PRN) Medication Administration Record (MAR) showed no pain medications were administered to Resident #6 at any time on 11/02/10. * 11/02/10 at 3:30 p.m. - After a staff member lifted Resident #6's left foot to place it back on the footpedal, the resident hollered out "[Profanity] that hurts so bad. My leg hurts so bad." The resident grimaced, became red in the face, and jerked his body back. When asked what part of his body hurt, he said his left leg and foot. Review of the resident's medical record showed the facility failed to provide any interventions to relieve the resident's pain. * 11/03/10 at 12:00 p.m. - The resident was refusing to eat dinner, yelling out, and swearing. A staff member asked the resident if he was in pain and he stated, "My leg hurts and my arm hurts all the time." The resident was then given 1000 milligrams (mg) of Extra Strength (ES) Tylenol. Observation of Resident #6 during the survey showed him periodically hollering out, swearing, self-propelling in the hallways (without apparent purpose), going into resident rooms, resisting prompts to eat/drink, and resisting cares. Untreated pain has the potential to cause an increase in agitation and restlessness. Review of Resident #6's medical record occurred on all days of survey. Diagnoses included insomnia, chronic back pain, history of a cerebrovascular accident (CVA) with left hemiplegia, anxiety, and depression. The record identified the resident showed increased confusion, mood/behavior, agitation, and restlessness, impacting his cares. The current	F 309	New orders for Residents #5, #6 and #7 have been obtained from their physician regarding hypoglycemic incidences. Guidelines have been written, for the nurses, for monitoring and when to repeat blood glucose levels. It also has guidelines of when to use a glucagon injection. This will be placed in the medication administration record for easy access. The nurses will be inserviced on 12/08/10 and will discuss the importance of pain management and the guidelines from our policy on hypoglycemic incidents. QA's will be done by QA coordinator and DON and will be the same ones as Ftag 157. ADDENDUM: The nurses were also inserviced about the relationship between pain and behaviors. They will also be instructed regarding the guidelines from the physicians on hypoglycemic occurances. The CNA's were inserviced on 12/09/10 and 12/10/10 and were given instruction of reporting any signs of pain to the nurses. A list of PRN meds will be made monthly for 3 months. QA forms regarding diabetics will be done by nursing staff daily for 2 weeks. From this, the QA coordinator and DON will do random checks of 3 residents 2x monthly for 3 months. All newly diagnosed diabetics and new admissions that are diabetics will have blood parameters in place. A chart review revealed no evidence of giving meds to unresponsive residents.	12/14/10

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F 309	Continued From page 32 significant change Minimum Data Set (MDS), dated 10/04/10, identified the resident understands others and is usually able to make his self understood, and showed the resident exhibited verbal behavioral symptoms directed toward others. During the pain interview, the MDS showed the resident stated he experienced almost constant pain in the last five days that made it hard for him to sleep at night and limited his day-to-day activities. Resident #6 rated the intensity of his worst pain over the last five days as a "3" indicating "severe." Review of the Resident Care Area Assessment for Delirium, dated 10/04/10, stated, " . . . He has increased in restlessness and becoming more agitationed [sic] in recent months . . . He does report having pain daily . . . Pain was referred to Unit Supervisor. . . ." Review of the Resident Care Area Assessment for Cognitive Loss/Dementia, dated 10/04/10, stated, " . . . Resident had more nights of poor sleep recorded than were good, during the assessment period. . . ." Review of the Resident Care Area Assessment for Pain, dated 10/04/10, stated, " . . . [Name of Resident] report having pain, which interupts [sic] his daily activity and sleep and is rated as moderate to severe which indicated a need for planning . . . [Name of Resident] indicates he has pain in rt [right] leg . . . he indicated it occurs everyday. He is not on a scheduled plain [sic] meed [sic] and has taken prrn [sic] ES Tylenol 17 [17 times] in September. He is confused with some inconsistent communication. He does verbalize. He also report [sic] difficulty sleeping at night and MD [medical doctor] is aware of this Med were reviewed [sic] because of increased confusion . . . Unit supervisor was informed of comments regarding pain. . . ."	F 309		

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F 309	Continued From page 33 Review of Resident #6's "Pain Management Review," dated 10/01/10 and completed in conjunction with his current significant change MDS, stated, "He admits to having pain daily. He states, "Yes all along the side and down the front of my leg" (indicates Rt leg). [sic] He points to severe on the verbal descriptor scale. He replies "Yes, I have it every day."He has used the PRN ES Tylenol 17 times in Sept [September] 2010 for various c/o [complaints of] - usually general discomfort. I reported the pain to his nurse who relates that he usually doesn't c/o the leg pain. He [Resident #6] related that the response to his c/o pain is usually "we will see what we can do." Will suggest asking physician for scheduled pain Rx [medication] or trial of PRN pain Rx used regularly as pain could be a contributing factor to his mood [and] behavior problems." The resident was last seen by his physician on 10/14/10. The resident's medical record and the progress note from the visit on 10/14/10 lacked evidence the facility notified the resident's physician on his constant, severe pain and the amount of PRN Tylenol used. Review of Resident #6's current medication regimen showed the only medication available for pain was as needed (PRN) ES Tylenol, 1000 mg every four to six hours. The resident's Medication Administration Record for the months of July 2010 - November 2010 showed the resident took PRN ES Tylenol 19 times in July, 25 times in August, 17 times in September, 24 times in October, and 1 time in November (November 3rd at 12:00 p.m.). Review of Resident #6's current care plan, dated	F 309		

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F 309	Continued From page 34 10/12/10, listed as problem "Altered comfort R/T [related to] chronic back pain, mild degenerative changes Lt [left] shoulder." Approaches listed included, "Medicate as ordered . . . Report pain to Nurse. Pain assessment quarterly and PRN. Provide non-drug pain relief one time each pain episode when appropriate." There is no evidence in the medical record to indicate the facility provided non-drug pain relief interventions when Resident #6 experienced pain. During an interview on 11/02/10 at 9:00 a.m., a nursing supervisor (#4) stated she doesn't recall Resident #6's physician being notified of the results and recommendations from the pain assessment completed on 10/01/10. During an interview on 11/04/10 at 10:45 a.m., an administrative nursing staff member (#3) agreed Resident #6's physician should have been notified in a timely matter regarding the resident's increased pain and excessive use of PRN Tylenol. The staff member (#3) agreed his uncontrolled pain could be contributing to his insomnia and increased agitation/restlessness. 2. Based on record review, review of facility policy and procedure, review of professional references, and staff interview, the facility failed to ensure the provision of necessary care and services for 5 of 5 sampled diabetic residents (Resident #1, #3, #5, #6, and #7) and 1 of 1 closed resident record (Resident #14) regarding high and low blood glucose parameters and when to contact a physician. Failure to establish high and low blood glucose parameters and when to contact a physician placed all diabetic residents at risk and limited the physicians' ability to ensure the quality of care.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	11/04/2010

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F 309	Continued From page 35 Findings include: "Managing Diabetes in the Long-Term Care Setting," Clinical Practice Guideline, 2002, American Medical Directors Association, pages 27-30, states "When to Call the Physician, A systematic facility approach to diabetes management can streamline day-to-day care and reduce the frequency of episodes of hypoglycemia [low blood glucose], hyperglycemia [high blood glucose], and other acute metabolic complications. The following are steps that facilities may consider implementing. . . . Develop protocols that guide first-line caregivers (nurses and nursing assistants) in deciding when a prompt physician referral is necessary for a diabetes-related problem. Make use of standing orders that are approved by the primary care physician when the patient is admitted. For example, the physician may write an order stating that he or she is to be notified when an individual patient's blood glucose values are outside of a specified range. When patients' blood glucose levels are poorly controlled and when patients are extremely frail or cognitively impaired, the physician may wish to note specific individual blood glucose or symptom parameters in the orders. These parameters should be transcribed to the Medication Administration Record and the patient's care plan. Treating Hypoglycemia . . . Hypoglycemia is the most feared short-term complication of treatment for diabetes. If not promptly recognized and treated it can result in long-term disability,	F 309		

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F 309	Continued From page 36 particularly in cognitively impaired individuals. . . ." Review of the facility procedure, "Hypoglycemic Incidents" occurred on 11/04/10. This document, revised 01/09, stated, "Indications of hypoglycemia may be weakness, sweating, tachycardia, headache, visual disturbances, confusion, poor concentration, drowsiness, altered behavior . . . PURPOSE, To protect from complications of hypoglycemia. RESPONSIBLE STAFF, Licensed Nurse. PROCEDURE, . . . 1. On admission or when a resident is newly diagnosed with diabetes, an individual physician's order should be obtained for treatment of hypoglycemia and parameters for when treatment should be initiated. . . . 4. If resident is unable to swallow and has an order for glucagon IM [intramuscular] or SG [subcutaneously], it should be administered, or the resident should be transported to local emergency room via 911. a. Glucagon should be given per physician's order and physician notified per policy. b. Monitor blood glucose levels every 15 to 30 minutes until blood glucose level is above 70 [mg/ml]. 5. Document incident, actions taken and results of blood glucose testing on the Interdisciplinary Progress Notes (GSS [Good Samaritan Society] #239). 6. Transport to emergency room if glucagon is ineffective or blood sugar remains below 45 [mg/ml] after 30 minutes from the beginning of the hypoglycemic event. 7. If resident is unable to swallow and does not have an order for glucagons, notify physician immediately. If physician is not available, call 911."	F 309		

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F 309	Continued From page 37 Review of the facility policy and procedure, Blood Glucose Monitoring, occurred on 11/04/10. This document, revised 01/09, stated "PURPOSE, To accurately monitor resident's level of blood glucose, To maintain control of diabetic condition . . . NOTES, The physician's orders should include blood glucose high and low parameters and when to notify the resident's physician. . . ." - During the initial tour, on 11/01/10 at 1:40 p.m., a supervisory nursing staff member (#5) reported Resident #1 had unstable diabetes, was hospitalized the previous week due to low blood glucose levels, and the resident was treated in the hospital emergency department that morning for low blood glucose levels. Review of Resident #1's medical record occurred on November 01-04, 2010. The facility admitted the resident in 09/07. Current diagnoses included insulin dependent diabetes mellitus. The resident's annual Minimum Data Set (MDS), dated 09/06/10, identified short and long term memory problems, moderately impaired daily decision making, required limited to extensive assistance of one or more persons for all activities of daily living, identified no nutritional problems, received a therapeutic diet, and a dietary supplement between meals. Resident #1's current care plan, dated 09/06/10, identified a goal of maintaining the resident's blood glucose between "70-200" milligrams per milliliter (mg/ml) and "Monitor as ordered, S/S [signs/symptoms] hyperglycemia/hypoglycemia." Resident #1's physician orders, prior to 10/28/10, included the following:	F 309		

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F 309	Continued From page 38 *Initiated 06/19/09, Glucophage 3 grams (gm) by mouth (p.o.) two times each day (BID) *Initiated 10/07/10, Lantus Insulin 80 units, subcutaneously (SQ), each morning (a.m.) *Initiated 10/07/10, Lantus Insulin 50 units, SQ, at bedtime (HS) *Initiated 09/07/07, Humalog Insulin Sliding Scale, four times daily (6:00 a.m., 11:00 a.m., 5:00 p.m., and HS) 200-250 (mg/ml) - 4 units 251-300 - 6 units 301-350 - 8 units 351-400 - 10 units greater than 400 - 12 units and call the physician Review of Resident #1's Diabetic Sheet (a facility form used to record blood glucose measurements and comments) showed blood glucose monitoring four times each day. For the period October 07-27, 2010, this form identified the following: *10/07/10, 11:00 a.m. - 498; Comments - none. The resident's Diabetic Sheet, Medication Administration Record (MAR), and the Interdisciplinary Progress Notes (IDPN) lacked evidence of a re-check of the blood glucose. *10/12/10, 5:30 p.m. - 64; Comments "OJ [Orange Juice] given @ [at] 4:30 p.m.;" No re-check; 8:30 p.m. - no measurement. *10/13/10, 5:00 a.m. - 53; Comments "OJ given @ 5:00 a.m.;" No re-check. *10/15/10, 5:00 a.m. - 55; Comments "Gave O [orange] juice. Re [check] 83." *10/17/10, 5:00 a.m. - 48; Comments "Gave milk. Re [check] 75." *10/21/10, 5:30 p.m. - 53; Comments - none, No re-check. *10/23/10, 5:00 a.m. - 50; Comments - none, No re-check.	F 309		

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F 309	Continued From page 39 *10/26/10, 5:00 a.m. - 40; Comments "Gave (i) tube glucose gel.;" No re-check. *10/27/10, 5:00 a.m. - 34; Comments "1 amp [ampule] D50 [Dextrose 50%]." *10/27/10, no time - 37; Comments "2 amp D50." *10/27/10, no time - 47; Comments - none" Review of Resident #1's medical record showed the facility staff failed to re-check the resident's blood glucose level, as noted above. Failure to monitor the resident's blood glucose levels as identified in the facility's policy and procedure prevented the staff from identifying if Resident #1's hyperglycemic and hypoglycemic episodes resolved and placed the resident at risk of complications of hypoglycemia, including convulsions and coma. During interview, on 11/04/10 at 9:30 a.m., an administrative nursing staff member confirmed Resident #1's medical record lacked high and low blood glucose parameters and when to notify the resident's physician. - Medical record review for Resident #5 occurred November 01-04, 2010. Diagnoses for Resident #5 included diabetes mellitus. The physician's orders include "glucose [blood sugar] monitoring every other day - fasting." - Review of Resident #7's medical record occurred on November 01-02, 2010. Medical diagnoses included diabetes mellitus type II. The physician's orders identified blood glucose monitoring three times daily before meals and a Humalog insulin sliding scale as follows: "0-150 = 0 units [of insulin] . . . > [greater than] 400 = 12 units."	F 309		

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F 309	Continued From page 40 - Review of Resident #6's medical record occurred on all days of survey. Medical diagnoses included diabetes mellitus. The physician's orders identified blood glucose monitoring daily in the morning. - Review of Resident #3's record occurred November 01-04, 2010. Medical diagnoses for Resident #3 included diabetes mellitus. The physician's orders identified "Glucose monitoring TID [three times a day] before meals. Cover with Humalog Insulin with sliding scale as follows: 0-150 = 0 units . . . >401 = 12 units." - Review of Resident #14's closed record occurred November 03-04, 2010. Medical diagnoses for Resident #14 included diabetes mellitus. The physician's orders identified "Accuchecks TID with sliding scale Humalog Insulin as follows: 0-200 = 0 units . . . > 400 = 6 units." The physicians' orders for Resident #1, #3, #5, #6, #7, and #14 lacked high and low blood glucose parameters and guidelines for notifying the residents' physicians regarding their blood glucose levels as identified in the facility's policy and procedure. Failure to ensure each diabetic resident's medical record contained the required parameters and guidelines limited the facility's ability to accurately control the residents' blood glucose level, placed all diabetic residents at risk, and limited the physicians' ability to ensure the quality of resident care. 3. Based on record review, review of a professional reference, and staff interview, the facility failed to provide the necessary care and services to attain or maintain the highest	F 309		

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F 309	Continued From page 41 practicable physical and mental well being for 1 of 1 sampled resident (Resident #1) who was administered oral medications while unresponsive. Provision of oral medications while experiencing hypoglycemic events on 10/27/10 and 11/01/10 placed Resident #1 at risk of aspiration and development of pneumonia. Findings include: "Managing Diabetes in the Long-Term Care Setting," Clinical Practice Guideline, 2002, American Medical Directors Association, pages 27-30, states "Treating Hypoglycemia . . . Patients who are obtunded (incoherent but not comatose) may be treated with oral glucose paste rubbed onto the buccal [inner surface of the mouth] mucosa, intramuscular glucagon, or intravenous 50% dextrose. If possible, caregivers should be trained to administer intramuscular glucagon in the facility. Administration of 1 mg [milligram] glucagon can achieve sufficient clinical recovery to enable safe consumption of oral carbohydrates . . ." - For background information regarding Resident #1, see Base Statement 2. Resident #1's Interdisciplinary Progress Notes stated, *10/22/10, 9:30 p.m. - "No treatments at this time." The next entry stated, *10/28/10, 11:00 a.m. - "Resident readmitted to facility, dx [diagnosis]: hypoglycemia. . . ." Resident #1's Diabetic Sheet (a facility form used to record blood glucose measurements and comments) included the following: *10/27/10, 5:00 a.m. - 34; Comments "1 amp	F 309		

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F 309	Continued From page 42 [ampule] D50 [Dextrose 50%]." *10/27/10, no time - 37; Comments "2 amp D50." *10/27/10, no time - 47; Comments - none" At the surveyor's request, on 11/04/10 at 8:45 a.m., the facility provided a copy of Resident #1's acute care facility admission history and physical (H & P), dated 10/27/10. The H & P stated ". . . noted to have a low blood sugar this morning, it was 34 [mg/ml]. . . . tried giving D-50 orally and they rechecked it and it was 37. Then it looks like they gave a second amp of D-50 again trying to give it orally and they got it up to 47. . . . Patient was found to be minimally responsive and EMS [emergency medical services] was called. She was transferred to our ER [emergency room]. . . . ASSESSMENT: Hypoglycemia . . ." Resident #1's Interdisciplinary Progress Notes, dated 11/01/10, stated the following: *4:30 a.m. - "Res. [Resident] was unresponsive. CNA [Certified Nursing Assistant] was unable to arouse. Checked BS [blood glucose/sugar]. BS was 35 [milligrams per milliliter (mg/ml)]. Gave i [one] tube oral Glucose Gel and 16 oz. [ounces] Enlive [high calorie liquid nutritional supplement]. Res. was unable to drink from straw. Poured small amounts in her mouth at a time." *4:50 a.m. - "Rechecked BS. BS was 41 [mg/ml]. Res. was still unable to respond . Gave Glucagon injection SQ [subcutaneously]." *5:20 a.m. - Rechecked BS. BS was 199 [mg/ml]. Res. still not able to respond. . . ." *6:15 a.m. - "Ambulance arrived. Res. transferred to [acute care facility]." At the surveyor's request, on 11/04/10 at 12:45 p.m., the facility provided a copy of the acute care facility's Emergency Room Report regarding	F 309		

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F 309	Continued From page 43 Resident #1's visit on 11/01/10. This document stated ". . . had incidents of low blood sugars. She was found unresponsive. She was then given her glucagon and oral sucrose. . . . Lungs: Clear to auscultation. . . . discharged in improved stable condition . . ." During interview, on 11/04/10 at 9:30 a.m., an administrative nursing staff member (#3) reported she was not aware facility staff had administered oral medications to Resident #1 when she was unresponsive. Following this interview, this staff member (#3) agreed oral fluids or medications should not be administered to unresponsive residents.	F 309	Since the survey, Resident #1 has died. Instruction has been given to nurses, CNA's, Restorative adies, MDS staff, and other staff that care for residents, to offer fluids before they leave a resident's room. Staff will return these instructions signed, to the DON. Observation will be done by QA coordinator and DON on Resident #10 and other residents. A QA form will be filled out 2x/week for 4 weeks and then weekly x2 by the QA coordinator and DON. A sample will be done on each shift and departments that are listed above. An inservice will be given to nurses on 12/08/10 and CNA's on 12/09/10 and 12/10/10. The importance of offering fluids will be given.	
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy and procedure, and staff interview, the facility failed to provide fluids during resident cares for 2 of 4 sampled residents (Resident #1 and #10) identified by the facility as consuming insufficient fluids. Failure to provide these residents who are dependent on staff with fluids placed them at risk of dehydration, constipation, and urinary tract infections. Findings include: Review of the facility policy, Hydration, occurred on 11/04/10. This document, revised 01/09,	F 327	ADDENDUM: The facility continues to monitor intake of Resident #10 and is documenting this. The facility continues to monitor intake of all residents. When they are at risk of not drinking adequate fluids, residents are put on a hydration list. This record review is done by the Dietary Manager. The QA form will be filled out 2x/week for 4 weeks and then weekly for 2 weeks and then monthly for 2 months.	12/14/10

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F 327	Continued From page 44 stated "POLICY, The center will assist each resident in maintaining acceptable parameters of hydration status . . ." Review of the facility procedure, Hydration of Residents, occurred on 11/04/10. This document, revised 01/09, stated "PURPOSE, To maintain hydration status of residents. PROCEDURE . . . 7. Fresh water will be available to the residents at bedside unless contraindicated. 8. Residents needing thickened liquids will have appropriate beverages offered between meals. . . ." - Review of Resident #1's medical record occurred on November 01-04, 2010. The facility admitted the resident in 09/07. Current diagnoses included insulin dependent diabetes mellitus, constipation, and recent urinary tract infections. The resident's annual Minimum Data Set (MDS), dated 09/06/10, identified short and long term memory problems, moderately impaired daily decision making, required limited assistance of one person for eating and drinking, and consumed insufficient fluids in the last three days of the assessment period. Resident #1's Dehydration/Fluid Maintenance Resident Assessment Protocol Summary (RAPS), dated 09/06/10, identified the resident "At risk for dehydration." The resident's current care plan, dated 09/06/10, identified "Offer fluids every shift." Resident #1's medical record identified positive urinalyses on 09/30/10 and 10/06/10 and antibiotics initiated on those dates for urinary tract infections. The medical record also identified the resident experienced low blood glucose levels throughout October 2010, requiring overnight	F 327		

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F 327	Continued From page 45 hospitalization on one occasion and an emergency room visit on another occasion. Resident #1's medical record identified a recent decline in her ability to eat and drink, including an Interdisciplinary Progress Note, dated 10/29/10 at 12:25 p.m., which stated ". . . totally fed by staff. . . . Staff member gave her a drink and it ran out of her mouth with a little swallow. . . ." Observation throughout the survey showed the resident totally dependent on staff for eating. On 11/02/10 at 12:20 p.m., a staff member stated "Doesn't hold it [regular texture] in her mouth." and obtained a pureed diet for the resident. Observation of the following cares for Resident #1 on 11/02/10 showed these staff members failed to offer fluids to the resident: *9:15 a.m. - Restorative Therapy/certified nursing assistant (CNA) staff member (#11) completed exercises with the resident. The resident was reclined in her wheelchair with her mouth open, appeared to be breathing through her mouth. *9:35 a.m. - CNAs (#12) and (#13) transferred the resident from her wheelchair to her bed. *9:43 a.m. - Licensed nursing staff member (#14) checked the resident's oxygen saturation level. *10:10 a.m. - Licensed nursing staff member (#4) checked the resident's lung sounds, noted the resident's mouth breathing and dried lips. This staff member (#4) requested CNA (#13) provide the resident oral care with mouthwash and lemon swabs. CNA (#13) failed to offer fluids to the resident. *1:25 p.m. - CNAs (#7) and (#13) transferred the resident from her wheelchair to her bed, removed the resident's dentures, and swabbed the resident's mouth with mouthwash and lemon swabs.	F 327		

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F 327	Continued From page 46 During these observations, Resident #1 opened her eyes and responded to the staff during the cares. During these observations, the resident breathed with her mouth open resulting in increased dryness of her mouth. - Review of Resident #10's medical record occurred on November 03-04, 2010. The facility admitted the resident in 05/08. Current diagnoses included dementia, renal insufficiency, and constipation. The resident's quarterly MDS, dated 08/09/10, identified short and long term memory problems, severely impaired daily decision making abilities, required extensive assistance of one person for eating, and consumed insufficient fluids in the last three days of the assessment period. Resident #10's current care plan, dated 08/12/10, identified "Offer fluids every shift to meet daily fluid requirements." The resident currently receives a pureed consistency diet with nectar thick liquids. Observation of facility staff providing cares for Resident #10 on 11/03/10 at 4:25 p.m. showed CNAs (#15) and (#16) provided perineal cares, changed the resident's brief, transferred the resident to her wheelchair, combed her hair, provided her eyeglasses, and assisted her into the hall where she propelled her wheelchair in a random fashion. The staff members failed to offer fluids to the resident. During interview, on 11/04/10 at 9:30 a.m., an administrative nursing staff member (#3) agreed the facility staff should have offered fluids to Resident #1 and Resident #10 during the care observations.	F 327		

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	355093	A. BUILDING _____ B. WING _____	11/04/2010

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F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not 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. This REQUIREMENT is not met as evidenced by: Based on record review, review of policy and procedure, review of professional references, and staff interview, the facility failed to ensure the drug regimen for 2 of 8 sampled residents (Resident #5 and #10) receiving antipsychotic medications and antianxiety medications remained free of unnecessary medications. This failure resulted in Resident #10 receiving an antipsychotic medication for an extended	F 329	Reduction committee will meet on 12/06/10 to see if a reduction of Resident #10's antipsychotic could be reduced. The Reduction Committee is headed by the QA coordinator who has been monitoring reductions for the residents. We will discuss and fill out a form regarding date started, last reduction, any behaviors and what action will be done. The psychiatrist, who visits monthly, visited with Resident #10 on 11/19/10. He was made aware of the AIMS score. He documented, "On our visit, I don't see these movements and I was with her for at least 15 minutes. Continue with the AIMS scale every 3 months. Right now, I don't think the AIMS concern is strong enough for me to take any other action. We will continue to watch her on a regular basis." The form that is used to give the psychiatrist report, now has the AIMS score on it. When he visits any resident with an AIMS score, he will know what it is. The psychiatrist started a reduction of Risperdal on 07/30/10 for REsident #5. Her behaviors were worsening and her skin was clammy. The psychiatrist felt the clammy skin could be side effects of Risperdal. He was slowly weaning Resident #5 off of it. On 07/30/10, he started Resident #5 on Seroquel and since then has been weaning her off of that. When he visited on 11/19/10, he put Resident #5 back on Seroquel as Resident #5's behaviors had worsened. When the psychiatrist visited on 11/19/10, he wrote an order not to give Seroquel at the same time Ativan is given. This has been added to the medication administration record for the nurses to see.	

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F 329	Continued From page 48 duration, without an attempted gradual dose reduction (GDR), and after facility staff identified adverse consequences; and, resulted in Resident #5 receiving an antipsychotic and potentially receiving an antianxiety medication without adequate indications for use. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding the management and monitoring of each resident's medication regimen to achieve goals and the tapering of a medication dose/GDR, including: ". . . Each resident receives only those medications, in doses & [and] for the duration clinically indicated to treat the resident's assessed condition(s); . . . Clinically significant adverse consequences are minimized; and, The potential contribution of the medication regimen to an unanticipated decline or newly emerging or worsening symptom is recognized & evaluated, & the regimen is modified when appropriate. . . . Medication management is based in the care process & includes recognition or identification of the problem/need, assessment, diagnosis/cause identification, management/treatment, monitoring, & revising interventions, as warranted. The attending physician plays a key leadership role in medication management by developing, monitoring, & modifying the medication regimen in conjunction with residents &/or representative(s) & other professionals & direct care staff (the interdisciplinary team). . . . the medication is benefiting the resident. Tapering may be indicated when the resident's clinical condition has improved or stabilized, the underlying causes of the original target symptoms	F 329	Nurses will be inserviced on 12/08/10 regarding nonpharmacological interventions to be done before any PRN antipsychotics are used. The interventions will be documented on the back of the medication administration record. The QA coordinator will have a reduction committee meeting every month x2 and then will go back to every other month. ADDENDUM: On 07/30/10, the psychiatrist signed a form to continue on this dose- benefits outweight the risks. The facility will attempt gradual dose reduction unless the physician wants to continue on that dose. When the Reduction Committee met on 12/06/10 all residents receiving antipsychotics were reviewed. If, after the meeting, a decision to see if the antipsychiatic can be reduced, the physician will be notified. The QA coordinator keeps a file and knows when the last reduction has been made and also gets forms ready for the physician to determine if the medication should be decreased or if it should stay the same. The nurses will also be instructed to give medications as ordered. The MDS nurse will notify Unit Managers of a positive AIMS. The unit managers will then inform the DON or QA Coordinator. Besides letting the physician know, the AIMS will be brought to the Reduction Committee and the consulting pharmacist.	12/14/10

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F 329	Continued From page 49 have resolved, &/or non-pharmacological interventions, including behavioral interventions, have been effective in reducing the symptoms. . . . Within the first year in which a resident is admitted on an antipsychotic medication or after the facility has initiated an antipsychotic medication, the facility must attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, a GDR must be attempted annually, unless clinically contraindicated. For any individual who is receiving an antipsychotic medication to treat behavioral symptoms related to dementia, the GDR may be considered clinically contraindicated if: The resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility; and The physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or increase distressed behavior. . . ." CMS defines adverse consequence as "An unpleasant symptom or event that is due to or associated with a medication, such as impairment or decline in an individual's mental or physical condition or functional or psychosocial status." Review of the facility policy and procedure, Psychopharmacological Medications and Sedative/Hypnotics, occurred on 11/04/10. This document, revised 01/07, stated "PURPOSE, To evaluate behavior interventions and alternatives before using psychopharmacological medications and sedative/hypnotics, To eliminate unnecessary psychopharmacological medications and	F 329		

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F 329	Continued From page 50 sedative/hypnotics . . . DEFINITIONS . . . Medical Symptom - an indication or characteristic of a physical or psychological condition; Psychopharmacological Medication - any medication used for managing behavior, stabilizing mood or treating psychiatric disorders. POLICY, The resident will be free from any chemical restraint . . . not required to treat the resident's medical symptoms. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: . . . c. without adequate monitoring or d. without adequate indications for its use or e. in the presence of adverse consequences which indicate the dose should be reduced or discontinued, f. any combination of the reasons above. . . ." Review of the facility policy and procedure, Abnormal Involuntary Movement Scale (AIMS), occurred on 11/04/10. This document, dated 09/07, stated ". . . USE: . . . Required at least every six (6) months when resident is receiving an antipsychotic. . . . PURPOSE: To determine presence of and/or changes in any involuntary movements possibly attributed to antipsychotic . . ." "Nursing 2009 Drug Handbook," 29th edition, Lippincott, Williams and Wilkins, Philadelphia, pages 671-673, identified Risperdal as an antipsychotic medication and states "ADVERSE REACTIONS, CNS [Central Nervous System]: . . . agitation, anxiety . . . tremor . . ." - Review of Resident #10's medical record occurred on November 03-04, 2010. The facility admitted the resident in 05/08. Current diagnoses	F 329		

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F 329	Continued From page 51 included dementia and delirium. Resident #10's current physician orders included Risperdal 0.5 milligrams (mg), every day at bedtime, initiated on 07/25/08. The resident's quarterly Minimum Data Set (MDS), dated 08/09/10, identified severely impaired daily decision making ability and no mood or behavioral symptoms. Resident #10's MDSs dated 05/1//10 (annual), 02/09/10 (quarterly), and 11/09/09 (quarterly) also lacked identification of mood or behavioral symptoms. Resident #10's Psychotropic Drug Use Resident Assessment Protocol Summary (RAPS), dated 05/10/10, stated ". . . Resident has dementia [with] behavioral disturbances & receives Risperdal 0.5 mg qd [every day] HS [bedtime]. . . . Her last AIMS done 05/05/10 & did score positive findings in oral movements which could suggest S/E [side effects] from Risperdal usage. No reported mood or behavior issues. . . . Proceed to care plan: . . . To maintain stable mood & ensure minimal S/E from psychotropic med [medication] use. . . ." Resident #10's AIMS documentation, dated 05/05/10, identified "mild, 2" "chewing" and "lateral movement" of the jaw. Previous AIMS results showed no movements. The resident's Interdisciplinary Assessments and Summary Reviews Nursing MDS Assessment, dated 05/05/10, stated "AIMS assessment done per visual exam. Resident is unable to follow instructions. Mild lateral jaw movements noted & chewing movements. Informed nurse - this will [be] monitored et [and] if persists the physician will be notified." Resident #10's medical record included a medication review, identified as "stable," by the	F 329		

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F 329	Continued From page 52 consulting psychiatrist on 05/28/10. The medical record also included visits by the resident's primary care providers, most recently on 10/06/10. The medical record did not include a follow-up AIMS. The medical record lacked evidence the facility staff notified Resident #10's physicians of the positive AIMS. During interview, on 11/04/10 at 9:30 a.m., an administrative nursing staff member (#3) reported she was not aware of Resident #10's positive AIMS assessment. Following this interview, this staff member confirmed the positive AIMS assessment and stated the facility staff should have notified Resident #10's physician of the positive AIMS assessment. Resident #10 continued to receive the same dose of Risperdal since initiated on 07/25/08, despite a lack of mood or behavior issues. The facility staff identified Resident #10's positive AIMS assessment on 05/05/10. Failure to notify the providers of the positive AIMS assessment limited the providers' ability to manage the resident's medication regimen to ensure Resident #10 reached her highest mental and physical well being. This failure may have resulted in Resident #10 continuing to receive the antipsychotic Risperdal despite the demonstrated adverse consequences, the lack of mood and behavior issues and placed her at risk of long term side effects if the Risperdal were reduced or discontinued. - Medical record review for Resident #5 occurred on November 01 - 04, 2010. Diagnoses included Alzheimer's disease, depressive disorder, osteoarthrosis, and senile dementia with delusional features. Review of Resident #5's	F 329		

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F 329	Continued From page 53 annual MDS, dated 06/06/10, and significant change MDS, dated 09/06/10, identified wandering daily and not easily redirected. The significant change MDS also identified verbally abusive behavioral symptoms, physically abusive behavioral symptoms, and resisted cares one to three days during the assessment period, not easily redirected, and a deterioration of behavior symptoms. The physician's orders for September 2010 showed an order for Ativan (an anxiolytic) 0.25 - 0.5 mg (milligrams) every four hours as needed. Review of the September Medication Administration Record (MAR) showed nursing staff administered Ativan 1 mg on 09/17/10, twice the amount ordered by the physician. A nurse's note, dated 09/17/10 at 2:45 p.m., identified, "Res [resident] was quite restless [and] agitated requiring one-on-one attention from staff. 1 mg of Ativan was given since it appears that the 0.5 mg of Ativan was ineffective in the past few days." The nurse failed to follow the physician's order and administered a higher dose of Ativan. The physician's orders included the following medications for Resident #5: * "Risperdal [an antipsychotic] 0.25 MG PO [orally] Q [every] 12 HRS [hours], PRN [as needed]." Changed 07/30/10 to "Risperdal .5 mg po q HS (hour of sleep)". The physician discontinued all Risperdal on 10/13/10. * "Ativan .25 - .5 MG PO Q 4 HRS, PRN." Changed by the physician on 10/14/10 to "Ativan .5 mg PO BID [twice daily] PRN." * "Seroquel [an antipsychotic] 25 mg [one] po q AM [morning] and [one] po q 4 [hour] prn." Changed by the physician on 08/09/10 to read "Seroquel 50 mg po q AM" with the prn dose	F 329		

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F 329	Continued From page 54 continuing as previously ordered. Review of the MAR for June 2010 thru October 2010, showed Resident #5 received the following: * Risperdal combined with Ativan twice in June, and seven times in July. * Seroquel combined with Ativan three times in August, nine times in September, and twice in October. * PRN Ativan an additional 14 times in June, 18 times in July, 12 times in August, 13 times in September, and nine times in October. * PRN Risperdal an additional two times in June and July. * PRN Seroquel an additional 17 times in August, four times in September, and two times in October. Administering an antipsychotic and an anxiolytic together prevented nursing staff from determining if the Risperdal/Seroquel or the Ativan assisted the resident to control, or failed to control, his/her behaviors. The record lacked evidence of assessment of the causes/contributing factors of the behavior exhibited by Resident #5, and monitoring after administration of the psychotropic medications for effectiveness. Stating Resident #5 is "agitated" without identifying nonpharmalogical interventions attempted, as care planed, to alter his/her behaviors failed to demonstrate the facility gave the medications with adequate indications for their use. Stating the result of administering the medication as "[questionable] effect" or "helped" failed to identify the change or lack of change in Resident's #5's behavior, and whether the continued use of the psychotropic medications out weighed the risks of side effects from the	F 329		

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F 329	Continued From page 55 medications.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review, review of policy and procedure, review of professional reference, and staff interview, the facility's consultant pharmacist failed to report medication irregularities for 1 of 1 sampled resident (Resident #10) who received an antipsychotic for more than one year without an attempted gradual dose reduction (GDR) and who demonstrated a positive Abnormal Involuntary Movement Scale (AIMS) assessment. Failure to identify the need for an attempted GDR and failure to report the positive AIMS may have resulted in Resident #10 continuing to receive the antipsychotic medication and develop long term side effects. Findings include: Review of Resident #10's medical record occurred on November 03-04, 2010. The facility admitted the resident in 05/08. Current diagnoses included dementia and delirium. Resident #10's	F 428	The psychiatrist, who visits monthly, visited with Resident #10 on 11/19/10. He was made aware of the AIMS score and use of Risperdal. He documented, "On our visit, I don't see these movements and I was with her for at least 15 minutes. Continue with the AIMS scale every 3 months. Right now, I don't think the AIMS concern is strong enough for me to take any other action. We will continue to watch her on a regular basis." The form that is used to give the psychiatrist report, now has the AIMS score on it. When he visits any resident with an AIMS score, he will know what it is. The reduction committee will meet on 12/06/10 to discuss every resident that is on an antipsychotic. We will look at the AIMS score and how long the resident has been on that dose. Information will be put on the "Reduction Committee" form use for FTAg 329. This list of residents with the AIMS score will be given to the consultant pharmacist during her monthly visit in December. She will then fill out the Pharmacy Review QA form. This QA form will be given to the QA coordinator who will decide if it's time for a gradual dose reduction with the reduction committee. If the decision is to reduce the antipsychotic, the QA coordinator will contact the physician or the psychiatrist.	12/14/10

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F 428	Continued From page 56 current physician orders included Risperdal 0.5 milligrams (mg), every day at bedtime, initiated on 07/25/08. Resident #10's Psychotropic Drug Use Resident Assessment Protocol Summary (RAPS), dated 05/10/10, stated ". . . Resident has dementia [with] behavioral disturbances & [and] receives Risperdal 0.5 mg qd [every day] HS [bedtime]. . . . Her last AIMS done 05/05/10 & did score positive findings in oral movements which could suggest S/E [side effects] from Risperdal usage. . . ." Resident #10's AIMS documentation, dated 05/05/10, identified "mild, 2" "chewing" and "lateral movement" of the jaw. Previous AIMS results showed no movements. The resident's Interdisciplinary Assessments and Summary Reviews Nursing MDS [Minimum Data Set] Assessment, dated 05/05/10, stated "AIMS assessment done per visual exam. Resident is unable to follow instructions. Mild lateral jaw movements noted & chewing movements. . . ." Review of the facility's consultant pharmacist monthly resident medication regimen reviews failed to identify the pharmacist reported Resident #10's continued use of Risperdal without an attempted GDR and the positive AIMS assessment as a medication irregularity and adverse reaction or side effect. During interview, on 11/04/10 at 9:30 a.m., an administrative nursing staff member (#3) confirmed the consultant pharmacist failed to report the positive AIMS assessment as a medication irregularity and she expected the pharmacist would.	F 428	ADDENDUM: The consulting pharmacist visits monthly and reviews the medication regimen. She will address any potential drug irregularities and bring them to the attention of the DON. Together, the facility staff and consulting pharmacist will review the medications. She will be informed about the QA form. The QA form has the Resident's name, AIMS and if the physician should be notified. This will be done monthly x3.	
F 514	483.75(l)(1) RES	F 514		

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F 514 SS=D	Continued From page 57 RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review, review of professional reference, and staff interview, the facility failed to maintain clinical records in accordance with accepted professional standards and practices for 1 of 1 sampled resident (Resident #1) who required hospitalization for an episode of low blood glucose levels (hypoglycemia). Failure to document an episode of hypoglycemia limited the facility's ability to ensure the provision of appropriate resident care and services. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding the accuracy and completeness of clinical information about each resident, including: "A complete clinical record contains an accurate and functional representation of the actual experience of the individual in the facility. It must	F 514	Since the survey, Resident #1 has died. The nurses, who know the residents, will fill out a form entitled "List of Residents Whose Condition is Unstable". They will list the residents and check the chart for an initial entry and if a followup note has been done. From this list, the unit manager will check daily with the charge nurses to make sure a note has been done. As the condition stablizes, the resident's name will be highlighted meaning daily entries do not need to be made unless there is a change in condition. At that point, the name will be put back on the list. The nurses have been given instruction on this form. They will also discuss this at a nurses meeting on 12/08/10. The QA coordinator will do a QA on the entries from the above mentioned list. She will do this weekly x4. ADDENDUM: There was a record review to identify accurate documentation for residents who experienced significant episodes in the recent past. None were found. At the inservice, the nurses were instructed that the documentation must tell a story and followup charting is to be done. The QA will be done weekly x4 and then monthly x2.	12/14/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	11/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 514	Continued From page 58 contain enough information to show that the facility knows the status of the individual . . . and provides sufficient evidence of the effects of the care provided. Documentation should provide a picture of the resident's progress, including response to treatment, change in condition, and changes in treatment. . . ." - Review of Resident #1's medical record occurred on November 01-04, 2010. The facility admitted the resident in 09/07. Current diagnoses included insulin dependent diabetes mellitus. During the initial tour, on 11/01/10 at 1:40 p.m., a supervisory nursing staff member (#5) reported Resident #1 had unstable diabetes resulting in hospitalization the previous week due to low blood glucose levels. Resident #1's Interdisciplinary Progress Notes stated, *10/22/10, 9:30 p.m. - "No treatments at this time." The next entry stated, *10/28/10, 11:00 a.m. - "Resident readmitted to facility, dx [diagnosis]: hypoglycemia. . . ." The Interdisciplinary Progress Notes lacked entries between 10/22/10 and 10/28/10 regarding events resulting in Resident #1's hospitalization. Resident #1's Diabetic Sheet (a facility form used to record blood glucose measurements and comments) included the following: *10/27/10, 5:00 a.m. - 34; Comments "1 amp [ampule] D50 [Dextrose 50%]." *10/27/10, no time - 37; Comments "2 amp D50." *10/27/10, no time - 47; Comments - none" At the surveyor's request, on 11/04/10 at 8:45 a.m., the facility provided a copy of Resident #1's	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 514	Continued From page 59 acute care facility admission history and physical (H & P), dated 10/27/10. The H & P stated ". . . noted to have a low blood sugar this morning, it was 34 [mg/ml]. . . . tried giving D-50 orally and they rechecked it and it was 37. Then it looks like they gave a second amp of D-50 again trying to give it orally and they got it up to 47. . . . Patient was found to be minimally responsive and EMS [emergency medical services] was called. She was transferred to our ER [emergency room]. . . . ASSESSMENT: Hypoglycemia . . ." During interview, on 11/04/10 at 9:30 a.m., an administrative nursing staff member (#3) confirmed facility staff failed to include information in Resident #1's medical record regarding the events leading up to her hospitalization on 10/27/10. The facility staff failed to document a complete and accurate description of Resident #1's hypoglycemic episode and care in the facility. Failure to document the events leading to Resident #1's hospitalization on 10/27/10 prevented the staff from determining what care and services were provided, if the care and services were appropriate, and failed to document a change in the resident's condition and her response to treatment. Failure to document resident care and services may result in duplication or inappropriate withholding of medications or treatment, prevents the facility from reviewing the care provided, and considering any necessary corrective action, placing all residents at risk of illness and injury.	F 514		