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APR 16 2012
Division of Health Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355074	A. BUILDING _____ B. WING _____	03/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HOMES	305 8TH AVE NE MINOT, ND 58702

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on March 12, 2012 and completed on March 15, 2012, the sampled included five (5) residents for complete review, 22 residents for focused review, and three (3) closed records for review. The sample included 11 additional residents to verify specific concerns during the survey.	F 000	**Note: Trinity Nursing Home has been part of the "One Less" project with North Dakota Health Care review since September, 2011 of which we have been looking at reducing restraints. In discussion with our contact person from NDHCR, she neither was aware nor has heard of 4 side rails, used in conjunction with air mattresses, being considered a restraint from other facilities she is working with. Our contact person will be meeting with nursing leaders at Trinity Homes on Monday, April 16th regarding this issue.	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to assess the use of and continued need for physical restraints for 3 of 4 sampled residents (Resident #7 - a seat belt and a lap buddy cushion, Resident #8 - a merry walker, and Resident #21 - a seat belt) observed with physical restraints. Failure to assess, monitor, and re-evaluate the necessity of these devices limited the residents' freedom of movement and access to their body and placed them at risk for decreased physical functioning, skin breakdown, and a loss of dignity. Findings include: Review of the facility policy titled "Physical Restraints" occurred on 03/15/12. This policy,	F 221	Resident # 7, 8 and 21 have had all aspects of the assessment completed per the Restraint Checklist and Trinity Homes Restraint Policy and Procedure. Written education has been provided to staff on following the Restraint Checklist and Trialing a Restraint Checklist and Trinity Homes Restraint Policy and Procedure. The care plan/guides have been updated to reflect any changes made. All residents have the potential to be affected. Staff has been in-serviced and re-educated on following the policy and procedures for restraints. The Restraint and Trialing a Restraint Checklist are available in the "Quick Look" books at each of the Nurses Stations. Observations will be done weekly and reported monthly to the QA committee until compliance is obtained. Once compliance is obtained, monthly observations with quarterly reporting will be done. The Director of Nursing will be responsible for this process. Date for completion is April 15th, 2012.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rhonda Tenberg	Administrator	April 13, 2012

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 221	Continued From page 1 revised October 2008, stated, ". . . PROCEDURE . . . 1. . . . For those devices that are restraints, a physician's order will be obtained and a restraint consent form will be signed. 2. A monthly Device Reduction Assessment will be done on each unit on those residents using restraints. . . ." - Review of Resident #7's medical record occurred on March 13-15, 2012. Diagnoses included Alzheimer's disease, bipolar disorder, and arthropathy (joint disease). The current Minimum Data Set (MDS), 03/07/12, identified short term and long term memory problems and severely impaired daily decision-making skills. Resident #7's current care plan stated, ". . . Problem . . . COGNITIVE DEFICITS . . . no regard for personal safety . . . Approach . . . Seat belt- seat belt when up in w/c [wheelchair] q [every] shift (started March 12, 2012 - continuing) . . ." Observation on 03/13/12 at 11:00 a.m. showed a certified nursing assistant (CNA) (#21) and a nurse (#11) assisted Resident #7 from her bed to the wheelchair. The CNA and nurse placed a lap buddy across the resident's lap. The nurse asked the CNA if Resident #7 used the seat belt also, and the CNA responded, "No, just this [indicating the lap buddy]." Observation until approximately 12:30 p.m. showed Resident #7 seated in her wheelchair with the lap buddy in place. Observations throughout the rest of the survey showed Resident #7 used a seat belt when in her wheelchair. Review of nurses' notes identified the following:	F 221		

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F 221	Continued From page 2 * 03/06/12 at 9:02 p.m.: "Resident taken off floor by activities - did well but everytime [sic] they stopped she tried to get out of chair. Maybe lap buddy can be tried next time. . . ." * 03/10/12 at 10:05 a.m.: ". . . daughter here this a.m. . . . Voices concern at the lap buddy. . . . asked [physical therapist] to use a seatbelt instead of he [sic] lapbuddy [sic] as it would allow her more freedom of movement. Lapbuddy [sic] does fit snugly against her abdomen. Work order sent to apply a seatbelt to her w/c. . . ." * The nurses' notes fail to identify the exact date that staff initiated the lap buddy and the seat belt. A fax to the physician, dated 03/12/12, stated, ". . . Message: Daughter insists on use of a seat belt when in w/c, may we have an order to use seat belt when in w/c? . . . Advice given: Please use seat belt in wheelchair . . ." Resident #7's medical record lacked any type of assessment related to the use of the lap buddy or seat belt. The record also lacked a physician's order related to the use of the lap buddy. During an interview on 03/15/12 at 11:50 a.m., a supervisory nursing staff member (#7) stated she was unsure when staff initiated the lap buddy and seat belt restraints. She also stated Resident #7 should have an initial device assessment for both restraints. - Review of Resident #8's medical record occurred on March 13-15, 2012. Diagnoses included dementia without behavioral disturbance. The current MDS, dated 01/09/12, identified short term and long term memory problems and moderately impaired daily	F 221		

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decision-making skills.

Nurses' notes identified three instances (05/15/11, 08/27/11, and 11/14/11) when facility staff placed Resident #8 in a merry walker due to the resident being "restless." The resident's medical record lacked a physician's order, consent, assessment, or care plan related to the use of a merry walker.

During an interview on 03/14/12 at 4:30 p.m., a nursing staff member (#22) stated she was unsure of the last time Resident #8 used the merry walker, but that she remembered the resident using it "on occasion."

During an interview on the afternoon of 03/15/12, a supervisory nursing staff member (#7) confirmed Resident #8 did not have an order, assessment, or consent for the use of the merry walker.

- Review of Resident #21's medical record occurred on March 14-15, 2012. Diagnoses included Alzheimer's disease, dementia, confusion, Parkinson's disease, and history of hip fracture. The current Care Guide (a part of the care plan used by CNAs) indicated, ". . . may use lap buddy in wheelchair when restless. . . ."

Record review identified staff failed to complete an assessment prior to implementing the use of the lap buddy.

During an interview on 03/15/12 at 1:30 p.m., while discussing Resident #21's lap buddy, an administrative nursing staff member (#16) and a managerial nursing staff member (#7) stated, "He

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F 221	Continued From page 4 [Resident #21] is now able to remove his lap buddy." Although the lap buddy is currently not considered a restraint, at the time the facility requested orders for and applied the lap buddy (03/07/12) it was considered a restraint. Both the administrative nursing staff member (#16) and the managerial nursing staff member (#7) acknowledged staff failed to complete an assessment related to the use of the lap buddy, and acknowledged the care plan should have included the use of the lap buddy as an approach used to prevent falls.	F 221		
F 240 SS=E	483.15 CARE AND ENVIRONMENT PROMOTES QUALITY OF LIFE A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview the facility failed to maintain an environment which promotes maintenance or enhancement of each resident's quality of life for 1 of 1 cognitively impaired sampled resident (Resident #19) and 7 cognitively impaired supplemental residents (Resident #35, #36, #37, #38, #39, #40, and #41) who reside on the facility's 4 Central Neighborhood/Unit. Closing the door to the dining/activity room and only allowing access after the placement of a code into the panel system, limited the ability of these cognitively impaired resident's to enter the dining/activity room.	F 240	The magnets on the doors between the 4C area and the dining room were removed on 3/16/2012. This allows the residents access to the dining room and activity area without having to enter a code to open the doors. All residents in this area had the potential to be affected. Since the doors can open without difficulty, all current and future residents on 4C will have the ability to move freely on and off that area. Weekly QA will be completed until compliance is obtained and then completed monthly. All audits will be reported to the monthly Quality Assurance committee. The DON is responsible for this process. completion date 3/16/12 Jen - DON (per phone call 4/18/12)	

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F 240	Continued From page 5 Findings include: Observation of the 4th floor during the initial tour of the facility on the morning of 03/12/12 showed the facility divided this floor into three different neighborhoods/units: East Neighborhood, 4 Central (also known as the "semi-secured unit), and West Neighborhood (a secured unit). Observation of the main dining/activity area utilized by residents who reside on the East and Central Unit, showed tables and chairs, a television set, and a computer. During the initial tour, observation showed the door leading from the dining/activity area into the Central corridor open, which allowed the residents who lived on the Central Unit free access to this dining/activity area. Observation on 03/13/12 at 2 p.m., revealed the dining/activity door to be closed and a touch pad panel located on the wall. A random observation at 5:00 p.m. showed an unidentified resident seated in a wheelchair (w/c) directly in front of this shut dining/activity door, leaning forward in her w/c, and pounding on this door with her closed fists. Random observations on the afternoon of 03/14/12 and at 10:10 a.m. on 03/15/12, showed the dining/activity door closed which limited the access of residents on the Central Unit to freely enter this area. During interview on 03/14/12 at 5:00 p.m., an administrative nurse (#7) stated the above dining/activity doors were "recently" installed in response to a resident on the Central	F 240		

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F 240	Continued From page 6 Neighborhood/Unit who wandered and entered the East Neighborhood. This nurse stated the staff members who work on the Central Neighborhood/Unit determine when the doors to the dining/activity room are closed based on how closely they can or cannot supervise the residents on this unit. This nurse confirmed that when these doors are shut, a code must be entered on the panel to allow access to dining/activity area by residents, staff, and visitors. A random observation on 03/15/12 at 10:10 a.m. showed the dining/activity door closed and two unidentified residents self propelling their w/c's in the corridor. Observation showed the closed door restricting these resident's access to the dining/activity area. During interview on 03/15/12 at 9:25 a.m., a licensed social worker (#14) stated the facility installed the dining/activity doors by the Central Neighborhood/Unit in January 2012. This staff member confirmed the facility failed to assess how securing/closing the dining/activity door would reduce the quality of the environment for all the residents (Resident #19, #35, #36, #37, #38, #39, #40, and #41) who reside in the Central Neighborhood.	F 240		
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.	F 246		

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F 246	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on group interview, confidential resident interviews, and record review, the facility failed to ensure staff answered call lights in a timely manner as reported by 4 of 8 residents who attended the group interview (Resident A, B, C, and D) and 4 confidential residents who were interviewed (Resident E, F, G, and H). Failure to answer call lights in a timely manner resulted in Resident F being incontinent and may affect the quality of life/care provided to all residents residing in the facility. Findings include: - On the initial tour on 03/12/12, Resident E stated he/she frequently had to wait for staff to answer his/her call light. The resident stated the response time occasionally was from 1-to-1 1/2 hours. - During an interview on 03/13/12 at 8:05 a.m., when asked if she felt she received assistance from the staff when she needed it, Resident F stated, "One hour fifteen minutes was the longest [I've waited.] It's just irritating. I've had them come in, turn off my light, and go back out without acknowledging me. I've brought this up in care plan meetings." - During the group interview on 03/13/12 at 10:00 a.m., when asked if they feel they receive assistance from the staff when they need it, the residents made the following statements: * Resident A - "I've waited 45 minutes."	F 246	All staff have been re-educated on residents rights to receive care in a timely manner, which includes call lights being answered in a reasonable amount of time. This includes all direct care staff, such as nurses, CNA's, and environmental aides. All residents have the potential to be affected. Written staff education has been provided to staff on answering call lights in a timely manner. Social workers will randomly select at least 2 residents per week, identified as interviewable, to determine if call lights are being answered within a reasonable timeframe. Weekly observations are to be conducted, on all shifts, by staff members to determine length of time as to when lights are answered. Weekly QA will be conducted until compliance is obtained then QA will be completed monthly. All audits will be reported to the monthly Quality Assurance committee. Completion date is April 15th. DON and Director of Social Services are responsible for this process.	

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F 246	Continued From page 8 * Resident B - "In the evenings, I've had to wait 30 minutes or more." * Resident D - "[I've waited for] an hour." * Resident E - "Occasionally it happens where I wait 30 minutes, they come in and say 'We'll be right back,' and I have to wait another 30 minutes [for them to return.]" - During the initial tour of the facility the morning of 03/12/12 and on 03/13/12 at 4:45 p.m., Resident G stated he/she frequently has to wait 40 minutes for staff to answer the call light to assist him/her to or from the commode. He/she stated, "call lights are worse in the afternoons." Earlier on 03/13/12, Resident G stated he/she put his/her call light on, a staff member came into the room, turned the call light off without saying anything, and he/she waited another 10 minutes for help to the commode. Review of Resident G's medical record occurred on all days of survey. The most current Minimum Data Set (MDS), dated 01/25/12, identified the resident as cognitively intact, no behaviors, and required extensive assistance with toilet use. - Observation on 03/15/12 at 9:05 a.m. showed Resident H's call light on. During an interview at this time, Resident H stated he/she needed to use the bathroom and placed his/her call light on approximately five minutes earlier. The resident stated he/she usually waits about 15 minutes before a staff member answers the call light and just recently he/she had an "accident" while waiting. Observation showed facility staff answered Resident H's call light at 9:20 a.m., 15 minutes after this surveyor noted the light on.	F 246		
F 250	483.15(g)(1) PROVISION OF MEDICALLY	F 250		

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F 250 SS=D	Continued From page 9 RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to assess factors/circumstances contributing/causing aggressive behavior and failed to establish/implement preventative interventions for 1 of 1 sampled resident (Resident #12) identified as exhibiting aggressive behavior toward another resident and failed to assess the wandering behavior of 1 of 2 sampled residents (Resident #19). Failure to assess behaviors, implement interventions, and monitor resident responses to interventions does not allow for planning and implementation of interventions to prevent/minimize the occurrence of wandering and aggressive behaviors and may result in resident injury. Findings include: - Review of Resident #12's medical record occurred on March 12-15, 2012. Diagnoses included brain hemorrhage and dementia. The annual (Minimum Data Set) MDS, dated 11/14/11, identified severely impaired cognitive skills, behavioral symptoms such as threatening, screaming, and cursing at others, additional behavioral symptoms not directed towards others such as pacing, and identified her behaviors as	F 250	Social Services will monitor residents who display aggression towards other residents, appropriate problems will be addressed on the residents care plan, and appropriate interventions will be addressed on their care guide. All residents have the potential to be affected. Social Services will read every residents progress notes and communication notes daily to capture any new aggressive behavior. This will be discussed in the morning report with the rest of the team to determine whether the resident can continue to reside in the facility or if interventions can be put in place to ensure the behavior won't happen again. The Social Worker for that resident will be responsible for assessing circumstances that may possibly be related to the aggressive behavior and updating the residents care plan and care guide. The Director of Social Services will also monitor the care plans and the care guides of the residents affected. The QA on for the residents displaying aggression towards other residents was completed on 3/29/12 and interventions on the care guide were added or updated. Ongoing QA will be done by the Director of Social Services on the residents displaying aggression towards other residents, along with a monthly QA done on all residents to monitor all behavior charting and that all behaviors are addressed on their care plan and care guide. Completion date for all education is April 15, 2012, and the Director of Social Services and Director of Nursing are responsible for this.	

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F 250	Continued From page 10	F 250		

being significantly disruptive in her environment.

The current Care Guide (a part of the care plan used by certified nurse aides [CNAs]), stated, ". . . Behavior Approaches: document mood and behaviors, Provide re-orientation [and] cues prn [as needed], Monitor sadness/depression, Monitor anxiety, Explain all care/procedures in simple terms to promote compliance, Maintain consistent environment [and] routine. . . ."

The current Care Plan stated, "Problem: . . . BEHAVIOR: Physical and verbal abuse toward [sic] her roommate which required a room change for [Resident #12]. Goal: [Resident #12] will be monitored for any further episodes of physical and verbal abuse towards other residents. Approach: ADL [activities of daily living] - Behavior . . . Behavior PRN [as needed]. . . ."

The Nursing Progress Notes identified the following:
* 09/21/11, "[Resident #12] was very nasty to her roommate, the roommate was laying down in her bed taking a nap and [Resident #12] went over to her and told her to get the hell out of her room, she stated, 'I pay rent here', Her roommate then got out of bed and started ambulating down the hall . . . writer then walked beside her [roommate] and put her in the recliner . . . [Resident #12] was pacing up and down the halls with her walker mumbling to herself. [Resident #12] was [sic] been very negative towards other residents and staff, denying things she has said or done."
* 09/23/11, "Resident was telling her roommate that she did not belong in her room. Her roommate came out to the nurses station and slept in the recliner until her roommate was

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sleeping and we put her to bed. . . ."
* 09/25/11, "Resident was upset this evening that her roommate had her pj's on. I advised to [sic] her that they were hers [roommate's] and that some people may have similar ones [pjs] but everyone has their clothes labeled. She was very hard to redirect . . ."

The Behavior Tracking Intervention Assessments identified the following:
* 02/03/12, ". . . residents roommate was walking around the room and resident [sic] like that so resident was screaming at her and writer could hear them writer got into the room and she was still screaming at reisdent [sic] and resident was hitting residents arm and pushing her away, writer and another cna removed residents roommate and now is sitting at the nurses station, nurse was told about the situation."

The Nursing Progress Notes identified the following:
* 03/11/12, "[Resident #12] found yelling at her roommate x 3 [three times]. 1st [First] time her roommate was sitting on her bed. Roommate was redirected. 10 minutes later roommate was walking towards her room - [Resident #12] started yelling at her to 'not go in there! Stay out!' Directed roommate to her bed to sit down. Told [Resident #12] the room was her roommates room also and she had a right to be in there just as much as she did. About 20 minutes later daughter of roommate relayed to me that she observed [Resident #12] yelling at her mother to 'get out of there!' Roommate was in the drawers of the TV stand. Daughter . . . then noted that [Resident #12] approached her mother and hit her with an open hand on left forearm. . . . We

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F 250	Continued From page 12 are to move [Resident #12] . . . social services will take over tomorrow and decide what to do. . . . This writer spoke with resident regarding the altercation she had with her roommate. It was explained to this resident that physical aggression will not be tolerated. Resident will be moved . . ." The Social Services Progress Notes identified the following: * 09/30/11, "Social Worker visited with [Resident #12] this morning. . . . Staff informed me that [Resident #12] was upset with observing another resident abusing a CNA . . . [Resident #12] was provided with reassurance and seemed to be doing well." * 03/12/12, "Social Worker . . . called [name] who is a contact person and she was aware of the situation. . . ." * 03/13/12, "Social Worker visited with [Resident #12] today. She is [sic] seems to be adjusting to her new room." During an interview on 03/15/12 at 3:45 p.m., when asked if facility staff had formally assessed Resident #12, a managerial nurse (#24) stated, "I don't know if anyone actually assessed her." When asked what interventions staff implement when Resident #12 begins displaying behaviors, the managerial nurse (#24) responded, "We separate them." The facility failed to determine the causes/precipitating situations which resulted in Resident #12's verbally/physically aggressive behaviors towards other residents. Failure to determine and implement individual interventions, placed Resident #12 and other residents at risk of injury.	F 250		

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F 250	Continued From page 13 - Review of Resident #19's medical record occurred on March 14-15, 2012 and identified diagnosis of Alzheimer's disease and dementia without behavioral disturbances. Resident #19's quarterly MDS, dated 02/08/12, identified the resident displayed moderately impaired daily decision making skills, utilized a walker for ambulation, and required supervision with ambulation in her room, the corridor, and locomotion on/off the unit. Social Service Notes in October 2011 identified Resident #19 wandered from her unit twice and the facility held conversations/discussions with Resident #19's family to see if she would benefit from placement in the facility's secured dementia unit (located on the 4th floor). The facility transferred Resident #19 to the secured unit on 10/19/11. During the 11/17/11 care plan review meeting, Resident #19's family inquired if she can be moved from the secured unit. On 11/18/11, the facility relocated Resident #19 from the secured unit to the 4 Central Unit. Review of Resident #19's Progress Notes from Jan-March 2012, identified: *01/06/12 at 10:00 p.m. - "Received a call from . . . 4E that resident was laying in bed with one of their male residents. When this nurse went over to assist the resident back to 4C she asked me, 'Am I in trouble and am I going to be given the 3rd rite.' This nurse said no. You are fine, just walk with me." *01/07/12 at 2:37 p.m. - ". . . resident was found on 3E, she was redirected back to her room with no problems. Later this shift she was found naked in her room. Staff got her ready for	F 250	Social Services will monitor all residents at risk for wandering and appropriate problems will be addressed on their care plan and appropriate interventions will be addressed on their care guide. All residents have the potential to be affected. Social Services will read every residents progress notes and communication notes daily and recognize all residents that are at risk for wandering. This will be discussed in the morning report with the rest of the team to determine if the resident is at an immediate risk to self or other residents. Nursing Services will start a wandering assessment and update their MD. Social Services will contact the resident's family and start a QA report. The wandering assessment will be completed for 3 days and a decision will be made by the team to determine appropriate placement to keep the resident and all others safe. The Social Worker for that resident will be responsible for updating the residents care plan and their care guide. The Director of Social Services will also monitor the care plans and care guides of the residents affected. A QA will be done on all residents who have episodes of wandering, Nursing Services will update their MD and Social Services will update their family, their care plan, and care guide. Their care plans and care guides will to be monitored and a QA completed monthly after in compliance and Social Services will be responsible to start a QA and start the process on each new resident that has any episodes of wandering.	

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F 250	Continued From page 14 bed No further problems this shift." *01/08/12 at 1:52 p.m. - ". . . Staff informed this writer today, that toward the end of the day shift yesterday, that this resident kept disrobing while her roommate's husband was in the room. Frequent redirection necessary . . . ." In response to the residents's recent wandering and behaviors of disrobing, facility staff collected an urine sample from Resident #19, faxed the results of this test along with her current medication list to her doctor for review. *01/25/12 at 9:16 p.m. - "Resident spent afternoon until suppertime on the other side to hear accordian music and then to visit. Later in the evening resident was found in resident lounge fully unclothed. CNA helped resident get dressed and took her to room to get ready for bed . . . ." *02/02/12 at 11:57 p.m. - "Found in bed of a male resident on 4 East midshift. Doors to the dining room had been left open after supper. Staff reminded to close the doors after meals." Resident #19's "Ongoing Safety Assessment," dated 02/03/12, identified the following ". . . Locked doors have been added to the open doorway on 4C as a means to prevent this resident from wandering into male resident's room on 4 East. She does know the code but is unable to input the code and also open the door. Staff cautioned to monitor her whereabouts." Resident #19 current Care Plan and Care Guide reviewed on 03/14/12, failed to identify her problem of wandering and episodes of being found in a male resident's room on two separate occasions, and approaches and goals identified to manage/minimize this behavior.	F 250	Completion date for all education is April 15, 2012, and the Director of Social Services and Director of Nursing are responsible for this.	

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F 250	Continued From page 15 During interview on 03/14/12 at 5:00 p.m., when asked to provide specific information regarding how the facility investigated Resident #19's two separate incidents of being found in a male resident's bed, an administrative nurse (#7) stated the only information available is what the nurse on duty wrote in the Progress Notes (dated January 6 and February 2). This administrative nurse confirmed these incidents involved the same male resident and the facility installed locked doors sometime in late January 2012 to prevent Resident #19 from leaving the 4 Central Unit via the dining room. During interview on 03/15/12 at 9:35 a.m., a social service staff member (#14) stated she failed to thoroughly assess the two episodes of Resident #19's wandering into a a male resident's bedroom to determine potential causative/precipitating factors. This staff member acknowledged she did not know whether or not Resident #19 had disrobed and believed no sexual behavior/interaction occurred. This staff member confirmed Resident #19's care plan and care guide failed to identify these episodes and list approaches/interventions for staff to implement to decrease or minimize Resident #19's interaction with the male resident. The Care Plan and Care Guide lacked any reference to Resident #19's specific individualized behaviors, measurable goals to minimize/decrease the occurrence of the behaviors and no identified social services related to approaches/interventions to manage the resident's existing behavioral problem of wandering.	F 250		
F 278	483.20(g) - (j) ASSESSMENT	F 278		

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F 278 SS=E	Continued From page 16 ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure the accuracy of the assessment regarding the use of side rails for 4 of 4 sampled residents (Resident #3, #10, #15, and #16) using air mattresses as pressure	F 278	Resident #3, 10, 15, 16 have had the Trialing a Restraint check list completed. The results have shown that 4 side rails will be considered a restraint on resident #15 only. The MDS nurses have been educated on this. This has the potential to affect all residents on air mattresses as the 4 side rails are required as a safety feature to keep the mattress in place. The Wound Care Nurse will identify which residents will need an air mattress, place the air mattress and order the "Initial Device Assessment Questionnaire" and "Initial Safety Questionnaire" and update the nurse in charge. Once this has been completed, the Wound Care Nurse will notify the MDS Nurses of the results. The MDS nurses will then enter the information into the MDS at the appropriate times if the 4 side rails have been considered a restraint. QA will be completed weekly until compliance is achieved and then will be done quarterly. The QA will consist of 2 parts: (1) The "Initial Device Assessment Questionnaire" and "Initial Safety Questionnaire" will be ordered, completed, and the results sent to the MDS nurses. (2) The MDS nurses receives the results, enters the data into the MDS at the appropriate time, and verifies its presence prior to submission. Date for completion will be April 15th, 2012. Individuals responsible for this process are the DON, and the EHR/MDS Project Manager.	

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F 278	Continued From page 17	F 278		

relieving devices and side rails as safety measures for the air mattresses. Failure to identify and assess the side rails as potential restraints did not ensure the facility staff implemented the care planning process, considered alternative approaches, and ensured the least restrictive resident environment.

Findings include:

- Observation during the initial facility tour, on 03/12/12 at approximately 12:00 noon, identified Resident #10 in bed laying on her left side on a pressure relieving mattress and two side rails in the upright position on each side of the bed covering the upper two thirds of the bed.

Review of Resident #10's medical record occurred on March 13-15, 2012. The resident's current diagnoses included an unstageable pressure ulcer on the left heel. The 60 day Minimum Data Set (MDS), dated 03/06/12, failed to identify the use of side rails.

- Observations on 03/12/12 at 10:30 a.m. and 03/13/12 at 8:15 a.m., showed Resident #3 lying in bed with a First Step mattress covering the mattress and two side rails in the upright position on each side of the bed covering the upper two thirds of the bed.

Review of Resident #3's medical record occurred on all days of survey. Diagnoses included pressure ulcers on his hip and heel. The quarterly MDS, dated 02/08/12, failed to identify the use of side rails.

- Observation showed Resident #16 in bed laying

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F 278	Continued From page 18 on a pressure relieving mattress and two side rails in the upright position on each side of the bed covering the upper two thirds of the bed at the following times: * 03/12/12 at 11:15 a.m. * 03/13/12 at 8:55 a.m. and 3:30 p.m. * 03/14/12 at 9:25 a.m. * 03/15/12 at 10:15 a.m. Review of Resident #16's medical record occurred on March 13-15, 2012. Medical diagnoses included dementia and a stage IV pressure ulcer on her coccyx. Initiation of the First Step mattress and four side rails occurred on 12/16/11. The annual MDS, dated 01/26/12, failed to identify the use of side rails. - Observations on 03/12/12 at 10:55 a.m., 03/13/12 at 11:15 a.m., and 03/14/12 at 9:35 a.m., showed Resident #15 lying in bed and two side rails in the upright position on each side of the bed covering the upper two thirds of the bed. Review of Resident #15's medical record occurred on all days of the survey. Diagnoses included macular degeneration, dementia, and pathological fracture of vertebrae. The quarterly MDS, dated 03/02/12, failed to identify the use of side rails. During an interview on 03/14/12 at 10:10 a.m., a nursing staff member (#1) stated staff utilize the side rails when a resident lies on the First Step mattress to prevent residents from rolling out of bed. During an interview on 03/15/12 at 11:25 a.m., an administrative staff member (#2) confirmed	F 278		

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F 278	Continued From page 19 facility staff failed to complete an assessment related to the use of side rails. Resident #3, #10, #15, and #16's medical records lacked evidence the facility completed assessments to determine if the use of side rails restrained the residents in any way.	F 278		
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 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 facility policy, and staff interview, the facility failed to review and revise the care plan (which includes the Care Planning Report and/or Care Guide) for	F 280	Residents # 5, 7, 10, 13, 16, 18 , 21, 24, 25 have had their Care Plans and Care Guides revised to reflect residents' status changes. This will ensure that staff will have a complete understanding of the resident's problems and concerns and interventions. This has the potential to affect all residents. Care plans and care guides will be changed/updated as indicated by a change in a resident's condition or plan of care. All Care Plans/Guides will be reviewed once a month to check that any status changes have been added to both the Care Plan and Care Guide. This will be monitored by the Unit Managers. Staff has also been educated on the correct process for reviewing and making changes to the Care Plan and Care Guide. QA will be done at care conferences and reported monthly to the QA committee. Completion date is April 15th, 2012. The DON is responsible for this process.	

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F 280	Continued From page 20 9 of 27 sampled residents (Resident #5, #7, #10, #13, #16, #18, #21, #24, #25). Failure to revise the care plan as the residents' status changes has the potential to affect staff's understanding of the residents' problems/concerns and required interventions, limits staff's ability to communicate resident care issues, and may lead to lack of or inconsistency in cares provided. Findings include: Review of the facility policy titled "RESIDENT CARE PLANNING" occurred on 03/15/12. This policy, dated October 2009, stated, ". . . OBJECTIVES: . . . 4. To increase intradisciplinary team understanding and promote a team approach to resident care. . . . PROGRESS RECORD: . . . 4. Care plans are to be revised according to the resident's condition. . . . CARE PLAN REVIEW: . . . 1. . . . the CNA's and Nurse review care plans and care guides so that each resident's care plan is reviewed . . . monthly adding or deleting problems, goals, and approaches as appropriate." - Review of Resident #13's medical record occurred on March 12-15, 2012. Diagnoses included quadriplegia, pain, constipation with manual extraction, and history of hospitalization for fecal impaction (11/27/11 and 03/09/12). The Progress Notes stated, "11/25/11: Dulcolax Suppository . . . 12/09/12: Senna . . . 12/11/12: Lactulose . . . 12/25/12: Colace . . . Milk of Magnesia . . . 03/12/12: digital stimulation . . ." The current care plan stated, ". . . Bowel management program, Inc [incontinent] of stool - has a liner or a brief under her in bed . . ."	F 280		

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F 280	Continued From page 21 Record review identified Resident #13's care plan failed to identify the medications, suppository, and digital stimulation as approaches used to treat constipation. During an interview on 03/15/12 at 10:30 a.m., while discussing Resident #13's constipation issues, an managerial nursing staff member (#23) acknowledged the care plan should have included the use of the medications, suppository, and digital stimulation as approaches used to treat constipation. - Review of Resident #21's medical record occurred on March 14-15, 2012. Diagnoses included Alzheimer's disease, dementia, confusion, Parkinson's disease, and history of hip fracture. The Progress Note stated, "03/13/12: Current Interventions: . . . routine hourly round[s] . . ." The current care plan stated, ". . . may use lap buddy in wheelchair when restless . . . Bed alarm, Chair alarm . . ." Observation on March 14, 2012 at 5:30 p.m., showed Resident #21 asleep in his wheelchair with the chair alarm and lap buddy in place. Record review identified Resident #21's care plan failed to identify the hourly checks as approaches used to prevent falls. During an interview on 03/15/12 at 1:30 p.m., while discussing Resident #21's lap buddy, an administrative nursing staff member (#16) and a managerial nursing staff member (#7) acknowledged the care plan should have included the hourly checks as an approach used to prevent falls.	F 280		

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- Review of Resident #24's medical record occurred on March 14-15, 2012. Diagnoses included anxiety, dementia, depression, and osteoarthrosis. The Progress Notes stated "03/01/12: Bed alarm [and] sensor pad put on his bed . . . 03/06/12: mat placed on floor bedside [sic] bed. . . ." The current care plan stated, ". . . Hi-Lo Bed. . ."

Record review identified Resident #24's care plan failed to identify the bed alarm/sensor pad and floor mat as approaches used to alert the staff of falls.

During an interview on 03/15/12 at 10:40 a.m., while discussing Resident #21's falls, a managerial nursing staff member (#20) acknowledged the care plan should have included the use of the bed alarm/sensor pad and floor mat as approaches used to alert the staff of falls.

- During initial tour of the facility on 03/12/12 at 12:25 p.m., signage outside of Resident #5's room instructed "Visitors please check at the nurses station, Direct Caregivers: wear gloves, wear gown for close contact with your clothing. Visitors: Use hand sanitizer each time you leave the room."

Review of Resident #5's medical record occurred on March 13-15, 2012 and identified an admission date of 03/06/12. The medical record identified on admission Resident #5 had a pressure sore to the coccyx which was unstageable due to slough and/or eschar. The transfer sheet, dated 03/06/12, from the

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F 280	Continued From page 23 transferring facility identified Resident #5 with a drug resistant organism. Review of the current care plan on the afternoon of 03/13/12 failed to identify Resident #5's pressure sore and failed to identify the necessary precautions for facility staff to implement when completing personal cares for a resident with a drug resistant organism. During an interview on 03/14/12 at 9:55 a.m., an administrative nursing staff member (#13) stated Resident #5's "precautions were put in place on admission." During an interview on 03/15/12 at 9:50 a.m., an administrative nursing staff member (#2) stated she would expect the precautions to be identified on Resident #5's CNA care plan under safety and the pressure sore identified under skin. - Observation during the initial facility tour, on 03/12/12 at approximately 12:00 noon, identified Resident #10 in bed on her left side with a pressure relieving mattress and two side rails the upper two thirds on each side of the bed. Review of 10's medical record occurred on March 13-15, 2012. The resident's current diagnoses included an unstageable pressure ulcer on the left heel. The 60 day Minimum Data Set (MDS), dated 03/06/12, failed to identify the use of side rails. Resident #10's care plan failed to identify the pressure ulcer on the left heel or treatment approaches. The care plan also failed to identify use of the side rails.	F 280		

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- Review of Resident #7's medical record occurred on March 13-15, 2012. Diagnoses included Alzheimer's disease, arthropathy (joint disease), and bipolar disorder.

During an interview on the morning of 03/13/12, a nursing staff member (#11) stated Resident #7 was more sleepy than usual, possibly due to the initiation of scheduled Xanax on 03/10/12.

Observation on 03/13/12 at 4:41 p.m. showed two CNAs (#9 and #10) transferred Resident #7 to a commode located at the resident's bedside. A CNA (#10) stated Resident #7 has been "sleepy" so they use the commode now.

On 03/15/12 at 1:27 p.m., a supervisory nursing staff member (#7) stated the staff have recently started using a commode due to Resident #7's increased lethargy.

Resident #7's care plan stated, ". . . Toileting . . . toilet every 2-4 hours . . ." but failed to identify the use of a bedside commode.

- Review of Resident #25's medical record occurred on March 14-15, 2012. Diagnoses included dementia, multiple sclerosis, and osteoarthrosis.

Resident #25's current care plan stated, ". . . SAFETY - potential for injury from falls . . . Approach . . . Chair Alarm: q [every] shift . . ."

Observations throughout the survey showed Resident #25 in her wheelchair without a chair alarm present.

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During an interview on 03/15/12 at 1:27 p.m., a supervisory nursing staff member (#7) stated Resident #25 no longer uses a chair alarm, and the staff discontinued Resident #25's chair alarm "awhile ago" because the resident can safely transfer herself.

- During the initial tour of the facility on 03/12/12 at 11:15 a.m., signage outside Resident #18's door stated, "Direct Caregivers: wear gloves, wear gown for close contact with your clothing. Visitors: Use hand sanitizer each time you leave the room."

Review of Resident #18's medical record occurred on March 13-15, 2012. A wound culture report, dated 02/21/12, identified Methicillin Resistant Staphylococcus Aureus (MRSA) in the resident's left axilla.

Review of Resident #18's current care plan on the afternoon of 03/13/12 failed to identify the necessary contact precautions related to the drug resistant organism MRSA.

During an interview on the morning of 03/15/12, an administrative nurse (#12) stated contact precautions were initiated on 02/21/12 for Resident #18 and she would expect the precautions to be identified on the residents care plan.

- Observation made on all days of survey showed Resident #16 in bed laying on a pressure relieving mattress. On 03/12/12 at 11:15 a.m., 03/13/12 at 10:30 a.m., and 03/15/12 at 10:15

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F 280	Continued From page 26 a.m., observation showed barriers between the resident and the pressure relieving mattress such as an extra sheet, a bedspread, and a hoyer lift pad; and two side rails in the upright position on each side side of the bed and covering the upper two thirds of the bed. Review of Resident #16's medical record occurred on March 13-15, 2012. Medical diagnoses included dementia and a stage four pressure ulcer on her coccyx. Initiation of the pressure relieving mattress and four side rails occurred on 12/16/11. Resident #16's care plan, reviewed on the afternoon of 03/13/12, failed to identify the use of bed rails, the proper use of the pressure relieving mattress, and her stage four pressure ulcer. During an interview on 03/14/12 at 9:25 a.m., the wound nurse (#5) stated the only items placed between Resident #16 and the pressure relieving mattress should be a single sheet and an airflow disposable pad. Also, she expected facility staff to place all four bed rails in the upright position to prevent the resident from slipping off the mattress.	F 280		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		

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F 309	Continued From page 27 This REQUIREMENT is not met as evidenced by: 1. Based on observation, record review, review of facility policy/procedure, and staff interview, the facility failed to provide the necessary care and services regarding pain management for 1 of 1 sampled resident (Resident #2) who experienced pain after a fall and for 2 of 4 sampled residents (Resident #6 and #16) who expressed pain during the survey. Failure to initiate an effective pain management regimen for Resident #2 to control her pain following her falls; and failure to provide pain medication for Resident #16 when she voiced pain and for Resident #6 when she communicated non-verbal signs of pain; resulted in these residents experiencing unrelieved pain without appropriate management. Findings include: Review of the facility policy titled "Comfort Verses Discomfort" occurred on 03/15/12. This policy, dated 2009, stated, ". . . Procedure: The assessment of the residents' pain level will be recorded using the verbal or nonverbal rating scales, and results recorded in the residents' record. . . . If there is evidence of uncontrolled pain, reassessment will be documented. . . . Physician re-notification does not need to be daily, but periodically as deemed appropriate by nursing staff . . . Staff members including nurses and C.N.A.'s [certified nurse aides] will receive instructions on how to perform pain assessment, the tools used and how to comply with the above policy."	F 309	Resident # 2, 6, 16 have had pain monitoring scheduled. Care Plans/Guides have been updated to reflect changes. Staff have been educated again on following policy/procedure on pain management and the importance of proper assessment and follow-through with pain management. All residents with pain have the potential to be affected. Residents will be assessed for pain and if a resident requests or requires prn pain medication more than 3 times daily, pain monitoring will be completed for 3 days. The resident's name will be added to the QA study. On day 4, a pain follow-up is completed and the resident's physician will be updated of the results. Any orders will be observed and any change in condition will be added to the Care Plan/Guide. Trinity Homes policy and procedure on Pain Management has been updated to reflect the changes. Staff have been re-educated on the importance of assessing for pain for all residents, and the necessity to be timely in giving pain medication and monitoring for effectiveness. Education also provided to all staff regarding following Physician orders for adaptive devices, etc. used for residents. QA will be ongoing and will be reported monthly to the QA committee. Date of completion is April 10th, 2012. The DON is responsible for this process.	

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- Review of Resident #2's medical record occurred on all days of survey. Resident #2's medical diagnoses include Alzheimer's dementia, osteoarthritis, osteoporosis, and history of frequent falls.

Resident #2's Minimum Data Set (MDS), dated 10/11/11, identified the resident displayed short and long term memory problems; moderate impairment in daily decision making; independent with bed mobility, transfer, and ambulation; received a scheduled pain medication during the past five days; daily indicators of pain which included vocal complaints and facial expressions of pain; and sustained fall without injury and two or more falls with minor injuries.

Resident #2's December 2011 Medication Administration Records (MARs) identified physician orders for the following pain medications:

*Tylenol (also known as Acetaminophen, an over-the-counter [OTC] pain medication) 650 milligrams (mg) every four hours as needed; ordered on 01/13/11

*Advil (also known as Ibuprofen, an OTC nonsteroidal anti-inflammatory [NSAID] medication) 400 mg four times a day at 12:01 a.m., 6 a.m., 11 a.m., and 5 p.m., ordered on 03/22/11

*Tylenol Extra Strength 500-1000 mg as needed; no frequency specified on the MAR and ordered on 12/20/11

*Fentanyl (a narcotic medication) patch 12.5 micrograms (mcg) every three days; ordered on 12/22/11

*Vicodin 5/500 mg (a narcotic pain medication containing 5 mg of hydrocodone [a narcotic] and

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500 mg of Tylenol) every six hours around the clock dosing for two days; ordered on 12/22/11.

Resident #2's Progress Notes from December 01-16, 2012 showed the resident experienced difficulty sleeping at night and would wander the hallways.

Summarization of Resident #2's "Falls Documentation," (a computerized form containing a description of what happened, when, where, and why it occurred, if the resident sustained any injuries and what adjustments are made to the resident's plan of care) identified the resident fell three times without injury in December 2011 (on December 12 at 8 a.m., December 16 at 5:55 p.m., and December 16 at 6:05 p.m.).

Resident #2's Falls Documentation, dated 12/16/11 at 10:50 p.m., stated, "CNA heard noise while in day area, turned to see [name of Resident #2] sitting on floor." The facility concluded this fall occurred because the "resident unsteady, behind in sleep." Resident #2 incurred "swelling to right knee" following this fall. The adjustment/intervention implemented by the facility following this fall was to "continue close observation."

A Progress Note, dated 12/17/11 at 5:02 a.m., identified Resident #2's right knee as "slightly larger than the left, but appears this may be a chronic condition rather than new occurrence . . . has c/o [complaints of] groin discomfort when tries to get up from chair especially the right groin area and once c/o discomfort in lower back to sacral area when stood, has remained in chair all night possible due to discomfort in groin when

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trying to stand." At 5:44 a.m., a Progress Note identified when Resident #2 attempted to stand she placed her hand on her right hip and then sat back down. At 7:26 a.m., a Progress Note stated three staff needed to assist the resident with transferring, and the resident "jumped and looked distressed" when the nurse manipulated her right knee and leg.

The facility sent Resident #2 to the emergency room (ER) on the morning of 12/17/11 to obtain x-rays. Resident #2 returned to the facility with a diagnosis of a "muscle sprain of the lower [right] extremity" and home care (discharge) instructions of non-weight bearing and elevate the injured leg, application of apply ice and oral pain management medications (acetaminophen or ibuprofen). Upon return from the ER at 2:45 p.m., facility staff noted Resident #2 experienced "discomfort with movement." Resident #2's MAR showed facility staff failed to administer/provide any type of as needed pain medication to Resident #2.

A Progress Note, dated 12/18/11 at 6:34 a.m., stated: ". . . this am incontinent of urine, agitated with brief change and c/o of pain in right groin with turning, spit out the ibuprofen . . . and bit off end of plastic spoon in anger, tried to get out of bed but layed back on bed from pain right groin when tried to stand."

Resident #2's Falls Documentation, dated 12/18/11 at 6:35 a.m., identified facility staff found Resident #2 on the floor in room.

Resident #2 received 650 mg of Tylenol at 7:58 a.m. (a hour and half after exhibiting signs of

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pain), and facility staff documented the effectiveness (two and half hours later) as "sleeping" at 10:30 a.m.

A Progress Note, dated 12/18/11 at 10:41 a.m., a Progress Note stated, "Heard screaming from room . . . found resident sitting on floor with back against bed . . . Tried to check her ROM [range of motion] but grabs her inner rt [right] thigh area stating it hurts . . . With assist of 4 able to satand [sic] her up and place her in a w/c. Continues to whimper that it hurts. Refuses to put feet on foot pedals. Tries to bite and/or hit staff if we try to move her at all. Had been given ibuprofen [approximately] 30 min [minutes] ago . . . ." Nursing staff applied warm packs to the resident's right thigh area to promote pain relief.

At 3:30 p.m., charting identified the resident "becomes agitated with transfers" and "won't allow staff to touch her rt inner thing area--states it hurts too much." Resident #2's MAR showed facility staff administered Tylenol 650 mg at 6:16 p.m.(two and half hours later).

On 12/19/11 at 3:07 p.m., a Progress Note stated, ". . . requiring the assist of 3 when transferring in and out of w/c or on and off of bsc [bedside commode]. To be monitored during transfers as she will bite, hit or pinch due to the pain she is feeling . . . ." Resident #2's MAR showed facility staff administered as needed pain medication (Tylenol) once to the resident on December 19 (at 8:50 p.m.).

On 12/20/11 at 12:06 p.m., a Progress Note stated, ". . . She does complain of pain to right leg with movement . . . Becomes restless [at] times

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sitting in the w/c as she is more accustomed to ambulating ad lib [per self] throughout the unit." The MAR showed facility staff administered as needed pain medication (Tylenol) twice to Resident #2 (at 2:32 a.m. and 8:13 p.m.).

On 12/21/11 at 6:53 a.m., ". . . Resident . . . does yell out with movement . . . Resident remains restless and has had to be settled several times . . . ." The MAR showed facility staff administered as needed pain medication (Tylenol - unsure if 500 or 1000 mg was provided) twice to Resident #2 (at 2:15 a.m. and 8:07 a.m.).

The facility contacted Resident #2's doctor on 12/22/11 to inform him of the resident's continued "terrible" pain with movement. The doctor responded with orders for Fentanyl patch 12.5 mcg every three days, routinely administered Vicodin 5/500 mg every six hours for two days, a hospice consult, and instructions to provide an update of the resident's status in two days. On 12/23/11, the facility received an order to send Resident #2 to the ER for x-rays. The record showed Resident #2 was admitted to the hospital for treatment of a right hip fracture.

Resident #2 experienced increased pain to her right hip/groin area following a fall the morning of December 18. Nursing staff sent two separate faxes to Resident #2's doctor dated December 19 and 21 requesting an order for a K-Pad (a type of heating pad) to be used PRN to promote comfort. Nursing staff once again contacted the doctor on December 22 to inform him of Resident #2's "terrible" pain with movement. Resident #2's MAR identified facility staff failed to promptly administer oral pain medications in an attempt to provide

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F 309	Continued From page 33 relief of and/or manage her pain for four days. During an interview on the morning of 03/15/12, an administrative nurse (#7) provided no explanation/rationale why nursing staff failed to provide PRN pain medications promptly to treat Resident #2's signs and symptoms of acute pain, why nursing staff failed to assess and locate the potential cause(s) of her increased pain (following her fall on December 18), and failed to inform the doctor of her increase verbalizations of pain with movement for four days (December 18-21). Failure of the facility to provide the necessary care and services to treat Resident #2's pain resulted in the resident experiencing avoidable pain and delayed treatment of a fracture. - Review of Resident #16's medical record occurred on all days of survey. Diagnoses included a Stage IV pressure ulcer to her coccyx, osteoarthritis, and dementia. Medications included Ibuprofen 200 mg three times a day and Tylenol with codeine (an opioid pain reliever) every six hours as needed (PRN). The quarterly MDS, dated 01/26/12, identified Resident #16 as having short and long term memory difficulties, rarely/never makes herself understood, sometimes able to understand others, experienced pain one to two days a week, and pain interventions included scheduled pain medication and non-medicine type interventions. The most recent pain assessment, dated 01/23/12, confirmed the quarterly MDS.	F 309		

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Review of Resident #16's progress notes identified the following:
* 03/10/12 - "Facial grimacing noted. Asked to squeeze her hand to indicate pain scale and Res [resident] squeezed as hard as 10. Pain scale 10/10 ["0" indicating no pain and "10" the worst pain]. Non med interventions - repositioning." Even though the resident expressed pain of a "10", facility did not administer any PRN medication.
* 03/14/12 - "Daughter [name] 'so discouraged [from appointment with the doctor]. Coccyx wound worse, now Stage 4 with bone exposed and he [doctor] recommended a colostomy. [daughter's name] not in favor. Told infection will kill her [Resident #16]."

Review of the PRN MAR identified Resident #16 received no Tylenol with codeine from 09/16/11 to 01/18/12. Facility staff administered the PRN medication on:
* 01/19/12
* 01/21/12
* 02/20/12
* 03/20/12

Observation on 03/14/12 at 8:00 a.m. showed Resident #16 seated in a rocking wheelchair in the dining room. The resident picked at the right side of her pants and appeared to lift her her right hip. The resident remained in her wheelchair until 9:25 a.m. At that time, two CNA's (#30 and #33) utilized a hoyer lift (full body mechanical lift) and transferred Resident #16 into her bed. Observation showed the resident grinding her teeth. The CNA (#30) stated, "She does that when she's ready [to go to bed]." Two nurses (#34 and #5) entered the room, assessed the

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resident's coccyx pressure ulcer, cleansed the area, and applied a new dressing. Observation showed Resident #16 shaking and clutching the siderail so tightly her knuckles turned white. The nurse (#5) stated, "I know this hurts."

The medical record identified worsening of Resident #16's pressure ulcer with "bone exposed." A progress note, dated 03/10/12, identified pain of a "10" and facility staff provided a non-medication intervention of "repositioning." Observation showed the resident experienced pain while seated in her wheelchair and again during treatment to the pressure ulcer. The facility failed to notify Resident #16's physician regarding her increased pain related to the Stage IV pressure ulcer and failed to administer her PRN pain medication when she experienced pain.

- Review of Resident #6's medical record occurred on March 13-15, 2012. Diagnoses included Alzheimer's disease and osteoarthritis. On 03/13/12, the resident fell and sustained abrasions to her left knee and left wrist, as well as hitting her head on the floor.

Observation on on 03/13/12 at 4:03 p.m. showed a CNA (#21) assisted Resident #6 to use the bathroom. Observation showed a bruise to the resident's left eye, and abrasions to the left wrist. A nurse (#22) entered the room to assess the resident's bruise. The nurse asked the resident if she was having any pain related to her fall. The resident did not respond verbally and made unintelligible noises while rocking back and forth in her wheelchair. The nurse asked Resident #6 if she would like a Tylenol, and the resident stated, "Yes!" The nurse then stated, "Ok, I'll see about

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TRINITY HOMES	305 8TH AVE NE MINOT, ND 58702

(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 309	Continued From page 36 getting you some Tylenol," and left the room. Resident #6's medical record contained physician's orders for Tylenol 500 mg every six hours, and Ibuprofen 200 mg twice per day as needed (prn). The medical record did not contain an order for prn Tylenol. Review of Resident #6's MAR identified the nurse failed to administer any type of analgesic until 6:00 p.m. (two hours later), at which time she provided the resident her scheduled Tylenol. Record review identified facility staff failed to assess Resident #6's nonverbal indicators of pain. During an interview on the afternoon of 03/15/12, an administrative nursing staff member (#7) indicated the nurse should have followed up with the resident's request for pain medication. 2. Based on observation, record review, and staff interview, the facility failed to provide the necessary care and services to maintain the highest practicable physical well-being for 1 of 4 sampled resident (Resident #14) identified with contractures. Failure to ensure facility staff placed a cloth pad (as ordered by the provider) to Resident #14's left hand may delay in the healing of the resident's wound. Findings include: Review of Resident #14's medical record occurred on all days of the survey. Diagnoses included diabetes and cerebral vascular disease. The quarterly Minimum Data Set (MDS), dated 02/24/12, indicated intact cognition, extensive	F 309		

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F 309	Continued From page 37 assistance of one for personal hygiene and limited range of motion of upper and lower extremity on one side of her body. Physician's orders, dated 03/12/12, stated, "Clean q [every] shift-cloth pad L [left] hand. Betadine BID [twice daily] (paint wounds till healed)." The current care plan listed the problem "SKIN INTEGRITY . . . Monitor Skin-left hand in the inside knuckle in the two middle fingers Two times daily. . ." The care guide and care plan failed to address the wound care ordered per physician. Observation on 03/13/12 at 2:10 p.m. showed a nursing staff member (#5) assessing Resident #14's left hand wounds. The nurse (#5) noted two areas on the inside of the resident's left hand, one measuring 0.5 centimeters (cm) x 0.5 cm and the other wound measuring 0.5 cm x 0.8 cm. Observations on 03/14/12 at 09:40 a.m. and 03/15/12 at 8:10 a.m. and 10:30 a.m. showed Resident #14 without a cloth in her left hand. During an interview on 03/15/12 at 11:25 a.m., a nursing administrative staff member (#2) stated she would expect staff to follow physician's orders regarding the left hand wounds.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced	F 312		

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F 312	Continued From page 38 by: Based on observation, record review, review of facility policy and procedure, and staff interview, the facility failed to ensure 3 of 11 sampled residents (Resident #22, #23, and #27) and 1 supplemental resident (Resident #32) requiring extensive or total assistance with meals received the necessary assistance and services regarding positioning and assistance at meals. Failure to provide assistance at meals limited the residents' ability to ensure good nutrition, improve their independence, and limited their ability to reach their highest practicable physical, mental, and psychological well-being possible. Findings include: Review of the facility policy and procedure, "Feeding of the Impaired Resident," occurred on 03/15/12. This document, revised 02/12, stated "POLICY: Staff will give resident cares in accordance with the standards established by Trinity Homes. PURPOSE: To provide nourishment. PROCEDURE: . . . 2. Prepare resident. a) Position resident appropriately. . . . 2. [sic] Check with resident as to what order they may wish their foods be given to them. 3. Feed slowly . . ." The facility staff identified each resident's Care Guide is used by the staff during daily cares and is considered a part of the resident's current care plan. - Observations in the 3 South Unit dining room identified Resident #22 seated in a wheelchair at the dining room table at arm's length from her	F 312	Resident # 22, 23, 32, 27 were affected. OT has assessed these residents for positioning and recommendations have been added to the Care Plan/Guide. Dietary staff will serve those residents that require feeding assistance last and staff will be available immediately to assist in eating. This has the potential to affect all residents. Staff has been educated that residents need to be fed in a timely manner. Residents that require help will be served at the end of the tray pass. Nurses and C.N.A.'s will observe residents in the dining room for positioning and staff will monitor that meals will be served in a timely manner and residents will be assisted as needed. OT will make monthly observations on residents positioning in the dining room. Care Plans/Guides will be updated to reflect any resident changes. QA will be completed weekly for nursing staff and then monthly until compliance is achieved. QA will be completed monthly for OT until compliance is achieved. All audits will be reported to the monthly QA committee. The DON and OT Manager are responsible for this process. Corrective Action completed April 11, 2012.	

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meal items as follows:
*03/13/12, 12:00 noon -
- The facility staff provided set up of her meal items but failed to offer or attempt to move her closer to the table. The resident reached to arm's length, her sleeves dragging through her meal items to access fluids, as she consumed approximately 25% of her meal items in ten minutes. The resident then stopped eating and sat at the table until an unidentified staff member began to assist her at 12:25 p.m.
*03/14/12, 7:55 a.m. -
- The resident ate cold cereal and french toast independently, dropping meal items on her clothing protector and dragging her sleeve through her plate as she accessed fluids. A certified nursing assistant (CNA) (#15) and an unidentified staff member assisted other residents at the table and failed to offer assistance or re-position Resident #22.
- 11:53 a.m. -
- The resident ate pizza and salad independently, dropping meal items on her clothing protector and dragging her sleeve through her plate as she accessed fluids. At 12:15 p.m. the resident had consumed approximately 50% of her meal items and an unidentified staff member offered her coffee, but failed to offer repositioning or prompting. At 12:25 p.m., another unidentified staff member offered Resident #22 a supplement and failed to offer repositioning.
- 5:45 p.m. -
- The resident ate casserole and cole slaw independently, dropping meal items on her clothing protector and dragging her sleeves through her meal items as she accessed her fluids. Three unidentified staff members assisting

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F 312	Continued From page 40 other residents at the table failed to offer to reposition or assist Resident #22. - Review of Resident #22's medical record occurred on March 14-15, 2012. The facility admitted the resident in April 2007. Current diagnoses included osteoarthritis. The annual Minimum Data Set (MDS), dated 01/17/12, identified severe cognitive impairment and the resident required extensive assistance of one person for eating. Resident #22's current care plan identified the resident required set up assistance and cues for eating. - Observations in the 3 South Unit dining room, on 03/13/12 at 12:00 noon identified the following: - Resident #23 - seated in her wheelchair at the dining room table and received her meal items on a covered plate. Residents seated at her table ate independently or with assistance or prompting. At 12:25 p.m., 25 minutes after being served her meal, an unidentified staff member began to feed Resident #23. The staff member failed to re-heat the meal items. -Review of Resident #23's medical record occurred on March 14-15, 2012. The facility admitted the resident in April 1977. Current diagnoses included cerebral palsy and mental retardation. The resident's annual MDS, dated 12/20/11, identified severe cognitive impairment and the resident required extensive assistance of one person for eating. Resident #23's Care Guide identified the resident required meal tray set up and staff to feed the	F 312		

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F 312	Continued From page 41 resident. The resident's current care plan, dated 09/21/11, stated "Problem, Nutrition/Feeding - total feed . . ." During interview, on 03/15/12 at 8:15 a.m., a supervisory nursing staff member (#12) agreed facility staff should have moved Resident #22 closer to the table. This staff member confirmed facility staff should provide assistance to Resident #22 and #23 with meals when served and facility staff should not have waited 25 minutes after the meal was served to feed Resident #23. - On 03/13/12 at 8:10 a.m. observation in the 4 East Dining Room showed Resident #32 seated at a table and an uncovered plate of uneaten food on the table in front of this resident. Resident #32 leaned forward in her specialized wheelchair, touched her pureed food items with her fingers, and put her fingers in her mouth. Observation showed no staff member seated at the table to provide assistance to Resident #32. Review of Resident #32's medical record occurred on the morning of 03/15/12. Resident #32's MDS, dated 12/20/11, identified the resident required extensive assistance of one person for eating. Resident #32's current Care Guide stated, ". . . Eating- Deliver [and] setup tray, Open food containers, Prepare food (cut meat/butter bread/crack eggs etc), Feeds self some - staff assist to finish, Provide encouragement for eating, Provide cuing for eating, Feed all meals, Monitor for chewing/swallowing problems . . . Monitor for coughing/choking, position upright as possible, pureed food with honey thickened	F 312		

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F 312	Continued From page 42 liquids . . . ." - Observations on 03/13/12 at 8:15 a.m. and on 03/15/12 at 8:30 a.m. showed Resident #27 seated in a Broda chair in the dining room. The resident's upper chest was at the height of the dining room table. The resident needed to reach up and over the table to access her food and observation showed her right elbow occasionally hit the table as she reached for her food. Review of Resident #27's medical record occurred on March 14-15, 2012. The significant change MDS dated 01/23/12, indicated severe cognitive impairment and extensive assist of one for eating. The Care Guide, dated 03/15/12, identified, ". . . Eating . . . Provide encouragement for eating, Provide cueing for eating . . . Feeds self after setup; staff assist to finish at times . . ." An interview with an administrative nursing staff member (#2) occurred on 03/15/12 at 11:25 a.m. This staff member agreed facility staff should assess Resident #27's position at the dining room table due to the low position of the Broda chair.	F 312		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident 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.	F 314		

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This REQUIREMENT is not met as evidenced by:
Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide necessary treatment and services to aid in the prevention and promote the healing of pressure ulcers for 4 of 9 sampled residents with pressure ulcers (Resident #7, #10, #14, and #16). Failure to reposition residents with existing pressure sores and failure to properly use pressure relieving air mattresses placed these residents and all residents at risk for skin breakdown and worsening of existing pressure ulcers.

Findings include:

Review of the facility policy titled "Routine Care of Pressure Sores" occurred on 03/15/12. This policy, dated 2011, stated, ". . . Procedure: . . . 2. Institute measures to reduce or relieve pressure. Keep head of bed at or below 30 degree angle and flat when not contraindicated. Use knee gatch when head of bed is elevated. If knee gatch is contraindicated, use foot board. 3. Utilize a pressure reduction device, in conjunction with a position change schedule. . . ."

- Review of Resident #16's medical record occurred on all days of survey. Medical diagnoses included a Stage IV pressure ulcer to her coccyx, diabetes mellitus, and dementia. A physician's order, dated 12/16/11, identified a First Step Air Overlay (a pressure relieving air mattress).

The quarterly Minimum Data Set (MDS), dated

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F 314	Continued From page 44 10/27/11, identified the resident required extensive assistance for bed mobility and toilet use, total assistance for transfers and personal hygiene, and at risk for pressure ulcers. The most recent MDS, dated 01/26/12, identified the resident required extensive assistance for bed mobility and personal hygiene, total assistance for transfers and toilet use, and a Stage IV pressure ulcer. Review of Resident #16's current Care Guide (a part of the care plan used by certified nurse aides [CNAs]), occurred on the afternoon of 03/13/12. This guide stated, ". . . Skin: Check/change & [and] provide peri-care w/ [with] each incontinent episode, Pressure relief cushion on chair, First step air overlay mattress . . ." The Care Guide and Care Planning Report failed to identify the resident's Stage IV pressure ulcer to her coccyx and additional interventions to aid in the healing of the ulcer. Review of Resident #16's progress notes and ulcer management notes identified the following: * 12/14/11 - "open area on coccyx noted 0.4 cm [centimeter] depth. no tunneling noted. 1.2 cm length, 1 cm width, wound bed dark red, small amount of slough . . ." * 12/16/11 - "unstageble pressure ulcer to coccyx 2 x [by] .5 x .3 [cm] . . . have spoken to family about more bed rest until pressure ulcer resolved. Family agreed." * 12/23/11 - "1.8 x 1.0 x 0.3 cm (slight increase from last week)" * 01/13/12 - ". . . DC'd [discontinued] current treatment change to . . ." * 01/25/12 - "no change in pressure ulcer. Treatment changed . . ."	F 314	Written education has been provided on the correct use of air mattresses to staff. A turning schedule has been developed by the Wound Care Nurse and will be utilized on all residents that have pressure ulcers. The schedule will be made into a standard form to be used at the Trinity Nursing Home. All residents have the potential to be affected. Residents that have the potential to develop pressure ulcers will be identified on admission by a Braden scale less than 12. The Wound Care Nurse will then assess the resident and develop a plan as needed. Residents who have been identified of being at risk or have pressure ulcers will have this addressed on the care plan and care guide, along with interventions listed on the care plan. Nursing Staff/ CNA's will be educated at the start of their employment by the Wound Care Nurse on the use of air mattresses, turning schedules, and the role of the Wound Care Nurse and when to call her on a consult. New employees that are in the Trinity Homes Certified Nurse Assistant class will receive education during their class from the Wound Care Nurse. Weekly QA will be done on residents who are using special mattresses and residents who require repositioning. This will continue until 100% compliance is obtained then done monthly. All audits will be reported to the monthly QA committee. The DON is responsible for this process.	

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F 314	Continued From page 45 * 02/13/12 - "Noted foul odor from coccyx, gauze was turquoise green in color . . ." * 02/23/12 - "Noted increase in depth and slough remains. Slight odor and increase in yellow excudate noted. Treatment . . . ongoing since 01/26/12. Resident experiencing much pain with area. . . . New orders for surgical consult received." * 02/24/12 - Coccyx pressure ulcer 2.0 x 1.0 cm * 02/26/12 - [treatment changed] . . . "Surgical consult 03/05/12." * 03/02/12 - Coccyx pressure ulcer 3.0 x 1.2 cm * 03/09/12 - Coccyx pressure ulcer 4.5 x 1.0 cm * 03/14/12 - "Daughter [name] so discouraged . . . coccyx wound worse, now stage 4 with bone exposed . . ." Observation of Resident #16 showed the following: * 03/12/12 at 11:15 a.m. - Observation showed the resident laying on her bed with a bedspread, sheet, airflow disposable pad, and the hoyer pad between her and the pressure relieving mattress. * 03/13/12 at 8:55 a.m. - Two certified nursing assistants (#29 and #30) transferred the resident from her wheelchair to the bed. The CNAs placed her on top of the bedspread, a sheet, and a disposable pad. * 03/13/12 at 10:30 a.m. - The resident returned from a doctor's appointment. Two CNAs (#30 and #31) layed her on her bed with a wrinkled bedspread, sheet, and disposable pad between her and the pressure relieving mattress. * 03/15/12 at 10:15 a.m. - Observation showed the resident laying on her bed with 2 sheets, a bedspread, and a disposable pad between her and the pressure relieving mattress.	F 314	The Wound Care Nurse will to audits of all residents to ensure that those residents with pressure ulcers have this addressed on their care plan and care guide. Date of Completion: April 11, 2012	

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F 314	Continued From page 46 During an interview on 03/14/12 at 9:25 a.m., a wound nurse (#5) stated for the airflow mattress to work effectively, only a sheet and a airflow disposable pad should be between Resident #16 and the mattress. Even though the facility implemented the First Step Air Overlay air mattress on 12/16/11, failure to utilize the mattress correctly contributed to the worsening of Resident #16's coccyx pressure ulcer. - Review of Resident #10's medical record occurred on March 13-15, 2012. The facility readmitted the resident to the facility on 01/06/12 after hospitalization and identified the left heel as "reddened" and "spongy" on 01/10/12. The MDS, dated 03/06/12, identified the left heel pressure sore as "unstageable", "4.5" cm long, "6.5" cm wide and no depth identified. The MDS also identified the resident required extensive assistance of two or more persons for bed mobility. Resident #10's Care Guide stated "Bed Mobility, Assist to reposition in bed."; and, "Skin, . . . Positioning, repositioning . . . First step select air mattress . . ." The resident's current care plan, dated 02/02/10, stated "Problem, Bed Mobility . . . Requires extensive assistance . . . Goals . . . will turn & [and] position successfully w/ [with] physical help. . . .;" and, dated 02/22/12, "Problem, Skin integrity . . . Approach . . . First Step Air Overlay [mattress] . . ." Observation throughout the day on 03/13/12 showed the following: * 7:45 a.m. - Resident #10 laying on her left side	F 314		

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with the left heel supported off the mattress.
* 8:30 a.m. - The resident remained on her left side, certified nursing assistant (CNA) (#15) fed the resident her breakfast.
* 8:55 a.m. - A CNA (#17) provided the resident a bed bath, changed the resident's brief, turned her from side to side during the bath, and positioned her on the her left side with the heel supported off the mattress at the end of the cares. The CNA offered to get the resident up to the beauty shop and resident declined.
* 12:13 p.m. - The resident remained on her left side with the left heel supported off the mattress. CNA (#17) fed the resident lunch.
* 2:55 p.m. - The resident was sleeping on her left side with her left heel supported off the mattress.
* 3:50 p.m. - Two CNAs (#18) and (#19) offered and the resident agreed to be transferred from the bed to a wheelchair with a full body lift.

During the more than eight hour period of observation facility staff did not offer to reposition Resident #10 except as noted at 8:55 a.m. Random observations showed the resident remained on her left side with the left heel supported off the mattress. It is unknown how long she was on her left side before 7:45 a.m.

During interview, on 03/15/12 at 11:50 a.m., a supervisory nursing staff member (#12) reported facility staff should have repositioned Resident #10 from her left side.

- Review of Resident #7's medical record occurred on March 13-15, 2012. Diagnoses included Alzheimer's disease, a Stage I pressure ulcer to the buttocks, a Stage II pressure ulcer to

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(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 314	Continued From page 48	F 314		

the right trochanter (hip bone), and an unstageable pressure ulcer to the left trochanter. The resident's medical record identified a physician's order for a First Step Air Overlay.

Review of Resident #7's Care Guide occurred on 03/13/12. The Care Guide stated, "Skin: Check/change & Provide peri-care w/ each incontinent episode, Moisturizing Lotion with care, Pressure relief cushion on chair, first step select air overlay mattress, padded footrests of w/c [wheelchair] . . ."

Observation on 03/13/12 at 7:50 a.m. showed Resident #7 asleep on her right side on a First Step mattress. The unit used to inflate the mattress was not turned on, and the air mattress was not fully inflated. At 8:12 a.m., two nursing staff members (#5 and #11) entered the room to assess the resident's pressure ulcers. The nurse (#5) identified the air mattress was not on, and the other nurse (#11) stated, "I must have forgotten to turn it on when I laid her down [after breakfast]." The nurse (#5) then turned on the unit used to inflate the air mattress. Failure to utilize the mattress correctly does not allow the mattress to aid in healing the resident's Stage II pressure ulcer.

- Review of Resident #14's medical record occurred on all days of the survey. Diagnoses included cerebral vascular disease, morbid obesity, pressure ulcer to coccyx area, wound to left lateral foot, and diabetes. The quarterly MDS, dated 02/24/12, identified the resident required extensive assistance with bed mobility, and limited range of motion of the upper and lower extremity on one side of her body. The current

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	355074	A. BUILDING _____ B. WING _____	03/15/2012

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F 314	Continued From page 49 Care Guide stated, " . . . Skin-Turn and reposition resident q [every] 2 h [hours] and prn [as needed], . . . Pressure relief mattress . . . " Observation on 03/13/12 from 9:20 a.m. to 11:45 a.m. (two hours and 20 minutes) showed Resident #14 in bed with the First Step mattress in place and the resident positioned on her back. Observation on 03/13/12 at 2:10 p.m., showed a wound nurse (#5) assessed Resident #14's ulcers. Observation and interview with the nurse (#5) showed a fitted sheet, a cloth soaker pad, and a disposable soaker pad (not made for this particular mattress) all on top of the First Step mattress. Observation showed the blue mattress cover, which comes with the First Step mattress and aids in repositioning the resident, underneath the mattress (between the bed frame and the mattress). The wound nurse (#5) instructed the CNA (#6) not to use fitted sheets, and to use the disposable soaker pads designed for the First Step mattress. After the nurse completed wound care, the CNA (#6) positioned the resident on her back. Observation showed Resident #14 positioned on back from 2:10 p.m. to 5:00 p.m. (two hours and 50 minutes). An interview with an administrative nursing staff member (#2) occurred on 03/15/12 at 11:25 a.m. The staff member (#2) agreed facility staff failed to reposition Resident #14 as indicated in the resident's Care Guide.	F 314		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323		

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F 323	Continued From page 50 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: 1. Based on observation, medical record review, review of facility policy, review of professional reference, and staff interview, the facility failed to ensure the use of assistive devices necessary to prevent accidents for 2 of 5 sampled residents (Resident #6 and #7) who utilized a gait belt for transfers, and for 1 of 11 sampled residents (Resident #6) who utilized a chair alarm. Failure to consistently implement assistive devices has the potential to result in avoidable falls and/or injuries. Findings include: Review of the facility policy titled "Gait Belts" occurred on 03/15/12. This policy, revised March 2012, stated, ". . . POLICY: Gait belts will be used on residents who require staff assistance with transfers or ambulation. . . . PROCEDURE: . . . 4. Wrap the gait belt snugly around the resident's waist. The belt should neither bind the resident nor slip around the resident's waist. . . ." Berman and Snyder, "Kozier & [and] Erb's Fundamentals of Nursing, Concepts, Process, and Practice," 9th ed., Pearson Education Inc., Upper Saddle River, New Jersey, 2012, page 1158-1159, stated, ". . . TRANSFERRING CLIENTS . . . Because wheelchairs . . . are	F 323	Written education has been provided to staff on the proper use of gait belts and transferring residents safely, with wheelchair brakes locked. The education was provided by Jennifer Parks, DPT. An in-service will be provided to CNA's and nurses on April 11th at 0630, 1000, and 1330 on Lifting and Transferring Technique and Review. Included in this in-service is use of the gait belt and transferring residents safely. All residents have the potential to be affected. Physical Therapy staff will provide biannual training on transferring residents safely to include gait belt training. In-services will be co-coordinated through Nursing Service. Transferring techniques will continue to be taught through the CNA class at Trinity Nursing Home. All newly hired staff will complete an initial training with the Physical Therapy department on transferring techniques. Staff will be required to complete a return demonstration on correct transferring techniques. Physical Therapy will identify 2 residents on each floor (14 residents), each week and observe staff transferring those residents. Feedback and correction will be provided to staff at these times. QA will be conducted weekly until compliance is achieved and then monthly. All audits will be reported to the monthly QA committee. The DON and Physical Therapist are responsible for this process. Date for completion: April 15th, 2012.	

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F 323	Continued From page 51 unstable, they can predispose the client to falls and injury. Guidelines for the safe use of wheelchairs . . . are shown in the accompanying Practice Guidelines. PRACTICE GUIDELINES: Wheelchair Safety: Always lock the brakes on both wheels of the wheelchair when the client transfers in or out of it. . . ." - Review of Resident #6's medical record occurred on March 13-15, 2012. Diagnoses included Alzheimer's disease, osteoarthritis, osteoporosis, and a history of falls. The current Minimum Data Set (MDS), dated 03/07/12, identified short term and long term memory problems, severely impaired daily decision-making skills, and extensive assistance from one person for transfers. Resident #6's current "Care Guide" (a part of the care plan used by certified nursing assistants [CNAs]) stated, ". . . Transfer . . . Transfer belt . . . Safety . . . lapbuddy [sic] in w/c [wheelchair], Chair alarm . . ." A nurses' note dated 09/22/11 identified staff added a chair alarm to Resident #6's wheelchair due to the resident removing her lap buddy, standing up, and sustaining a fall. Observations throughout the survey identified no chair alarm present on Resident #6's wheelchair. Observation on 03/13/12 at 4:03 p.m. showed a CNA (#21) assisted Resident #6 to ambulate from the toilet to her wheelchair using a gait belt. The resident was not fully alert and was unsteady during ambulation. The CNA failed to apply the gait belt snugly, which resulted in an approximate	F 323	↑ Need to addressed Res #6 (alert B. 5-4) ↑	

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six inch gap between the gait belt and the resident's back. Upon reaching her wheelchair, the resident bent forward and grasped the arm rests of her wheelchair. Because the wheelchair brakes were unlocked, the wheelchair rolled backward and the resident stumbled forward. The CNA then locked the brakes and assisted Resident #6 into her chair.

Observation on 03/14/12 at 9:52 a.m. showed two CNAs (#27 and #28) assisted Resident #6 to transfer from her bed to the wheelchair using a gait belt. The resident was lethargic and did not open her eyes. The CNAs failed to lock the wheelchair brakes, and one CNA (#28) put her hand on top of the right armrest to steady the chair. As the resident attempted to sit, she backed into the chair, causing it to roll backward on the left side. The other CNA (#27) grabbed the left arm rest to steady the chair, and the resident sat down.

- Review of Resident #7's medical record occurred on March 13-15, 2012. Diagnoses included Alzheimer's disease, arthropathy (joint disease), lumbago (low back pain), and a history of falls. The current MDS, dated 03/07/12, identified short term and long term memory problems, severely impaired daily decision-making skills, and extensive assistance from two or more people for transfers.

Observation on 03/13/12 at 4:41 p.m. showed two CNAs (#9 and #10) applied a gait belt around Resident #7's waist and pivoted her from the bed to the commode. The CNAs then pivoted the resident from the commode to her wheelchair. The CNAs failed to lock the wheelchair brakes,

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F 323	Continued From page 53 and as a result, the wheelchair rolled backward a few inches. During this observation, the gait belt was loose around Resident #7's waist and slid approximately 6 inches up the resident's back. During an interview on 03/15/12 at 2:00 p.m., a supervisory nursing staff member (#7) stated Resident #6 should have a chair alarm on her wheelchair at all times and agreed the above transfers were unsafe. 2. Based on observation and staff interview, the facility failed to ensure the resident environment remained as free of accident hazards as possible regarding equipment obstructing the hallways and limiting residents' access to the handrails, for 3 of 7 resident care units (2 East, 3 South, and 3 East) for 4 of 4 days of survey. Equipment routinely stored in the hallways against the handrails, placed residents at risk of accidents if they attempted to ambulate around the equipment without the handrail support, or move the equipment, limited the residents' ability to move in the hallways, limited the residents' access to emergency exits, and limited the staff's ability to assist residents in the event of an emergency. Findings include: - Observation during the initial facility tour on the 3 East resident care unit, on 03/12/12 at 10:50 a.m., identified equipment stored on both sides of the hallways, including: a power wheelchair, mechanical patient lifts, infection control carts containing clean equipment, and standard wheelchairs. In some areas, the equipment limited a wheelchair and an individual to pass in	F 323	Staff has been educated on the importance of keeping the hallways free of clutter and the handrails accessible to residents. All residents have the potential to be affected. We have increased the use of over-the-door bags for isolation equipment and removed carts that had been utilized to hold the equipment. Staff has been instructed to fold wheelchairs up when not in use and either place in the residents' room or the locker room (for the east units only). Linen carts are to be put in the shower room/or dirty linen room when not in use. Other equipment is to be stored in appropriate places when not in use. Hallways are to be checked throughout the day and evening shifts to ensure that the hallways are kept clear. The nurse is to sign the QA form for that shift that the hallway has been in compliance with the standard. This is to be done on a daily basis. Date for completion: April 11th, 2012	

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F 323	Continued From page 54 opposite directions at the same time. Observations on the 3 East unit throughout each day of the survey identified equipment stored in the halls as observed during the initial tour. - Observation during the initial facility tour on the 2 East resident care unit, on 03/12/12 at 10:50 a.m., identified a bed and equipment stored on both sides of the hallways, including: mechanical patient lifts, infection control carts containing clean equipment, clean linen carts, and wheelchairs. The bed remained in the hallway through 03/14/12. Observations showed the remainder of the equipment remained in the hallway on all days of survey. - Observation on the 3 South resident care unit, on 03/13/12 from 2:45 p.m. to 6:00 p.m., and on 03/14/12 from 4:30 p.m. to 6:00 p.m., identified a covered clean linen cart and two carts containing three hampers each for soiled facility linen, soiled resident's personal clothing, and garbage. These carts were placed along one wall in the hall outside resident rooms, including during the residents' evening meal. - Observation during the environmental tour, on 03/15/12 at 9:30 a.m., identified the equipment in the halls on the 3 East unit. Observation also identified similar equipment in the halls on the 2 East unit. During interview while on the environmental tour, an environmental services management staff member (#8) confirmed the equipment should not be kept in the halls except during immediate resident care needs.	F 323		

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F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview, and staff interview, the facility failed to ensure each resident's medication regimen was free of unnecessary drugs when used in excessive dose (duplicate therapy), without adequate monitoring, without adequate indications for their use, and in the presence of adverse consequences, for 1 of 1 sampled	F 329	Resident #9's physician updated on April 2, 2012 regarding resident behavior and drug requests. Orders were received and observed to discontinue the oxycodone, consult psychiatry, and hold Ambien. This is has the potential to affect all residents During pharmacist monthly review, the pharmacist will identify any resident who is taking psychoactive, sedative/hypnotic and narcotics and determine if these medications are being given less than one hour apart from each other. Those identified residents names will be given to the Unit Managers who will send an update to the physician for medication review. If a resident requires a pain medication non-narcotics will be given before narcotics are given. Inservice on pain management and unnecessary drugs has been given to staff QA will be ongoing and will be reported monthly to the QA committee. The Pharmacist and the DON will be responsible for this process Date of Completion: April 13, 2012	-

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F 329	Continued From page 56 resident (Resident #9) receiving a sedative-hypnotic, an opioid pain reliever, and an anti-anxiety medication at the same time. Failure to ensure the medication regimen is free of unnecessary drugs limited the facility staff's ability to determine the effectiveness of any of the medications, limited the physician's ability to ensure the appropriateness of the medications, and limited Resident #9's ability to reach or maintain her highest practicable mental, physical, and psychosocial well-being possible. Findings include: Review of Resident #9's medical record occurred on March 13-15, 2012. The facility readmitted the resident in November 2011 after hospitalization following a right arm fracture. Current diagnoses included backache, history of pathological vertebral fracture, psychosis, post fracture right arm (11/25/11), insomnia, history of epilepsy, dementia, anxiety, and depression. The significant change Minimum Data Sets (MDSs), dated 12/02/11 and 02/22/12, identified the resident was cognitively intact, demonstrated fluctuations in disorganized thinking, mild depression (12/02/11), and minimal depression (02/22/12). The MDSs also identified pain on a scale of 0 to 10, with 0 being no pain and 10 being most severe pain, 12/02/11 - frequent pain to a level "9" affecting sleep and activities, and 02/22/12 - occasional pain to a level "10" affecting sleep. Resident #9's current physician orders included the following psychoactive and pain relief medications and their classifications: *Prozac 60 milligrams (mg), one time every day.	F 329		

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F 329	Continued From page 57 (anti-depressant) *Seroquel 50 mg, three times every day. (antipsychotic) *Abilify 2 mg, every day. (antipsychotic) *Oxycodone 5 mg, every three hours, as needed (prn), ordered 11/25/11. (opioid pain reliever) *Lorazepam 1 mg every 12 hours, prn, ordered 11/25/11. (anti-anxiety) *Ambien 10 mg, no more than three times each week, prn, ordered 01/25/12. (sedative-hypnotic) *Tylenol Extra Strength 500 mg, every six hours, prn, ordered 03/05/12. (non-narcotic pain reliever) *Discontinued 03/05/12 - Tramadol 50 mg, every eight hours, prn, ordered 01/31/12. (opioid pain reliever) Resident #9's Pain Assessment, dated 01/20/12, identified daily indicators of pain including non-verbal sounds, vocal complaints, facial expressions, and protective body movements/postures. Pain assessment documentation, dated 01/21/12, identified the resident frequently requested pain medications and Lorazepam; the physician was aware of her requests; and, the physician did not want to increase her medications. The Pain Care Area Assessment, dated 02/24/12, identified the resident reported a pain level of "10" which interfered with her sleep and the physician was aware of her complaints. Resident #9's medical record included psychiatric consultations every two to three months, most recently on 01/20/12. The psychiatric consultation notes indicated monitoring medications and considering reducing the Seroquel on the next visit, anticipated in two months, approximately 03/20/12.	F 329		

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Resident #9's current care plan identified the following:
*02/24/12, "Problem, Behavior-Hx. [History] of occasional episodes of being sad, crying, mood changes . . . sarcastic remarks towards staff and residents. . . . Approach [psychoactive medications previously listed]."
*03/07/11, "Problem, Cognitive Deficits-alert and oriented, intermittent confusion r/t [related to] disease process, Goal . . . Resident will accept reminders and cues when exhibiting forgetfulness . . ."
*12/08/09, "Problem, Pain-chronic pain, Goal . . . Will appear relaxed and able to perform ADLs [activities of daily living] . . . Approach, Oxycodone . . . Voltaren 1 Transdermal Gel to painful areas of body . . . 4 times daily PRN . . ." The care plan lacked other interventions regarding back pain.

Resident #9's nurse's notes medication administration record (MAR)regarding medication administration for the period March 01-14, 2012 identified the facility staff administered medications as follows:
*03/03/12, 8:15 p.m. - Tramadol 50 mg - generalized pain, pain scale "8/10"
8:45 p.m. - Lorazepam 1 mg - ". . . anxiety, no outward signs . . ."
*03/05/12, 9:00 p.m. - Ambien 10 mg, insomnia
9:00 p.m. - Lorazepam 1 mg, ". . . anxiety, no outward signs . . ."
*03/06/12, 12:30 p.m. - "Resident c/o [complains of] back pain. MD [Physician] ordered try tylenol [sic] before using oxycodone. . . ."
*03/07/12, 2:40 p.m. - Oxycodone 5 mg, back

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F 329	Continued From page 59 pain, grimacing, pain scale "7/10". *03/08/12, 1:04 a.m. - Ambien 10 mg, difficulty sleeping 1:04 a.m. - Oxycodone 5 mg, back pain, grimacing, pain scale "7/10". 6:44 a.m. - Lorazepam 1 mg, restless 9:17 p.m. - Oxycodone 5 mg, back pain, pain scale "7/10". 9:18 p.m. - Ambien 10 mg, requested for sleep *03/09/12, 11:05 p.m. - Oxycodone 5 mg, back pain, pain scale "8/10". 11:50 p.m. - Lorazepam 1 mg, anxious about talk with husband *03/10/12, 5:30 p.m. - Oxycodone 5 mg, generalized pain, facial grimace, pain scale "9/10". *03/11/12, 9:00 p.m. - Ambien 10 mg, insomnia 9:00 p.m. - Lorazepam 1 mg - ". . . anxiety, no outward signs . . ." *03/12/12, 6:45 p.m. - Oxycodone 5 mg, left shoulder pain, grimacing, pain scale "7/10". *03/13/12, 11:03 a.m. - Oxycodone 5 mg, leg pain, pain scale "8-9/10". 8:59 p.m. - Ambien 10 mg, resident request 9:01 p.m. - Lorazepam 1 mg, resident request *03/14/12, 8:17 p.m. - Lorazepam 1 mg, ". . . anxiety, no outward signs . . ." 8:18 p.m. - Oxycodone 5 mg, generalized pain, facial grimace, pain scale "8/10". The nurse's notes and the MAR lacked evidence the facility staff attempted Tylenol before administering the Oxycodone on eight occasions, 03/07, 03/08 at 1:04 a.m. and 9:17 p.m., 03/09, 03/10, 03/12, 03/13, and 03/14. The nurse's	F 329		

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(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 329	Continued From page 60	F 329		

notes identified the facility staff administered the sedative-hypnotic or anti-anxiety medication or opioid pain relievers at the same time on eight occasions in the 14 day period.

Observation on the morning of 03/14/12 showed Resident #9 sat at the edge of her bed to eat her breakfast at 8:10 a.m., then laid on her bed and slept until the noon meal at 11:53 a.m. At 9:45 a.m., a licensed nurse (#32) reported the resident "Sleepy today."

During random observations on March 13-14, 2012, Resident #9 reported having increased right leg pain described as "sciatica" which she reports having in the past. She reported the medications provided by the facility staff do not always provide relief. The resident indicated a desire for physical therapy treatment regarding the "sciatica." The medical record lacked any information regarding treatment for the "sciatica."

During interview, on 03/14/12 at 4:45 p.m., Resident #9 reported the pain medications received the previous evening did not provide relief. The medical record identified the resident received Extra Strength Tylenol 500 mg at 4:23 p.m., Oxycodone 5 mg at 6:05 p.m., Ambien 10 mg at 8:59 p.m., and Lorazepam 1 mg at 9:01 p.m. on 03/13/12.

During interview, on 03/14/12 at 11:00 a.m., a supervisory nursing staff member (#12) and a management nursing staff member (#16) reported facility staff provide Resident #9 with medications as ordered by her physician. Additional information regarding administration of Resident #9's medications was requested at this

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	355074	A. BUILDING _____ B. WING _____	03/15/2012

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F 329	Continued From page 61 time. The facility staff did not provide additional information. Resident #9 received psychoactive and pain medications as ordered by her physicians. For the period March 06-14, 2012, the facility staff provided opioid pain medications eight times without trying Tylenol first, as ordered. On eight additional occasions the facility staff provided Lorazepam or Ambien or an opioid pain reliever within 45 minutes of the other medication placing Resident #9 at risk of central nervous system depression. The medical record lacked information the facility staff informed Resident #9's physician of the increased medications provided, despite the physician's documented desire to avoid an increase in medications. These failures resulted in Resident #9 receiving unnecessary medications.	F 329		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431		

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F 431	Continued From page 62 In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: 1. Based on observation, professional reference review, record review and staff interview, the facility failed to ensure the labeling of medication containers in accordance with the physician order for 1 of 1 eye drop (Resident #33) and 1 of 6 insulins (Resident #34) randomly observed during medication pass. Findings include: Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 9th Edition, dated 2012, page 904, states, "Administering Ophthalmic Instillations . . . Preparation 1. Check the MAR [medication administration record]. Check the MAR for the drug name, dose, and strength. Also confirm the prescribed frequency of the instillation and which eye is to be treated. . .	F 431	Resident #33, 34 have had medications labeled to reflect the correct orders on the MAR. Education was provided to staff on the correct process for administration of medications. All residents have the potential to be affected. Staff has been educated on the correct process for administrating medication. Staff will be randomly observed during a medication pass for following the correct steps and processes. Staff has been educated on the process for obtaining new labels on medications if an order is changed. Pharmacies that supply medications to Trinity Homes will be responsible for putting the new label on the medication. Weekly QA will be done on random medication passes to ensure staff is following correct procedures. This will be done until 100% compliance is achieved for 3 consecutive months. QA will be completed monthly and all audits will be reported to the monthly QA committee. Weekly QA will be conducted to ensure that the new label is placed on medication that has been changed by the pharmacy supplying the medication until compliance is achieved at 100% for 3 consecutive months, and then audits will be done monthly. All audits will be reported to the monthly QA committee. Completion date is April 12, 2012. DON is responsible for this process.	

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F 431	Continued From page 63 Performance 1. Compare the label on the medication tube or bottle with the medication record . . ." - Observation during medication pass on 03/13/12 at 11:07 a.m., showed a nursing staff member (#4) administered a drop of Pilocarpine 2% in Resident #33's left eye. Review of the label on the Pilocarpine eye drops identified administration of the drop four times per day to each eye. Review of Resident #33's electronic medication administration record (MAR) identified the eye drop to be administered to the left eye. Review of the resident's medical record identified a physician order, dated 01/19/12, for Pilocarpine 2% eye drops four times per day to left eye only. The label did not match the physician order. The nursing staff member (#4) confirmed the label directions on the bottle of Pilocarpine eye drops did not match the MAR at the time she administered the eye drop. Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 9th Edition, dated 2012, page 878, states, "Preparing Medications . . . Check the MAR, Check the label . . . carefully against the MAR to make sure that the correct medication is being prepared. Follow the three checks for administering medications. Read the label on the medication (1) when it is taken from the medication cart, (2) before withdrawing the medication [from the vial], and after withdrawing the medication. . . ." - Observation during medication pass on 03/13/12 at 11:15 a.m., showed a nursing staff member (#4) administered Novolog Insulin 12 units subcutaneous in Resident #34's abdomen.	F 431		

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F 431	Continued From page 64 Review of the label on the bottle of Novolog Insulin identified administration of 8 units three times a day with meals. Review of Resident #34's electronic MAR identified the dosage of the Novolog Insulin as 12 units subcutaneous three times a day. Review of the resident's medical record identified a physician order, dated 02/23/12, for Novolog 12 units three times a day. The label did not match the physician order. The nursing staff member (#4) confirmed the label directions on Resident #34's vial of insulin did not match the MAR at the time she administered the insulin injection. During an interview on 03/15/12 at 9:50 a.m. an administrative nursing staff member (#2)stated staff should contact the pharmacy to get a new label when the dosage of a medication changes. 2. Based on observation, review of professional literature, and staff interview, the facility failed to date multi use insulin vials/pens when opened and failed to discard the insulin when opened beyond the recommended time frames in 1 of 7 nursing units (3E). Failure to record the open date on the vials/pens and to ensure a current date prior to administering insulin allows use beyond the recommended discard time frames. This practice may affect the potency and sterility of the insulin. Findings include: Diabetic Care, Volume 26, Number 9, September, 2003, pages 2666-2667, "How Long Should Insulin Be Used Once a Vial Is Started?" states, ". . . Insulin products are sterile until the first dose is withdrawn by syringe. . . After first	F 431	Expiration dates on insulin Expired vials of insulin have been removed and discarded from the 3E medication refrigerator. Staff has been educated on the policy "Insulin Labeling/Discard Dates, and Disposal of Insulin Vials". Staff that gave expired insulin have received an Education/Counseling sheet. All residents receiving insulin have the potential to be affected. A policy was developed that addresses insulin labeling/discard dates, and disposal of insulin vials. Staff on all units have been educated on this policy. Weekly QA will be conducted to ensure that insulin is being discarded after 28 days. Once compliance is achieved, audits will be done monthly. All audits will be reported to the monthly QA committee. The DON is responsible for this process. Completion Date: April 11, 2012	

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F 431	Continued From page 65 use, the contents of the vial . . . are technically no longer sterile . . . Sterile products should be used in as short a time as possible to minimize concerns about microbiological contamination once the container has been punctured. The CPMP [Committee for Proprietary Medicinal Products] has proposed a maximum-use period of 28 days for sterile products . . . including insulin products. . . . Although an expiration date is stamped on each vial of insulin, a loss of potency may occur after the bottle has been in use for > 1 [more than 1] month . . . changes in insulin action can lead to significant changes in blood glucose control." Observation of the 3E medication refrigerator occurred on 03/15/12 at 9:30 a.m. with a registered nurse (#26). The refrigerator contained the following: * Two insulin vials used beyond the maximum-use period (dated 02/12/12 and 02/13/12) * One insulin pen with an unreadable open date * Five insulin vials/pens with no open date identified During an interview on the morning of 03/15/12, an administrative nurse (#12) agreed staff should label insulin vials and insulin pens with the open date and discarded after 28 days. The facility did not provide a policy and procedure related to insulin labeling or disposal.	F 431		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.	F 502		

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F 502	Continued From page 66 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure completion of laboratory tests for 1 of 1 sampled resident (Resident #10) whose laboratory tests were not completed as ordered. Failure to complete Resident #10's potassium level laboratory test as ordered resulted in the facility provided the physician inaccurate information, limited the physician's ability to ensure the quality and appropriateness of care, and placed Resident #10 at risk of illness related to high or low potassium levels. Findings include: Review of Resident #10's medical record occurred on March 13-15, 2012. The facility re-admitted the resident in January 2012 after an acute hospitalization related to pneumonia. Current medical diagnoses included atrial fibrillation and chronic kidney disease. Resident #10's physician orders for medications included: *Lasix 40 milligrams (mg), one tablet, every day, ordered 01/07/12. *Hydrochlorothiazide 12.5 mg, one tablet, every second day, ordered 01/07/12. *Potassium 10 milliequivalents (meq), two times every day for three days (March 04-06, 2012), then once daily, ordered 03/03/12. Resident 10's physician orders for laboratory tests included: *Potassium level, 03/02/12 and repeat in one	F 502	Resident #10's provider was contacted regarding the incorrect timing of the lab draw and orders were received. This has the potential to affect all residents. After the order has been received from the provider, the lab test is ordered and the date for the test is placed on a calendar. The ward clerk checks to make sure the lab work is ordered and completed on the date required. QA will be done weekly until compliance is achieved, and then monthly. The DON is responsible for this process. Date for completion is April, 15th 2012.	

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F 502	Continued From page 67 week (03/09/12). Resident #10's medical record included the following potassium laboratory test results: *03/02/12, "3.1 meq/L [per liter] Normal (3.6-5.0)" *03/05/12, "4.3 meq/L Normal (3.6-5.0)" The resident's medical record lacked evidence the facility staff completed a potassium laboratory test on 03/09/12 as ordered, or after 03/05/12. Completion of the potassium laboratory test on 03/05/12 while Resident #10 received potassium chloride two times every day resulted in an elevated level. Failure to complete the test after the potassium chloride medication was reduced to one time every day, as ordered on 03/09/12, did not provide accurate laboratory information for the physician and placed Resident #10 at risk of cardiac complications. During interview, on 03/15/12 at 2:00 p.m., a supervisory nursing staff member (#12) confirmed the facility staff failed to follow the physician's orders regarding the laboratory test for potassium.	F 502		