STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355082	A. BUILDING _____ B. WING _____	01/06/2011

RECEIVED FEB 7 2011 Division of Health Facilities

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVE MARIA VILLAGE	501 19TH ST NE JAMESTOWN, ND 58401

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 01/03/11 and completed on 01/06/11, the sample included five residents for complete review, 12 residents for focused review, and three closed records for review. The sample included one additional resident to verify specific concerns during the survey.	F 000		
F 221 SS=E	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure residents remain free of physical restraints for 5 of 5 sampled residents (Resident #1, #6, #9, #13, and #16) observed with seat belts, and 1 of 1 sampled resident (Resident #9) who utilized a merry walker. Failure to perform an initial assessment, ongoing assessments, obtain a physician's order, and release the restraints limited the residents' ability to attain and maintain their highest practicable level of well-being. Findings include: Review of the facility policy titled "Restraint Use" occurred on 01/06/11. This policy, dated September 2010, stated, "Policy: It is the policy of Ave Maria Village to avoid the use of restraints to the greatest extent possible. Restraints shall be	F 221	**F-221 Right to be free from physical restraints.** **We are challenging this allegation, however in the spirit of cooperation, and per regulation, we submit the following plan of correction:** 1. Resident #1F--Additional assessment has been completed per algorithm. **See attachment #1** On 09/20/10 family was notified of use of seatbelt for a safety restraint, since a lesser restrictive intervention was not effective. On 09/21/10 an order was received and seat belt was placed on 9/21/10. Professional nursing staff were re-educated at monthly nurses meeting on 01/20/10. C.N.A. staff were re-educated at neighborhood meetings on 01/10/11, 01/17/11, and 1/31/11, and also at C.N.A. monthly meeting on 01/27/11. A mandatory meeting for all affected staff will be held on 02/09/11, at which time all employees will be re-educated. Re-education includes the importance of removal of restraints every 2 hours as indicated.	

ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Timothy N. Buckhill | TITLE: CEO | (X6) DATE: 2/4/11

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that r safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days wing 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 s following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ıram participation.

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F 221	Continued From page 1 used only for the safety and well-being of the resident and after other alternatives have been tried unsuccessfully. On admission and on an ongoing basis each resident will be evaluated as to independence and/or need for restraint alternatives . . . Procedure: . . . 2. The need for a restraint alternative is established and documented. a) The least restrictive alternative to physical restraints is attempted initially progressing to restrictive devices only as needed. Use Restraint algorithm as a guide . . . A physician order is obtained and identifies the specific medical symptom requiring use of the restraint. This information is identified in ongoing assessments and care plans . . . The resident or legal representative is informed and educated . . ." - Review of Resident #1's medical record occurred on all days of survey. Medical diagnoses included depression, dementia, anxiety, osteoarthritis, and a history of a left hip fracture. Review of a physician's order, dated 10/01/10, stated, "Seat Belt as restraint." Review of the current Minimum Data Set (MDS), dated 12/19/10, identified Resident #1 required extensive assistance for transfers, toileting, and personal hygiene, frequently incontinent of bladder, at risk for pressure ulcers, and used a chair restraint daily. Review of Resident #1's current care plan stated, "Restraint on w/c [wheelchair]. Release & [and] change position every 2 hrs [hours]. Seat belt that is buckled in the back - she cannot reach it." Observations of Resident #1 on 01/04/11 showed the following: * 8:00 a.m. - A certified nursing assistant (CNA)	F 221	Resident # 9 An OT evaluation for positioning took place on 01/19/1. This resulted in a different wheelchair being given to the resident. On 1/21/11, the seat belt was discontinued. Resident # 16 Additional assessment has been completed per algorithm **See attachment # 2.** The Velcro belt was discontinued on 1/31/11. Resident # 6 Resident expired 1/30/11. Resident # 13 Resident no longer has a belt in use. Will continue to monitor for safety. 2. All residents who have displayed behaviors that could place them at risk for falls have the potential to be affected. 3. Residents who display behaviors that place them at risk for falls will be assessed by a nurse. If the results of the assessment process show that a restraint is indicated, a physician order for restraint will be sought and family will be notified. Professional nursing staff were educated on 01/20/11 at the monthly nurses meeting. C.N.A. staff were educated at neighborhood meetings on 01/10/11, 01/17/11, and 1/31/11, and again on 01/27/11 at the monthly C.N.A. meeting. Affected staff will be re-educated at a mandatory meeting held	

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F 221	Continued From page 2 (#11) assisted Resident #1 with morning cares, assisted her to her wheelchair, and placed a seatbelt restraint around the resident's waist. The seatbelt fastened behind the wheelchair. * 8:40 a.m. - Seated in her wheelchair in her room eating breakfast with the seatbelt restraint fastened. * 9:45 a.m. - Asleep in her wheelchair in her room with the seatbelt restraint fastened. * 10:45 a.m. - Seated in her wheelchair in the activity room viewing postcards with an unidentified staff member. The seatbelt restraint remained fastened. * 11:05 a.m. - A CNA (#11) released Resident #1's seatbelt and assisted her to the bathroom. * 1:00 p.m. - Seated in her wheelchair in the hallway with the seatbelt restraint fastened. A CNA (#11) asked Resident #1 if she needed to use the bathroom and the resident shook her head "no." * 3:00 p.m. - Seated in her wheelchair in the hall with the seatbelt restraint fastened. A CNA (#13) offered Resident #1 a nutritional drink and the resident declined. * 4:45 p.m. - Seated in her wheelchair at a small group activity with the seatbelt restraint fastened. * 5:45 p.m. - Seated in her wheelchair in the dining room, the seatbelt restraint fastened, and a CNA (#13) assisted her with her meal. When asked if CNAs provided any cares such as repositioning or personal cares for Resident #1 that afternoon, the CNA (#13) replied "no." Review of the CNA computer charting indicated the CNAs released Resident #1's seatbelt restraint every two hours on 01/04/11, however, observations showed staff did not. During an interview on the afternoon of 01/06/11,	F 221	on 02/09/11. Education includes the importance of releasing restraints every 2 hours as indicated, and overall restraint reduction principles. 4. Quality Assurance Manager (QAM) or a nurse manager will conduct or delegate QA monitoring for residents with a restraint and/or restraint alternative, as follows: weekly x 4 weeks; then monthly x 3 months, then quarterly thereafter. **See Attached Form A.** 5. 2/10/11	

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F 221	Continued From page 3 an administrative nurse manager (#8) stated other seatbelt restraints and a lap buddy were tried in the past, but Resident #1 removed the restraints and experienced a couple of falls. She stated the facility had not completed a physical restraint assessment, had not explained the risks and benefits of the restraint to Resident #1's legal guardian, and had not obtained consent from the resident or her legal guardian. Failure of facility staff to perform ongoing restraint assessments has the potential for Resident #1 to decline both mentally and physically and failure of facility staff to release the seatbelt restraint every two hours as ordered by the resident's physician has the potential for the resident to experience skin breakdown related to incontinence and immobility. - Review of Resident #9's medical record occurred January 3-6, 2011. The facility admitted the resident with diagnoses including Alzheimer's dementia. A physical therapy note, dated 08/02/10, stated "Allow Ind [independence] in w/c [wheelchair] or merry walker (a combination chair/walker ambulation device) [with] aides such as seat belts/alarms recommended to prevent injury to pt [patient]." The current care plan identified the following interventions for the focus of falls, ". . . Use merry walker when resident is restless and doesn't want to sit or lie down. . . . Seatbelt to w/c . . . Make sure seatbelt is fastened when in w/c, resident is able to unfasten seatbelt [at] times." The quarterly MDS, dated 10/24/10, identified Resident #9 experienced falls, but failed to identify the trunk restraint utilized for Resident #9. Nurse's notes identified unsafe use of both	F 221		

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F 221	Continued From page 4	F 221		

restraint devices. Resident #9 experienced three falls/near falls while utilizing the merry walker on 08/11/10, 08/27/10, and 08/31/10, see F 323. A note written 12/28/10, at 5:28 p.m., identified Resident #9 fell out of his wheelchair with the seatbelt restraint in use, but the resident probably removed the seatbelt. Facility staff failed to re-evaluate the merry walker and the seatbelt after the falls experienced by Resident #9.

Observations on 01/03/11 at 4:35 p.m., 01/04/11 at 11:30 a.m., 12:25 p.m., 5:07 p.m., and 01/05/11 at 4:10 p.m. showed Resident #9 seated in his wheelchair with a buckle type seatbelt secured over his lower abdomen. According to the care plan Resident #9 can only remove the seat belt at times.

During an interview, on 01/05/11 at 4:55 p.m., two administrative nursing staff members (#2 and #5) stated facility staff do not complete an assessment before initiating a seatbelt or merry walker, as per facility policy. They also identified a device is not reassessed after a resident who utilizes a restraint has had a fall.

Resident #9's medical record lacked evidence facility staff completed an assessment to determine the use of a seatbelt and merry walker restraint for Resident #9 as the least restrictive device to promote his safety. Facility staff failed to assess Resident #9's capability to remove/release the seatbelt and open the merry walker restraint upon command and failed to obtain an order from the physician prior to initiating the seatbelt and merry walker restraint.

- Review of Resident #16's medical record occurred on January 05-06, 2011. Resident #16's

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F 221	Continued From page 5 diagnoses included dementia with behavioral disturbances, depressive disorder, essential hypertension, and osteoporosis. Review of Resident #16's quarterly MDS, dated 07/24/10, identified impaired short and long term memory, severely impaired daily decision making capability, required extensive for bed mobility, transfers, dressing, and toilet use, and a history of falls. This MDS failed to identify Resident #16's use of a trunk restraint. Review of Resident #16's current MDS, dated 10/27/10, identified the resident as able to make herself understood, cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 3 (a BIMS Score of 0-7 indicates severe cognitive impairment), and required extensive assistance with bed mobility, transfer, dressing, and toilet use. This MDS failed to identify Resident #16's use of a trunk restraint. Review of an MDS note, dated 10/25/10, stated Resident #16 utilized a wheelchair and a walker for mobility, and "Velcrobelt when in wheelchair and easy chair in her room to remind resident to call for assistance. Bed and chair alarms in place." Review of Resident #16's care plan for falls identified an intervention, dated 06/18/10, of "Velcro belt applied to wheelchair and easy chair to remind resident to ask for assistance." Review of Resident #16's Interdisciplinary Progress Notes (IPN) and Progress Notes identified the resident sustained a fall on 04/11/10, 04/17/10, 06/14/10 and 06/18/10.	F 221		

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F 221	Continued From page 6 Review of a Progress Note for Resident #16, dated 06/18/10 at 1:20 p.m., identified Resident #16's son approached nursing staff regarding Resident #16's numerous falls and nursing staff responded by suggesting the placement of a seatbelt in the resident's recliner/easy chair. A Progress Note, dated 06/21/10, stated, "Velcro seatbelt installed on w/c and easy chair. Able to undo belt if wants." During the initial tour of the facility on the morning of 01/03/11, observation showed the presence of a Velcro seatbelt on Resident #16's easy chair in her room. Observations of Resident #16 on 01/05/11 at 3:30 p.m. and on 01/06/11 at 7:40 a.m. and 8:50 a.m., showed a Velcro seatbelt around Resident #16's waist while seated in her wheelchair. Resident #16's medical record lacked evidence facility staff completed an assessment to determine the use of a seatbelt restraint for Resident #16 as the least restrictive device to promote her safety. Facility staff documented Resident #16's capability to undo or release her seatbelt one time (on 06/21/10). Resident #16's record lacked evidence of her continued ability to remove/release the seatbelt upon command. Facility staff failed to obtain an order from the physician prior to initiating the seatbelt restraint. During interview on 01/06/11 at 10:50 a.m., an administrative nurse manager (#8) stated the facility failed to complete an assessment pertaining to Resident #16's Velcro seatbelt. - Review of Resident #6's medical record occurred on January 03-06, 2011. The facility admitted Resident #6 on 11/22/10. Diagnoses	F 221		

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F 221	Continued From page 7 included, in part, right cerebral vascular accident with left hemiparesis and neglect, alcoholism, depression, and poor impulse control. Resident #6's admission MDS, dated 12/03/10, identified the resident as able to make himself understood, cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) Score of 15 (a BIMS Score of less than 13 indicates cognitive impairment), required extensive assistance for bed mobility, dressing, eating, and toilet use, and total assistance for transfers. Review of Resident #6's complete care plan identified two "Fall" care plans, dated 11/22/10 and 12/13/10. Resident #6's care plan, dated 11/22/10, identified the problem of "At risk for falls- last fall 10/31/10" with approaches of "Reposition q [every] 2 hours. Assess for necessary safety interventions. Fall assessment of 11." On 12/13/10, facility staff revised Resident #6's fall care plan to include the approach of "Chair alarm in w/c." Resident #6's care plan, dated 12/13/10, identified a problem of "Falls - Actual falls (past 30 days or less)" with approaches of "1. Orientate to room, bathroom, call light use. 2. Encourage to call for assistance. 3. Chair alarm to w/c when up. 4. Seatbelt in w/c." Record review identified the implementation of the seatbelt to the care plan occurred on 12/15/10. Review of Resident #6's Progress Notes identified the resident sustained a fall on 11/30/10 and 12/13/10. Observations of Resident #6 on 01/03/11 at 3:45 p.m., 01/04/11 at 9:15 a.m. and 12:45 p.m.,	F 221		

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F 221	Continued From page 8 01/05/11 at 8:00 a.m. and 3:00 p.m., and 01/06/11 at 9:15 a.m. showed a Velcro seatbelt around Resident #6's waist while seated in his wheelchair. Resident #6's medical record lacked evidence facility staff completed an assessment to determine the use of a seatbelt restraint for Resident #6 as the least restrictive device to promote his safety. Facility staff failed to assess Resident #6's capability to remove/release the seatbelt restraint upon command and failed to obtain an order from the physician prior to initiating the seatbelt restraint. During an interview on 01/06/11 at 10:15 a.m. with an administrative nurse manager (#5), the surveyor requested further information (an assessment and rationale) pertaining to the facility's implementation of a wheelchair seatbelt for Resident #6. This administrative nurse manager (#5) stated the facility did not complete an assessment prior to implementing the wheelchair seatbelt for Resident #6 and provided no information for review. - Review of Resident #13's medical record occurred on January 5-6, 2011. Resident #13's diagnoses included degenerative joint disease, dementia, unspecified psychosis, confusion, and agitation. Review of Resident #13's current MDS, dated 12/11/10, identified short-term and long-term memory problems and moderately impaired daily decision making capability, required extensive with transfers, dressing, eating, toilet use, and a history of falls. This MDS failed to identify Resident #13's use of a trunk restraint.	F 221		

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F 221	Continued From page 9 Review of Resident #13's progress notes identified the following: *07/13/10, 10:45 a.m. - " . . . Fax sent to MD [physician] to update on resident's use of seat belt in w/c for safety. He opens seatbelt at x's [times] but not on command; seeking order for seat belt restraint. *07/13/10, 6:00 p.m. - " . . . [physician's name] responded to fax and said it was fine to use a seat belt restraint." A physician's order, dated 07/13/10, stated, "Okay for seat belt restraint." Resident #13's progress notes identified the resident sustained falls on 06/10/10, 06/18/10, and 06/19/10, then following the placement of the seat belt in the resident's wheelchair, on 07/25/10, 10/22/10, and 12/18/10. Resident #13's current care plan for falls included the following interventions dated 02/03/10, " . . . chair check in place at all times. Sensor and chirpy alarm used in w/c" and dated 12/14/10, ". . . He has a seat belt in his w/c also. Does not open the seat belt on command but is able to open it if he wants out of the chair. . . ." Observations on 01/05/11 at 3:05 p.m., 5:00 p.m., and 5:45 p.m. and on 01/06/11 at 8:15 a.m., 9:30 a.m., 11:00 a.m., and 1:15 p.m., showed Resident #13 seated in his wheelchair with a buckle-type seat belt secured around his waist. Resident #13's medical record lacked evidence facility staff completed an initial assessment or ongoing assessments to determine the use of a seat belt restraint for Resident #13 as the least restrictive device to promote her safety. The medical record lacked evidence the facility received consent from Resident #13's family prior to implementing the restraint.	F 221		

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F 221	Continued From page 10 During an interview on 01/06/10 at 11:00 a.m., an administrative nursing staff member (#8) stated she could not identify why a less restrictive restraint had not been initiated for Resident #13. This staff member confirmed if you tell [Resident #13] to open the seat belt, he can't understand what you are asking him to do. This staff member failed to provide the requested evidence of restraint assessments. During an interview on 01/06/10 at 2:00 p.m., an administrative nursing staff member (#8) stated the IDP notes should include consent from family for a restraint.	F 221		
F 250 SS=E	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 resident interview, record review, review of facility policy, and staff interview, the facility failed to assess residents' behaviors for 4 of 7 sampled residents (Resident #6, #12, #13, and #17) and 1 of 1 closed record resident (Resident #18) identified by the facility as exhibiting behaviors. Failure to develop, implement, and modify individual interventions specific to each resident's behavior has the potential for residents to injury each other. Findings include:	F 250	**F-250 Provision of medically related social services.** 1. Residents #12, #13, and #17 The facility will better define behaviors, and social service staff (or nursing, as appropriate) will care plan identified specific interventions for defined behaviors. (Resident #6 expired 1/30/11). 2. Residents who have displayed inappropriate behaviors have the potential to be affected. 3. A resident with identified inappropriate behaviors will have specific interventions care planned by the care plan team. Professional nursing staff were educated at the monthly nurses meeting on 01/20/11. C.N.A. staff were educated at neighborhood meetings on 01/10/11, 01/17/11, and 1/31/11 and also at monthly C.N.A.	

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F 250	Continued From page 11 Review of the facility policy, "Behavior Management," occurred on 01/06/11. This policy, dated 01/09, stated, "POLICY: Behavior monitoring and assessment will be carried out and documented. Any nurse or social service staff can implement the Daily Behavior Tracking Log if a resident is displaying challenging behavior. Each targeted behavior will be monitored separately. PURPOSE: 1. To provide a baseline of behaviors and interventions. 2. To provide a means to set up a plan of care. 3. To provide a system of communicating, assessing, monitoring, and implementing interventions for challenging behaviors of residents. . . . PROCEDURE: 1. When a new behavior develops or an inappropriate behavior worsens . . . staff will document the occurrence in the Progress Notes. . . . 3. The person witnessing any behavior records it on the Daily Behavior Tracking Log filling in all sections of the form for each targeted behavior they witnessed. . . . 6. Inform physician of any significant behaviors or changes as necessary. 7. Initiate or update the care plan problem with current information. 9. After five to seven days, resident's team evaluates occurrences for possible causes, patterns and/or trends along with appropriate interventions and decision [sic] if continued tracking is needed. 10. A summary of tracking is documented in the Interdisciplinary Progress Notes by Social Services staff and review care plan for changes . . . Refer to psychiatrist as needed with attending physician and family consent." - Review of Resident #6's medical record occurred on January 03-06, 2011. The facility admitted Resident #6 on 11/22/10. Diagnoses included, in part, right cerebral vascular accident	F 250	meeting on 01/27/11. Education will be provided to affected staff at a mandatory meeting on 02/09/11. 4. QAM or a nurse manager will conduct or delegate QA monitoring, utilizing a random sample of 5% of residents who display behaviors, as follows: weekly x 4 weeks, then monthly x 3 months, then quarterly thereafter. **See Attached Form B.** 5. 2/10/11.	

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with left hemiparesis and neglect, alcoholism, depression, and poor impulse control.

Resident #6's admission Minimum Data Set (MDS), dated 12/03/10, identified the resident able to make himself understood and cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) Score of 15, the presence of the following moods over the previous two weeks of little interest or pleasure in doing things, trouble falling asleep, feeling tired or having little energy, poor appetite, feeling bad about himself, fidgety or restlessness, a Total Severity Score (a score that indicates the extent of potential depression) of 12 (a score of 10-14 indicates moderate depression) and a display of verbal behaviors directed towards others. This MDS further identified Resident #6 required extensive assist of two or more staff members for bed mobility, dressing, eating, and toilet use, and total assist of two or more staff members for transfers.

Review of Resident #6's Behavior Log and Progress Notes, from November-December 2010, identified the resident exhibited behaviors of:
"Foul language" on November 22, 29, 30 and December 01.
"Flipped off" a nurse on November 26.
"Sexual behavior towards a CNA [certified nursing assistant]" on November 29
"Res [resident] touching own genitals" and made inappropriate gestures to female CNAs with the provision of cares on December 14.
Made sexual comments/behaviors directed towards female staff members on December 15 and 16.

The current plan of care for Resident #6 in

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regards to verbal behavior problems, initiated on 12/03/10, stated: "Focus - Resident has had verbal behavioral symptoms directed towards others" with interventions of "Monitor for observable mood fluctuations, Notify BSW [Bachelor of Social Work] as needed. Behavior Tracking Log will be set in place if [resident's name] has any behaviors. Offer reassurance and validate when needed." Facility staff failed to identify potential causes, patterns, and/or trends for Resident #6's verbal behaviors, and determine whether Resident #6's verbal behaviors and comments are targeted primarily towards staff or other residents.

The current plan of care for Resident #6 in regards to sexual behaviors directed towards others, initiated on 12/22/10, stated: "Resident has had sexual behaviors directed towards others" with interventions of "Staff will offer positive comments when [resident's name] demonstrates positive behavior. Staff will validate and give reassurance to [resident's name] when needed. Notify and inform BSW as needed." Facility staff failed to define the specific sexual behavior(s) displayed by Resident #6, identify potential causes, patterns, and/or trends for these sexual behaviors, and include specific interventions tailored to manage or reduce the incidents of sexual behaviors towards others (staff).

Review of Resident #6's physician orders, showed Resident #6 received Zoloft (an anti-depressant medication) 100 milligrams (mgs) daily. Resident #6's physician ordered a psychiatric consultation on 11/24/10; however both the resident and his Durable Power of Attorney declined this treatment recommendation.

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F 250	Continued From page 14 On 12/23/10, the physician prescribed Carbamazepine (an anticonvulsant medication used in the treatment of psychotic behaviors associated with dementia) 100 mgs daily to treat and manage the resident's verbal and sexual behaviors. Review of the Resident #6's Behavior Logs and Progress Notes, from November 2010 thru January 06, 2011, identified facility staff members implemented various interventions in response to the resident's behaviors including ignoring Resident #6's verbal comments and sexual gestures, informing Resident #6 his verbal language is unacceptable, and at times left the resident's room when the sexual behaviors did not stop. Resident #6's record lacked instructions to caregivers on which specific interventions were most successful in the limitation or minimization of the inappropriate behaviors. - Review of Resident 12's medical record occurred on January 03-06, 2011. The facility admitted the resident in June 2007. Diagnoses included, in part, history of alcohol abuse, peripheral vascular disease resulting in an above the knee amputation, and history of cerebrovascular accident. Nurse's Notes describe the following behaviors: * 08/21/10, 3:05 p.m. the note, in part, stated: a nurse went in and noted that resident had eaten all of his food. When asked if it was a good meal, the resident responded, "Good enough for the garbage." The nurse then noticed the resident had thrown the entire meal in the garbage. When asked why, the resident stated "Cause then they think I ate all of it and believe that I'm healthy." * 12/24/10 at 11:16 p.m., identified Resident #12	F 250		

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F 250	Continued From page 15 experienced an unwitnessed fall. The note, in part, stated: "Resident found sitting beside bed hollering for help with just his brief on, resident had apparently attempted to transfer self from chair to bed and lost all balance. Upon entrance to room noted six small alcohol containers in garbage and in recliner chair resident stated a friend brought them up. Resident was intoxicated uncooperative, resistive and argumentative with staff when found. Two lacerations noted to top of head, abrasion outer left thigh. Resident scalp bleeding moderate amount and resident continued to resist treatment. Resident was able to be assisted into bed. On call medical doctor and nurse manager updated on situation received recommendation to send to emergency room (ER) due to persistent bleeding via ambulance." Resident #12's quarterly MDS, dated 12/23/10, identified a BIMS score of 13 (cognitively intact), mood identified an overall Total Severity Score of eight (mild depression) and no behaviors. This MDS identified Resident #12 independent for bed mobility, transfer, walk in room and corridor, locomotion on and off the unit, with extensive assistance of one staff member for toileting. The current care plan identified the following in relation to behaviors and nourishment: * (Behaviors) Initiated on 07/10/10, stated, "Focus: Resident has triggered for behavioral symptoms due to resisting cares. Goals: [Resident #12] will make own decisions until safety and personal hygiene needs are not being met. Display appropriate response to situation. Interventions: Reapproach [Resident #12] with safety and hygiene needs. Validate/Encourage [Resident #12] of his personal and safety needs." * (Nourishment) Initiated on 07/09/09 identified	F 250		

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"Focus: . . . 12/13/10 [greater than] 5% unplanned wt [weight] loss . . . Intervention . . . Provide unified positive approach by all staff in support of diet regime; Assess for/provide food preferences; If meals refused, offer menu alternatives . . . Refer to dietitian for evaluation/recommendations." The care plan failed to address the resident's history of alcohol abuse.

A dietary assessment, completed 9/20/10, and a dietary assessment note, dated 10/19/10 both failed to address the resident's behavior of throwing meals into the garbage or otherwise disposing of food. The first dietary assessment which included this behavior occurred on 12/13/10 in a dietary follow-up note that stated, ". . . Reviewed wt loss with nurse management who indicated res has been observed to throw food away in trash can [and] pretend he ate it. . . ."

The review by facility staff failed to assess for possible cause, patterns and/or trends of the behavior exhibited by Resident #12 related to disposing of food, and the excess alcohol consumption. The facility's determination of appropriate interventions and need for continued tracking of the behavior is not identified, as per facility policy.

- Review of Resident #13's medical record occurred on January 05-06, 2011. The facility admitted Resident #13 on August 2009. The resident's diagnoses included dementia, unspecified psychosis, confusion, and agitation.

Resident #13's quarterly MDS, dated 09/23/10, identified wandering occurred daily. The resident's annual MDS, dated 12/11/10 identified

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wandering behavior occurred 4 to 6 days but less than daily and the wandering significantly intruded on the privacy or activity of others.

Review of Resident #13's interdisciplinary (IDP) notes identified the following wandering/behaviors:
*01/12/10, 10:00 p.m. - "Up ambulating in hallway [with] walker. Going into other residents' room [sic] being verbally loud [and] waking up other residents . . ."
*02/21/10, 12:00 a.m. - ". . . Res found wandering into two different residents' rooms. Has been ripping apart bedding, pounding on walker [and] other objects in room. . . ."
*03/11/10, 9:30 a.m. - "resident continues to have disruptive [and] aggressive behaviors - behavior tracking will continue . . ."
*03/19/10, 12:15 p.m. - "reviewed behavior tracking - resident continues to have behaviors - we will continue to track . . ."
*04/22/10, 9:00 a.m. - "reviewed behavior forms - he continues to have wandering issues - so we will continue behavior tracking at this time . . ."
*04/28/10, 3:40 p.m. - " . . . Wander guard is used due to occassional [sic] wandering for residents' safety . . ."
*12/13/10, 2:00 p.m. - ". . . he tends to wander - he is able to propel himself by his feet in his wheelchair . . . he can have a tendency to enter rooms or areas in which he is not welcome (other residents' rooms) and staff try to direct him away as soon as they are able . . ."

An interview occurred on 01/06/11 at 11:00 a.m. with an administrative nursing staff member (#8) and a social services staff member (#32). These staff members confirmed Resident #13 wanders into other residents rooms, specifically rooms with

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mesh strip guards on doors. The staff member (#8) stated, "Two residents across the hall are upset."

During an interview on 01/04/11 at 11:15 a.m., Resident A, identified as interviewable by the facility, voiced he/she dislikes when Resident #13 wanders into his/her room.

The facility failed to assess and identify potential causes, patterns, and/or trends of Resident #13's behaviors and develop specific interventions for staff to utilize in response to the resident's wandering behaviors which affected other residents in the facility.

During an interview on 01/06/10 at 11:00 a.m., an administrative nursing staff member (#8) and a social services staff member (#32) agreed the facility should have initiated interventions related to Resident #13's behaviors.

- Review of Resident #17's medical record occurred on January 03-06, 2011. The facility admitted Resident #17 in February 2009. Diagnoses included, in part, Alzheimer's disease, dementia, anxiety, and depression. The resident's medications included, in part, Zoloft (antidepressant medication) 50 mg daily, Risperdal (antipsychotic medication) liquid 0.125 mg twice daily, Ativan (antianxiety medication) 0.5 mg daily at 4:00 p.m., and Ativan 0.5 mg 30 minutes before weekly bath.

Review of Resident #17's Behavior Log and Progress Notes identified the resident exhibited the following behaviors:
* 02/02/10 "Resident sleeping in someone else's bed . . . When asked that we should move,

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F 250	Continued From page 19 Resident became agitated and swung arms . . ." * 02/10/10 "Resident pinched roommate in right forearm . . ." * 05/18/10 ". . . She does wander into others' rooms, resists care/meds [medications] at times et [and] was lower pants in halls x2 [times two] today. . . ." * 05/24/10 ". . . getting more and more aggressive with staff and other residents. Striking out at CNAs when they are trying to do cares and at other residents if they get too close to her or her baby. Harder and harder to redirect." * 05/28/10 ". . . resident defecated into wastebasket et also on floor in room. Resident states 'it was the ducks.'" * 07/06/10 ". . . resident had hit CNA x2 in face and then hit another CNA in his (L) [left] eye causing his contact lens to tear. . . . Hit CNA on the head and then pulled her hair . . ." * 07/16/10 ". . . refused meds 5 days out of 7 . . ." Resident #17's Minimum Data Set (MDS), dated 11/25/10, identified the resident sometimes able to make herself understood and understand others, short and long term memory problems, behaviors fluctuated related to inattention and disorganized thinking, physical and verbal behaviors towards others, rejected care, and wandering. This MDS further identified Resident #17 required extensive assistance with transfer, dressing, toileting, personal hygiene, and bathing. The resident required set up assistance only for locomotion and eating. The current plan of care for Resident #17 in regards to inappropriate behaviors, revised on 11/11/10, stated, "Focus: . . . diagnosis of Alzheimer's dementia and is prescribed psychotropic medication to aide in the reduction	F 250		

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of inappropriate behaviors related to above said diagnosis. Goals: She will exhibit less inappropriate behaviors as evidenced by staff reports. Interventions: Medication Review Committee to follow. Staff will monitor for observable mood fluctuations and behaviors and update RN [Registered Nurse] and SW [Social Worker] as needed. Establish routine with resident."

The facility staff failed to define the specific inappropriate behaviors and identify potential causes, patterns, and implement specific behaviors to manage or reduce the incidences of Resident #17's inappropriate behaviors.

- Review of Resident #18's medical record occurred on 01/06/11. Medical diagnoses included Alzheimer's disease. The medical record indicated the resident experienced a decline in his physical status the end of September 2010 and expired on 10/27/10.

Resident #18's quarterly MDS, dated 10/03/10, identified a BIMS score of 5 which identified severe cognitive impairment. The MDSs, dated 04/01/10 and 07/01/10, identified short term memory problems, moderately impaired in daily decision making, and a behavior of wandering. Review of the care plan from January 2010 to October 2010 failed to identify any behaviors exhibited by Resident #18.

Review of Resident #18's progress notes identified the following:
* 01/25/10 - "CNA [certified nursing assistant] from B neighborhood reports that resident was touching female residents breasts [identifier #] . . . heard [identifier #] say 'Don't do that' . . ."

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F 250	Continued From page 21 * 01/26/10 - LSW [licensed social worker] visited w/ [with] resident re: [regarding] inappropriate touching w/ female resident the night before . . . admits to brushing up against her breasts. After LSW visited w/ resident he asked the author to come closer. He then unzipped LSW's sweater (teeshirt was underneath) & [and] attempted in a joking manner to touch LSW's breasts. LSW educated resident that this was inappropriate & that female residents and staff do not find this behavior funny. Nursing notified." * 01/27/10 - "Activity staff report that during activities this afternoon, resident was following [identifier #] around, and also lightly grabbed her wrist. When told by activity staff that this was inappropriate, resident just laughed." * 01/28/10 - "Behavior tracking started due to increase in sexually inappropriate behaviors. Will continue to follow." [signed by LSW] * 02/04/10 - "Completed 1 wk [week] behavior tracking. Only behavior noted was on 01/30/10 - resident was staring at female resident. No other behaviors noted. Will continue to follow." * 02/05/10 - "Another resident reported to activity staff that resident attempted to hold resident [identifier #] hand @ [at] activity. Resident [identifier #] pulled her hand away from resident. Resident tried to hold resident [identifier #] hand again and she again pulled hand away. No further attempt made by resident. Resident not confronted by staff as incident wasn't witnessed by staff, and reported [after] the fact." * 05/17/10 - "Activity staff reported that resident approached activity staff and stated 'I'm sorry, I'm sorry for staring @ your tits.' Resident then walked away." * 07/30/10 - "Family of resident, A.G., in room [room number], spoke to C [C Neighborhood] -Nurse regarding resident hovering over her bed.	F 250		

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F 250	Continued From page 22 Resident ambulates halls of facility frequently and stops to visit with staff and residents. [room number] family concerned of residents behavior because he has not stopped . . . 30 minute checks initiated to monitor residents whereabouts." * 08/01/10 - "CNA witnessed Resident kissing a female resident in the hallway next to her room. The resident has been talked to about these behaviors before and told that these are inappropriate actions . . . CNA asked resident to go back to his room and the nurse talked to resident in his room about that behavior being unacceptable . . ." * 08/03/10 - "Call placed to MD [medical doctor] re: behaviors . . ." * 08/04/10 - "Order: Seroquel [an antipsychotic medication] 25 mg [milligrams] BID [twice a day] . . . Reason for order: Increased behaviors . . ." * 08/05/10 - "due to his recent behaviors - and the medication change - we will began [sic] behavior tracking as of today 8/5/10 - this will go for 2 weeks - review as needed." * 08/19/10 - "due to behaviors - [Resident name] had a medication change - behavior tracking forms were done for 8/5 to 8/18 - only one incident was documented and he was easily redirected - behavior tracking stopped . . ." * 08/27/10 - "CNA caught res. [resident] kissing res. [room and bed number] and having hand on leg. Separated residents and explained that was not appropriate. Res. laughs about situation." * 09/01/10 - "Family Communication. Data: information on his behavior situation - when he is inappropriate towards another female resident. Action: had a discussion with [Resident name], his sons, [names of three facility staff members] - we reinforced the seriousness of the situation . . . we will continue to have him on 30 minute checks	F 250		

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F 250	Continued From page 23 at this time." * 09/26/10 - "Was found in room [room number] X2 [two times] in past hour. Escorted out of room and back to his bed both times; cooperative with redirection." * 10/06/10 - "30 min [minute] checks d/c'd [discontinued] per nursing dicretion [sic]. No resent [sic] behaviors toward female residents." During interview on the afternoon of 01/06/11, an administrative nurse manager (#8) stated facility staff redirected the resident when the behavior occurred and placed him on 30 minute checks to monitor his where-about's in the facility. Failure of facility staff to develop and implement a behavior management plan, evaluate occurrences for possible causes, patterns and/or trends, and remain consistent in the management plan resulted in several occurrences of the resident's inappropriate behavior directed towards other residents, and may have resulted in the facility initiating an antipsychotic medication unnecessarily.	F 250		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of manufacturer's recommendations, and staff interview, facility staff failed to properly administer medication to 2 of 5 residents (Resident #3 and #21) who received insulin via an "insulin pen" (a small pen shaped device which contains prefilled	F 281	**F-281 Services provided meet professional standards.** 1. This was an isolated incident involving one nurse, who was re-educated on proper procedure regarding priming of insulin pens on 1/07/2011, at which time she verbalized understanding. This nurse is also a diabetic, and she stated that she used the insulin pen the same way that her pharmacist had recommended. 2. Residents receiving insulin per pen have the potential to be affected.	

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F 281	Continued From page 24 amounts of insulin). Failure of facility staff to follow the manufacturer's recommendation of "priming" (a procedure to expel the air from the needle attached to the insulin pen) prior to giving Resident #3 and #21 their scheduled insulin injections did not provide these residents with the exact amount of insulin as prescribed. Findings include: Review of the manufacturer's medication package insert for NovoLog Flex Pen occurred on 01/04/11. This insert, dated 07/14/09, stated, ". . . Small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: . . . E. Turn the dose selector to select 2 units. F. Hold your NovoLog Flex Pen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of cartridge. G. Keep the needle pointing up, press the button all the way. The dose selector turns to zero. A drop of insulin should appear at the needle tip. If not, change the needle, and repeat the procedure . . . ." Review of the manufacturer's medication package brochure for Humalog Pen occurred on 01/05/11. This brochure, dated 04/17/09, pages 10-14 stated, "III. Priming the Pen. Prime every time. The Pen must be primed to a stream of insulin (not just a few drops) before each injection to make sure the Pen is ready to dose . . . If you do not prime, you may get too much or too little insulin . . . 4. Turn the dose knob clockwise until the number '2' is seen in the dose window . . . 5. Hold your Pen with the needle pointing straight up. Tap the clear cartridge holder gently with your finger so any air bubbles collect near the top.	F 281	Professional nursing staff were re-educated on the proper procedure for priming of insulin pens at the monthly nurses meeting on 1/20/2011. They will be re-educated on 02/09/2011 at mandatory meeting for affected staff. 4. QAM or a nurse manager will conduct or delegate QA monitoring, utilizing a random sample of 50% of residents receiving insulin via insulin pen as follows: weekly x 4 weeks, then monthly x 3 months, then quarterly thereafter. **See Attached Form C.** 5. 2/10/11	

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F 281	Continued From page 25 Using your thumb, . . . push in the injection button completely. Keep pressing and continue to hold the injection button firmly while counting slowly to 5. You should see a stream of insulin come out of the tip of the needle . . . 6. At the completion of the priming step, a diamond [shape] must be seen in the center of the dose window . . . Note: A small air bubble may remain in the cartridge after the completion of the priming step. If you have properly primed the Pen, this small air bubble will not affect your insulin dose. . . ." Observation of medication pass on 01/03/11 at 5:05 p.m. and 5:10 p.m. with a nurse (#6) showed the nurse obtained Resident #21's Humalog (insulin) Pen and Resident #3's NovoLog (insulin) Flex Pen from the medication cart, attached a new needle to the top of each insulin pen, and turned the "dose selector or dose knob" on each pen to the number of units prescribed by the provider. The nurse entered each resident's room separately and administered the insulin injection to the residents. The nurse failed to "prime" or expel the air from the attached needle on the Humalog Pen or NovoLog Flex Pen. During interview on 01/05/11 at 10:55 a.m., an administrative nurse (#8) stated she expected staff to "prime" the needle of the insulin pen prior to administering insulin to the resident.	F 281		
F 309 SS=G	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.	F 309	**F-309 Provide care/services for highest well being.** 1a. Resident #7: Proper positioning devices have been placed on care plan and routine care sheet. 1b. Resident # 14—Fistula assessment form was placed on medication	

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F 309	Continued From page 26 This REQUIREMENT is not met as evidenced by: 1. Based on observation, record review, and staff interview, the facility failed to implement adequate interventions to ensure 1 of 1 sampled resident (Resident #7) received a wedge positioning device between her contracted knees. Failure to utilize the wedge resulted in expressions of pain and observed crying and moaning, and compromised the resident's ability to maintain or reach her highest practicable well-being. Findings include: Review of Resident #7's medical record occurred January 03-06, 2011. Diagnoses included, in part, osteoarthritis (chronic wearing down of cushioning joint cartilage leading to bone on bone) involving multiple sites with contractures and pain, cerebrovascular disease, dementia, seizures, and depression. The resident's medications included, in part, Hydrocodone/APAP (pain medication) twice daily and every 6 hours as needed. Resident #7's Minimum Data Set (MDS), dated 11/09/10, identified the resident is sometimes able to make herself understood and understand others, short and long term memory problems, and severe impairment with daily decision making. The resident required total assist of two staff with all activities of daily living and is functionally limited in range of motion of all upper and lower extremities. The current plan of care for Resident #7 in	F 309	administration record on 01/06/2011, with education provided to nursing staff at that time. 2a. Residents identified as needing positioning device(s) have the potential to be affected. 2b. Residents receiving hemodialysis who have a fistula in place have the potential to be affected. 3a. C.N.A. staff were educated on 01/10/11, 01/17/11, and 1/31/11 at neighborhood meetings and also at monthly C.N.A. meeting on 01/27/11. Professional nursing staff were educated at the monthly nurses meeting on 01/20/11. Education will be provided to affected staff at a mandatory meeting, to be held on 02/09/11. 3b. Professional nursing staff was re-educated at monthly nurses meeting on 1/20/2011. They will again be re-educated on 02/09/2011 at mandatory meeting for affected staff. 4a. QAM or a nurse manager will conduct or delegate QA monitoring, utilizing a random sample of 50% of residents who have a postioning device, as follows: weekly x 4 weeks; then monthly x 3 months, then quarterly thereafter. **See Attached Form D.** 4b. QAM or a nurse manager will conduct or delegate QA monitoring, assessing all residents with a fistula:	

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F 309	Continued From page 28 Resident #7 seated in her wheelchair at the nurses station. The resident cried and moaned loudly. A CNA (#22) approached her and stated, "Are you having pain?" The resident replied, "Yes" and continued crying. The CNA (#22) stated, "Do your knees hurt again?" Resident #7 replied, "Yes." The CNA (#22) began rubbing the resident's knees with her hands and stated, "You don't have your wedge pillow between your knees, no wonder you're hurting." An unidentified nurse asked Resident #7 if she wanted something for pain. The resident stated, "Yes". The nurse went to the medication room to obtain pain medication. The CNA immediately went to Resident #7's room and returned with the wedge cushion and placed it between the resident's knees and secured it with a velcro strap. The CNA (#22) asked the resident, "Is that better now?" and the Resident stated, "Yes." The nurse administered the pain medication and the CNA took the resident to her room and assisted her to bed. An interview occurred on 01/05/11 at 8:09 a.m. with an Restorative Therapy CNA (#19). The CNA stated she had notified nursing staff two months ago to use the wedge cushion between Resident #7's knees when she is in the wheelchair based on her own assessment. She stated she'd advised the nursing staff and CNAs to place a small pillow between the resident's knees when she is in bed as well. She also stated that both items were in the resident's room and had been for 2 months. She stated she inserviced the CNAs on the wedge cushion's use, but could provide no inservice attendance roster or documentation of the instruction given. An interview occurred on 01/05/11 at 9:50 a.m.	F 309	4. QAM or a nurse manager will conduct or delegate QA monitoring, assessing a 5% random sample of residents that are taking bowel medications or narcotic medications, as follows: weekly x 4 weeks, then monthly x 3 months, then quarterly thereafter. **See Attached Form D.** 5. 2/10/11	

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with a Physical Therapy staff member. The staff member stated, "What is on the RA [Restorative Therapy Program sheet] is what I recommend RT [Restorative Therapy] do to and whatever [Restorative Therapy CNA #19] tells nursing to do would be between her and the nursing staff and nurse manager."

An interview with an administrative staff member (#5) occurred 01/06/11 at 12:25 p.m. at which time, the staff member agreed facility staff failed to position the wedge between Resident #7's knees as directed.

An interview with administrative staff members (#2 and #12) occurred on 01/06/11 at 2:00 p.m. Both staff members agreed staff should have used the wedge for Resident #7 and the resident's care plan should be updated to ensure continuity of care.

2. Based on record review, staff interview, and resident interview, the facility failed to ensure the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well being for 1 of 2 sampled residents (Resident #14) with an implanted fistula used for hemodialysis, a process where blood is removed from the body filtered and returned to the body. Failure of facility staff to implement dialysis recommendations of monitoring the dialysis fistula has the potential for fistula complications to go unnoticed and could cause loss of the dialysis access site.

Findings include:

Review of Resident #14's medical record occurred January 05-06, 2011. The facility

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admitted the resident in May 2007 with diagnoses including chronic kidney disease and renal dialysis status. A quarterly Minimum Data Set, dated 11/29/10, identified a cognitive pattern summary score of 11 (moderate impairment) and the resident received dialysis. The facility resident roster identified Resident #14 as interviewable.

The current care plan for Resident #14 identified a focus or "At risk . . . due to dialysis treatments . . ." with interventions including "Dialysis 3 times per week as ordered." The care plan included "Care plan for hemodialysis residents," dated 04/09/08, which stated, ". . . Vital Signs, Weights and Care of Dialysis Access Sites . . . D. Access Site Checks: Every shift check access site for patency by auscultating bruit, palpating pulse, checking for color and warmth, document in Nurses Notes. If evidence of clotting, notify physician and/or KDC [kidney dialysis clinic]. . . ."

Medication pass observation for Resident #14 occurred on 01/03/11, at 5:20 p.m. When asked what type of dialysis Resident #14 received (hemodialysis or peritoneal) the nurse (#6) stated "hemodialysis." Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) failed to show monitoring of the fistula site.
During an interview, on 01/06/11 at 8:45 a.m., an administrative nursing staff member (#8) identified staff check dialysis access sites daily and document on the MAR.

Review of the MARs and TARs for October 2010 thru January 2011 showed staff failed to include monitoring of Resident #14's dialysis access site on these records. Nurses' notes also failed to demonstrate every shift monitoring of the dialysis

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F 309	Continued From page 31 access site. During an interview, on 01/06/11 at 9:20 a.m., the staff nurse (#7) caring for Resident #14, stated Resident #14 does not have a dialysis fistula site. The nurse (#7) reported Resident #14 had one in the past, but not currently. This staff nurse (#7) went with the surveyor to examine Resident #14 for a fistula site. Observation showed Resident #14 had a fistula dialysis access site in his left upper arm, with scabbed over needle marks demonstrating access by the dialysis unit. The nurse (#7) identified the January MAR/TAR lacked an intervention to check the dialysis access site daily. The nurse then added monitoring the dialysis access site each shift to the MAR/TAR for Resident #14. During an interview, on 01/06/11 at 10:55 a.m., Resident #14 identified staff check his dialysis access site "occasionally." Resident #14 stated he does not believe staff check the access site three times a day or once every shift. A current physician order, with an original order date of 05/31/07, stated "Ok to follow dialysis recommendations." During an interview, on 01/06/11 at 1:25 p.m., an administrative nursing staff member (#8) stated orders, on return from placement of the fistula in June 2007, failed to indicate monitoring of the dialysis access site, so the intervention was never added to the MAR/TAR. The physician gave a general order to follow recommendations from the dialysis unit. The dialysis unit identified the monitoring of the dialysis access site in April 2008.	F 309		

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3. Based on record review, staff interview, and review of professional literature, the facility failed to implement adequate interventions to ensure 1 of 1 sampled resident (Resident #3) maintained normal bowel elimination patterns to prevent constipation/fecal impaction. Failure to comprehensively assess and implement approaches/interventions for constipation resulted in Resident #3 requiring manual extraction of stool. Manual extraction of stool has the potential to cause the resident great discomfort and irritation of the rectal mucosa.

Findings include:

Taylor, Lillis, LeMone, "Fundamentals of Nursing, The Art and Science of Nursing Care," 4th edition, J.B. Lippincott Company, Pennsylvania, Pages 1185 and 1204, stated, ". . . Constipation is often a chronic problem for older adults . . . fecal impaction . . . can also result from physiologic or lifestyle changes . . . Most people have individual regular patterns or bowel elimination involving frequency . . . Changes in any of these may upset a person's routine and lead to constipation. . . . Digital Removal of Stool: . . . If a patient with a fecal impaction cannot expel the fecal mass voluntarily . . . the impaction must be broken up manually. A physician's order is required. This procedure may cause great discomfort to the patient as well as irritation of the rectal mucosa and bleeding. . . ."

Turkoski, Lance, Bonfiglio, "Drug Information Handbook for Nursing," 8th edition, Lexi-Comp, Ohio, pages 612-614, identifies Hydrocodone and Acetaminophen (brand name Vicodin) as a restricted Controlled III narcotic pain medication

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used in the treatment of moderate to severe pain and lists constipation as one potential adverse reaction of taking this medication. Nursing actions to consider include, in part, maintaining adequate hydration (2-3 liters/day of fluids) unless instructed to restrict fluid intake.

- Review of Resident #3's medical record occurred on January 03-06, 2011. The facility admitted the resident in November 2010 from an acute care hospital. Diagnoses, included, in part, open reduction, internal fixation (ORIF) right hip fracture, insulin dependent diabetes, osteoporosis, and peripheral neuropathy.

Review of Resident #3's admission Minimum Data Set (MDS), dated 11/24/10, identified the resident as able to make herself understood and cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) Score of 15, required extensive two person assist with bed mobility, transfer, and toilet use, continent of bowel, no issues with constipation at the present time, and received as needed oral pain medications.

Review of Resident #3's Nutritional Risk Assessment, completed by the facility's licensed registered dietician (LRD) on 11/29/10 identified Resident #3's "Overall Risk Category" as "High." Resident #3 scored high in the areas of fluctuation in weight status, 5 or more medications, and a Stage IV pressure ulcer. The LRD recommended, in part, a total intake of fluids from 1720-2500 cc's/day, diabetic snacks, and 8 ounces of Arginaid (a protein supplement) everyday.

Review of Resident #3's "Snack, Breakfast, and

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Lunch/Supper" computerized intake records identified the resident consumed less than her recommended daily fluid intake of 1720-2500 cc/day on:
*12/18/10 consumed 650 cc
*12/19/10 consumed 1260 cc
*12/20/10 consumed 680 cc
*12/21/10 consumed 940 cc
*12/22/10 consumed 1300 cc
*12/23/10 consumed 960 cc
*December 24-25 - "Resident not available" (out of the facility)
*12/26/10 consumed 1040 cc
*12/27/10 consumed 900 cc
*12/28/10 consumed 830 cc
*Consumed 720 cc on December 29, 30, 31

Review of Resident #3's Progress Note, dated 12/18/10 at 10:05 p.m., stated, "Res [resident] was straining to get BM [bowel movement] out. Author had to manually extract BM, was clay like and soft. Large results from extracting. Faxed [name of provider] to schedule a stool softener." Review of additional progress notes for Resident #3 failed to provide any further follow-up nursing assessment pertaining to the 12/18/10 episode of constipation.

Review of Resident #3's November 2010 Medication Administration Record (MAR) showed the resident received Vicodin 2 tablets orally every evening at 8 p.m. from November 24-30. In addition, Resident #3 received ten PRN Vicodin tablets in November 2010.

Review of Resident #3's December 2010 MAR showed the resident received the following pain medications:
*Vicodin 2 tablets at bedtime for five days

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F 309	Continued From page 35 (from December 01-05) *PRN Vicodin 1 tablet nine times (twice on December 01-02, and once between December 03-07). On 12/06/10, Resident #3's physician changed her pain medications to Vicodin 2 tablets three times a day (TID). The facility failed to initiate interventions for Resident #3 in the form of medication or additional dietary fiber to prevent constipation. Review of Resident #3's December 2010 MAR showed the resident received Milk of Magnesia (an oral laxative use in the treatment constipation) on December 04, 17, and 25, a bisacodyl suppository (a medication inserted into the rectum to promote the expulsion of stool) on December 20 and 29, and the initiation of Senna-S (an oral medication used in the short-term treatment of constipation and in the management/prevention of narcotic induced constipation) beginning on December 22 (two weeks after Resident #3's physician increased the narcotic pain medication to TID dosing). During interview on the afternoon of 01/04/11, a dietary staff member (#33) stated she was not aware of Resident #3's constipation incident on 12/18/10 and stated she did not complete a dietary assessment and/or implement any interventions in response to Resident #3's constipation incident. A dietary staff member (#34) stated Resident #3 already received prunes every morning with breakfast since admission to the facility. During interview on 01/05/11 at 7:40 a.m., an administrative nurse manager (#8) responded to	F 309		

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F 309	Continued From page 36 the 12/18/10 constipation incident, and stated "the nurse just assisted" Resident #3 to expel stool as she "was already on the toilet." This administrative nurse manager stated nursing staff failed to inform the dietary department of the incident. Review of Resident #3's care plan lacked evidence of dietary interventions implemented in response to Resident #3's constipation. Failure to inform dietary staff of Resident #3's constipation limited their ability to implement additional dietary interventions to help prevent further episodes of constipation and the need for manual extraction of stool.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide proper pericares for 3 of 13 sampled residents (Residents #4, #6, and #7). Failure to cleanse the area of skin in contact with urine and/or feces places residents at risk for skin irritation and/or skin breakdown. - Observation on 01/03/10 at 3:50 p.m., showed the certified nursing assistants (CNAs) (#20 and #21), provided pericares for Resident #7. The	F 312	**F-312 ADL care provided for dependent residents.** 1. Re-education was provided to C.N.A. staff at neighborhood meetings on 1/10/11, 1/17/11, and 1/31/11 and at monthly C.N.A. meeting on 1/27/11. 2. All residents requiring assistance with toileting have the potential to be affected. 3. All staff will be re-educated and increase our toileting hygiene education bi-annually. C NA staff were re-educated at neighborhood meetings on 01/10/11, 01/17/11, and 1/31/11 and also at monthly C.N.A. meeting on 01/27/11. Professional nursing staff were educated at monthly nurses meeting on 01/20/11. Education of affected staff will be provided at mandatory meeting to be held on 02/09/2011.	

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F 312	Continued From page 37 CNA (#20) removed the resident's brief and turning blanket, (both soiled with stool), and cleansed the resident's rectal and buttock area with periwipes. The CNA (#20) failed to cleanse the resident's perineal or groin area. - Observation on 01/04/11 at 11:05 a.m., showed the CNAs (#18 and #22), provided pericares for Resident #4 following urinary incontinence. The CNA (#18) removed the urine soaked brief, and began to cleanse the perineal and groin areas. Stool was found in the perineal and groin areas. The CNA (#18) continued cleansing with multiple periwipes and stated, "Where is all this [stool] coming from?" The presence of stool in the groin and perineal area, for a resident incontinent only of urine, indicated poor previous incontinence care. Review of the facility policy titled, "Perineal Care With or Without a Catheter", occurred on January 3-6, 2011. This policy, reviewed/revised September 2009, stated, "Policy: Perineal Care will be completed as part of the AM care and HS care; and whenever the resident is incontinent of urine and/or feces. Soap and water will be used for perineal care in the AM and HS. Disposable wipes will be used for perineal care at times when the resident is incontinent of urine and/or feces (incontinence care). . . . Purpose: Provide cleanliness and comfort to the resident. Prevent infections and skin irritation. Observe the resident's skin condition. . . . Procedure: . . . f. If resident is incontinent of stool, wipe excess stool away with toilet paper and wipes. Procedure for a female resident: . . . c. Separate labia, washing front to back, wash down each side of labia then down center over urethra and vaginal openings using a different part of cloth for each stroke. Pat	F 312	4. QAM or a nurse manager will conduct or delegate QA monitoring, assessing a 5% random sample of residents who are incontinent, as follows: weekly x 4 weeks; then monthly x 3 months, and then quarterly thereafter **See Attachment E.** 5. 2/10/11	

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F 312	Continued From page 38 dry. e. Wash upper and outer buttocks and down back of thighs. Pat dry. f. Wash rectal area wiping from base of labia towards anus. Change area of wash cloth with each stroke. Pat dry. 10. Procedure for a male resident: . . . b. Wash the penis from the urethral opening at the tip of the penis down towards the bottom of the penis and then wash the scrotum. . . . 1. Wash the inner thighs. 2. Pull back the foreskin of the uncircumcised male and clean under it. 3. Return the foreskin. 4. Dry the area. . . . d. Wash the rectal area thoroughly, including the area under the scrotum and anus. e. Dry thoroughly. An interview occurred on 01/06/11 at 2:00 p.m. with administrative nursing staff members (#2 and #12) regarding pericares. Both staff members agreed the CNAs (#10 and #20) failed to follow appropriate pericare procedures. - Observation on 01/03/11 at 4:15 p.m. showed two staff members (#15 and #16) transferred Resident #6 to bed. With Resident #6 in bed, the staff members (#15 and #16) donned gloves and changed the resident's incontinent brief. Upon removal of incontinent brief, observation showed it saturated with a large amount of feces. A staff member (#15) positioned Resident #6 on his right side while a staff member (#16) used numerous disposable wipes to cleanse the resident's buttock and coccyx area. Upon positioning/turning Resident #6 onto his back, these staff members (#15 and #16) failed to cleanse or wipe the resident's penial area, scrotum, or groin area to ensure the removal of all feces and/or urine.	F 312		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident	F 314	**F-314 Treatment/Services to Prevent/Heal Pressure Sores** **We are challenging this allegation, but in the spirit of cooperation, and per regulation, we propose the following plan of correction:**	

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F 314	Continued From page 39 who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, review of facility policy, and professional reference review, the facility failed to ensure that 1 of 1 resident with a facility acquired pressure sore (Resident #3) received the necessary treatment and services to promote healing of the pressure sore. Failure to assess, monitor, evaluate, and implement appropriate interventions resulted in Resident #3 developing an avoidable Stage IV (a pressure ulcer characterized, in part, as full thickness tissue loss with the present of dead or devitalized tissue [eschar] that is hard or soft in texture, usually black, brown or tan in color). Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding pressure ulcers. The standards state,"The care plan for a resident who is reclining and is dependent on staff for repositioning should address position changes to maintain the resident's skin integrity. This may include repositioning at least every 2 hours or more frequently depending upon the resident's condition and tolerance of the tissue load (pressure). Depending on the individualized	F 314	1. Resident #3 was evaluated by a podiatrist on 1/28/11. She is being monitored on an ongoing basis by facility wound team. LRD completed dietary assessment on11/29/10 with Arginaid implemented to aid in wound healing. Resident has an air overlay mattress, her heels are being floated, and repositioning continues every 2 hours as resident allows. Continues to be closely monitored. 2. Residents identified as at risk for skin breakdown have the potential to be affected. 3. We will continue to make team wound rounds on a weekly basis. Wound team will continue to do ongoing monitoring of any identified skin concerns. Braden Scale will continue to be done per protocol on all admissions to facility, as well as quarterly. 4. QAM or a nurse manager will conduct or delegate QA monitoring, assessing a 50% random sample of residents who have been identified as being at risk for skin issues, as follows: weekly x 4 weeks; monthly x 3 months, then quarterly thereafter **See Attached Form F.** 5. 2/10/11	

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assessment, more frequent repositioning may be warranted for individuals who are at higher risk for pressure ulcer development or who show evidence (e.g., Stage I pressure ulcers) that repositioning at 2-hour intervals is inadequate."

Review of the facility policy, "Skin Care Protocol" occurred on 01/05/11. This policy dated, 06/2005, stated, "POLICY: All residents will be assessed for their level of developing pressure areas at admission, quarterly/significant change, and hospital return. Efforts will be aimed at early intervention and prevention. Efforts will be made to ensure a resident who enters without a pressure area will not develop one unless the individual's clinical condition demonstrates that it is unavoidable. If a resident enters with a pressure area or any impaired skin integrity, efforts will be made to promote healing of the skin and tissue. OBJECTIVE: 1. To identify residents at risk for skin breakdown and those with skin breakdown. 2. To promote preventative measures to avoid the incident of pressure areas. 3. To promote measures for healing of pressure areas/ulcers and other impaired skin integrity. . . ."

Review of the facility's protocol titled, "Pressure Area Prevention/Healing" occurred on and identified interventions of " . . . Reposition every two hours . . . 11. Offer and record cc's [cubic centimeters] of supplement intake on snack sheet and meal sheet. . . ."

- Review of Resident #3's medical record occurred on January 03-06, 2011. The facility admitted the resident on November 2010 from an acute care hospital. Diagnoses, included, in part, open reduction, internal fixation (ORIF) right hip

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fracture, insulin dependent diabetes, osteoporosis, and peripheral neuropathy. Review of Resident #3's Progress Notes identified the resident experienced swelling and edema to her bilateral lower extremities.

Review of Resident #3's admission Minimum Data Set (MDS), dated 11/24/10, identified the resident as able to make herself understood and cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) Score of 15, required extensive two person assist with bed mobility, transfer, ambulation in room and corridor, dressing, and toilet use, and not at risk for the development of pressure ulcers.

Resident #3's Braden Scale scores, dated November 17 and 24, 2010, showed a score of 16. A Braden Scale score of 16 identified the resident as "at risk" for impaired skin integrity and/or pressure areas/sores.

Review of Resident #3's Progress Notes identified the resident exhibited pitting edema to her left and right lower extremities daily between November 18-25, 2010. Review of Resident #3's record lacked evidence of facility staff elevating or ensuring Resident #3's bilateral heels were "floated" to aide in decreasing the lower extremity peripheral edema and/or prevent pressure to her lower extremities.

Review of Resident #3's November and December 2010 Treatment Administration Records (TARS) stated, "Daily diabetic foot inspection," and bacitracin ointment to leg sores twice a day until healed, beginning on 12/22/10. Review of these TARS lacked a specific dressing change to the resident's left heel.

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During interview on 01/05/11 at 10:50 a.m., an administrative nurse manager stated "daily diabetic foot inspection" means a licensed nurse monitors diabetic resident's feet to check for areas of skin redness or breakdown. This nurse stated if redness or breakdown is noted, she would expect this to be documented in the resident's Progress Notes. Review of Resident #3's Progress Notes between November 17-25, 2010 included, in part, documentation pertaining to the resident's surgical incisions and peripheral edema, but lacked information pertaining to the status of her feet until a notation on 11/26/10.

Review of the Progress Note, dated 11/26/10 at 1:19 p.m. stated, "Ulcer/Wound Note. Location: L [left] heel. Type: Stage 4. Measurements: Purple blister to the center measures 2.7 cm [centimeters] X [by] 1.5 cm and the redness around it measures 5.5 cm X 3.7 c.m. Appearance: Res [resident] has Stage 4 to L heel. See measurements above. Blister is purple in color and soft and boggy with redness around it. Treatment/Plan: Ace wraps applied instead of TED hose. Spenco's [a type of pressure relieving boot] applied. Air mattress overlay applied to bed. Heels are floating." The facility notified Resident #3's physician of the above via fax on 11/26/10.

Review of the Resident #3's weekly Pressure Area/Ulcer/Wound Record, showed Resident #3's Stage IV left heel pressure ulcer measured:
*11/26/10 - length of 2.7 cm and width of 1.5 cm
*12/03/10 - length of 3.1 cm and width of 1.3 cm
*12/10/10 - length of 3.4 cm and width of 1.8 cm

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F 314	Continued From page 43 *12/17/10 - length of 3.4 cm and width of 1.7 cm *12/24/10 - length of 3.2 cm and width of 1.5 cm *12/31/10 - length of 1.0 cm and width of 2.2 cm Resident #3 required two person assist with bed mobility. Review of the facility's computerized "Toileting" Records showed the resident's position and length of time in that position as: *11/17/10 - positioned on back from 4 p.m. until 11 p.m. (total of 8 hours- hrs) *11/18/10 - positioned on back from 10 p.m. until 6 a.m. (total of 8 hrs) *11/20/10 - positioned on back from 7 p.m. until 6 a.m. (total of 11 hrs) *11/21/10 - positioned on back from 7 p.m. until 5 a.m. (total of 10 hrs) *11/22/10 - positioned on back from 7 p.m. until 3 a.m. (total of 8 hrs) *11/25/10 - positioned on back from 7 p.m. until 1 a.m. (total of 6 hrs) Review of Resident #3's care plan, dated 11/26/10, identified a problem of "Impaired Skin Integrity- Pressure Area d/t [due to] [decreased] mobility, fluid retention" with approaches of "1. Implement Pressure Area Protocol. 2. Wound care as ordered. 3. Monitor [and] record wound progress as indicated . . . 7. Pressure relieving [sic] device in chair or wheelchair . . . 9. Provide and record fluid, supplement, protein intake. 10. Assist and record repositioning and toileting. 11. Minimize shearing/friction: boots, lift sheet, heel protector, Spenco's . . . 18. Reposition q [every] 2 hrs [hours] . . . 23. Pressure reducing mattress. - air mattress overly- float heels when able."	F 314		

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Review of Resident #3's Nutritional Risk Assessment, completed by the facility's licensed registered dietician (LRD) on 11/29/10 identified Resident #3's "Overall Risk Category" as "High." Resident #3 scored high in the areas of fluctuation in weight status, 5 or more medications, and a Stage IV pressure ulcer. The LRD recommended a total caloric intake of 1500 calories/day, total protein intake requirements of 71-89 grams (gr) or 1-1.25 gr/kilogram, total intake of fluids from 1720-2500 cc's/day, diabetic snacks, and 8 ounces of Arginaid (a protein supplement) everyday.

Review of Resident #3's care plan, dated 12/03/10, identified a "Focus" statement of "I have nutritional problems or potential for nutritional problem r/t [related to] s/p [status post] hip fx [fracture] [and] surgery, IDDM [insulin dependent diabetes mellitus], hypercalcemia, HTN [hypertension], osteoporosis, hx [history] colon ca [cancer], occ [occasional] B.G. [blood glucose] [greater than] 200, open area. Anticipate unplanned wt [weight] loss r/t dx [diagnosis]" and with interventions of "Nutritional supplements prn [and] Arginaid [protein supplement to promote healing]. Provide liberal diabetic DAT [diet as tolerated] . . . Provide high protein menu features (meat, dairy, eggs, nutritional supplements) . . . ." Review of Resident #3's current plan of care for Nutrition, identified the initiation of high protein menu items of meat, dairy, eggs and nutritional supplements beginning on 12/03/10, seven days after the facility noted a Stage IV pressure ulcer to Resident #3's left heel.

Review of Resident #3's Nutrition and Dietary Progress Notes, dated December 12 and 30, 2010, and January 04, 2011, failed to assess the

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managers." Placing Resident #3's TED hose around the resident's lower ankles during this dressing change has the potential to cause more constriction to Resident #3's heels.

During interview on the morning of 01/06/11, the surveyor informed an administrative nurse manager (#8) of the nurse's (#23) failure to assess and observe Resident #3's bilateral heels during the above dressing change observation. This administrative nurse manager stated she expected the nurse to remove Resident #3's bilateral TED hose and inspect the heels during each scheduled dressing change.

During interview on 01/06/11 at 12:45 p.m., administrative nurse (#2 and #12) stated all resident bed mattresses in the facility are pressure relieving and upon the identification of the Stage IV pressure ulcer to Resident #3's heel, they added an air overlay mattress to the resident's bed as per their protocol. These nurse managers confirmed Resident #3's Braden Score of 16 indicated the resident as "at risk." These nurse managers stated the earlier placement of a more specialized mattress (air overlay mattress) would not have prevented the development of Resident #3's left heel pressure ulcer.

Review of Resident #3's record showed the resident exhibited severe peripheral edema to her bilateral legs and feet upon admission to the facility. Resident #3's "Toileting" records identified many instances of the resident laying supine for greater than two hour intervals. Resident #3's record lacked evidence the facility attempted to elevated her heels off the bed until after the discovery of the the Stage IV pressure ulcer to the left heel.

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F 314	Continued From page 47 Failure of the facility to ensure preventative measures were implemented immediately in response to Resident #3's "at risk" status for pressure ulcer development and to ensure elevation of the resident's heels while in bed or lying supine contributed to the development of Resident #3's Stage IV avoidable pressure ulcer.	F 314		
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, and staff interview, the facility failed to supervise the use of an assistance device or to provide a needed assistance device for the prevention of accidents for 1 of 1 sampled resident (Resident #9) who had a merry walker (a combination chair/walker ambulation device) available for safety, and 1 of 1 sampled resident (Resident #7) who uses padded side rails to prevent skin tears. Failure to assess the use of, or provide identified safety devices, has the potential to increase the risk of injury for residents. Findings include: - Review of Resident #9's medical record occurred January 3-6, 2011. The facility admitted	F 323	**F-323 Free of Accident Hazards/Supervision/Devices** 1a. Resident # 9 no longer utilizes merry walker, nor had he used it for a number of months. On 01/07/11 the merry walker was removed from the care plan. 1b. Resident # 7's siderails have been padded. 2a. A resident who has been assessed for use of merry walker per facility algorithm has the potential to be affected. (There are none in the facility at this time.) 2b. Residents utilizing side rails have the potential to be affected. The attached checklist has been implemented to assure any resident with padded side rails have them in place. **See Attachment # 3.** 3a. Residents considered for use of a merry walker will be assessed using facility algorithm prior to implementation and quarterly thereafter. Said resident who subsequently sustains a fall will be	

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F 323	Continued From page 48 the resident with diagnoses including Alzheimer's dementia. A physical therapy note, dated 08/02/10, stated "Allow Ind [independence] in w/c [wheelchair] or merry walker [with] aides such as seat belts/alarms recommended to prevent injury to pt [patient]." A quarterly Minimum Data Set (MDS), dated 10/24/10, identified Resident #9 required extensive assistance of two staff members for transfers; walking in the room or corridor did not occur; required total assistance of one staff member for locomotion on and off the unit; and used a wheelchair for a mobility device. The current care plan identified the following interventions, ". . . Use merry walker when resident is restless and doesn't want to sit or lie down. . . 1:1[one to one] while in merry walker when having [increased] anxiety/restlessness." Nurse's Notes identified the following occurrences as Resident #9 utilized the merry walker: * 08/11/10, [5:30 p.m.] Type of Fall: Res. [resident] crawled out of merry walker. Time of Fall: 5:30 PM. Location: HALLWAY BY NURSES STATION. Description of Incident: Res. found sitting sideways on floor. Alarm was in place before fall but res. shirt slippery and managed to unhook it. He lifted foot over belt with bar locked managed to crawl out from proper position. No injuries noted to body or head. Hourly checks started. Staff was assisting residents to dining room for supper. . . . Interventions: Supervision of 1:1 while in merry walker. * 08/27/10, [8:45 p.m.] Type of Fall: Resident was found on [right] side in half sitting position [with] [left] leg on strap of merry walker. Merry walker was in upright position & [and] bar across front was closed. Resident had gotten his head under	F 323	reassessed per algorithm for appropriateness of merry walker use. (Refer to F-221) Professional nursing staff were educated at the monthly nurses meeting on 01/20/11. C.N.A. staff were educated at neighborhood meetings on 01/10/11, 01/17/11, and1/31/11, and also at the monthly C.N.A. meeting on 01/27/11. Education will be provided to affected staff at mandatory meeting on 02/09/11. 3b. Professional nursing staff were re-educated at the monthly nurses meeting on 1/20/11. C NA staff were re-educated at neighborhood meetings on 1/10/11, 1/17/11, and 1/31/11, and also at monthly C.N.A. meeting on 01/27/11. Re-education will be provided to affected staff at mandatory meeting on 02/09/11. 4a. QAM or a nurse manager will conduct QA monitoring, assessing all residents who use a merry walker, as follows: weekly x 4 weeks, then monthly x 3 months, then quarterly thereafter **Refer back to QA Assessment A.** 4b. QAM or a nurse manager will conduct or delegate QA monitoring, assessing all residents who have padded side rails, as follows: weekly x 4 weeks, then monthly x 3 months, then quarterly thereafter. **Refer back to QA Assessment A.** 5. 2/10/11	

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F 323	Continued From page 49 bar before he was on floor. Time of Fall: 8:35 p.m. Location: End of D hall by the island; near soiled utility room. Description on incident: CNA [certified nurse aide] [staff's name] exited room 2 doors down the hall & saw the resident on the floor as described in above note. Author was in room around the corner; but did not hear resident fall, holler out or call for help. Staff unclipped strap from bar & moved merry walker away from resident. Assisted resident into lying position on floor. Resident able to move extremities [with] usual ROM [range of motion]. Resident started talking about other things when author asked if resident was hurt anywhere or if he had pain. No indications of pain [with] movement. No injuries noted. Assisted resident up [with] 2 assist & gaitbelt. Then assisted into Merry walker. Resident started on hourly checks . . . Injuries: None noted. . . . Interventions: Plan to continue [with] current fall interventions: use merry walker PRN [as needed] when resident is restless & doesn't want to sit or lie down, chair check when in WC [wheelchair], 1:1 friendship time PRN, low bed [with] bed alarm & mat next to it when resident is in bed, keep room/hallway clutter free, keep personal items within reach, wear hip protectors when up, has watch mate to prevent him from going outside unattended, & resident usually stays up late do not assist to bed before 10pm unless requests to go earlier. * 08/31/10, [3:00 p.m.] Type of Fall: [blank] Time of fall: 215pm [2:15 p.m.]. Location: CNA station, d neighborhood. Description of Incident: Resident was sitting in merry walker at desk, very restless and anxious this afternoon. Author was in nurses station and resident began yelling out "help." Author found resident sitting on strap of merry walker, turned sideways with feet on floor outside of merry walker. Lower back was against bar on	F 323		

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F 323	Continued From page 50	F 323		

right side of merry walker. Assisted back into upright position with 3 assist and gait belt. Injuries: Lower back reddened from pressure of bar. . . . Interventions: Resident will need 1 on 1 supervision while in merry walker when resident is having increased anxiety/restlessness.

Following the fall involving the merry walker on 08/11/10, the staff member's intervention identified "Supervision of 1:1 while in merry walker." The descriptions of the incidents on 08/27/10 and 08/31/10 do not identify staff provided one to one supervision while Resident #9 utilized the merry walker.

During an interview, on 01/05/11, at 10:05 p.m., an administrative nursing staff member (#5) stated Resident #9 is not currently using the merry walker, due to his condition. The care plan identified the merry walker remains available for Resident #9 to utilize.

During an interview, on 01/05/11, at 4:44 p.m., two administrative nursing staff members (#2 and #5) stated facility staff did not complete an assessment before initiating the merry walker for Resident #9. They also identified the merry walker was not reassessed after Resident #9 had a fall involving the merry walker. One staff member (#2) stated after the 08/11/10 incident the use of the merry walker changed to as needed. Both staff members (#2 and #5) identified the merry walker is still available for Resident #9's use.

Review of the medical record failed to identify facility staff assessed the use of the merry walker by Resident #9 prior to initiating the merry walker. The facility failed to assess the continued use of

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the merry walker after the resident "crawled" out of the square framed device on 08/11/10, and again following the incidents on 08/27/10 and 08/31/10. Crawling out of and/or falling out of the merry walker increases Resident #9's risk for injury.

- Resident #7's medical record, reviewed January 3-6, 2011, identified the resident's medical diagnoses included, in part, Alzheimer's disease, dementia, depression, osteoarthritis and seizures. Resident #7's medications included, in part, Risperdal (antipsychotic medication) 0.25 milligrams (mg) daily, Hydrocodone/Acetaminophen (pain relief medication) 5/500 twice daily and every 6 hours as needed (prn), Ativan (antianxiety medication) 0.5 mg-1 mg 1 hour before bathing, and Zoloft (antidepressant medication) 25 mg daily.

Resident #7's Minimum Data Set (MDS), dated 11/09/10, identified Resident #7 sometimes able to make self understood and understand others, short and long term memory problems, severely impaired daily decision making, with delirium, required total assist for bed mobility and transfers. The resident's MDS's, dated 08/06/10 and 02/06/10 indicated physically abusive behavioral symptoms and resistance of cares.

Resident #7's care plan, revised 12/06/10, stated, "Focus: Potential for impaired skin integrity . . . Interventions: Padded side rails x 2 [times 2]."

Resident #7's Interdisciplinary Care Plan Conference Record, dated 11/09/10, stated, "Zoloft d/c [discontinued] 11/3/10. Seeing increased crying, agitation, restlessness. Family wants [Zoloft] back." The record indicated the

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F 323	Continued From page 52 Zoloft was resumed. Observation on 01/03/11, during initial tour at 11:00 a.m., showed Resident #7 lying in bed, violently shaking her hands in the air, top side rails in the upright position on both sides of the bed. Observation showed no padding on the side rails. Interview with an administrative nursing staff member (#5) occurred at this time. The staff member stated, "[Resident #7] must be agitated. She does that when she gets agitated." Observation on 01/03/11 at 3:35 p.m., showed Resident #7 lying on her right side facing the door, pulling and tearing at her bedsheet. Observation showed two side rails in the upright position and not padded. Observation on 01/03/11 at 3:50 p.m., showed facility staff providing cares for Resident #7. The bed side rails remained upright, without padding, before and after completion of cares. Observation on 01/04/11 at 8:10 a.m., showed Resident #7 in bed with two unpadded side rails in the upright position. Observation on 01/04/11 at 10:10 a.m., showed facility staff returning Resident #7 to bed using a mechanical lift. The staff positioned the resident on her side, placed the side rails upright, and observation showed the side rails remained unpadded. An interview with an administrative nursing staff member (#5), and nursing staff members (#9 and #10) occurred consecutively on 01/04/11 from 10:00 a.m. to 10:30 a.m. All staff members stated Resident #7's side rails should be padded as	F 323		

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F 323	Continued From page 53 careplanned for her safety. The facility's failure to provide padded side rails placed Resident #7 at risk for accident and injury.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview, and staff interview, the facility failed to ensure acceptable parameters of nutritional status for 1 of 3 sampled resident (Resident #2) who experienced weight loss. Failure to implement additional interventions or evaluate the effectiveness of current interventions may have contributed to Resident #2's significant weight loss. Findings include: Review of Resident #2's medical record occurred on all days of survey. Medical diagnoses included depression and chronic obstructive pulmonary disease (COPD). Medications included Cymbalta (an antidepressant) increased to 60 milligrams	F 325	**F-325 Maintain Nutrition Status Unless Unavoidable** 1. Resident #2—Supplement use has been added to daily documentation in the clinical record. Initiation of snack changes per resident's preference was completed on 1/6/11. LRD will continue to meet with resident on an ongoing basis for food preference updates. Diet card was revised to indicate high-calorie menu features and favorite foods. 2. Any resident with the assessed potential of experiencing a significant weight loss has the potential to be affected. 3. Documentation of supplements will be added to the resident's clinical record for those residents with weight loss, or residents identified as not having adequate dietary intake. The LRD will evaluate, assess and discuss food preferences and/or alternatives with any resident who meets the above criteria. Will continue with bi-monthly nutrition-at-risk meetings to review residents' nutritional status and implement interventions as indicated. Dietary staff were re-educated at monthly dietary department meeting on 1/27/11. Professional nursing staff were re-educated at the monthly nurses	

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F 325	Continued From page 54 daily on 12/14/10. Review of Resident #2's Minimum Data Set (MDS), dated 12/03/10, identified no concerns with long or short term memory and a weight loss of five percent or more in the last 30 days. Review of Resident #2's current care plan stated, ". . . At nutrition risk d/t [due to] depression, COPD . . . Res [resident] dislikes nutritional suppl. [supplement] but has agreed to try. Interventions: High protein and high calorie menu features. Provide liberal geriatric DAT [diet as tolerated] per MD [medical doctor] . . . report to unit supervisor when 75 percent of meal not eaten x [times] 3 days. Refer to dietician for evaluation/recom. [recommendation]." A nutritional risk assessment, completed on 11/29/10, identified Resident #2 as a high nutritional risk related to a five percent weight change in 30 days, taking five or more medications daily, and a diagnosis of depression. Review of Resident #2's weight summary record showed an overall weight loss. Monthly weights included the following: * 01/28/10 - 116.0 pounds * 02/25/10 - 114.8 pounds * 03/25/10 - 115.1 pounds * 04/29/10 - 110.4 pounds * 05/27/10 - 107.4 pounds * 06/24/10 - 105.9 pounds * 07/29/10 - 107.1 pounds * 08/26/10 - 105.6 pounds * 09/30/10 - 104.0 pounds * 10/28/10 - 106.1 pounds * 11/25/10 - 100.4 pounds * 12/23/10 - 98.6 pounds	F 325	meeting on 1/20/11. C.N.A. staff were re-educated at neighborhood meetings on 1/10/11, 1/17/11, and 1/31/11, and also on 1/27/11 at monthly C.N.A. meeting. Education will be provided to affected staff at mandatory meeting on 2/09/11. 4. QAM or LRD will conduct or delegate QA monitoring, reviewing dietary interventions and appropriateness thereof, as follows: weekly x 4 weeks, then monthly x 3 months, then quarterly thereafter. **See QA Assessment G.** 5. 2/10/11	

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F 325	Continued From page 55 Review of Resident #2's dietary progress notes identified the following: * 02/23/10 - ". . . Res wt [weight] 115# [pounds]. Wt stable. Meal intakes good . . ." * 06/01/10 - "Res at high risk . . . wt 107#. Gradual, unplanned wt loss [greater than] 7.5 % [percent] significant wt loss x 3 months. * 06/11/10 - "Res wt 107#. [greater than] 7.5% wt loss 3 months . . . Res declines [high] calorie snacks between meals. Visited with res. Res declines other [high] calorie food/beverage options." * 08/30/10 - ". . . Res at moderate risk . . . nutritional supplements prn [as needed], high calorie menu features . . . wt 106#." * 11/26/10 - "100.4# - 5% change over 30 days . . . Meal intakes vary but average 75%. Visited res regarding wt loss, intake, etc. Res stated she isn't in the mood for anything, appetite isn't what it used to be, etc. Res spending time outside in frigid weather. Calorie may be increased [sic]. Will continue to offer favorite foods, high calorie foods, etc. Anticipate unplanned wt loss r/t [related to Dx [diagnosis]." The resident's smoking area is located outside and Resident #2 smoked often. * 12/12/10 - ". . . [greater than] 5% unplanned wt loss . . . nutritional supplements prn, high calorie menu features. Wt 100# . . . Res stated she eats enough, feels she is heavy enough, doesn't want to gain wt . . . Res agreed to try Resource [a nutritional juice supplement] daily." * 12/30/10 - "98.6# . . . res eats one good meal and the other 0-25%. Visited to ask about appetite. Res stated she isn't doing good, doesn't feel like eating. Discussed with Nurse Manager. Anticipate unplanned wt loss d/t Dx." Resident #2's meal card, provided by a dietary	F 325		

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F 325	Continued From page 56 staff member, stated, "Lib [liberal] Ger [geriatric] DAT. The diet card failed to indicate the resident received high calorie menu features or list of her favorite foods. Observation showed Resident #2 made her foods selections from the same menu all the residents chose from. The 2:45 p.m. snack menu indicated the resident received four ounces of Resource. During an interview on 01/04/11 at 3:00 p.m., a certified nursing assistant (CNA) (#13) stated Resident #2 never accepts the Resource and asks for coffee instead. Review of the computerized snack intake records identified Resident #2 as not in the tracking system. During an interview on 01/05/11 at 12:45 p.m., Resident #2 stated she "hates those juice drinks (referring to Resource)." She tried the pink drink, Ensure (a nutritional supplement), and liked it. She also stated she likes cookies. Observation showed Resident #2 received neither the pink Ensure or a cookie. During an interview on 01/06/11 at 9:15 a.m., a Licensed Registered Dietician (LRD) (#33) stated Resident #2 received one Resource drink every day for the afternoon snack. She didn't realize the resident refused the drink every day, or that she liked the pink Ensure and cookies. Resident #2's snack intakes are not documented in the computer tracking system. The LRD stated she has considered adding benecalorie (a high calorie/protein supplement to foods or drinks) to Resident #2's food item. Failure to evaluate Resident #2's current dietary interventions, initiate new interventions, or consider the resident's food preferences may have contributed to her significant weight loss.	F 325		
F 329	483.25(l) DRUG REGIMEN IS FREE FROM	F 329		

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F 329 SS=D	Continued From page 57 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 a professional reference, and staff interview, the facility failed to ensure a drug regimen free of unnecessary drugs, including adequate monitoring, for 2 of 3 sampled residents (Resident #9 and #17) receiving antipsychotic medications without adequate indication for their use. Failure to monitor the need for, and attempt a dose reduction of antipsychotic medications may result	F 329	**F-329 Drug Regimen is Free From Unnecessary Drugs** **We are challenging this allegation, but in the spirit of cooperation, and per regulation, we propose the following plan of correction:** **Part 1** 1. Physician to review clinical record of Resident #17. On 12/16/10 per consultant pharmacist's medication review, physician was asked to make assessment of psychotropic medications for continued need and trial dose reduction, unless clinically contraindicated. Pharmacist requested this be reviewed on his next visit but no later than 2 months. Resident was seen by physician during rounds on 1/31/11. 2. Residents receiving psychotropic medication have the potential to be affected. 3. A tool will be developed tracking all residents receiving psychotropic medications. Resident's physician will be requested to address gradual dose reduction or provide clinical rationale for continued medication use. Continued monitoring will be done during facility's monthly medication review. **See Attachment #4.** Professional nursing staff were re-educated at the monthly nurses meeting on 01/20/11. Re-education of affected staff will be provided on 2/9/11 at mandatory meeting.	

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F 329	Continued From page 58 in residents receiving unnecessary medications. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding the tapering of medications, including the GDR, stating the purpose of tapering a medication is to find an optimal dose or to determine whether continued use of the medication is benefiting the resident. Tapering may be indicated when the resident's clinical condition has improved or stabilized or the underlying causes of the original target symptoms have resolved. Often, however, the only way to know whether a medication is needed indefinitely and whether the dose remains appropriate is to try reducing the dose and to monitor the resident closely for improvement, stabilization, or decline. For antipsychotic medication, within the first year the facility must attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. - Resident #17's medical record, reviewed on January 5-6, 2011, identified the facility admitted the resident in February 2009. Medical diagnoses included, in part, Alzheimer's disease, anxiety, and depression. Resident #17's current medications included, in part, Risperdal (antipsychotic medication) liquid 0.125 milligrams (mg) twice daily (bid) Ativan (antianxiety medication) 0.5 mg daily at 4:00 p.m. and 0.5 mg every 4 hours as needed (prn). Resident #17's pharmacy review notes, progress notes, and physician orders failed to identify any attempt of a gradual dose reduction for Risperdal or Ativan in 2010.	F 329	4. QAM or a nurse manager will conduct or delegate QA monitoring, assessing a 5% random sample of residents who are on psychotropic medications, as follows: weekly x 4 weeks, monthly x 3 months, then quarterly thereafter. **See Attached Form H.** 5. 2/10/11 **Part 2** 1. Attending physician declines an attempted dose reduction of Haldol because two antipsychotic medications are not to be reduced at the same time. A dose reduction on the Ativan was implemented on 11/30/10. We are continuing to monitor. 2. Residents receiving psychotropic medications have the potential to be affected. 3. A tool will be developed tracking all residents receiving psychotropic medications. Resident's physician will be requested to address gradual dose reduction or provide clinical rationale for continued medication use. Continued monitoring will be done during facility's monthly medication review. **Refer back to Attachment #4.** Professional nursing staff were re-educated at the monthly nurses meeting on 01/20/11. Re-education for affected staff will also be provided on 02/09/11 at mandatory meeting.	

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F 329	Continued From page 59 Resident #17's Minimum Data Set (MDS), dated 11/25/10, identified long and short term memory problems, rarely understands others or makes self understood, moderately impaired decision making, physical and verbal behaviors, wandering and resistive with cares. Resident #17's care plan, revised on 11/11/10, stated, "Focus: [Resident name] has a diagnosis of Alzheimer's dementia and is prescribed psychotropic medication to aide in the reduction of inappropriate behaviors related to above said diagnosis. Goals: She will exhibit less inappropriate behaviors as evidenced by staff reports. Interventions: Medication Review Committee to follow. Staff will monitor for observable mood fluctuations and behaviors - All and update RN [Registered Nurse] and SW [Social Worker] as needed. Establish routine with resident." During an interview on 01/06/11 at 10:30 a.m., a nursing administrative staff member (#2) agreed Resident #17's medical record lacked evidence of a gradual dose reduction for Risperdal or physician documentation of contraindications for the reduction. - Review of Resident #9's medical record occurred January 03-06, 2011. The facility admitted the resident in July 2010. Medical diagnoses included, in part, Alzheimer's disease, dementia, and anxiety/restlessness. Current medications included, in part, Haldol 0.5 (an antipsychotic medication) milligrams (mg) daily at bed time (ordered 07/26/10), and Ativan (an antianxiety medication) 0.25 mg daily at bed time (ordered 11/30/10).	F 329	4. QAM or a nurse manager will delegate or conduct QA monitoring, assessing a 5% random sample of residents who are on psychotropic medications, as follows: weekly x 4 weeks, then monthly x 3 months, then quarterly thereafter. **See Attached Form H.** 5. 2/10/11	

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F 329	Continued From page 60 Resident #9's quarterly MDS, dated 10/24/10, identified long and short term memory problems, sometimes understands others or makes self understood, severely impaired decision making, and no behavioral symptoms. Resident #9's care plan, revised on 12/28/10, stated, "Focus: Resident has a diagnosis of Dementia and is prescribed Ativan PRN and Haldol HS (Hour of sleep). - Ativan HS. Goals: [Resident #9] will maintain a stable mood with the use of medication. Interventions: Followed by Medication Review Committee. Monitor for observable mood fluctuations. Inform and consult BSW [Bachelor of Social Work] as needed." Behavior tracking sheets for Resident #9 dated September 08-21, 2010, October 06-19, 2010, and November 30, 2010 - December 13, 2010 were blank, indicating no behaviors. Physician progress notes for Resident #9 indicated the following: * 09/29/10, " . . . He had quite a bit of problem initially because [sic] his behavior. . . .We have made several medication changes and currently he is on Haldol and Ativan at night and Ativan before bathing. This actually is working quite well. . . .About three or four days ago, we noticed a sudden decline in his energy level and activity . . ." * 10/29/10, ". . . His wife was quite concerned over the last few weeks because he was very fatigued and was 'sleeping 20 hours a day' according to her report. However, I talked to the nursing staff who does not feel that has been a very significant change in his status. His wife has requested to stop the Namenda as she is	F 329		

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concerned that this was a side effect. I assured her that this would be an unlikely cause and suspected it be from the [sic] either the Haldol or the Ativan we have had to use because of his aggressive uncontrolled behavior. Unfortunately, these medications could be causing some mild sedation but there are times when staff simply could not perform their routine care as he was combative or aggressive. There have been no recent complaints about that type of behavior. There has also been less wondering [sic] the halls and disrupting of other patients. . . . As long as he is not considered to have episodes of aggressive or combative behavior, I am hoping we can start to titrate down off the Haldol and Ativan. . . ."

The decline in Resident #9's medical status/behavior was noted in September, yet in October the facility failed to titrate Resident #9's Haldol or Ativan.

* 11/30/10, " . . .However, she [Resident #9's wife] did leave a note that she would like us to try decreasing his 'sedating' medication. According to the staff, he has not had as much aggressive and combative behavior. They also agree that he is spending more time sleeping. In fact, he was getting [Ativan] 30 minutes before bathing and recently the staff that have performed the bathing had made the comment that he probably does not require it any longer. . . . Plan: We are going to try decreasing his [Ativan] to 0.25 mg at bedtime. We are also going to change his bathing [Ativan] to PRN [as needed]. . . ."

Observations of Resident #9 demonstrated the following:

* 01/03/11, during the initial tour at 11:00 a.m., Resident #9 in his recliner with his feet elevated and eyes closed. The resident's roommate identified Resident #9 was sleeping.

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F 329	Continued From page 62 - 3:05 p.m. observation showed Resident #9 in bed with his eyes closed. - 4:35 p.m., two certified nurse aides (CNAs) (#24 and #25) assisted Resident #9 out of bed. A CNA (#25) fed Resident #9 an afternoon snack. Resident #9 did not open his eyes while eating and slowly ate the entire snack. The CNA (#25) then washed the resident's face and, without opening his eyes, Resident #9 asked if she got it all. - 5:30 p.m., Resident #9 sat at the dining room table eating with his eyes closed. * 01/04/11 at 8:15 a.m., Resident #9 kept his eyes closed while a CNA (#26) attempted to assist the resident to eat breakfast. The CNA (#26) frequently encouraged the resident to open his mouth by rubbing his shoulder and asking him to wake up. Resident #9 would open his mouth far enough to get the spoon in, but never opened his eyes. Resident #9 consumed less than 25% of his meal. At the end of breakfast, two CNAs (#26 and #31) reclined Resident #9 back in his recliner. Resident #9 did not open his eyes while in the recliner. - 9:30 a.m., two CNAs (#30 and #27) assisted Resident #9 to bed. The CNAs offered Resident #9 water, but the resident did not respond. A CNA explained "He will usually take a drink. Today he is so sleepy." - 12:25 p.m., Resident #9 sat in the dining room with his eyes closed during the noon meal, consuming less that 75% of the meal. - 5:07 p.m. Resident #9 sat in his wheelchair, in his room, with his eyes closed leaning to the left and slightly forward. * 01/05/11 at 7:55 a.m., two CNAs (#10 and #27) assisted Resident #9 to transfer from his bed to his recliner for breakfast. Resident #9 did not open his eyes during the transfer.	F 329		

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F 329	Continued From page 63 - 4:10 p.m. two CNAs (#28 and #29) assisted Resident #9 from bed into his wheelchair. The resident did not open his eyes during the transfer. A CNA (#28) fed Resident #9 an afternoon snack. The resident did not open his eyes while eating very slowly, and opened his mouth only enough to get the spoon into his mouth. During an interview, on 01/03/10, a family member (#1) expressed concerns that Resident #9 sleeps all the time. This family member also voiced concerns regarding Resident #9's continued use of Haldol. The family member stated understanding using the medication when Resident #9 had behavior issues, but feels Resident #9 no longer has behavior issues. During an interview on 01/05/11 at 10:05 a.m., an administrative nursing staff member (#5) confirmed Resident #9's physician reduced the Ativan, but had not yet addressed the continued use of the antipsychotic Haldol.	F 329		
F 373 SS=D	483.35(h) FEEDING ASST - TRAINING/SUPERVISION/RESIDENT A facility may use a paid feeding assistant, as defined in §488.301 of this chapter, if the feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and the use of feeding assistants is consistent with State law. A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). In an emergency, a feeding assistant must call a supervisory nurse for help on the resident call	F 373	**F-373 Paid Feeding Assistants** 1. This was a one-time occurrence, and residents experienced no negative effect or outcome. PFA involved has been re-educated on role and job duties of PFAs. 2. Any resident who has a complicated eating problem has the potential to be affected. 3. PFA's are assigned to specific residents who do not have a complicated eating problem and have been assessed by a nurse or speech therapist to be appropriate to be fed by	

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F 373	Continued From page 64 system. A facility must ensure that a feeding assistant feeds only residents who have no complicated feeding problems. Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings. The facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care. NOTE: One of the specific features of the regulatory requirement for this tag is that paid feeding assistants must complete a training program with the following minimum content as specified at §483.160: o A State-approved training course for paid feeding assistants must include, at a minimum, 8 hours of training in the following: Feeding techniques. Assistance with feeding and hydration. Communication and interpersonal skills. Appropriate responses to resident behavior. Safety and emergency procedures, including the Heimlich maneuver. Infection control. Resident rights. Recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting those changes to the supervisory nurse. A facility must maintain a record of all individuals used by the facility as feeding assistants, who have successfully completed the training course for paid feeding assistants.	F 373	a PFA. Professional nursing staff were re-educated at monthly nurses meeting on 01/20/11. C.N.A. and PFA staff were re-educated on 01/10/11, 01/17/11 and 1/31/11 at neighborhood meetings, and also on at monthly C.N.A. meeting on 01/27/11. Re-education will be provided to affected staff at mandatory meeting on 02/09/11. 4. QAM or a nurse manager will conduct or delegate QA monitoring, assessing 100% of residents who are being fed by PFAs, as follows: weekly x 4 weeks, then monthly x 3 months, then quarterly thereafter **See Attached Form I.** 5. 2/10/11	

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This REQUIREMENT is not met as evidenced by:
Based on observation, policy and procedure review, record review, and staff interview, the facility failed to ensure 1 of 1 sampled resident identified with a swallowing difficulty was not fed by a Paid Feeding Assistant (PFA). Failure to ensure a PFA feeds only residents with no complicated feeding problems has the potential to place residents at risk for choking and aspiration.

Findings include:

The Centers for Medicare and Medicaid Services (CMA) has outlined the standard of practice regarding allowing PFAs to assist residents with eating and stated, "The intent of this regulation is to ensure that employees who are used as paid feeding assistants are: . . . assisting only those residents without complicated feeding problems and who have been selected as eligible to receive these services from a paid feeding assistant; and providing assistance in accordance with the resident's needs, based on individualized assessment and care planning."

Review of the facility's policy titled "Paid Feeding Assistant," dated December 2009, occurred on the morning of 01/06/11. The policy stated, "Paid Feeding Assistants will only feed residents who have no complicated feeding problems. Complicated feeding problems include, but are not limited to, difficulty swallowing, . . . Paid Feeding Assistants may also be referred to as Mealtime Assistants. . . ."

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Observation on 01/04/11 at 11:45 a.m., showed a mealtime assistant (#1) seated next to Resident #13. This assistant attempted to feed Resident #13 for approximately 10 minutes before an unidentified certified nursing assistant stated "do you want me to try" and relieved her.

Review of Resident #13's medical record occurred on January 05-06, 2011. The resident's diagnoses included dysphagia (difficulty swallowing).

Review of Resident 13's current Minimum Data Set (MDS), dated 12/11/10, identified the resident required extensive assistance of one person with eating. Review of a "Paid Feeding Assistant Assessment," dated 12/06/10, identified the resident had a complicated feeding problem and should not be fed by a paid feeding assistant.

Review of Resident 13's current plan of care, identified the problem of "requires assistance/potential to restore function to maximum self-sufficiency for eating related to confusion" and the approach, revised 12/12/10, of "Not approved for PFA."

Review of the "Meal Assistance Requirements" form posted in the dining room showed Resident #13's name included under the category heading of "residents who cannot be assisted by meal assistants."

During an interview on 01/06/11 at 9:10 a.m., the meal assistant (#1) identified she sometimes gets [Resident #13] going at a meal and clarified this meant offering the resident sips of water and putting food up to his mouth to take bites. This staff member stated she had assisted Resident

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F 373	Continued From page 67 #13 in this manner two to three times in the last month. This staff member stated she did not check the "Meal Assistance Requirements" form on 01/05/11 and took direction from other staff members who told her where to sit when she assisted residents in the dining room. During an interview on 01/06/11 at 10:15 a.m., an administrative nursing staff member (#2) stated PFAs are expected to check the "Meal Assistance Requirements" form and not feed residents with complicated feeding problems.	F 373		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review, review of professional reference, and staff interview, the facility's consultant pharmacist failed to recommend a gradual dose reduction (GDR) for 1 of 5 sampled residents (Resident #17) receiving an antipsychotic. Failure to report and monitor for GDRs may result in residents receiving unnecessary medications and has the potential to affect the residents' highest level of functioning.	F 428	**F-428 Drug Regimen Review** **We are challenging this allegation, but in the spirit of cooperation, and per regulation, we submit the following plan of correction.** 1. Physician to review clinical record of Resident #17. On 12/16/10 per consultant pharmacist's medication review, physician was asked to make assessment of psychotropic medications for continued need and trial dose reduction. Pharmacist requested this be reviewed on his next visit but no later than 2 months. Physician reassessment was done on 1/31/11. Continued monitoring is being done. 2. Residents receiving psychotropic medications have the potential to be affected. 3. Psychotropic medication use continues to be reviewed on a monthly basis during facility monthly medication review. A tool has been developed and	

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F 428	Continued From page 68 Findings include: Resident #17's medical record, reviewed on January 5-6, 2011, identified the facility admitted the resident in February 2009. Medical diagnoses included, in part, Alzheimer's disease, anxiety and depression. Resident #17's current medications included, in part, Risperdal (antipsychotic medication) liquid 0.125 milligrams (mg) twice daily (bid). Review of Resident #17's pharmacy review notes, progress notes, and physician orders failed to identify any attempt of a gradual dose reduction for Risperdal in 2010. During an interview on 01/06/11 at 10:30 a.m., a nursing administrative staff member (#2) agreed Resident #17's medical record lacked evidence of a gradual dose reduction for Risperdal or physician documentation of contraindications for the reduction. The staff member agreed the pharmacist should have recommended a GDR.	F 428	placed in consultant pharmacist's books for tracking purposes. **See Attachment 4.** Professional nursing staff were re-educated at monthly nurses meeting on 01/20/11. Affected staff will be re-educated at mandatory meeting on 02/09/11. 4. QAM or a nurse manager will conduct or delegate QA monitoring, assessing a 5% random sample of residents who are on psychotropic medications, as follows: weekly x 4 weeks; then monthly x 3 months, then quarterly thereafter. **See Attached Form H.** 5. 2/10/11	
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 431	**F-431 Drug Records--Record, Label/Store Drugs & Biologicals** **We are challenging this allegation, but in the spirit of cooperation, and per regulation, we submit the following plan of correction:** 1. No residents were directly affected by this. 2. No residents were directly affected by this. 3. The refrigerators in the nurses stations on A, B, and C neighborhoods	

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F 431	Continued From page 69 instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of professional reference, the facility failed to ensure only appropriately licensed personnel have access to medication rooms located on 4 of 4 Neighborhoods within the facility (Neighborhood A, B, C, and D) and failed to store all medications in a secure manner in 3 of 4 medication rooms (Neighborhood A, B and C). Failure to limit access to the medication room to only appropriately licensed professionals (licensed nurses or pharmacist) has the potential to endanger the security of drugs. Failure to ensure all medications are stored in a secure manner could result in unauthorized access to medications.	F 431	have had locks installed on them. Professional nursing staff were re-educated at monthly nurses meeting on 01/20/11, and will also be re-educated at mandatory meeting on 2/09/11. 4. QAM or a nurse manager will conduct or delegate QA monitoring, assuring refrigerators in nurses stations are locked, as follows: weekly x 4 weeks; monthly x 3 months, then quarterly thereafter. **See Attached Form H.** 5. 2/10/11	

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F 431	Continued From page 70 Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding the labeling and storage of drugs and biologicals. The facility must secure all medications in locked storage areas and limit access to authorized personnel. Storage areas may include drawers, cabinets, medications rooms, refrigerators, and carts. The facility must have a system to limit who has security access and when access is used. A random observation of the facility on the afternoon of 01/03/11 showed each "Neighborhood" or wing of the facility contained one room designated as a nursing station/medication room. Observation of the items found in each of the facility's four designated nursing station/medication rooms included the residents' current medical record, a medication cart, and a medication refrigerator. Observation on the afternoon of 01/04/11 showed a facility social worker unlocked the door to the medication room on Neighborhood C to allow the surveyor access to residents' medical record. Observation showed no nursing staff present. During review of the Neighborhood C nursing station/medication room on 01/05/11 at 9:30 a.m. with a nurse (#41), observation showed an unlocked medication refrigerator containing 2 opened insulin vials, 5 insulin pen boxes, an opened box of Tylenol suppositories, a vial of injectable Interferon (an immunomodulator medication), and liquid omeprazole (an antinuclear medication). In addition, observation showed an unlocked cupboard which contained	F 431		

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Neighborhood C's stock medications. The nurse (#41) stated "housekeeping staff have a key so they can come and clean the room."

Observation on 01/05/11 at 9:55 a.m. showed the chaplain unlocked the door to the nursing station/medication room on Neighborhood D. Observation showed no nursing staff present in the medication room at this time.

A random observation on the morning of 01/05/11 showed an unidentified housekeeping staff member cleaning the Neighborhood C nursing station/medication room without nursing staff present.

During review of the Neighborhood B nursing station/medication room on 01/05/11 at 3:40 p.m. with a nurse (#42), observation showed an unlocked medication refrigerator. The refrigerator contained insulin vials, insulin pens, liquid omeprazole, liquid neurontin (an anticonvulsant medication), and Tylenol suppositories.

During review of Neighborhood the A nursing station/medication room on 01/05/11 at 4:00 p.m. with a nurse (#9), observation showed an unlocked medication refrigerator. The refrigerator contained insulin vials, insulin pens, liquid omeprazole, and Tylenol suppositories.

Observation on 01/06/11 at 7:50 a.m. showed no nursing staff present at the Neighborhood B nursing station/medication room. An unidentified housekeeper entered the nursing station/medication room and stated "I have keys to everything."

Observation on 01/06/11 at 9:15 a.m. showed an

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	355082	A. BUILDING _____ B. WING _____	01/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVE MARIA VILLAGE	501 19TH ST NE JAMESTOWN, ND 58401

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F 431	Continued From page 72 administrative dietary staff member (#33) used a key and entered the Neighborhood A nursing station/medication room. Observation showed no nursing staff present. Observation on 01/06/10 at 1:15 p.m. showed a housekeeping staff member (#36) used a key and entered the Neighborhood A nursing station/medication room. Observation showed no nursing staff present. Upon entering the Neighborhood C nurses station/medication room on 01/06/11 at 9:20 a.m., observation showed pantoprazole (an antinuclear medication) and Tramadol (a pain medication) located on the countertop. During interview on 01/06/11 at 12:45 p.m., administrative nurse (#2 and #12) stated the facility has authorized housekeeping staff, the chaplain, the social service designees, and administrative dietary staff members to have a key to the locked nurses station/medication rooms. These staff members confirmed the only locked medication refrigerator is located in the nurses station/medication room on Neighborhood D.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -	F 441	**F-441 Infection Control, Prevent, Spread, Linens** 1a. Resident #3 has had no negative outcome noted from dressing change. This was an isolated occurrence, and the nurse involved was re-educated at time of the occurrence. 1b. No known resident negative outcome. Peri-care re-education has been provided at C.N.A. meeting and	

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F 441	Continued From page 73 (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, review of facility policy and procedure, and staff interview, the facility failed to follow infection control procedures for 1 of 1 sampled resident (Resident #3) observed during a dressing change and 5 random dining observations of staff handling resident's ready-to-eat foods with bare hands. Failure to follow infection control practices has the potential to spread infection within the facility.	F 441	neighborhood meetings since the survey. (Refer to F tag 312) 1c. Re-education has been provided to all staff on and continues on proper hand hygiene, glove usage, and handling of dishes and utensils. Education continues on an ongoing basis. 2a. All residents requiring dressing changes have the potential to be affected. 2b. Any residents requiring assistance with toileting has the potential to be affected. 2c. All residents in the facility have the potential to be affected 3a. Professional nursing staff were re-educated at nurses meeting on 01/20/11. Re-education will be provided to affected staff at mandatory meeting on 02/09/11. 3b. Affected staff will be re-educated and we will increase our mandatory peri-care education and return demonstrations from annual to bi-annual. C.N.A. staff were re-educated at neighborhood meetings on 01/10/11, 01/17/11, and 1/31/11, and also on 1/27/11 at monthly C.N.A. meeting. Affected staff will receive re-education at mandatory meeting on 02/09/11. Professional nursing staff were educated at the monthly nurses meeting on 01/20/11	

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F 441	Continued From page 74 Findings include: Review of the facility policy titled, "Dressing changes", occurred on January 3-6, 2011. This policy, reviewed/revised September 2010, stated, "Policy: Dressing changes will be completed utilizing clean techniques as ordered by the attending physician or nurse practitioner. Purpose: 1. To promote wound healing by primary intention. 2. To prevent infection, re-infection or superimposed infection. . . . Procedure: . . . 4. Wash hands. . . . 8. Don clean gloves and remove the dressings, tape, or ties. . . . 9. Lift the dressing from the wound. . . 11. Observe the character and amount of drainage on the dressings. . . . 13. a. Note the condition of the wound, drainage, suture or skin integrity, and character of the drainage. 14. Complete the cleansing and treatment of the wound as ordered. a. Handle containers/tubes of ointments only with clean gloves. 15. Dispose of the gloves and don a clean pair of gloves. 16. Apply dressings to the area as ordered. . . . 20. Disinfect the reusable items. 21. Wash hands prior to leaving the resident's room. . . ." Review of the facility policy titled "Hand Hygiene" occurred on January 3-6, 2011. This policy, reviewed/revised May 2009, stated, "Policy: Each staff member is responsible to practice hand hygiene. Hand hygiene is sanitizing hands with soap and water (handwashing) or with hand gel. Handwashing must be done when hands are visibly soiled with blood and/or body fluids. Hand Gel may be used when hands are not visibly soiled with blood and/or body fluids. Purpose: To prevent cross-contamination between staff and residents. Procedure: 1. Hand hygiene should be	F 441	3c. All staff will be re-educated on the importance of hand hygiene and glove usage. C NA staff educated at neighborhood meetings on 01/10/11, 01/17/11, and 1/31/11, and also at monthly C.N.A. meeting on 01/27/11. Affected staff will receive re-education at mandatory meeting on 02/09/11 Professional nursing staff were re-educated at monthly nurses meeting on 01/20/11. 4a. QAM or a nurse manager will conduct or delegate QA by assessing a 50% random sample of dressing changes as follows: weekly x 4 weeks; then monthly x 3 months, then quarterly thereafter. **See Attached Form K.** 4b. QAM or a nurse manager will conduct or delegate QA, assessing a 5% random sample of residents needing assistance with toileting, as follows: weekly x 4 weeks, then monthly x 3 months, then quarterly thereafter. **See Attachment Form E.** 4c. QAM or a nurse manager will conduct or delegate QA monitoring, assessing a 5% random sample of staff hand hygiene, weekly x 4 weeks, then monthly x 3 months, then quarterly thereafter. **See Attachment K.** 5. 2/10/11	

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practiced: . . . c. Before serving meals, feeding a resident, eating and afterwards. d. Before filling water glasses; before serving fluids. e. After using the toilet or assisting at toilet. . . . k. after blowing your nose or resident's nose. l. Before and after changing dressings. m. Before applying and after removing gloves. n. Whenever necessary, including any time employee questions contamination of his/her hands. . . ."

Review of the facility policy titled "Food Storage and Preparation Guidelines" occurred on January 3-6, 2011. This undated policy stated, ". . . When in direct contact with food gloves are to be worn. . . ."

- Observation on 01/05/11 at 10:00 a.m. showed a nurse (#23) performed a dressing change to Resident #3's bilateral legs. The nurse (#23) washed her hands and donned gloves. The nurse used scissors to cut off and remove the soiled dressing from Resident #3's right leg and placed the dressing into a plastic bag. Observation of the old dressing showed no visible drainage. With the same gloves, the nurse (#23) removed some Bacitracin ointment from the tube, placed some ointment on her index finger, and applied the ointment to Resident #3's right leg. A nurse (#23) grabbed a tissue/Kleenex and wiped off the excess ointment from her gloved finger. With these same gloves, the nurse applied a clean dressing as ordered by the provider. The nurse removed her gloves.

Before completing the dressing change to Resident #3's left leg in the same manner as described above, the nurse (#23) donned a pair of gloves and failed to perform any type of hand hygiene (with either hand sanitizer or soap and

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water). Observation of the dirty dressing removed from Resident #3's left leg showed a scant amount of yellow drainage on the gauze pad. Upon completion of the dressing change to the Resident #3's left leg, the nurse (#23) removed her gloves, placed the supplies on a shelf in Resident #3's closet and failed to wipe or cleanse the scissor used to cut the dirty leg dressings.

During interview on the morning of 01/06/11, an administrative staff nurse (#8) stated she would expect staff to change gloves after removing the old (dirty) dressing and perform hand hygiene before donning a clean pair of gloves.

- A random observation on 01/06/11 at 8:45 a.m. showed a staff member (#17) brought Resident #3's breakfast tray to the resident's room. The staff member asked Resident #3 if she "wanted an egg sandwich" and the resident stated "Yes." The staff member used a fork to place an egg on a half of slice of toast and with her ungloved hand proceed to place the other half slice of toast on top of the egg.

- Observation on 01/04/11 at 8:55 a.m. showed a CNA (#10) assisting an unidentified male resident with the breakfast meal. The CNA picked up the resident's toast and handed it to him with her bare hand.

- Observation on 01/04/11 at 9:01 a.m. showed a CNA (#10) assisting an unidentified female resident with the breakfast meal. The CNA picked up the resident's toast and handed it to her with her bare hand.

An interview occurred on 01/06/11 at 2:00 p.m. with administrative nursing staff members (#2 and

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F 441	Continued From page 77 #12) regarding dining room observations. Both staff members agreed the CNAs (#10 and #20) failed to follow appropriate infection control procedures and handling of resident's food in the dining room. - On 01/04/11 at 11:35 a.m., observation showed two CNAs (#37 and #38) assisted Resident #3 to the bathroom, and removed a brief wet with urine. One CNA (#38), working from behind the resident, cleansed Resident #3 from the pubis to the rectum using disposable wipes. The CNA (#38) failed to cleanse all skin exposed to urine from the wet brief. - Observation on 01/04/11 at 8:20 a.m., showed a CNA (#3) used her bare hands to butter an unidentified resident's toast. - Observation during the noon meal on 01/04/11 at 11:45 a.m., showed a dietary assistant (#4) taking meal orders for the residents seated in the independent dining room in Neighborhood A/B. The assistant (#4) wiped her nose with her right hand and then, with the same hand, picked up an unidentified resident's coffee cup from the top (fingers on the lip of the cup) and placed it in front of the resident. The assistant (#4) proceeded onto the next resident and assisted her with her napkin. The dietary assistant (#4) failed to sanitize her hands after wiping her nose with her hand.	F 441		