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MAY 02 2013
Division of Health Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355069	A. BUILDING _____ B. WING _____	C 04/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND CARE CENTER	620 14TH AVE NE DEVILS LAKE, ND 58301

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey and complaint investigation started on April 8, 2013 and completed on April 11, 2013, the sample included four (4) residents for complete review, nine (9) residents for focused review, and three (3) closed records for review. The sample included two (2) additional residents to verify specific concerns during the survey.	F 000		
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)	F 156		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Karissa Olson — TITLE: Administrator — (X6) DATE: 4/29/13

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 156	Continued From page 1 (i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance	F 156		

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F 156	Continued From page 2 directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on review of the facility's admission packet, and staff interview, the facility failed to provide newly admitted residents the most current information regarding covered and noncovered services provided by the facility for 1 of 1 admission packet provided by the facility. Failure to provide residents with current information regarding services covered and not covered by the facility's daily rate limits the residents' and families' right to be fully informed regarding services included in the daily rate. Finding include: Review of the facility's admission packet occurred on the morning of 04/10/13. This packet, provided by the facility, contained the handout "Durable Medical Equipment and Supply program, Non-Covered Equipment and Supply List" dated April 1997.	F 156	1. The current Appendix A Listing of Routine Drugs, Supplies and Durable Medical Equipment will be added to all Admission Packets. 2. Current Heartland Care Center resident and/or legal representatives will receive the current Appendix A Listing of Routine Drugs, Supplies and Durable Medical equipment for Nursing Facilities. 3. The Social Service Designee will review the Appendix A Lising of Routine Drugs, Supplies and Durable Medical Equipment for Nursing Facilities at Resident Council meetings yearly. 4. Licensed Social Worker Consultant will review Heartland care Center Admission packet once yearly during her quarterly visits to ensure compliance with Resident Rights. Notice of this requirement for consultant communicated 4/24/13.	4/10/13 4/26/13 5/7/13

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F 156	Continued From page 3 During an interview on 04/10/13 at 5:30 p.m., a social services staff member (#8) identified the handout "North Dakota Department of Human Services Medical Services, Non-Covered Services" undated, is the current handout provided in the facility's admission packet. This staff member identified the handout "Appendix A, Listing of Routine Drugs, Supplies & Durable Medical Equipment for Nursing Facilities" revised in July 2012 was not included in the facility's admission packet.	F 156		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. , The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225		

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F 225	Continued From page 4 violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, staff interview, and review of facility policy, the facility failed to report 1 of 2 allegations of neglect and/or abuse to the state survey and certification agency immediately (within 24 hours), and report the results of the investigation within five working days of the incident. In addition the facility failed to investigate 1 of 2 alleged allegations of abuse/or neglect. Failure to report and thoroughly investigate all alleged violations involving neglect and/or abuse has the potential to place all residents at risk of possible neglect and abuse. Findings include: Review of the facility policy titled "Resident Abuse" occurred on 04/11/13. This policy, dated 06/04/10, stated, ". . . Response: . . . In case of mistreatment, neglect, abuse, including injuries of unknown source and misappropriation of property the Administrator, DON, [director of nursing] and Social Services will follow the clarification on	F 225	1. There were not any residents affected by deficient practice. 2. All residents are at risk to be affected. 3. We feel our Resident Abuse policy is well written. We have changed our forms to be more directive to staff as to reporting of suspected abuse to DHS within 24 hours. All nursing staff will be educated on the completion of these updated forms and reporting. Staff meetings will be held on May 8, 2013. 4. Each week at the Interdisciplinary Team Meetings, the Team will review the prior week's Reports of Alleged Resident Abuse, if any. These reports will then be reviewed quarterly at the QA Meetings. 5. 5/8/13	

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F 225	Continued From page 5 reporting submitted by the Health Dept. . . . Which defines 'Immediately' to mean as soon as possible, but ought not to exceed 24 hours after discovery of the incident. . . . Investigation: . . . 1) The employee who witnesses or has knowledge of an act of abuse shall notify the Administrator, Director of Nursing, Social Services, Assistant Director of Nursing or Charge Nurse. The employee must document the alleged abuse including but not limited to, the nature of the abuse and where and when it occurred. 2) The Administrator, Director of Nursing, [sic] Social Services, will meet to determine what action is needed to insure the safety of the residents while the investigation is conducted. . . . 3) All alleged acts or suspected acts of abuse . . . shall be investigated and reported to other officials through established procedures in accordance with state law . . . - The results of the investigation must be reported to the Administrator . . . and to the State Survey and Certification Agency within five [5] working days of the incident. . . ." - During the resident group interview on 04/09/13 at 10:00 a.m., Resident #18 reported that during the evening shift on Monday (04/08/13) the nurse that brought in her evening medications, "was very rude and just poked the pills in my mouth." When the surveyor asked if she reported this to anyone, Resident #18 stated she told the nurse that was working the day shift today. Review of the facility's investigations of alleged abuse/neglect incidents occurred on the morning of 04/11/13, with a social service staff member (#8). This staff member identified no reports of allegations in the past year and had no	F 225		

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F 225	Continued From page 6 information regarding the resident complaint made to the survey team on 04/09/13. During an interview on the morning of 04/11/13 an administrative staff member (#3) stated she had one "Investigative Report." This report identified an incident on 04/21/12. The facility notified the State survey and recertification agency on 04/23/12, two days after the incident. The facility sent the final report to the State survey and recertification agency on 05/18/12, 27 days after the incident. During an interview on the morning of 04/11/13, an administrative staff member (#3) stated she did not notify the state agency within 24 hours because the incident occurred on the weekend. During an interview on 04/11/13 at 8:35 a.m., an administrative nurse (#7) stated she was aware of a complaint on 04/09/13 from Resident #18, but had not conducted an investigation. This staff member stated she would gather information on the incident. On the afternoon of 04/11/13, an administrative nurse (#7) provided a "Problem/Resolution Form." This form identified Resident #18 had a complaint related to an incident that occurred during the medication pass on the evening of 04/08/13. The resident stated when she received her pills on the evening of 04/08/13 and they were "shoved" in her face. This form identified Resident #18 reported the incident to the nurse on the morning of 04/09/13. Staff completed the "Problem/Resolution Form" on 04/11/13, two days after the resident reported the incident.	F 225		
F 278	483.20(g) - (j) ASSESSMENT	F 278		

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F 278 SS=E	Continued From page 7 ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), and staff interview, the facility failed to complete Minimum Data Set (MDS) assessments which	F 278	1. Residents from the sample that were affected are resident #1, #4, #5 #6, #10, #11 and #13. Resident #11 is no longer is our facility. This resident has passed away. The MDS's for these residents have been corrected in regards to toileting programs. 2. Any resident that requires assist with toileting may be affected. All residents on toileting programs have been identified and toileting programs have been reviewed. 3. Unit Managers/Nurse Managers will be educated on the specific and correct way that a toileting program is to be written and how to code it correctly on the MDS. All current MDS's of the affected residents in the sample and further residents identified that were affected will be corrected and resubmitted to CMS QIES Assessment Submission & Processing System and to the North Dakota Department of Human Services. If any of the incorrectly coded assessments affected payment, billing adjustments will be made accordingly.	

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F 278	Continued From page 8 accurately reflected the resident's status for 7 of 13 sampled residents (Resident #1, #4, #5, #6, #10, #11, and #13) coded on the MDS on either a urinary toileting program or bowel toileting program and for 3 of 3 sampled residents (Resident #1, #11, #12) who had an admission MDS completed after being discharged from the facility with return anticipated. Failure to accurately assess and code the MDS may affect the level of care provided to residents. Findings include: The Long-Term Care Facility RAI User's Manual: version 3.0, October 2012, page H-5 "implementation of an individualized, resident-specific toileting program that was based on an assessment of the resident's unique voiding pattern, evidence that the individualized program was communicated to staff and the resident (as appropriate) verbally and through a care plan, flow records, and a written report, notations of the resident's response to the toileting program and subsequent evaluations as needed . . ." Page H-12 stated, "implementation of an individualized, resident-specific bowel toileting program based on an assessment of the resident's unique bowel pattern. . . " The Long-Term Care Facility RAI User's Manual, dated April 2012, on page 2-19 states for residents who have already been admitted at the facility an admission assessment can only be completed if they had a completed discharged MDS coded as ". . . discharged return not anticipated . . . " - Review of Resident #11's medical record	F 278	Residents affected by the coding of an assessment as an Admission after returning from a Discharge Return Anticipated was completed cannot be changed due to the fact that the system will not allow the altering of these assessments. This practice will not continue and assessments will be coded either a Significant Change or quarterly, whichever one is appropriate, upon return after discharge return anticipated in completed. This has been put into place immediately upon notification during the survey. 4. The MDS Coordinator will review all assessments prior to submission for the appropriate coding of toileting programs in relation to the proper documentation on the B/B assessment and Care Plan. 5. The completion date for correction and submission of the corrected assessments will be no later than 5/16/13. Education on writing specific and correct toileting program and coding correctly on MDS has been completed on 4/15/13. Reviewing the assessments prior to submission by the MDS Coordinator started on 4/19/13. Compliance date 5/16/13 per phone conversation on 5/6/13 ε Tammie DON KQB	

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F 278	Continued From page 9	F 278		

occurred on April 10-11, 2013. The admission MDS, dated 02/18/13, identified Resident #11 as continent of bowel and bladder and on bowel and urinary toileting programs.

The current care plan identified staff should toilet Resident #11 every two hours for bowels. The resident's care plan failed to identify a urinary toileting program.

Review of Resident #11's "Elimination Assessment Summary" dated 02/18/13, stated, " . . . toileting plan: Cont [continue] to prompt [every] 2 [hour] if Res hasn't called for BR [bathroom] . . ." The record failed to identify an individualized urinary and bowel toileting programs.

During a staff interview on 04/11/13 at 10:05 a.m., an administrative nurse (#1) stated Resident #11 has little urine output related to his diagnosis of end stage renal disease and requires dialysis. The staff member stated the resident is on the toileting program for his bowels. Staff take him to the bathroom every two hours. This staff member confirmed she coded Resident #11's MDSs incorrectly for the urinary and bowel toileting programs.

MDSs completed 08/27/12, 11/01/12, and 02/05/13 showed Resident #11 discharged with return anticipated. When the resident returned to the facility, staff incorrectly completed admission MDS assessments on 09/05/12, 11/11/12, and 02/11/13.

- Review of Resident #1's medical record occurred on April 8-11, 2013. An admission MDS, dated 03/01/13, identified Resident #1 as

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F 278	Continued From page 10 continent of bowel and on a bowel toileting program. The current care plan identified staff should toilet Resident #1 every two hours while awake and at 1:00 a.m. and 5:00 a.m. During a staff interview on 04/08/13 at 3:20 p.m., an administrative nurse (#1) stated Resident #1 had specific times assessed for a bladder program due to the resident being "soaked" in the morning. The facility failed to assess, monitor, and develop times specific to meet a bowel toileting program. Resident #1's record identified a hospital stay from 02/18/13 to 02/22/13. The facility completed a discharge assessment return anticipated MDS and upon return from the hospital, the facility incorrectly completed an admission MDS. - Review of Resident #12's medical record occurred on April 10-11, 2013. The record identified a hospital stay from 02/16/13 to 02/25/13. On 02/16/13, the facility completed a discharge assessment return anticipated MDS. Upon Resident #12's return from the hospital, the facility incorrectly completed an admission MDS. During an interview on 04/11/13 at 8:20 a.m., a nurse (#2) stated she had completed admission MDSs instead of quarterly MDSs after hospital stays, even if residents were discharged with return anticipated. - Review of Resident #4's medical record occurred on April 08-11, 2013. A quarterly MDS dated 02/05/13 identified the resident as	F 278		

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F 278	Continued From page 11 frequently incontinent of urine and occasionally incontinent of bowel, and on urinary and bowel toileting programs. An "Elimination Assessment Summary" dated 02/05/13, stated, ". . . we will cont to prompt q [every] am & pm cares and p [after] meals and prn [as needed] as res [resident] asks . . . " The facility failed to assess, monitor, and develop an individualized bowel toileting program for Resident #4. - Review of Resident #10's medical record occurred on April 8-11, 2013. A quarterly MDS dated 01/27/13 identified the resident as frequently incontinent of bowel and bladder and on urinary and bowel toileting programs. Resident #10's "Elimination Assessment Summary" dated 01/28/13, stated, ". . . scheduled toileting q [every] 2 [hours] during waking hours and NOC's [nights] to toilet at midnight, 0300 et [and] 0500." The facility failed to assess, monitor, and develop an individualized bowel toileting program for Resident #10. During an interview on 04/10/13 at 1:00 p.m., an administrative nurse (#7) stated, they had "not addressed a specific time" for a bowel program for Resident #10. - Review of Resident #13's medical record occurred April 10-11, 2013. A quarterly MDS, dated 03/24/13 identified the resident as occasionally incontinent of urine and bowel, and on urinary and bowel toileting programs. An "Elimination Assessment Summary" dated	F 278		

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F 278	Continued From page 12 03/28/13, stated, ". . . cont to prompt toilet q 2 [hours] during waking hours and PRN as she asks. We will prompt at 9 pm, 1 am & 5 am . . ." The facility failed to assess, monitor, and develop an individualized bowel toileting program for Resident #13. - Review of Resident #6's medical record occurred on April 08-10, 2013. The admission MDS, dated 02/14/13, identified Resident #6 as continent of urine and bowel and on a urinary and bowel toileting programs. Resident #6's current care plan identified staff should assist the resident to the bathroom right after breakfast, then every two hours thereafter. Resident #6's "Elimination Assessment Summary" dated 02/21/13, stated, " . . . Describe toileting plan: Cont prompted [every] 2 [hour] toileting program but will make sure is around 9-9:30 and prn at noc [night] . . . " The facility failed to assess, monitor, and develop an individualized bowel toileting program for Resident #6. - Review of Resident #5's medical record occurred on April 08-10, 2013. The current MDS, dated 02/03/13, identified Resident #5 as frequently incontinent of bladder, continent of bowel, and on a bowel and urinary toileting programs. Resident #5's current care plan identified the resident on a toileting program with prompted voiding every two hours during waking hours. Review of Resident #5's "Elimination Assessment	F 278		

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F 278	Continued From page 13 Summary" dated, 02/01/13, stated, " . . . Describe toileting plan: cont. [with] prompted toileting [every] 2 [hours] during waking hours and prn . . ."The facility failed to assess, monitor, and develop an individualized bowel toileting program for Resident #5. During a staff interview on 04/10/13 at 5:30 p.m., an administrative nurse (#1) confirmed she coded Resident #6 MDS incorrectly for the urinary toileting program and coded Resident #5's MDS incorrectly for the urinary and bowel toileting program.	F 278		
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: 1. Based on record review, review of professional reference and facility policy, and staff interview, the facility failed to provide care in accordance with professional standards for 1 of 4 sampled residents (Resident #10) who experienced a fall with a potential head injury. Failure to complete a neurological assessment following such a fall has the potential for a head injury to go undetected. Findings include: Walters and Kluwar, Lippincott's Nursing Procedures, 5th Edition, 2009, pages 66-67 stated, "Managing Falls . . . Provide first aid for minor injuries as needed. Monitor the patient's	F 281		

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F 281	Continued From page 14 status for the next 24 hours. Even if the patient shows no signs of distress or has sustained only minor injuries, monitor vital signs every 15 minutes for 1 hour, then every 30 minutes for 1 hour, then every 1 hour for 2 hours, or until his condition stabilizes. Monitor neurological assessments with vital signs, as per your facility protocol. . . ." Review of the facility policy titled "Neurological Observations" occurred on 04/11/13. This policy, stated, ". . . Purpose . . . 2. To insure standardization of care of a person with a suspected head injury. . . Procedure: . . . 6. Check the pupil reaction. 7. Take the resident's blood pressure. 8. Take the resident's temperature. 9. Take the pulse rate. 10. Determine the respiratory rate. 11. Check the strength of hand grasp in both extremities. . . " - Review of Resident #10's medical record occurred on all days of survey. Diagnoses included dementia and anxiety. Review of Resident #10's nursing notes stated, on 02/22/13 at 7:50 a.m., "resident found on the floor on her back next to bed, 'I don't know where I was going?' Lt [left] eye & [and] cheek abrasion rt [right] forearm abrasion, ambulates as before ROM [range of motion] as before . . ." The record lacked evidence staff performed a neurological assessment following this fall which resulted in injury to her eye and cheek. During an interview on 04/10/13 at 11:30 a.m., an administrative nurse (#7) indicated the incident dated 02/22/13 lacked a neurological assessment. The staff member (#7) stated if staff	F 281	1. Resident #10 did not show any signs or symptoms of head injury upon nursing assessment done. Resident was monitored for 72 hours per policy and procedure (see exhibit C). 2. Any resident with a history of falls has the potential to be affected. All recent post fall reports have been reviewed per DON and there has been no indication that residents have not been appropriately assessed. 3. The Fall policy and procedure has been updated from completing neurological assessment on any suspected head injury to complete a neurological assessment with any suspected/actual facial or head injury (see exhibit D) updated 4/25/13. 4. Memo will be placed at both nurses' stations with updated policy and procedure and change in neurological exams (competed 4/25/13). Unit managers will review each fall to make sure all assessments are completed and will educate staff as needed (see exhibit D). Mandatory all nursing meeting to review changes has been scheduled for 5/8/13. All falls continue to be reviewed at weekly IDT meeting and quarterly at QA meeting. Next QA meeting will be 7/2013. 5. QA monitoring will go into effect 5/1/13. Compliance date 5/8/13 per phone conversation on 5/6/13 & Tammie DON KQB	

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F 281	Continued From page 15 suspect any head injury they would do a "neuro check." 2. Based on record review, review of professional reference, and staff interview, the facility failed to follow professional standards of practice regarding the completion of physician's orders for 1 of 1 sampled resident (Resident #2) with a missing laboratory report. Failure to ensure staff follow through with physician's orders places residents at risk for delayed treatment and inadequate monitoring of disease conditions. Findings include: Berman and Snyder, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 9th ed., Pearson Education, Inc., New Jersey, page 73, states, ". . . Carrying Out a Physician's Orders . . . If the order is neither ambiguous nor apparently erroneous, the nurse is responsible for carrying it out. . . ." Review of Resident #2's medical record occurred on all days of survey. Diagnoses included polymyalgia rheumatica, osteoarthritis, and generalized pain. A fax sent by the facility to Resident #2's physician on 01/31/13 stated, ". . . [Resident #2] cont. [continues] to c/o [complain of] pain all over et [and] often cries due to pain. She cont. to receive Lorcet [a pain medication] 5/325 mg [milligrams] po [by mouth] TID [three times a day] and Celebrex [an anti-inflammatory] 200 mg po daily. Is there any other anti-inflammatory medication that would provide better relief? . . ." The physician then ordered an erythrocyte	F 281		

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F 281	Continued From page 16 sedimentation rate (ESR), a blood test that indirectly measures inflammation in the body. A lab report, dated 02/01/13, identified an elevated ESR of 52 millimeters per hour (mm/hr) (normal range 2-15 mm/hr). On 02/01/13, the physician ordered a dose pack of Medrol (a steroid used to treat inflammation) for six days. On 02/08/13, the physician wrote an order which stated, ". . . Prednisone 20 mg PO QD [daily] x 2 weeks, then see Doctor [and] draw ESR before appt. [appointment] . . ." The February Medication Administration Record (MAR) identified Resident #2 received Prednisone February 9-22, 2013. The record failed to show a repeat ESR drawn upon completion of the course of Prednisone. During an interview on 04/10/13, a supervisory nurse (#7) stated a staff nurse drew the ESR on 02/27/13, along with a PT/INR (prothrombin time/international normalized ratio, a test that measures the clotting tendencies of blood). The PT/INR results came back from the lab, but the ESR did not.	F 281	1. Resident #2 ESR was drawn on 4/2/13 and was addressed with PMD on rounds 4/2/13. There were no changes made to her current treatment at that time. 2. Any resident with an order for lab to be drawn has the potential to be affected. Recent dictations reviewed from doctor rounds indicate there has not been any missed labs. 3. For better continuity, the unit managers will be responsible for completing the Heartland Care Center Scheduled Lab Report which will be sent directly to Altru Clinic Lab. Unit Managers will also be responsible for reviewing and keeping track of all lab reports for blood drawn in the facility. They will indicate date lab report received at HCC on the Scheduled Lab Report (See Exhibit B). Education completed with Unit Managers on 4/24/13 and will go into effect 4/29/13. 4 & 5. Unit Managers will review all reports weekly (refer to Exhibit B). Reports will then be handed into DON for review on a monthly basis for 1 year. Any concerns will be discussed at quarterly QA meeting. Next QA meeting is 7/2013. Compliance date 5/8/13 per phone conversation on 5/6/13 @ Tammie DON KQB	
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. This REQUIREMENT is not met as evidenced	F 323		

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F 323	Continued From page 17 by: Based on observation, record review, review of Material Data Safety Sheets (MSDS), and staff interview, the facility staff failed to maintain a safe environment for 1 of 1 cognitively impaired resident (Resident #1) who accessed a secured area by using a key hanging on the door frame. Failure to ensure storage areas are secure places residents at risk for accidents and injuries. Findings include: Review of Resident #1's medical record occurred on all days of survey. A quarterly Minimum Data Set (MDS) dated 07/28/12, identified severe cognitive impairment, 1 to 3 days of physical and verbal behaviors and rejection and care, and 4 to 6 days of other behaviors. The MDS failed to identify wandering on the MDSs dated 07/28/12 and 10/28/12. Resident #1's medical record showed an admission to the secured memory care unit on 10/15/12. Resident #1's current care plan stated, ". . .Problem . . . 11/4/2011 Thought Process: Resident has short term memory deficits, secondary to her Alzheimer's disease. . . . Has some difficulty finding her way around the unit. . . . Approaches . . . Placement in the Memory Care Unit 10/15/12. . . . . 11/4/2011 Behavior: . . . hx [history] of exhibiting aggressive agitation including verbal abuse and a history of resisting cares. . . can become short tempered with staff and other residents. . . . Approaches . . . Provide safety for self & others . . ." Review of Resident #1's nursing notes, dated 08/21/12 at 10:15 p.m., stated, "Res. [resident]	F 323	1. Resident #1 is no longer ambulatory and is total assist for locomotion. She is no longer at risk to get into unsafe areas of the building. 2. Any resident that is cognitively impaired and independent in mobility is at potential risk. Nurses notes are reviewed weekly by DON and there has not been any other resident that has been affected. 3. Keys will be placed in a secured Deluxe Magnetic Key Locker out of reach of all residents. Any area that is unsafe for residents that require locked doors will have Magnetic Key Locker. 4. This will go into effect immediately with completion date of 5/1/13.	

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F 323	Continued From page 18 used key to unlock RT [restorative therapy] gym door [and] went in. Took a mod. [moderate] amt. [amount] of redirecting to come back into main NH [nursing home]. Did not attempt to exit main doors to go outside . . . " Observation during all days of survey showed locked doors with a key hanging from a plastic, coiled cord attached to the door frame. These locked areas included clean utility, soiled utility, housekeeping, and storage closets, and the RT gym. The soiled utility and housekeeping closets contained various cleaning chemicals as follows: *Oasis 499 HBV Disinfectant (the MSDS stated "causes digestive tract, eye, and skin burns," and "causes respiratory tract irritation") *Oasis 137 Orange Force (the MSDS stated "causes eye and skin irritation," and "may cause allergic reactions") *Oasis 259 Glass Force (the MSDS stated "may cause respiratory tract, eye, and skin irritation") *Oasis 299 Heavy Duty Bathroom Cleaner (the MSDS stated, "Causes respiratory tract, digestive tract, eye, and skin burns") *Reliance Germicidal Bleach (the MSDS stated, "Corrosive; may cause severe skin and eye irritation or chemical burns to broken skin. Vapors extremely irritating to eyes and respiratory tract. Harmful and potentially fatal if swallowed") A storage closet near the nurses' station included needles and supplies for drawing blood and placing intravenous lines. The RT gym contained a Hydrocollator (a liquid heating device which warms hot packs and can	F 323		

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F 323	Continued From page 19 reach temperatures of 170 degrees) on a table in the gym. During an interview on 04/10/13 at 9:35 a.m., a nurse (#2) stated the facility placed keys on plastic cords after the incident on 08/21/12, so the keys would no longer be on hooks.	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. This REQUIREMENT is not met as evidenced by:	F 329		

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F 329	Continued From page 20 Based on record review, review of professional reference and staff interview, the facility failed to ensure a drug regimen free from unnecessary medications for 1 of 1 sampled resident (Resident #8) receiving a hypnotic. Failure to attempt a gradual dose reduction (GDR) (unless contraindicated) quarterly for hypnotic medications places residents at risk of receiving unnecessary medications and experiencing adverse drug effects related to their use. Findings include: The Nursing 2013 Drug Handbook, 33rd Edition, Lippincott, Williams, and Wilkins, pages 1421-1422, stated, ". . . Ambien . . . Hypnotic . . . Indications & Dosages . . . Short-term management of insomnia . . . Nursing Consideration . . . use drug only for short-term management of insomnia, usually 7 to 10 days. . . ." Review of Resident #8's medical record occurred on all days of survey. Diagnoses included seizure disorder, narcolepsy (neurological disorder that affects the control of sleep and wakefulness) with cataplexy, (sudden loss of muscle tone) and insomnia. Current medications included Ambien (a hypnotic) 5 milligrams at bedtime, initiated on 09/08/08. Resident #8's care plan lacked documentation of the Ambien use. Resident #8's physician's progress notes, dated 10/11/12 through 02/16/13 lacked documentation to identify continued indications for the use of Ambien or contraindications for a GDR. Resident #8's medical record identified the last Ambien review by a physician occurred on 04/03/12.	F 329	1. Resident #8 was seen by PMD on rounds 4/18/13 and Ambien was reviewed. No changes made to her medication at this time. See dictation dated 4/18/13. 2. Any resident on a hypnotic is at risk to be affected. Currently resident #8 is the only resident in the facility on a hypnotic. 3. Unit manager will review with MD or Psychiatrist on all rounds all psychotropic medication used to ensure proper supportive documentation. Dictations will then be reviewed when received, per unit manager. If proper documentation is not received, unit manager or designee will contact PMD and request supportive documentation for continued use. If unwilling, then a psych consult will be requested. Changes reviewed with unit managers 4/25/13. 4. Psychotropic QA report will be updated with date of last pharmacy review and last MD review (see exhibit B). QA reports will be handed into DON monthly for reviewed and will be reviewed quarterly at QA meeting. Next scheduled QA meeting is 7/2013. 5. Initiated 5/1/13. Compliance date 5/1/13 per phone conversation on 5/6/13 c Tammie DON KQP	

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F 329	Continued From page 21 During an interview on the morning of 04/11/13, an administrative nurse (#1) confirmed Resident #8's medical record lacked a GDR attempt or contraindication use of the Ambien in the past year.	F 329	1. Report of Nursing Staff was updated immediately 4/11/13 and was accessible to residents and visitors. 2. There were no resident at risk for harm with deficiency issued. 3. Administrative Assistant or designee in charge of scheduling will put out Report of Nursing Staff (see Exhibit F) the evening prior and will be updated upon Administrative Assistant or designee arrival to work the following day. For staffing of the weekend, the report will be put out the evening of Friday for Saturday, Sunday and Monday. Any changes with staffing over the weekend will be updated by the day shift front charge nurse. 4. Education will be given 5/8/13. 5. Administrative assistant or designee will responsible to ensure that staff have updated changes for shifts as they occur.	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 356	• Adm. Assistant will complete QA daily M-F. Charge nurse will update staffing if needed Sa & Su. • Compliance date 5/8/13 per phone conversation on 5/6/13 w Tammie DON KQB	

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F 356	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure nurse staffing information accurately reflected the number of and actual hours worked by licensed and unlicensed personnel providing direct resident care during 2 of 2 days of observation (April 10-11, 2013). Failure to ensure nurse staffing data is updated daily and accurate at the beginning of each shift infringes on residents' and visitors' rights to access/review staffing patterns of the facility. Findings include: Review of nurse staffing information occurred during the environmental tour on 04/10/13 at approximately 10:00 a.m. The staffing information posted was dated 04/09/13. Observation showed the form dated 04/09/13 was still present at 12:30 p.m. Observation on 04/11/13 at 9:25 a.m. and approximately 1:45 p.m. showed staffing data dated 04/10/13. During an interview on the morning of 04/11/13, an administrative nurse (#5) stated they also post staffing data for each shift by the nurses' station; however, observations throughout the survey showed staff failed to update this staffing data at the beginning of each shift and identify the actual hours worked by staff.	F 356		
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	F 428		

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F 428	Continued From page 23 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 and staff interview, the facility's consultant pharmacist failed to recognize and report drug regimen irregularities for 1 of 1 sampled resident (Resident #8) receiving a hypnotic. Failure to review residents' medication regimens and report irregularities placed residents at risk of receiving unnecessary medications and experiencing adverse drug effects related to their use. Findings included: The Nursing 2013 Drug Handbook, 33rd Edition, Lippincott, Williams, and Wilkins, pages 1421-1422, stated, ". . . Ambien . . . Hypnotic . . . Indications & Dosages . . . Short-term management of insomnia . . . Nursing Consideration . . . use drug only for short-term management of insomnia, usually 7 to 10 days. . . ." Review of Resident #8's medical record occurred on all days of survey. Diagnoses included seizure disorder, narcolepsy with cataplexy, and insomnia. Current medications included Ambien (a hypnotic) 5 milligrams at bedtime, initiated on	F 428	1. Resident #8 was seen by PMD on round 4/18/13. Ambien usage reviewed and no changes were made at that time. Pharmacy Consultant reviewed hypnotic medication on 4/25/13and recommendations made for PMD to review (refer to Consultant Pharmacist's Medication Regimen Review Report). 2. Any resident on a hypnotic is at risk to be affected. Current resident #8 is the only resident on a hypnotic. 3. DON visited with Mark Lundy, Pharmacist Consultant on 4/25/13 regarding resident #8 hypnotic medication use. Mark had clearly indicated reason for annual review versus quarterly review on resident #8 hypnotic. Mark felt that the annual review was sufficient due to her Ritalin usage and her Neurologist recommendation. Effective immediately the Pharmacy Consultant will review all psychotropic medication strictly according to CMS guidelines. 4. Psychotropic QA report will be updated with date of last pharmacy review and last MD review (See exhibit E). QA reports will be handed into DON monthly for review and will be reviewed quarterly at QA meeting. Next scheduled QA meeting is 7/2013. 5. 5/1/13 • Unit managers update as changes occurd report to DON • Compliance date 5/1/13 per phone conversation on 5/6/13 & Tammie DON KB	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355069	A. BUILDING _____ B. WING _____	C 04/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 428	Continued From page 24 09/08/08. Resident #8's medical record lacked evidence the pharmacist recommended a gradual dose reduction of Ambien within the past year. During an interview on the morning of 04/11/13 an administrative nurse (#1) confirmed the lack of pharmacy recommendations regarding Resident #8's use of the Ambien.	F 428		
F9999	FINAL OBSERVATIONS Based on observation, record review, and resident interview, the complaint investigated in conjunction with the standard Medicare and Medicaid survey was not substantiated.	F9999		