STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355094	A. BUILDING _____ B. WING _____	04/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MOHALL	602 E MAIN ST MOHALL, ND 58761

(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 04/16/12 and completed on 04/19/12, the sample included three (3) residents for complete review, nine (9) residents for focused review, and one (1) closed record for review. The sampled included six (6) additional residents to verify specific concerns during the survey.	F 000		
F 224 SS=G	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed for 2 of 2 sampled residents (Resident #2 and #6) who exhibited wandering, physical, and abusive behaviors to: 1. Implement the facility's own policy to identify residents and/or situations with potential for the occurrence of injury, prevent resident to resident injury, and protect residents from recurring resident to resident injury. 2. Adequately assess resident behaviors, including monitoring for patterns/trends, causative factors, including time, place, persons involved, happenings prior to and at the time of the behavior, and implement appropriate interventions to prevent behaviors from	F 224	F224: Prohibit Mistreatment/ Neglect/Misappropriation: 1. A. Resident #2 's wife was given a 30 day notice due to Resident #2's physical aggression on 4/19/2012. LSW and DON continued to make calls to facilities for alternative placement. The wife had a list to call a number of foster care facilities. His wife chose to take him home on 4/20/2012. Dr. C. Swenson gave telephone orders that he could go home with current meds. B. Resident #6: Revised current plan of care for nursing/ activities to increase staff involvement and use of activity box on 4/30/2012. 2. All residents with physical/verbal aggression have the potential to be affected.	5/20/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Scott Schroeder	ADMINISTRATOR	5/16/12

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

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F 224	Continued From page 1 escalating. 3. Monitor the effectiveness of interventions and revise interventions as appropriate. 4. Implement an interdisciplinary approach to address behaviors which have the potential to result in resident to resident altercation. Failure to adequately assess and monitor residents' behaviors and implement effective interventions or evaluate current interventions to prevent further behaviors resulted in other residents being victims of physical, verbal, and mental abuse. Findings include: Review of the facility policy titled "Abuse and Neglect" occurred on 04/19/12. This policy, revised January 2011, stated: "Purpose: * To ensure that the center has in place an effective system that, regardless of the source, prevents mistreatment, neglect and abuse of residents . . . * To ensure that residents are not subjected to abuse by anyone, including, but not limited to, center staff, other residents . . . * To identify and remedy any abusive situations. * To prevent future injuries . . . * To identify events, such as . . . occurrences, patterns and trends that may constitute abuse and to determine the direction of the investigation . . . Procedure: . . . B. If it is an allegation of resident to resident abuse, the residents will be immediately separated and both assured a safe environment . . ."	F 224	3. A. Behavioral Causes and Interventions Procedure will be reviewed with Nursing and Activities Staff 5/10/2012 thru 5/16/2012. B. Educate Staff in the revised care plan for Resident #6 on 5/10/12 thru 5/16/2012. C. Will increase our Behavior Management meetings to 2x a month following Care Plans to closer monitor behaviors exhibited by residents. 4. A. The nursing staff will audit to see that Care Plan interventions for Resident #6 are being carried out weekly x 2, then in 2 weeks, and then monthly x 2; and then random audits as needed. B. The LSW will audit through observation of staff caring for Resident #6 weekly x 2, then in 2 weeks, then monthly x 2, and as needed.	

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F 224	Continued From page 2 Review of the facility policy titled "Abuse Definitions" occurred on 04/19/12. This policy, revised January 2011, stated, ". . . Definitions: . . . Verbal Abuse: Any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents . . . Physical Abuse: Includes hitting, slapping, pinching, kicking, etc . . . Mental Abuse: Includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation . . ." - During the initial tour of the facility's south unit on 04/16/12 at 11:15 a.m., a staff member (#2) stated the residents who require more care and supervision live on the south unit. Observation on all days of survey showed Resident #2 walked independently throughout the facility with the aid of a front-wheeled walker and lived on the south unit. Review of Resident #2's medical record occurred on all days of survey. The facility admitted the resident June 2011. Diagnoses included Alzheimer's disease and dementia with behavioral disturbances. Medications included Namenda (used to treat moderate to severe Alzheimer's disease) 10 milligrams (mg) twice a day. Review of Resident #2's quarterly Minimum Data Set (MDS), dated 01/16/12, identified both long and short term memory difficulties, physical and verbal behaviors exhibited four to six days a week, supervision of one staff member for locomotion on and off the unit, and wandering one to three days a week. Resident #2's current care plan identified the	F 224		

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F 224	Continued From page 3 following: "Problem: Sexually inappropriate behavior R/T [related to] dx [diagnoses] of dementia . . . Goal: Will have less than one episode of sexually inappropriate behavior per day. Approaches: . . . * Provide guidance, set limits &[and] redirection in calm voice. Remove him from situations . . . Problem: Verbal and physical aggression R/T dementia w/ [with] behavioral disturbances M/B [manifested by] acute agitation, poor impulse control, incompatibility with other residents and wandering. Goal: [Resident #2] will have less than one combative behavior per day. Approaches: * . . . approach with caution. Use firm, kind, calm approach with low soft tone of voice and smile. * Agitated behaviors - escort [Resident #2] to calm and quiet environment. * Anger - Keep [Resident #2] away from residents that are loud, making loud repetitive noises, or are continually calling out. * Contact wife about [Resident #2's] inappropriate behaviors . . . Assist [Resident #2] to engage in independent activities in common areas. * Provide diversion as situation warrants such as providing a baby doll to hold and comfort, walk outside, deck of playing cards to sort, balloon toss or Lawrence Welk. . . Problem: Ineffective Ind. [individual] coping R/T cognitive impairment M/B verbal/physical aggression during meal time. Goal: Will not have any episodes of behavior during meal time. Approaches: 1) Try to limit how early he goes up to dining room. 2) When he goes to dining room, Take him to his	F 224		

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F 224	Continued From page 4 assigned seat. 3) If uncooperative [after] redirection he may have to eat in hobby room . . ." Review of Resident #2's progress notes, physician notes, and incident details identified the following: * 08/11/11 (physician note) - ". . . cont [continues] to pace the halls attempting to enter other residents rms [rooms] . . . Freq [frequent] verbally and physically aggressive [with] cares . . . No changes." * 08/12/11 (incident detail) - "[Resident #2] tried to take a chair check away from another resident when she was giving it to a CNA [certified nursing assistant] & squeezed the other resident's arm." * 09/08/11 (physician note) - ". . . Stable . . ." * 10/12/11 at 5:30 a.m. (progress note) - "Noted [Resident #2] to be holding on to another residents wrist. Staff intervened et [and] [Resident #2] let go of wrist." * 10/13/11 at 3:30 p.m. (incident detail) - "[Resident #2] hit [female resident] on her left arm as she tried to pass him at the south nurses station. She had bumped into him with her w/c [wheelchair] - she was not aware of it. [Resident #2] did not explode when he hit resident from [room number] but did deliberately hit her." * 10/19/11 at 6:10 p.m. (progress note) - ". . . When [Resident #2] got close enough to other resident he punched him two times in right arm . . . other resident stated 'he is trying to kill me.'" * 10/21/11 at 2:00 p.m. (progress note) - "CNA reported that while redirecting [Resident #2] verbally from another female resident that he struck her [with] his hand twice - once to her breast and once to her arm . . ." * 10/23/11 at 11:05 a.m. (incident details) -	F 224		

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F 224	Continued From page 5 "[Resident #2] hit a fellow resident in Rt [right] arm then proceeded to hit the Nsg [nursing] Home Staff." * 10/24/11 at 9:00 a.m. (progress note) - "[Resident #2] approached a female resident and was shaking her arm . . ." * 10/24/11 at 12:00 p.m. (progress note) - "[Resident #2] yelled '[profanity].' The male resident swore at him & they yelled at each other for a moment before [Resident #2] left the room." * 10/24/11 (social worker progress note) - ". . . met with [Resident #2's spouse] to discuss [Resident #2] current physical and abusive behaviors . . . discussed resident safety and alternatives for [Resident #2] if discharged from G.S.S. [Good Samaritan Society] . . . Team and staff will continue to observe [Resident #2's] behaviors and monitor safety of residents . . ." * 10/25/11 at 10:00 a.m. (progress note) - ". . . Does have special interest & attraction to a specific resident here. Has came close to her - but has not touched her today . . ." * 10/29/11 at 8:00 p.m. (incident details) - "[Resident #2] was attempting to push the w/c of a female resident. She became upset, yelling, [Resident #2] was swearing and when she yelled, he reached his hand over her head bringing his palm down over her face and eye glasses and pulled her backward." * 10/30/11 (progress note) - "Call received from [physician name] re: [regarding] incident report last evening. He understands the severity of his behaviors [with staff & other residents . . . has tried antipsychotics [without] success . . . orders to [increase] Namenda to 10 mg BID [twice a day] . . ." * 10/30/11 at 7:45 p.m. (incident details) - "[Resident #2] was standing in front of a female	F 224		

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F 224	Continued From page 6 residents w/c. She yelled and staff noted that she was holding her upper lip [with] swelling et blood noted. She stated 'he hit me.'" * 11/12/11 at 7:35 p.m. (incident details) - "Res [Resident] hit staff member x [times] 2 when staff was trying to redirect." * 11/30/11 at 4:30 p.m. (incident details) - "[Resident #2] went up to another resident & hit her arm." * 12/04/11 at 7:50 p.m. (incident details) - "[Resident #2] standing with walker, grabbed female residents pajama top during a conversation with her. When told to stop he did." * 02/25/12 at 1:25 p.m. (incident details) - "[Resident #2] had hold of [resident initials] Rt arm and was holding it up in the air . . ." * 03/12/12 at 7:30 p.m. (incident details) - Resident to resident incident in which physical contact made. * 03/25/12 at 8:45 p.m. (incident details) - Resident to resident incident in which physical contact made. * 04/08/12 at 7:02 p.m. (incident details) - "[resident room number] was sitting in her chair and slapping the tray and [Resident #2] was walking like he was going to go around her but instead he punched her 2 x on her left bicep. On the 2nd punch she said 'ow' at which point I was able to step between them and divert [Resident #2] elsewhere." * 04/08/12 at 7:30 p.m. (incident details) - "Res punched staff in stomach." * 04/14/12 at 5:05 p.m. (incident details) - Resident to resident incident in which physical contact made. * 04/16/12 at 9:30 p.m. (incident details) - "staff assisting res out of [another resident's room number]. Res hit staff . . ."	F 224		

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F 224	Continued From page 7 During an interview on 04/18/12 at 11:05 a.m., two administrative staff members (#6 and #15) stated because of Resident #2's aggressive behaviors, they are concerned about the welfare of the other residents who reside in the nursing facility. Failure of the facility to monitor, track, and trend Resident #2's behaviors and thoroughly assess the causative/precipitating factors leading up to, or resulting in the resident's aggressive and abusive behavior, develop and implement effective interventions (proactive approach versus reactive), as well as revise them as necessary; resulted in numerous altercations and harm to other residents. Record review identified Resident #2 abused other residents both physically and verbally, and observation during the survey showed the resident walked independently throughout the facility. These factors all contribute to the potential for Resident #2 to seriously injure another resident and/or for another resident to cause serious harm to Resident #2. - Review of Resident #6's medical record occurred on April 16-19, 2012. Diagnoses included lacunar infarct (stroke), malignant neoplasm of the cerebrum (cancer), dementia, psychosis, and sexual behaviors. Current medications for Resident #6 included: Ativan (used for anxiety/agitation), Prozac (used for depression/panic disorder), and Risperdal (used for irritability/aggression). The quarterly Minimum Data Set (MDS), dated 03/09/12, identified Resident #6 had long and short term memory problems, moderately	F 224		

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F 224	Continued From page 8 impaired daily decision making skills, continual inattention and/or disorganized thinking, behavioral symptoms, and independent with locomotion on/off unit. The Resident Care Area Assessment (CAA), dated 06/09/11, stated, ". . . These are [sic] not the first time wandering behaviors have occurred. . . ." The current care plan, dated 03/15/12, identified, " . . . Problem: Potential for verbal and physical aggression . . . Approaches: Use a firm/kind/calm approach. Escort [Resident #6] to an environment that reduces agitation and provides a sense of safety and security. Assist to identify causes of anger. Listen and provide support when [Resident #6] expresses thoughts and feelings. Staff to monitor [Resident #6's] wandering. Redirect [Resident #6] to supervised areas if found in other residents room or wandering the halls. Report [Resident #6's] verbal and physical behaviors to charge nurse. Staff to document aggressive behaviors. All staff to monitor [Resident #6's] wandering. Encourage [Resident #6] to stay in dinning [sic] area thru [through] out meals do [sic] to his sundowing [sic] behaviors and excessive wandering. Escort and encourage [Resident #6] to participate in evening activities or engage in independent activities in common area." In addition, the current care guide identified, "Independent Ambulatory. Secure Care. Bed check - silent [at] night." The "Interdisciplinary Progress Notes" identified the following: * 05/10/11, ". . . he gets up in staff faces . . ." * 05/18/11, ". . . [Resident #6] became physically aggressive - grabbing CNA's hands [and] arm [and] started pushing [and] shoving CNA . . ."	F 224		

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F 224	Continued From page 9 * 06/01/11, ". . . Today a male resident found that [Resident #6] had been in his room - [Resident #6] had pulled out his large liner [incontinent product] that was soiled [with] bm [bowel movement] [and] left it in that residents [sic] garbage can. - That other resident is very upset, does not want [Resident #6] even to walk in that hallway. [Resident #6] does let us redirect him [and] guide him. . . ." * 06/18/11, "Pacing up [and] down halls [and] entering rooms/agitated [and] redirects poorly . . ." * 07/26/11, "Res [Resident] up wandering in/out of res room [sic]. Redirected often. Medicated x 1 for agitation. Res cont. [continues] to wander and redirected to room. Resting in his room at 11:30 p." * 08/18/11, "Noting increased wandering today. Repeatedly removed from other resident rooms. Restless . . . Medicated [with] Ativan to [decrease] anxiety [and] agitation. . . . Brow was furrowed as well as forehead. He attempted to kick CNA as they toileted him. He has had more anger . . ." * 09/02/11, "Res wandering in and out of female res [sic] rooms. Mult [multiple] female rooms wandering into. Redirects from behavior poorly. Refused prn [as needed] med [medication] when offered. Female res states feeling scared of res. Res even used female res bathroom. Female res unable to [sic] res to leave." * 09/05/11, "Has been wandering all day today in and out of residents rooms. . . . Does redirect somewhat. . . ." * 09/06/11, "[Up] x 1 tonight in another residents room not easy to redirected [sic] . . ." * 09/14/11, ". . . later found taken clothes off left them on nurses station along with brief found	F 224		

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F 224	Continued From page 10 wandering rooms . . ." * 09/19/11, "Continuous wandering in and out of others rooms - not easily directed. . . ." * 10/06/11, "Has slept poorly . . . wandering up [and] down halls looking in other residents rooms - agitated [and] anxious - redirection unsuccessful. . . " * 10/20/11, "[Resident #6] was approached by another resident on 10-19-11 and was cornered by resident. Resident proceeded to punch [Resident #6] in upper right arm 2x. S.W. [Social Worker] was present and redirected resident away from [Resident #6] . . ." * 10/30/11, "Constantly wanders hallways at times goes into others [sic] rooms able to redirect." * 11/01/11, "Restless evening ambulating hallways and in and out of others [sic] rooms . . . easy to redirect." * 11/13/11, ". . . he suddenly became resistive and then raised his arm up and tried to pin staff member against the wall . . . began to wander, not redirectable going into resident rooms. Needed 1:1 supervision. . . ." * 11/25/11, "assisted [Resident #6] [with] replacing dry pullups . . . [Resident #6] stated, 'I should just slap the hell out of you' and clapped his hands." * 12/12/11, "CNA entered a female resident's room and witnessed [Resident #6] slapping female resident on [left] side of face. Female resident stated she had entered her room to find [Resident #6] lying in her bed - that when she questioned him, he slapped her. [Resident #6] was easily directed from room . . ." * 12/13/11, "DON (Director of Nursing), S.W. and Administrator met to discuss incident on 12-12-11. . . . CNS (Certified Nursing Staff), RN (Registered Nurse) stated [Resident #6]	F 224		

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F 224	Continued From page 11 demonstrating wandering but from report views as isolated incident. . . . S.W. will continue to monitor behaviors. . . ." * 12/15/11, ". . . He grabbed ahold of CNAs wrist [and] stated, 'Watch out or I will beat the shit out of you.'" * 12/28/11, ". . . refusing assist from staff making threatening comments 'Watch it or I'll knock your brain out' [and] attempting to hit strike [at] other staff. . . ." * 01/05/12, ". . . Is wandering in [and] out of other residents [sic] rm [room] [sic]. Is difficult to redirect. . . . Had went into another resident rm [and] shut the door. When staff tried to open the door he blocked it then was reported that he slapped at CNA. . . ." * 01/12/12, ". . . [Resident #6] cont [continued] to smile [and] then grabbed the back of CNA's neck [with] aggressive manner [and] then let go. . . ." * 01/18/12, "Unable to locate res. Search of [facility] completed by CN [Certified Nursing Staff]. Res located in [room number's] bed, lying on bed. Asst [assist] [two] to redirect out of room. Notable agitation obs [observed] [with] moving of res out of [room number]. . . ." * 01/28/12, "Heard CNA call for help - went to [Resident #6's] room - he had CNA in a head lock [and] a hold of her Rt [right] forearm [and] would not let her go. . . ." * 01/31/12, ". . . was wandering in [and] out of other resident's rooms - unable to redirect - ripping chair pad [and] pulling wipes out of container . . ." * 02/01/12, ". . . [Resident #6] refused - pushing staff away . . ." * 02/02/12, "9:30 p noted [Resident #6] to be wandering in [and] out of other resident's rooms . . . very restless this afternoon. Found in a bed in	F 224		

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F 224	Continued From page 12 a ladies room. Also, was found going out the front door by CN who responded to alarm. It took 3 staff to remove him from the area. . . ." * 03/10/12, "[Resident #6] was found on another residents bed laying down. 2 ladies tried to redirect him to dinning [sic] room. He refused his dinner d/t agitation. Tried calm approach [with] him but still very agitated [and] aggressive [with] the aides . . ." * 04/01/12, "[Resident #6] pacing halls in a jogging speed. He also goes into other residents' rooms. . . . Tried to redirect [with] activity but wanted nothing to do [with] that." * 04/10/12, " . . . redirection unsuccessful . . . carrying shaver cord around . . ." Observation revealed the following: * 04/17/12 at 12:25 p.m., Resident #6 wandered the hallways and into other residents' rooms. He spent up to 5 minutes in some rooms. An unidentified nursing staff member noticed the resident in the hallway with the surveyor, and walked him to the lounge and assisted him into a recliner. Staff made no attempts to engage Resident #6 in any independent activities. Interviews with the direct care staff revealed the following: * 04/17/12 at 1:55 p.m., a CNA (#4) stated, "[Resident #6] was wandering in/out of other residents rooms [minutes before]." She "walked him to the lounge and assisted him into a recliner." * 04/17/12 at 4:05 p.m., a CNA (#5) stated, "I found [Resident #6] in a female resident's room [minutes before]. (The female resident was identified by the facility as being non-interviewable.) He was lying on her bed. She	F 224		

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F 224	Continued From page 13 was very angry. He was not aggressive, even though she was yelling at him." The CNA (#5) further stated she was able to "redirect him back out of her room." During an interview on 04/19/12 at 9:00 a.m., when asked what the facility has done to discourage Resident #6 from entering other residents' rooms, an administrative nursing staff member (#2) stated, "Some residents close their door, some have brown strips . . . certain residents have requested them." She did not respond when asked what the facility has done to discourage Resident #6 from entering the rooms of residents who are unable to request a brown strip or their door be closed. Failure of the facility to implement/revise effective interventions resulted in Resident #6's wandering and/or altercations with other residents. Record review and observation identified Resident #6 has wandered into other residents' rooms, availed himself of their beds and/or toilets, disturbed items within their rooms, and slapped a resident. Record review and staff interview identified other residents have stated they are "very upset, angry and/or afraid" of him. These factors all contribute to the potential for Resident #6 to injure another resident and/or for another resident to cause harm to him.	F 224		
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.	F 280		

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F 280	Continued From page 14 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 plans (which included Care Guides) for 4 of 12 sampled residents (Resident #3, #4, #8, and #10). Failure to revise the care plan as the residents' status changes has the potential to affect staff's understanding of the residents' problems and required interventions, limits the staff's ability to communicate resident care issues, and may lead to lack of or inconsistency in the care provided. Findings include: Review of the facility policy titled "Comprehensive Care Plan and Care Conferences" occurred on 04/19/12. This policy, dated 2010, stated, ". . . Care plans are to be reviewed with each MDS completed, if there is a significant change in the	F 280	F280 Revision of Care Plans. 1. A. Resident # 3 care plan was revised to reflect current diet and specific swallow guideline on 4-26-2012. B. Residents #4, #8, and #10 care plans were revised to reflect current treatment and care. 2. All residents with changes in care have the potential to be affected by the same deficient practice. 3. The DON will review the procedure for revision of Care Plans with all nurses on 5-10-12 thru 5-16-12. 4. A. The clinical monitoring nurses will audit 5-6 charts each week x 4 weeks, then every month x 2 months, then quarterly x 1, and PRN. If concerns are identified, immediate corrective action and re-education will be implemented. The DON will submit a report of the monitoring result to the QA committee at each scheduled meeting. B. The Care Plan Coordinator will audit charts for revision of Care Plans when she does the MDS weekly x 1 month, monthly x 2, Quarterly x 1, then PRN. If concerns are identified, immediate corrective action and re-education will be implemented. The MDS Coordinator will submit a report of the monitoring result to the QA committee at each scheduled meeting.	5/20/12

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F 280	Continued From page 15 resident's condition and/or in accordance with state regulations." - Review of Resident #8's medical record occurred on April 16-19, 2012. Diagnoses included osteoporosis, osteoarthritis, and history of right hip pinning and left clavicular fracture (09/25/11). The "Falls Data Collection Tool," dated 09/25/11, identified the resident as being at high risk for falls. The "Incident Details" reports identified the resident had fallen on three occasions; 09/25/11, 12/03/11, and 02/01/12. The current care plan identified, ". . . Goals: [Resident #8] will be free of injury from falls. [Resident #8] will transfer and ambulate safely. . . . . Approaches: Ambulate using walker with 1 staff. For longer distances have 1 staff bring w/c behind. Transfer with 1 staff. Provide bedcheck alarm system . . . Provide chaircheck alarm system . . . Fall mat on floor next to bed when resident is lying down, has a 'low' bed. Siderail padding between wall [and] bed to prevent injury when resident is lying down. Pad to footboard of bed when lying down. . . ." In addition, the current care guide identified, "Days . . . NOC [nights]: Transfer with 1, w/c [wheelchair] . . . Eves [evenings]: Transf. [transfer] with 1-2." Observation revealed the following: * On 04/17/12 at 10:20 a.m., a Certified Nursing Assistant (CNA) (#1) assisted Resident #8 to stand-pivot into her bed. The CNA (#1) placed a piece of sheep skin under Resident #8's feet, tucked a swimming noodle under the sheet on each side of her bed, and lowered the bed before exiting the room. Observation further revealed a bed alarm in place.	F 280		

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F 280	Continued From page 16 * On 04/18/12 at 11:25 a.m., Resident #8 in bed with her eyes closed. Staff had placed a piece of sheep skin under Resident #8's feet, placed a swimming noodle under the sheet on each side of her bed, and lowered the bed. Observation further revealed a bed alarm in place. During an interview on 04/19/12 at 12:50 p.m., an administrative nursing staff member (#2) agreed Resident #8's care plan did not reflect the current interventions being utilized by the facility to prevent Resident #8 from falling. The administrative nursing staff member (#2) stated, "I'm unsure when [Resident #8] stopped walking . . . December-ish. She uses a wheelchair to get around." She further stated, the padded side rails/foot board "were used up until [Resident #8] got a new bed. I'm unsure of the date." She was unable to locate any additional documentation regarding the discontinued use of the fall mat or the initiation of the swimming noodles. During an interview the afternoon of 04/19/12, a managerial nursing staff member (#3) stated, "[Resident #8's] fall mat was discontinued on April 1st." She was unable to locate any additional documentation regarding the discontinued use of the padded side rails/foot board or the initiation of the swimming noodles. - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included dysphagia and history of pneumonia (hospitalized February 15-21, 2012). A physician's order, dated 03/26/12, changing Resident #3's liquids from honey thick to nectar thick, stated, "Dietary Services, Nectar thick	F 280		

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F 280	Continued From page 17 liquids, Nursing provides regular [water] [without] consistency change between meals . . . If nursing serves beverages other than [water] between meals they need to be nectar thick." A physician's order, dated 03/28/12, advanced Resident #3's diet from pureed to a mechanical soft diet. A speech therapist created a swallow guide (undated, but observed by a nurse on 03/28/12) for Resident #3 which stated, ". . . * Encourage small sips/bites and to take a drink every 1-2 bites * Patient benefits from taking extra time for chewing between bites. He may require verbal cues throughout meal to slow rate * Patient should be positioned at 90 degrees when drinking or eating * [Resident #3] may consume regular water only (no juice, pop, milk, etc.) - BETWEEN MEALS ONLY. Regular water SHOULD NOT BE CONSUMED UNTIL THIRTY MINUTES FOLLOWING A MEAL. DO NOT GIVE HIM PILLS WITH REGULAR WATER. Nectar-thick liquids should be provided with pills and at meals. * ORAL CARES NEED TO BE PROVIDED AFTER EACH MEAL. * If his vocal quality sounds "wet" cue him to throat clear and use an effortful swallow." The resident's current care plan, dated 03/08/12, stated, ". . . 03/08/12, Problem: . . . Altered nutrition less than body requires R/T [related to] cognition deficit, drowsiness, nausea, pain, loss of appetite . . . Approaches: . . . Serve diet as ordered . . . 03/08/12, Problem: Potential for fluid volume deficit R/T inadequate fluid intake, diuretics . . . Approaches: . . . Provide adequate fluid intake at meals/snacks . . . offer/assist with	F 280		

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F 280	Continued From page 18 fluids B/T [between] meals and when providing cares . . . provide water for drinking at bedside . . ." On the bottom of the care plan, along with the resident's name, name of physician, admit date, birth date, diagnoses, etc., incorrectly identified his diet as "Level 1 (Pureed) no added NA [sodium] honey thick liquids." Resident #3's care plan failed to identify his current diet, dysphagia diagnosis, history of aspiration pneumonia, and lacked the specific swallow guidelines developed by the speech therapist. The CNA care card (an abbreviated care plan the certified nurse aides carry with them) also lacked Resident #3's current diet and specific swallow guidelines. During an interview on 04/18/12 at 3:15 p.m., an administrative nurse (#6) stated the facility's goal is to update care plans as changes occur and verified Resident #3's care plan should accurately reflect his current diagnoses, diet, and swallow guidelines. - Review of Resident #10's medical record occurred on April 19, 2012. Diagnoses included a history of and a recent (03/11/12) cerebrovascular accident and dysphagia. A physician's order, dated 03/13/12, identified a pureed diet with thin liquids. Review of a speech therapy note, dated 04/04/12, stated, ". . . [Increased] coughing was noted 2 [times] at the end of the meal possibly due to pocketed residue slipping over posterior blade of tongue. Continue [with] utilization of compensatory techniques ([decreased] bite size,	F 280		

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F 280	Continued From page 19	F 280		

bite/sip/bite [and] tongue sweep) . . ." A speech therapy note (date unknown), written prior to the note on 04/04/12, stated, ". . . Nursing staff will be educated on compensatory strategies to facilitate carry over into dining setting . . ."

The resident's current care plan, dated 04/04/12, stated, ". . . 03/22/12, Problem: Altered nutrition less than body requires R/T poor appetite related to recent stroke . . . Approaches: . . . Serve diet as ordered . . . provide needed assist [assistance] to eat/drink, including adaptive [and]/or assistive devices . . ." On the bottom of the care plan, along with the resident's name, name of physician, admit date, birth date, diagnoses, etc., identified her diet as "Pureed diet with thin liquids, no added salt."

The care plan failed to specifically identify Resident #10's dysphagia and lacked the compensatory feeding strategies identified by the speech therapist. The CNA care card lacked Resident #10's current diet and compensatory feeding strategies.

- Review of Resident #4's medical record occurred on all days of survey. Medical diagnoses included dementia, osteoarthritis, and a left hip fracture on 10/28/11. The resident's care plan stated, "Problem: Potential for injury R/T [related to] impaired mobility . . . Approaches: . . . Bedcheck system in place . . . sensor light at bedside."

Observation on 04/17/12 at 12:55 p.m. showed two CNAs (#4 and #7) transferred Resident #4 from her wheelchair to the bed. Before leaving the room, the CNA (#4) placed a swimming

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F 280	Continued From page 20 noodle under the sheets on the exit side of the resident's bed. The CNA (#4) stated staff use the noodle, "so she won't fall out (of bed)." Resident #4's care plan failed to identify the use of the swimming noodle. During an interview on 04/19/12 at 1:20 p.m., an administrative nurse (#6) stated facility staff utilized swimming noodles to help prevent a resident from falling out of bed and staff may have initiated Resident #4's noodle after she fractured her hip last October. She expected the intervention of a swimming noodle to be on the resident's care plan.	F 280		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide oral cares to 1 of 1 sampled resident (Resident #3) who required assistance with oral cares after every meal. Failure to perform oral hygiene after each meal has the potential to negatively affect the teeth and gums and allow the introduction of pathogens which could cause infections, including pneumonia. Findings include:	F 312	F312 ADL Care Provided for Dependent Residents: 1. Resident # 3's care plan was revised to include oral cares after meals on 4/26/2012. 2. All dependent residents have the potential to be affected by the same deficient practice. 3.CNAs will be in-serviced in Assistance to Maintain ADLs and following revision of Care Plans interventions 5/10/12 thru 5/16/2012. 4.The Nursing Staff will audit cares of residents that need assistance with ADLs weekly x 2, then in 2 weeks, then monthly x 2; and then random audits as needed. If concerns are identified, immediate corrective action and re-education will be implemented. The DON will submit a report of the monitoring result to the QA committee at each scheduled meeting.	5/20/12

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F 312	Continued From page 21 - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included dysphagia and history of pneumonia (hospitalized February 15-21, 2012). The quarterly Minimum Data Set (MDS), dated 02/27/12, identified the resident required extensive assistance from two staff members for personal hygiene. A physician's order, dated 03/26/12, changed Resident #3's liquids from honey thick to nectar thick. Another physician's order, dated 03/28/12, advanced Resident #3's diet from pureed to a mechanical soft diet. A speech therapist created a swallow guide (undated, but observed by a nurse on 03/28/12) for Resident #3 which stated, ". . . *ORAL CARES NEED TO BE PROVIDED AFTER EACH MEAL." Observations of cares and/or interviews with staff after each meal showed staff failed to provide oral cares after the following meals: *04/17/12 - Breakfast *04/17/12 - Noon meal *04/18/12 - Breakfast	F 312		
F 314 SS=D	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	F 314		

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F 314	Continued From page 22 prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy/procedure, record review, and staff interview, the facility failed to provide the necessary treatment and services to prevent the development of pressure ulcers for 1 of 2 sampled residents (Resident #1) on a repositioning schedule. Failure to provide pressure relieving interventions may result in Resident #1 developing pressure ulcers. Findings include: Review of the facility procedure titled "Pressure Ulcers: Skin Assessment and Prevention" occurred on 04/19/12. This procedure, revised January 2011, stated, ". . . PROCEDURE . . . 6. Residents who are unable to reposition themselves independently should be repositioned as often as directed by the care plan approaches. Developing an individualized repositioning schedule is recommended based on observation of the resident's skin over a period of time. Individual pressure points are observed for redness or discomfort (tissue tolerance) . . . The positioning schedule should be communicated to the nursing assistants using the care plan approaches module . . . Any resident at risk will be placed on pressure redistribution surface as determined appropriate . . ." - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included rheumatoid arthritis, muscle weakness,	F 314	F314 Treatment/Svcs to Prevent/Heal Pressure Sores: 1. Resident #1 will be repositioned every 2 hours for prevention of Pressure Ulcers. 2. All dependent residents on Pressure Sore Prevention measures have the potential to be affected by this practice. 3. Educate Nursing staff 5/10/12 thru 5/16/2012 on Pressure Sore Prevention (PSP) Protocol and Standards of Care. Review the procedures that nursing staff are expected to follow to prevent pressure ulcers. 4. Nursing Staff will audit/monitor that PSP measures are implemented 2 x a week x 2 weeks, then weekly x 2 weeks, them monthly x 2, and PRN. If concerns are identified, immediate corrective action and re-education will be implemented. The DON will submit a report of the monitoring result to the QA committee at each scheduled meeting.	5/20/12

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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 23 history of a cerebrovascular accident, aphasia, bulbar paresis, and dementia. The quarterly Minimum Data Set (MDS), dated 03/06/12, identified the resident was unable to speak; sometimes able to make herself understood; usually understood others; and had moderately impaired cognition. The MDS also revealed the resident required extensive assistance from two or more staff members for bed mobility, transfers, and toileting; was frequently incontinent of bowel and bladder; and at risk for developing pressure ulcers. The resident's current care plan, stated, ". . . 03/15/12 Problem: . . . Potential impaired skin integrity R/T [related to] dependent mobility & [and] presence of G-tube [gastrostomy tube] . . . Approaches: . . . Provide pressure sore prevention - reposition @ [at] least every 2 hours, provide pressure reducing cushion in W/C [wheelchair] & mattress on bed . . ." Observations of Resident #1 during the survey showed the following: *04/17/12 from 8:35 a.m. to 2:30 p.m. - resident remained in her wheelchair until toileted by staff at 2:30 p.m. During an interview on 04/17/12 at 1:00 p.m., a certified nurse aide (CNA) (#11) stated Resident #1 uses her call light when she needs to use the bathroom. The CNA stated the resident declined toileting before and after the noon meal on 04/17/12. When asked if staff provided any other cares or assistance to Resident #1 the CNA (#11) stated, "No." *04/18/12 from 8:25 a.m. to 1:15 p.m. - resident remained in her wheelchair until toileted by staff at 1:15 p.m.	F 314		

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	355094	A. BUILDING _____ B. WING _____	04/19/2012

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F 314	Continued From page 24 Interviews with staff occurred on 04/18/12 at 10:15 a.m. with a CNA (#12), and at 1:15 p.m. with two CNAs (#13 and #14). During both interviews, when asked if staff provided any other cares or assistance to Resident #1 unobserved by the survey team, all three of the CNAs responded, "No." The staff members stated Resident #1 declined toileting when offered until taken to the bathroom at 1:15 p.m. The staff members failed to reposition Resident #1 at least every two hours, as care planned. During an interview on 04/19/12 at 10:45 a.m., an administrative nurse (#6) stated even with her communication deficits, Resident #1 directs her own care, but stated she expected staff to at least attempt to reposition the resident according to her care plan.	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 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, record review, and staff interview, the facility failed to provide supervision and assistive devices necessary to prevent accidents for 3 of 7 sampled residents (Resident #1, #3, and #5) transferred with a gait belt or	F 323		

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F 323	Continued From page 25 sit-to-stand mechanical lift and failed to ensure the resident environment remained as free of accident hazards as possible for 1 of 1 sampled resident (Resident #3) observed with a long call light cord stretched across his room. The use of a long call light cord and failure to use gait belts and sit-to-stand lifts appropriately has the potential for residents to experience falls, injuries, and/or pain. Findings include: - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included rheumatoid arthritis, history of a cerebrovascular accident, osteoporosis, and dementia. The quarterly Minimum Data Set (MDS), dated 03/06/12, identified extensive assistance of two or more staff members for transfers. The current care plan identified the resident transferred with assistance of two staff members. Observation on 04/16/12 at 4:20 p.m. showed two certified nurse aides (CNAs) (#16 and #17) transferring Resident #1 from her wheelchair to the toilet, from the toilet back to her wheelchair, and from her wheelchair to bed. During each transfer, the CNA (#16) failed to use a gait belt and transferred the resident by holding onto her sides, lifting, and pivoting the resident to the desired location. During an interview on 04/19/12 at 10:45 a.m., an administrative nurse (#6) stated she expected staff to use a gait belt when transferring Resident #1.	F 323	F323 Free of Accident Hazards/Supervision/Devices: 1. A. Mop bucket and brooms in bathroom at South lounge were removed on 4/19/2012 to an area not used by residents. B. Resident # 3 had a second call cord installed so the cord is not stretched across the walk area on 4/25/2012. C. Gait belts will be used properly to transfer Residents #1 and #3. D. Resident # 5 Transfer lift assessment was updated and care plan revised. 2. A. All residents that need extensive assist with transfers are affected for need of proper Gait belt use and the correct number of staff for transfers. B.All residents that are ambulatory are at risk for obstacles in the walk way area of room or bathroom. 3. A. In-service will be provided to Certified Nursing Assistants regarding proper gait belt use and following the care plans for transfers with correct number of staff 5/10/12 thru 5/16/2012.	5/20/12

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F 323	Continued From page 26 - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included a probable compression fracture to the lumbar region and osteoporosis. The quarterly MDS, dated 02/27/12, identified extensive assistance of two or more staff members for transfers. The current care plan, revised 04/05/12, identified the resident transferred with assistance of one staff member. Observation on 04/17/12 at 8:50 a.m. showed a CNA (#4) applied a gait belt, obtained the resident's walker, and assisted Resident #3 to ambulate from his wheelchair to the toilet and from the toilet to his recliner. When assisting the resident to a standing position, the CNA (#4) lifted under the resident's right arm and pulled up on the back of the resident's pants, failing to utilize the gait belt. The CNA (#4) then obtained the call light (located across the room on the wall by the resident's bed) and clipped it to his recliner. The CNA (#4) identified the call light as a safety hazard and stated another CNA brought it to a nurse's attention, but nothing changed. Additional observations on April 17-19, 2012, showed Resident #3's call light positioned as above (a distance of over seven feet). Review of Resident #3's medical record showed the resident self-transferred at times and experienced falls during several of these attempts. During an interview on 04/19/12 at 10:45 a.m., an administrative nurse (#6) stated she expected staff to grasp the gait belt when transferring residents and not lift under residents' arms or pull on their pants to stand. - Review of Resident #5's medical record	F 323	B. In-service will be provided to all Nursing Staff and Environmental service regarding the awareness of safety hazards in residents' rooms and bathrooms esp. call light cords and misc. obstacles 5/10/12 thru 05/16/2012. 4. A. Nursing Staff will audit/monitor that gait belts are used properly and residents are transferred with correct number of staff: weekly x 2 weeks, then monthly x 2, and PRN. If concerns are identified, corrective action will be implemented. The Director of Nursing will submit a report of the monitoring results to the QA Committee at each scheduled meeting. B. Audits will be done by Environmental service for safety hazards weekly x 2 weeks, then monthly x 2 months, and then quarterly as needed. . If concerns are identified, corrective action will be implemented. The Environmental Services Manager will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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F 323	Continued From page 27 occurred on all days of survey. Diagnoses included osteoarthritis, degenerative joint disease, and dementia with behaviors. The annual MDS, dated 02/23/12, identified extensive assistance of two or more staff members for transfers. The current care plan identified the resident transferred with assistance of two staff members using a sit-to-stand lift. Observation on 04/17/12 at 1:45 p.m. showed a CNA (#10) transferring Resident #5 from the bath chair to her wheelchair using a sit-to-stand lift. The CNA failed to transfer the resident with a second staff member present as care planned. During an interview on 04/19/12 at 10:45 a.m., an administrative nurse (#6) stated Resident #5 required assistance of two staff members for transfers due to the resident's behaviors during cares. 2. Based on observation, record review, review of facility policy, and staff interview, the facility failed to maintain an environment free of hazardous chemicals on 4 of 4 days of survey. This practice placed residents with memory loss and/or wandering behaviors at risk of exposure to hazardous chemicals. Findings include: Review of the facility policy titled "Housekeeping and Laundry Departments Safety Rules" occurred on 04/19/12. This policy, dated 2008, stated, ". . . 5. Keep cleaning equipment properly stored and locked when not in use. Never leave cart unattended . . . 7 . . . Do not leave any chemicals unattended in resident rooms or in any area to	F 323		

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F 323	Continued From page 28 which residents have access. Store chemicals in locked area. . . ." During the initial tour on 04/16/12 at 11:15 a.m., observations of the environment revealed a spray-can of End Bac II Disinfectant on top of the cupboard above the toilet in room 314 and a can of Lysol Disinfectant Spray on top of the cupboard above the toilets in room 409 and 414. The product labels stated the following: * Lysol Disinfectant Spray: ". . . causes moderate eye irritation . . ." * End Bac II Disinfectant: "Avoid contact with skin and eyes" and "Keep out of the reach of children." The environmental tour of the facility occurred on 04/18/12 at 3:00 p.m. with an administrative staff member (#9). Observation showed the chemicals remained in room 314, 409, and 414. Additional findings included the following: * 500 wing tub room - A spray-can of End Back II Disinfectant on the shelf above the toilet. * An unlocked storage closet on the 300 wing - The closet contained spray-cans of 409 Disinfectant, Lysol Disinfectant Spray, and numerous bottles of floor and carpet cleaning chemicals. * An unlocked bathroom in the south resident lounge area - A mop bucket on wheels filled with water and an unknown disinfectant; a mop in the bucket and another mop propped in the corner by the light switch. The staff member (#9) stated the housekeeping staff store the mop bucket in the bathroom for easy access. She stated residents do not utilize the bathroom unless assisted by a staff member. During the environmental tour, observation	F 323		

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F 323	Continued From page 29 showed Resident #2 wandered down the 300 wing hallway and stopped at random doorways. The resident's Minimum Data Set (MDS), dated 01/16/12, identified both long and short memory difficulties and a behavior of wandering. Observation on 04/19/12 at 9:05 a.m. showed Resident #19, unaccompanied by a staff member, entered the south lounge bathroom and exited at 9:15 a.m. Review of the resident's MDS, dated 03/09/12, identified both long and short term memory difficulties. During an interview on the afternoon of 04/19/12, an administrative nurse (#6) stated she expected chemicals to be kept out of reach of the residents.	F 323		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, review of professional reference, record review, and staff interview, the facility failed to ensure 1 of 2 sampled residents (Resident #5) on a scheduled fentanyl patch (an opioid analgesic used for pain) remained free from significant medication errors. Failure to remove the existing fentanyl patch when applying the new patch has the potential to affect the therapeutic level of the medication and may result in harmful effects to the resident, including oversedation.	F 333		

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F 333	Continued From page 30 Findings include: Kozier and Erb's "Fundamentals of Nursing," 9th Edition, Pearson Education, Inc., New Jersey, page 1232, stated, ". . . The nurse must remember that fentanyl is 100 times more potent than morphine . . . It provides drug delivery for up to 72 hours . . . Used patches should be disposed of in a tamper-proof container. This is especially true in the home setting because a used patch can contain enough residual medication to harm a small child or animal if ingested . . ." - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included osteoarthritis, degenerative joint disease, and dementia. Review of the resident's Medication Administration Record (MAR) identified "Fentanyl patch 25 mcg [micrograms]/ [per] HR [hour] topical, change every 3 days." A nurse initialed the fentanyl patch as administered on the morning of 04/17/12. Observation at the beginning of Resident #5's bath occurred on 04/17/12 at 1:15 p.m. Observation showed two fentanyl patches on the resident's back, one located on the right upper back and dated 04/17/12, and the other patch located on the left lower back and dated 04/14/12. During an interview on the afternoon of 04/17/12, a nurse (#8) stated she applied the new fentanyl patch between 6:00-6:30 a.m. on the morning of 04/17/12, and removed the old patch, dated 04/14/12, at approximately 2:00 p.m. that same day after the bath aid (#10) notified her two patches remained on the resident. The nurse	F 333	F333 Resident Free of Significant Med Errors: 1. Resident # 5 had the old patch removed and the Incident Report was completed. 2. All residents with transdermal patches are at risk. 3. Charge Nurses will be re-educated on the procedure for the removal of transdermal patches. A place to document that the patch was removed has been added to the Medication Administration Record. 4. Nursing staff will audit for proper removal of transdermal patches weekly x 2, then every 2 weeks x 2, then monthly x 1, and random audits as needed. If concerns are identified, corrective action will be implemented. The Assistant Director of Nursing or designee will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	5/20/12

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F 333	Continued From page 31 stated she "missed it" when applying the new patch that morning.	F 333		
F 431 SS=D	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. 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.	F 431	F431 Drug Records, Label/Store Drugs and Biologicals: 1. Charge nurses will be re-educated in the procedure for locking the medication cart. 2. All residents are at risk to be potential affected if the Med cart is not locked. 3. In-service will be provided to the Nurses on the locking of the medication cart and the new procedure will be introduced 5/10/12 thru 5/16/2012. 4. Med Carts will be audited to see that the medication cart is locked by the QA Coordinator or designee 2 x week x 1 week, then weekly x 2 weeks, then monthly x 2 months, and PRN. If concerns are identified, corrective action will be implemented. The QA Coordinator will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	5/20/12

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F 431	Continued From page 32 This REQUIREMENT is not met as evidenced by: Based on observation, review of facility procedure, and staff interview, the facility failed to store all medications in a secure manner for 2 on 4 days of survey (April 17-18, 2012). Failure to store all medications securely could result in unauthorized access to medications. Findings include: Review of the facility procedure titled "Procedure: Acquisition, Receiving and Dispensing of Medications" occurred on 04/19/12. This procedure, dated 2009, stated, ". . . 4. Medications will be stored in a locked medication room and/or medication cart. . . ." - Observation on 04/17/12 from 3:30 p.m. to 3:45 p.m. showed a nurse (#8) assisting Resident #1 in her room. While she remained in Resident #1's room, the nurse left the medication cart unlocked in the hall outside the room. Observation throughout the survey showed cognitively impaired residents ambulating and self-propelling independently in the hallways. - Observation on 04/18/12 from 10:15 a.m. to 10:25 a.m. showed a nurse (#8) entered four different resident rooms to administer medications. Each time the nurse entered a room, she left the medication cart unlocked in the hall outside the room. Observation showed Resident #4 (severely impaired cognitive status) in her wheelchair and self propelling in the vicinity of the medication cart.	F 431		

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F 431	Continued From page 33 During an interview on the afternoon of 04/18/12, an administrative nurse (#6) stated she would expect the staff to lock the medication cart at all times unless it is in direct view of the nurse.	F 431		