STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355036	A. BUILDING _____ B. WING _____	01/29/2015

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MARIAN MANOR HEALTHCARE CENTER	604 ASH AVE E GLEN ULLIN, ND 58631

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on January 26, 2015 and completed on January 29, 2015 the sample included 4 residents for complete review, 9 residents for focused review, and 2 closed records for review.	F 000		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy, and staff interview, the facility failed to ensure 1 of 9 sampled residents (Resident #10) reviewed with pain received the necessary services for comfort. Failure to provide and evaluate the effectiveness of pain management measures for Resident #10's recurrent verbal reports of pain resulted in the administration of frequent unscheduled pain medications and limited the ability to determine the causative factors for the pain which may affect the resident's quality of life. Findings include: Review of the facility "PAIN MANAGEMENT POLICY" occurred on 01/29/15. The policy, undated, stated:	F 309	Plan of Correction for 2015 Survey **F309:** It is the policy of Marian Manor HealthCare Center (MMHCC) to assure that resident #10 from the survey roster and all residents will have the necessary care and services to attain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. In regards to resident #10 and his pain management the following was put in place and /or ordered: 1. Between shift changes on days and pms on 01/29/15 several Nurses were visited with by DON (director of nursing) and informed of the concern with resident #10. Nurses informed DON that they would offer the APAP #3 (Tylenol with codeine) but often resident would refuse and requested regular APAP (Tylenol). DON informed nurses that the documentation is not there to support that therefore if not documented it isn't done. Teaching was done verbally by the DON to those nurses at that time if the pain level for resident #10 is moderate to severe to offer the stronger analgesic for pain management and if resident refuses the stronger medication to document as to why it was refused.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
LoreHa Dewing RN	Director of Nursing	02-19-15

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 309	Continued From page 1 "Philosophy: "(Facility) commits to the individual right of residents to be able to function at their optimum level without debilitating pain or undue suffering. . . . Policy: All residents have the right to . . . optimum pain management. All residents will be assessed for presence or absence of pain. All residents have the right to expect a quick response to reports of pain. . . . Procedure: . . . Ongoing pain assessment will be done quarterly with MDS [Minimum Data Set] review or sooner if necessary. . . . a) a numeric scale . . . is used with residents able to communicate. . . . Complete a pain assessment . . . a) Upon admission of resident of any resident with a diagnosis or medication related to pain. b) If a resident receives a change in analgesic . . . c) With a report of new pain. . . 5. Implement a pain management plan of care and goals. Evaluate effectiveness on a continuous basis . . . Pharmacological as well as non-pharmacological measures will be considered. . . ." - Review of Resident #10's medical record occurred on January 28-29, 2014. Admission occurred in May 2014. Admission diagnoses included osteoarthrosis, degenerative disc disease, and pain. An admission MDS, dated 05/27/14, quarterly MDSs dated 08/14/14 and 11/13/14, identified Resident #10 on scheduled pain medication, PRN (as necessary) pain medication, and non-medication interventions for pain. Both the 05/27/14 and 08/14/14 MDS identified the numeric pain scale (on a scale of 1-10) as a 7, and the 11/13/14 identified the numeric pain scale as a 10. The quarterly MDSs, dated 08/14/14 and	F 309	A message was also sent out 01/29/15 through ECS (electronic charting system) in regards to the concerns with pain management for Resident #10 (a copy is enclosed noted as Copy #1). With ECS when a nurse signs in for her shift the message pops up for them to review. 2. On 01/30/15 resident #10's provider visited with him in length as to why he wouldn't take the stronger analgesic when offered. • After much discussion with provider, resident did agree to take a routine analgesic in hopes to reduce the use of the PRN (whenever necessary) analgesics (copy of those orders-noted as copy #2- along with the nurses notes(NN)-noted as copy #3 are enclosed). Tylenol #3 300/30mg ½ tab BID (twice daily) was ordered as well as pain assessment completion for 2 weeks (copy of pain assessments enclosed –noted as copy #4 & has 3 pages). • PRN analgesic use has lessened: see enclosed copies of MAR (medication admission record) & NN from 01/30/15 through 02/16/15 (this information is stapled together and noted as copy #5 & has 9 pages).	

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F 309	Continued From page 2 11/13/14, identified the pain as almost constant and affecting function with activities. The Care Area Assessment (CAA) for the admission MDS, dated 05/27/14, triggered the pain CAA. The assessment stated "Resident has limited day-to-day activity because of pain over past 5 days . . . Pain numeric intensity rating has a value from 7 to 10 . . ." The CAA identified the resident took APAP (Tylenol, used for mild pain) 650 milligrams (mg) two times a day (bid), scheduled for 8:00 a.m. and 8:00 p.m. The CAA identified the resident as having headache ("resolved with prn analgesic"), hip pain ("goes to chiropractor this afternoon"), and achy shoulders and lower back. Review of quarterly MDS notes stated the following: * 08/15/14: ". . . BEHAVIOR . . . no complaint except pain, and muscle cramps/spasms. Family has had success with Mg [magnesium] Citrate for pain and sleep. . . PAIN . . . most of pain is his back, neck and shoulders. He will also c/o [complain of] hip pain and has quite frequent headache complaints. He is on Magnesium Citrate and this is to help make muscle relax, ease pain and help him rest. He likes to have the Biofreeze daily in the evening. He said once he has his sleeping pill he does not wake from his pain. He told me ice and heat does not work for him. He agreed to see . . . our chiropractor who comes out weekly . . . intermittent massages from a local massage therapist. . . . received APAP 650 mg Bid. PRN [as necessary] APAP was used 14x [times]/June, 23x/July, and 12x in August [through 08/15/14]. . . ." * 11/14/14: ". . . most of his pain is his headaches, neck and right hip. . . He receives APAP 650 mg	F 309	• Resident was hospitalized from 02/02/15 and returned 02/12/15 (see page 6 of copy 5 for further information) and is receiving comfort care as condition is terminal. Pain is being managed with routine Analgesics ordered and PRN analgesics. 3. In-service with Nurses was held on 02/11/15 at which time the updated "Pain Management Policy" was reviewed. A Pain Management tool was also reviewed from the Quality Improvement Organizations & this tool was placed in each wings chart back for nurses to refer to for suggestions. It was stressed at the in-service the importance of looking at PRN pain med use and if PRN's are being used often to make note for provider to review for other options/interventions. Provider also informed DON that she also will be reviewing PRN pain med use with her rounds and/or updates from nursing and will probably be ordering more pain assessments to help her determine what needs to be done to better manage residents' pain concerns (Refer to Nurse's In-service packet noted as Copy #6). 4. In ECS the following was added: when the nurses tab PRN Analgesics for charting, a reminder pop up screen appears & asks to "chart non-pharmacological interventions tried".	

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F 309	Continued From page 3 Bid. PRN APAP was used 29x in August, 25x/September, 35x October and 13x so far in November. . . . PT [physical therapy] did evaluate for using a Ten's [a non-invasive treatment for pain] unit but he refused this . . ." Review of PT notes identified the following: * 07/10/14: ". . . did cite pain in R [right] hip and low back when up and walking. . . ." * 09/18/14: ". . . has been refusing RT [restorative therapy] ambulation citing sore back or knee and often stomach issues. . . ." * 10/14/14: ". . . he informed me he tried electrical stimulation before at the chiropractor and it didn't work. . . . I explained that it would benefit him to complete some exercises to decrease stiffness and pain from his extremities. He said he would just continue with the Tylenol." * 12/11/14: ". . . he did finally agree to a trial [of the TENS unit] . . ." The resident stated on the following day he thought the TENS unit was helping his knee. A physician's progress note, dated 11/20/14, stated ". . . He mentioned having a headache today which is localized over the occipital region. This comes off and on. He rated this as 10/10 as per the patient. It was recommended to have TENS unit in the recent past, which he has declined. . . . I counseled the patient to begin using TENS unit. I will also start the patient on Tylenol 3 [APAP with codeine] [pain medication used for moderate pain]. If pain persists, we will get CT [computerized axial tomography] scan of brain and brain stem. . . ." Resident #10's current care plan identified the problem of pain "alteration in comfort and mobility . . . related to: arthritis . . . Osteopenia . . .	F 309	5. The following will be the Quality Assurance (QA) Monitoring that the DON will conduct to assure Pain concerns are being addressed: • Are Pain assessments continuing to be conducted according to policy and/or as ordered? • The DON will also randomly review residents for PRN pain med use, will note any concerns & review those with the resident's Resident Care Coordinator (RCC) and report concerns to the provider. • With monitoring the PRN pain med use, the DON will also monitor if follow-up documentation is being done (e.g. was med effective in relieving pain). If it was feasible, were non-pharmacological interventions tried before PRN pain med given. • Frequency of QA monitoring: Weekly for one month-02/02/15 through the week of 02/023/15(that is 4 full weeks). Monthly for three months (March-April-May 2015) and then quarterly (August & November 2015) with QA monitoring completed November 30, 2015. If concerns are noted with the monitoring immediate corrective action will be taken (e.g. teaching with nurses involved).	

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F 309	Continued From page 4 Manifested by . . . Communication of pain description, headaches . . . backaches . . . hip, neck, & rib pain, knee . . ." Approaches included the administration of pain medications . . . "Consult Dr. [doctor] if not getting adequate pain relief. . . ." The care plan included non-pharmacological interventions of holistic medications/vitamins from a chiropractor "supplied by family." Refused TEN's unit use . . . Tiger Balm Ointment at bedside PRN to temples and neck for headaches . . . Chiropractor . . . massage therapist as desires . . . massage areas of discomfort, attempt distraction, position changes. Analgesic balm, heat or cold not effective . . . back rubs PRN . . ." Current pain medications included PRN Acetaminophen (APAP) 650 milligrams (mg) every four hours as needed (order dated 05/20/14); and APAP with codeine 300/30 mg every six hours as needed for pain (order date of 11/20/14). Current medications also included a sleeping pill of Zolpidem scheduled for every evening and with the provision of repeating once between 2:00 and 4:00 a.m. if needed. The medication administration record (MAR) showed the facility assessed Resident #10 for self administration of routine (scheduled) medications "after set up by charge nurse without nurse observation." Resident #10's record showed he received a scheduled dose of APAP 650 mg bid beginning 05/20/14 and discontinued 11/20/14. On 11/20/14, the provider ordered APAP with codeine PRN. Review of the November MAR showed Resident #10 received a total of 25 doses of PRN APAP; and two doses of PRN APAP with codeine. In December, nursing staff administered 37 doses	F 309	• The DON will submit a report of the deficiency at the next QA meeting only and the monitoring results to the QA Committee at each scheduled quarterly meeting through November 30, 2015 (Next quarterly QA meeting is tentatively set for April 20, 2015). In the absence of the DON and monitoring is due to be conducted, it will be done by an RCC. (copy of QA monitoring for weeks of 02/02 and 02/09/ and thus far for 02/16, 2015 are enclosed with packet noted as Copy #6)	03/5/15

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F 309	Continued From page 5 of PRN APAP; and 21 doses of PRN APAP with codeine. In January nursing staff administered 28 doses of PRN APAP; and 15 doses of PRN APAP with codeine, through 01/27/15. Review of Resident #10's MAR for the prn APAP between October 2014 through January 27, 2015 showed nursing staff administered the APAP for reasons including headache, neck, shoulders, knee, right hip, left thigh, and back pain with pain ratings varying from moderate (4-5-6) to severe (7-8-9-10). The entries included the following: * 10/07/14 when the resident obtained no relief from APAP two hours after the administration, the nurse noted, ". . . informed that it is too early to re-medicate. Offered ice or cold compress to area [for headache], he declined. Back to his bed to rest." * 11/05/14, when Resident #10 received APAP with results of "improved but not resolved [pain]" the nurse wrote "-gets routine acetaminophen 650 mg with breakfast." Four hours after that morning scheduled APAP, the nurse noted "[moderate to severe headache] not resolved, rests much of the time on his bed, is able to nap well throughout the day." * 11/11/14 for severe pain in the neck and headache "Med [medication] ineffective requested another dose of tylenol [APAP]. Will give in 30 min. [minutes]" * 12/29/14 in the afternoon: Medicated with APAP for severe headache, with medication results noted of "Med ineffective - unchanged, res. [resident] says, 'It's not any better.' Refuses offer of ice pack to neck/head. Lying in bed at this time." * 01/05/15 in morning into the early afternoon: Medicated with APAP with codeine for severe pain "in 'back of head,' feels like it is going to split	F 309		

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F 309	Continued From page 6	F 309		

open." Reassessment in 1.5 hours stated, "Not a bit better." Four and a half hours later the nurse wrote, ". . . unchanged states, 'It's no better.' Resident teaching done re: [regarding] smoking and constriction of blood vessels that adds to his frequency of headaches. No comments made by resident."

After 11/20/14, when the provider discontinued the scheduled APAP, nursing staff administered more monthly doses of PRN APAP, and APAP with codeine (see frequency as noted above). The PRN MAR showed inconsistency of the use of the APAP verses APAP with codeine in relation to the residents reported pain level. (i.e. APAP given for severe pain on occasions, and APAP with codeine given for moderate pain on occasions)

During interview on the afternoon of 01/28/15, a provider (#3) and supervisory nurse (#4) stated they did not believe Resident #10 is having as much pain as he verbalizes. The nurse attributed this to the resident can get up and go out to smoke when having the pain, will request which pain medication he wants, has refused the scheduled medication, and may wait a half hour before taking the pain medication after given. The nurse stated the resident has refused the TENS unit and chiropractor, but does get a massage one time per week. The provider stated Resident #10's family does not want him "snowed" and stated there could be more side effects to stronger medications, including constipation. The provider, when reviewing the PRN MAR, stated a review of the time of day staff administers the PRN med given should occur. Neither the provider nor nurse could account for why the scheduled APAP was discontinued.

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F 309	Continued From page 7 During interview on 01/29/14 at 9:00 a.m., an administrative staff nurse (#1) agreed if a resident verbalizes having pain then they should be provided effective measures to relieve that pain. The nurse stated not providing effective measures to control pain could affect that resident's involvement in activities, sleep and quality of life.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide adequate supervision and assistive devices necessary to prevent accidents for 3 of 10 sampled residents (Resident #2, #6, and #12) who required assistance with transfers. Failure to apply the shin strap on a stand lift (Resident #2); failure to use a stand lift when indicated (Resident #6); and failure to use the appropriate assistance as indicated (Resident #12) placed the residents at risk of accidents and injury and resulted in falls for Resident #6 and #12. Findings include:	F 323	**F323:** It is the policy of MMHCC to assure that residents receive adequate supervision and assistance devices to prevent accidents. This tag is in relation to the Plan of Care (POC) and/or Activity of Daily Living Tasks (ADL'S) not being followed by the Certified Nurse Assistant (CNA) with transfer tasks thus causing a fall(s) for Residents #6 & #12 (falls noted were without injury) and increasing the risk of a fall & potential injury for Resident #2. On 01/28/15 with the exit report provided for that day to the DON by a surveyor, the concerns noted with Resident #2 and Resident #12 were voiced to the DON. No transfer concerns with Resident #6 were voiced to the DON on 01/28/15 but were voiced on 01/29/15 with the pre-exit report. The following was put in place on 01/28/15 & 01/29/15 to assure that ADL'S are followed with transfers for all the Residents (this includes Residents #2, #6, & #12 from the survey sample) in order to maintain residents' safety & prevent accidents.	

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F 323	Continued From page 8 Review of the facility policy titled "E-Z Stand Operating" occurred on 01/29/15. This undated policy stated, "Objective: To provide safe transfers. . . . Procedure: . . . 7. Have resident place feet . . . on platform and position their shins into the shin forms. NOTE: use Velcro belt provided for legs if necessary for safety of resident. . . ." - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included organic brain syndrome, anxiety, and epilepsy. Resident #6's quarterly Minimum Data Set (MDS), dated 10/29/14, identified extensive assistance of two or more people for transfers. The current care plan stated, "PROBLEM: Alteration in mobility with a potential for falls . . . APPROACH . . . see current ADL's [activities of daily living] for transfers and mobility . . ." Resident #6's current Certified Nursing Assistant (CNA) ADL door card stated "TRANSFERS: if more or less staff are needed than what is on the door card/care plan, or the need to go from stand to lift you need to get the nurse to assess before the transfer can be made TRANSFER WITH: EZ stand [sit to stand lift] with extensive assist of one . . ." A nurse's note, dated 10/16/14 at 3:24 p.m., stated, "INCIDENT TYPE: observed on floor DATE OF INCIDENT: 10/16/2014 TIME OF INCIDENT: 03:00 PM TIME OF DAY: evening shift LOCATION: resident's room MENTAL STATE: alert normal ACTIVITY AT THE TIME: transferring EQUIP. [equipment] INVOLVED: wheelchair, recliner TRANSFER BELT USED: yes . . . DESCRIBE THE INCIDENT: CNA [name	F 323	1. A note was placed in the CNA and nurses dept. communication notebook on 01/28/15 & on 01/29/15 after our exit review with the survey team addressing the transfer concerns (copy of the 01/28/15 & 01/29/15 note is enclosed and is in the packet noted as Copy #7). 2. In-service with the CNAS was held on 02/11/15. The concerns noted with F Tag 323 were reviewed (Copy of the in-service notes addressing this is enclosed and is in the packet noted as Copy #7). Also note that the nurses were also made aware of this concern with their In-service as the CNA in-service notes are always attached to the nurses' in-service notes for them to review. 3. The following will be the Quality Assurance (QA) Monitoring that the DON will conduct to assure the ADL task for transfers is being followed. • The DON will randomly observe residents transfers (this includes Residents #2, #6, & #12 from the survey roster) to assure that the ADL task for transfers is being followed as careplanned. Concerns with these observations will be immediately addressed by the DON with the CNAS involved.	

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F 323	Continued From page 9 of CNA] summoned staff to room. Resident observed sitting upright on his buttocks on the floor with his back against the recliner. She reports that she was transferring resident from his recliner to w/c [wheelchair] via pivot and as resident reports 'my feet gave out' and did not accomplish transfer, causing him to slide down the recliner to the floor. Resident laughing. No injuries noted. . . . TEACHING DONE: staff reminded to use EZ stand only for transfer for this resident . . ." A nurse's note, dated 11/13/14 at 4:08 p.m., stated, "INCIDENT TYPE: fall witnessed DATE OF INCIDENT: 11/13/2014 TIME OF INCIDENT: 03:35 PM LOCATION: resident's room MENTAL STATE: normal alert oriented ACTIVITY AT THE TIME: transferring EQUIP. INVOLVED: none TRANSFER BELT USED: yes . . . DESCRIBE THE INCIDENT: CNA [name of CNA] was transferring Resident #6 from his recliner to his wheelchair. She began to hook him up to the EZ stand but Resident #6 told her 'don't bother with that, I'll just stand' (Resident #6 told me this himself). She did transfer with a transfer belt and pivot transfer and the wheelchair brakes were locked but as he began to turn the brake loosened and he started to go down slowly to the floor. She called for assist but none came immediately so she lowered him slowly to the floor. Resident was not injured and did not bump his head. . . . TEACHING DONE: I did visit with both the CNA and resident and reminded them that it is on resident's ADL's to always use the EZ stand (due to unpredictability of his transfers), also note placed in staff communication book to remind them. . . ." Failure to transfer Resident #6 with an EZ stand	F 323	• Frequency of QA monitoring: Weekly for one month-02/02/15 through the week of 02/023/15(that is 4 full weeks). Monthly for three months (March-April-May 2015) and then quarterly (August & November 2015) with QA monitoring completed November 30, 2015. If concerns are noted with the monitoring immediate corrective action will be taken (e.g. teaching with CNAS involved). The DON will submit a report of the deficiency at the next QA meeting only and the monitoring results to the QA Committee at each scheduled quarterly meeting through November 30, 2015 (Next quarterly QA meeting is tentatively set for April 20, 2015). In the absence of the DON and monitoring is due to be conducted, it will be done by an RCC. (copy of QA monitoring for weeks of 02/02 and 02/09/ and thus far for 02/16, 2015 are enclosed with packet noted as Copy #7)	03/05/15

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	355036	A. BUILDING _____ B. WING _____	01/29/2015

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according to his care plan resulted in two falls.

- Review of Resident #12's medical record occurred on January 28-29, 2015. Diagnoses included Parkinson's disease and Alzheimer's disease. The care plan, dated 05/12/10, stated, "PROBLEM: Potential for alteration in mobility and comfort with a potential for falls related to [R/T]: Parkinson's, kyphosis, DJD [degenerative joint disease], back pain R/T compression fx [fracture] history of falls, radiculopathy [spinal nerve/root disease causing pain to other areas] both legs, osteoporosis, myalgia [muscle pain] 11/12/2013 Manifested by: Unsteady gait, Arthritis or joint pain, History of falls, impaired sense of balance, Fluctuating wt [weight] bearing. . . . APPROACH: . . . see current ADL's for transfers and mobility . . ."

A nurse's note, dated 10/16/14 at 10:50 p.m., noted Resident #12 had a witnessed fall at 5:00 p.m. in her room while "transferring w/ [with] assist of 1" and a transfer belt. The note stated, ". . . DESCRIBE THE INCIDENT: started to slide out of bed when cna was attempting to transfer her to w/c [wheelchair], assisted to sit on the floor and on cnas leg. No injury . . ."

On 01/29/15 at 5:00 p.m., an administrative nurse (#1) provided the transfer ADL care plan in effect at the time of the above incident and stated two staff should have assisted the resident with transfers. The Transfer ADL, dated 12/31/13, stated, "TRANSFERS: . . . with extensive assist of or [sic] with total assist of two . . ."

Failure to utilize the required number of staff as assessed by the facility to safely transfer Resident #12 resulted in a fall, with the potential

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F 323	Continued From page 11 to cause injury. - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included dementia with behavioral disturbance, Alzheimer's disease, Parkinson's disease, and osteoporosis. The care plan, dated 03/20/08, stated, "Problem: Alteration in self care related to very severe cognitive impairment and poor comprehension of tasks. . . . Approach: In regards to ADL tasks refer to daily CNA ADL flow sheets, and door card . . ." The current CNA door card stated, ". . . TRANSFERS: if more or less staff assist are needed than what is on the door card/care plan, or the need to go from stand to lift you need to get the nurse to assess before the transfer can be made TRANSFER WITH: EZ stand with leg strap with extensive assist of two . . ." On 01/27/15 at 10:16 a.m., observation showed two CNAs (#5 and #6) assisted Resident #2 to sit at the edge of the bed, applied a mechanical lift harness to her trunk, secured the waist belt, cued/guided her to hold the lift handles, and transferred the resident with the EZ stand into her wheelchair. The staff failed to apply the leg strap as care planned. During an interview on 01/28/15 at 2:15 p.m., an administrative nurse (#7) stated staff should use the shin (leg) strap with transfers if a resident's care plan indicated transfer with an EZ stand and included the shin strap. Failure to apply the leg strap the facility care planned as necessary for safe transfers increased the risk of Resident #2 sustaining a fall and/or injury during transfers with the EZ stand.	F 323		

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F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure drug regimens free from unnecessary medications for 3 of 5 sampled residents (Resident #3, #5, and #13) on as needed (PRN) anti-anxiety medication. Failure to attempt non-pharmacological interventions prior to Ativan administration may result in residents receiving unnecessary medications and experiencing	F 329	**F329:** It is the policy of Marian Manor HealthCare Center (MMHCC) to assure all residents (including residents #3, #5, & #13 from the survey roster) drug regimen is free from unnecessary drugs. This tag is in relation with non-pharmacological interventions not attempted prior to a med being given to manage behavior concerns (e.g. anxiety, restlessness etc...). In regards to resident #3, #5, #13 and all residents who require PRN medication due to behavior concerns the following was put in place. 1. Between shift changes on days and pms on 01/28/15 & on 01/29/15 several Nurses were visited with by DON (director of nursing) and informed of the concern with residents #3, #5, & #13. Nurses informed DON that they do attempt non-pharmacological interventions. DON informed nurses that the documentation is not there to support that therefore if not documented it isn't done. Teaching was done verbally by the DON to those nurses at that time to always try non-pharmacological intervention and to make sure they chart what they tried prior to giving the med. A note was placed in the CNA and nurses' communication book on 01/28/1/ & 01/29/15 addressing the concern of non-pharmacological interventions not being utilized and a message was also sent out 01/29/15 through ECS (electronic charting system) in regards to the concerns with the non-pharmacological interventions needing to be attempted prior to med use (a copy of the note in ECS is enclosed noted as Copy #1 and the copy of the note placed in the CNA & nurses communication book is in packet noted as Copy # 6). With ECS when a nurse signs in for her shift the message pops up for them to review.	

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F 329	Continued From page 13 adverse consequences related to their use. Findings include: Review of the facility policy titled, "Guidelines for Psychoactive Medication Monitoring" occurred on 01/28/15. This undated policy stated, ". . . 6. Prior to PRN medication for behavior concerns, to try non-pharmacological interventions. . . ." Review of the facility policy titled, "PRN Medications" occurred on 01/28/15. This undated policy stated, ". . . f. Prior to giving PRN psychoactive medications, non-pharmacological interventions need to be attempted. . . ." - Review of Resident #3's medical record occurred on all days of survey and included diagnoses of anxiety and dementia. The significant change Minimum Data Set (MDS), dated 01/13/15, identified severely impaired cognition and extensive to total assist for all activities of daily living. The current care plan indicated "PROBLEM: Potential alteration in comfort related to feelings of anxiousness . . . related to anxiety . . . Insomnia. APPROACH: . . . Medicate as ordered . . . encourage to voice when feeling anxious . . . If unable to sleep offer other interventions such as toilet, back rub, watch TV, position change, check if wet, food/drink etc. . . ." Resident #3's current Physician Orders indicated, "Lorazepam 0.5mg [milligrams] tab 1 tab by mouth or intramuscular q. [every] 4 h. [hours] as needed . . . (anxiety) Original Order Date: 09/26/2014." Resident #3's medication administration record	F 329	2. In-service with Nurses was held on 02/11/15 at which time the procedure for "PRN medications" and "Guidelines for Psychoactive Medication Monitoring" was reviewed. It was stressed at the in-service the importance of attempting non-pharmacological interventions first and to allow time for that intervention to see if effective before giving the PRN med to manage the behavior. (Refer to Nurse's In-service packet noted as Copy #6). 3. In ECS the following was added: when the nurses tab PRN Psychotropic for charting, a reminder pop up screen appears & asks "did you chart non-pharmacological interventions?" 4. The following will be the Quality Assurance (QA) Monitoring that the DON will conduct to assure unnecessary drug concerns are being addressed: • The DON will randomly review residents #3. #5, & #13 from the survey roster as well as other residents for PRN psychotropic med use, will note any concerns & review those with the resident's Resident Care Coordinator (RCC) and report concerns to the provider. • With monitoring the PRN psychotropic med use, the DON will also monitor if follow-up documentation is being done (e.g. was med effective in managing the behavior concerns). If it was feasible, were non-pharmacological interventions tried before PRN pain med given.	

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F 329	Continued From page 14 (MAR) identified Ativan 0.5 mg PRN administered without non-pharmacological interventions attempted: - Twenty-seven out of thirty-five times in October 2014. - Thirty-eight out of forty-one times in November 2014. - Three out of five times in December 2014. - One out of three times in January 2015. - Review of Resident #5's medical record occurred on all days of survey and included diagnoses of anxiety and dementia. The quarterly MDS, dated 12/23/14, identified moderately impaired cognition and extensive to total assist for all activities of daily living. The current care plan indicated "PROBLEM: alteration in comfort related to feelings of depression . . . Anxiety . . . APPROACH: . . . See list of non-drug interventions to try. (toilet, back rub, watch TV, position change, check if wet, food/drink etc.). . . ." Review of Resident #5's physician orders indicated, "Lorazepam 0.5mg tab 1 tab by mouth Q. 4 h. as needed (anxiety) Original Order Date: 10/03/2014" and "Lorazepam 1 mg intramuscular q. 4 h. as needed (Severe Anxiety) Original Order Date: 10/03/2014." Resident #5's MAR identified Ativan 0.5 mg PRN administered without non-pharmacological interventions attempted: - Six out of eleven times in October 2014. - Six out of seven times in November 2014. - Three out of six times in December 2014. - Review of Resident #13's medical record occurred on January 28-29, 2014. Diagnoses	F 329	• Frequency of QA monitoring: Weekly for one month-02/02/15 through the week of 02/023/15(that is 4 full weeks). Monthly for three months (March-April-May 2015) and then quarterly (August & November 2015) with QA monitoring completed November 30, 2015. If concerns are noted with the monitoring immediate corrective action will be taken (e.g. teaching with nurses involved). The DON will submit a report of the deficiency at the next QA meeting only and the monitoring results to the QA Committee at each scheduled quarterly meeting through November 30, 2015 (Next quarterly QA meeting is tentatively set for April 20, 2015). In the absence of the DON and monitoring is due to be conducted, it will be done by an RCC. (copy of QA monitoring for weeks of 02/02 and 02/09/ and thus far for 02/16, 2015 are enclosed with packet noted as Copy #6)	03/05/15

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F 329	Continued From page 15 included Alzheimer's disease, dementia, and anxiety. The quarterly MDS, dated 11/17/14, identified severely impaired cognition. The current care plan stated "PROBLEM: Alteration in Thought processes, and comfort RELATED TO: Alzheimer's/dementia . . . MANIFESTED BY: . . . anxiety . . . APPROACH: . . . Redirect and reorient resident when needed Divert resident's attention as needed . . . Involve in activity program as able and do daily 1:1 [one on one] visits . . . May try validation or diversion if . . . increasing anxiety . . . See further non-med interventions attached to back of care plan . . ." The "NON-MED [medication] INTERVENTIONS FOR BEHAVIORS", updated 11/17/14, identified, "Toilet, Looking at nursing home photo albums, Visit 1:1, Food and drink, Animal dvd's, Likes to paint, Check for pain, Take for w/c [wheelchair] ride, Use Validation." Resident #13's current physician orders indicated, Lorazepam 0.5 mg one or two tabs (0.5 mg to 1 mg) by mouth every four hours as needed for anxiety. Review of the November 2014 MAR identified PRN Ativan administered two out of three times without non-pharmacological interventions attempted prior to the administration of Ativan. During an interview on 01/28/15 at 12:30 p.m. an administrative staff nurse (#1) verified staff failed to document non-pharmacological interventions attempted before administering PRN Ativan.	F 329		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441		

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F 441	Continued From page 16 Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and	F 441	F441: It is the policy of MMHCC to assure that the Infection Control Program is designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. This tag is in relation to CNAS failure to perform hand hygiene in a timely manner following perineal cares and after completion of therapy. On 01/28/15 with the exit report provided for that day to the DON by a surveyor, the concerns noted with Resident #2 from the survey roster were voiced to the DON. The following was put in place on 01/28/15 & 01/29/15 to assure that hand hygiene is done in a timely manner when cares are provided for Resident #2 as well as all residents to help in prevention of development & transmission of disease & infection 1. A note was placed in the CNA and nurses dept. communication notebook on 01/28/15 & on 01/29/15 after our exit review with the survey team addressing the hand hygiene concerns (copy of the 01/28/15 & 01/29/15 note is enclosed and is in the packet noted as Copy #7). 2. In-service with the CNAS was held on 02/11/15. The concerns noted with F Tag 441 were reviewed (Copy of the in-service notes addressing this is enclosed and is in the packet noted as Copy #7). At this in-service the procedures for peri-cares and hand washing/hand hygiene were reviewed (copy of those procedure are enclosed and are in the packet noted as Copy #7). Also note that the nurses were also made aware of this concern with their In-service as the CNA in-service notes are always attached to the nurses' in-service notes for them to review. 3. The following will be the Quality Assurance (QA) Monitoring that the DON will conduct to assure that procedures for peri-care and hand washing/hand hygiene are being followed.	

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F 441	Continued From page 17 staff interview, the facility failed to follow standard infection control practices for 1 of 9 sampled residents (Resident #2) observed receiving cares or therapy. Failure to perform hand hygiene in a timely manner following perineal cares and after completion of therapy has the potential to spread infection to other residents. Findings include: Review of the facility policy titled "Pericare with Disposable Washcloth and/or Periwash with Washcloth" occurred on 01/28/15. This undated policy stated, ". . . Female Perineal Care: . . . 12. Remove gloves following pericare. Assure resident is safely positioned and then wash hands (soap and water or hand gel) before carrying out other duties. . . ." Review of the facility policy titled "Handwashing Guidelines & Procedure" occurred on 01/28/15. This undated policy stated, ". . . Some CDC [Centers for Disease Control] guidelines: . . . 2. Staff is required to wash their hands in accordance with accepted professional practice. 3. Handwashing should always follow the removal of gloves, to remove bacteria, harboring moisture buildup. . . . Situations that require hand washing with soap and water: . . . 6. Before and after assisting a resident with toileting. . . ." - On 01/27/15 at 10:16 a.m., observation showed Resident #2 incontinent of a large amount of stool. One certified nurse aide (CNA) (#5) cleansed the resident's perineal area, and a second CNA (#6) assisted with repositioning and applied Vitamin E cream to the resident's rectal/buttock areas. Both CNAs removed their gloves, applied a clean brief and pants, and	F 441	• The DON will randomly observe residents peri cares (as well as other cares that would involve the necessity of hand hygiene such as on hands restorative therapy tasks & this includes Resident #2 from the survey roster) to assure that peri care and hand washing/hand hygiene with any type of care including restorative therapy are being properly done. Concerns with these observations will be immediately addressed by the DON with the CNAS involved. • Frequency of QA monitoring: Weekly for one month-02/02/15 through the week of 02/023/15(that is 4 full weeks). Monthly for three months (March-April-May 2015) and then quarterly (August & November 2015) with QA monitoring completed November 30, 2015. If concerns are noted with the monitoring immediate corrective action will be taken (e.g. teaching with CNAS involved). The DON will submit a report of the deficiency at the next QA meeting only and the monitoring results to the QA Committee at each scheduled quarterly meeting through November 30, 2015 (Next quarterly QA meeting is tentatively set for April 20, 2015). In the absence of the DON and monitoring is due to be conducted, it will be done by an RCC. (copy of QA monitoring for weeks of 02/02 and 02/09/ and thus far for 02/16, 2015 are enclosed with packet noted as Copy #7)	03/05/15

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F 441	Continued From page 18	F 441		

placed the resident's slippers on. Without washing their hands, the CNAs proceeded to assist Resident #2 to sit at the edge of the bed, applied the EZ stand mechanical lift harness, physically guided the resident to hold the lift handles, transferred her to the wheelchair, and removed the harness. One CNA (#5) handed Resident #2 her doll, and the other CNA (#6) applied her seat belt and combed her hair. The CNAs performed hand hygiene before leaving the room.

- On 01/27/15 at 10:29 a.m., observation showed a therapy staff member (#8) assisted Resident #2 with upper and lower extremity exercises and range of motion. The staff member held onto the resident's arms and legs to assist her to complete the therapy, and moved Resident #2's doll from the resident's right arm to her left as she progressed with the therapy. The staff member (#8) failed to perform hand hygiene upon leaving the room, and proceeded to help an unidentified staff member assist another resident stand from a seated position in the hall.

During an interview on the afternoon of 01/28/15, an administrative nurse (#1) stated staff should wash their hands after removing gloves following perineal cares, whether incontinent of urine and/or stool. This nurse agreed staff having physical contact with a resident should wash their hands before working with another resident.