STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355106	A. BUILDING _____ B. WING _____	C 08/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH CONTINUING CARE CENTER OFF COLLINS	201 14TH STREET NW MANDAN, ND 58554

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification and complaint survey started on August 25, 2014 and completed on August 28, 2014, the sample included 4 residents for complete review, 9 residents for focused review, and 2 closed records for review. The sample included 5 additional residents to verify specific concerns during the survey.	F 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the state operations manual.	
F 177 SS=E	483.10(o) RIGHT TO REFUSE CERTAIN TRANSFERS An individual has the right to refuse a transfer to another room within the institution, if the purpose of the transfer is to relocate a resident of a SNF, from the distinct part of the institution that is a SNF to a part of the institution that is not a SNF, or a resident of a NF, from the distinct part of the institution that is a NF to a distinct part of the institution that is a SNF. A resident's exercise of the right to refuse transfer under paragraph (o)(1) of this section does not affect the individual's eligibility or entitlement to Medicare or Medicaid benefits. This REQUIREMENT is not met as evidenced by: Based on information provided by a complainant, record review, review of information/agreement, and staff interview, the facility differentiated long-term care (LTC) beds and transitional care (TC) beds while all beds in the facility are licensed and certified as skilled nursing beds. Review of 3 of 13 sampled resident records (Resident #2, #3, and #11) identified the facility required residents to apply to other LTC facilities	F 177	F-177: Right to Refuse Certain Transfers It is the intent of this facility to remain in compliance with F-177 and assist a resident with either their continued stay in the facility or assist with transfer or discharge needs. To correct the deficiency for all residents the following has been completed: The Resident Room Information sheet has been revised, clarifying that it is an information sheet only. The goal of this information sheet being to ensure the resident is made aware that a room or roommate change may become necessary during their stay at Sanford Off Collins	

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

Mindy Marcus | Administrator | 10-23-14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 177	Continued From page 1 in the state of North Dakota following their TC needs being met. By having residents sign this information/agreement upon admission, the facility has violated these residents' right to stay in a skilled nursing facility (SNF) bed and not be transferred during their stay. Findings include: Review of information/agreement within the admission packet provided to residents occurred on the morning of 08/28/14. The information/agreement, undated, titled "Resident Room Information" stated: "Sanford Health Continuing Care Center off Collins is made up of two distinct units within one building. Both units were developed with the intent of meeting the needs of residents who reside in the facility and the people who care for them. The Transitional Care Unit [TCU] is a highly skilled unit made up of 21 private rooms located on the 400 and 500 hallways. Residents who require intense rehabilitation or Medicare skilled therapy services following a hospitalization are admitted to this unit when it is anticipated their stay will last approximately 30 days. If the resident stays longer than 45 days they are transferred to a long stay bed located at off Collins or an alternative nursing facility of their choice. The Skilled Nursing Unit consists of 43 long term beds for residents requiring a stay that will last an undetermined length of time. Residents placed on this unit require a lower level of skilled care, close supervision and assistance meeting their daily needs. . . . Sanford Health . . . reserves the right to move a resident from one unit or room to another when	F 177	due to staffing patterns. All 64 licensed beds at Sanford Off Collins are dually certified for Medicare/Medicaid. Bed placement does not affect a resident's eligibility or entitlement to Medicare or Medicaid benefits. A facility P & P Change of Room or Roommate has been developed to address changes in room and/or roommate. This policy allows for the timely notification of a change when it is determined that a change in room or roommate is to occur. Due to staffing patterns, a change in room and/or roommate may be advised upon completion of intense nursing care or skilled therapy services. Transfer and discharge of a resident outside of the facility will be accomplished when it is initiated voluntarily by the resident or their legal representative. The facility will initiate transfer or discharge only when at least one of the six criteria stated in 42 CFR 483.12 Admission, Transfer, and Discharge Rights are met. A Discharge Planning Observation is to be completed for all residents admitted to the facility during the assessment reference period of the first MDS completed. This Observation is a screening tool used to determine resident preferences and is utilized when assisting the resident if and when discharge or	

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F 177	Continued From page 2 their . . . needs have changed. When clinical needs change a move to the other unit may be appropriate. An interdisciplinary team makes the recommendation to move based on the care needs of the resident. The need for a room or unit change is conveyed to the resident or a representative as soon as it is identified and determined to be necessary. . . . These room changes are for the direct purpose of meeting the individualized care needs of the resident in the best way possible." The form contained a signature line for the resident or personal representative to acknowledge they were informed in writing of Sanford Health Continuing Care off Collins practices regarding room changes. - Information provided by the complainant indicated staff were reluctant to readmit a resident to the facility following a hospital stay. The complainant stated, "They felt she was more of a long-term care resident. [Another local nursing home] took her." - Review of Resident #2's medical record occurred on August 25-28, 2014. Progress notes identified the following: * 07/15/14, ". . . Resident (who is currently residing on the TCU unit) is open to LTC in a SNF [skilled nursing facility] if it [sic] that is what is recommended by care team. Resident would like to remain in Bismarck Mandan and stated a preference . . ." * 08/04/14, "Faxed information to [a town 76 miles from the Bismarck/Mandan area] for LTC placement." * 08/06/14, ". . . Resident . . . understands need for SNF care at this time with no definite date of discharge. Resident aware of the need to look for	F 177	transfer planning is indicated. Discharge planning continues throughout the resident's stay in the facility. Resident #2 remains in the facility as of 10-3-14 with no discharge date established. The LSW continues to follow and will assist according to the resident's personal preferences. Resident #3 was discharged on 9-24-14 to a Memory Care Unit which was determined to be appropriate as it would provide a quieter environment and dementia programming. Resident #11 remains in the facility as of 10-3-14. There are no plans for discharge. The Discharge Planning Observation was completed for Residents #2 and #11 on 10-6-14 to better document their discharge preferences. Those residents who entered the facility with plans for a temporary stay have been identified. A Discharge Planning Observation was completed for these residents prior to 10-13-14. Staff education occurred on 10-7-14 and 10-22-14 for all members of the Interdisciplinary Team. The Change of Room or Roommate P & P was reviewed along with the Discharge Planning Observation form, Resident Information	

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F 177	Continued From page 3 long term placement at this time . . . Will assist in finding longer term placement for Resident." - Review of Resident #3's medical record occurred on August 25-28, 2014. Progress notes identified the following: * 07/21/14, ". . . Resident (who is currently residing on the TCU unit) is currently on a waiting list for LTC to remain here." * 07/29/14, "Information was faxed to [two local LTC facilities] for resident to be placed in a memory care unit. . . ." * 08/04/14, ". . . Follow-up was then done on 8/5 and [one of the two local LTC facilities] stated that [Resident #3] was not appropriate for their memory care unit and at that time, they added her to their general waiting list." * 08/12/14 and 08/15/14, ". . . Information has been sent to other facilities in hopes resident will be able to establish permanent residency in an appropriate setting. Resident will remain in short term [TCU] until an opening becomes available." * 08/25/14, ". . . Resident is currently on a waiting list at facilities with Memory Care Units as this has been the referral recommended from nursing staff. Resident will remain here until a placement becomes available." - Review of Resident #11's record occurred on 08/28/14. A progress note, dated 07/31/14, stated, "Expressed concern with LTC room. Will return to transitional care bed and stated understanding that application will be sent through the state to find LTC placement. Res. [resident] agreeable to this." During interview on the morning of 08/28/14, an administrative staff member (#22) stated the facility is not licensed separately for TC and LTC.	F 177	Sheet and room/roommate change requirements. The need for a room or roommate change and also transfer or discharge from the facility has the potential to affect residents entering the facility anticipating a temporary stay. These residents have been identified. QI monitoring will be completed weekly X4 and then monthly X2 by the CQI Coordinator and/or his designee beginning the week of October 6th to ensure that the Discharge Planning Observation has been completed, and that room or roommate changes, and/or transfers or discharges are accomplished in consideration of the resident's care needs and/or personal requests. Results of the CQI monitoring will be reviewed as part of the monthly facility CQI meetings and then summarized at the Quarterly CQI Meeting with the Medical Director in attendance. The need for further monitoring will be determined based upon these results. Date Certain: 10-22-14	

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F 177	Continued From page 4 The administrative staff member (#22) stated the facility attempts to keep beds available for TCU residents. TCU residents who no longer require TCU services, but do need LTC, may need to apply to other LTC facilities if no skilled nursing beds are not available at their facility. This SNF does not have a distinct part SNF within its walls. All SNF services are available in each bed without the need to transfer the resident to another SNF facility.	F 177		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and staff interview, the facility failed to provide care in a manner that maintained or enhanced dignity for 3 of 7 sampled residents (Resident #1, #2, and #3) and one supplemental resident (Resident #19) observed during toileting cares. Failure to knock on the door prior to entering a resident's bathroom (Resident #19) and/or provide privacy during cares (Resident #1, #2, and #3), does not promote residents' dignity or enhance their quality of life. Findings include: The facility failed to provide a copy of their policy regarding treating residents in a dignified manner and/or maintaining residents privacy when	F 241	F-241: Dignity It is the intent of this facility to provide resident care in a dignified manner as evidenced by the following: A P & P titled Resident Dignity was developed outlining guidelines for the provision of resident care in an environment that maintains or enhances each resident's dignity and respect Education was provided for all nursing staff on 9-23-14 that focused on maintaining privacy and resident dignity especially during the provision of personal cares such as peri-care, toileting, and use of a shared bathroom. Instructions included knocking and then pausing prior to entering a resident's personal space to allow time for a response and always closing blinds and curtains. Education pertinent to the Resident Dignity P & P will also be held on 10-7-14 for all nursing staff.	

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F 241	Continued From page 5 requested. - During the group interview on 08/25/14 at 1:30 p.m., when asked if the facility makes an effort to assure their privacy, Resident #18 stated, "You get caught in the bathroom. There are no locks on the doors, and they [certified nursing assistants (CNAs)] don't knock [before entering]." - Observation on 08/25/14 at 4:02 p.m. showed two CNAs (#19 and #20) assisting Resident #2 with toileting cares as she lay in bed. The bed was positioned with Resident #2 facing the bathroom, with the foot of the bed a few feet from the open bathroom door. As the two CNAs (#19 and #20) provided frontal pericares to Resident #2, Resident #19 entered the shared bathroom from her adjoining room and closed Resident #2's bathroom door. After completing Resident #2's frontal pericares, one of the CNAs (#19) opened the door to the bathroom without knocking/announcing herself, and stated, "Can I wash my hands or should I wait?" Observation showed Resident #19 sitting on the toilet, with her pants/incontinence brief pulled down to her ankles. She stated, "Can't you give me a minute to finish?" The CNA (#19) backed out of the bathroom, allowing Resident #2 to be seen exposed from the waist down and Resident #19 to be seen sitting on the toilet. Following the above observation, Resident #19 was interviewed. When asked if the CNAs had entered the bathroom without knocking/announcing themselves at any other time, Resident #19 stated, "It happens occasionally." - Observation on 08/26/14 at 8:58 a.m. showed	F 241	QI monitoring will be completed by the QI Coordinator and/or his designee beginning the week of 10-6-14 and will include Residents #2 whose care was identified during the survey. Residents #1, #3 & #19 have been discharged. Residents who share a bathroom and those residents who require assistance with peri-care and are bed-bound have been identified. QI monitoring will be completed on 10 of these residents weekly X4 and then monthly X2 to ensure that the privacy and dignity of all Off Collins residents is maintained. Resident #18 will be interviewed prior to 10-13-14 to determine that improvement has occurred & that staff no longer enter his room or bathroom without knocking Results of the QI monitoring will be reviewed as part of the monthly facility CQI meetings and then summarized at the Quarterly QI Meeting with the Medical Director in attendance. The need for further monitoring will be determined based upon these results. Date Certain: 10-16-14	

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F 241	Continued From page 6 two CNAs (#17 and #26) assisting Resident #3 with toileting cares. The CNAs (#17 and #26) failed to close the door to the bathroom and the window blinds; allowing Resident #3 to be seen sitting on the toilet, with her pants/incontinence brief pulled down to mid shin. - Observation on 08/26/14 at 1:20 p.m. showed two CNAs (#17 and #18) assisting Resident #1 with toileting cares. The CNAs (#17 and #18) failed to close the door to the bathroom and the window blinds; allowing Resident #1 to be seen sitting on the toilet, with her pants/incontinence brief pulled down to mid shin. During an interview the afternoon of 08/28/14, an administrative nurse (#1) confirmed she would expect facility staff to shut window blinds and/or doors prior to providing toileting cares, and would expect them to knock and wait for a response prior to entering a bathroom.	F 241		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of	F 280	F-280: Right to Participate in Planning Care-Revise CP It is the intent of this facility to remain in compliance with F-280 and maintain a resident's care plan so that care needs are communicated for each resident as evidenced by the following: The Sanford Interdisciplinary Care Plan P & P was reviewed and remains intact. Emphasis is placed on adhering to this P & P so that a resident's care plan is reviewed and revised to reflect their current needs.	

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F 280	Continued From page 7 the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of policy and procedure, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the residents' status for 5 of 13 sampled residents (Resident #2, #3, #4, #6, and #7) and one discharged resident (Resident #14). Failure to review and revise the care plans limited staff's ability to communicate care needs and ensure continuity of care for each resident. Findings include: Review of the policy and procedure titled "INTERDISCIPLINARY CARE PLAN," dated 10/06/11, stated, "POLICY . . . The development, implementation, and maintenance of a resident's Care Plan are an interdisciplinary process. . . PURPOSE: 1. To provide a Care Plan that allows the resident to reach their highest practicable physical, mental, and psychosocial well-being. . . . The Care Plan is reviewed as often as changes occur in the resident's condition and is revised electronically to maintain accuracy. . . ." - Review of Resident #7's record occurred on all days of survey. Diagnoses included Alzheimer's disease, dementia, and constipation. Current physician orders included three scheduled	F 280	Education was held with the Interdisciplinary team on 9-23-14 and again on 10-7-14 to review the importance of up-to-date care plans & the reports now utilized to identify necessary updates. The Interdisciplinary Care Plan P & P was also reviewed at this meeting. Residents #3 & #14 have been discharged. Resident #2's care plan has been reviewed and updated to address constipation & the residents need for staff assistance during transfers to ensure her weakened right arm is protected. Resident #4's care plan has been reviewed and updated to address hydration. Resident #6 was discharged from the facility on 9-10-14 to return home with family. He was readmitted on 9-25-14 after a hospitalization d/t a fracture. A temporary care plan is currently in place & correctly does not include the presence of a Foley catheter. Skin care interventions including a gel mattress are in place on the care plan and also interventions to address the diagnosis of neurogenic bladder. Resident #7's care plan has been revised & includes interventions to address constipation. A process was devised to monitor resident care plans for the inclusion of changes in physician orders via an EMR report titled "Facility Activity Report". This report is run Monday through Friday and then	

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F 280	Continued From page 8 laxatives, and as needed (prn) laxatives. The record identified nursing administered additional prn laxatives four to five times a month in July and August 2014. Resident #7's care plan failed to address the problem of constipation and individualized interventions. - Review of Resident #6's record occurred on all days of survey. Resident #6's admission occurred in July 2014. Admission diagnoses included an ulcer on the calf (right), neurogenic bladder and constipation. Admission orders included a Foley catheter and Foley cares twice a day. A urinary incontinence and indwelling catheter Care Area Assessment, completed on 08/04/14, stated, "Resident has a Foley catheter in place due to a neurogenic bladder. It had been in long term, removed and then replaced in the ER [emergency room] due post void residual. . . ." The record identified the catheter removed on 08/20/14. The current care plan identified toileting needs as "Foley cares every shift and PRN" and the problem of "FOLEY CATHETER: Resident requires an indwelling catheter." Failure to address removal of the catheter may result in not assessing and monitoring Resident #6 for urinary retention in relation to the neurogenic bladder. Current medication orders included a scheduled laxative and two prn laxatives. The current care plan failed to address the problem of constipation and approaches. Observation on the morning of 08/27/14 identified scabbed/eschar areas to Resident #6's right heel,	F 280	compared to the resident's care plan to ensure that changes are made. Diagnosis reports are also utilized to ensure that diagnoses such as constipation are addressed with an individualized care plan when necessary. Because the accuracy of a care plan has the potential to affect each resident, a chart review was completed for each Off Collins resident the week following the survey. Care plans were updated where necessary to ensure that all orders were correct and carried through to the resident's care plan. Monitoring of resident care plans will begin the week of 10-6-14 and will be done by the QI Coordinator and/or his designee. Monitoring of a minimum 10 residents per week will be done weekly X4 and then monthly X2 to ensure that care plans remain up-to-date. Care plan monitoring will be done along with other specific monitoring to ensure that as other survey concerns are improved upon, the care plan for those concerns is included. Emphasis will be placed on care plan accuracy in the specific areas of constipation, hydration, skin precautions, transfer needs and physician ordered treatments. The first weeks monitoring will include Resident's #2, #4, #6, & #7. Results of the QI monitoring will be reviewed as part of the monthly facility	

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F 280	Continued From page 9 and lateral side and medial sides of the right foot distal to the great toe and distal to the little toe. The current care plan identified an unstageable pressure ulcer to the right lower extremity, present on admission, and did not identify and include approaches for the pressure areas/sores observed by a surveyor on 08/27/14. Admission orders, dated 07/30/14, included pressure reducing measures including a gel mattress. The care plan lacked this approach. - Review of Resident 4's medical record occurred on all days of survey and diagnoses included dementia, constipation, and a history of urinary tract infections. The current physician's orders, dated 03/10/14, identified strict I & O [intake and output]. Resident #4's care plan failed to address the problem, goal, and individualized interventions for the strict I & O. - Resident #2's medical record, reviewed August 25-28, 2014, identified diagnoses including constipation, weakness, and obesity. The resident's quarterly Minimum Data Set (MDS), dated 08/06/14, identified intact cognition and extensive assistance of one person for toileting and transfers. The documentation of Resident #2's BM (bowel movement) Report between July 8-August 26, 2014 identified the resident failed to have a bowel movement for three days on one occasion, four days on three occasions, and five days on one occasion. Observation on 08/26/14 at 8:35 a.m. showed two certified nursing assistants (CNAs) (#7 and #17)	F 280	QI meetings and then summarized at the Quarterly QI meetings with the Medical Director in attendance. The need for further monitoring will be determined based on these results. Date Certain: 10-16-14	

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F 280	Continued From page 10	F 280		

transferred Resident #2 from the commode to her bed with a stand lift. Observation showed the harness of the lift pushed up into Resident #2's axilla causing her shoulders to shrug upward. Her upper right arm (shoulder to elbow) was parallel to the floor and her lower arm (elbow to fingers) hung downward.

Observation on 08/26/14 at 5:30 p.m. showed two CNAs (#23 and #24) transferring Resident #2 from her bed to the wheelchair with the stand lift. Observation showed the harness of the lift pushed up into her axilla causing her shoulders to shrug upward, and her right arm to hang at her side.

Resident #2's current care plan failed to address Resident #2's episodes of constipation. The care plan stated, "Problem: ADL's [Activities of Daily Living] . . . Approach: Transfers: EZ stand with assist of 2 for transfers. . . . Toileting: . . . EZ stand with assist of 2 to transfer to commode for toileting needs. . . ." The current care plan failed to address Resident #2's need for staff assistance to ensure her weakened right arm was held in front of her body during transfers.

During an interview the afternoon of 08/28/14, an administrative nurse (#1) confirmed Resident #2's episodes of constipation and her need for staff assistance with her weakened right arm during stand lift transfers.

- Resident #3's medical record, reviewed August 25-28, 2014, identified diagnoses including dementia, anxiety, current aspiration pneumonia and constipation. The resident's admission MDS, dated 07/14/14, identified intact cognition, and the need for a mechanically altered diet and

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F 280	Continued From page 11 extensive assistance of one person for eating. The documentation of Resident #3's BMs between June 28-August 7, 2014 identified the resident failed to have a bowel movement for three days on one occasion, four days on two occasions, five days on one occasion, and eight days on one occasion. The current care plan failed to address Resident #3's problem of constipation and individualized interventions. The current care plan identified, "Problem . . . hx [history] swallowing difficulty . . . Direct supervision w/meals - follow individualized swallow guide on tray card. . . ." The current care plan failed to address Resident #3's individualized swallow recommendations [direct supervision, sit upright, alternate small sips with small bites, do not lie down for 30 minutes]. The current care plan also identified, ". . . Approach . . . . Attempt non-pharmacological interventions. . . ." The current care plan failed to identify the specific behaviors Resident #3's exhibited and the individualized non-pharmacological interventions staff were to use prior to administering anti-anxiety medications. During an interview the afternoon of 08/28/14, an administrative nurse (#1) confirmed Resident #3's episodes of constipation, individualized swallow recommendations, and non-pharmacological interventions were not addressed on her care plan. - Resident #14's medical record, reviewed August	F 280		

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F 280	Continued From page 12 27-28, 2014, identified diagnoses including constipation and insulin dependent diabetes. The resident's admission MDS, dated 03/24/14, identified moderately impaired cognition and extensive assistance of two or more persons for toileting. The documentation of Resident #14's BMs between March 17-May 8, 2014 identified the resident failed to have a bowel movement for three days on one occasion and four days on another occasion. The medication administration record (MAR), dated 03/17/14-05/12/14, identified thirteen incidents of low blood sugar/hypoglycemia [blood sugars under 60] and one incident of high blood sugar/hyperglycemia [blood sugars over 400]. The current care plan stated, "Approach . . . 03/26/14, Diet: 1800 cal ADA . . . regular textures/thin liquids. . . ." The physician's progress note, dated 04/16/14, identified the physician changed Resident #14's diet from an 1800 cal [calorie] ADA [American Diabetes Association] diet to a cardiac (low salt)/diabetic diet. The current care plan failed to address Resident #14's episodes of constipation and hypo/hyperglycemia, and failed to reflect the physician prescribed diet change. During an interview the afternoon of 08/28/14, an administrative nurse (#1) confirmed Resident #14's episodes of constipation and/or hypo/hyperglycemia were not addressed on her care plan, and confirmed staff failed to revise	F 280		

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F 280	Continued From page 13 Resident #14's care plan so that it reflected the physician prescribed diet change.	F 280		
F 281 SS=E	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 policies, and staff interview, the facility failed to follow and/or clarify physicians' orders for 6 of 20 sampled residents which included Resident #4, #5, #6, #11, #14 (discharged), and #20 (supplemental) who received medical treatments or medications. Failure to follow and/or clarify physicians' orders may result in medication errors and failure to follow physicians' order may result in a decline in residents' health status. Findings include: Review of the facility policy titled "Principles of Medication Administration-LTC [Long-Term Care]" occurred on 08/28/14. This policy, revised 08/29/12, stated, ". . . PROCEDURE: . . . 18 . . . c. Remove medication from the drawer. Read each order entirely on the MAR [Medication Administration Record] to check for the right resident, right time, right drug, right route, and right dose and compare to the label on the medication . . . g. Read and follow any special instructions written on label when administering. . . ." - Review of Resident #4's medical record	F 281	F-281: Services Provided Meet Professional Standards It is the intent of this facility to remain in compliance with F-281 and provide care and services that meet professional standards of quality as evidenced by the following: The care plan for Resident #4 was updated and staff educated on a 1:1 basis on the wear schedule of the Prevalon boots. The Morphine order for Resident #5 has been clarified to include indications other than chest pain for its use. The dressing orders for Resident #11 have been clarified to identify where the dressings are to be used. The orders for the eye ointment administered to Resident #20 have been clarified to include which eye they are to be administered. Resident #6 was discharged from the facility on 9-10-14. He returned on 9-25-14 and does have a gel overlay mattress in place on his bed according to a nursing order. His skin prevention care plan includes the presence of a gel overlay mattress. The presence was verified via QI observations completed on 10-6-14.	

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F 281	Continued From page 14 occurred on all days of survey and diagnoses included a stroke with left-sided weakness. The quarterly Minimum Data Set (MDS), dated 06/10/14, identified extensive assist of two or more persons for bed mobility and transfers, wheelchair for mobility, and risk of pressure ulcers. Review of the Treatment Administration History for July and August 2014 identified staff applied a Mepilex border from 07/18/14 to 08/22/14 to the resident's left heel for protection. Staff discontinued the dressing when the heel was "no longer red and spongy." A practitioner's order, dated 08/22/14, stated, "Prevalon boots to bilateral feet at all times when out of bed. While in bed, float bilateral heels off bed with pillow placed under calves." Observation on all days of survey identified staff did not apply the Prevalon boots on Resident #4 when out of bed. Staff did not float the resident's heels when in bed, but applied the boots after transferring the resident into bed. During an interview on 08/26/14 at 9:48 a.m., a certified nursing aide (CNA) (#2) verified staff applied the Prevalon boots only when Resident #4 was in bed and not when in his/her wheelchair. During an interview on 08/28/14 at 10:00 a.m., a nurse manager (#1) confirmed the current order, dated 08/22/14, on the MAR for Prevalon boots on at all times when out of bed and float heels when in bed. Staff initialed those orders as completed each day on the MAR since 08/22/14. - Review of Resident #5's medical record occurred on all days of survey. The MAR identified a physician's order, dated 07/22/14, for "Morphine concentrate . . . solution 100 mg	F 281	Resident #14 was transferred to the hospital on 5-8-14 and did not return. Because professional services have the potential to affect all residents of the facility the following has been accomplished: 1. The facility Medication Administration P & P has been reviewed with minor revisions. The P & P does include the importance of verifying orders and clarifying discrepancies to ensure that orders are carried out as written. a. The medication and treatment orders of all residents have been verified to ensure there are directions for use that include the location of dressings, designation of which eye medications are to be administered, when Prevalon boots are to be worn, indications for medication administration, and standing orders for the follow-up treatment for accu-check results outside the established parameters. 2. To address the concerns related to sliding scale insulin orders, the physician standing orders have been revised and sent to physicians with instructions to designate the high and low parameters for accu-check results and corresponding treatment for each. Also, standing orders have been developed for documentation of accu-check results and corresponding treatment according to physician orders for follow-up treatment.	

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F 281	Continued From page 15 [milligrams]/5 ml [milliliters]; amount to Administer: 5 mg; oral . . . Frequency: Every 4 Hours - PRN [as needed] . . . Special Instructions: for chest pain. . . ." Staff administered the Morphine four times in August 2014 for reasons of "hand pain, neck pain, right foot pain, and pain all over body." During an interview on 08/28/14 at 10:00 a.m., a nurse manager (#1) verified staff should have clarified the order to include other pain issues than just chest pain. - During review of Resident #11's medical record on 08/28/14, the record included an order for a dressing change every three days, dated 08/05/14. The order stated, ". . . remove dressing down to mepitel silicon. Leave silicon intact irrigate with copious salin [sic] and rewrap. Aquacel extra ag [silver], 4 x 4's, webril, and coban." The record included an order, dated 08/26/14, to "Keep dressing dry and intact." Both orders failed to identify the location of the dressings. - During review of Resident #6's record on all days of survey, the record included a physician's order for a gel mattress, dated 07/30/14. On the morning of 08/27/14, observation of a pressure ulcer to the resident's right lateral/posterior calf, showed the facility failed to provide a gel mattress for Resident #6. During an interview on the afternoon of 08/27/14, an administrative staff (#14) confirmed Resident #6's bed lacked the gel mattress. - During observation of medication pass on the morning of 08/26/14, a certified medication	F 281	a. A facility Hypoglycemia P & P has been developed that provides treatment guidelines for residents with accu-check results below the parameters set by the physician. The standing orders entered into the EMR allow for documentation of the treatment provided. 3. Education for all nursing and CMA staff members was held on 9-23-14 and is scheduled again for 10-7-14 at which time the importance of completing the 5-Rights of medication administration and clarifying orders will be reviewed. The Medication Administration P & P was reviewed along with the Hypoglycemia P & P which provides guidelines for the treatment of accu-check results below the parameters set by the physician. To ensure compliance with professional standards QI monitoring will begin the week of 10-6-14 and will be completed by the QI Coordinator and/or his designee. Monitoring of 20 physician orders for the location of eye drops/ointments, location of dressings, indications for PRN pain medications, and documentation of treatment carried out following accu-check results outside established parameters will be accomplished weekly X4 and monthly X2 to ensure that compliance is achieved and maintained. Residents #5, #11, & #20 will be included in the first week of QI monitoring. Use of Prevalon Boots for Resident #4 will be	

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F 281	Continued From page 16 assistant (CMA) (#27) instilled an eye drop into Resident #20's left eye. The record showed the medicine ordered on 8/04/14. The medication administration record (MAR) failed to specify which eye to instill the eye drop. The CMA (#27) stated the instructions on the label specified which eye to instill the eye drop (the label specified left eye). - Resident #14's medical record, reviewed August 27-28, 2014, identified diagnoses including decreased mobility secondary to a cerebrovascular accident (CVA) and insulin dependent diabetes. The resident's admission MDS, dated 03/24/14, identified moderately impaired cognition and extensive assistance for all activities of daily living (ADLs). The physician's order, dated 03/17/14, identified a sliding scale [for insulin] with "blood sugar (BS) reading > [greater than] 400 = 14 units and recheck BS in two hours, If still > 400 on recheck notify medical doctor." The MAR, dated 04/24/14 at 6:00 a.m., identified a blood sugar reading of 403. Facility staff failed to recheck Resident #14's blood sugar within two hours [at 8:00 a.m.] as per physician's order. During an interview the afternoon of 08/28/14, an administrative nurse (#1) confirmed she was unable to find evidence facility staff rechecked Resident #14's blood sugar following the 6:00 a.m. reading.	F 281	monitored for compliance with F-280-Care Plans. Results of CQI monitoring will be reviewed at least monthly as part of the facility QI meetings and then summarized at the Quarterly QI meeting to be held with the Medical Director in attendance. The need for further monitoring will be determined based upon these results. Date Certain: 10-16-14	
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must	F 309	F-309: Provide Care/Services for Highest Well Being	

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F 309	Continued From page 17 provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: SWALLOWING 1. Based on observation, record review, review of professional literature, and staff interview, the facility failed to ensure 2 of 2 sampled residents (Resident #2 and #3) received the care and services necessary to attain the highest degree of safety possible while being fed in their rooms. Failure to ensure a resident with a known risk of aspiration was alert and positioned properly prior to administering medications and/or providing food/liquid resulted in Resident #3 aspirating. Findings include: The facility failed to provide a copy of their policy regarding assessing and/or treating residents with dysphagia when requested. Nancy B. Swigert, "The Source for Dysphagia: Third Edition", LinguiSystems, Inc, 2007, pages 15, 47, 125, 128 and the educational handouts identified, ". . . Signs of pharyngeal dysphagia are coughing or choking during a meal [Observed 08/26/14 during medication administration]. . . During the oral intake of medicines, foods and/or liquids, it is optimal for a patient to be seated at a 90 degree angle, whether in a bed or in a chair. . . . Even a slightly reclined position while eating	F 309	SWALLOWING: It is the intent of this facility to remain in compliance with F-309 as evidenced by the following: Please note the facility did have a P & P regarding the assessment and/or treatment of resident's with dysphagia at the time of this survey. It is titled: Dysphagia Management: Resident Dining Levels and Nursing Supervision". It has since been revised to include specific directions and pictures that address the recommended positioning of a resident when taking food or fluids along with the signs and symptoms of aspiration. The rooms of residents with a swallow guide in place are identified with an orange "S" on their name plate. This serves as an alert for staff to review the swallow guide and provide food/fluids accordingly. The care plan for Resident #2 has been reviewed and continues to include instructions from the Speech Therapy Swallow Guide and instructions for when food/fluids are consumed. QI monitoring will be completed specific to this resident the week of 10-6-14. Resident #3 has been discharged.	

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F 309	Continued From page 18 greatly increases the risk of premature loss of food over the back of the tongue [Observed August 25-26, 2014 during cares and medication administration] . . ." - Resident #3's medical record, reviewed August 25-28, 2014, identified diagnoses including dementia, anxiety, reflux, and current aspiration pneumonia. The resident's admission Minimum Data Set (MDS), dated 07/14/14, identified intact cognition, and the need for a mechanically altered diet and extensive assistance of one person for eating. The current care plan identified, "Problem . . . hx [history] swallowing difficulty . . . mechanically altered diet w [with]/swallow guide . . . Approach . . . Direct supervision w/meals - follow individualized swallow guide on tray card. . . . Monitor for any increased need for assistance with . . . drinking . . . Speech therapy consult if needed." The individualized swallow guide printed on Resident #3's tray card identified, ". . . SWALLOW GUIDE: direct supervision, sit upright, alternate small sips w/small bites, do not lie down for 30 min [minutes]." The progress notes identified the following: * 08/18/14, "Resident was screened by SLP [speech language pathologist] today - diet changed to: Regular . . . mechanical soft textures w [with]/ground meats/Nectar thickened liquids." * 08/19/14, ". . . Currently on Medrol and Augmentin for upper respiratory [infection]. Lungs clear to diminished. . . ." A video fluoroscopic (modified barium) swallowing	F 309	All residents of Off Collins with swallowing precautions in place have the potential to be affected by improper positioning when given food/fluids in bed & failure by staff to recognize signs and symptoms of aspiration. QI monitoring of proper positioning will be completed by the QI Coordinator and/or his designee beginning the week of 10-6-14 and will include the resident's with an established swallow guide. A minimum of ten (10) observations per week will be completed X4 and then monthly X2 to ensure the desired results are achieved and maintained. CONSTIPATION: The facility Bowel Program P & P was reviewed and remains in place. Emphasis is placed on adhering to the policy and monitoring resident's bowel movements through close written and verbal communication with members of the interdisciplinary team. Monitoring includes tracking interventions in place for adequacy, or the need for a dietary and/or medication intervention. A BM tracking form was devised by staff to accurately track BM's and medication interventions tried. The Continence Care and Bowel Management P & P was extensively revised to provide a well-rounded assessment and management program for	

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F 309	Continued From page 19 study, dated 08/20/14, identified, "There is no evidence of laryngeal penetration or aspiration [when Resident #3 sat in an upright position (90 degree angle)]. Premature spillage [premature loss of food over the back of the tongue] [was identified]. . . ." The progress noted also identified the following: * 08/20/14, "Resident had video swallow completed today. Report shows no laryngeal penetration of thin liquids at this time. Speech to follow up. . . . . ." * 08/22/14, "Resident is again okayed per SLP & [and] video study to have thin liquids." Observation showed the following: * 08/26/14 at 9:12 a.m., two certified nursing assistants (CNAs) (#17 and #26) transferred Resident #3 into bed. The CNA (#26) handed Resident #3 a glass of water as she lay in a reclined position (45 degree angle). The resident refused to take a drink and handed the glass back to the CNA (#26). The CNA failed to raise Resident #3's bed to 90 degrees prior to offering her water. * 08/26/14 at 10:00 a.m., a nurse (#28) raised the head of Resident #3's bed (40 degree angle - placing Resident #3 at an increased risk of premature loss of food/liquid over the back of her tongue) and administered her medications. Resident #3 lay on her back with a pillow placed under her shoulders and her neck extended backwards. The nurse (#28) gave Resident #3 a spoonful of medication crushed in pudding, followed by a drink of water. The resident coughed twice (an indication Resident #3 had poor vocal fold closure and secretions had entered her airway). She then gave Resident #3 a sip of liquid medication from a straw. The resident	F 309	staff to utilize in planning for continence/incontinence care of bladder and bowel. This process includes completion of a Bowel Observation, Urinary Incontinence Observation, and 7-days of BM & voiding history. This information is used by the interdisciplinary team to develop an individualized care plan. The LRD redesigned the dietary approach taken for residents with constipation to be more aggressive (where indicated) with the use of hi fiber foods and supplements. The care plans of residents with a diagnosis of constipation will be updated prior to 10-13-14 to include constipation with corresponding dietary approaches. A P & P titled Fiber Interventions was initiated to establish guidelines for the use of fiber to treat/prevent constipation. BM tracking, Bowel Observations, and Urinary Incontinence Observations have been completed for Resident's #2, #6, & #7. This new information was utilized to develop an individualized Bowel and Bladder care plan. Resident #3and #14 were discharged. Resident #6 was discharged home from the facility and then re-admitted on 9-25-14. Observations & tracking of bowel & bladder function has been completed and used to develop an up to date care plan.	

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F 309	Continued From page 20 again coughed (an indication Resident #3 had poor vocal fold closure and secretions had entered her airway). The nurse failed to recognize Resident #3's obvious signs/symptoms of aspiration and failed to raise her bed to 90 degrees prior to administering her medications. Prior to leaving the room, the nurse (#28) stated, "She's on this medication, because she has aspiration pneumonia." * 08/26/14 at 4:20 p.m., a CNA (#24) transferred Resident #3 into bed. The CNA (#24) handed Resident #3 a glass of water as she again lay in a reclined position. The resident refused to take a drink and handed the glass back to the CNA (#26). The CNA failed to raise Resident #3 bed to 90 degrees prior to offering her water. During an interview on 08/26/14 at 11:20 a.m., an SLP (#29) verified residents should be able to sit in an upright position before being fed. She also added staff "should not push it" if a resident is fatigued. - Resident #2's medical record, reviewed August 25-28, 2014, identified diagnoses including cerebrovascular disease and weakness. The resident's quarterly MDS, dated 08/06/14, identified intact cognition and assistance of one person for tray set-up. The current care plan identified, ". . . Approach . . . Encourage and assist with . . . fluid intakes as needed. Monitor for any increased need for assistance with . . . drinking . . . Speech therapy consult if needed." Observations showed the following: * On 08/25/14 at 2:00 p.m., an unidentified CNA offered Resident #2 a glass of water as she lay in	F 309	Residents with a diagnosis of Constipation and those using PRN laxatives five times or more per month have been identified. Constipation care plans for these residents will be developed prior to 10-13-14 utilizing the information gathered from the observations completed and the 7-day voiding and BM tracking. The QI Coordinator and/or his designee will complete QI monitoring beginning the week of 10-6-14 to verify that Observations & tracking are completed according to P & P and that individualized care plans, including dietary interventions, have been initiated. A minimum of 10 resident's charts with a diagnosis of Constipation will be monitored weekly X4 and monthly X2. Monitoring will include checking meal trays to ensure that fiber supplements are served at meal time according to the care plan. Monitoring done the week of 10-6-14 will include Resident #2 #6 & #7. Anti-Anxiety Medications: The Behavior Program P & P was reviewed and revised to include the completion of a Behavior Meeting Observation during each Behavior Team meeting. These meetings are held at least monthly & PRN as needed. Residents targeted for review during this meeting are those residents receiving meds	

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F 309	Continued From page 21 bed (with the head of the bed raised to an approximate 25 degree angle). Resident #2 drank from the glass. The CNA failed to raise Resident #2 bed to 90 degrees prior to offering her water. * On 08/26/14 at 8:35 a.m., two CNAs (#7 and #17) transferred Resident #2 into bed using the stand lift. After repositioning Resident #2, one CNA (#17) offered her a glass of water as the other CNA (#7) raised the head of the bed (to an approximate 75 degree angle). Resident #2 drank from the glass. The CNA failed to raise Resident #2 bed to 90 degrees prior to offering her water. During an interview the morning of 01/09/14, an administrative nurse (#4) confirmed staff are to ensure residents are alert and positioned properly (90 degrees) prior to any feeding attempts. The facility staff failed to recognize Resident #3's signs/symptoms of aspiration (coughing) and failed to position/reposition Resident #2 and #3 as close to 90 degrees as possible prior to offering liquids resulting in Resident #3's aspirating her medication and/or water. CONSTIPATION 2. Based on observation, record review, policy and procedure review, and staff interview, the facility failed to assess and implement an individualized/specific plan of care for management of constipation and lacked evidence of monitoring the effectiveness of an established plan in promoting regular bowel patterns/habits for 4 of 8 sampled residents (Resident #2, #3, #6 and #7) and one discharged resident (#14). This resulted in excessive use of laxatives with accompanying discomfort for for Resident #7. Other residents at risk included Resident #2, #3,	F 309	including anti-anxiety, anti-psychotic, hypnotic, & anti-depressants. Residents who display behavior adversely affecting themselves or others are also monitored by this team. Physician orders for PRN medications (anti-anxiety, anti-psychotic, hypnotics, & anti-depressants) entered into the eMAR include documentation space for non-pharmacologic interventions trialed prior to the administration of the PRN medication. The Behavior Team will identify those interventions that are meaningful for the resident and care plan accordingly. Resident #3 has been discharged. Residents meeting the criteria for monitoring by the Behavior Team have been identified. The team will complete a Behavior Team Observation prior to 10-13-14 on each resident. Care plans will be updated prior to 10-13-14 to include interventions that are successful for managing a resident's behaviors. PRN medication orders for these residents will be audited prior to 10-13-14 to insure that the eMAR entry includes documentation space for the non-pharmacologic interventions. QI monitoring will be completed by the QI Coordinator and/or his designee starting the week of 10-6-14 and will	

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F 309	Continued From page 22 #6, and #14, each with diagnosis of constipation. Findings include: Review of the "BOWEL PROGRAM" policy occurred on 08/27/14. The policy, dated 04/12/14 stated: "POLICY: 1. The licensed nurse monitor's resident bowel habits daily and directs the administration of bowel meds [medications] as necessary. PURPOSE: 1. To monitor and assist a resident in maintaining regular bowel habits. PROCEDURE: 1. The licensed nurse checks the resident BM [bowel movement] list daily to determine the need for administration of a bowel med. . . . 2. If the resident offers complaints or demonstrates signs or symptoms of constipation (evidenced by a lack of BM) a licensed nurse completes an assessment. The need for a bowel med is determined by this assessment. a. Absence of adequate BM as evidenced by 2 - 24 hour periods with a small BM or less recorded. i. Day 2 - Begin with a laxative, either in a liquid or tablet form. Utilize medications as listed in Standing Orders or as ordered specific for the resident. May increase to BID [two times a day] if necessary. ii. Day 3 - Dulcolax 1 tablet PRN [as needed] daily. May increase to BID as necessary for constipation or Bisacodyl Suppository 1 rectally PRN daily for constipation iii. Day 4 - consider use of Tap Water or Fleets enema. Contact MD [medical doctor] for specific orders. . . . 4. Nursing . . . document medication administration via eMAR [electronic medication administration record]. . . . 6. A resident consistently utilizing a bowel medication on a	F 309	include those residents with PRN medication orders for anti-psychotic, anti-anxiety, anti-depressants and hypnotics to ensure Observations are completed; interventions identified, care plans updated, and eMAR entries include documentation space for non-pharmacologic interventions. Monitoring will be done weekly X4 and then monthly X2 to ensure that compliance is achieved and maintained. Diabetes: The Hypoglycemia P & P was revised along with physician standing orders specific to diabetic management of low accu-check results. The revised standing orders include parameters for high & low accu-check results and instructions for further treatment/physician contact. The eMAR order entry for scheduled and PRN accu-check results include documentation space for nursing interventions for each accu-check completed. A documentation "key" for interventions identified in the Hypoglycemia P & P has been updated and included in the order entry for accu-checks. The following has been completed for Resident #9: 1. Updated physician orders for sliding scale insulin including high and low	

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F 309	Continued From page 23 PRN basis from the standing orders is identified. Resident specific orders are received from the physician. a. Consistently is identified as greater than 5 PRN administration times per month. b. Resident specific bowel program supersedes the bowel meds standing orders. 7. Increased hydration is encouraged. 8. Dietary consult with the LRD [licensed registered dietician] is initiated for those resident [s] identified as consistently using a bowel med. a. Consistently is identified as greater than 5 PRN administration times per month. b. Dietary interventions are initiated to aid in the non-medication management of constipation. c. This includes an increase in fluids where possible. 9. The licensed nurse is responsible to evaluate and update individualized bowel management plans PRN as needed." Review of the facility's "Standing Orders for Medications and Treatment" occurred on 08/28/14. These orders, identified on the morning of 08/28/14 by a facility administrative staff member (#1) specific for Resident #7, stated: ". . . Constipation: a. Milk of Magnesia Regular Strength 30 ml [milliliters] PO [by mouth] Daily . . . b. Bisacodyl [sic] 10 mg [milligram] suppository 1-2 rectally per day prn c. Dulcolax 5 mg 1-2 tablets per day prn constipation d. Senna-Gen (Senokot) 1-2 tablets po daily & up to TID [three times a day] prn e. Senna-S 1-2 tablets po daily & up to TID prn f. Tap Water Enema prn daily per rectum g. Fleets Enema (Sodium Phosphate or Mineral Oil) per rectum prn daily During an interview on 08/28/14 at 9:30 a.m., when asked how dietary staff are informed of	F 309	parameters and instructions for accu-check results outside of parameters. 2. Updated eMAR entries for documentation of results and action taken. 3. Care plan updated to address diabetic care and interventions in case of hypo & hyperglycemia Residents with sliding scale insulin orders in place have been identified. Prior to 10-13-14 physician orders will be updated to include clarification of high and low parameters & treatment instructions. The eMAR order entry for scheduled & PRN accu-check results will include documentation space for nursing interventions completed. Care plans for these residents will be updated to address diabetic care. QI monitoring will be completed by the QI Coordinator and/or his designee beginning the week of 10-6-14. Monitoring of a minimum of 10 residents eMAR documentation for adherence to the sliding scale parameters, treatment documentation, and care plan completion addressing diabetic care will be completed weekly X4 and then monthly X2 to ensure that compliance is achieved and maintained. Results of all QI monitoring will be reviewed as part of the monthly facility CQI meetings and then summarized at the Quarterly CQI meetings with the Medical	

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F 309	Continued From page 24 residents experiencing constipation, a managerial dietary staff member (#3) stated, "During an assessment, I look at their diagnoses, and I interview the resident. I review the BM [bowel movement] records, and sometimes the nurse will tell me [if they are constipated.] When asked what types of interventions dietary staff initiate if a resident is identified as experiencing constipation, the managerial dietary staff member (#3) stated, "high fiber liquid mixed with coffee or juice, high fiber powder mixed with mashed potatoes, prunes, prune juice, whole wheat bread, and supplements (Boost Breeze)." She further stated, "We encourage an increase in their fluid intake too." - Review of Resident #7's record occurred on all days of survey. Diagnoses included Alzheimer's disease, dementia, chronic heart failure and constipation. Current physician orders for laxatives with start dates included: * 10/18/13: Psyllium husk two capfuls daily at 8:45 a.m. * 02/20/14: Initial order as a standing order, Bisacodyl 10 mg suppository 1-2 rectally per day prn * 05/13/14: Miralax 17 grams (gm) daily at 8:45 a.m. * 05/23/14: Senna-S one tablet twice a day; scheduled for 8:45 a.m. and 6:30 p.m. * 05/24/14 at 2:50 p.m.: Initial order as a standing order, TWE (tap water enema) prn daily per rectum Physician orders for laxatives following 05/24/14 included: * 06/02/14: Senna S one two times a day; discontinued on 08/08/14 * 06/03/14: Dulcolax 5 mg 1-2 tablets per day prn constipation	F 309	Director in attendance. The need for further monitoring will be determined based on these results. Summary: Education was initially completed on 9-23-14 with CNA, CMA, and Nursing staff and included the following: 1. Swallowing precautions 2. Shift to shift reporting of pertinent clinical information will be emphasized to ensure that a clinical issue affecting a resident is reported and addressed by a Licensed Nurse. 3. BM Tracking & treatment interventions Further education will be provided for all clinical staff on 10-7-14 & will include the following: 1. Revised Dysphagia Management P & P along with the recommended positioning of residents when taking food or fluids in bed. The importance of following the individual swallowing precautions listed for each resident in their individualized care plan will also be stressed. 2. Bowel Program P & P 3. Continence Care and Bowel Management P & P including the Bowel Observation & Urinary Incontinence Observation 4. Behavior Program P & P including the Behavior Team Observation completion 5. Hypoglycemia Management P & P	

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F 309	Continued From page 25 * 08/08/14: Senna S one every evening; and 2 tablets scheduled every day in the morning Resident #7's care plan identified the use of anti-depressant medications (scheduled dose of Zoloft since 10/18/13, Remeron since 01/15/14 and Effexor XL since 04/23/14); and use of an antipyschotic medication (scheduled Seroquel, since 04/24/14). Additional medications within Resident #7's medication regimen that can cause constipation included three medications for hypertension, two daily doses of a diuretic, and a calcium supplement. Two "Incontinence History and Assessment Form[s]," one un-dated, and one dated, 07/31/14, identified Resident #7 as occasionally incontinent of bladder and continent of bowel. The forms provided no assessment of bowel patterns. During interview on the afternoon of 08/27/14, a staff nurse (#10) stated an assessment of bowel history/patterns is not completed but rather nurses run a report every day to determine who has not had a BM. The nurse did not identify how nursing staff determined resident's bowel patterns from this information. Progress notes included the following: * 05/24/14: "Resident's abd [abdomen] in the LLQ [left lower quadrant] distended and painful to palpation only. Bowel sounds are hypoactive. Resident is on day 5 for BM's. Dulc [dulcolax] tabs [tablets] were given this AM [morning] with no effect. Suppository given just now. Will wait for results, or give enema in 30 minutes. . . ." The eMAR showed on 05/23/14 at 10:27 p.m. nursing staff administered Resident #7 two	F 309	6. Orange "S" on name plate indicating swallowing precautions in effect 7. Importance of conveyance of pertinent clinical information CNA to Nurse 8. Strict documentation of non-pharmacologic interventions prior to administration of anti-anxiety medications 9. Revised standing orders and sliding scale parameters 10. Care Plan importance: a. Swallow guide/precautions b. Constipation, Bowel & Bladder function c. Dietary interventions d. Diabetic care e. Education will be presented by the LRD for the dietary staff on the importance of providing all food/fluids as listed on the diet cards for each resident. The variety of fiber sources will be reviewed. This education is planned for 10-8-14. Date Certain: 10-16-14	

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F 309	Continued From page 26 Dulcolax tablets. On 05/24/14 nursing staff administered the three scheduled laxatives and two tablets of Dulcolax tablets at 9:27 a.m.; a bisacodyl suppository at 1:45 p.m. and a TWE at 3:26 p.m. The record identified Resident #7 then expelled four large and one medium BM between 4:25 p.m. on 05/24/14 and 4:50 a.m. on 05/25/14, over a 12 hour period. * 05/25/14 (Sunday): Nursing progress notes at 12:35 p.m. stated, "Resident's LLQ remains distended today and is slightly more firm than yesterday despite enema and large results of BM x 4 [four times]. Dr. [name] was called to make a physician aware of this. Dr. [name] feels that upon description it sounds like a hernia and we are to monitor it and have Dr. [different doctor] assess on Tuesday." * 05/28/14: "VSN [undefined] abdomen ordered by Dr. [name]." * 06/02/14: Resident #7's family refused the request for an abdominal ultrasound. * 06/04/14: "Discussed code status change . . . due to recent refusal of ultrasound for hernia. Family stated that resident has had that hernia for years and Dr. [name] stated that it would be more dangerous to operate on then to keep it as it is. Family decided not to change code status at this time and prefers to wait and re-evaluate when resident starts to decline." Review of physician progress notes included: * 05/23/14: " . . . The patient was seen today and she has been stable. . . . no problem with . . . change in bowel habits . . . reported constipation for which I did start her on MiraLAX 17 grams p.o. daily and Senna-S 1 tab p.o. b.i.d." * 05/28/14 [four days after the prn laxative usage]: ". . . I was notified by the nursing staff that	F 309		

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she has some pain in her left lower quadrant. She does have a history of a ventral hernia. I went in to see the patient. She has no pain now and there was no tenderness as well. Her mass seems to have increased . . . No change in bowel habits. . . . It is not incarcerated. . . ." The note lacked evidence the nursing staff informed the physician regarding the use of multiple laxatives on 05/24/14.

Resident #7's eMARs identified in the month of July, nursing staff administered dulcolax tablets for constipation on five occasions, and from August through August 25, 2014 on four occasions. The records identified inconsistencies with when nursing staff administered Dulcolax tablets based on the number of days since the last BM (varied between one and four days following a BM).

Review of "Nutritional Assessment[s]," dated 10/24/13, 01/17/14, and 04/18/14 failed to address Resident #7's bowel problems including medication management for constipation, and each included an entry to "Continue Current Plan of Care." The 01/17/14 assessment identified medications included "laxatives," the 04/18/14 assessment identified the use of "laxatives - PRN;" and a "Nutritional Assessment," dated 07/18/14 identified the implementation of "Hyfiber" [a liquid fiber substitute] at breakfast.

Review of Resident #7's diet/menu card showed the dietary department provided a cardiac diet without any supplements including Hyfiber at breakfast. The menu selection, specific for Resident #7, did not include the option of the Hyfiber for the breakfast meal. The medical record lacked evidence Resident #7 refused the

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F 309	Continued From page 28 Hyfiber. During observation of meal service on the morning of 08/26/14, Resident #7 received a bowl of bran flakes and ate a few bites. Observation showed no prompting/encouragement by staff to consume the cereal. The presence or lack of Hyfiber could not be determined. During observation on the afternoon of 08/25/14, a certified nursing assistant (CNA) (#11) assisted Resident #7 to the bathroom. When the CNA removed the resident's garment and incontinence product, the product contained light reddish bloody drainage. The CNA stated she had been told earlier about the bleeding, and would tell the nurse also. The record lacked evidence this occurred. During observation of toileting cares at 9:55 a.m. on 08/26/14, Resident #7 expelled a small BM on the toilet. A CNA (#12) stated the rectal area felt like the resident was "impacted" and then stated "constipated." The CNA stated she would let the nurse know. The bowel movement vitals report for 08/26/14 included the documentation of the small BM and one hour later, by a different staff member, a large "Dry/Hard" BM expelled. The facility failed to: * Assess Resident #7's bowel habits and implement a consistent bowel program, and evaluate the effectiveness of the bowel program, in an attempt to lessen the use of scheduled and prn laxatives. * Ensure physician's orders included specific and individualized orders for the use of prn standing orders to avoid inconsistencies in laxative usage by nursing staff.	F 309		

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F 309	Continued From page 29 * Implement non-pharmacological measures in an attempt to address Resident #7's history of constipation and excessive use of laxatives. This failure resulted in Resident #7 experiencing distress by frequent elimination episodes following the use of several laxatives on 05/24/14. - Review of Resident #6's record occurred on all days of survey. Resident #6's admission occurred in July 2014. Admission diagnoses included constipation. Current medication orders included laxatives of Ducosate Sodium 100 mg two times a day "hold if loose stools;" Miralax 17 gm every day as needed and Bisacodyl rectal suppository 10 mg 1-2 per day prn. A "Nutritional Status" Care Area Assessment, completed on 08/04/14, failed to address Resident #6's history/diagnosis of constipation or current medication use for constipation. Review of Resident #6's diet/menu card showed the dietary department provided a "Renal Considerations" diet. Review of the upcoming menu choices for 08/29/14 included no offerings of high fiber foods including whole grains, minimal high fiber vegetables (including cooked), and fresh fruit choices. - Resident #2's medical record, reviewed August 25-28, 2014, identified diagnoses including cerebrovascular disease, weakness, obesity, and constipation. The resident's quarterly MDS, dated 08/06/14, identified intact cognition and extensive assistance of one person for toileting. The record lacked evidence the facility completed a bowel assessment for Resident #2. The documentation of Resident #2's BMs from	F 309		

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F 309	Continued From page 30 July 8-August 26, 2014 identified the resident failed to have a bowel movement for three days on one occasion, four days on three occasions, and five days on one occasion. The physician's orders identified the following: * 07/18/14 and discontinued 07/28/14, Senna-S 8.6-50 mg three times a day as needed for constipation * 07/31/14, Docusate Sodium 100 mg twice a day for constipation * 08/04/14, Dulcolax 5 mg daily as needed for constipation * 08/10/14, Milk of Magnesia 10 milliliters (ml) as needed for constipation The MAR identified the facility failed to schedule/administer stool softeners/laxatives in a manner that stimulated bowel activity and may have prevented constipation from occurring. The current care plan failed to address Resident #2's episodes of constipation. The facility failed to assess and implement an individualized/specific plan of care for management of Resident #2's episodes of constipation and lacked evidence of monitoring the effectiveness of an established plan in promoting normal bowel patterns/habits for Resident #2. - Resident #3's medical record, reviewed August 25-28, 2014, identified diagnoses including dementia and constipation. The resident's quarterly MDS, dated 08/06/14, identified intact cognition and extensive assistance of two or more persons for toileting. The record lacked evidence the facility completed a bowel	F 309		

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F 309	Continued From page 31 assessment for Resident #3. The documentation of Resident #3's BMs from June 28-August 27, 2014 identified the resident failed to have a bowel movement for three days on one occasion, four days on two occasions, five days on one occasion, and eight days on one occasion. The physician's orders identified the following: * 06/24/14 and discontinued 07/08/14, Senna 8.6 mg at bedtime * 07/08/14, Bisacodyl Suppository 10 mg once a day as needed for constipation * 07/08/14, Docusate Sodium 100 mg twice a day as needed for constipation * 07/08/14, Miralax 17 grams once a day as needed for constipation * 08/08/14, Senna with Docusate Sodium 8.6-50 mg once a day for constipation * 08/10/14, Milk of Magnesia Concentrated 10 ml daily as needed for constipation The MAR identified the facility failed to schedule/administer stool softeners/laxatives in a manner that stimulated bowel activity and may have prevented constipation from occurring. The current care plan failed to address Resident #3's episodes of constipation. The facility failed to assess and implement an individualized/specific plan of care for management of Resident #3's episodes of constipation and lacked evidence of monitoring the effectiveness of an established plan in promoting normal bowel patterns/habits for Resident #3.	F 309		

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F 309	Continued From page 32 - Resident #14's closed medical record, reviewed August 27-28, 2014, identified diagnoses including decreased mobility secondary to a cerebrovascular accident (CVA) and constipation. The resident's admission MDS, dated 03/24/14, identified moderately impaired cognition and extensive assistance of two or more persons for toileting. The record lacked evidence the facility completed a bowel assessment for Resident #14. The documentation of Resident #14's eliminations (BM Report) between 03/17/14-05/08/14 identified the resident failed to have a bowel movement for three days on one occasion and four days on another occasion. The physician's orders identified the following: * 03/20/14, Dulcolax 5 milligrams (mg) daily as needed for constipation * 03/20/14, Senna-S8.6-50 mg twice a day for constipation The medication administration record (MAR) identified the facility failed to schedule/administer stool softeners/laxatives in a manner that stimulated bowel activity and may have prevented constipation from occurring. The current care plan failed to address Resident #14's episodes of constipation. The facility failed to assess and implement an individualized/specific plan of care for management of Resident #14's episodes of constipation and lacked evidence of monitoring the effectiveness of an established plan in promoting normal bowel patterns/habits for Resident #14.	F 309		

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F 309	Continued From page 33 ANTI-ANXIETY MEDICATIONS 3. Based on record review, review of facility policy, and staff interview, the facility failed to provide the necessary care and services to manage behavioral symptoms for 1 of 1 sampled resident (Resident #3) who received as needed (prn) anti-anxiety medication for behaviors prior to attempting non-pharmacological interventions. Failure to attempt non-pharmacological interventions and monitor the effectiveness of those interventions prior to administering an anti-anxiety medication did not allow staff to evaluate what interventions were most effective to manage Resident #3's behavior. Findings include: Review of the facility policy "Behavior Management Program" occurred on 08/28/14. The policy, dated 10/09/13, stated, ". . . The interdisciplinary team . . . determine[s] interventions to be tried resulting in a behavior care plan. . . . The resident specific care plan includes specific interventions to protect staff, resident, and other residents from threatening behaviors as they occur. . . . Staff uses the approaches care planned and documents the resident's response and/or outcome. . . . CNA [certified nursing assistant] staff convey the resident response to interventions to the nurse in charge . . ." Review of the facility policy "Principles of Medication Administration - LTC [long term care]" occurred on 08/28/14. The policy, dated 10/04/12, stated, ". . . When a PRN medication is administered the following documentation is provided . . . symptoms for which the medication	F 309		

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F 309	Continued From page 34 was given. . . ." - Resident #3's medical record, reviewed August 25-28, 2014, identified diagnoses including dementia, insomnia, and anxiety. The resident's admission Minimum Data Set (MDS), dated 07/14/14, identified intact cognition and need for antipsychotic and antianxiety medications. The current care plan identified, ". . . Approach . . . Assess if the resident's behavioral/mood symptoms present a danger to the resident and/or others. Intervene as needed. . . . Administer meds [medications] as ordered by MD [medical doctor]. Monitor side effects/effectiveness of meds. . . . Attempt non-pharmacological interventions. . . ." The current physician's orders identified the following: * 07/08/14: Lunesta (an hypnotic) 1 milligram (mg) at bedtime as needed * 07/10/14: Ativan (an anti-anxiety) 0.5 mg every 8 hours as needed * 06/14/14: Seroquel (an anti-psychotic) 12.5 mg at bedtime; monitor behaviors will discontinue if remains stable * 08/23/14: and discontinued 08/23/14, Ativan (an anti-anxiety) 1 mg one time dose The medication administration record (MAR), dated August 1-25, 2014, identified the following dates when staff administered prn Lorazepam without attempting non-pharmacological interventions prior to administration: * 08/04/14, 08/08/14, 08/14/14, 08/17/14, 08/19/14, and 08/22/14, "anxiety" * 08/07/14, "anxious" * 08/15/14, "restless"	F 309		

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F 309	Continued From page 35 * 08/18/14, "Anxiety per resident request" * 08/19/14 and 08/20/14, "anxiety, restless" * 08/21/14, "anxiety and restlessness" and "crawling out of bed, looking for other peoplke [sic]" * 08/22/14, "crawling out of bed, restless" * 08/24/14, "anxiety, crawling out of bed" * 08/25/14, "aggitated" The progress notes, dated August 1-25, 2014, also identified: * 08/15/14, ". . . She has been medicated for sleep and also for anxiety which has been effective." * 08/17/14, ". . . Res [resident] requested and received PRN for anxiety . . ." * 08/20/14, ". . . She recieved [sic] medication for anxiety which was effective. . . ." During an interview the afternoon of 08/28/14, an administrative nurse (#1) confirmed she could not locate documentation showing the non-pharmacological interventions staff attempted prior to administering the Lorazepam. DIABETES 4. Based on information received from the complainant, record review, policy and procedure review, review of a professional reference, and staff interview, the facility failed to ensure adequate monitoring of blood glucose readings for 1 of 8 sampled insulin dependent diabetic residents (Resident #9), and one discharged resident (Resident #14). Failure to monitor and provide necessary interventions for low and elevated blood glucose levels has the potential to impair function, contributing to accidents, injuries, seizures and coma.	F 309		

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Findings include:

Review of the facility policy, "Hypoglycemia, Treatment of" occurred on 08/28/14. The policy, dated 11/13, stated, ". . . PURPOSE: 1. To provide a consistent treatment procedure for treating hypoglycemia . . . POLICY: 1. A licensed nurse who identifies symptoms of hypoglycemia, follows the procedure for treatment of hypoglycemia. DEFINITIONS: Hypoglycemia - symptomatic or asymptomatic blood glucose value [less than] 60 mg/dl [milligrams per deciliter]. Low blood sugar - any level [less than] 70 mg/dl . . . Hypoglycemia . . . Insulin reactions can occur at any time and come on quickly. They are most apt to occur: Before meals or if meals/snacks are skipped or delayed. . . . Treatment . . . Give 15 gms [grams] of carbohydrate orally. . . . Recheck blood sugar within 10-15 minutes . . ."

The American Diabetes Association (2014 guidelines) defined hypoglycemia as "condition characterized by abnormally low blood glucose usually less than 70 [mg/dl] . . . Severe hypoglycemia has the potential to cause accidents, injuries, coma and death . . . Treatment: Consume 15-20 grams of glucose or simple carbohydrates; Recheck your blood glucose after 15 minutes; If hypoglycemia continues, repeat. Once blood glucose returns to normal, eat a small snack if your next planned meal or snack is more than an hour or two away. . . ."

- Review of Resident #9's record occurred on August 27-28, 2014. Diagnoses included insulin dependent (Type II) diabetes. Current insulin

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F 309	Continued From page 37 orders included Humalog insulin 6 units once a day at breakfast time, scheduled for 7:00 a.m.; Humalog 4 units twice a day, scheduled for 11:30 a.m. and 5:30 p.m.; Lantus insulin 15 units once in the morning, scheduled for 7:00 a.m.; and Humalog insulin according to sliding scale before meals and at bedtime, scheduled for 7:00 a.m., 11:30 a.m., 5:30 p.m., and 8:45 p.m. Current physician's orders included accuchecks/blood glucose monitoring four times a day scheduled for 6 a.m., 11:30 a.m., 5:30 p.m., and 8:45 p.m. The specific orders also stated: "Call primary provider if blood sugar is greater than 400 [mg/dl]. If blood sugar is [less than] 80 [mg/dl], treat with 15 gm [grams] carbs [carbohydrates] and recheck in 15 minutes. Repeat until [greater than] 80. Once blood sugar is [greater than] 80, ok to give scheduled humalog. Please chart rechecks in PRN [as necessary]." The orders stated to perform accuchecks PRN as well. The facility's scheduled meal times were: breakfast at 7:45 a.m., lunch at 11:30 a.m., and supper at 5:45 p.m. Review of Resident #9's accucheck results from 08/01/14 through 08/24/14 identified 17 occurrences where nursing staff identified accucheck readings less than 80 mg/dl at the scheduled accucheck times. The electronic medication administration record (eMAR) and/or nurses' notes lacked evidence nursing staff provided Resident #9 a 15 gram carbohydrate snack and rechecked the blood glucose on 12 of those 17 occasions. Those 12 readings ranged from 51 to 79 mg/dl.	F 309		

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F 309	Continued From page 38 During interview on the afternoon of 08/26/14, an administrative staff member (#1) confirmed Resident #9's medical record lacked interventions implemented by nursing for the hypoglycemic/lower than normal blood glucose readings. During this interview two administrative staff members (#1 and #25) stated nursing staff may not provide the snack for a resident if it occurs prior to the serving of a meal. Information provided by the complainant indicated staff failed to monitor Resident #14's blood sugars. The complainant stated, "Blood sugars way out of control. . . . When high, they would add additional insulin and she would plummet to 40-60's. When we stressed our concerns staff again advised that's how they handle hypo and hyper glycemic issues." - Resident #14's medical record, reviewed August 27-28, 2014, identified diagnoses including cerebrovascular accident (CVA) and insulin dependent diabetes. The resident's admission Minimum Data Set (MDS), dated 03/24/14, identified moderately impaired cognition and extensive assistance for all activities of daily living (ADLs). The current care plan failed to address Resident #14's episodes of low and/or high blood sugars. The physician's orders identified the following: * 03/17/14, Humalog Insulin 18 units three times a day before meals; 7:30 a.m., 12:00 p.m., 6:00 p.m. * 03/17/14, Humalog Insulin sliding scale: blood sugar (BS) reading of 110-149 = 1 unit, 150-199 = 2 units, 200-249 = 4 units, 250-299 = 7 units, 300-349 = 10 units, 350-400 = 12 units, > [greater	F 309		

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F 309	Continued From page 39 than] 400 = 14 units and recheck BS in two hours, If still > 400 on recheck notify medical doctor. The facility failed to establish individualized parameters for Resident #14, for those times she experienced low blood sugars. * 03/17/14, Accu Check four times a day: 6:00 a.m., 11:45 a.m., 5:45 p.m., and 8:45 p.m. * 05/05/14, Levemir Insulin 26 units once an evening; 8:45 p.m. The MAR, dated March 17-May 12, 2014, identified the following incidents of low blood sugar (hypoglycemia) and the one incident of high blood sugar (hyperglycemia): * 03/18/14 at 8:45 p.m., 58, one apple juice given * 04/05/14 at 8:45 p.m., 20 * 04/15/14 at 11:45 a.m., 62 * 04/16/14 at 11:45 a.m., 59 * 04/17/14 at 11:45 a.m., 56, two orange juice taken, 15 minute recheck 65, one slice jelly toast given * 04/20/14 at 11:45 a.m., 61 * 04/21/14 at 11:45 a.m., 55 * 04/24/14 at 11:45 a.m., 59 and at 5:45 p.m., 403 The facility failed to recheck Resident #14's blood sugar in two hours [following the > 400 reading] as per physician's order. * 04/25/14 at 11:45 a.m., 55, at 5:45 p.m., 59 and at 8:45 p.m., 59 * 05/04/14 at 11:45 a.m., 56 During an interview the afternoon of 08/28/14, when asked for information regarding blood sugar parameters, an administrative nurse (#1) confirmed she could not locate individualized parameters on either the physician's orders or the MAR, for those times Resident #14 experienced low blood sugars.	F 309		

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F 309	Continued From page 40 The facility failed to: * address Resident #14's episodes of low and/or high blood sugars on her care plan, * establish individualized parameters for Resident #14, for those times she experienced low blood sugars. * recheck Resident #14's blood sugar two hours after obtaining a > 400 reading; as per the physician's order.	F 309		
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 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, review of facility policy and procedure, and staff interview, the facility failed to ensure 2 of 3 sampled residents with current or a history of pressure sores (Resident #6 and #8) received the necessary treatment and services to prevent pressure sores, prevent recurrence of healed pressure sores, promote healing, and prevent infection. Failure to identify, monitor and implement treatment measures resulted in delayed healing and risk of serious harm/injury from delayed healing.	F 314	F-314: Treatment/Services to Prevent/Heal Pressure Ulcers It is the sincere intent of this facility to achieve and maintain compliance with F-314 as evidenced by the following: The Skin Risk Assessment, Treatment and Care Plan P & P was reviewed and remains in place except for the initiation of the Pressure Ulcer Documentation Observation to be completed in the EMR instead of in the eMAR. This Observation is used to document the weekly skin rounds completed by the Licensed Nurse which includes a wound exam with measurements and an accurate description of wound characteristics. Initial education was completed on 9-23-14 for CNA, CMA, and nursing staff that focused on importance of following MD orders and care plan interventions for prevention of skin issues/pressure ulcers, especially the importance of adhering to directions for use of Prevalon boots and	

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F 314	Continued From page 41 Findings include: Review of the facility "SKIN RISK ASSESSMENT, TREATMENT, AND CARE PLAN" policy occurred on 08/27/14. The policy, dated 01/11/13, stated: "The Skin Risk Assessment with Braden Scale (Acuity) Observation is completed: a. On admission . . . b. On a weekly basis for the first three (3) weeks . . . 2. Skin is assessed by the caregiver during routine cares and during baths to identify . . . developing skin condition. . . . PURPOSE: 1. The facility strives to prevent the development of a pressure ulcer(s) in a resident who is admitted without pressure ulcer(s), unless the development is clinically unavoidable. 2. The facility provides necessary treatment and services to promote healing, prevent infection and prevent new ulcers from developing. . . . Treatment: . . . Obtain and follow treatment orders. . . . Monitoring and Documentation: 1. Documentation of the wound is done weekly and PRN [as needed] when indicated by wound complications or changes in wound characteristics. Documentation includes but is not limited to the following: a. Date b. Length x [times] Width (in cm2) [sic] c. Exudate amount d. Tissue type 1. Necrotic . . . 2. Slough . . . Granulation tissue . . . Epithelial tissue [a stage of wound healing] . . . Closed/Resurfaced . . . Monitoring is done to determine patency of the dressing. Monitoring includes . . . pain . . . status of dressing . . . Edge of peri-ulcer area. d. Presence of possible complications i. Induration ii. Infection iii. Increasing ulceration. . . ." - Review of Resident #6's medical record occurred on all days of survey. Admission diagnoses included a calf ulcer and peripheral vascular disease. Admission orders included a	F 314	pressure relieving cushions. Further education will be completed on 10-7-14 to review the P & P Skin Risk Assessment, Treatment, and Care Plan including completion of the Pressure Ulcer Documentation Observation. Education was presented by Erin Schwinkendorf, FNP-Wound Practitioner, on 10-3-14 for CNA & Nursing associates. Education for staff included instructions on what skin issues (including pain) staff must be aware of while completing personal cares, bathing and toileting. Education also included components of a head to toe nursing assessment and the importance of accurate documentation. The importance of communication between CNA staff & nursing was stressed so that clinical concerns are treated in a timely manner. The Wound Practitioner completed rounds on 10-3-14 for all residents with a pressure ulcer/significant skin concern. Rounds included an exam of resident's wounds and documentation of each which establishes a baseline & reference for nursing staff moving forward. The following has been completed for Resident #6 & #8: 1. Updated care plan with preventive measures in place-specifically gel mattress	

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F 314	Continued From page 42 Mepilex dressing to the right posterior calf, changed three times per week. A Minimum Data Set (MDS), dated 08/01/14, identified one unstageable pressure ulcer on admission with dimensions of 1.6 centimeters (cm) by 2 cm by 0.2 cm (length, width, and depth). The MDS showed Resident #6 required extensive assistance with bed mobility and transfers; with a pressure reducing device for the chair and bed; a turning and repositioning program, and pressure ulcer care. A pressure ulcer Care Area Assessment (CAA), dated 08/04/14, stated: "Braden score is 18 indicating he is at risk for pressure sores and he currently has an unstageable pressure sore to his right lower extremity that was present upon admission. He is receiving treatment with a Mepilex border three times a week. Preventative measures are in place. . . ." Resident #6's current care plan included assist of 1 for positioning; identified the problem of "PRESSURE ULCER: Resident has unstageable pressure ulcer to right lower extremity (present on admission)." Approaches included "Assess and record the condition of the skin surrounding the pressure ulcer. Assess the pressure ulcer for location, stage, size (length, width, and depth), presence/absence of granulation tissue and epithelization as ordered by MD [Medical Doctor]. . . . Keep bony prominences from direct contact with one another. Keep clean and dry as possible. . . . Observe and report signs of cellulitis . . . of osteomyelitis . . . of sepsis . . . Treatment: As ordered by MD."; and identified the problem of "risk for alteration to skin integrity d/t [due to] impaired mobility . . ." with approaches including ". . . Encourage to elevate legs when in bed;	F 314	2. Completion of Pressure Ulcer Documentation Observation 3. Heal protector schedule and use of roho cushion clarified for Resident #8 4. Pain assessment completed on 10-7-14 & progress note completed to address pain during lift transfer and also during incontinence care. Facility residents with current pressure ulcers and those utilizing Prevalon boots gel mattresses, and cushions for pressure relief have been identified. QI Monitoring will be completed by the QI Coordinator and/or his designee beginning the week of 10-6-14 for those residents with an identified pressure ulcer. Monitoring will be completed weekly X4 and monthly X2 to ensure that compliance is achieved and maintained. Monitoring will include care plan accuracy for preventive measures ordered & in place and also accuracy of Pressure Ulcer Documentation Observation. Monitoring of Resident #6 & #8 will be completed prior to 10-8-14 Results of QI monitoring will be reviewed at least monthly as a part of the facility CQI meetings and then summarized at the Quarterly CQI meeting to be held with the Medical Director in attendance. The need for further monitoring will be determined based on these results. Date Certain: 10-16-14	

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	355106	A. BUILDING _____ B. WING _____	C 08/28/2014

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F 314	Continued From page 43	F 314		

Encourage to lay down twice a day . . . monitor skin and report skin breakdown. . . ." The care plan failed to include the use of a gel mattress to reduce pressure to bony prominences, included on admission orders, dated 07/30/14.

During observation on the morning of 08/27/14 a nurse (#15) provided wound cares to Resident #6's right posterior calf ulcer. The area appeared fleshy red in color. Observation showed scabbed areas: over the resident's right heel, distal to the right small toe, and distal to the right great toe. Observation identified no gel mattress in place, as ordered.

During interview on the morning of 08/27/14, a nurse (#15), upon entering the electronic medication administration record (eMAR), stated the eMAR links the assessment of pressure ulcers, which generally occurred weekly on Fridays.

On the morning of 08/27/14, an administrative staff member (#1) stated a speciality clinic provider directing the care of the pressure areas completed the assessment and measurements of Resident #6's pressure ulcer and additional pressure areas/wounds. The staff member stated the speciality clinic orders the pressure ulcer treatment, and required the facility to follow its specific orders for pressure ulcer management.

The medical record included provider orders of "Admission Body Observation on admission/readmission and then weekly x [times] 3." The electronic record showed the assessments identified:
* July 29: A description of "any additional body marks or sores" stated "Callous with dark spot on

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F 314	Continued From page 44 right 5th Metatarsal. Callous next left great toe. Ulcer to posterior right leg yellow slough 1.6 x 2 x 0.2 surrounding area dark purple and soft." * August 5: The observation did not include an assessment of the unstageable pressure area to the "right lower extremity" as noted on the admission MDS and CAA. A description of "any additional body marks or sores" stated "Macules distributed throughout the body. Edema to ankles bilaterally. Bruises to hands bilaterally." * August 12: The observation did not include an assessment of the unstageable pressure area to the "right lower extremity" as noted on the admission MDS and CAA. A description of "any additional body marks or sores" stated "2 pea sized sores top LT [left] foot one scabbed. callous bottom Lt foot by great toe. callous top 3rd toe Rt [right] foot, et lateral side Rt foot by 5th metatarsal with black center, numerous brown marks back" * August 19: The observation did not include an assessment of the unstageable pressure area to the "right lower extremity." A description of "any additional body marks or sores" stated "Right foot 3rd toe red and swollen with a scab, Right lateral great toe has a scab. Bilateral feet swollen." Provider (physician or nurse practitioner) progress notes stated: * 08/04/14 (wound nurse): Visit included measurements of the posterior calf and stated the "Large ulcer to the posterior calf, improving. . . . follow up here at the Wound Clinic as needed. . . ." * 08/06/14: "Follow up right calf ulcer . . . Skin Lesion Reported by staff. Location: upper right calf . . . started 1 week(s) ago . . . Mepilex dressing . . . Right Posterior calf ulcer - Cleanse wound with normal saline moistened gauze,	F 314		

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F 314	Continued From page 45 cover with Mepilex border and change 3 times per week . . ." The assessment lacked measurements of the ulcerated area. * 08/13/14: ". . . Skin . . . (Pressure ulcer to right posterior calf. Scabbed area to right upper buttocks.) * 08/20/14: ". . . Skin lesion Reported by staff. Location: buttocks . . . Couple of days ago; Onset/Timing: abrupt; Context: moisture; Alleviating Factors: Mepilex dressing . . . recently seen and evaluated 8/11/14. At that time we ordered to cover upper buttocks with a Mepilex border and change 3 x/week . . . No further documentation re: [regarding] lesion to buttocks. Right posterior calf ulcer . . . No further nursing documentation re: ulcer to leg. . . . (Pressure ulcer to right posterior calf. Scabbed area to right upper buttocks.). . . . Right posterior calf ulcer . . . continue to have nursing staff monitor with each dressing change and as needed. . . ." Observation on all days of survey showed Resident #6 seated in a wheelchair or on the bed except during the observed dressing change. Failure to implement pressure reduction measures, including a gel mattress ordered upon admission, identify newly developed areas of eschar on Resident #6's right foot; identify the development of a coccyx pressure ulcer as noted in a provider progress note on 08/20/14, and implement preventative (verses treatment only) measures; monitor pressure areas to determine changing characteristics, including size/measurements, appearance, and drainage on a weekly basis as per facility policy; resulted in delayed healing and resulted in the development of additional pressure areas for Resident #6.	F 314		

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F 314	Continued From page 46 - Review of Resident #8's medical record occurred on all days of survey and included Parkinson's Disease, diabetes, traumatic brain injury, and a history of pressure ulcers. The quarterly MDS, dated 06/05/14, identified extensive assist of two plus persons for bed mobility and transfer, moderately impaired cognition, risk for pressure ulcers, frequently incontinent of bowel and bladder, and a pressure reducing device for chair and bed. The current care plan identified an "Approach Start Date: 02/21/2014 Place Roho cushion in recliner chair when resident sits in recliner and then continue to place roho in whatever chair the resident is sitting in . . . Approach Start Date: 08/20/13 . . . Remove prevalon boots for transfers. . . ." Review of Resident 8's progress notes regarding skin issues identify: * 01/10/14 - "Left heel diabetic ulcer healed. Continue mepilex for 2 weeks. Coccyc [sic] has 2 pin point openings. . . ." * 01/30/14 - "CNA approached this nurse and stated that resident's bottom was really sore and painful during peri-cares. . . ." * 01/31/14 - "Buttocks is healed with only dry skin present. . . ." * 02/07/14 - ". . . moisture fissure to intercocygeal fold that measure 5.5cm x 1.5cm. . . ." * 02/08/14 - "Coccyx area very sore and several open fissures noted . . . having #9 pain to coccyx . . . ." No further documentation until 02/21/14. * 02/21/14 - ". . . no open area noted . . . New orders received to place roho cushion in recliner and then move to each area resident will be sitting." * 03/07/14 - ". . . stage 2 pressure sore to the right gluteal [buttocks] that measures 3.9cm x 2.7cm. . . . MDS: Significant change assessment	F 314		

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F 314	Continued From page 47 . . . Braden score is 14 indicating . . . at moderate risk for skin breakdown . . . has a history of healed pressure ulcers. . . ." * 03/14/14 - Right gluteal ulcer measures 2.1 x 1.2cm. No further documentation until 03/21/14. * 03/21/14 - ". . . New orders to D/C [discontinue] Mepilex border to bottom. . . ." * 06/02/14 - ". . . CNA found a pressure sore to residents lateral aspects of residents left foot. . . ." * 06/13/14 - "Changed dressing to left lateral 5th metatarsal head. Wound measures 0.8 x 0.4 cm dark purple and red surrounding painful to touch. . . ." * 06/20/14 - " . . . left foot . . . continue Mepilex for protection and prevention . . . boil on perineum . . . measures .2 x .2 x .6 cm. . . ." * 06/27/14 - ". . . boil measured today: 0.6 x 0.7cm, no open areas noted." No further documentation until 07/11/14. * 07/11/14 - ". . . New order to D/C Mepilex to left lateral foot, wound healed. . . D/C from services." Review of a referral note by a wound practitioner, dated 06/06/14, stated, " . . . PHYSICAL EXAMINATION SKIN: The patient has a left lateral foot area of discoloration over his 5th proximal metatarsal head. It measures 0.4 cm x 0.8 cm. The skin is intact over this area. It does not blanch. I am considering this as suspected deep tissue injury versus a diabetic foot ulcer. . . PLAN: . . . Mepilex border over this area for protection . . . continue to utilize blue foam heel protector boots at all times to patient's feet to help offload the heel, as well as to help protect the left lateral foot area of concern. Continue ROHO cushion to patient's wheelchair and to patient's recliner. . . ."	F 314		

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F 314	Continued From page 48 Observations * 08/25/14 at 4:05 p.m. - Resident #8 in his recliner without a Roho cushion. Staff had left the Roho cushion in his wheelchair. * 08/26/14 at 11:15 a.m. - Two CNAs (#5 and #6) transferred the resident from his room recliner which contained no Roho cushion to his wheelchair containing the Roho cushion. The CNAs removed the protector boots leaving the resident's socks on, the calf strap from the EZ Stand lift slipped under the resident's left foot. The CNAs did not readjust the strap during the transfer putting additional pressure on the foot's previous pressure ulcer area. * 08/26/14 at 1:45 p.m. - Two CNAs (#5 and #6) transferred the resident from his wheelchair to his room recliner. The CNAs did not take the Roho cushion from the wheelchair and place it into the recliner. * 08/27/14 at 9:25 a.m. - Two CNAs (#8 and #9) cleansed the resident's coccyx area after an incontinent stool. The resident moaned in pain each time the CNA cleaned the reddened area with a cleansing wipe. Review of Resident 8's progress notes identified staff failed to document the resident's reddened coccyx area or pain during incontinence care. During an interview on 08/28/14, a nurse manager (#1) indicated CNAs should report any pain or reddened areas during incontinence care to the nurse. The nurse should document those issues in the progress notes. Staff should make sure the EZ Stand calf strap is appropriately placed during transfers and not under a resident's foot.	F 314		
F 323	483.25(h) FREE OF ACCIDENT	F 323		

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F 323 SS=G	Continued From page 49 HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of policy, review of manufacturer's recommendations, and staff interview, the facility failed to re-evaluate the appropriateness, and ensure safe transfer during the use of assistive devices for 2 of 4 sampled residents (Resident #2 and #8) observed during stand lift transfers. Failure to protect Resident #8 from experiencing pain in relation to assessed transfer techniques resulted in repeated episodes of pain during transfers, and placed Resident #2 and #8 at risk of falls due to unsafe transfer techniques in relation to each resident's capabilities. Findings include: Review of the EZ Stand Operating Instructions occurred on 08/28/14. The instructions, dated January 2001, stated ". . . To utilize the EZ Stand, patients must be able to bear some weight. . . . The Seat Strap provides additional support and comfort to patients who have a tendency to quit bearing weight . . . As patients do vary in size, shape, weight and temperament, these conditions must be taken into consideration when deciding if the EZ Stand is suitable for their need. Patients	F 323	F-323: Free of Accident Hazards/Supervision/Devices It is the intent of this facility to remain in compliance with F-323 and provide care in an environment that remains free of accident hazards as evidenced by the following: The Use of Standing and Total Lifts P & P was reviewed and remains in place with emphasis placed on compliance with these guidelines. Intense education was provided the week of 9-1-14 on a 1:1 to basis with CNA and nursing staff to detail the importance of adhering to the P & P and correct use of the seat straps. A new screening process P & P titled "PT/OT Transfer and Mobility Specific Screening" was developed. This screening is completed by a physical or occupational therapist within 24 hours of admission and/or the first working day following admission. It is also to be completed on an annual basis, with a resident's change in condition, and PRN. Completion of this screen provides guidance for nursing to develop an individualized care plan specific to transfer and mobility needs and also provides guidance for staff on the safest means for completing transfers. A PT/OT Transfer and Mobility Screen were completed for both resident #2 and	

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F 323	Continued From page 50 should be able to bear some weight . . . If necessary to keep patients shins or feet on the foot plate, secure the shin straps around the patients legs . . . Lengthen the Seat Strap so that it will slide around and under the patient. . . . slide the Seat Strap around behind the patient and underneath the patient's buttocks. Press the button up again, and release it when the patient is in the standing position. Now adjust the Seat Strap to the desired tension. . . . Position patient's arms on the outside of the harness and have them place their hands on the padded handles. . . ." Review of the facility policy titled "Use of Standing and Total Lifts - General Guidelines" occurred on 08/27/14. This policy, dated 06/19/09, stated, " . . . PURPOSE: 1. Mechanical lifts, either standing or total, are used to transfer a resident from one position to another in a safe, dignified, and comfortable manner . . . PROCEDURE: 1. Nursing associates determine the need for use of a standing lift or a total lift based on the resident's functional and cognitive ability . . . 5. Physical or Occupational therapists are consulted as necessary to determine the appropriate lift to use for a resident based on the resident's functional and cognitive ability . . . 7. Seat straps are used to provide additional support and comfort to residents who have a tendency to quit bearing weight during a transfer. . . ." - Review of Resident 8's medical record occurred on all days of survey and included diagnoses of Parkinson's Disease, a traumatic brain injury, and a history of pressure ulcers. The quarterly Minimum Data Set (MDS), dated 06/05/14, identified extensive assist of two or more persons for bed mobility and transfer and moderately	F 323	#8. Their care plans have been updated to include instructions for their safe transfer. Resident #8 was also assessed for pain during transfers. Staff education on the proper use of an EZ stand lift including use of the seat straps was completed on 9-23-14 and will be again on 10-7-14. Training on 10-7-14 will include a review of the Use of Standing and Total Lifts P& P and also the PT/OT Transfer and Mobility Specific Screening P & P. Residents requiring the use of an EZ Stand have been identified. Prior to 10-13-14 a PT/OT Transfer and Mobility Screen will be completed and the information used to develop an individualized care plan to meet their transfer and mobility needs. QI Monitoring will be completed by the QI Coordinator and/or his designee starting the week of 10-6-14. Monitoring of those residents using an EZ Stand lift for transfers will be done weekly X4 and then monthly X2 of to achieve and maintain compliance with the P & P and ensure safe resident transfers. Monitoring will include direct observation to ensure that the transfer is accomplished according to the care plan directions. Results of the CQI Monitoring will be reviewed at least monthly as a part of the	

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F 323	Continued From page 51 impaired cognition. The current care plan stated, " . . . Approach [intervention] Start Date 08/20/13, Transfers: Assist of two and EZ stand. Remove prevalon boots for transfers. Hoyer [total body lift] PRN [as needed] when he refuses to hold on to EZ stand. . . ." Observations of staff transferring Resident #8 with the EZ Stand: * 08/25/14 at 5:15 p.m. - Two certified nursing assistants (CNA) (#2 and #4) transferred the resident from his room recliner to the toilet and then into his wheelchair using the EZ Stand lift. The resident held onto the hand grips as the sling slid up under the resident's arms. The resident appeared to hang in the lift with pressure under his axilla and minimal weight on his legs as his knees remained bent as in a sitting position. Resident #8 stated, "Hurts arms!" One of the CNAs stated, "Sorry. Almost done." The CNAs did not use the Seat Strap. * 08/26/14 at 9:00 a.m. - Two CNAs (#5 and #6) transferred the resident from his wheelchair to his room recliner. The resident did not bear any weight on his left foot and only the toe of his right foot came in contact with the foot plate. The CNAs used the Seat Strap, but it was placed above the buttocks providing no support. The resident moaned as the CNA raised the sling and it slid under his axilla. One of the CNAs asked if that hurt, and the resident stated, "Yes." * 08/26/14 at 11:15 a.m. - Two CNAs (#5 and #6) transferred the resident from his room recliner to his wheelchair. When the CNAs applied the calf strap it slipped under his left foot. They did not readjust it. The resident moaned as the sling raised and slid under his axilla. The CNAs used the Seat Strap, but it was placed above the buttocks providing no support.	F 323	facility CQI Meetings and then summarized at the Quarterly CQI Meeting to be held with the Medical Director in attendance. The need for further monitoring will be closely monitored and determined based on these results. Date Certain: 10-16-14	

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F 323	Continued From page 52 * 08/26/14 at 1:45 p.m. - Two CNAs (#5 and #6) transferred the resident from his wheelchair to his room recliner. When the CNAs applied the calf strap it slipped around his right ankle. They did not readjust it. The resident moaned as the CNA raised the sling and it slid under his axilla and stated, "Oh! My underarms! Oh God!" Staff positioned the resident quickly into his recliner. The CNAs used the Seat Strap, but it was placed above the buttocks providing no support. * 08/27/14 at 9:25 a.m. - Two CNAs (#8 and #9) transferred the resident from his wheelchair to his bed. The CNAs positioned the Seat Strap appropriately. The resident moaned as the CNA raised the sling and it slid under his axilla and stated, "Stop!" The CNAs did not reposition the Seat Strap to provide more support. The CNA (#8) did not understand what the resident had said and asked him to repeat it, but the resident said nothing more. Review of the progress notes during survey identified the staff had not reported or documented any of the observed pain issues when using the stand lift for Resident #8. During an interview on 08/28/14, a nurse manager (#1) indicated CNAs should report any pain or difficulty with any stand lift transfers to the nurse. - Resident #2's medical record, reviewed August 25-28, 2014, identified diagnoses including cerebrovascular disease, weakness, obesity, and lower limb ulcer. The resident's quarterly MDS, dated 08/06/14, identified intact cognition and extensive assistance of one person for transfers. Resident #2's current care plan stated, "Problem:	F 323		

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F 323	Continued From page 53 ADL's [Activities of Daily Living] . . . Approach: Transfers: EZ stand with assist of 2 for transfers. . . . Toileting: . . . EZ stand with assist of 2 to transfer to commode for toileting needs. . . ." The current care plan failed to address Resident #2's weakened right arm. Observation on 08/26/14 at 8:35 a.m. showed two CNAs (#7 and #17) prepared to transfer Resident #2 utilizing a stand lift. The CNAs (#7 and #17) placed Resident #2's feet on the foot plate, secured the shin pad, and attached the harness and seat strap to the stand lift. The CNAs (#7 and #17) then assisted the resident to hold onto the padded handles and transferred her to the commode. Following cares, the CNAs (#7 and #17) transferred Resident #2 from the commode to her bed. Observation showed the resident's knees bent at an approximate 50 degree angle, and the harness pushed up into her axilla causing her shoulders to shrug upward. Her upper right arm (shoulder to elbow) was parallel to the floor and her lower arm (elbow to fingers) hung downward. Staff failed to ensure the resident was able to bear weight, slide the seat strap under her buttocks, and ensure her weakened right arm was held in front of her body during the transfer. Observation on 08/26/14 at 5:30 p.m. showed two CNAs (#23 and #24) prepared to transfer Resident #2 into her wheelchair utilizing a stand lift. The CNAs (#23 and #24) assisted the resident into a sitting position at the edge of the bed, placed her feet on the foot plate, secured the shin pad, and attached the harness and seat strap to the stand lift. The CNAs (#23 and #24) then assisted the resident to hold onto the padded handles, and raised the lift. They attempted, but failed to slide the seat strap under	F 323		

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F 323	Continued From page 54 her buttocks. Observation showed the resident's knees bent at an approximate 55 degree angle, the harness pushed up into her axilla causing her shoulders to shrug upward, and her right arm hanging at her side. The CNAs (#23 and #24) lowered Resident #2 back onto the bed after she complained of pain. One CNA (#23) left the room to speak with the nurse. She returned with the Hoyer lift, and stated, "[Resident #2's] sling is in the laundry." Staff failed to ensure the resident was able to bear weight, supported her weakened right arm in front of her body when attempting a transfer, and provided the necessary equipment to accommodate Resident #2's size. During an interview on the afternoon of 08/28/14, an administrative nurse (#1) confirmed residents should be able to bear their own weight when using a stand lift. She also confirmed staff should ensure they have the necessary equipment to accommodate a resident's size prior to attempting a transfer and should ensure a resident's safety during the transfer if they have a weakened/paralyzed limb.	F 323		
F 327 SS=G	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, review of professional literature, and staff interview, the facility failed to provide adequate fluid intake for 1 of 1 sampled resident	F 327	F-327: Sufficient Fluid to Maintain Hydration It is the intent of this facility to remain in compliance with F-327 and monitor resident's intake and output to maintain proper hydration and health as evidenced by the following: The Licensed Registered Dietician reassessed the hydration status and fluid needs for resident #4 on 9-10-14.	

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F 327	Continued From page 55 (Resident #4) dependent on staff for fluid intake and an order for strict intake and output. Failure to provide adequate fluid intake resulted in the resident's dehydration, urinary tract infection (UTI), and hospitalization with a UTI sepsis. Findings include: Review of the facility's policy titled "Hydration Assessment and Maintenance" occurred on 08/28/14. The policy, dated 01/02/09, stated, "POLICY: 1. Residents are provided a fresh supply of water at the bedside unless otherwise contraindicated. 2. Resident's are offered fluids with medications, with cares, during regularly scheduled snack passes and meals, therapy sessions, activities, and PRN [as needed] as requested . . . PURPOSE: 1. To ensure that a resident is offered sufficient fluids based on their individual needs to maintain proper hydration and health. . . ." The Center for Medicare and Medicaid Services (CMA) has outlined the standards of practice regarding hydration. "Sufficient fluid" means the amount of fluid needed to prevent dehydration and maintain health. The amount needed is specific for each resident, and fluctuates as the resident's condition fluctuates. A general guideline for determining baseline daily fluids needs is to multiply the resident's body weight in kg [kilograms] times 30cc [cubic centimeters] (2.2 lbs [pounds] = 1kg). Review of Resident 4's medical record occurred on all days of survey and included diagnoses of UTIs, hypertension, constipation, atrial fibrillation, and cerebral vascular accident (CVA). Resident's medications reviewed February 2014 through	F 327	Residents #4's physician discontinued strict I & O on 9-11-14 following 9-10-14 Nutritional Observation completed by LRD which revealed average intake of greater than 1000ml per day. A nursing order was written on 10-3-14 to offer 240ml nectar fluids in Styrofoam cup with lid six times per day and PRN. All fluids provided at mealtime, between meals, and at the Resident #4's bedside were re-evaluated and preferences have been readdressed. Resident #4 has been educated on the risks and benefits of proper hydration. Resident #4's care plan has been reviewed and updated to reflect current hydration interventions. Residents who require strict intake and output monitoring are at risk for hydration issues. As this time, there are no resident's at Sanford off Collins with physician orders for Intake and Output monitoring. To ensure that I & O orders are followed in the future the Intake and Output P & P has been revised to place emphasis on accurate recording of food and fluids consumed by the resident when ordered by the physician. Emphasis is placed on the importance of clear and concise documentation by all staff. Education was held with all nursing staff members, activity and dietary staff on 10-7-14 and 10-8-14 where the revised Intake and Output P & P was reviewed. Documentation was emphasized as well	

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F 327	Continued From page 56 August 28, 2014 included Risperdal, Seroquel, Xanax, Zoloft, Tramadol, and hydrochlorothiazide. The quarterly Minimum Data Set (MDS), dated 06/10/14, identified cognitively intact, extensive assist of at least two staff for bed mobility and transfers, extensive assist of one staff for eating, and a weight of 160 lbs. The Care Area Assessment (CAA), dated 10/18/13, identified Dehydration - Fluid Maintenance for care planning due to constipation, dependant on staff for fluid intake, diuretics, and medications. The current care plan stated, "Problem Start Date: 03/17/2014. Category: Nutritional Status. [Resident is triggering HIGH nutrition risk r/t [related to] . . . swallowing difficulties . . . insufficient fluid intakes at times . . . medications . . . hx [history] UTI . . . on strict I & O [Intake and Output] per MD [medical doctor] ordered . . . Approach Start Date: 10/22/2013 . . . nectar thkn [thickened] liquids . . . Food/fluid intake monitoring per facility . . . limited to extensive assistance with eating & drinking. Encourage food/fluid intakes . . . Problem Start Date: 10/28/13. Urinary: Alteration in patterns of urinary elimination . . . Approach: Monitor for s/s [signs/symptoms] of UTI ie [for example]: fever, hematuria, odor, and increased confusion. . . ." During observation on 08/25/14 at 8:20 a.m., a staff member assisted the resident with breakfast. The resident used her right hand to feed herself. The staff member assisted when the resident drank from a cup. Observation at 9:20 a.m. identified a certified nursing assistant (CNA) (#2) emptied the resident's bedpan into the toilet. The CNA failed to measure the urine output. Review of the "Medications Administration History: 02/01/2014 - 02/28/2014" identified	F 327	as the significance of accurate reporting and documentation of fluids. Also discussed is the need to prompt residents in the dining room who are eating or drinking slowly or taking decreased amounts. To ensure compliance with I & O documentation CQI monitoring will begin the week of 10-6-14 and will be completed by the CQI Coordinator and/or his designee. Random monitoring of 10 residents per week will be accomplished x4 and 10 residents monthly x2 to ensure that resident intake is documented accurately. Residents with physician orders for Intake or Output will be added to the monitoring if/when orders are written. Results of the CQI monitoring will be reviewed as part of the monthly facility CQI meetings and then summarized at the Quarterly CQI meeting with the Medical Director in attendance. The need for further monitoring will be determined based on these results. Date Certain: 10-16-14	

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F 327	Continued From page 57 Senna Lax 8.6 mg administered twice a day for constipation. Staff administered Dulcolax 5 mg tablet PRN for constipation six times in February 2014 before hospitalization on 02/24/14. Review of the "Events Report" identified UTIs treated with antibiotics on 01/08/14, 01/27/14, and 07/17/14. Review of Resident #4's progress notes prior to hospitalization identified: * 02/04/14 - "Spoke with [family] regarding . . . condition and behaviors . . . [resident] refused to eat and thrown water at staff . . . [family] request of starting an IV [intravenous] for fluid's to prevent dehydration . . . [staff] would have to consult [physician] . . . [physician] with orders to utilize PRN medication for behaviors . . . continue to monitor. . . ." [The physician did not order IV fluids.] * 02/12/14 - "INFECTION: . . . Resident with recent UTI, treated with Ampicillin x7 days . . . [Physician] does not feel it is necessary to obtain a repeat UA/UC [urine analysis/urine culture] . . . behaviors are related to . . . Vascular Dementia with bizarre behaviors vs. [versus] UTI. Nursing to continue to monitor . . . New orders for Seroquel 25 mg [milligrams] po [by mouth] Q [every] HS [bedtime]. . . ." * 02/18/14 - ". . . NP [nurse practitioner] here . . . New orders received for risperdal 0.25 mg PO BID [twice daily], increase xanax to 0.25mg PO in the morning, xanax 0.5 mg prior to noon meal and 0.25 mg prior to pm [evening] meal. . . ." * 02/19/14 - ". . . resident has been sleepy all day and [nurse] believes it is due to the recent medication adjustment of xanax . . . new orders received to decrease xanax [0.25 mg BID] and risperdal [0.25 mg at bedtime]. . . ."	F 327		

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F 327	Continued From page 58 * 02/24/14 - "Resident very lethargic today. Not eating. When spoken to resident stares off and not responding most of the time . . . Heartrate very irregular 107 bpm [beats per minute] . . . O2 [oxygen] applied . . . send to ER [emergency room] . . . BP [blood pressure] 162/100. . . ." Review of Resident #4's "Treatments Administration History" dated January 2014 identified an order stating, "Strict I & O. Encourage fluids. Frequency TID - Three Times A Day. Start/End Date 10/18/2013 - 03/04/2014 (DC [discontinue] Date). Review of the "Treatments Administration History" dated August 2014 identified an order stating, "Strict I & O. Encourage fluids. Frequency TID - Three Times A Day. Start/End Date 03/10/2014 - Open Ended." Review of Resident #4's "Vitals Report," dated 02/01/14 through 02/28/14 identified an average fluid intake of 334mL [milliliters] per day from 02/01/14 through 02/24/14. According to CMS guidelines a person with a weight of 160 lbs. should have approximately 2181 mL of fluid per day. Staff failed to measure the resident's output in the report, but documented the number of times continent or incontinent. Review of Resident #4's hospital History and Physical, dated 02/24/14, stated, "to the ER due to lethargy and elevated blood pressure and low oxygen saturations . . . is aphasic [non-verbal] . . . Lethargy possibly due to some dehydration . . . Mildly elevated creatinine likely due to dehydration. . . ." The Discharge Summary, dated 03/10/14, stated, " . . . DISCHARGE DIAGNOSES 1. Proteus urinary tract infection (UTI) with sepsis . . . MEDICATION CHANGES . . . Xanax . . . discontinued . . . HOSPITAL	F 327		

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F 327	Continued From page 59 COURSE . . . A. [atrial] fibrillation . . . required a Cardizem drip . . . Hypernatremia [elevated sodium level] resulted in a 3-day additional stay for continued monitoring . . . taken off triamterene-hydrochlorothiazide. Most likely that medication will promote dehydration. . . so it is avoided . . . acute renal failure, resolved . . . hypokalemia [low potassium level] had resolved . . . " During an interview on 08/28/14 at 10:00 a.m., a nurse manager (#1) indicated the strict I & O order started on admission in October 2013 and was discontinued on 03/04/14. Staff did not currently monitor the resident's I & O. She failed to identify the current order for strict I & O. The nurse manager did not know the reason for the strict I & O admission order. Failure to accurately record and monitor a strict fluid intake and output order with a resident's diagnosis of constipation, history of UTIs, and medication changes affecting hydration and constipation resulted in the resident's decline and hospitalization.	F 327		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329	F-329: Drug Regimen Free from Unnecessary Drugs It is the intent of this facility to achieve and maintain compliance with F-329. Because the deficient process has the potential to affect all residents of Off Collins the following has been completed: The Behavior Program P & P was reviewed and revised to include the	

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F 329	Continued From page 60 Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, review of professional literature, and staff interview, the facility failed to ensure 3 of 13 sampled residents (Resident #3, #4, and #7) were free from unnecessary drugs. Failure to address appropriateness of certain drug therapies may result in residents receiving unnecessary medications and experiencing adverse drug effects related to their use. Findings include: Review of the facility's policy titled "Behavior Management Program" occurred on 08/27/14. This policy, dated 10/09/13, stated, "POLICY: . . . e. Critical Thinking Related to Antipsychotic Drug Use. The resident should only be given medication if clinically indicated and as necessary to treat specific conditions and target symptoms as diagnosed and documented in the record. i. Residents who use antipsychotic drugs must	F 329	completion of a Behavior Meeting Observation during each Behavior Team meeting. These meetings are held at least monthly & PRN as needed to address exhibited behaviors adversely affecting the resident or others along with anti-anxiety, anti-psychotic, anti-depressant, & hypnotic medication use. Non-pharmacologic interventions are utilized to decrease use of medications and alleviate behavioral symptoms whenever possible. Physician orders for PRN medications (anti-anxiety, anti-psychotic, anti-depressant, & hypnotic) entered into the eMAR include documentation space for non-pharmacologic interventions trialed prior to the administration of the PRN medication. The Behavior Team will identify those interventions that are meaningful for the resident and care plan accordingly. The Consultant Pharmacist Medication Review P & P has been revised to include directions for staff to follow in the event the Monthly Pharmacy Review is not addressed by the primary care physician or Consultant within 30-days of completion by the Consulting Pharmacist. The DON and/or her designee will track the return of Pharmacy Reviews and contact either the Primary Care Physician or the Medical Director to address the	

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F 329	Continued From page 61 receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue the use of these drugs. . . . The interdisciplinary team . . . determine[s] interventions to be tried resulting in a behavior care plan. . . . The resident specific care plan includes specific interventions to protect staff, resident, and other residents from threatening behaviors as they occur. . . . Staff uses the approaches care planned and documents the resident's response and/or outcome. . . . CNA [certified nursing assistant] staff convey the resident response to interventions to the nurse in charge . . ." "Nursing 2015 Drug Handbook", 35th ed., Wolters Kluwer, Philadelphia, pages 696, 1205,1245, states, * "Haldol . . . Black Box Warning: Elderly patients with dementia-related psychosis treated with atypical or conventional antipsychotics are at increased risk for death. Antipsychotics aren't approved for the treatment of dementia-related psychosis." * "Seroquel . . . Black Box Warning: Drug isn't indicated for use in elderly patients with dementia-related psychosis because of increased risk of death from CV [cardiovascular] disease or infection." * "Risperdal . . . Black Box Warning: Elderly patients with dementia-related psychosis treated with antipsychotics are at increased risk for death. Drug isn't approved to treat elderly patients with dementia-related psychosis." - Review of Resident #4's medical record occurred on all days of survey and included diagnoses of dementia with bizarre behaviors, cerebral vascular accident, and depression. Staff	F 329	issues identified by the Consultant Pharmacist. A letter was mailed to all medical providers responsible for care of residents in a Sanford Continuing Care Center on 10-3-14. The purpose of this letter is to raise their awareness of their responsibility to address duplicate mediations and respond to the monthly Pharmacy Review in a timely manner. The facility physicians Standing Orders have been revised to correspond to the changes made in the Bowel Program and Continence Care and Bowel Observation P & P. Residents who use more than 5 PRN laxatives per month will be assessed so that an individualized care plan is developed to address constipation and medication use. The Consultant Pharmacist will address the use of multiple laxatives when noted in the monthly pharmacy reviews. Resident #3 has been discharged. The following has been completed for Resident #4: 1. A Behavior Team Observation will be completed on 10-7-14 and will address medications currently in use, plan for reduction if indicated, behavior improvement or worsening, physician orders, pharmacist recommendations, and care plan updates.	

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F 329	Continued From page 62 sent the resident to the emergency room (ER) on 02/24/14 due to unresponsiveness, high blood pressure of 160/100, and low oxygen saturations. The hospital History and Physical, dated 02/24/14. stated, ". . . lethargy and elevated blood pressure and low oxygen saturations . . . aphasic [non-verbal] . . . dehydration. . . . " The Discharge Summary, dated 03/10/14, stated, ". . . Xanax . . . discontinued. . . UTI [urinary tract infection] with sepsis . . . A. [atrial] fibrillation with rapid ventricular rate . . . hypertension . . . pulmonary hypertension. . . ." Review of Resident #4's antipsychotic medications started before the 02/24/14 hospitalization and administered during the consultant pharmacist's March, April, and May 2014 review included: * Seroquel 25 milligrams (mg) at bedtime started 02/12/14 * Risperdal 0.25 mg at bedtime started 02/19/14 * Haloperidol (Haldol) 1 mg every 6 hours as needed for anxiety started 01/31/14. Nine doses administered on February 1, 2, 4, 6, 8, 10, 11, 17, and 18. * Haldol lactate 1 mg injection every 6 hours as needed for anxiety started 01/31/14. Two doses administered in May 2014. The current care plan states, "Problem Start Date: 02/18/2014. Category: Psychotropic Drug Use. ANTIPSYCHOTICS: Resident on psychotropic medication . . . Approach . . . Consultant pharmacy review done monthly and prn [as needed] . . . Psych [psychiatric] consult as needed . . . Medications as ordered. Monitor side effects and effectiveness of medications. . . . Problem Start Date: 03/18/14 . . . BEHAVIORS . . . Approach . . . Administer medications: Monitor	F 329	The following has been completed for Resident #7: 1. The resident's care plan has been updated to reflect the resident's use of medications and the importance non-pharmacologic interventions prior to med administration. 2. The constipation care plan has been revised to provide an individualized plan for this resident's bowel program. (Please also see POC for F-309) 3. Monthly Pharmacy Review written 10-3-14 and sent to MD to address laxative use. Education was held with the CNA, CMA, and nursing staff on 9-23-14 to address documentation of behaviors along with a trial of non-pharmacologic interventions and documentation of BM's. Education is scheduled for 10-7-14 and will address the revised P & P along with the importance of clear, concise documentation of interventions attempted and individualized care plans established. To insure the deficiency noted is corrected for all residents QI monitoring will be completed by the QI Coordinator and/or his designee beginning the week of 10-6-14. Because this process has the potential to affect all residents, a full chart review was completed. It included but was not limited to pharmacy reviews. The prior 6 months	

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F 329	Continued From page 63 and record effectiveness. . . ." Review of Resident #4's Consultant Pharmacist Review, dated 03/11/14, stated, "Patient is currently on Scheduled RISPERDAL AND SEROQUEL in addition to PRN HALDOL. The use of Three Antipsychotics is considered Therapeutic Duplication. Please Discontinue one of the scheduled medications and the prn Haldol. . . ." The physician bracketed this paragraph with a handwritten note stating, "will evaluate," and signed/dated the form 03/17/14. The Consultant Pharmacist Review, dated 04/11/14, had no recommendations. The Consultant Pharmacist Review, dated 05/05/14, stated, ". . . Could you please review RISPERDAL, SEROQUEL & PRN HALDOL use? . . . The use of three antipsychotics can be seen as therapeutic duplication. Please consider using only one scheduled medication here. The use of prn antipsychotics is on the Beers list and is not recommended in the nursing home setting. . . ." The form lacked evidence the physician responded to the recommendation. The director of nursing signed and dated the form on 06/17/14 over a month later. Review of Resident #4's "Behavior Team" notes identified: * "4/8/2014 1. Behaviors Documented/Reported Since Last Meeting . . . Verbally Abusive Towards others x 1 occurrence, easily redirected . . . Mood Observation (Short tempered) x1 occurrence, easily redirected. c. Behavioral Binder . . . No behaviors documented. d. Nursing Progress Notes . . . No behaviors documented. . . . No changes desired, doing much better since readmission. . . ." * "5/8/2014 Monthly meeting, no changes . . . ." At	F 329	were reviewed, ensuring all were address in a satisfactory manner in accordance with the policy and routing to MD if necessary. Monitoring will be completed weekly X4 and then monthly 2 to ensure that Consulting Pharmacy Reviews are addressed by the MD when recommendations for a reduction or clarification of medication use have been recommended. Monitoring will also include review of Behavior Team Observation documentation, individualized constipation medication dosing and care plan interventions to ensure that desired results are achieved and maintained. Results of the QI monitoring will be reviewed as part of the monthly QI meetings and then summarized at the Quarterly QI meetings with the Medical Director in attendance. The need for further monitoring will be determined based upon these results. Date Certain: 10-16-14	

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F 329	Continued From page 64 this meeting and the 04/08/14 meeting the team failed to address the concurrent use and potential adverse consequences of three antipsychotics, the resident's decreased behaviors, and the pharmacist's recommendation, dated 03/11/14, to discontinue one of the three antipsychotic medications. * "6/17/2014 1. Behaviors Documented/Reported since last meeting: . . . Short Tempered/Easily Annoyed x5, not easily redirected. c. Nurses Progress Notes . . . No behaviors documented. d. Behavior Binder . . . 05/14/2014: Resident was verbally abusive when they [CNAs] were trying to get her up for the AM [morning] . . . 05/29/2014: Resident was being changed after lunch and the resident yelled at the CNA to get out of her room and tried punching her in the face . . . Resident seen by . . . MHNP. Orders received to D/C [discontinue] Risperdal. . . ." Review of Resident #4's "Nursing home progress note," dated 06/17/14, identified a mental health nurse practitioner (MHNP) discontinued the Risperdal. During an interview on 08/28/14 at 10:00 a.m., a nurse manager (#2) indicated the primary physician wanted the MHNP to address the antipsychotic medications. The nurse manager faxed the Consultant Pharmacist Review, dated 03/11/14, to the MHNP and indicated the MHNP did not address the medications until the next visit to the nursing home on 06/17/14, three months after the consultant pharmacist's recommendation to the physician. - Review of Resident #7's record occurred on all days of survey. Diagnoses included Alzheimer's disease, dementia, chronic heart failure,	F 329		

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F 329	Continued From page 65 depressive disorder, anxiety, non-organic psychosis, and constipation. Review of Resident #7's Minimum Data Sets (MDS), dated 10/24/13 (admission), 04/18/14, and 07/18/14 identified severe cognitive impairment, minimal depression on 04/18/14 and 07/18/14 MDS, and mild depression on 10/24/13 MDS. All three MDSs identified a mood problem of "Thoughts that you would be better off dead, or of hurting yourself in some way." All three MDSs identified no behavioral symptoms. Each MDS identified Resident #7 received antipyschotic and antidepressants seven days a week. The admission MDS, dated 10/23/13 identified the resident had one fall prior to admission; the 04/18/14 identified the resident experienced one fall with no injury and the 07/18/14 identified the resident experienced two falls with no injury during each respective assessment period. Each MDS identified Resident #7 required the extensive assistance of one person for bed mobility, transfers, walking and locomotion on and off the unit. Review of current medications identified Resident #7 received three concurrent antidepressant medications as followed: * Sertraline 200 mg every day, ordered on 10/18/13 * Remeron 7.5 mg at bedtime daily, ordered on 01/15/14. A progress noted stated the resident experienced confusion, was anxious, and depressed when the physician provided this order * Effexor XR 75 mg every day, ordered on 04/23/14. Resident #7's current medication regimen included an antipyschotic medication of Seroquel 75 mg at bedtime daily, ordered on 04/24/14. A	F 329		

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F 329	Continued From page 66 previous order, dated 04/23/14, included Seroquel 25 mg two times a day in addition to the 75 mg at bedtime. The 2014 Nursing Drug Handbook identified Effexor XR has Black Box Warnings of ". . . to closely monitor patient for signs of worsening condition or suicidal ideation;" identified Remeron has a Black Box Warning of ". . . Use cautiously in patients with conditions that predispose them to hypotension [drop in blood pressure], such as dehydration, hypovolemia [low blood volume] , or antihypertensive [used to treat elevated blood pressures] therapy. Give drug cautiously to elderly patients . . . closely observe patient for increasing suicidal thinking and behavior;" and sertraline with a Black Box Warning of ". . . closely observe patient for increased suicidal thinking and behavior." The 2014 Nursing Drug Handbook identified Seroquel with a Black Box Warning of "Drug isn't indicated for use in elderly patients with dementia-related psychosis because of increased risk of death from CV [cerebrovascular] disease or infection . . . be alert for anxiety, agitation . . . insomnia, irritability . . . worsening of depression, and suicidal thoughts. . . ." Progress notes included: * 05/08/14: "Behavior team met today to discuss resident current antipyschotic medication regimen. Resident had a medication adjustment on 04/23/14 [Seroquel and Effexor] following behaviors that resulted in safety monitoring. Residnet [sic] has been doing well since that medication adjustment. . . . Will continue to monitor and make adjustments as needed." This meeting occurred two weeks following the initiation of Effexor, failed to address the	F 329		

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F 329	Continued From page 67 concurrent use of three antidepressants, and potential adverse consequences; and change in Seroquel dose on 04/23/14. The notes failed to identify specific non-pharmacological interventions attempted and the effectiveness of those interventions. * 05/28/14: (Four days after receiving a number of laxatives within a 24 hour period - Refer to F309): "Resident depressed during the night and teary with comments that she wants to die, support given and monitoring, resident denies pain when asked." The note lacked what "support" the staff member provided, and whether the "support" was effective. * 06/17/14: Less than two months after the initiation of the Seroquel: "BEHAVIOR: Behavior Team met today to discuss resident's antipyschotic medication regimen. Resident with noted increase in sleeping, anxiousness in activities, decreased attention span. Resident frequently requests to go back to her room immediately following an activity where she proceeds to take a nap. [mental health practitioner] to round today. Will make sure she evaluates resident for change in sleep patterns and anxiety level. Will make any necessary changes at that time. Will continue to discuss resident at our monthly behavior team meetings." * 06/18/14: Mental health practitioner discontinued a 25 mg morning dose of Seroquel, decreased 6:30 p.m. dose with a discontinuation after 14 days; and continued a bedtime dose of 75 mg per day. * 07/09/14 and 07/10/14: Resident #7 experienced a fall both days within her room. * 07/14/14: "BEHAVIOR: Behavior team met today to discuss the resident's antipyschotic medication regimen. No changes are desired at this time. . . ." The team did not review the use of	F 329		

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F 329	Continued From page 68 the concurrent use of antidepressants, and potential adverse consequences. * 08/10/14 and 08/12/14: assisted falls without injury on each day while ambulating with the assist of one staff member * 08/26/14: Behavior meeting held "discuss resident's current use of antipyschotic. . . . at [bedtime]. . . . has diagnoses of Nonorganic Psychosis with Hallucinations and Senile Dementia. . . . has been stable . . ." The team did not review the use of the concurrent use of three antidepressants, and potential adverse consequences. Resident #7's care plan identified the following problems: * "SUICIDE PRECAUTIONS" with approaches of "Administer meds [medications] . . . Encourage . . . visits. Encourage resident to talk about feeling and frustrations. Psychiatric evaluation as indicated/ordered. Staff to investigate items when return from outings. Room searches PRN [as needed]. Suicide precautions per facility protocol. Update physician and family of changes as needed." The record included notations, dated 12/16/13 of "very depressed . . . Give me something to make it better," 01/17/14 when she stated she would be better off dead, and 04/18/14 stating she wished she was dead. The care plan included a single specific intervention (" Encourage resident to talk about feeling and frustration") to address the resident's feelings. * "ANTI-DEPRESSANT MEDICATION . . ." with approaches of medications as ordered. "Monitor side effects/effectiveness of meds." Additional approaches resembled approaches for suicide precautions. * "PSYCHOTROPIC MEDICATIONS" with approaches including ". . . Consultant pharmacy	F 329		

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F 329	Continued From page 69	F 329		

review done monthly and prn. . . ." This care plan lacked a single approach for the resident.

Review of Resident #7's admission MDS, dated 10/24/13, did not identify the resident with constipation, and identified continence of bowel; the 07/18/14 and 04/18/14 MDS identified the resident occasionally incontinent of bowel.

Current physician orders for laxatives included scheduled psyllium husk two capfuls every day; Miralax 17 grams every day; Senna S once every evening and once every morning. As necessary medications, documented on Resident #7's electronic medication administration record (eMAR), included Bisacodyl 10 mg suppository rectally as needed if oral "options fail for constipation;" Dulcolax 5 mg 1-2 tablets per day as needed for constipation, and TWE (tap water enema) once a day as needed per rectum.

Review of Resident #7's signed "Standing Orders for Medications and Treatment" included additional prn laxatives for constipation of Milk of Magnesia Regular Strength 30 ml (milliliters) daily, and Fleets Enema (Sodium Phosphate or Mineral Oil) per rectum prn daily

On 05/23/14 at 10:27 p.m. nursing staff administered two Dulcolax tablets; and on 05/24/14, nursing staff administered two Dulcolax tablets at 9:27 a.m., the scheduled Miralax, scheduled psyllium husk, scheduled Senna S (two scheduled doses), a prn dose of bisacodyl suppository, and a TWE. Resident #7 received all these medications within less than a 24 hour span of time.

- Resident #3's medical record, reviewed August

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F 329	Continued From page 70 25-28, 2014, identified diagnoses including dementia, insomnia, and anxiety. The resident's admission MDS, dated 07/14/14, identified intact cognition, feeling tired or restless, and need for antipsychotic and antianxiety medications. The MDS failed to identify the specific behaviors Resident #3's exhibited. The current care plan identified, ". . . Approach . . . Assess if the resident's behavioral/mood symptoms present a danger to the resident and/or others. Intervene as needed. . . . Administer meds [medications] as ordered by MD [medical doctor]. Monitor side effects/effectiveness of meds. . . . Attempt non-pharmacological interventions. . . ." The care plan failed to identify the specific behaviors Resident #3's exhibited and the individualized non-pharmacological interventions staff were to use prior to administering medications. The "Behavior meeting" progress notes failed to identify identify the specific behaviors Resident #3's exhibited. The medication administration record, dated August 1-25, 2014, identified staff administered 19 prn Lorazepam (Ativan) without attempting non-pharmacological interventions prior to administration. Facility staff documented "anxiety, anxious, restless, per resident request, crawling out of bed, looking for other peoplke [sic], aggitated" as behaviors for which the medication was given. During an interview on the afternoon of 08/28/14, an administrative nurse (#1) confirmed she could not locate (on the careplan or in the progress notes) the specific behaviors Resident #3	F 329		

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F 329	Continued From page 71 exhibited and/or the non-pharmacological interventions staff were to attempt prior to administering Lorazepam.	F 329		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, review of policy and procedure, and staff interview, the facility failed to follow professional standards of practice while preparing 3 of 4 insulin doses via insulin pens. Failing to prepare and prime the insulin pens according to manufacturer guidelines may affect the quantity of the dose administered. This resulted in a medication error rate of 8%. Findings: Review of the facility policy "USE OF INSULIN PENS" occurred on 08/27/14. The policy, dated October, 2011, stated, "POLICY: 1. Insulin Pens are used according to manufacturer guidelines to insure accuracy of insulin administration. PURPOSE: 1. To aide in the administration of insulin according to physician orders. PROCEDURE . . . Remove the pen cap . . . 4. Always use a new sterile needle for each injection. . . . 5. Wipe the rubber seal with alcohol. . . . 9. Select a dose of 2 - units by turning the dosage selector. . . . 11. Hold the pen with the needle pointing upwards. 12. Tap the insulin reservoir so that any bubbles rise up towards the	F 332	F-332 – Free of medication error rate greater than 5% It is the intent of Sanford Health Continuing Care Center off Collins to remain in compliance with F-332 and prevent medication error rates greater than 5% that are related to use of an insulin pen. The following interventions will correct the deficient practice for all residents receiving insulin via an insulin pen: Because the practice has the potential to affect all insulin receiving diabetic patients, education with satisfactory re-demonstration was initiated with all nursing staff the week of 9-8-14. Nursing Education was held on 9-23-2014. Reeducation on the Insulin Pen P & P was completed. Special attention was paid to wiping off rubber tip with alcohol swab, priming with 2 units of insulin and holding pen in an upright position. Demonstration/re-demonstration of proper use of flex pens was completed by all nursing staff. Nurse #25 was reeducated along with the rest of the nursing staff. He has since	

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F 332	Continued From page 72 needle. 13. Press the injection button all the way in. Check to see if insulin comes out of the needle tip. 14. The safety test may need to be performed several times before insulin is seen. . . ." On the morning of 08/27/14, a nurse (#25) prepared and administered insulin via insulin pens on three separate occasions. On each occasion the nurse primed the pens with one unit of insulin, held the pens without removing the pen cap, and primed the needles in a downward position. This resulted in the failure of seeing if the insulin came out of the needle tip. The nurse failed to wipe the rubber seal of the pens with alcohol prior to the attachment of a new sterile needle. On August 25-27, 2014, observation of the preparation and administration of 34 medications occurred. The medications observed included the improper preparation and potential inaccurate doses of insulin on three occasions. This resulted in a medication error rate of 8%. During interview on the afternoon of 08/27/14, an administrative staff member (#14) and a staff nurse (#25) agreed an error had occurred in the preparation of the insulin pens before administration.	F 332	completed his nursing orientation and provided return demonstration correctly several times. QI monitoring will begin the week of 10/6/2014 and will be completed by the CI coordinator and/or his designee. Monitoring will be completed on 10 administrations per week x 4 weeks and then monthly x 2 with special attention to wiping off the rubber tip, proper priming, and position of the pen. Results of the QI monitoring will be reviewed with DON and Administrator as part of the facility CQI meetings and then summarized for the quarterly CQI meeting with the Medical Director present. The need for additional monitoring will be determined based upon these findings. Date Certain: 10-16-2014	
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F – 371: Food Procure, Store/Prepare/Serve – Sanitary It is the intent of this facility to remain in compliance with F-371 and ensure food is prepared, distributed, and served under sanitary conditions as evidenced by the following:	

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F 371	Continued From page 73 This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy and procedure, and staff interview, the facility failed to ensure food was prepared, distributed, and served under sanitary conditions regarding cleaning the stove hood in 1 of 1 kitchen on 2 of 4 days of survey (August 25 - 26, 2014). Failure to ensure the hood above the oven and stove were cleaned may result in non food particles in foods prepared above the hood and reduces the risk of having an exhaust fire. Findings include: During the initial tour of the kitchen on 08/25/14 at 8:30 a.m., observation showed accumulated dust and debris on the light bulbs above the stove and oven. Material could be seen dangling between the light bulbs and the hood. When asked about a cleaning schedule, a dietary management staff member (#16) reported the hood "is cleaned weekly." During the general dietary tour, on 08/26/14 at 3:15 p.m., palpation of the interior surface of the hood and the metal "lip" of the hood revealed accumulation of dust, grimy build up, and pieces of material. A dietary management staff member (#16) agreed the hood and the lip were not clean. On the morning on 08/28/14, a dietary management staff member (#16) provided a four week dietary "Mandatory Cleaning Duties," dated	F 371	The Cleaning and Sanitizing P & P has been reviewed and remains in place. The stove hood and hood lip have been thoroughly cleaned. All residents in the facility have the potential to be affected as food is prepared on the stove on a daily basis. The weekly dietary cleaning schedule has been updated to include the cleaning of not only the hood but the hood lip. Education was provided to dietary staff on 10-8-14 regarding cleaning of the hood and hood lip as well as adherence to the Cleaning and Sanitizing P & P. To ensure food is prepared, distributed, and served under sanitary conditions QI monitoring will begin the week of 10-6-14 and will be completed by the QI Coordinator and/or his designee. Monitoring of the hood and hood lip will be accomplished weekly x4 and monthly x2 to ensure that the hood and lip are cleaned per dietary cleaning schedule. Results of the QI monitoring will be reviewed as part of the monthly facility CQI meetings and then summarized at the Quarterly CQI meeting with the Medical Director in attendance. The need for further monitoring will be determined based on these results. Date Certain: 10-16-14	

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F 371	Continued From page 74 "August 04, (no year)" which identified "clean the hood" each week on Sunday. The schedule also included an undated, handwritten entry for Tuesday "lip of hood."	F 371		
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 policy, and staff interview, the facility failed to ensure the physician acted upon irregularities as reported by the pharmacist, and the pharmacist reported irregularities to the attending physician for 2 of 13 sampled residents (Resident #4 and #7). Failure to address, including duplicative therapy, report those irregularities, and ensure these reports are acted upon by the attending physician may result in residents receiving unnecessary drugs, overmedication, and experiencing adverse reactions. Findings include: Review of the facility policy titled "Consultant Pharmacist Medication Review Regimen"	F 428	F-428: DRUG Regimen Review, Report Irregular Action It is the intent of this facility to remain in compliance with F-428 as evidenced by the following: The Consultant Pharmacist Medication Review P & P has been revised to include directions for staff to follow in the event the Monthly Pharmacy Review is not addressed by the primary care physician or Consultant within 30-days of completion by the Consulting Pharmacist. The DON and/or her designee will track the return of Pharmacy Reviews and contact either the Primary Care Physician or the Medical Director to address the issues identified by the Consultant Pharmacist. A letter was mailed to all medical providers responsible for care of residents in a Sanford Continuing Care Center on 10-3-14. The purpose of this letter is to raise their awareness of the responsibility to address duplicate mediations and respond to the monthly Pharmacy Review in a timely manner. .	

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F 428	Continued From page 75 occurred on 08/27/14. This policy, dated 10/14/12, stated, "PURPOSE: 1. To maintain the resident's highest practicable level of functioning. 2. To prevent or minimize adverse consequences related to the medication therapy to the extent possible. POLICY: . . . 2. Irregularities are identified and reported to a physician and to the Director of Nursing. 3. The action taken in response to the irregularities is documented . . . PROCEDURE: . . . 2. . . . a. If the attending physician has documented adequately their reasoning for not making a medication adjustment the Consulting Pharmacist does not need to continue to document the irregularity month after month . . . 4. . . . b. MRR's [Medication Regimen Reviews] with noted irregularities are forwarded to the physician . . . to be addressed . . . d. The Physician returns the completed MRR to the living center . . . 5. . . . The attending physician refers medication irregularities to a consultant physician to be addressed if that consultant is primarily responsible for the medication in question . . . b. If there is a potential for serious harm and the attending physician does not agree with or take action on the report, the Living Center and/or the Consulting Pharmacist contacts the facility's medical director for guidance and possible intervention to resolve the issue. . . ." - Review of Resident #4's medical record occurred on all days of survey and included diagnoses of dementia, cerebral vascular accident (CVA), atrial fibrillation, hypertension, cardiomegaly, depression, history of urinary tract infections, constipation, and diabetes. Review of Resident #4's antipsychotic medications administered during the consultant	F 428	A Monthly Pharmacy Review was completed for Resident #7 which noted the duplicate laxative use on 10-3-14. This was forwarded to the MD to be addressed. The Consultant Pharmacist will address the use of duplicate medication use in the October monthly pharmacy reviews completed for all Off Collins residents. This will be accomplished prior to 10-13-14. Resident #4: The duplicate medications were address by the Psychiatric FNP on June 17, 2014. The Risperdal was discontinued by the FNP. The resident is followed by the Behavior Team with a Behavior Team Observation completed on 10-7-14. The tracking process of the Monthly Pharmacy Reviews has been improved upon to ensure that these reviews are addressed and returned to the facility within 30-days. Because this process has the potential to affect all residents, a full chart review was completed. It included but was not limited to pharmacy reviews. The prior 6 months were reviewed, ensuring all were address in a satisfactory manner in accordance with the policy and routing to MD if necessary	

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F 428	Continued From page 76 pharmacist's March 11, 2014 review included Seroquel 25 milligrams (mg) at bedtime, Risperdal 0.25 mg at bedtime, haloperidol 1 mg every 6 hours as needed for anxiety, and Haldol lactate 1 mg injection every 6 hours as needed for anxiety. Review of Resident #4's Consultant Pharmacist Review, dated 03/11/14, stated, "Patient is currently on Scheduled RISPERDAL AND SEROQUEL in addition to PRN [as needed] HALDOL. The use of Three Antipsychotics is considered Therapeutic Duplication. Please Discontinue one of the scheduled medications and the prn Haldol. . . ." The physician bracketed this paragraph with a handwritten note stating, "will evaluate," and signed/dated the form 03/17/14. The Consultant Pharmacist Review, dated 04/11/14, had no recommendations. The Consultant Pharmacist Review, dated 05/05/14, stated, ". . . Could you please review RISPERDAL, SEROQUEL & PRN HALDOL use? . . . The use of three antipsychotics can be seen as therapeutic duplication. Please consider using only one scheduled medication here. The use of prn antipsychotics is on the Beers list and is not recommended in the nursing home setting. . . ." The form lacked evidence the physician responded to the recommendation. The director of nursing signed and dated the form 06/17/14. Review of Resident #4's "Nursing home progress note," dated 06/17/14, identified a mental health nurse practitioner (MHNP) discontinued the Risperdal. During an interview on 08/28/14 at 10:00 a.m., a nurse manager (#2) indicated the primary physician wanted the MHNP to address the	F 428	This revision corrects the deficient process for all residents of Sanford Off Collins. QI monitoring will be completed by the QI Coordinator and/or his designee beginning the week of 10-6-14 and will include Resident #4. Monitoring will be completed of 10 resident charts weekly X4 and then monthly X2 to ensure that Consulting Pharmacy Reviews are addressed by the MD and DON within 30 days of receipt when recommendations for a reduction or clarification of medication use have been made. Results of the QI monitoring will be reviewed as part of the monthly QI meetings and then summarized at the Quarterly QI meetings with the Medical Director in attendance. The need for further monitoring will be determined based upon these results. Date Certain: 10-16-14	

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F 428	Continued From page 77 antipsychotic medications. The nurse manager faxed the Consultant Pharmacist Review, dated 03/11/14, to the MHNP. She verified the MHNP did not address the medications until the next visit to the nursing home on 06/17/14, three months since the consultant pharmacist's recommendation to the physician. - Review of Resident #7's record occurred on all days of survey. Current physician orders for scheduled laxatives included psyllium husk, Miralax and Senna S. PRN medications included Bisacodyl 10 mg suppository rectally as needed if oral "options fail for constipation;" Dulcolax 5 mg 1-2 tablets per day as needed for constipation, and TWE (tap water enema) once a day as needed per rectum. Signed standing orders included additional medications for constipation of Milk of Magnesia and Fleets Enema (Sodium Phosphate or Mineral Oil) per rectum prn daily. Review of current medications identified Resident #7 received three concurrent antidepressant medications which included Effexor XR, Remeron and sertraline(Zoloft). Current medication also included an antipsychotic medication of Seroquel. A pharmacy review, dated 05/08/14, requested indications for the use of the Dulcolax tablet and Dulcolax suppository order. The physician and the director of nurses failed to respond. The pharmacy review, dated 06/04/14, stated, "Also, please add a PRN indication to the MAR for: Dulcolax tablet: Dulcolax suppository:" The physician responded with the indication of constipation "if po [oral] options fail for constipation." Pharmacy reviews completed between 02/19/14	F 428		

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F 428	Continued From page 78 and 08/15/14 failed to address the concurrent use of the scheduled and prn laxatives, including the orders for daily dosing of each prn; failed to address the resident's medication regimen for medications with constipation side effects; failed to address the concurrent use of the psychopharmacological medications, including the three antidepressant medications. On the afternoon of 08/28/14, a consulting pharmacist (#13) acknowledged he addressed the Dulcolax tablet and suppository for indications of use. The pharmacist did not provide additional information regarding the concurrent use of the laxatives and antidepressants.	F 428		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must	F 441	F-441 – Infection Control, Prevent Spread, Linens It is the intent of this facility to remain in compliance with F-441 as evidenced by: HANDWASHING: The Hand Hygiene P & P was reviewed and revised. Adjustments were made to reflect the ability to use alcohol based hand sanitizer unless hands are visibly soiled. Education and QI monitoring will focus on adherence to this policy and preventing the spread of infection by proper hand hygiene for both staff and resident's. Education, including policy review, was provided at the mandatory All Staff	

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F 441	Continued From page 79 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 policy and procedure, and staff interview, the facility failed to follow standard infection control practices during 3 of 7 observations of toileting, one observation after meals, and with insulin pen preparation on 3 of 4 observations. Failure to follow infection control practices related to hand hygiene and medication administration has the potential to cause or spread infection within the facility. Findings include: Review of facility policy and procedure for "Hand Hygiene" occurred on 08/28/14. The policy, dated 11/04/09, stated ". . . PURPOSE: . . . Hand hygiene is the single most important procedure to prevent infections. . . . Recommendations for Hand Hygiene include but are not limited to: . . . Before and after eating . . . After personal use of the toilet (hand washing with soap and water) . . .	F 441	meeting held on 9-23-2014 as well as again on 10-7-14. This education included proper Hand Hygiene for both resident's and staff, with special attention to toileting and the dining experience for residents especially when hands have come in contact with items that are visibly soiled. Improperly performed hand hygiene has the potential to affect all residents. Beginning the week of 10-6-14 the QI Coordinator and/or his designee will complete QI monitoring of 10-15 direct care opportunities weekly X4, and monthly x 2 to ensure that residents are offered the opportunity to perform hand hygiene. Care provided to residents #7 will be monitored also beginning the week of 10-6-14 to insure that hand hygiene is completed for the resident after use of the toilet and prior to eating. Results of the CQI monitoring will be reviewed as part of the facility CQI meeting and then summarized by the CQI Coordinator at the Quarterly CQI Meetings with the Medical Director present. The need for further monitoring will be determined based upon these results. FLEX PEN: Please see POC for F-332 to note education, re-demonstration, and CQI	

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F 441	Continued From page 80 General Rules . . . Antimicrobial wipes (towelettes) may be used during dining when assisting residents to clean hands between residents." - During observation on the afternoon of 08/25/14, a certified nursing assistant (CNA) (#11) assisted Resident #7 to the bathroom. When the CNA removed the resident's garment and underwear, an incontinence product contained a light reddish blood drainage and Resident #7 touched the drainage on the incontinence product. The CNA failed to offer Resident #7 hand hygiene following the resident touching the soiled incontinence product and after assisting with toileting. - During observation on the morning of 08/26/14, observation of each table in the dining room identified the presence of hand hygiene wipes. During observation of meal service, a random staff, before assisting/moving Resident #7 from the dining room by wheelchair, failed to offer the resident hand hygiene. - During observation of toileting cares on the morning of 08/26/14, Resident #7 expelled a small BM (bowel movement) on the toilet. The CNA failed to offer the resident hand hygiene after toileting. During interview on the afternoon of 08/26/14, two administrative staff (#1 and #14) stated staff are expected to offer residents hand hygiene after toileting and after meals. - During observation on the morning of 08/27/14, a staff nurse (#25) prepared three different insulin pens for administration to residents. With	F 441	plan for correction of the infection control portion of the Flex Pen Use. Date Certain: 10-16-14	

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F 441	Continued From page 81 preparation of each insulin dose (three occasions) the nurse failed to wipe the rubber seal of the pens with alcohol prior to the attachment of a new sterile needle. During interview on the afternoon of 08/27/14, an administrative staff member (#14) and a staff nurse (#25) stated the nurse should have wiped the rubber seal prior to attaching a new needle.	F 441		
F9999	FINAL OBSERVATIONS Based on record review, staff interview, and family interview, the complaint issues investigated in conjunction with the standard Medicare/Medicaid survey were substantiated in regards to ensuring adequate monitoring of blood glucose readings for insulin dependent diabetic residents, and in regards to refusal to admit/re-admit residents who required a long term care bed following hospitalization.	F9999		