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	355110	A. BUILDING _____ B. WING _____	07/03/2013

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 07/01/13 and completed on 07/03/13, the sample included four (4) residents for complete review, nine (9) residents for focused review, and two (2) closed records for review.	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and review of facility policy, the facility failed to ensure freedom from physical restraints for 1 of 1 sampled resident (Resident #10) observed with a lap cushion. Failure to assess the use of and continued need for the lap cushion placed Resident #10 at risk for unnecessary restraint use and injuries. Findings include: Review of the facility policy titled "Monitoring Policy on Restraints Use" occurred on 07/03/13. This policy, dated July 2005, stated, ". . . 7. Restraints are assessed and care plan is updated quarterly and prn [as needed] by interdisciplinary team. 8. Annually a comprehensive restraint consent form is done. . . . 10. Prior to use of restraints a therapist may be consulted to assess for alternatives. . . ."	F 221	1. Resident #10 was assessed by therapy F221A, in regards to ability to remove lap cushion per self. Due to inconsistency of ability to remove lap cushion per self in relations to cognitive deficit and mental health diagnosis affecting resident's safety awareness a restraint consent form was obtained from resident #10's representative F221B. Restraint Assessment forms were completed 7/18/13, see attachment F221C. 2. Policy referring to restraints was reviewed at the All Staff meeting on July 16, 2013. The policy will be reviewed again specifically at the nurses meeting on July 29, 2013 and the CNA meeting on August 13, 2013. See attached agendas F221 D, E & F. In order to insure that Res #10 does have the least restrictive method needed to maintain resident's safety, therapy continues to	

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

Administrator 8-15-13

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.

August 19, 2013

Please add addendum to F 221 Section 1:

At this time, Elm Crest Manor has no other residents using a lap cushion, lap buddy or lap tray. If a resident is needing one in the future an order would be obtained by the physician and the restraint assessments would be completed per our restraint policy.

Vanessa Vogt Administrator

Donald McClenahan DON

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F 221	Continued From page 1 Observations throughout the survey showed Resident #10 seated in a wheelchair with a lap cushion in place. Observations showed at times staff secured the cushion with Velcro straps to the back side of the wheelchair's arm rests, and at other times staff did not attach the Velcro straps to the arm rests. Review of Resident #10's medical record occurred on July 2-3, 2013. The current Minimum Data Set (MDS), dated 05/23/13, did not identify any restraints used. The current care plan stated, ". . . Use rocking W/C [wheelchair] for mobility due to agitation and increased risk of falls. . . . Remove padded lap tray at meals, snacks, and table activities. Removes per self at times. . . ." Current physician's orders stated, ". . . Rocking W/C with leg strap, foot pedals, and releasing padded lap tray . . ." Therapy progress notes stated the following: *06/15/11: ". . . Lap tray changed. Maintenance removed interlocking straps on lap tray and leaving [sic] Velcro straps. Now lap tray attaches on each side around arm rest and hooks [with] Velcro. Able to release as needed and remove. . . ." *04/24/12: ". . . OT [occupational therapy] consult for lap cushion. New lap cushion added to W/C due to slight tears in previous cushion. The new cushion attaches to the front bar of the arm rests and is removable via Velcro. . . ." The medical record lacked further assessment of Resident #10's lap tray, a yearly signed consent, and a specific care plan related to its use. Observation on 07/01/13 at 2:15 p.m. showed	F 221	assess Res #10 in attempt to eliminate the lap cushion. At the present time, it has been evident that Res #10 is not safe without the lap cushion use due to increased restlessness and numerous attempts to self-transfer without the lap cushion. To simplify the self-releasing cushion, maintenance did extend the arm rests allowing for the Velcro strap to slide under the armrest and attach to the front of the lap cushion to allow resident easier access. Continued assessment of restraint necessity will be completed with the MDS and as needed with change in resident condition. See F221G for Monitoring Policy on Restraint Use. 3. Monitoring of proper restraint assessments will be completed weekly x4 weeks then monthly there after by the MDS nurse or designee. See F221-I for Therapy Monitor. Monitoring of resident's ability to self-release the lap cushion will be completed by therapy or designee weekly x 2 months then monthly thereafter. Review of the findings will be discussed at the monthly interdisciplinary meetings. See F221H for restraint monitor.	8/13/13

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F 221	Continued From page 2 Resident #10 seated in a wheelchair with the lap cushion not attached to the arm rests. The resident was able to remove the cushion, and she attempted to stand. The resident's chair alarm began to sound, and two unidentified certified nursing assistants (CNAs) approached Resident #10 and assisted her to sit down. One CNA placed the lap cushion and secured the Velcro straps. At 2:22 p.m., the resident began saying "Help" repeatedly and pushed against the lap cushion. The resident pulled at the cushion, but was unable to remove it herself. At 2:27 p.m., Resident #10 attempted to stand and pulled on the strap of the lap cushion. An unidentified CNA approached the resident, unhooked the Velcro straps, and offered to take the resident to a music program. Observation on 07/03/13 at 10:08 a.m. showed Resident #10 seated in her wheelchair with the lap cushion attached to the arm rests with Velcro. The resident attempted to stand, but was unable due to the cushion. At 10:28 a.m., an unidentified CNA approached Resident #10 to ask if she would like to lie down. Resident #10 attempted to stand again, and the CNA stated, "No, no. I'll take that off for you when we get to your room." Observations showed Resident #10 was unable to remove the lap cushion herself with the Velcro straps in place; however, the facility failed to identify this as a possible restraint and assess, monitor, and evaluate the use of/continued need for the lap cushion.	F 221		
F 323 SS=K	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323		

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F 323	Continued From page 3 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 by: Immediate jeopardy identified at 3:20 p.m. on 07/02/13 related to door security alarm system not functioning properly. During the standard recertification survey on July 01-03, 2013, it was determined the facility failed to thoroughly monitor and evaluate the status of the Code Alert alarm system after Resident #8 eloped from the facility's Willow exit door on three separate occasions. The survey team contacted management staff at the State Agency (SA) on 07/02/13 at 3:20 p.m. to discuss a potential immediate jeopardy situation. From 3:25 p.m. to 4:05 p.m., all the residents with code alert bracelets (nine), either on their ankle or on their wheelchair, were escorted out and back into the facility through the Willow exit door. Three of the nine resident's code alert bracelets failed to activate the alarm system. At 4:30 p.m., the survey team (in concurrence with management staff at the SA) determined an immediate jeopardy situation existed. At 4:34 p.m., the survey team notified the facility administrator (#6) and the director of nursing (DON) (#1) of the immediate jeopardy situation. Between 4:45 p.m. and 5:15 p.m., the maintenance supervisor (#3) changed the antenna on the Willow door Code Alert system, facility staff escorted Resident #8 and #11	F 323	1. New Transmitters were placed on Resident #8 and #11 on July 2, 2013. We started doing twice daily checks with the 2 transmitters that initially did not trigger the alarm. Please see attachments F323 Part 1 (A & B). Servicemen from RF Technologies have been here on July 9-July 22-July 29-and July 30, 2013. Please refer to attachments F323 Part 1 (F). On the July 23 visit it was decided that the frequency that the code alert boxes were set to for our transmitters was not strong enough and too much radio interference was coming through. So on July 23, 2013 Elm Crest Manor ordered all new transmitters as well as 2 new box kits to replace some older models. On July 29 the new box kits were placed. On the morning of July 30 all of the antennas frequencies were changed over to the new transmitters. All 10 transmitters that were ordered were tested through every door. They all worked appropriately. Please refer to attachments F323 Part 1 (C). During the time of transfer and checking all new transmitters the code alerts currently on the residents did not work and so all	

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F 323	Continued From page 4 through the Willow exit door and the alarm sounded, which confirmed for facility staff members the alarm system failed to activate due to placement of the sensors on the doorways. The administrator contacted the company who installed the Code Alert system to send out a service person to perform maintenance on the system. At 5:40 p.m., the DON removed the code alert bracelets from Resident #8 and #11 ankles. The DON applied new bracelets on Resident #8 and #11 and facility staff members placed the bracelets, which they had removed from the residents, on their own ankles for testing purposes on the other five exit doors. Two of these doors (Spruce and one in the Great Room) did not alarm when staff members walked through while wearing the Code Alert device (as identified below). At 6:00 p.m., it was determined the Code Alert system on the Spruce exit door failed. The maintenance supervisor replaced the antenna and the system functioned properly. At 6:30 p.m., it was determined the Code Alert system on the right side exit door (double doors) of the Great Room failed. The facility did not have a replacement antenna for this door alarm. The administrator stated she would contact the company and order an antenna the next morning. At 6:40 p.m., the facility administrator and DON placed a sign on the right side exit door in the Great Room, which stated to use the left door, placed two heavy cones in front of the door, and placed "caution" tape on the door. The administrator and DON developed a plan to check the Code Alert system on all exit doors twice a day until the company sent out a service person.	F 323	staff was alerted first and they kept a close monitor on these residents at the time of testing. Immediately after all new transmitters were tested then they were placed on the residents. The testing of the 2 extra transmitters were then tested again the afternoon of July 30, twice on July 31 and twice on August 1st. At which times both transmitters worked appropriately. Please refer to attachment F323 Part-G. 2. Elm Crest Manor will continue to do once daily checks of all doors with the 2 new transmitters on August 2, 2013 for one week. Then we will check 1 transmitter weekly and ongoing. Maintenance will do the weekly checks and they have been instructed to always check the alarms by placing the transmitter on the left ankle or inside their left boot to assimilate as much as possible a resident walking through the door. Please refer to attachment f323 Part 1 (D). We also decided to place a new kit box on the entrance door by the garage. This door was tested and will be added to the weekly code alert check. We also developed a "New Code Alert Protocol" form. This will be used when a new resident that has either been	

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F 323	Continued From page 5 At 6:50 p.m., the administrator provided the survey team with a plan of correction. The survey team determined the immediate jeopardy situation was reduced, and lowered the scope and severity to an "E." 1. Based on observation, record review, and staff interview, the facility failed to ensure the safety of wandering residents at 3 of 6 outside exits (Willow, Spruce, and the Great Room) equipped with a Code Alert system. Failure to ensure the functionality of the system after a resident equipped with a code alert left the building without setting off the alarm on three occasions placed this resident and all residents who have a Code Alert device at risk of injury when leaving the building without staff knowledge. Findings include: - Review of Resident #8's medical record occurred July 1-3, 2013. This facility admitted Resident #8 on 03/20/2013 with diagnosis which included Alzheimer's disease, senile dementia with behavior disorder, mood disorder, and agitation. A quarterly Minimum Data Set (MDS), dated 06/19/13, identified the resident had moderately impaired cognition; experienced fluctuating behaviors of inattention and disorganized thinking; wandered one to three days in the last seven; walked independently in her room; and required one person setup help for walking in the corridor and locomotion on and off the unit. Review of Resident #8's care plan, dated 04/01/13, stated, "Problem: Alteration in ADLs [Activities of Daily Living] R/T [related to] . . . needs cues reminders and supervision. . . .	F 323	admitted or is new to needing a code alert. Prior to placing a transmitter on a resident that particular transmitter will be tested on all the doors first. Nursing was educated on July 29 on this assessment by Director of Nursing. This form became effective July 30 with the testing of all the new transmitters. We also modified the "Elopement Incident Report" to indicate which door the resident exited; to ask the resident why they exited; and a procedure to follow if the code alert did not function appropriately. Please refer to attachment F323 Part 1-(E). 3. On July 31, 2013 Elm Crest Manor signed up for a Preventative Service Plan with RF Technologies where a service technician will come to Elm Crest annually to check all code alert boxes, antennas and frequencies. 4. Monitoring of the code alert checks will be done by Maintenance weekly on an ongoing basis. Review of the findings will be discussed at the monthly Interdisciplinary Meetings. F323 Part 2 1. On July 17, Administrator contacted Harlow's bus service as this is where the	8/9/13

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F 323	Continued From page 6 Approaches. . . . 19. Code Alert on left ankle/right wrist. . . . Problem: Alzheimer's, dementia, anxiety, depression, and agitation. Looking for a way home. . . . Problem: . . . Also resident occasionally eloping from facility and packing clothes. . . . Approaches: . . . 4. Elopement log started 05/07/12 [sic]. . . ." A nurse's note showed facility staff applied a Code Alert to Resident #8's left ankle on 03/21/13 when she talked about going home. Nurse's notes identified the following incidents when Resident #8 eloped from the building without the Code Alert system alarming: * 04/28/13, 8:30 p.m., " . . . Res [resident] attempted to go out Cedar door staff brought res away from door. Moments later went out Willow door. Alarm didn't sound. Res slid through rails on guardrail et [and] slid down enbankment [sic] into parking lot. Did not fall. Staff brought res back into facility et took res to Rm [room]. Res did get ready for bed. . . " * 05/05/13, 10:00 a.m. "Res. had been in Church and when left Chapel was looking for her car. Staff noticed Res. going to Willow door. Res was able to get out door before staff member got to her Res has code alert on ankle, but alarm did not go off. Staff member walked with Res to main door & [and] then came in, and that door alarm did go off. . . . Nurse did go and checked [sic] Willow door with different alarm & alarm did go off." * 05/10/13, 2:45 p.m. "Attempted to leave out of Cedar door. Staff brought her away from door [sic] Res crying. Wanting to go home. Went to Great Rm then out Willow exit, alarm didn't sound. Was out to end of ramp et returned [with] staff. Sat [with] staff at NS [Nurses' Station]."	F 323	restraints were purchased from. The restraints used in the Transportation Van were Sure-Lok. The Administrator ordered 2 sets of 4 restraints for the transportation van to have new restraints to use. The Administrator also asked Harlows to make a copy of the Operational guide and Application Instruction for our reference. Please refer to Attachment F323 A-B. These instructions were placed in the transportation van. The new restraints arrived on July 24, 2013. On July 25 and 26th an in-service was conducted for all employees who have either driven the transportation van or rode along in the past year. Please refer to attachment F323-C. We also included some staff members who could potentially do either of these in the future. An instructional video found on www.sure-lok.com was shown to all of these employees as well as the operational and application instructions. Then all of these employees went out to the van and each one was able to have the opportunity to manually learn how to properly and safely apply the restraints to the wheelchair.	

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F 323	Continued From page 7 An "Elopement Incident Report," dated 04/28/13, identified "maintenance is aware that code alert did not sound and are checking on this." After the elopement on 05/10/13, when the alarm failed, the "Elopement Incident Report" identified "second alarm [code alert] placed on Res." The report failed to identify the effectiveness of the code alert in relation to the door alarm. During an observation, on 07/02/13 at 1:55 p.m., an administrative nurse (#1) walked with Resident #8 out the Willow door. The alarm failed to sound. The nurse confirmed Resident #8 had a code alert on her left ankle under the fold in her sock. The nurse (#1) continued to walk with Resident #8 around to the main entrance. Upon entering the building, the code alert sounded. Prior to an observation on 07/02/13 at 3:45 p.m., an administrative nurse (#1) identified staff placed a new code alert on Resident #8's left ankle. The nurse (#1) and Resident #8 walked out the Willow door, and the alarm failed to sound. Resident #8 stated, "I found a way to walk to not set off the noise." The nurse (#1) and the resident walked around the parking lot and came in the Willow door. Again the alarm failed to sound. The nurse (#1) pulled the code alert out of the fold of Resident #8's sock, walked out Willow door, and again the alarm did not sound. The nurse (#1) and Resident #8 continued to walk around the building to enter through the main entrance, where the alarm sounded. Following this observation, an interview with a maintenance staff member (#3) and an administrative staff member (#6) identified the facility had previously changed the position of the alarms at the Willow exit in order to prevent	F 323	2. If there are any employees who in the future that would assist in transporting residents to medical appointments then those employees must first go through an in-service of watching the Instructional video on the Sure-Lok website, go through the Operational and Application Instructions and manually restrain a wheelchair into the van. This will be done in observance of the Administrator or designee. 3. A random check will be done 1 time monthly by the Administrator or designee to check how a resident's wheelchair is restrained in the transportation van prior to them leaving for an appointment. Please refer to attachment F323 Part 2- D. This monitoring will be reviewed monthly at the Monthly Interdisciplinary Meetings.	7/26/13

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F 323	Continued From page 8	F 323		

further elopements by Resident #8. The maintenance staff member (#3) could not recall the specific date the alarm was moved. These staff members (#3 and #6) could not verify the facility tested Resident #8's code alert after moving the alarms.

2. Based on observation, record review, review of facility job description, review of professional reference, and staff interview, the facility failed to ensure transport staff were adequately trained to prevent accidents for 1 of 1 sampled resident (Resident #3) who experienced a fall/injury while being transported in the facility van. Failure to ensure adequate training and to investigate a fall placed Resident #3 and other residents at risk for an injury when riding in the facility van.

Findings include:

Review of the facility job description titled " EMPLOYEE JOB DESCRIPTION" occurred on 07/03/13. This undated job description, stated, "Position Title: Van Driver . . . ESSENTIAL JOB FUNCTIONS: . . . 2. Transports residents and tenants to appointments and activities as scheduled. This will include operating the mechanical lift for wheelchairs, . . . and securing passengers' wheelchairs to restraining devices in order to stabilize them during the trip. . . ."

Information obtained from an administrative staff member (#6) identified the facility used Q' Straint wheelchair tie-downs in the facility van. Review of the Internet website www. amsvans.com/mobility-equipment/wheelchair-tie-downs/qstraints stated, ". . . All Q'Straint systems include four (4) tie-downs. When securing a wheelchair passenger, be sure to follow the

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F 323	Continued From page 9 safety procedures outlined in the user manual for the Q' Straint system you purchased. . . ." The facility failed to provide a manufacturer's user manual, including instructions for securing a wheelchair, in the facility van. Review of Resident #3's medical record occurred on all days of survey. Diagnoses included bilateral above the knee amputee. The quarterly MDS (Minimum Data Set), dated 05/02/13, identified Resident #3 required extensive assistance of one for locomotion off the unit. Resident #3's Incident Report identified the following: " . . . Date of incident: 04/08/13; Time of incident: 10:20; Incident: Fall; . . . Other: sitting in van; . . . Describe the incident: On way back from Dr. [doctor] appt. [appointment] in van res. [resident] attempted to adjust self in w/c [wheelchair] et [and] tipped w/c into back seat, hitting back of head. Chair uprighted [sic] by driver - Res denies pain to back of head. Neuro [neurological] checks started on return to facility. . . . Functional Status: Wheelchair dependent; Contributing Medical Conditions: recent double amputation to lower legs . . ." Nurse's Notes, dated 04/08/13, stated, "C/O [complain of] pain to both stumps #10 [worst possible pain]. Hydrocodone [one] po [by mouth] given, Stated while in w/c in van, w/c tipped backward onto back seat causing res. to hit back of head. [No] marks noted to back of head. States didn't hurt his head. Neurochecks started. . . ." Observation on 07/03/13 at 12:23 p.m., showed an administrative nurse (#1) demonstrated the procedure to secure a w/c into the facility van.	F 323		

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F 323	Continued From page 10 The nurse positioned the wheelchair against the back seat of the van and locked the brakes. The nurse secured two "S" hook Q' straint tie-downs to the back of the w/c, but none to the front. The w/c did not tip backwards in this position. Moving the w/c approximately 3 inches away from the backseat and unlocking the w/c brakes allowed the w/c to tip backwards. During an interview on the morning of 07/03/13, an administrative nurse (#1) was unable to locate documentation indicating the van driver, CNA (#7) had received training on proper use of the van equipment. The facility failed to complete an investigation related to this incident, failed to ensure the manufacturer's instructions were available for staff to reference, and failed to ensure staff were trained in the use of van equipment.	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	F 329	1. Resident #7 was started on routine APAP on 7/3/13 to address pain which may have been contributing to her behaviors. Nursing staff will continue to monitor and address pain level. Resident #7 was seen by a mental health specialist on 7/23/13 with medication adjustment. 2. PRN psychotropic medication assessment F329A will be implemented on all residents with orders for PRN psychotropic medications. The assessment will show evidence of non-pharmacological interventions	

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F 329	Continued From page 11 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 observation, record review, review of facility policy, and staff interview, the facility failed to assess and monitor psychotropic medications to ensure a medication regimen free from unnecessary medications for 1 of 2 sampled residents (Resident #7) receiving as needed (prn) antipsychotic medications. Failure to ensure non-pharmacological interventions were attempted prior to administering a prn antipsychotic medication placed the residents at risk of receiving unnecessary psychotropic medications and experiencing adverse consequences related to their use. Failure to complete a Dyskinesia Identification System-Condensed User Scale (DISCUS), an assessment for dyskinesia (a form of involuntary muscle movements), for 2 of 2 sampled residents (Resident #8 and #12) prior to initiating an antipsychotic, or upon hospital return with a new order for an antipsychotic medication, placed these residents at risk of experiencing adverse drug effects related to their use. Findings include: Review of the facility policy titled "Monitoring for Tardive Dyskinesia" occurred on 07/03/13. This	F 329	attempted prior to administration of PRN psychotropic medication. The new from will be presented at the nurses meeting on July 29, 2013 see agenda F329B and will be implemented by nursing staff on August 1, 2013. 3. Monitoring of completion of the PRN assessment will be completed by DON or designee weekly x 4 weeks then monthly thereafter. Findings will be discussed at the monthly interdisciplinary meetings. See F329C for PRN Psychotropic monitor. 4. DISCUS for resident #8 was completed on 4/25/13. The completed DSICUS was found in resident #1010's chart while completing the DISCUS QA monitor on 7/26/13. A copy has been provided as well as a copy of the DISCUS for resident #12 which was completed on 9/18/12 and provided prior to exit on 7/3/13 F329D. 5. All charts were reviewed on 7/26/13 and all residents present have a completed DISCUS F329E. DISCUS will be completed per facility policy F329F. Monitoring of DISCUS completion will be done by the DON or designee on a monthly basis. These findings will be discussed at the monthly	

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F 329	Continued From page 12 policy, dated May 2012, stated, "Purpose: To detect abnormal involuntary movements of individuals who take neuroleptic (antipsychotic) medication and to ensure diagnosis and treatment of Tardive Dyskinsia (TD). . . . Explanation: Psychoactive drugs may be prescribed for the management of psychotic disorders and/or behaviors of an aggressive nature. These drugs are approved treatment for these disorders but are capable of causing profound motor effects. Most neuroleptic medications are anti-psychotics. . . . Procedures: 1. Residents shall be assessed for abnormal movement disorders as follows: a. Upon recommendation for treatment with neuroleptic medication, prior to the administration of the drug. b. Upon admission to the long-term care facility if the individual has a recent history (i.e. within the last 6 months) of taking neuroleptic medication. . ." - Review of Resident #7's medical record occurred July 1-3, 2013. Diagnoses included dementia, Alzheimer's, agitation, dementia stable with behavioral disorder, osteoarthritis, and degenerative joint disease bilateral hips. A quarterly Minimum Data Set (MDS), dated 06/15/13, identified the resident had severely impaired cognition; experienced fluctuating behaviors of inattention and disorganized thinking; displayed other behaviors one to three times in seven days; received a prn pain medication; and received an antipsychotic seven of seven days. Review of Resident #7's care plan, dated 12/28/2012, stated, "Problem: Dementia, and agitation. . . Approaches: 1. Invite and assist throughout facility on a daily basis. 2. 1 to 1 by	F 329	interdisciplinary meetings. See F329G for QA monitor of DISCUS.	8/5/2013

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staff and volunteer 3 to 4 times weekly and during periods of increased agitation. 3. Give resident time to express feelings and offer reassurance during periods of agitation and increased confusion or take to quiet area . . . 5. Medications as ordered. . . . Problem: Increased behaviors of agitation, yelling, screaming, [sic] out, trying to hit, kick, and bite staff with cares due to poor eye sight. Also yells "Yoo-Hoo" to seek attention. . . . Approaches: 1. Due to poor hearing and eye sight make sure she hears and understands what staff will be doing with her. 2. 1 to 1 time as needed. 3. Medications as ordered . . . 4. Remind her that they are here to assist her. 5. Seen by mental health routinely (began 06/20/13) 6. Document behaviors [and] effectiveness of interventions on behavior log. (began 06/20/13). Problem: Rhabdomyolysis, crush injury with fall, and moderate to severe degenerative joint disease bilateral hips. Goal: Pain will be less than a 2 on a scale of 0-10 by next review. Approaches 1. Medications as ordered . . ." This was the only approach identified to manage/treat Resident #7's pain.

Review of Resident #7's physician orders identified the following medication orders:
* Tylenol 500 milligrams (mg) 1 to 2 orally every four hours prn, maximum dose three grams per day, pain/fever.
* 01/23/13, Risperidone (an antipsychotic medication) 0.25 mg orally every 12 hours prn agitation. Changed 03/14/13, increased to Risperidone 0.25 mg every four to six hours prn.

A "Consulting Pharmacist Communication to Physician" note, dated 12/20/12, stated, "RE [regarding]: Risperdal PRN (DX [diagnoses]= Dementia -stable (without behaviors?) Please

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evaluate the usefulness of this medication. Given sporadically (prn) its effectiveness, other than, sedation is questionable. It probably takes two weeks or longer for any appreciable receptor activity at the the [sic] dopamine and serotonin level. With the antipsychotics, the crux of the immediate response is related to histamine and sedation in terms of behavior control. With this in mind please consider using a short acting benzodiazepine for acute behavior problems These agents are much less expensive and ultimately more effective for acute behavioral control." The physician's response, dated 01/23/13, "Behavior unstable."

Review of Resident #7's PRN medication administration records (MARs), dated March 1 - July 1, 2013, identified staff administered Risperidone 23 times for agitation, calling out, (increased) agitation, and/or yelling. Nurses Notes on 11 occasions failed to identify any non-pharmacological interventions attempted before nursing staff administered an antipsychotic medication.

On 07/01/13 at 12:45 p.m., observation of care for Resident #7 showed two CNAs (#10 and #15) assisted the resident to transfer utilizing a sit to stand lift. As the CNA raised Resident #7's arm to place the sling, the resident moaned. The CNA (#10) responded "I know it hurts." As the CNAs (#10 and #15) used the lift to raise Resident #7 to a standing position, the resident's body tightened, she grimaced and repeated "That's enough" twice. When the CNAs (#10 and #15) used the lift to transfer Resident #7 from the toilet to her wheelchair, she again grimaced stating "Enough. Watch it." Review of the Nurses Notes and the PRN MAR showed staff failed to address the pain

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F 329	Continued From page 15 expressed by Resident #7. Failure to assess pain experienced by Resident #7 may contribute to the behaviors exhibited by the resident. Failure to identify the specific behavior exhibited, attempt non-pharmacological interventions and monitor the effectiveness of those interventions prior to administering a prn psychotropic medication to Resident #7, does not allow staff to evaluate causative factors and what interventions are most effective. During an interview at 9:40 a.m. on 07/03/13, an administrative nursing staff member (#1), identified they do try other interventions with Resident #7 before giving her a psychotropic, but fail to document those attempted interventions. This same nurse (#1) confirmed they do not provide a regularly scheduled pain medication for Resident #7. - Review of Resident #8's medical record occurred July 1-3, 2013. Diagnoses included Alzheimer's disease, senile dementia with behavior disorder, mood disorder, and agitation. A quarterly MDS, dated 06/19/13, identified the resident,had moderately impaired cognition; experienced fluctuating behaviors of inattention and disorganized thinking; and received an antipsychotic seven of seven days. Review of Resident #8's physician orders identified the following medication orders: * 04/30/13, Risperdal 0.25 mg orally daily prn for agitation. Resident #8's medical record lacked a DISCUS assessment. Facility staff failed to complete a DISCUS assessment prior to initiation of this	F 329		

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F 329	Continued From page 16 antipsychotic on 04/30/2013. - Review of Resident 12's medical record occurred July 1-3, 2013. Diagnoses included agitation, mild dementia, and sleep disorder. Resident #12 returned from the hospital on 12/17/12 with orders for Risperidone 0.25 mg orally at bedtime and 0.25 mg every 12 hours prn. Facility staff failed to complete a DISCUS as identified by facility policy.	F 329		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of	F 431	1. All insulin bottles have been assessed and dated with current open date. All nurses were re-educated and policy review was completed at the nurses meeting on 7/29/13 see F431A for Insulin Storage Policy. See nurses meeting agenda and policy F431B 2. Monitoring of the insulin bottles for open dates will be completed by DON or designee weekly x4 then monthly thereafter. Findings will be discussed at the monthly interdisciplinary meetings. See F431C for Insulin monitor.	7/29/2013

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F 431	Continued From page 17 controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to date four multidose bottles of insulin on 2 of 2 medication carts. Failure to identify an open date on insulin bottles may result in use beyond 28 days and affect the potency and efficacy of the medication. Findings include: Review of the facility policy titled "INSULIN STORAGE" occurred on 07/03/13. This policy, dated May 2012, stated, "1. Prior to opening each insulin bottle, the bottle/box will be dated to ensure the insulin in [sic] discarded after 28 days of being opened . . . 7. Insulin needs to be disposed of after being open for 28 days . . ." Observation of the medication carts occurred on the morning of 07/03/13 with two licensed nurses (#4 and #5). The Willow/Oak medication cart showed two boxes dated 06/21/13 and 07/02/13 which contained an undated bottle of Lantus insulin in each box. The Spruce/Cedar medication cart showed two boxes dated 06/09/13 and 06/10/13 which contained an undated bottle of Novolog insulin in each box. Observation showed several other insulin boxes and bottles of insulin,	F 431		

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F 431	Continued From page 18 all dated on the box and on the bottle. During an interview on 07/03/13 at 8:55 a.m., the nurse (#4) stated the nurses should date both the box and the bottle of insulin.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	1. Review of hand washing policy F441A and infection control policy F441B focusing on hand hygiene and mechanical lift cleaning was completed at the All Staff meeting on July 16, 2013 F441C. These policies will again be reviewed at the nurses meeting on 7/29/13 and the CNA meeting 8/13/13 see agendas F441D and F441E. 2. Resident # 6's catheter privacy bag and tubing were repositioned to not drag on the floor on 7/3/13. Monitoring of proper catheter privacy bag and tubing placement will be completed weekly x4 then monthly thereafter. This monitor will be completed by DON or designee and findings will be discussed at the monthly interdisciplinary meetings. See F441F. Resident #6 is no longer on contact precautions but re-education of mechanical lift cleaning was provided at the nurses meeting and CNA meeting.	

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F 441	Continued From page 19 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow contact infection control practices for 1 of 1 sampled resident (Resident #6) in isolation and failed to follow standard infection control practices for 1 of 4 sampled residents (Resident #3) observed during perineal cares after a bowel movement. Failure to follow infection control practices related to glove usage, hand hygiene, and sanitation of an EZ stand (a mechanical lift) has the potential to cause or spread infection within the facility. Findings include: Review of the facility policy titled "CARE OF INDIVIDUALS WITH MRSA/VRE [Methacillin Resistant Staphylococcus Aureus/Vancomycin Resistant Entercocci] INFECTION OR COLONIZATION" occurred on 07/03/13. This policy, dated 2009, stated: "Policy: 1. To help prevent the transmission of MRSA/VRE, standard precautions should be used for all residents care . . . 2. To further prevent or control actual infection, contact precautions will be utilized a. Staff should wash their hands with soap and water after physical contact . . . b. Disposable gloves should be worn if contact	F 441	3. Monitoring of proper hand hygiene with a focus on hand hygiene following toileting will be on going to ensure all CNA's are assessed completing by August 17, 2013. This monitor will be completed by DON or designee and all findings will be discussed at the monthly interdisciplinary meetings. Hand hygiene monitor F441G will be completed weekly x4 then monthly thereafter. See F441G and F441H for QA monitor of hand hygiene and CNA hand hygiene assessments.	JV 8-17-13 ~~9/1/2013~~

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with body fluids is expected. Hands should be washed after removing gloves . . .
e. Equipment used on resident will be for them specifically of [sic] disinfected after use . . ."

Review of the facility policy titled "Proper Handwashing" occurred on 07/03/13. This policy, undated, stated, " . . . POLICY: Hands must be washed: . . . Before and after resident care and treatments. If gloves are worn, wash hands after removing gloves. . . ."

- Review of Resident #6's medical record occurred on all days of survey. Diagnoses included urethral stricture with an indwelling suprapubic catheter and a MRSA urinary tract infection. The current Minimum Data Set, dated 06/23/13, identified the resident required extensive assistance with toilet use and personal hygiene.

Observation on 07/01/13 at 1:08 p.m.. showed two certified nursing assistants (CNAs) (#8 and #9) donned gloves and gowns and utilized an EZ stand to transfer Resident #6 off the toilet. The CNA (#8) provided perineal cares to the resident, applied a barrier cream, and removed the glove used to provide pericares. The CNAs (#8 and #9) utilized the EZ stand and transferred Resident #6 to his bed. The CNA (#8) sanitized her hands rather than washing with soap and water as per facility policy before she left the room.

Observation on 07/01/13 at 2:50 p.m. showed two CNAs (#10 and #11) donned gloves and gowns and utilized an EZ stand to transfer Resident #6 from bed to his wheelchair. The CNAs removed the EZ stand from the room and failed to sanitize it.

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Observation on 07/02/13 at 12:33 p.m. showed two CNAs (#12 and #13) donned gloves, gowns, and masks and entered Resident #6's room. The CNA (#12) opened and closed the drainage spigot on the catheter bag. The CNA (#12) failed to remove her gloves and wash her hands with soap and water. The two CNAs then utilized an EZ stand to transfer Resident #6 to the toilet. After a few minutes, the CNAs raised the resident off the toilet with the EZ stand, CNA (#13) provided perineal cares, and both CNAs transferred Resident #6 to his bed. The CNA (#13) removed her gloves, gown, and mask, sanitized her hands, and exited the room. The CNA (#13) failed to change her gloves or wash her hands with soap and water after providing perineal cares and failed to wash her hands before exiting the room as per facility policy.

Observation on all days of survey showed Resident #6's Foley catheter tubing and the privacy bag (enclosing the catheter bag) dragged on the floor as the resident propelled in his wheelchair throughout the facility.

- Observation on 07/01/13 at 2:20 p.m., showed a CNA (#2) donned gloves and provided perineal care for Resident #3 after a bowel movement on the bedpan. After completing perineal care, the CNA removed the gloves, placed the gloves into the garbage, and opened the door to exit the room. The CNA failed to perform hand hygiene before exiting the room. The CNA (#2) returned to the Resident #3's room and sanitized her hands.

During an interview on the afternoon of 07/03/13, an administrative nurse (#1) stated she expected

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F 441	Continued From page 22 staff to wash their hands immediately after perineal care and to follow contact precautions related to MRSA.	F 441		