STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355111	A. BUILDING _____ B. WING _____	09/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - CROSBY	705 SE 4TH ST CROSBY, ND 58730

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey, started on 08/30/10 and completed on 09/02/10, the sample included 2 residents for complete review, 7 residents for focused review, and 1 closed record for review.	F 000		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. 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 ensure staff followed professional standards by failing to clarify incomplete or unclear physician's orders for 1 of 9 sampled residents (Resident #2). Findings include: Review of the facility policy "Physician's Orders" occurred on 09/02/10. The policy, dated August 2008, stated, "Clarification orders are needed when reviewing any type of physician's orders that are incomplete or raise questions. Never attempt to guess or determine what an order might say. Orders need to be clarified for the following reasons: lack of clarity of the order . . . dosage questions . . . Prior to entering an order in Resident Services, the HIM [Health Information Management] department is responsible for reviewing any medication physician's order for the following components: . . . Dosage . . . Strength (e.g. [for example] 500 mg [milligrams], 100 mg) . . ."	F 281		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Elaine Heide TITLE: Administrator (X6) DATE: Revised 10-18-10

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 281	Continued From page 1 Lippincott, William, and Wilkins, "Nursing 2009 Drug Handbook," Wolters Kluwer, Philadelphia, page 1410 identified Darvocet N as a pain reliever supplied in two strengths: Darvocet N 50 contains 325 mg acetaminophen and 50 mg propoxyphene napsylate; and Darvocet N 100 contains 650 mg acetaminophen and 100 mg propoxyphene napsylate. - Resident #2's medical record, reviewed August 31 - September 2, 2010, identified the resident as having a pressure ulcer on the coccyx. The record identified a physician's order, dated 07/09/10, for Tylenol (acetaminophen) 500 mg, two tablets, every 4 to 6 hours as needed for pain, and an order, dated 07/29/10, for Tylenol 1000 mg twice a day. A physician's note, dated 08/04/10, identified the resident had "tailbone" pain, not relieved by Tylenol. A physician's order, dated 08/04/10, stated, "DC [discontinue] Tylenol. Start Darvocet 1 tab [tablet] PO [orally] TID [three times a day]." The physician's order failed to specify a dose (50 or 100 mg) for the Darvocet and failed to identify if one or both orders for Tylenol should be discontinued. Review of Resident #2's Medication Administration Records (MARs) identified the facility discontinued the scheduled Tylenol, but continued to administer the as needed dose. The MAR failed to identify a dose for the Darvocet. Review of Resident #2's medication cassette, on 08/31/10 at 4 p.m., identified the Darvocet dose as 100/650 mg. The record lacked evidence the nurse observing	F 281	F281 1. The medication order was clarified for the resident. 2. All residents who receive medications have the potential to be affected. 3. All new medication orders will be reviewed for clarification prior to administration and HIM office will review the order prior to entering the information in the medical record. The DON reviewed taking a medication order and essential components: right drug, right dose, right route, right resident and right time with charge nurses at their October 12 monthly meeting. 4. Completion date: thirty-five days from date of survey which is October X 12 2010. 5. The director of nursing or designee will audit weekly x1 month, then monthly x2 months, then quarterly thereafter for new medication orders to check for completeness with results reported to the monthly QA meeting with follow-up if needed. See Attachment F281A. per TIC Brenda, DON Bobbie 10/25/10 2:00pm	

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F 281	Continued From page 2 the physician's order on 08/04/10 clarified the incomplete Darvocet order or the unclear Tylenol order. An interview with an administrative nurse (#1) occurred on 09/01/10 at 12:10 p.m., the nurse (#1) stated the physician made rounds today and planned to change the orders because the resident's pain was not relieved by the Darvocet. Review of Resident #2's physician's orders identified an order, dated 09/01/10 at 3:30 p.m., to discontinue both the Darvocet and the Tylenol. Failure to clarify the Darvocet and Tylenol orders may have resulted in Resident #2 receiving a stronger or weaker dose of Darvocet than the physician intended and receiving Tylenol after the physician discontinued the medication.	F 281		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, procedure, and guidelines, and staff interview, the facility failed to ensure residents with pressure ulcers received the necessary treatment and services to promote healing of the	F 314		

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F 314	Continued From page 3	F 314		

pressure ulcers for 2 of 5 sampled residents (Resident #1 and #6) with current pressure ulcers. This failure could result in delayed healing of the pressure ulcers.

Findings include:

Review of the facility's procedure "Pressure Ulcers: Skin Assessment and Prevention" occurred September 1 - 2, 2010. The procedure, dated 3/08, stated, ". . . All residents will be identified by a licensed nurse for their risk of developing pressures ulcers on admission/readmission . . . using the Braden Scale for Predicting Pressure Sore Risk . . . Risk factors are those factors that increase a resident's susceptibility to develop or impact healing times of pressure ulcers. They include, but are not limited to: . . .
* History of a previous ulcer/healed stage III or IV ulcer . . .

Residents who are unable to reposition themselves independently should be repositioned periodically (as often as the plan of care indicates a need or at least every two hours). Developing an individualized repositioning schedule is recommended based on observation of the resident's skin over a period of time. Individual pressure points are observed for redness or discomfort (tissue tolerance). . . ."

Review of the facility's "Pressure Ulcer Practice Guidelines" occurred September 1- 2, 2010. The guidelines, dated 3/08, stated, "Staging - Definitions . . . A pressure ulcer is localized injury to the skin and/or underlying tissue over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction. . . .

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F 314	Continued From page 4 'Stage II' . . . May also present as an intact or open/ruptured serum-filled blister. . . ." Review of the facility policy "Wound Flow Sheet" occurred 09/02/10. The policy, dated 3/08, stated, "Required at least weekly when skin integrity is impaired or open area is present (i.e. [that is] pressure ulcer, surgical wound, venous ulcer, etc.) . . ." Resident #6's medical record, reviewed August 31 - September 2, 2010, identified diagnoses including right below knee amputation due to peripheral vascular disease (PVD), diabetes mellitus, and dementia. A quarterly Minimum Data Set (MDS), dated 05/27/10, identified Resident #6 had short and long term memory problems, moderately impaired decision making, required extensive assistance with bed mobility, total assistance with transfers, and had a history of resolved pressure ulcers. Braden Scales, completed on 06/02/10 and 08/26/10, identified a score of 17, indicating the resident at mild risk for pressure ulcers. Resident #6's record identified ongoing pressure ulcers/excoriation to the coccyx/buttocks area. Resident #6's Comprehensive Care Plan, dated 06/03/10, identified "Potential for skin breakdown R/T [related to] history of PVD and excoriated bottom." A problem, dated 07/12/10, stated, "Stage II's to buttock" and a problem, dated 08/19/10, stated, "Stage 1 to (L) [left] heel." The care plan identified approaches to these problems including "Reposition to heal skin breakdown . . . Pressure relief. . . . Broda chair . . ."	F 314		

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F 314	Continued From page 5 An interdisciplinary progress note, dated 08/21/10, stated, "[Resident #6] has a reddened 2 x 2 [centimeter] area to his left heel. To keep pressure off that area pillow placed on his foot rest of his chair to reposition keeping pressure off that area." Review of Resident #6's Wound Sheets failed to identify the Stage I pressure ulcer to the left heel. Observation of cares for Resident #6 occurred on 08/31/10 at 9:35 a.m. Two Certified Nursing Assistants (CNAs) (#5 and #6) assisted the resident to bed using a Hoyer lift. The CNAs positioned the resident in bed without floating his left heel, to keep pressure off the area. On 08/31/10 at 11:10 a.m., the two CNAs (#5 and #6) assisted Resident #6 out of bed. Observation identified the resident's left lateral heel resting directly on the mattress. When the CNAs removed Resident #6's sock, observation identified a reddish/pale purple area approximately two centimeters in diameter on the left lateral heel. On 08/31/10 at 1:35 p.m., observation again identified the resident in bed with a pillow under his left leg, but not keeping the heel off the mattress. At 3:15 p.m. observation of the area occurred with an administrative nurse (#1) to call her attention to the pressure to the area. The nurse stated she would check to see if Resident #6 had a history of a pressure ulcer to that heel as she felt the area could be a scar. On the morning of 09/01/10, the administrative nurse (#1) provided wound sheets indicating Resident #6 had a pressure ulcer on the left heel in July 2009. A history of a previous pressure	F 314		

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F 314	Continued From page 6 ulcer increases the resident's risk for developing another ulcer in the same area. On 09/01/10 at 9:15 a.m. and 09/02/10 at 9:20 a.m., observation again showed the resident in bed with his left lateral heel resting directly on the mattress. Observations on 08/31/10 and 09/01/10 failed to identify a pillow on the foot rest while Resident #6 sat in the Broda chair. Failure to properly position Resident #6's left leg to keep pressure off the heel and to track the Stage I ulcer on a Wound Sheet could delay healing and placed the resident at increased risk for the Stage I ulcer to become a Stage II. - The medical record for Resident #1 occurred on September 1 - 2, 2010. The record identified diagnoses including venous insufficiency, osteoarthritis and schizophrenia. An annual MDS, dated 08/05/10 identified Resident #1 had short and long term memory problems, moderately impaired decision making, required extensive assistance with bed mobility and transfers, and had no current or history of pressure ulcers. Braden Scales, completed on 06/26/10 and 08/11/10 identified a score of 15, indicating a mild risk for pressure ulcers. Resident #1's medical record identified the resident with current pressure ulcers to the heel and buttock. An interdisciplinary note, dated 08/12/10 identified a 3 centimeter (cm) red area to the right heel with a 1 cm intact blister. This conflicts with the care plan which identified the blister on the left heel. Resident #1's Wound Sheet, dated 08/16/10 identified a Stage II pressure ulcer to the right	F 314	F314 Pressure Ulcers Resident #6—Part 1 1. The wound flow sheet for Resident #6 has been updated to include the Stage 1 pressure ulcer on the left heel. Resident #6 care plan has been updated to identify location of pressure ulcer. Resident is now using a pressure-relieving air mattress and larger pillow/let support to keep pressure off heel. 2. All residents with a potential for a pressure ulcer have the potential to be affected. 3. The wound flow sheet has been updated to indicate the pressure ulcer. The care plan has been updated to indicate the location of the pressure ulcer and of the necessity of checking the placement of the pillow/support to keep pressure off the heel. Charge nurse education took place on October 12 at the monthly nursing meeting when the DON reviewed "assessment and documentation in wound care". C NA education will occur at their meeting on October 28 to review re-positioning to prevent pressure ulcers.. 4. Completion date: thirty-five days from date of survey, which is October X, 2010. 10/28/10 5. The charge nurse or designee will audit 1 x per shift x1 week, then 1x week for one month, then 1x monthly for one month, then quarterly thereafter to check for correct placement of pillow with results being reported to the monthly QA meeting with follow-	pat TC Brenda DON Bobbi 10/25/10 2:00pm

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F 314	Continued From page 7 buttock. On 08/28/10, the sheet identified the area as healed. A second Wound Sheet, dated 08/12/10, identified a 3 cm intact blister to the right medial heel. On 08/26/10, the wound sheet identified the area as a 3 x 3 cm dark red dry scab. Resident #1's Comprehensive Care Plan, dated 05/13/10 identified "Potential for skin breakdown R/T osteoarthritis & allergic reaction M/B [manifested by] stiff to move & needs extensive help to reposition & rash to groin & blister to [sentence not completed]." The care plan identified a handwritten approach, dated "8/13" which stated, "Use padded boot tx [treatment] to blister (L) on heel as ordered. Reposition q [every] 2-3 [hours] & keep heel off bed." The care plan failed to identify the Stage II pressure ulcer to the right buttock. Review of Resident #1's Nutrition Risk notes identified the most recent note dated 06/14/10. That note stated, "Skin reported intact. . . . Goal: Stable wt [weight] & intact skin. F/U. [follow-up] prn." Observations of the noon meal took place on August 31 and September 1, 2010. During the observations, Resident #1 consumed approximately 50% of her meals. An interview with a supervisory dietary staff member (#8) occurred on 09/01/10 at 2:45 p.m. The staff member stated she was aware Resident #1 "had a blister on her foot," but was not aware of any pressure ulcers. She stated she received no communication from nursing regarding pressure ulcers for Resident #1. She stated the Nutrition Risk committee has not followed	F 314	up if needed. See attachment F314B. The director of nursing or designee will audit the wound care flow sheet and care plan for completeness and accuracy for other residents with pressure ulcers weekly x1 month, then monthly x1 month, then quarterly thereafter and report results to the monthly QA committee meeting with follow-up if needed. See Attachment 314C. Resident #1—Part 2 1. The care plan for resident #1 has been updated to identify the Stage II pressure ulcer to the right buttock. The consulting dietitian has reviewed resident #1 for nutritional status and resident will be followed on the nutritional risk committee monthly. 2. All residents have the potential to be affected. 3. Care plans will be updated as soon as a pressure ulcer is identified on the skin assessment, and resident will be referred to nutritional risk committee for review and follow up. Charge nurse education took place on October 12 at the monthly nursing meeting when the DON reviewed "assessment and documentation in wound care". 4. Correction date: thirty-five days from date of survey, which is October X, 2010. 10/28/10 5. Director of nursing or designee will audit the wound flow sheet weekly x1 month, then monthly x2 months then quarterly thereafter, with results reported to the monthly QA meeting and follow-up if needed. See attachment F314C.	per TIC Brenda DON 8066 10/25/10 2:00pm

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F 314	Continued From page 8 Resident #1 since June 2010 because her skin was intact. The staff member stated an administrative nurse (#7) reports all pressure ulcers at the Nutrition Risk committee meetings and did not discuss Resident #1 at the 08/16/10 meeting. An interview with an administrative nurse (#9) occurred on 09/02/10 at 9:05 a.m. The nurse stated she verbally informed dietary to start the supplement on 08/12/10. She confirmed the care plan lacked identification of the pressure ulcer on Resident #1's buttocks and stated the resident should have been followed by the Nutrition Risk committee. Observations of Resident #1's pressure ulcers occurred on 09/02/10 at 9:10 a.m. A licensed nurse (#10) and a CNA (#11) assisted Resident #1 to turn in bed. Observation identified a dark red area approximately 2.5 cm in diameter on the right heel and superficial open area approximately .25 cm in diameter on the right buttock. Failure to identify the correct site of the heel ulcer and include interventions for Resident #1's buttock pressure ulcer on the care plan, and to monitor the resident through the Nutrition Risk committee could result in delayed healing of the pressure ulcers.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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This REQUIREMENT is not met as evidenced by:
Based on observation, record review, review of facility policy, review of professional literature, and staff interview, the facility failed to provide adequate supervision and appropriate assistive devices to prevent skin tears for 1 of 1 sampled resident (Resident #4) identified by the facility as having repetitive skin tears related to transfers. Failure to implement interventions to reduce hazard(s) and risk(s), and modify interventions when necessary, placed Resident #4 at risk for repetitive injury.

Findings include:

The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding accidents which states the facility must ensure each resident receives adequate supervision and assistance devices to prevent accidents. The facility must provide an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. This includes identifying, evaluating, and analyzing hazard(s) and risk(s), implementing interventions to reduce hazard(s) and risk(s), and monitoring for effectiveness and modifying interventions when necessary. Mechanical assistive devices for transfer include portable total body lifts. Residents who become frightened during transfer in a mechanical lift may exhibit resistive movements that can result in avoidable accidents.

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F 323	Continued From page 10 Review of the facility's policy titled "Skin Tear Treatment and Prevention" occurred on 09/02/10. This policy, revised 03/08, stated, ". . . Prevention Procedure: . . . 3. Note location, size (measure) and shape of skin tear for documentation. . . . 9. Document size (measured) of skin tear and shape (drawing); also document treatment and any other pertinent information. . . . Guidelines for Prevention of Skin Tears: Skin tears occur most commonly on the arms and hands. Resident who needs assistance in ADLs [activities of daily living] is at the greatest risk for developing a skin tear. . . . Of the known causes, approximately half of the skin tears are due to . . . bumping into objects. - Observation on 08/30/10 identified: * At 2:05 p.m., Resident #4 lying in her bed; her right forearm wrapped with guaze wrap. A nursing staff member (#13) identified the resident with a skin tear "due to a lift transfer." - Observation on 08/31/10 identified: * At 9:47 a.m. and 10:52 a.m., two certified nurse assistants (CNAs) (#6 and #14) transferred Resident #4 from her Broda chair to her bed, and back again, using a Hoyer lift. At 3:45 p.m., two CNAs (#14 and #15) transferred Resident #4 from her bed to her Broda chair using a Hoyer lift. Resident #4 became agitated both times when the CNAs raised the sling and grabbed at and rubbed both of her wrists/forearms against the canvas straps of the sling. Observation showed no padding on the canvas straps of the sling/lift. - Observation on 09/02/10 identified: * At 11:00 a.m., nursing staff member (#10) lifted Resident #4's sleeve so that the skin tear on her right forearm could be viewed. The nursing staff member (#10) measured a skin tear on the	F 323	F323 Prevention of Accidents 1. Padded sheepskin "sleeves" will be put on resident #4's arms just prior to using the mechanical lift to prevent skin tears. The lift may not be modified with coverings per manufacturer's instruction. The resident is also dressed with long sleeved upper garments and long pants on the legs. 2. All residents who use lifts have the potential to be affected. 3. At the monthly nursing meeting on October 12, charge nurses reviewed the "skin tear" flow sheet that was developed to track skin tears. A notice was placed in the communication book for all staff instructing them of changes for the residents who use lifts. At the next C NA meeting on October 28, staff will review availability of protective sheepskin "sleeves" and be instructed to use them for residents with fragile skin. 4. Completion date: thirty-five days from date of survey which is October ~~X~~, 2010. 10/28/10 5. Director of nursing or designee will audit use of protective sleeve coverings and/or long pants and long sleeves on resident #4 3x weekly for 1 month then 1x monthly for 2 months then quarterly thereafter and report results to the monthly QA committee meeting with follow-up if needed. See attachment F323.	per TC Brenda, DON Bobbi 10/25/10 2:00pm

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F 323	Continued From page 11 resident's forearm 1.4 x 0.7 centimeters (cm) in diameter. Review of Resident #4's medical record on August 30-September 2, 2010 identified the facility admitted the resident in January 2009. The resident's diagnoses included skin tears (The "Cumulative Diagnosis List" identified twelve skin tears between 01/22/09 - 08/24/10), malnutrition, senile dementia with behavioral disturbances, history of CVA (cerebral vascular accident), and possible Parkinson's disease. A quarterly Minimum Data Set (MDS), dated 07/07/10, identified short and long term memory impairment, severely impaired daily decision making skills, and total assistance of two or more persons with transfers. Resident #4's Resident Assessment Protocol (RAP) summary, dated 01/11/10, stated, ". . . ADL Function/Rehabilitation Potential: . . . She needs help with all cares. She rarely if ever makes a decision on her own. . . . . Falls: . . . She . . . has no safety awareness. . . . She is . . . transferred with a total lift and 2 people. . . ." Resident #4's current care plan, dated 07/12/10, identified the following problems: ". . . *Potential for injury r/t [related to] weakness . . . Approaches . . . Transfer with total lift . . ." Resident #4's "Interdisciplinary Progress Notes" identified the following: * 06/05/10 at 9:45 p.m., "Resident aggressive to staff [at] hs [night] [and] flinging arms when they were assisting her to bed. Developed skin tear (R) [upper] arm." * 06/15/10 at 7:30 p.m., "Resident has a skin tear (R) forearm - she attained this during transfer	F 323		

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F 323	Continued From page 12 from bed to Broda chair. COPA dressing [sic] q [every] 3-5 days prn [as needed] till healed - weekly skin assessment till healed." * 07/15/10 at 2:00 p.m., "[Resident #4] received 2 skin tears to her (R) calf during a transfer by CNA staff. The top one is triangular shaped and measures 5 cm x 5 cm at widest to longest points. The 2nd one just below that is triangular shaped and measures 1.5 cm x 1.5 cm at the longest and widest. Areas were cleaned and steri-strips applied. Covered with a protective dressing and guaze wrap. Dr. [doctor] . . . notified." * 08/24/10 at 10:00 a.m., "Skin tears (R) forearm. Steri strips to skin tears. Padded dressing for protection. Weekly skin assess (R) forearm. Change drsg [dressing] weekly. CNAs state the skin tears were noted [per] use of sling/mech [mechanical] lift." Resident #4's "Therapy Documentation Notes," dated 09/30/09, stated, ". . . Resident is totally dependent on staff for all ADLs and cares. . . . Transfers via mechanical lift occasionally cause extreme agitation and flaing [sic] of arms and legs even when continuous reassurance is given. In these situations the lift is questionable for safety. . . . I would recommend the CNAs contact the charge nurse if this level of anxiety is occurring . . . The nurse will determine if transfers are safe and /or appropriate. . . ." During an interview on 08/31/10 at 3:15 p.m., when asked what interventions the facility staff attempted in order to protect Resident #4 from skin tears during transfers, an administrative staff member (#1) stated, "We tried sleeves. They were recently discontinued on August 11th, because the patient pulled them off. We tried	F 323		

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F 323	Continued From page 13 socks before that. She was pulling on them constantly." When asked regarding any interventions specific to the canvas straps on the sling/lift, she stated, "We didn't think to do that." Failure of facility to identify, analyze hazard(s) and risk(s), implement interventions to reduce them, and modify interventions when necessary, placed Resident #4 at risk for repeat skin tears during care provided with a mechanical lift.	F 323		
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.	F 329		

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F 329	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, review of professional literature, and staff interview, the facility failed to ensure a drug regimen free of unnecessary drugs for 1 of 3 sampled residents (Resident #4) receiving antianxiety medication. Failure to monitor the need for, and attempt a dose reduction may result in residents receiving medications which provide no therapeutic benefit and has the potential to cause harm. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding the tapering of a medication dose/Gradual Dose Reduction (GDR) which states the purpose of tapering a medication is to find an optimal dose or to determine whether continued use of the medication is benefiting the resident. Tapering may be indicated when the resident's clinical condition has improved or stabilized or the underlying causes of the original target symptoms have resolved. Often, however, the only way to know whether a medication is needed indefinitely and whether the dose remains appropriate is to try reducing the dose and to monitor the resident closely for improvement, stabilization, or decline. For antipsychotic medications, after the first year, a GDR must be attempted annually, unless clinically contraindicated. Review of the facility's policy, titled "Psychopharmacological Medications and Sedative/Hypnotics" occurred on 09/02/10. This policy, revised 11/09, stated, ". . . Gradual Dose	F 329	F329 Dose Reduction 1. The psychiatric nurse consultant on September 15 wrote a statement that a dose reduction is not recommended at this time for resident #4. 2. All residents with anti-anxiety medications have the potential to be affected. 3. On September 22, the director of nursing spoke with the pharmacist re: dose reduction procedure and use of gradual dose reduction calendar, GSS #166. We will continue with monthly pharmacy review and quarterly dose reduction committee. The dose reduction calendar, GSS#166, will be utilized by both pharmacy review and dose reduction committee. See copy attached F329A. The director of nursing reviewed on September 6 with the GDR (Gradual Dose Reduction) committee nurse and the QA nurse our GDR procedures. No other nursing staff is involved with the committee. 4. Completion date: thirty-five days from date of survey which is October 7, 2010. 5. Director of nursing or designee will complete an audit of the dose reduction calendar weekly x three months then 1x per month for 2 months, then quarterly thereafter with results reported to the monthly quality assurance committee for follow-up if needed. See attachment F329B.	

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Reductions: The purpose of tapering medication is to . . . determine if continued use of 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 have resolved, and/or non-pharmacological interventions have been effective in reducing the symptoms. . . . 3. Other Psychopharmacological Medications: a. . . . After the first year, a tapering should be attempted annually unless clinically contraindicated. . . ."

- Review of Resident #4's medical record on August 30-September 2, 2010 identified the facility admitted the resident in January 2009. The resident's diagnoses included senile dementia with behavioral disturbances. The comprehensive care plan, dated 07/12/10, stated, ". . . Problems . . . Alteration in behavior r/t [related to] dementia m/b [manifested by] hitting out at staff [and] resisting cares, verbal aggression, restlessness . . . Approaches . . . Medicate as ordered . . . Monitor for side effects of Klonopin . . ."

Resident #4's current Physician Orders, signed 08/25/10, identified the following:
* "02/25/09, Klonopin 0.25 mg [milligrams] po [by mouth] bid [twice daily]"

During an interview on 09/01/10 at 10:20 a.m., an administrative staff member (#1) confirmed a dose reduction had not been attempted within the past year.

Resident #4's medical record failed to provide clinical rational for the continued use of Klonopin or the contraindications for a dose reduction attempt.

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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 facility policy, review of professional literature, and staff interview, the facility's consulting pharmacist failed to identify and report irregularities to the attending physician and the director of nursing for 1 of 3 sampled residents (Resident #4) receiving an antianxiety medication. Failure to identify and report the need for a gradual dose reduction (GRD) of a antianxiety medication has the potential for the residents to receive unnecessary medications, develop adverse consequences, and fail to maintain their highest level of functioning possible. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined the the standards of practice regarding the drug regimen review which states the facility's intent should be to maintain the resident's highest practicable level of functioning and prevent or minimize adverse consequences related to medication therapy by providing a	F 428	F428 Dose Reduction Refer to F329 Plan of Correction	

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licensed pharmacist's review of each resident's regimen of medication. The pharmacist should identify and report irregularities to the attending physician and the director of nursing.

Review of the facility's policy, titled "Psychopharmacological Medications and Sedative/Hypnotics" occurred on 09/02/10. This policy, revised 11/09, stated: ". . . Non-Emergency Administration: . . . 10. e. Gradual dose reductions must be done according to federal regulations. . . ."

- Review of Resident #4's medical record on August 30-September 2, 2010 identified the facility admitted the resident in January 2009. The resident's diagnoses included senile dementia with behavioral disturbances. The comprehensive care plan, dated 07/12/10, stated, ". . . Problems . . . Alteration in behavior r/t [related to] dementia m/b [manifested by] hitting out at staff [and] resisting cares, verbal aggression, restlessness . . . Approaches . . . Medicate as ordered . . . Monitor for side effects of Klonopin . . ."

Resident #4's current Physician Orders, signed 08/25/10, identified the following:
* "02/25/09, Klonopin 0.25 mg [milligrams] po [by mouth] bid [twice daily]"

Revies of the consultant pharmacist's medication reviews from November 2009 - August 2010 failed to show annual recommendations for a GDR of Resident #4's Klonopin.

During an interview on 09/01/10 at 10:20 a.m., an administrative staff member (#1) confirmed a dose reduction had not been attempted within the past year, and failed to provide any additional

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F 428	Continued From page 18 information indicating the pharmacist had addressed the Klonopin. Refer to F329.	F 428	F441 Infection Control 1. Infection control log has been updated with culture results and causative agents of infections, whether the infection was center acquired, and pharmacist notified of antibiotics used. 2. All residents have the potential to be affected. 3. Policy on disease surveillance will be reviewed with all nursing staff at their next meeting (October 12). All specimens will be cultured as ordered by the physician and documented in the infection control log and indicated whether center acquired or not. Charge nurses were instructed at their monthly meeting on October 12 to verify whether medication is sensitive on culture report; if not, to notify physician and pharmacist. If infectious or symptomatic, then isolation precautions will be taken and residents kept in their room. Such action will be entered on the infection control log. Infection control nurse or designee will indicate on the Log that pharmacy was notified of antibiotic use. See Attachment F441A. 4. Completion date: thirty-five days after date of survey which is October ~~X~~ 2010. 10/12/10 5. HIM or designee will audit weekly x 4 weeks, then monthly x 2 months then quarterly thereafter for completion of infection control log for inclusion of cultures and causative agents, whether the infection was center acquired or not, and what action was taken by facility to prevent the spread of infection and pharmacist notified.	per TIC Brenda, DON Debbi 10/25/10 2:00pm
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and	F 441		

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F 441	Continued From page 19 transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on review of the facility's infection control program, review of facility policy, professional literature, and staff interview, the facility failed to maintain an infection control program designed to prevent the development and transmission of disease and infection within the facility for 5 of 5 months reviewed (March - July 2010). Failure to maintain an infection control program has the potential to affect the health and safety of all facility residents, staff, and visitors. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding infection control which includes implementing and maintaining an Infection Prevention and Control Program in order to prevent, recognize, and control, to the extent possible, the onset and spread of infection within the facility. The program will perform surveillance and investigation to prevent the onset and the spread of infection, and use records of infection incidents to improve its infection control processes and outcomes by taking corrective actions. An effective infection prevention and control program incorporates process and outcome surveillance, monitoring, data analysis, documentation, and antibiotic review, including reviewing data to monitor the appropriate use of antibiotics in the resident population. Determining the origin of infections helps the facility identify	F 441	See attachment F441B. Results of audit will be reported to monthly QA committee meeting with follow-up if necessary.	

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the number of residents who developed infections within the nursing home. Comparing current infection control surveillance data to past data enables detection of unusual or unexpected outcomes, trends, effective practices, and performance issues. The facility can then evaluate whether it needs to change processes or practices to enhance infection prevention and minimize the potential for transmission of infections. Review of the use of antibiotics is a vital aspect of the infection prevention and control program. As part of the medication regimen review, the consultant pharmacist can assist with the oversight by identifying antibiotics prescribed for resistant organisms or for situations with questionable indications, and reporting such findings to the director of nursing and the attending physician.

Review of the facility's policy, titled "Disease Surveillance" occurred on 09/02/10. This policy, effective date 07/03, stated: ". . . Uses of the surveillance data may be the following: . . . *Identify problems *Evaluate control measures . . . . Procedure: 1. Define the events to be surveyed and develop definitions of nosocomial infections . . . 3. Determine the purpose of the data collection . . . b. Determine endemic level of specific organisms . . . d. Identify outbreaks . . . 6. An outbreak investigation may be used to find ways to interrupt further transmission of disease-causing agent. a. Outbreak investigation steps 1) Verify the diagnosis and identify the agent . . . 3) Look for additional cases . . . 6) Consider control measures; initiate the most appropriate 7) Evaluate the measures . . ."

Review of the facility's policy, titled "Surveillance/Report Forms" occurred on

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F 441	Continued From page 21 09/02/10. This policy, effective date 07/03, stated: ". . . Surveillance is the activity that a health care institution employs to find, analyze, control and prevent nosocomial infections; and also the collection, collation, analysis of data and passing of information to those who need to know in order to take action. . . . Components of surveillance are the following: . . . Analysis by using cultures, changes in prevalent organisms . . ." Review of the Infection Control Log for the the past five months (March-July) occurred on 09/01/10 at 9:00 a.m. The infection control log contained incomplete information about cultures results and the causative agent. The infection control log further failed to include the action taken by the facility to prevent the spread of infection and whether the infection was center acquired. During an interview on 09/01/10 at 9:40 a.m., the infection control nurse (#7) stated, the facility "only cultures UTIs [urinary tract infections] and wounds." She further stated, "I mark the causative agents for UTIs." When asked what control measures the facility used with those residents identified as being positive for MRSA [methicillin resistant staphylococcus aureus], the infection control nurse (#7) stated, "The residents with MRSA were on isolation and were care planned." She further stated, "95% of the infections we identify are center-acquired. I mark the infections acquired outside the facility." An interview with the infection control nurse (#7) occurred on the morning of 09/02/10. When asked if the pharmacist performed antibiotic reviews, she stated she was not sure, but thought he did.	F 441		

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F 441	Continued From page 22 An interview with a pharmacist (#3) occurred on 09/02/10 at 9:50 a.m. When asked if he completed a review for appropriate antibiotic use with the monthly drug regiment reviews, the pharmacist stated he did not. Failure of the facility to maintain an infection control program that included complete information about culture results, the causative agents, the actions taken by the facility to prevent the spread of infection, whether the infection was center-acquired, and data review to monitor the appropriate use of antibiotics has the potential to affect the health and safety of all facility residents, staff, and visitors.	F 441		
F 454 SS=D	483.70 LIFE SAFETY FROM FIRE The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. This REQUIREMENT is not met as evidenced by: Based on observation, review of professional reference, and staff interview, the facility failed to comply with Life Safety Code requirement NFPA 99 for Health Care Facilities to protect the health and safety of residents, personnel, and the public, regarding oxygen storage in 2 of 3 oxygen storage areas (North and South medication rooms). This failure could result in oxygen tanks tipping and becoming a safety hazard. Findings include: Life Safety Code requirements state, "Nonflammable medical gas systems and	F 454		

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F 454	Continued From page 23 equipment used for the administration of inhalation therapy and for resuscitative purposes comply with National Fire Protection Association (NFPA) 99, 13-5.1, 7-1.2, NFPA 70." Standard for Storage, Use, and Handling of Compressed Gases and Cryogenic Fluids in Portable and Stationary Containers, Cylinders, and Tanks, NFPA 55, 7.1.4.4 states, "Securing Compressed Gas Containers, Cylinders and Tanks. Compressed gas containers, cylinders, and tanks in use or in storage shall be secured to prevent them from falling or being knocked over by corralling them and securing them to a cart, framework, or fixed object by use of a restraint, unless otherwise permitted by 7.1.4.4.1 and 7.1.4.4.2.7." - Observation of the South medication room occurred on 09/01/10 at 1:40 p.m. with a licensed nurse (#10). Observation identified an oxygen tank stored against the north wall of the medication room. A strap, attached to the wall on each side of the tank and designed to secure three tanks, hung loosely across the one tank. The nurse agreed the strap did not secure the tank in an upright position. - Observation of the North medication room occurred on 09/01/10 at 2 p.m. with a licensed nurse (#12). Observation identified two oxygen tanks stored in the same manner with a strap loosely across the tanks. Failure to securely store the oxygen tanks placed residents, staff, and the public at risk if the tanks fell or were tipped on their side.	F 454	F454 Life Safety O2 storage 1. Storage boxes were built and attached to the wall in the north and south nurses stations. The storage boxes were approved by the survey team before they left at the end of the survey. 2. All residents have the potential to be affected by this deficiency. 3. Storage boxes were built and attached to the wall in the south and north nurses station. 4. Completion date: thirty-five days from date of survey which is October 7, 2010. 5. Director of nursing or designee will audit correct placement of oxygen tanks in storage weekly x1 month then 1x monthly for one month, then quarterly thereafter with follow-up if needed. See F454.	
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION	F 456		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355111	A. BUILDING _____ B. WING _____	09/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 456	Continued From page 24 The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain 2 of 2 suction machines (North and South units) readily available for use. Failure to have the suction machines readily available placed residents requiring emergency suction at risk for choking and/or aspiration. Findings include: - Observation of the South medication room occurred on 09/01/10 at 1:40 p.m. with a licensed nurse (#10). Observation identified a suction machine on a rolling stand in the medication room. Observation showed no connecting tube or suction cannula available with the machine. Review of the medication room cupboards identified no tubing or cannulas stored in the room. The nurse stated the facility stored the items in the 200 wing store room. - Observation of the locked 200 wing store room took place on 09/01/10 at 1:50 p.m. with a licensed nurse (#12). Observation showed the storeroom located in a short hall off the main 200 hallway, approximately half way down the hall. A chair blocked the entrance to the short hall. The nurse was not able to immediately locate the tubing and cannulas and stated she was not sure on which shelf staff stored the items. After looking about the room, the nurse located the items in a box on the top shelf.	F 456	F456 Essential equipment – Suction machine 1. Tubing and cannula were attached immediately to the suction machines. 2. All residents have the potential to be affected by this deficiency. 3. The tubing and cannula placement will be checked weekly and replaced as necessary by charge nurse. 4. The director of nursing or designee will complete an audit weekly x 4 weeks and monthly for 2 months and quarterly thereafter to check that tubing and cannula are attached to the suction machines. Results of audit will be reported to monthly QA meeting with follow-up if necessary. See attachment F456A. 5. Completion date October 7, 2010.	

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F 456	Continued From page 25 - Observation of the North medication room occurred on 09/01/10 at 2 p.m. with a licensed nurse (#12). Observation identified a suction machine on a rolling stand in the room. Observation showed a cannula available, but no connecting tube. Failure to have essential tubing and cannulas immediately available could delay the implementation of emergency treatment for a resident requiring suctioning.	F 456		
F 516 SS=C	483.75(l)(3), 483.20(f)(5) RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS A facility may not release information that is resident-identifiable to the public. The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. The facility must safeguard clinical record information against loss, destruction, or unauthorized use. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of professional literature, and staff interview, the facility failed to ensure protection of stored resident-identifiable health information in 1 of 1 medical record storage area. This placed stored resident-identifiable health information at risk for loss, destruction, and/or unauthorized	F 516		

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F 516	Continued From page 26 use. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding access to resident-identifiable information which states facilities are required to keep confidential all information contained in the resident's record and to maintain safeguards against the unauthorized use of a resident's clinical record information, regardless of the storage method of the records. Review of the facility's policy, titled "Access to the Health Information Management (HIM) Department" occurred on 09/02/10. This policy, revised 11/08, stated: ". . . Policy: . . . Access to the HIM department or the room(s) which contain(s) medical records and PHI [protected health information] will be limited to authorized staff. . . . Procedure: . . . 2. Only Authorized staff and HIM staff, may access the a [sic] locked HIM office. . . . a. Authorized staff include the administrator and director of nursing services. . . ." - The following observation occurred during the environmental tour on 09/01/10 at 2:15 p.m., an environmental services staff member (#4) unlocked the door and entered the HIM storage room located on the 400 wing. Observation of the room revealed file cabinets containing accessible resident medical records. During an interview on 09/01/10 at 2:15 p.m., the environmental services staff member (#4) reported she had keys to access the room which in turn allowed her access to resident medical	F 516	F516 Safeguard clinical records 1. All keys to the locked medical records storage area have been turned into the administration office. 2. All residents have the potential to be affected by this. 3. Only authorized staff and HIM staff may access the locked medical records storage area. Authorized staff include the administrator and director of nursing. 4. Completion date: thirty-five days from the date of the survey which is October 7, 2010. 5. Director of nursing or designee will audit the proper security of medical records weekly x1 month, then 1x monthly for one month then quarterly thereafter. See attachment F516	

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F 516	Continued From page 27 records. She also reported she was unsure who else had keys to the room. An interview with an administrative staff member (#2) occurred on 09/01/10 at 4 p.m. The staff member confirmed environmental services staff should not have keys to the medical records storage area. The facility failed to safeguard resident health information by allowing unauthorized personnel accessibility to the medical record storage area.	F 516		