STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355063	A. BUILDING _____ B. WING _____ FEB 3 2010	01/07/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES HOME	242 10TH ST W DICKINSON, ND 58601

(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 01/04/10 and completed on 01/07/10, the sample included 4 residents for complete review, 10 residents for focused review, and 3 closed records for review. The sample included 2 additional residents to verify specific concerns during the survey.	F 000	F225 Treatment of Residents 1. Resident #16 was found to have been on a bedpan for 2.25 hours on 11/19/09. An accident/incident report was completed on 11/19/09 but an investigation was not conducted at that time. A corrective action could not be applied to Resident #16 as this resident is now deceased however an investigation related to this accident/incident was completed and filed with the North Dakota Department of Health – Health Facilities Division on 1/15/10. The investigation did contain information from the record that the resident was able to use the call light at the time of the accident/incident, however the length of time on the bedpan was more than acceptable. 2. Other residents having the potential to be affected by the same deficient practice would include all of those residents using a bedpan for elimination and also those residents for whom an accident/incident form is completed. 3. The deficiency will be corrected by education of the nursing staff on proper bedpan procedure including monitoring of those on the bedpan. Revision of the bedpan service procedure will be completed to include monitoring timing for bedpan usage and documentation of bedpan usage beyond the accepted procedure guidelines. Additional correction	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS 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 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	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	2/2/10

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 225	Continued From page 1 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, staff interview, and review of the facility's alleged incidents and investigations of abuse/neglect, since the previous survey, the facility failed notify the State survey and certification agency and to investigate an incident of possible neglect for 1 of 1 closed record (Resident #16) whose medical record identified a possible incident of neglect. Failure to report and investigate a possible incident of neglect places current residents at risk of ongoing abuse/neglect when not appropriately addressed by the facility. Findings include: Review of the facility's policy "Abuse Prohibition Policy [and] Procedure", occurred on 01/05/10. The policy dated 07/09, stated in part: "3. Implementation: St. Luke's Home will investigate alleged violations and report the results of the investigation to the proper authorities. . . . The facility will have evidence that all alleged violations are thoroughly investigated, and will prevent further potential abuse while the investigation is in progress. All alleged violations involving mistreatment, neglect, and abuse, including injuries of unknown source and misappropriation of resident property	F 225	will include screening of all accidents/incidents for potential neglect/abuse and follow-up QA measures by the QA nurse and the DNS to ensure prompt reporting of any potential neglect/abuse issues. All staff will receive additional educational information from the DNS on identifying and reporting issues or neglect and abuse. 4. The initial investigation for Resident #16 was completed on 1/15/10 by the DNS and the Abuse team. Further deficiency corrections will be completed by 2/11/10. 5. The facility will monitor all accident/incident reports for the screening of potential neglect/abuse issues and proper reporting. This will occur with 100% of all accident/incident reports ongoing. The QA monitoring for this area will be done by the DNS and the QA nurse.	2/11/10

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F 225	Continued From page 2 will be reported immediately to the administrator of the facility and to other officials in accordance with State Law through established procedures (including the State survey and certification agency). . . ." - Review of the medical record for Resident #16 occurred January 6-7, 2010. Diagnoses includeo multiple sclerosis (MS), paraplegia, peripheral vascular disease, neuropathy, catheter (suprapubic), and Parkinson's disease. Review of the abuse/neglect allegations, the facility had investigated in the last year, occurred on 01/05/10. Facility staff members (#1 and #2) identified the facility investigated three incidents of possible abuse/neglect. Review of the documentation provided failed to include the following incident with Resident #16 and the bedpan. Nursing documentation showed: "11/20/09, 0720 [7:20 a.m.] Resident found in bed on bed pan at 0015 [12:15 a.m.]. CNA [certified nursing assistant] reports a moderate amount of blood in bedpan. Blood on blue pad as well. Resident has open area on right lower buttocks. Area is circular in shape and 5.5 cm at widest part. Area covered with brief but open to air. No reports of pain from resident." During an interview on 01/07/10 at 11:50 a.m., a staff member (#3) stated she completed the facility "Accident/Incident Report" for Resident #16 and did not investigate this incident as possible neglect. This staff member (#3) further stated she felt staff placed Resident #16 on the bedpan at 10:30 p.m. and forgot to pass on this information to the next shift. This same staff	F 225		

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F 225	Continued From page 3 member (#3) stated Resident #16 could not feel the bedpan due to his condition and at that point Resident #16 could not use the call light. Review of the completed "Accident/Incident Report" on the afternoon of 01/07/10, identified the incident occurred on 11/19/09 at 10:00 p.m., and identified Resident #16 as memory impaired. The medical record showed Resident #16 had existing skin issues prior to being left on the bedpan for a period of 1 3/4 to 2 1/4 hours. With Resident #16's pre-existing conditions, including peripheral vascular disease and paraplegia, along with his inability to call for assistance, the facility did not consider neglect and therefore, did not report this incident to the State Health Department. The definition from the Centers for Medicare and Medicaid Services states, "Neglect means failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness." Refer to F 309.	F 225		
F 248 SS=E	483.15(f)(1) ACTIVITIES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and family interview, the facility failed to develop and implement individualized activity programs to respond to the interests, and current capabilities of 6 of 7 sampled residents (Resident #3, #4, #7, #8, #11, and #13) dependent on staff	F 248		

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F 248	Continued From page 4 to provide a meaningful activity program responsive to their sensory problems/needs, and physical/mental health strengths or deficits. Findings include: Interviews occurred with Family Member A on the afternoon of 01/05/10, and Family Member B on the afternoon of 01/06/10. The residents of both family members have diagnoses of dementia, short and long term memory deficits, and require staff assistance for the provision of all social, recreational, leisure, and religious/spiritual needs. Both Family Member A and B expressed a concern with the lack of activities provided their family member, and expressed concern of typically finding their family member either in bed, or in the large activity room asleep in their wheel chair in front of the bird aviary, with "the TV blasting behind them." Both family members (A and B) stated they felt the resident could participate in many of the small and large group activities they previously enjoyed "if encouraged or provided a little assistance," and would also benefit from more meaningful/purposeful individual staff to resident encounters. - Review of Resident #8's medical record January 04-07, 2010, of Resident #8's-medical record showed the facility admitted the resident on 10/08/08 with diagnoses including dementia with behavioral disturbance, unspecified psychosis, Alzheimer's disease, and depression. The resident's most recent Minimum Data Set (MDS) completed 10/07/09 identified Resident #8's long and short term memory could not be determined, the resident experienced severely impaired decision making/cognitive skills, highly	F 248	F248 1. Those residents affected by the deficiency will have the deficiency corrected through the following: Address family member concerns that their loved ones are sleeping most of the time when they come, however, inform the families that when residents are in the very end stage of dementia, they often appear to be and may be sleeping most of the day and night. To try to over stimulate them to keep them awake would not benefit them. In order to provide a level of tolerable therapeutic activities for cited residents: #8 If resident calls out, observe if stimulation in the area is too great and move her to place of lesser stimulation. Residents with severe end stage dementia # 7, 8, and 11 will be included in new small group activity 3 times/week with a themed lesson plan indicating specific goal responses to the program. Religious services and larger social activities of potential benefit for the identified residents to attend will be highlighted on an activity calendar in their rooms. Residents #3 and #4 at this point need in-room very low-level stimulation. Again with severe dementia, residents #3 and #4 will have specific care plan directions for specific one-to-one activities with copies of the program available for use by any caregivers or families in the room with instructions for use.	

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F 248	Continued From page 5 impaired vision, could hear only in special situations, and exhibited sad/pained/worried facial expressions and repetitive physical movement. Observation showed Resident #8's routine during the survey as follows: * 01/04/10 - Following the noon meal, staff assisted the resident to the activity room and placed the resident within 4-5 feet of the bird aviary. Resident #8 slept in her wheelchair in that position until staff assisted her to bed approximately 45 minutes later. Resident #8 remained in bed until 3:05 p.m. when staff assisted the resident with personal care and transported Resident #8 back to the activity room and again placed the resident in front of the bird aviary. Observation also showed on the afternoon of 01/04/10, as Resident #8 exhibited crying/calling out behavior, no intervention to engage the resident in any diversional activity, and/or consideration of the degree of stimulation in the activity room, and placement of Resident #8 in a lower stimuli area occurred. * 01/05/10 - 9:05 a.m., staff assisted Resident #8 from bed, provided personal care, and assisted the resident to the activity room. Staff placed Resident #8 in front of the bird aviary. Resident #8 remained in front of the bird aviary until staff assisted her to the dining room at approximately 11:15 a.m. During random observations during this time frame, Resident #8 appeared asleep in her wheelchair, showing no reaction or awareness to the birds or her surroundings. * 01/05/10 - 3:55 p.m., staff assisted Resident #8 from bed, provided personal care, transported the resident to the activity room and placed the resident in front of the bird aviary. Observation showed the resident remained in front of the	F 248	2. Other residents potentially affected by this deficiency will be identified through assessment, MDS raps for behavior and mood, mental health team meeting data, plus care planning team processes. Overall all residents are affected by this deficiency as all residents require activity care planning. 3. The deficiency will be corrected by: a) systemic changes to ensure that care plans will note each resident's specific needs for any individualized programming, identifying specific interests and listing specific measurable time frames and goals; b) the development of themed small group activity programs with lesson plans targeting sensory and pleasure responses will be created for those residents with identified sensory and/or cognitive needs; c) the development of one-to-one programs with lesson plans for use by those residents identified as needing one-to-one activity in addition for use by staff and family members; d) the placement of activity calendars in each room with highlighted programs for those residents with communication/cognitive and/or physical challenges identifying the activities the resident would have interest or would benefit from.	2/11/10

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F 248	Continued From page 6 aviary asleep in her wheelchair at 5 p.m. * 01/06/10 - Random observations from approximately 3:30 p.m. to 5 p.m. showed the resident in the activity room asleep in her wheelchair approximately 10 feet from the aviary. Activity attendance records for Resident #8 showed activities participation on the above referenced days as follows: * 01/04/10 - Ball catch/kick - active participant, radio - active participant, towel folding - passive participant, TV - in room, watching out window - active participant, birds - active participant. Observation showed Resident #8 in the activity room during towel folding, however, the resident showed no awareness of the towel folding as she slept in front of the aviary. Observation did not identify a TV or radio on in Resident #8's room. Observation showed no specific instance of Resident #8 being engaged by staff to "watch out the window." * 01/05/10 - Ball catch/kick (4:00 small group activity) - passive participant, radio - active participant, TV - in room - active participant, watching out window - active participant, birds - active participant. Observation showed Resident #8 present in the activity room and asleep in front of the aviary during the ball catch/kick activity, no radio or TV on in the resident's room, and no specific "watching out of the window" planned activity. Review of Resident #8's activity plan of care identified the following as planned activities for Resident #8 to attend: Birthday party, mass & rosary, music, name that tune, outside, rhythm band, TV, van rides, wheelchair ride/walk, 4:00 small group. The plan of care provided no frequency Resident #8 would attend the planned	F 248	Each nursing unit will receive lists of small group or special group activity for identified residents with the time of the activity noted. Activity staff will be in-serviced on providing programs with lesson plans and on appropriate documentation related to these programs. All direct care staff and activity staff will receive information relating to one-to-one program binders. 4. The deficiency will be corrected by February 11, 2010. 5. The changes noted above will be monitored through use of the QA Care Planning monitoring already in place (see POC for F279). Each Master Care Plan and Activity Care Plan will be reviewed for Residents #3, #4, #7, #8, #11 and #13 by February 11, 2010 for clear consistent, measurable goals, thorough problem identification and specific individualized activity interventions. In addition the facility shall monitor performance of the Activity related Master Care Plan and Activity Care Plan changes through QA of 100% of all care plans being brought to care conferences monthly *(cont. next page)*	

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F 248	Continued From page 7 activities. The plan of care did not address any specific benefit(s) Resident #8 would gain from attendance at the designated activities, and/or expected responses/reactions. In addition, the plan of care lacked plans for activity attendance/participation which would address the resident's sensory needs, behavioral/mood indicators, cognitive and memory deficits, and based on the resident's interests, promote opportunities for the resident to attain/maintain her maximum level of physical, mental, and psychosocial well-being. Resident #8's activity attendance records for the months of November 2009 and December 2009 included "company, mail, radio, TV, birds, and watching out the window" as daily activities Resident #8 participated in. The plan of care provided no designation of specific TV/ radio programs of interest to Resident #8, and no plans for specific times staff should assist the resident to listen/watch favorite radio and TV programs. Observation throughout the survey showed a TV and/or a radio turned on in the activity room. Observation failed to show Resident #8 reacting to the presence of these environmental stimuli, nor could it be determined Resident #8 could fully benefit due to her sensory impairments and the residents distance/location from the TV and/or radio. Review of Resident #8's activity attendance record for the month of December 2009 showed the resident did not attend the facility Christmas Party. Resident #8 is not oriented to time, place, and person, and the plan of care provided no planned activities/opportunities to orient Resident #8, including opportunities for orientation to time, season and holidays.	F 248	for the first 3 months; 75% of all care plans brought to care conferences monthly for the next 3 months; 50% of all care plans being care conferenced monthly in the third 3 month period and 25% of all care plans being care conferenced monthly in a final 3 month period. The QA process shall include cross-discipline reviews of all each care plan being reviewed. The Activity Department shall also monitor the activity observations/level of participation/documentation for the same sample of residents being careplan QA monitored above.	2/11/10

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- Review, on January 04-07, 2010, of Resident #7's medical record occurred and showed the facility admitted the resident on 02/12/03 with diagnoses including, dementia with behavioral disturbance, Parkinson's disease, Alzheimer's disease, and psychosis. Resident #7's most recent MDS, completed 11/19/09, showed the resident's long and short term memory could not be assessed/determined, the resident exhibited severely impaired cognitive/decision making ability, and highly impaired vision.

Resident #7's most recent Activity Progress Notes included:

* 06/19/09 - "[Resident #7's family members] came to visit."
* 09/25/09 - "I held [Resident #7's] hands and danced with her at the 4:00 small group. She kept beat to the music and tapped her feet at the same time. I asked her if she and [spouses's name] danced a lot and she smiled."
* 10/09/09 - "[Resident #7] was smiling and visiting today about the snow and going outside to make a snowman. She was joking with staff about having to say the rosary for them."

The record included no Activity Progress notes after 10/09/09. Even though the above notes showed Resident #7 reacted positively to music and staff initiated conversation, the resident's plan of care did not include specific goals/reactions for Resident #7 to exhibit/express through an individualized planned activity program.

The resident's "Individualized Activity Care Plan" identified the following: "I am Catholic and my religion had always been important to me. Many

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times when I am upset I feel comfort in listening to the Rosary on the Catholic Channel. I also enjoy music, especially old time and classic country. Help me to music when scheduled. Also turn my TV to CMT [Country Music Television] to listen to music and records in the activity room." Planned activities for Resident #7 included: Balloon Volleyball, Bean Bag Toss, Birthday Party, Exercises, Mass and Rosary, Music, Name That Tune, Outside, Parachute, Reminisce/Trivia, Rhythm Band, TV, Wheelchair ride/walk." The plan of care lacked indication of the frequency Resident #7 would attend/participate in the scheduled activities, and lacked indication of the amount of assistance staff would provide to maximize the residents reaction and benefit from the activity.

Observation showed Resident #7 did not have a TV and/or radio in her room, nor did her roommate. Random observations throughout the survey showed no in room stimulation or activity occurring during times Resident #7 remained in bed or in her room. Resident #7's routine as observed during the survey included:

* 01/04/10 - 3:50 p.m. - Staff assisted Resident #7 with personal care and transported the resident from her room to the activity room. Staff placed the resident in front of the bird aviary, where the resident remained until at least 5 p.m. Resident #7 showed no reaction to the birds, and no evidence she could see the birds.

* 01/05/10 - 3:30 p.m. - Staff assisted Resident #7 with personal care and transported the resident from her room to the activity room. Staff placed the resident in her wheelchair in front of the bird aviary. Resident #7's activity participation/attendance record showed the resident as a "passive participant" at "Ball

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catch/kick" at 4 p.m. At 4 p.m., observation showed Resident #7 present in a circle of residents who were tossing and kicking a large ball. Observation did not show Resident #7 actively engaged in the activity, nor did staff encourage/assist the resident to participate.

* 01/06/10 - 9:20 a.m. - Observation showed Resident #7 sitting at the end of a long table heaping with towels while several other residents folded the towels. Resident #7 remained sitting at the table where staff had placed her throughout the activity, however, Resident #7 did not participate, staff did not encourage or assist the resident to participate, and Resident #7 showed no response/reaction to the towel folding taking place. Resident #7's activity attendance record showed Resident #7 as a "passive participant" at the towel folding activity.

Resident #7's plan of care provided no evidence of specific approaches/interventions to assist the resident in maintaining/attaining maximum physical, mental, psychosocial well-being through the incorporation of meaningful activities of interest to the resident, and incorporating into the resident's individualized plan consideration of the resident's orientation, and sensory impairments/needs. The lack of a specific individualized activity plan, and implementation of the plan, does not allow the resident the opportunity for optimum quality of life and maximum attainment of her physical, mental, and psychosocial well-being.

- Resident 4's medical record, reviewed January 04-07, 2010, identified diagnoses including Alzheimer's Disease, dysthymic disorder (anxiety and depression) and macular degeneration. A significant change in status MDS, completed on

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 11 12/31/09, identified the resident with short and long term memory problems, sometimes understands and sometimes understood, persistent anger with self or others (up to five times a week), and wandering (daily). The MDS identified Resident #4 as requiring total assistance with transfers and extensive assistance with locomotion on and off the unit. The MDS indicated Resident #4's preferred activity settings as: own room, day/activity room, inside NH [nursing home]/off the unit, and outside; and his general activity preferences as: exercise/sports, music, reading/writing, trips/shopping, watching TV, and talking or conversing. Resident #4's "Individualized Activity Care Plan," dated 12/09, stated "I was a farmer; I enjoy cattle and going outdoors. Help me outside when the weather is nice. Give me farming magazines to look at and visit with me about my farm, I enjoy watching westerns and farming programs, turn the tv to channel 55 for me to watch rodeo's [sic] and livestock auction and western tv programs and movies. I enjoy old time music, help me to music when scheduled, turn old time records on for me when I am in the TV Lounge also." The care plan listed Resident #4's interests, but failed to identify the frequency the resident should be involved in the planned activities and lacked goals for Resident #4 to attain his optimum level of psycho-social well-being. A quarterly activity assessment, dated 12/21/09, stated, "Res [resident] enjoys watching tv, especially westerns. He & his brother watch tv together. His brother visits him daily & also gives him wc [wheel chair] rides. We help him w/ [with] his mail. Res is restless & wanders in the halls.	F 248		

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	355063	A. BUILDING _____ B. WING _____	01/07/2010

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F 248	Continued From page 12 He at times will stay @ [at] music for brief amounts of time. He will wheel himself out of the room if he does not wish to stay @ act. [activity]." Review of Resident #4's activity participation sheets for November and December 2009 and January 2010 identified daily participation in TV in his room and lounge, wheel chair rides, watching out the window, and company. Review of activity calendars for November and December 2009 identified music activities scheduled seven times in November and six in December. Resident #4's activity participation sheets lacked evidence the resident attended the scheduled music activities, and indicated he refused to attend on two dates. Random observations on all days of survey identified the resident's TV off and no music or radio playing in his room. Observations failed to identify staff offering reading material such as farm magazines to Resident #4 or providing wheel chair rides. Observations throughout the survey failed to show Resident #4's brother visiting or the resident "watching out the window." During an interview on 01/05/10 at 3:50 p.m. a nurse manager (#15) stated Resident #4's brother does not visit daily, but comes three to four days a week. On 01/05/10 at 4 p.m., observation identified Resident #4 in the activity room seated in a wheel chair near a group of residents playing a beach ball game. Observation showed the resident actively watching the game. The activity staff member (unidentified) did not toss the ball to Resident #4 or encourage him to participate in the game.	F 248		

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F 248	Continued From page 13 When interviewed on 01/07/10, an activity staff member (#5) stated Resident #4's brother did not visit this week due to the weather. She stated the brother does not drive, but gets a ride from the assisted living facility where he resides. The staff member failed to identify individualized planned activities for the days Resident #4's brother is unable to visit. - Resident #13's medical record, reviewed January 6-7, 2010, identified diagnoses including Alzheimer's Disease, dysthymic disorder, and glaucoma. An annual MDS, completed on 12/29/09, identified short and long term memory problems, usually understands and usually understood, daily repetitive verbalizations, and socially inappropriate behaviors (occurring 1-3 days of the last 7 days). The MDS identified Resident #13 as requiring extensive assistance with transfers and locomotion on and off the unit. The MDS indicated Resident #13's preferred activity settings as: own room, day/activity room, inside NH/off unit, and outside; and her general activity preferences as: cards/other games, exercise/sports, reading/writing, spiritual/religious activities, walking/wheeling outdoors, watching TV, talking or conversing, and helping others. Resident #13's "Individualized Activity Care Plan," dated 12/20/09, stated, "I have a deep strength in faith; help me to Church Service Tuesdays at 9:30 a.m. and Worship Service the first and fourth Sunday of the month at 3:00 p.m. I have an Alan Jackson gospel cd [compact disc] in my room that I enjoy listening to, please turn it on for me when I am in my room. I enjoy both gospel and old time music, help me to music when scheduled. I need to keep active in activities during the day, so I can sleep at night, help me to	F 248		

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F 248	Continued From page 14 activities throughout the day." The care plan listed Resident #13's interests, but failed to identify the frequency the resident should be involved in the planned activities and lacked goals for Resident #13 to attain her optimum level of psycho-social well-being. An annual activity assessment, dated 12/16/09, stated, "Res has a slight change in the type of act [activities] she is interested in . . . She enjoys part [participating] in exercises/sports and helping others. She enjoys balloon volleyball & laughs while she is playing. She likes to help by folding towels & baking for our bake sales. . . . She attends music, clapping her hands & tapping her feet to the beat of the music, she attended music x1 [one time] this assess. . . ." Care conference notes, dated 12/29/09, identified the resident as "sundowning (exhibiting behaviors in the late afternoon)" and suggested activities of playing the piano in the dining room and writing. Review of Resident #13's activity participation sheets for November and December 2009 and January 2010 identified daily participation in radio and TV in her room or lounge. On 11 days in November and 10 days in December these were the only activities staff identified for Resident #13. Review of activity calendars for November and December 2009 identified baking activities scheduled on four days in November and six days in December. The calendars identified folding towels as a daily activity each Monday through Friday. Music activities occurred seven times in November and six in December. Resident #13's participation sheets failed to identify the resident participating in baking on any of the scheduled dates, nor did the sheets identify the resident	F 248		

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F 248	Continued From page 15 refused to attend. The sheets indicated Resident #13 folded towels four days each month in November and December. The resident participated two times each month in the offered music activities. The records lacked evidence the resident refused to attend on the other scheduled dates. The participation sheets lacked evidence the resident was offered or participated in piano playing or writing activities. Observations throughout the survey identified Resident #13 in her room with the TV or CD player on. Often Resident #13 could be heard calling out family member's names. Observations failed to identify staff offering to take Resident #13 to scheduled activities. When interviewed, on 01/07/10 at 10:10 a.m., an activity staff member (#5) stated the resident "sometimes will come" to activities and "sometimes not." - Review of Resident #11's medical record occurred on January 06-07, 2010. Resident #11's medical diagnoses included Alzheimer's disease, depression, adjustment disorder with mixed anxiety and depressive mood, and insomnia. A recent quarterly MDS, dated 11/11/09, identified Resident #11's long and short term memory could not be determined, identified the resident as severely impaired in daily decision making, rarely or never able to make self understood, sometimes understands others, and required total assistance with transfers and locomotion on and off the unit. The MDS indicated Resident #11's preferred activity settings as: own room, day/activity room, inside NH [nursing home]/off unit, and outside; and her general activity preferences as: exercise/sports, music,	F 248		

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F 248	Continued From page 16 spiritual/religious activities, walking/wheeling outdoors, and tv. An "Individualized Activity Care Plan," dated 11/10/09, identified Resident #11's current planned activities/interests included: ball, balloon volleyball, birthday party, church service, music, name that tune, outside, rhythm band, TV, van ride, WC (wheelchair) ride/walk, worship service, and small group TVL (TV lounge). The plan of care also stated, "I find strength in my faith . . . I enjoy listening to music, especially country western . . . turn music on for me when I am sitting in the TV lounge also. Help me to music when scheduled. Hold my hands and dance with me when there is music." The care plan did not identify how frequently Resident #11 would attend these activities, and lacked goals/objectives for Resident #11's activity needs. Review of Resident #11's activity attendance sheets for November and December 2009, identified daily company and daily TVL. In addition, attendance sheets for December 2009 identified the resident watched birds daily. Review of January 2010 activity attendance sheets identified daily company, daily activity room, and active participation in daily bird watching. Random observations of Resident #11 occurred on all days of survey. Multiple observations showed the resident seated in her wheelchair in front of the facility's bird aviary, with her eyes closed and head slumped forward. Observations failed to show Resident #11 reacted to the presence of the birds in the aviary, or reacted to the tv and/or radio turned on in the activity room throughout the days of survey.	F 248		

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F 248	Continued From page 17 - Resident #3's medical record, reviewed January 05-07, 2010, identified diagnoses including Alzheimer's Disease, depression, paranoid state, and dysthymic disorder (anxiety with depression). An annual MDS, completed on 12/24/09, identified short and long term memory problems, usually understands and usually understood. The MDS identified Resident #3 as dependent on staff for transfers and locomotion on and off the unit. The MDS indicated Resident #3's preferred activity settings as: own room, day/activity room, inside NH/off unit; and her general activity preferences as: music, watching TV, spiritual/religious activities, and talking or conversing. Resident #3's "Individualized Activity Care Plan," undated, stated, "I was a ranchwife; I am not one to socialize much, I worked on the ranch and in my garden. Take me outiside [sic] as I am able to, weather permitting. Visit with me about my ranch and garden. Since I returned from the hospital, I am tired more and resting throughout the day. I need activities in my room. I have a deep strenght [sic] in faith and would like you to pray with me and read the Bible to me. Show me pictures of gardens and visit about my garden. If I am feeling well, I would like to go to Church on Tuesdays at 9:30 and Worship Service the first and fourth Sunday of the month at 3:00." The care plan listed Resident #3's interests as "Church Service; Music; and One to One's." The care plan in Resident #3's room identified staff are to engage her in activities seven days a week. The same care plan, used by the activity staff, identified staff engage the resident in activities four days a week. The assessments concerning Resident #3's life, and MDS, show the facility failed to implement identified resident interests on the care plan	F 248		

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F 248	Continued From page 18 regarding watching TV and going outside. Review of Resident #3's "Activity Participation Record" notes from 11/11/09 thru 01/06/10, showed staff engaged Resident #3 in one to one activities 31 of 57 days. Documentation showed these one to one activities lasted from two to five minutes. Not one of the 31 visits identified staff prayed with or read the Bible to Resident #3 as she requested. Neither the time period indicated or the activities identified are of sufficient quantity or quality to engage Resident #3 in a meaningful/stimulating interaction with staff. Documented activities stated: "11/11/09, 1-1 [one to one]/ 3 mins [minutes]/ I took [Resident #3] to lunch [and] visited with her about how she was doing [and] what she wanted for lunch." "11/22/09, 1-1/ 3 mins/ I asked [Resident #3] if she wanted to come to worship service. [Resident #3] asked me if I could move her call light because she said it was bothering her. I moved it [and] she said she would go so I gave her a ride to the chapel." "12/01/10, 1-1/ 2 mins/ I woke [Resident #3] up [and] we looked at some winter pictures until she fell back asleep." "12/18/09, 1-1/ 3 mins/ I visited with [Resident #3] about x-mas [and] read her a story out of the x-mas book." "12/25/09, 1-1/ 3 mins/ I brought [Resident #3] some apple cider [and] helped her drink it." Throughout the survey, observations showed Resident #3 sleeping in her bed, in the dining room eating/waiting to eat, in her room sleeping in her wheelchair, or awake sitting in her wheelchair watching television with her roommate. During all	F 248		

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F 248	Continued From page 19 in room observations, either the roommates television was on or the radio was playing. Resident #3 left her room to attend meals only. On 01/05/10 at 9:45 a.m., two CNAs (#30 and #31) assisted Resident #3 to lay down. This observation occurred on a Tuesday morning. Resident #3's activity care plan identified she would like to attend church at 9:30 on Tuesday mornings. Resident #3's activity care plan failed to identify specific approaches/interventions to assist the resident in maintaining/attaining maximum mental and psychosocial well-being through the incorporation of meaningful activities of interest to the resident. The lack of a specific individualized activity plan, and implementation of the plan, does not allow Resident #3 the opportunity to achieve an optimum quality of life and maximum attainment of her mental, and psychosocial well-being.	F 248		
F 279 SS=F	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and	F 279		

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F 279	Continued From page 20 psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to develop a written comprehensive care plan for each resident, including measurable objective and timetables to meet the residents' needs, and failed to describe services furnished to attain and maintain the residents' highest practicable physical, mental, and psychosocial well-being for 14 of 14 sampled residents (Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, and #14). Failure to develop a written care plan could result in inconsistency in providing necessary resident care and result in resident decline and/or contribute to an adverse event for the resident. Findings include: Review of the facility policy "Care Planning - Interdisciplinary" occurred on 01/06/10. The policy, dated December 2008, stated, ". . . Our facility's Interdisciplinary Team, in coordination with the resident, his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. . . . Each resident's Comprehensive Care Plan has been designed to: a. Incorporate identified problem areas,; b. Incorporate risk factors; c. Build on the	F 279	F279 Comprehensive Care Plans 1. Corrective actions for sampled residents #1, #2, #3, #4, #5, #7, #8, #9, #10, #11, #12, #13 and #14 include a complete revision of their care plans to include a more detailed approach to problem/strength identification, formulation of clear, specific, measurable goals and formulation of appropriate interventions related to those goals. Resident #6 expired and the care plan was not reviewed or revised. Sample resident #5's care plan was reviewed for the need to include self-administered medication on the plan of care. This review was also completed for Sample Resident #6 in relation to self-administered medication. Sample resident's #3, #4, #5, #7, #8, #9, #10, #12 and #14 care plans were also reviewed and revised to address the risk for or presence of pressure sores and hydration/nutrition interventions. Sample residents #1, #4, #6, #8, #10 and #13 care plans were reviewed and revised as needed to address issues relating to potential constipation problems including appropriate measurable realistic goals and nutritional/hydration interventions. Sample residents #1, #2, #4, #8 and #13 care plans were reviewed and revised to address the issue of use and/or tapering of medications for behavior management including clear measurable realistic goals.	2/11/10

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F 279	Continued From page 21 resident's strengths; d. Reflect treatment goals and objectives in measurable outcomes; e. Identify the professional services that are responsible for each element of care. f. Aid in preventing or reducing declines in the resident's functional status and/or functional levels. . . ." - Review of Resident #5's medical record occurred on January 04-07, 2010, and identified the facility admitted the resident on 07/22/09. Resident #5's medical diagnoses included chronic obstructive pulmonary disease (COPD), severe end-stage pulmonary fibrosis, dyspnea, and emphysema. A significant change Minimum Data Set (MDS), dated 11/27/09, identified the resident had no short or long term memory problems, moderately independent in daily decisions, able to make self understood, and understands others. Physician orders for Resident #5, dated 07/23/09, stated the following in regards to nebulizer treatments: "Resident leaves mask in place and remains in upright position - may self administer for that portion of nebulizer treatment." Record review identified the facility completed Self Administration of Medication (SAM) assessments in 07/09, 10/09, and on 11/27/09 regarding nebulizer treatments, but failed to address the resident's ability to self administer the medication on her plan of care. - Review of Resident #6's medical record occurred on January 04-07, 2010. Resident #6's medical diagnoses included pruritic disorder, seborrheic keratosis, gastric tubular adenoma, glaucoma, and macular degeneration. A significant change MDS, dated 10/23/09, identified the resident as moderately independent in daily decisions, no short or long term memory	F 279	Sample residents #1, #2, #3, #4, #7, #8, #9, #10, #11, #12, #13, and #14 care plans were reviewed and revised to include clear measurable goals and interventions aimed at issues of cognitive impairment and sensory deficits. 2. All residents have the potential to be affected by this deficit. 3. The deficiency will be corrected through education on the care planning process with the management team and care planning team. Corrections to the Comprehensive Plan of Care Policy shall be made to address this deficiency. 4. The deficiency corrections shall be completed by 2/11/10. 5. The facility shall monitor performance of the care planning changes through QA of 100% of all care plans being brought to care conferences monthly for the first 3 months; 75% of all care plans brought to care conferences monthly for the next 3 months; 50% of all care plans being care conferenced monthly in the third 3 month period and 25% of all care plans being care conferenced monthly in a final 3 month period. The QA process shall include cross-discipline reviews of each care plan being reviewed, meaning that one discipline such as Dietary with monitor a discipline other than itself etc.	

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F 279	Continued From page 22 problems, usually understands others, and required extensive assist with personal hygiene. Current physician orders for Resident #6 included orders for the resident to self administer the following medications as needed: "Aspercreme" (indicated for bilateral leg pain), "Vicks Vapor Rub" (indicated for toenail fungus), and "Sarna lotion" (an anti-itch lotion). Record review identified the facility completed a recent SAM assessment, dated 10/22/09, for the above medications, but failed to address the resident's ability to self administer these medications on her plan of care. * The facility failed to incorporate a written interdisciplinary approach to care planning accessible to all staff responsible for resident interaction and care in the following areas: - All sampled residents' Activities of Daily Living care plans lacked measurable goals and interventions to assist residents to increase their independence or maintain their current level of functioning. - Residents with current pressure sores, history of pressure sores, or at risk for pressure sores lacked care plans with measurable goals, addressing their risk factors and incorporating nutritional and hydration interventions to prevent and/or treat pressure sores (Resident #3, #4, #5, #7, #8, #9, #10, #12 and #14). - All sampled residents lacked individualized care plans with goals and interventions to address nutrition and hydration needs such as weight loss, skin integrity problems, infections, altered dietary consistencies, and swallowing concerns.	F 279		

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F 279	Continued From page 23 - Residents at risk or experiencing constipation lacked written plans with measurable goals incorporating nutritional approaches as well as hydration needs (Resident #1, #4, #6, #8, #10, and #13). - All sampled residents' activities care plans lacked the frequency staff should implement interventions and measurable goals to assist residents to meet their optimum level of psychosocial well-being. - Residents' behavior intervention plans lacked interventions to address the use and/or tapering of medications used to control behaviors, and measurable goals for the resident to reach their highest level of physical, mental, and psychosocial well-being (Resident #1, #2, #4, #6, #8, and #13). - Residents with cognitive impairment and/or sensory deficits (hearing and vision) lacked written care plans with measurable goals and interventions to ensure each resident improved or maintained their optimum level of functioning (Resident #1, #2, #3, #4, #6, #7, #8, #9, #10, #11, #12, #13, and #14). During a meeting on 01/06/10 at 9 a.m. with administrative staff members (#1, #5, #15, #26, #27, #28, and #29) to discuss care planning concerns, staff members stated the facility recently switched to the "I" format for care plans. They stated, with that switch, items which had previously been part of the resident's care plans were no longer included.	F 279		
F 309 SS=D	483.25 QUALITY OF CARE	F 309		

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	355063	A. BUILDING _____ B. WING _____	01/07/2010

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F 309	Continued From page 24 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview the facility failed to provide the necessary care and services to maintain the highest practicable physical well-being in accordance with the comprehensive assessment for 1 of 1 closed record (Resident #16) dependent on staff remained on a bedpan for an extended period of time. Failure to assist Resident #16 off the bedpan in a reasonable amount of time caused increased pressure to the underlying tissues of his buttocks and may have contributed to the worsening of his pressure sore. Findings include: - Review of the medical record for Resident #16 occurred January 6-7, 2010. Diagnoses included multiple sclerosis (MS), paraplegia, peripheral vascular disease, neuropathy, catheter (suprapubic), and Parkinson's disease. Resident #16's quarterly Minimum Data Set (MDS), dated 09/17/2009, identified no short or long term memory problems, required extensive assist of two staff members for bed mobility, toilet use, and personal hygiene, and no skin issues. Resident Assessment Protocol notes, dated 06/19/09, completed with a significant change	F 309	F309 Quality of Care 1. Corrective action for Resident #16 is not possible as this resident is deceased. 2. Residents at risk are those who are dependent, need use of a bedpan for elimination and who are at high risk for or already have ulcerated skin. 3. The deficiency will be corrected with education of the staff relating to bedpan usage and monitoring of this usage. In addition the deficiency will be corrected through revision of the bedpan procedure to include resident monitoring/timing. 4. The deficiency will be corrected by 2/11/10. 5. The facility will monitor performance of these corrections through the implementation of timers for those using a bedpans and QA tools developed and utilized by the QA nurse which will focus on the time spent on a bedpan and documentation of time spent plus requests from a resident to remain longer on the bedpan. Bedpan monitoring shall include monitoring of all bedpan usage for 100% of all residents using a bedpan for the first 3 months; 75% of all resident using a bedpan for the next 3 months, monitoring of 50% of residents using a bedpan for the next 3 months and QA monitoring of 25% of the residents utilizing a bedpan for the final 3 months.	2/11/10

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F 309	Continued From page 24 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview the facility failed to provide the necessary care and services to maintain the highest practicable physical well-being in accordance with the comprehensive assessment for 1 of 1 closed record (Resident #16) dependent on staff remained on a bedpan for an extended period of time. Failure to assist Resident #16 off the bedpan in a reasonable amount of time caused increased pressure to the underlying tissues of his buttocks and may have contributed to the worsening of his pressure sore. Findings include: - Review of the medical record for Resident #16 occurred January 6-7, 2010. Diagnoses included multiple sclerosis (MS), paraplegia, peripheral vascular disease, neuropathy, catheter (suprapubic), and Parkinson's disease. Resident #16's quarterly Minimum Data Set (MDS), dated 09/17/2009, identified no short or long term memory problems, required extensive assist of two staff members for bed mobility, toilet use, and personal hygiene, and no skin issues. Resident Assessment Protocol notes, dated 06/19/09, completed with a significant change	F 309		

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MDS, identified the following: "Cognitive Loss/Dementia . . . [Resident's name] decision making has improved from moderately [sic] impaired to modified independence. . . ADL [activities of daily living] Functional Rehabilitation Potential . . . Res. [Resident] is independent with eating with tray set up. He does not walk. He requires extensive assist of 1-2 staff for all other ADL's. . . . Pressure Ulcers. Triggered due to needing assist with bed mobility . . . skin desensitized to pain/pressure . . . and incont. [incontinent] of bowel. . . . His Braden scale score is 15 placing him at mild risk. . . ."

The medical record for Resident #16 included the following entries:

Fax, to the resident's physician, dated 10/22/09, "New open red area crease of Rt [right] buttock." (No response from physician on copy provided by facility.)

Nurse's note (NN), "10/28/09, 0800 [8:00 a.m.], open skin noted to Scrotum, Rt Buttox [buttocks], [left] Buttox, [and] Rt hip area - fax to up date [physician's name] cont. [continue] to use vasaline [sic] to area."

Fax, to the resident's physician, dated 10/30/09, "Area does not appear to be pressure but would be a stage III non-pressure ulcer. Estimated 5 x 5 cm [centimeters]. No duoderm! He is very allergic. Can we hold vaseline for now and try Desitin?" Physician's response "Yes."

NN, "11/20/09, 0720 [7:20 a.m.] Resident found in bed on bed pan at 0015 [12:15 a.m.]. CNA [certified nursing assistant] reports a moderate amount of blood in bedpan. Blood on blue pad as well. Resident has open area on right lower buttocks. Area is circular in shape and 5.5 cm at widest part. Area covered with brief but open to air. No reports of pain from resident."

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F 309	Continued From page 26 NN, "11/22/09 (0730 [7:30 a.m.]) Large open area to right buttock with bloody drainage. Site tender. Numerous small open areas to peri area and scrotum. Desitin cream applied and Res. encouraged to rest in bed to relieve friction. Up for meals only." NN, "11/23/09, 1440) [2:40 p.m.] [Right] buttocks open area observed. Res. on bed rest until [medical practitioner] can observe this area in the AM. Desitin dc'd [discontinued] to this area. ABD pad [type of absorbant dressing] applied to site to contain drainage. Vaseline gauze to be applied to exfoliated testicle. Res. placed on turning schedule. Res. c/o [complains of] only minimal pain to the area. Res. aware of sore and is willing to remain in bed until tomorrow." Health practitioner progress note, "11/24/09, Reason for visit: 1. decubiti The onset was 2 weeks ago. Location is: right buttocks. Status: worse, rapidly. notes restarted med [medication] for urine - now having diarrhea and having increasing breakdown. pt. [patient] cannot tolerate usual dressings, incontinence products due to allergies. pt. has discussed with staff that he would like comfort measures only. . . . Integumentary: Comments: decubiti measured by staff 6x5.5 cm and 1.8 deep on R [right] buttock/upper thigh with black over wound, excoriations to lateral side of wound, draining yellow. Assessment Plan: Decubitus Ulcer, Buttock unable to use usual dressings, will order PT [physical therapy] for evaluation, discussed with staff that pt. is now level III at his request, await culture report for decision on antibiotic, continue wet to dry dressing as safest for skin, stop med for urine. . . ." Physician progress note, "11/26/09, Patient was seen in followup on nursing home founds [sic] at St. Luke's. [Resident #16] has a very large	F 309		

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open ulcer on the right buttock area extending down into the upper thigh. It is approximately 3x3" [inches] in size. It has a black necrotic base. This is due to his obesity and vascular changes. Cultures were positive for Proteus sensitive to everything except Tetracycline. He himself was converted to a level III, comfort measures only status, and so I questioned whether we should consider surgery. He could have this debrided, removed and then closed, however, with his poor circulation, odds of healing are very slim and it would probably break down again. We will give him a 2-week course of Cephalexin to see if this will help control infection and show improvement. If it does we could reconsider having a surgical consultation. However, he has indicated that he does not want to have surgery. Vital signs show a decrease in blood pressure. He has also lost a considerable amount of weight and the staff reports about 30 pounds. Impression 1. Decubitus ulcer, right buttock 2. MS 3. Terminal"

Physician orders for Resident #16 included:
12/01/09 Hydrocodone 10/650 one by mouth every four hours as needed.
12/04/09 May have Hospice.
12/04/09 Continue wet to dry dressings (right buttock ulcer) and discontinue antibiotics.
12/08/09 Hydrogel twice a day and as needed to decubiti (ulcer) with ABD - stop wet to dry dressings - will continue comfort cares.

A significant change MDS, signed by the registered nurse assessment coordinator on 12/09/09 as complete, identified Resident #16 as dependent on two staff for bed mobility and toilet use; required extensive assistance of two staff members for personal hygiene; having a stage three (a full thickness of skin is lost, exposing the

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F 309	Continued From page 28 subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue) ulcer to the right buttocks; and having a history of a resolved ulcer to the left buttock. A "Rap Summary," completed with this MDS, stated "This is a significant change MDS as [Resident #16] health has deteriorated and is now on bedrest, has developed an ulcer on his Rt. [right] buttocks, has had a wt. [weight] loss and declined in a number of ADL's. . . . but now his health has started to deteriorate rather rapidly and has been on bedrest for the entire assessment period. . . . He was having some pain in the Rt. buttock ulcer and his prn [as needed] Tylenol was discontinued and he was put on Hydrocodone 10/650 q4h prn [every four hours as needed]. He did not complain of any pain in the assessment period. . . .12/14/09 Res [resident] expired 12/12 before raps were due (12/21)." During an interview on 01/07/10 at 11:50 a.m., a staff member (#3) stated she completed the facility "Accident/Incident Report" for Resident #16. This staff member (#3) further stated she felt staff placed Resident #16 on the bedpan at 10:30 p.m. and forgot to pass on this information to the next shift. This same staff member (#3) stated Resident #16 could not feel the bedpan due to his condition and at that point Resident #16 could not use the call light. Review of the completed "Accident/Incident Report" on the afternoon of 01/07/10, identified the incident occurred on 11/19/09 at 10:00 p.m., and identified Resident #16 as memory impaired. The medical record showed Resident #16 had existing skin issues prior to being left on the bedpan. With Resident #16's pre-existing	F 309		

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F 309	Continued From page 29 conditions, including peripheral vascular disease and paraplegia, his inability to call for assistance, and then pressure from remaining on the bedpan for an extended period of time may have contributed to Resident #16's worsening pressure sore and condition.	F 309		
F 329 SS=D	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, the facility failed to adequately assess the probable cause of the behavior of 1 of 6 sampled residents	F 329		

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F 329	Continued From page 30 (Resident #2) identified by the facility as exhibiting behavior. Failure to adequately assess Resident #2's behavior, and implement non-pharmacological interventions resulted in the resident receiving both Tylenol (an analgesic pain medication) and Haldol (an anti-psychotic medication) at the same time, without an opportunity to determine if Tylenol alone may have been effective in stopping/controlling the behavior. Findings include: Review, on January 04-07, 2010, of Resident #2's medical record showed the facility admitted the resident on 12/14/09. During the initial facility tour on the morning of 01/04/10, a social services staff member (#2) indicated Resident #2 exhibited inappropriate behavior towards staff and his spouse. Resident #2's initial Minimum Data Set (MDS) completed 12/18/09 identified the Resident as "verbally abusive, and resistant to care." Resident #2's prescribed medications included Haldol 1 mg (milligram) IM (intramuscularly)every 8 hours PRN (as needed) for agitation ordered 12/22/09 and Tylenol 650 mg PRN for pain (a physician approved standing order). Review of the resident's medication administration record (MAR) and nurses notes, showed on 12/25/09 at 10:30 a.m. Resident #2 received both PRN Haldol IM and Tylenol 650 mg PRN for "agitation." Nurses notes stated the following: 12/25/09 - 1030, "BP [blood pressure] 119/69, R [respirations] 18, P [pulse] 53, T [temperature] 97.6, O2 [oxygen] 98% on room air. Oriented x [times] person. No edema noted. Lungs clear bilaterally. No c/o [complaint of] SOB [shortness of breath] or cough. C/o pain. PRN Tylenol given.	F 329	F329 Unnecessary Drugs 1. Staff caring for resident #2 were alerted to the issue of unnecessary medications as soon as it became apparent from information provided by the survey team. In addition education for all medication givers in the facility was done to ensure this process would not again occur with this resident. 2. Other resident's at risk for this deficiency would be those resident's who have as needed medications ordered for pain and who may also have as needed medication orders for behavior issues. 3. The deficiency will be corrected through education of the nursing staff and Medication Assistants on the assessment process prior to an as needed medication being given as well as the need to pursue other non-pharmacological approaches. Education also on clinical judgment making in giving as needed medication so that 2 medications would not be given for the same issue at the same time. 4. The deficiency will be corrected by February 11, 2010. 5. The facility will monitor compliance with this deficiency correction through a review of each resident's MAR monthly for 3 months. (*cont. next page*)	2/11/10

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F 329	Continued From page 31 Bowels active x 4 quadrants. Res [resident] yelling out part of AM." The record lacked any further assessment of Resident #2's behavior, including the use of non-pharmacological interventions prior to administration of the Haldol. In addition, administration of both the Tylenol and Haldol at the same time, did not allow sufficient assessment to determine Resident #2's complaint of pain as the causative/contributing reason for Resident #2's "yelling out." Review of Resident #2's plan of care failed to identify planned approaches/interventions to implement in response to Resident #2's agitation prior to administration of the PRN Haldol. During an interview with two social services staff members (#1 and #2) on the morning of 01/07/10, the staff members indicated a behavior plan of care had not yet been developed for Resident #2 until the surveyor requested the behavior plan of care on 01/06/10. During an interview with a nursing management staff member (#6) on the afternoon of 01/06/10, the staff member indicated nursing staff would be expected to implement other interventions prior to administering the Haldol, and if a resident complained of pain, the pain medication would be administered first and assessed for effectiveness prior to administration of an anti-psychotic medication. Failure of the facility to appropriately assess and implement behavioral interventions to manage Resident #2's behaviors may have resulted in utilization of the Haldol for staff's conveinence to	F 329	Then 75% of all resident MARs will be reviewed for as needed medications use for the next 3 months followed by a review of 50% of the resident MARS in the third 3 month period. 25% of the resident MARs will be reviewed for unnecessary medication usage in a final 3-month period of time. The QA nurse shall do the monitoring of this area.	

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F 329	Continued From page 32 control/manage the resident's behaviors.	F 329		
F 332 SS=E	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. 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 a medication error rate of 5% or less during observation of medication administration on 2 of 2 days of survey (January 4-5, 2010). Four errors occurred resulting in a 7% medication error rate. Findings include: Santon and Clark,, "Geriatric Medication Handbook," Seventh Edition, American Society of Consultant Pharmacists, page 77-78, stated "Spacing and proper sequence of the different inhalers is important for maximal drug effectiveness. . . . Wait one minute between 'puffs' for multiple inhalation of the same drug. . . . Technique for Proper Use of Metered Dose Inhalers* (MDIs) . . . 5. Press down on inhaler to release medication as you start to breathe in slowly. 6. Breathe in slowly (over 3 to 5 seconds). 7. Hold breath for 10 seconds to allow medication to reach deeply into lungs. 8. Repeat puffs as directed. (Waiting one minute between puffs may permit additional puffs to penetrate the lungs better.) . . ." Review of the facility policy "Oral Inhalation Administration" occurred on 01/05/10. The policy,	F 332		

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F 332	Continued From page 33 dated 1/10/08, stated, "Policy: To allow for correct administration of oral inhalers to residents . . . 8. Place holding chamber or spacer with inhaler attached into resident's mouth. 9. Instruct resident to inhale slowly as you depress the canister to release the medication. 10. Breathe in and out normally through the holding chamber or spacer for one to three breaths. 11. Repeat doses as prescribed. . . . a. Wait one (1) minute between 'puffs' for multiple inhalations of the same medication. . . ." - Observation of medication administration occurred on 01/04/10 at 4 p.m. A licensed nurse (#16) administered Ventolin MDI to Resident #18. The nurse administered one puff, and without instructing the resident to hold her breath, administered a second puff approximately 10 seconds later. - During observation medication administration on 01/05/10 at 6:35 a.m., a Certified Medication Assistant (CMA) (#17) administered oral medications for Resident #18, including Tiazac ER (extended-release) 240 milligrams. The CMA opened the capsule, which contained four small white tablets, and crushed them along with four other oral medications. The CMA stated the resident requests her medications crushed. Review of Resident #18's physician's orders identified an order, dated 12/15/09, stating, "May crush meds [medications] unless contraindicated by manufacturer." Wolters and Kluwer, "Nursing 2009 Drug Handbook," Lippincott, Williams, and Wilkins, page 314-316 identified diltiazem (Tiazak) as a cardiovascular medication and stated, "If patient	F 332	F332 Medication Errors 1. Corrective action for this deficiency relating to Resident's #18, #19, #3 included immediately notifying all staff of the errors made with the medications for these residents. In addition, notations were made on the MAR for DO NOT CRUSH on the Tiazak for Resident #18 and in fact the medication was then changed to a crushable form. The eye drops for Resident #3 had a label covering over the instructions to SHAKE WELL and the pharmacy was then contacted to provide an additional label so the bottle could be adequately marked. Those staff passing medications for these residents were also educated on the proper administering of eye drops, inhalers and long acting oral medications. 2. All residents taking medications are at for this deficiency. 3. The deficiency will be corrected through education of both nurses and Medication Assistants on the proper procedures for administering inhalation medication, long acting medications and eye drops. In addition, a DO NOT CRUSH list of medications has been added to each MAR book as a reference tool for staff. The procedures on DO NOT CRUSH medications; inhalation medication and eye drops administration shall also be reviewed and/or revised.	2/11/10

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F 332	Continued From page 34 is taking Tiazak extended-release capsules, inform him that these capsules can be opened and the contents sprinkled onto a spoonful of applesauce. He must eat the applesauce immediately and without chewing, and then drink a glass of cool water." During an interview on 01/06/10 at 1:15 p.m. a consulting pharmacist (#8) stated staff should not crush the small tablets within the diltiazem capsule. He stated, if the resident can not swallow the medication without crushing, the physician should consider switching from extended release capsules to immediate release, which can be crushed. - During a medication pass observation on 01/05/10, beginning at 9:20 a.m., the following two medication errors occurred: Observation showed a CMA (#7) administered Ventolin MDI, a bronchodilator, two puffs. The CMA (#7) assisted Resident #19 to take the first puff, did not encourage the resident to hold her breath, and 25 seconds later assisted the resident to take a second puff. Again, the CMA (#7) did not encourage Resident #19 to hold her breath. Observation showed a CMA (#7) administered Soothe XP, an emollient (lubricant) eye drop, to Resident #3 without first shaking the medication. During an interview following the administration of the eye drop medication, the staff member confirmed she did not shake the medication prior to administration. The manufacturer's "Drug Facts" for Soothe XP state, "Directions . . . shake well before using."	F 332	4. The deficiency will be corrected by February 11, 2010. 5. Monitoring of corrective actions taken for this deficiency will involve a review of each resident MAR for correct labeling of medications on the MAR that require a DO NOT CRUSH designation written next to the medication order. The review of each resident MAR shall include 100% of all MARS for a period of 3 months followed by a review of 75% of all resident MARS for a subsequent 3 months then 50% of all resident MARS the next 3 months. Finally 25% of all resident MARs shall be reviewed for the need for a DO NOT CRUSH designation the final 3 months. The MAR reviews shall be performed by nurse managers. In addition medication administration of inhalation medication and eye drops shall be monitored. Monitoring shall include observation of the administration of eye drops and/or inhalers for 100% of all residents for a period of 3 months followed by observations of eye drops and/or inhalation medication administration of 75% of all residents for a subsequent 3 months then 50% of all resident the next 3 months. Finally observations of 25% of all resident receiving eye drops and/or inhalation the final 3 months. The observations of meds being given shall be performed by the QA nurse.	

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F 332	Continued From page 35 During an interview on 01/06/10 at 1:20 p.m., the consultant pharmacist (#8) confirmed staff should shake Soothe XP before administration. During an interview on 01/06/10 at 4:25 p.m., an administrative staff member (#6) confirmed staff should be knowledgeable about the medications they administer, including knowing to wait a full minute between puffs of the same inhaled medication and shaking a medication when directed to do so by the manufacturer.	F 332		
F 441 SS=D	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy/procedure, and staff interview, the facility failed to implement appropriate handwashing to prevent the spread of infection during 3 of 4 days of survey. Findings include: Review of the facility policy "Dressings" occurred on 01/06/10. The policy, dated 7/12/07, referred to Perry, Potter, "Clinical Nursing Skills &	F 441		

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F 441	Continued From page 36 Techniques" 6th Edition for specifics. The text book pages 1279-1281 stated "Applying Hydrocolloid, Hydrogel, Foam, and Absorption Dressings . . . 2. Expose wound site, and cover client. 3. Cuff top of disposable waterproof bag, and place within reach of work area. 4. Perform hand hygiene and put on clean disposable gloves. . . . 5. Remove old dressing. . . . 6. Dispose of soiled dressings in waterproof bag. Remove disposable gloves by pulling them inside out, and dispose of them in waterproof bag. . . . 8. Prepare sterile dressing supplies. 9. Pour saline or prescribed solution of 4 x 4 sterile gauze pads, or open spray wound cleanser. 10. Put on gloves, sterile if required by policy. 11. Cleanse area gently with moist 4 x 4 sterile gauze pads, swabbing exudate away from wound, or spray with wound cleanser. 12. Thoroughly pat wound surface dry with dry 4 x 4 sterile gauze pads. Dry intact skin around the wound. 13. Inspect wound for tissue type, color, odor, and drainage. Measure wound size and depth. 14. Apply dressing according to manufacturer's directions. . . . 15. Remove sterile gloves by pulling them inside out, and discard in prepared bag. 16. Assist client to comfortable position. 17. Discard soiled dressing change materials properly. Perform hand hygiene." The facility's policy "Procedure for Handwashing", undated, reviewed on 01/06/10, stated in part: ". . . Procedure for Using Alcohol Hand Sanitizer . . . 5. Always wash hands with soap and water after blood or body fluid exposure." Review of the facility's policy "Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices" occurred on 01/06/10. The policy, revised on 11/04/09, stated in part: ". . .	F 441	F441 Infection Control 1. Corrective action for Residents #4 and #7 include the notification of all nursing staff of the infection control deficiency details and correct plan of action related to these deficiencies. 2. All residents in the facility are at risk of this deficiency. 3. The deficiency will be corrected first through education of all direct care and dietary staff on the proper principles of food handling and hand washing. In addition direct care staff (CNAs, Medication Assistants and Nurses) shall receive education on proper perineal care, handwashing and dressing change procedures. Procedures for perineal care and dressing changes shall be reviewed and revised as needed. 4. The deficiency will be corrected by February 11, 2010. 5. Monitoring for corrections to this deficiency include: a. Education provided to all CNAs on 1/19/10 and 1/21/10 on handwashing and handling of food. b. Education of dietary staff done on 1/18/09 on food handling. c. Education for all nurses and CNAs done on 2/2/10 perineal care procedures.	2/11/10

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F 441	Continued From page 37 Ungloved Hands, 8. Contact between food and bare (ungloved) hands is prohibited." - Resident #4's medical record, reviewed January 04-07, 2010, identified diagnoses including Alzheimer's Disease, peripheral vascular disease, hypoxemia, and anemia. A significant change in status Minimum Data Set (MDS), completed on 12/31/09, identified Resident #4 as having a stage 2 pressure ulcer. Physician's orders, undated, stated, "Mepilex dressing to coccyx ulcer - check and change PRN [as needed] when soiled." On 01/04/10 at 2:45 p.m. two Certified Nursing Assistants (CNAs) (#18 and #19) provided incontinence cares for Resident #4. Observation identified the resident with a foam dressing on his coccyx with an approximate 3 centimeter (cm) by 6 cm area saturated with brown drainage. A licensed nurse (#20) entered to perform a dressing change to the coccyx. The nurse donned gloves and removed the soiled dressing. Without changing her gloves or cleansing the wound, the nurse applied a new Mepilex dressing to Resident #4's coccyx ulcer. The nurse then disposed of the soiled dressing and removed her gloves and washed her hands. She stated, "I can't believe how soiled this got." On 01/05/10 at 7:25 a.m. two CNAs (#21 and #2) provided cares for Resident #4. When the CNAs assisted Resident #4 to his left side, observation identified the coccyx dressing loose and an area approximately 3 cm in diameter saturated with brown drainage. A licensed nurse (#23) entered to change the dressing. The nurse cleansed her hands with alcohol based hand rub, donned gloves, and removed and disposed of the soiled	F 441	d. Changes made to the dressing change procedure to include handwashing after glove changes. This change in the dressing change policy will also be reviewed with the nurses on 2/8/10. e. Management staff shall do food handling observations. These staff shall observe 1 meal per day for 3 months; observe 1 meal per day for 22 days on months 4,5,6; observe 1 meal per day for 15 days on months 7,8,9 and finally observe food handling during one meal per day for 7 days during months 10,11 and 12. f. Perineal care observations shall be done by the Staff Development Nurse as part of the CNA annual evaluation. In addition those residents on the UTI Protocol will have their perineal care observed by a nurse as the CNA performs the care.	

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F 441	Continued From page 38 dressing. Without changing her gloves, the nurse cleansed the wound with a wash cloth and warm water. She then measured the wound and applied a new dressing. The nurse then removed her gloves and washed her hands. During an interview on 01/06/10 at 7:20 a.m., a nurse manager (#15) stated she would expect a nurse to change gloves and perform hand hygiene after removing a soiled dressing, prior to cleansing the wound and placing a clean dressing. - Observation at 3:30 p.m. on 01/05/10 showed two certified nurse assistants (CNAs) (#4 and #24) assist Resident #7 to the bathroom. Following completion of toileting, the CNAs assisted Resident #7 to a standing position and completed peri-neal care (CNA #4). Upon standing, feces dropped onto the bathroom floor and observation showed feces visible on the cleansing cloth/wipe used to cleanse Resident #7's rectal area. Following the completion of Resident #7's peri-neal care, the CNA (#4) removed her disposable gloves and held Resident #7's water glass while the resident drank. The CNA (#4) again applied gloves and cleaned the fecal material from the bathroom floor, removed the gloves, used a hand sanitizer, and left the room. After leaving the resident's room, the CNA (#4) engaged in conversation with a resident in the corridor, touching the resident's arm and wheelchair. The CNA (#4) then entered another resident room (Room 10), and engaged in conversation and hand holding with a resident in the room.	F 441		

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Prior to leaving this room, the CNA (#4) used a hand sanitizer. After leaving the resident's room, the CNA (#4) obtained a glass of water from the water dispenser in the front lobby.

During the above described observations, the CNA (#4) did not wash her hands using soap and water as indicated in facility policy.

- Observation of care on 01/04/10 at 3:42 p.m. showed a CNA (#9) providing peri cares for Resident #3 following an episode of stool incontinence. At the end of this care, the CNA (#9) used an alcohol hand sanitizer to cleanse her hands. The CNA (#9) failed to wash her hands with soap and water as directed by facility policy.

- Observation showed facility staff failed to follow facility policy prohibiting bare hand contact with food.

Random observation of meal service at breakfast on 01/05/10 showed the following:
* 7:25 a.m., a dietary aide (#10) applied butter on stacked pancakes using her ungloved thumb to try to separate the pancakes to butter the bottom pancake.
* 7:55 a.m., a dietary aide (#10) held a peeled hardboiled egg in her ungloved hand and placed it on a resident's plate. The dietary aide (#10) then wiped her hands on her apron.

Random observation of meal service at breakfast on 01/06/10 showed the following:
* 7:37 a.m., a CNA/RT (restorative therapy aide) (#13) held a resident's slice of toast to spread jelly on it and handed it to the resident with an ungloved hand.
* 7:39 a.m., a CNA/RT (#11) touched a slice of

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F 441	Continued From page 40 bread with her ungloved hand while cutting the bread into small slices. While helping the same resident with a banana, this staff member (#11) touched the edible portion of the banana with her ungloved fingers. * 7:44 a.m., a dietary staff member (#14) touched a resident's toast with ungloved fingers as she buttered the toast. Then this same staff member (#14) peeled and held the resident's banana with ungloved fingers as she cut the banana up into the resident's cold cereal. * 7:45 a.m., a dietary staff member (#10) touched a resident's toast with ungloved fingers as she applied butter and jelly on the toast. This same staff member (#10) then held the resident's boiled egg with her ungloved hands as she peeled the egg. * 7:50 a.m., a CNA (#12) touched a resident's toast with ungloved fingers to apply butter and peanut butter to the toast.	F 441		