STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355115	A. BUILDING _____ B. WING _____ NOV 10 2010	10/13/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARRISON MEM HOSP NSG FAC	407 3RD AVE SE GARRISON, ND 58540

(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 10/11/10 and completed on 10/13/10 the sample included two residents for complete review, seven residents for focused review, and 1 closed record for review. The sample included five additional residents to verify specific concerns during the survey.	F 000		
F 224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy and procedure, and staff interview, the facility failed to ensure implementation of policies and procedures prohibiting mistreatment, for 1 of 1 sampled resident (Resident #9) mistreated and by another resident (Resident #2). Failure to implement the policies and procedures resulted in Resident #9 experiencing continued mistreatment and prevented Resident #9 from participating in activities she enjoyed. (Refer to F250.) Findings include: Review of the facility's policy and procedure, Abuse, Neglect or Misappropriation of Property, occurred on 10/13/10. This undated document stated ". . . POLICY: . . . The resident has the right to be free from verbal . . . mental abuse . . .	F 224	F 224 1. Resident #2's care plan (exhibit 1) has been updated. Resident #9 was offered a room change on 09/28/2010 and accepted. 2. All nursing facility residents could potentially be affected by this deficiency. Roommate of Resident #2 could be most affected. 3. The facility plans to put the following measures in place to address this deficient practice: a. Review Abuse Policy & Procedure and update as needed (exhibit 2) b. Notification of Behavior Occurrence form (exhibit 3) will be put into place to notify Unit Coordinator and Social Worker of behavior incident c. A new Behavior Management Protocol (exhibit 4) will be put into place. d. NF staff will be instructed on the implementation of the new Behavior Management Protocol at the November 22, 2010 NF staff	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Alan D Fuller	Administrator	11/09/2010

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 224	Continued From page 1 Residents will not be subjected to abuse by anyone including, but not limited to . . . other residents . . ." - During the initial facility tour, on 10/11/10 at 9:35 a.m., a nursing staff member (#8) reported Resident #9 had resided in her current room for approximately three weeks. This staff member reported Resident #9 previously resided in the same room as Resident #2 and moved because of conflicts with Resident #2. Review of Resident #9's medical record occurred on October 12-13, 2010. The facility admitted the resident in 08/10. Current diagnoses included anxiety, depression, urinary frequency, and pain related to history of back surgery and hip fracture. The resident's admission Minimum Data Set (MDS), dated 09/03/10, identified no short or long term memory problems, independent daily decision making ability, repetitive health complaints, insomnia, persistent mood easily altered, and no behavioral symptoms. Resident #9's Mood Resident Assessment Protocol Summary (RAPS) identified a decrease in mood related to pain. The resident's current care plan, initiated on 09/14/10, and updated on 09/21/10 and 10/12/10, lacked identification of problems or approaches regarding conflicts with other residents or a change in resident room due to conflicts. Resident #9's Nursing Notes identified the following: *09/12/10, untimed - Resident #2 complained Resident #9's arm chair was "in the way," wasn't being used, and should be removed. Resident #9 told facility staff she used the arm chair and	F 224	meeting. All NF staff will be required to read and sign off on the new protocol. (exhibit 5) e. Behaviors will be reviewed and commented on in notes during the monthly Psychosocial Committee meeting. 4. QA Plan- (exhibit 6) Social Worker will do a random chart review of 20% of the nursing facility population, monthly for 2 months. All results to be reviewed at the quarterly facility QA meeting for further action.	11/ 17/ 2010

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F 224	Continued From page 2 wanted it to stay in the room. *09/16/10, 4:30 a.m. - ". . . Resident c/o [complained of] roommate [Resident #2] going to bed so early and wanting the light turned off." *09/20/10, 4:10 p.m. - "Reading quietly in bed. States roommate constantly talking & [and] hollering at her 'and she sure swears alot.' States 'came around that curtain a couple of times swearing & telling me to stop being so loud.' Does not seem to be able to relax [with] constant interruptions from roommate. 'I'm trying not to upset her.' " *09/20/10, 7:00 p.m. - "Has not watched TV this eve [evening] in app. [apparent] attempt not to upset roommate & stopped reading much earlier than usual & going to sleep. Does not appear to rest or relax well @ [at] all." *09/21/10, 7:30 a.m. - "Resident up to bathroom X [times] 4 this shift. Peers around curtain to check on roommate before going into bathroom." *09/21/10, untimed - "Care Conference held today. . . . Voiced concerns [with] roommate & [social work staff member (#3)] is working on problem." *09/21/10, untimed - "Was not reading as she would normally like to, so not to upset roommate." *09/24/10, 10:45 a.m. - "Visited [with] [Resident #9] today about how her week has been with her roommate. She stated 'things are much better. Someone must have talked to her.' . . ." *09/26/10, 7:30 p.m. - "Going to bed much earlier than usual. Seems stressed & concerned being up late will upset roommate." *09/28/10, 2:00 p.m. - "Moved to [room number] due to conflict [with] roommate [sic]." *09/29/10, 7:00 p.m. - "Seems much more relaxed in new room [with] new roommate. Reading & watching TV some. . . ."	F 224		

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F 224	Continued From page 3 Resident #9's Social Services Progress Notes identified the following: *09/12/10 - "On 09/10 I had asked Resident [#9] about the arm chair in her room. Roommate [Resident #2] thought that Resident [#9] was not using it & that is [sic] was in the way. Resident stated that she does use it & her company sits in it & she wants it to stay. . . ." *09/28/10 - "Resident has had some incidents recently [with] roommate giving her a hard time about watching TV. The first incident was on 09/20 the evening before care conferences. We did discuss it at care conf [conference]. It was agreed that I would talk to the roommate & see if the situation would resolve. Roommate has reportedly continued to say things when Resident would try to watch TV. I asked Res. [resident] today if she would like to switch rooms & she said 'yes'. . . ." - Review of Resident #2's medical record occurred on October 11-13, 2010. The resident's Nurse's Notes identified the following: *09/20/10, 3:30 to 4:30 p.m. - "Amb [ambulating] quickly in hallway with walker. Appears very angry. Stopping to tell other residents and staff how upset she is with roommate. 'I'm not standing for this anymore - I want her out of there. She sits in there day and night reading out loud and it's driving me crazy'. Staff has not noticed roommate reading 'out loud'. . . ." *09/20/10, 5:30 p.m. - "Tried to take T.V. remote away from roommate." *09/20/10, 7:15 p.m. - "Would not allow nurse in her room to care for her roommate. . . . Staff now tells me resident had been swearing and hollering loudly to roommate and other residents earlier. Reminded should talk with manager and social worker in a.m. and try to rest until then. Stated	F 224		

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F 224	Continued From page 4 would 'try to hold it in until morning'." Social services notes included: *09/22/10 - "Resident had a behavior incident Monday evening 9/20 (see nurses notes). Yesterday I visited with resident in presence of her dgt.[daughter] . . . to ask her what had gone on the night before. She said that roommate was reading very loudly and that she wondered what was going on. She denied touching roommate's TV or TV remote. This resident quickly became agitated. When relating what had happened the night before she seemed to be jumping to many conclusions that were erroneous. She did a lot of swearing. . . ." During interview, on 10/13/10 at 10:40 a.m., a social services management staff member (#3) reported she was not aware of the Nursing Notes identifying Resident #9's inability to relax and stress related to Resident #2's behaviors towards her. This staff member reported she talked to Resident #2 regarding her behaviors towards Resident #9. The staff member (#3) confirmed Resident #9's care plan lacked any information identifying a conflict with Resident #2 and approaches to protect Resident #9 from further mistreatment or abuse by Resident #2. The facility staff identified conflict between Resident #2 and Resident #9 on 09/10/10. Resident #2 continued to harass Resident #9. The facility staff failed to implement approaches or interventions to protect Resident #9 until 09/21/10 when social services staff member (#3) "talked to" Resident #2. This failure resulted in Resident #2's continued harassment of Resident #9 and Resident #9's increased stress and inability to participate in activities she enjoyed	F 224		

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F 224	Continued From page 5 until the facility staff moved Resident #9 to another room on 09/28/10.	F 224		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview, and staff interview, the facility failed to provide care in a manner which enhanced each resident's dignity for 1 of 1 supplemental resident (Resident #11) observed receiving eye drops and an inhaler, 1 of 1 sampled resident (Resident #5) with a monitor in her room, 1 of 1 sampled resident (Resident #4) who received thickened liquids, and 3 of 11 residents (Resident A, B, and C) who attended the group interview. Failure to enhance the residents' dignity has the potential to cause feelings of unworthiness. Findings include: - Observation on 10/12/10 at 8:45 a.m. showed a licensed nurse (#8) approached Resident #11 in the hall and stated the resident needed to take her medicine. The nurse held the resident's inhaler to her mouth and said "OK, suck." Observation showed the resident unable to "suck" and other residents within visual and hearing distance. - Observation on 10/12/10 at 9:00 a.m. showed Resident #11 and 5 other residents in the	F 241	F- 241 1. Resident # 11 was be re-educated on 10-14-2010 for the proper use of the inhaler (exhibit 7) The medication time of administration was changed to 1400, when resident is more alert. The proper medication administration will be completed, ie, medication administration will not occur in a public area. Door will be closed on tub room while residents are in the tub. Resident # 4: Thickener was discontinued 11/8/2010 (exhibit 8) Resident # 5 had her care plan updated to reflect the use of monitor in her room. (exhibit 9) 2. All medications will be administered in the appropriate area to ensure privacy and dignity as evidenced by re-education of staff. No thickener agents will be left on the table, as a result of re-education. The monitor will be turned off when	

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F 241	Continued From page 6 elevator. A licensed nurse (#8) entered the elevator and administered Resident #10's eye drops. During an interview on 10/13/10 at 1:30 p.m., a nurse manager (#2) agreed Resident #11's inhalers and eye drops should have been administered in a private location. - During the initial tour of the facility on 10/11/10 at 9:35 a.m., observation showed a monitor positioned on the dresser next to Resident #5's bed in the "on" mode. Resident #5 shares a room with another resident. Observation also showed the monitor "on" at the nurses station and in Resident #5's room the afternoon of 10/11/10, 10/12/10 from 8:00 a.m. to 6:00 p.m. , and 10/13/10 from 7:30 a.m. to 8:45 a.m. Review of Resident #5's medical record on all days of survey identified a diagnoses of altered mental state. The Minimum Data Set (MDS), dated 07/26/10, identified both long and short term memory difficulties, moderately impaired in making daily decisions, and a deterioration in her cognitive status. Resident #5's care plan failed to identify the use of a monitor. During an interview on 10/13/10 at 1:30 p.m., a nurse manager (#3) stated she initiated the baby monitor in Resident #5's room a couple of weeks ago because the resident often yelled out at night for help. She stated she expected the monitor to be used only at night and turned off during the day. Failure of facility staff to administer Resident #10's medications in a private area and the failure to turn the monitor in Resident #5's room off	F 241	staff are in resident's room. The bath tub room door will be closed 3. Re-education of all nursing staff on proper administration of medications, removal of the thickener agents from the table, and turning the monitor off while in room will be done on 11-22-2010. Engineers will evaluate the ventilation system and re-balance the air flow supply and return to decrease the humidity in the room. 4. QA process will include, random times and shifts for monitoring for any medications that are not given in the appropriate private settings, any thickener agents left on the table, and to ensure that the monitor is turned off when staff is in the room and the bath tub room door is closed (exhibit 10)	11-22-2010.

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F 241	Continued From page 7 during the day showed a lack of respect and privacy for these residents and for Resident #5's roommate. - The resident group interview occurred on 10/11/10 at 2:45 p.m. During a discussion regarding facility rules and privacy, Residents A, B, and C stated the door to the bathing room is always opened and a curtain pulled across the doorway while they are assisted with baths. - Observation on 10/12/10 between 8:15 and 9:15 a.m. showed the door to the bathing room open and a curtain pulled across the entrance to the room. A conversation between Resident C and an unknown staff member occurred in the bathing room and could be heard from the hallway. During an interview on 10/13/10 at 2:00 p.m., an administrative nurse (#1) agreed facility staff should close the door to the bathing room when a resident is in the room to promote privacy. She stated facility staff keep the bathing room door open because the room is hot. - Observations, in the facility dining room on 10/12/10 at 11:00 a.m. during the noon meal and at 5:05 p.m. during the evening meal, identified a commercially labeled container of "thickener" used to thicken liquids on a table where four residents sat, including Resident #4. At 11:00 a.m., a certified nursing assistant (CNA) (#5), the licensed nursing staff member (#6), and nurse manager (#2) offered to thicken his fluids with the product before he consumed the fluids, and at 5:05 p.m., a CNA (#7) placed the "thickener" in Resident #4's fluids. The resident refused the use of the "thickener" and refused to drink the thickened fluids. The staff members failed to remove the "thickener" from the dining room table	F 241		

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F 241	Continued From page 8 during the meals. During interview, on 10/13/10 at 12:40 p.m., a nurse manager (#2) reported facility staff should add the "thickener" to Resident #4's fluids before they are brought to the table and the facility staff should have removed the container from the dining room table.	F 241	F 248 1. We will determine physical, mental and psych/social issues by developing a protocol for an activity outing that includes a nursing assessment.(exhibit 11) 2. All residents who go on an activity outing will have the protocol followed and assessments completed. (exhibit 12) 3. Nursing, dietary, and activity staff will be educated on the new protocol and assessments by 11-22-2010. 4. A collaborative QA process will be done between nursing and activities on all the outings, using the nursing assessments and activity protocol. This will be done for the next three months on all residents that go on an outside activity. The QA process will be shared with the QA committee. (exhibit 13)	11-22-2010
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident group interview, family interview, and staff interview, the facility lacked coordination between the activity department and other disciplines to ensure sufficient resources were available to meet the residents' medical needs during 1 of 1 scheduled facility outings (10/12/10) and during past outings. Failure of facility staff to assess the medical, physical, and psychological needs of the residents and ensure sufficient staffing and medications before extended outings occurred, placed the residents at risk for injury, elopement, respiratory distress, and incontinence. Findings include: The resident group interview occurred on 10/11/10 at 2:45 p.m. Four of the 11 residents stated they participated in a facility outing to the	F 248		

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F 248	Continued From page 9 casino in April 2010 and three of the 11 residents (Resident #8, #12, and #13) planned to participate in an outing the next day, 10/12/10, to the casino with facility staff members. Following the group interview, on request of the survey team, the facility staff provided a list of residents the staff anticipated to participate in the trip to the casino on 10/12/10. This list included Resident #4. At the end of the day, the facility staff identified Resident #4 would not be participating in the trip. During an interview on the afternoon of 10/13/10, an activity staff member (#4) stated prior to any outing, she asks each resident if they would like to go on the outing. She then gives a list of residents interested to nursing staff and nursing staff make the final decision as to which residents may attend the outing. - Review of Resident #4's medical record occurred on October 11-13, 2010. The facility admitted the resident in 08/09. The resident's current diagnoses included diabetes mellitus, confusion, dementia with behaviors, and congestive heart failure. The facility admitted the resident to an acute care hospital September 26 - October 6, 2010 for pneumonia. Resident #4's annual Minimum Data Set (MDS), dated 07/23/10, identified short and long term memory problems, moderately impaired daily decision making, required extensive assistance of one person for toileting and two persons for transfers, swallowing problems, and a mechanically altered diet. The resident's current care plan, dated 07/27/10, identified chopped meats at meals and transfers required the use of	F 248		

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F 248	Continued From page 10 a mechanical sit-to-stand lift device. The medical record identified the resident refused thickened liquids and had difficulty swallowing bread and meats. The facility staff noted the resident required increased assistance to eat since his return from the hospital. During interview, on 10/11/10 at 6:50 p.m., Resident #4's family member reported the resident had participated in many facility sponsored outings in the past. Resident #4's medical record identified the following: *04/13/10 - On outing from 9:00 a.m. to 4:40 p.m. and ". . . 11:00 a.m. Tyl. [Tylenol] sent along [with] staff to give. . . ." The medical record failed to identify what staff were responsible for providing the medication. *04/27/10 - On outing to the circus from 8:00 a.m. to 2:00 p.m. and ". . . Lasix [diuretic], 8:00 a.m., held til [until] returned @ [at] 2:00 p.m." *09/09/10 - On outing and on return to the facility the resident's blood glucose measured "500" milligrams per deciliter. The facility staff provided insulin, monitored the resident and his blood glucose levels, and the levels returned to an acceptable range. Observation during the survey showed two facility staff members used the mechanical sit-to-stand lift for all of Resident #4's transfers to and from his wheelchair, including toileting. Observation also showed Resident #4 required total assistance from staff for eating. Resident #4's medical record, family member, and facility staff identified the resident had participated in many facility sponsored outings in the past. Resident #4's medical record lacked evidence the facility staff assessed his needs,	F 248		

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F 248	Continued From page 11	F 248		

including toilet transfers, medications, and diet textures, and the availability of staff and toileting facilities to meet his needs during the past outings and the planned outing to the casino on 10/12/10. Failure to assess Resident #4's needs, the toileting facilities, and facility staff assistance available during outings placed him at risk of injury, high blood glucose levels, incontinence, and swallowing problems.

- Review of Resident #8's medical record occurred on October 12-13, 2010. Medical diagnoses included depression and Alzheimer's disease. The record revealed this resident went on an outing to a casino on 04/13/10 from 9:00 a.m. to 4:40 p.m. (seven hours and 40 minutes.)

Review of Resident #8's nursing and social services progress notes, dated 04/05/10, identified the resident wanted to go home, packed her belongs, and threatened to commit suicide. A facility nurse contacted the consulting psychiatrist and the psychiatrist admitted Resident #8 to the hospital on 04/05/10. She returned to the facility on 04/08/10.

Review of Resident #8's care plan stated, "Problem/Concern - [date initiated 04/05/10 and discontinued 05/18/10] suicidal thoughts R/T [related to] recent move into facility & [and] wanting to go home . . . Approaches - Assess, document & report to provider PRN [as needed]. Assess potential for harm to self &/or others. Remove all potentially harmful items from room . . ."

During an interview on the afternoon of 10/13/10, an activity staff member (#4) stated Resident #8 returned from the hospital in a pleasant mood and

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F 248	Continued From page 12 a family member thought it would be a good idea for her to go to the casino on 04/13/10. Resident #8's medical record failed to show any assessment by nursing staff or social services to determine her mental status in regards to an elopement risk or suicidal ideations prior to her seven hour and 40 minute outing to a casino. Failure to assess Resident #8's mental status placed this resident at risk for elopement, injury, and death and placed other residents and staff members at a risk for injury. - Observation on 10/12/10 at 8:45 a.m. showed Resident #11 walking in the hall towards the elevator. The nurse (#8) stopped the resident in the hall, placed an inhaler up to the resident's mouth, and said, "OK, suck." Observation showed the resident unable to "suck." Review of Resident #11's medication administration record (MAR) identified a scheduled administration time for the inhaler of 10:00 a.m. - Observation on 10/12/10 at 9:00 a.m. showed Residents #8, #11, #12, #13, #14, and #15 in an elevator with an activity staff member (#4) on their way out of the facility for a scheduled outing. The nurse (#8) entered the elevator and administered Resident #11's eye drops. Review of Resident #11's MAR identified a scheduled administration time of 10:00 a.m. - Observation on 10/12/10 at 9:10 a.m. showed the nurse (#6) prepared Resident #12's and #14's oral medications, scheduled for 11:00 a.m. and 2:00 p.m., and sent the medications downstairs with an administrative nurse (#1) who handed them to activity staff member (#4). The nurse (#1) informed Resident #12 and #14 the activity staff	F 248		

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F 248	Continued From page 13 member had their medication and would hand the medications to them at their scheduled times. - Review of Resident #12's and #13's physician's orders identified both residents scheduled for hand-held nebulizer treatments, (to help open and maintain the airway to the lungs), while away from the facility. Nursing staff failed to send the medications with the residents. Resident #12 missed a 12:30 p.m. treatment and Resident #13 missed a 10:00 a.m. and a 4:00 p.m. treatment. Resident #12's and #13's physician's orders also identified both residents required oxygen to keep their oxygen level above 95 % (percent) and 90 % respectively. Nursing staff failed to send oxygen with the residents. Observation showed the above referenced residents left the facility at approximately 9:45 a.m. on 10/12/10, and returned to the facility at approximately 5:00 p.m. (7 hours 15 minutes.) Review of Resident #11, #12, #13, #14, and #15's medical diagnoses and care plans occurred on 10/13/10 and identified the following: * Resident #11: Medical diagnoses: History of alcoholism and dementia Care Plan: "Problem - "I don't like to be too close to other people . . . Problem - Alteration in elimination . . . Toilet riser on toilet. Is on a scheduled toilet routine . . . Problem - I have some decaying teeth on bottom and I have trouble chewing some meats. Serve me a regular diet [with] soft, easy to chew foods . . ." * Resident #12: Medical diagnoses: Chronic obstructive pulmonary disease (COPD) Care Plan: "Problem - Alteration in respiratory	F 248		

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F 248	Continued From page 14 status R/t [related to] COPD [with] possible underlying interstitial fibrosis . . ." * Resident #13: Medical diagnoses: COPD, lung carcinoma, alcohol induced hepatitis, and confusion Care Plan: "Problem - I have lots of medical problems . . . COPD . . . Make sure I have my oxygen when needed it [sic]. Watch my oxygen levels. Monitor for me being short of breathe [sic] . . ." * Resident #14: Medical diagnoses: Depression and anxiety Care Plan: "Problem - Hx. [history] of depression & anxiety - mood is usually stable when in facility, anxiety [increases] when tries home alone [sic] . . ." Resident #15: Medical diagnoses: Alcoholism, history of seizure disorder, anxiety, depression, bipolar disorder, antisocial behavior, and poly substance dependence Care Plan: "Problem - I take medications for bipolar disorder, I get anxious at times & have a problem [with] seizures . . . Watch me for safety concerns & inform me if I am not being safe. Give me reassurance if I am anxious. If I have a seizure protect me from injury . . ." Observation of the events which preceded the residents' outing to a casino on 10/12/10 showed a lack of coordination and collaboration between the activity staff and the nursing staff. During interviews throughout the day on 10/13/10 with the administrative nurse (#1), the nurse manager (#2), and the activity director (#4) the staff members concurred the extended out of the facility outing did not include plans/arrangements for responding to the individual resident needs,	F 248		

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F 248	Continued From page 15 and ensuring availability of sufficient facility staff to respond to each individual resident's toileting, diet, hydration, and mental/physical health related needs. Failure to plan for these needs placed all residents participating in these outings at risk of illness and injury.	F 248	F250 1. An audiologist familiar with Resident #2's care has reviewed her hearing deficits and gave her two options to improve hearing (exhibit 14) which were discussed with Resident #2 on 11/08/10. Resident declined both options. Eye exam of 05/01/03 shows that Resident #2's vision is unable to be improved from current (exhibit15) Care plan was updated to reflect such. (Exhibit 1) Dr. Dornacker visited with Resident #2 during rounds on 11/03/10. He did change her antidepressant from Celexa to Effexor XR. (Exhibit 16) Resident #8 was assessed for suicidal ideation by nursing as evidenced by Medicare nursing notes of 04/08/10 through 04/12/10 (Exhibit 17). Elopement assessment was completed by nursing on 10/14/10 (exhibit 18) 2. Any resident that displays suicidal tendencies or elopement risk will require immediate intervention by staff.	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy and procedure, resident interview, and staff interview, the facility failed to adequately assess the causative/contributing factors associated with behavior exhibited, determine effective interventions to minimize/control the behavior, including consideration for further assessment by a mental health professional, and monitor the effectiveness of interventions implemented for 2 of 3 sampled residents (Resident #2 and #8) with current, or a history of mood/behavioral problems. Failure to assess the contributing factors/causative reasons for Resident #2's depression and verbally abusive behavior towards Resident #9 did not allow the resident the opportunity to experience a potentially attainable improved quality of life. Failure to adequately assess and monitor Resident #8's expressed depressive, suicidal, and elopement behaviors placed the resident at potential risk during community outing(s) away	F 250		

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F 250	Continued From page 16 from the facility. Findings include: Review of the facility policy and procedure, Abuse, Neglect or Misappropriation of Property, occurred on 10/13/10. This undated document stated "PURPOSE: The purpose of this policy is to assist all staff in identifying, documenting and reporting suspected abuse . . . This is in response to . . . concern for resident rights. POLICY: . . . The resident has the right to be free from verbal . . . mental abuse . . . Residents will not be subjected to abuse by anyone including . . . other residents . . . III. PREVENTION: . . . 11. Staff will provide for the assessment, care planning, and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as residents with history of aggressive behaviors . . . residents with self-injurious behaviors, residents with communication disorders . . . VI. PROTECTION: . . . 3. For cases of possible resident to resident abuse the resident suspected of abuse will be monitored, assessed and must have a care plan in place that addresses the abusive behavior and those who are abused must be protected from further injury or mental anguish. . . . " - During the initial facility tour at approximately 9:45 a.m. on 10/11/10, a licensed nurse staff member (#8) identified Resident #2 as "very hard of hearing, very impaired visually, very short tempered," and "She wants to die." An interview occurred with Resident #2 at 2:35 p.m. on 10/12/10. Observation showed the resident wearing a hearing aid in her right ear, but	F 250	3. Elopement assessments will be done at the following times: a)on all residents admitted or readmitted to facility, b)with each significant elopement attempt, and c)quarterly with the MDS. Any time that a resident exhibits suicidal inclination a suicide assessment (exhibit19) will be completed and action taken, if necessary. Refer to F 224 for dealing with behavior occurrences. Refer to F 248 regarding measures to assess residents prior to activity outings. 4. QA Plan- Suicide QA monitor will be completed with F tag 224 QA monitor. Elopement QA monitoring will be done with F tag 329 monitor (exhibit 22)	11/17/10

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F 250	Continued From page 17 the resident instructed the surveyor to communicate with her by facing her and sitting very close so she could see and read the surveyor's lips. Once the interview began, Resident #2 openly and freely discussed her visual and hearing impairments, commenting several times throughout the interview, "I can't do anything I used to do, and I should just die," and/or "I'm useless. It would be better if I were dead." Resident #2 explained her hearing loss prevented her from participating in group functions, and made it difficult for her to recognize sounds and the source of sounds. Resident #2 described these situations as, "Confusing noise." Resident #2 also acknowledged she always "had a short temper," and at times had said and done things to others she "was sorry for." The resident described problems with her previous roommate, Resident #9, as a situation where Resident #9 wanted to intentionally annoy and/or anger her, and stated "I think they both [Resident #9 and the nurse on duty/Resident #9's daughter] wanted to get me out of here." Resident #2 indicated as a result of the conflict, Resident #9 moved to a different room and she got a new roommate. Resident #2 indicated she had no problems with her new roommate because, "she is quiet and doesn't have the television going." Resident #2 stated several times she enjoyed visiting on a individual basis, and thanked the surveyor several times for taking the time to talk with her and allow her to express her frustrations. The resident stated at the conclusion of the interview, "Thank you for listening to me."	F 250		

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F 250	Continued From page 18 Review of Resident #2's medical record occurred October 11-13, 2010. The record included an annual Minimum Data Set (MDS) completed 06/23/10 and a quarterly review completed 09/23/10. The assessments showed Resident #2 experienced a significant change in mood and behavior from the 06/23/10 and 09/23/10 reviews. The 06/23/10 review showed Resident #2 exhibited easily altered sad, pained, and worried expressions, and at the time of the 09/23/10 review the resident no longer exhibited the sad/pained/worried expression, but did exhibit the following non-easily altered mood and behavior indicators: persistent anger; and verbally abusive, physically abusive, socially inappropriate, and resistance to care behaviors. The record lacked evidence of further assessment and review of the mood/behavioral changes identified, and included no interventions to minimize/decrease the behaviors exhibited by Resident #2, including consideration of referral and further assessment by a mental health professional, vision and hearing professionals, and/or further clinical assessment. Nurses notes included the following: * 01/20/10 - "Had lengthy conversation with [Resident #2] regarding her hearing and discomfort. . . . She stated x 3 that "I just want to die." Asked if we could increase her medication for depression and maybe she will feel better. . . . agreeable for me to call provider and ask for increase in depression medication. . . ." The record lacked evidence of interventions to address the resident's expressed desire "to die" until physician orders showed an increase in the dosage of Resident #2's Celexa (an antidepressant) on 02/10/10. The record lacked evidence of any other options provided to	F 250		

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F 250	Continued From page 19 Resident #2 regarding her depression other than the increase in medication. * 02/04/10 - "Resident very agitated during the night. She did not sleep at all. Up in hallway with any noise. At 0430 [4:30 a.m.] she was wanting to know whatever [sic] we were doing here and why we were here. 'I don't believe a word you say. Whatever your name is'. Told her my name and she moved to block doorway so we could not care for roommate. She said 'when that old bag gets back here you both go in that room and I will shut the door'. Then she was striking out, slapping, shaking her fist and threatening to hit us with a hanger. . . . She did take her meds [medication] but was suspicious of them. Refused her eyedrops." The record lacked assessment of cause/contributing factors for Resident #2's behavior, and lacked evidence staff implemented interventions to address the resident's inability to sleep, stop/minimize the behavior, and prevent the escalation of the behavior. * 02/04/10 - 4:30 p.m., "Resident very upset and agitated this a.m. Refused breakfast and a.m. meds. Was throwing hangers and hitting multiple staff. Very confused. . . . Did take 4 p.m. pain med. Smiles at staff and states 'I'm sorry'. Gave staff a hug. . . . " * 04/20/10 - "Heard resident hollering . . . found on floor . . . no visible injuries. . . . Resident states, 'Why don't you let me die. Just cut my head off'." * 04/25/10 - ". . . resident stated to staff 'I just want to die'. . . ." * 04/26/10 - "She doesn't feel good, just wants to die. Wanted to know if she could stop all her medications because she just wants to die. Told staff she doesn't have any reason to live. . . ." * 09/20/10 - "1530 - 1630 [3:30 to 6:30 p.m.]	F 250		

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F 250	Continued From page 20 Amb [ambulating] quickly in hallway with walker. Appears very angry. Stopping to tell other residents and staff how upset she is with roommate. [Resident #9] 'I'm not standing for this anymore - I want her out of there. She sits in there day and night reading out loud and it's driving me crazy'. Staff has not noticed roommate reading 'out loud'. Resident encouraged to relax and redirected." The record lacked further assessment of any/other environmental factors contributing to the behavior, i.e., television, radio, voices, etc. the resident may not be able to identify or may be causing the resident distress and/or confusion. "1700 [5 p.m.] Eating supper and slamming utensils down on table." The record lacked evidence of staff intervention. 1715 [5:15 p.m.] Came to station and demanded we call [family members] - notified and informed resident wants them 'up here now'." 1730 [5:30 p.m.] Tried to take T.V. remote away from roommate." The record lacked evidence of staff intervention or further assessment. 1755 [5:55 p.m.] Son here and told resident to relax and nothing can be done and she needs to 'settle down and let it go'! 1810 [6:10 p.m.] Son left and resident followed and continued to voice anger and directing much of anger now at roommates daughter. 1915 [7:15 p.m] Would not allow nurse in her room to care for her roommate. (Nurse is roommate's daughter). Pushed nurse with walker and blocked doorway. Swearing loudly and constantly - raised fist x 2 at nurse and nurse backed up x 2 quickly, truly believing could be hit. RN [registered nurse] on floor to 1920 [7:20 p.m.] and gave [Resident #2] meds. Instructed to stop	F 250		

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F 250	Continued From page 21 now and had her take numerous deep breaths while rubbing her back. Reminded none of this behavior will help her and told has been upsetting entire floor. Instructed that proper way to deal with any problem is to discuss situation. Staff now tells me resident had been swearing and hollering loudly to roommate and other residents earlier. Reminded should talk with manager and social worker in a.m. and try to rest until then. Stated would 'try to hold it in until morning'." The above referenced sequence of events on 09/20/10 showed an escalation of Resident #2's behavior without indication of staff intervention or assessment of the circumstances causing the behavior and measures taken to prevent the escalation of the behavior. The record lacked evidence of an assessment of the roommate's television volume, an opportunity to resolve the issue to the satisfaction of both residents, and an opportunity for Resident #2 to voice her feelings early on and receive assistance in resolving the issue(s) in a manner the resident found fair, reasonable and representative of the individual self worth of both residents. Social services notes included: * 09/22/10 - "Resident had a behavior incident Monday evening 9/20 (see nurses notes)). Yesterday I visited with resident in presence of her dgt.[daughter] . . . to ask her what had gone on the night before. She said that roommate was reading very loudly and that she wondered what was going on. She denied touching roommate's TV or TV remote. This resident quickly became agitated. When relating what had happened the night before she seemed to be jumping to many conclusions that were erroneous. She did a lot of swearing. She would not listen to reason by either her dgt. or myself. At first she said 'she be	F 250		

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F 250	Continued From page 22 damned if she was going to move but later told me to find her a room and she'd 'get the hell out of there'. Her agitation just continued to escalate. She would not listen to her dgt. or myself. . . . She said that roommate was probably reading aloud to make her mad and drive her out of the room so roommate could have the room to herself. . . . Resident was insisting she would no longer listen to me . . . resident went to her room and dgt. left the building. A little later resident went to 2nd floor on her own telling that staff that she needed to get away from 3rd floor and all that was happening. . . . Later 09/22/10 resident came to my office and said she wanted to apologize for yesterday and I accepted. But as soon as I tried to explain that her roommate had a right to watch TV she immediately started becoming agitated, raise her voice, arguing. I tried to calm her back down but she again insisted she had done nothing wrong, etc. She did a lot of talking but not much listening and then left." * 09/28/10 - "Roommate continued to say that resident continued to give her a bad time about watching TV. Roommate chose to move to another room. . . " The above referenced nursing and social services notes failed to represent a nonconfrontational approach in responding to Resident #2's behavior, complaints regarding roommate, and apologies to staff. The resident's plan of care included the following: "Problem [dated 07/13/10] Others notice that I seem depressed, anxious and irritable at times (sometimes I notice it too). Approaches: 1. Help keep my routine as stable as possible. I don't handle change well. 2. Noise bothers me, so please keep that in mind around me and my room. 3. I agree to take an	F 250		

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F 250	Continued From page 23	F 250		

antidepressant as ordered. 4. If I am anxious or irritable help me work through it. I usually calm down and even apologize after a while. 5. I am impatient, so the sooner you can deal with me the better."

The plan of care, as well as the medical record, lacked planned approaches for identifying causative/precipitating factors contributing to Resident #2's behavior, proactively monitoring and responding to identified/known contributing factors/causes for the resident's behavior, and specific planned approaches to prevent the escalation of the behavior.

During an interview on the afternoon 10/13/10, a dietary management staff member (#9) indicated at the time of the quarterly MDS review completed 09/23/10, Resident #2 indicated both her hearing and vision had worsened. Facility staff failed to address the decline Resident #2 identified with her hearing and vision, failed to evaluate/assess the impact the sensory declines had on the resident's mood/behavior, and failed to consider further evaluation of the resident's hearing and vision by qualified professionals.

For information regarding Resident #9, refer to F224.

During interview, on 10/13/10 at 10:40 a.m., a social services management staff member (#3) reported she was not aware of the Nursing Notes identifying Resident #9's inability to relax and stress related to Resident #2's behaviors towards her. This staff member reported she talked to Resident #2 regarding her behaviors towards Resident #9. The staff member (#3) confirmed Resident #9's care plan lacked any information

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F 250	Continued From page 24 identifying a conflict with Resident #2 and approaches to protect Resident #9 from further mistreatment or abuse by Resident #2. - Review of Resident #8's medical record occurred on October 12-13, 2010 and identified admission to the facility on 02/10. Medical diagnoses included depression and Alzheimer's disease. Medications included Zoloft (an antidepressant) 50 milligrams (mg) every day. Resident #8's significant change MDS, dated 04/12/10 (the last day of the observation period), identified a short term memory problem, indications of depression, anxiety, or a sad mood exhibited up to five days a week and identified Resident #8 made negative statements, persistent anger with herself or others, insomnia or a change in her usual sleep pattern, crying and/or tearful, and repetitive physical movements. Review of Resident #8's nursing notes identified the following: * 04/02/10 at 4:00 p.m. - ". . . [resident name] upset as wanted [name] to take her home. Crying [after] she left but told [name] 'Do you want me to commit suicide? That's what will happen you know.' . . ." * 04/04/10 at 4:00 p.m. - "Talking about going home again - Has suitcase out & [and] has been packing . . ." * 04/05/10 at 4:00 a.m. - "Talks about wanting to go home . . ." * 04/05/10 at 11:15 a.m. - ". . . Resident became very upset and & said , 'she had no right to go in my purse. She is the cause of all this, all I want to do is go home . . . I guess I'm going to have to get a lawyer & straighten this all out.' Resident hung her head & became teary & said, 'I should just	F 250		

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F 250	Continued From page 25 commit suicide.' Reassurance given . . . Resident was out to nurses station in a couple minutes [without] walker . . . hands have slight tremors . . . Resident again voiced 'I could just commit suicide if I'm such a bother & then I wouldn't be a bother in their lives anymore.' Resident hung head again . . ." * 04/13/10 at 9:00 a.m. - "Left on pass [with] activity staff for an outing for the day . . . 1640 [4:40 p.m.] Returns from pass [with] activities per walker." Review of the social progress notes and evaluation identified the following: * 04/05/10 - "Earlier this AM [sic] Resident's dgt-in-law [daughter in law] reported to me that Resident was asking her to take her home last Fri. [Friday] (4/2) [04/02/10]. When dgt-in-law told Resident that she couldn't do that, Resident reportedly told [name] that she would commit suicide. Today Resident's personal possessions are packed in bags in her room . . . She again voiced something about committing suicide if she couldn't go home . . . Resident threatening to kill herself/commit suicide when talking to [name] . . . I only had time to check her purse . . . for sharp objects. I removed pencils, pens & 2 nail files. All other possessions were bagged up . . . Staff are keeping an eye on resident for any suicide attempts. [name] RN [registered nurse] attempting to contact [doctor name] . . . provided transportation to [name of hospital] . . ." * 04/09/10 - "Resident returned to NF [nursing facility] yesterday . . . Is pleasant & smiling . . ." * 04/13/10 - ". . . She has seemed very cheerful since her return from [name of hospital]. Today is on pass to [name of casino] [with] other residents & activity staff . . . Resident was not started on any new meds [medications] while hospitalized.	F 250		

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F 250	Continued From page 26 She remains on Zoloft." Review of Resident #8's care plan stated "Problem/Concern - [date initiated 04/05/10 and discontinued 05/18/10] suicidal thoughts R/T [related to] recent move into facility & wanting to go home . . . Approaches - Assess, document & report to provider PRN [as needed]. Assess potential for harm to self &/or others. Remove all potentially harmful items from room . . ." During separate interviews on the morning of 10/13/10, the nurse manager (#2) and the social worker (#3) both stated Resident #8's medical record lacked an assessment to determine her mental state regarding suicidal and elopement risks prior to her all day outing with other residents and the activity staff on 04/13/10. Failure of facility staff to assess Resident #8's potential for harm to herself and/or to others and to assess the potential for elopement placed Resident #8, the other residents on the outing, staff members, and the general public at risk for harm and/or injury.	F 250	F- tag 274 1. Updated care plan to reflect the problems of vision and hearing loss. Developed additional approach to deal with mood and behavior problems (exhibit 1) 2. All residents with comprehensive MDS's completed that have two or more areas of change need a significant change of condition completed. 3. When there are two or more significant changes on the MDS, a significant change of condition will be completed or if a significant change of condition was not done, documentation will be done in chart as to why not. 4. QA process for significant change of condition will be done on 20% of the monthly MDS's for two months. (exhibit 20)	11-22-2010
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than	F 274		

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F 274	Continued From page 27 one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to complete a comprehensive assessment for 1 of 4 sampled residents (Resident #2) following a significant change. The lack of completion of a comprehensive assessment following a significant change in mood/behavior experienced by Resident #2 did not allow the resident the opportunity for complete assessment of the cause/reason for the change in mood/behavior, and did not, based upon the comprehensive assessment, provide the resident the opportunity for consideration of referral and further assessment by a mental health professional, hearing/vision professionals, further clinical assessment, etc. Failure to assess the contributing factors/causative reasons for Resident #2's depression and verbally abusive behavior did not allow the resident the opportunity for improved mood/behavior. Findings include: Review of Resident #2's medical record occurred October 11-13, 2010. The record included an annual Minimum Data Set (MDS) completed 06/23/10 and a quarterly review completed 09/23/10. The assessments showed Resident #2 experienced a significant change in mood and behavior between the 06/23/10 and 09/23/10 reviews. The 06/23/10 review showed Resident #2 exhibited easily altered sad, pained, and worried expressions, and at the time of the	F 274		

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F 274	Continued From page 28 09/23/10 review the resident no longer exhibited the sad/pained/worried expression, but did exhibit the following non-easily altered mood and behavior indicators: persistent anger, and verbally abusive, physically abusive, socially inappropriate, and resistance to care behaviors. The record lacked evidence the facility completed a significant change comprehensive MDS assessment. Nor, did the record show evidence the facility recognized Resident #2's significant change in mood and behavior, and determined/identified the reason/basis for not completing a significant change comprehensive assessment.	F 274	F- 329 1. The medication for resident # 4 was discontinued on 10-13-2010. (exhibit 21) 2. All residents that are admitted or re-admitted will have their medications reconciled for accuracy. If any questions arise the provider on call will be notified for clarification. 3. Re-education of the staff will be done on the medication reconciliation policy on 11-22-2010. 4. A QA process will be done on the next four admissions or readmissions to ensure proper medication reconciliation has occurred. (exhibit 22).	11-22-2010
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		

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This REQUIREMENT is not met as evidenced by:
Based on record review, review of professional reference, and staff interview, the facility failed to ensure the drug regimen for 1 of 1 sampled resident (Resident #4) receiving antipsychotic (Zyprexa) and antiparkinsonian (Sinemet) medications, remained free of unnecessary drugs used without adequate indications for use and used in the presence of adverse consequences. Failure to ensure Resident #4's drug regimen remained free of unnecessary drugs placed him at risk of increased rigidity and reduced swallowing ability.

Findings include:

Nursing 2009, "Drug Handbook," 29th edition, Lippincott, Williams, and Wilkins, Philadelphia, states
pages 635-637, "Levodopa and Carbidopa (Sinemet), antiparkinsonian . . . ADVERSE REACTIONS, CNS [central nervous system]: . . . dyskinetic movements . . . myoclonic body jerks . . . dementia . . . INTERACTIONS, Drug-drug. . . . Phenothiazines, other antipsychotics: May antagonize antiparkinsonian actions. Use together cautiously. . . .;" and,
pages 663-666, "Zyprexa, antipsychotic . . . ADVERSE REACTIONS, CNS: . . . parkinsonism . . . tremor . . . INTERACTIONS, Drug-drug. . . . levodopa. May cause antagonized activity of these drugs. Monitor patient. . . ."

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F 329	Continued From page 30 Review of Resident #4's medical record occurred on October 11-13, 2010. The facility admitted the resident in 08/09. Current diagnoses included dementia with behaviors and depression. The facility admitted the resident to an acute care hospital September 26-October 06, 2010 for pneumonia. The resident's annual Minimum Data Set (MDS), dated 07/23/10, identified short and long term memory problems, moderately impaired daily decision making, verbally abusive behaviors one to three days out of the seven day assessment period not easily altered, deteriorated behaviors, walking did not occur, required limited assistance of one person for eating, and identified swallowing problems. Resident #4's medical record included a physician's progress note, dated 08/11/10, which stated ". . . HISTORY . . . We are also concerned about the use of his Zyprexa. This was started on him for some behavioral and emotional issues and this seems to be doing well but he is having increased side effects from this. He does have increased tremor. He was started on Sinemet to see if this would make a difference and it does not appear to be making much of a difference. I discussed this with [Resident #4] and his POA [power of attorney] and we are going to be stopping the Sinemet. We are also going to decrease his Zyprexa to 1.25 mg [milligrams] p.o. [by mouth] q. [every] day. . . . ASSESSMENT . . . We did have cogwheel rigidity and this is one of the side effects of Zyprexa (Parkinsonism). We may actually be stopping the Zyprexa in the near future but we will see how he does." Resident #4's physician orders, dated 08/11/10, stated "[Change] Zyprexa to 1.25 mg q day. D/C [Discontinue] Sinemet. The resident's medication	F 329		

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F 329	Continued From page 31 administration record (MAR) identified the facility staff provided the lowered dose of Zyprexa and discontinued the Sinemet. Resident #4 was hospitalized on 09/26/10 and returned to the facility on 10/06/10. The physician's medication orders on that date included "Zyprexa 2.5 mg (1) q. H.S. [bedtime]" and "Sinemet 25/100, 1, (o) [orally] TID [three times each day]." The resident's MAR identified the facility staff provided these medications as ordered after 10/06/10. During interview, on 10/13/10 at 12:40 p.m., a supervisory nursing staff member (#2) reported facility staff identified the change in Zyprexa and resumption of Sinemet at the time of Resident #4's return to the facility. This staff member reported facility staff contacted the resident's POA, who indicated "O.K. to try it." The staff member (#2) reported the facility staff failed to bring the change in medications to the physician's attention. The medical record lacked evidence of discussion with the POA or physician regarding the medication changes. The staff member (#2) reported a health care provider extender reduced Resident #4's Zyprexa and discontinued the Sinemet on 10/13/10, at the POA's request. This staff member did not provide a rationale why the POA requested the change in medication. Observation throughout the survey identified Resident #4 demonstrated inability to bring food to his mouth with limited movement ability and jerking type movements. The resident received ground meats and soft foods and demonstrated coughing during all meals. During observation of	F 329		

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F 329	Continued From page 32 standing in Restorative Therapy, on 10/13/10 at 9:53 a.m., the resident demonstrated instability and some jerking type movements in the trunk and lower extremities. It is unknown if the coughing, jerking type movements, and limited ability to bring food items to his mouth are increased from previously or the result of the increase in medications. The facility staff and the physician identified Resident #4 experienced negative side effects from the medications and reduced or discontinued the medications on 08/11/10. The facility staff identified the physician orders of 10/06/10 resumed the medication and at the higher dose. The facility staff failed to contact the resident's physician to determine if the physician intended to resume the Sinemet and increase the Zyprexa, despite the negative side effects. The discontinuation and dose reduction of 10/13/10 occurred at the request of the resident's POA. Failure to ensure Resident #4's physician was aware of the change of medications on the resident's return to the facility placed the resident at risk of experiencing negative side effects, including cogwheel rigidity previously identified by the physician on 08/11/10. Resident #4 may have experienced an increase in side effects with the resumption of the medications.	F 329	F- 333 1. The self medication assessment form was completed on resident #12 on 7-27-2010 and again on 10-12-2010 and for resident # 13 it was completed on 10-13-2010. They both show they are able to self administer medication while on pass. (exhibits 23, 24, 25) 2. Any resident that goes on an outing and requires a hand held nebulizer treatment will be assessed for the ability to do self medication of the nebulizer medication. 3. We have purchased a converter for the HHN machine that makes them portable and therefore can be used on an outing. This can be used in the van to protect the privacy of the residents condition. Education of the staff will be as listed in the F-tag 248 on 11-22-2010., 4. The QA process is part of the QA process mentioned in F tag 248, see QA form.	11/22/2010
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by:	F 333		

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F 333	Continued From page 33 Based on observation, record review, review of a professional reference, resident interview, and staff interview, the facility failed to send scheduled respiratory medications with 2 of 2 supplemental residents (Resident #12 and #13) who left the facility with facility staff for a seven and a half hour trip to a casino. Failure to ensure the administration of all resident medications, including respiratory medications, has the potential to cause respiratory distress related to a restrictive airway. Findings include: Taylor, Lillis, and LeMone, Fundamentals of Nursing, The Art & Science of Nursing Care, 4th ed., Lippincott, Philadelphia-New York-Baltimore, 2001, page 109, stated, "Nurses are legally responsible for carrying out the orders of the physician in charge of a patient unless an order would lead a reasonable person to anticipate injury if it were carried out." Page 627-629 stated, "Omitted Drugs: Drugs may be omitted intentionally or inadvertently. The omission and the reason for it are documented on the patient's record . . . Medication Errors: Nurses should take every precaution to avoid errors when administering therapeutic agents. Common types of medication errors include the following: . . . Extra, omitted, or wrong doses . . . Prompt acknowledgment of errors may minimize their possible detrimental effect. The immediate priority is the safety of the patient. The following steps are recommended when a medication error occurs: . . . Notify the nurse manager and the physician . . . Write a description of the error on the patient's medical record . . ." - Review of Resident #12's medical record	F 333		

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F 333	Continued From page 34 occurred on 10/11/10. Medical diagnoses included chronic obstructive pulmonary disease (COPD) with underlying interstitial fibrosis. Review of the Medication Administration Record (MAR) identified the following, "Duoneb HHN [hand-held nebulizer] [a combination of albuterol sulfate and ipratropium bromide, medications to help open the airway to the lungs]; Inhalation TID [three times a day] (May self-administer) and O2 [oxygen] Humidified - Keep O2 sats [saturation] [greater than] 95 % [percent]." - Review of Resident #13's medical record occurred on 10/11/10. Medical diagnoses included COPD and lung cancer. Physician's orders included albuterol sulfate and ipratropium bromide via HHN four times a day and oxygen - ordered specifically "to keep O2 sats at 90% or greater, may try to be off O2 when at rest." Review of Resident #13's care plan identified the following problems: * "I need help with some of my cares . . . I will need help with my O2 machine getting to & [and] from my room, meals & activities (if I need O2)" * "COPD . . . Give my medications that the Doctor has ordered. Make sure I have my oxygen when I need it. Watch my oxygen levels. Monitor for me being short of breathe [sic] . . ." Observation on 10/12/10 at 9:00 a.m. showed Resident #12, #13, and four other residents left the facility for an outing to a casino accompanied by two activity staff members. The nurse (#6) failed to send oxygen and Resident #12's and #13's scheduled HHN treatments (Resident #12 scheduled for 12:30 p.m. and Resident #13 scheduled for 10:00 a.m. and 4:00 p.m.). The residents returned to the facility at 4:40 p.m.	F 333		

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F 333	Continued From page 35 On 10/12/10 at 4:50 p.m., an unidentified staff member checked Resident #12's oxygen saturation because she appeared short of breath and observation showed an oxygen level of 91%, below the physician's order "keep O2 sats [greater] than 95 %." During an interview at 5:00 p.m., Resident #12 stated staff has never taken oxygen or HHN treatments along on outings. During an interview on 10/12/10 at 2:00 p.m., an administrative nurse (#1)stated she was unaware Resident #12 and #13 missed scheduled HHN treatments while on the outing. Failure of facility staff to send medications and oxygen with Resident #12 and #13 when facility staff knew they would be gone for seven and a half hours placed these residents at risk for respiratory distress and/or failure.	F 333		