STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355095	A. BUILDING _____ B. WING _____	C 09/23/2010

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GOOD SAMARITAN SOCIETY - OAKES	213 N 9TH ST OAKES, ND 58474

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey and complaint survey, started on 09/21/10 and completed on 09/23/10, the sample included 4 residents for complete review, 12 residents for focused review, and 3 closed records for review. The sample included 3 additional residents to verify specific concerns during the survey.	F 000	General Disclaimer Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegations that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with sections 7305 of the State Operations Manual.	
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, review of professional reference, review of Resident Council Meeting Minutes, resident and staff interviews, the facility failed to ensure prompt efforts to resolve resident grievances related to missing clothing items for 1 of 1 sampled resident (Resident #10). Findings include: - The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding ". . . the resident's right to prompt efforts by the facility to resolve grievances . . . The intent of the regulation is to support each resident's right to voice grievances (e.g., . . . lost clothing . . .) and to assure that after receiving a complaint/grievance, the facility actively seeks a resolution and keeps the resident appropriately	F 166	1. Resident #10 individual needs have been met by addressing the resident grievance of missing clothing items. The facility was unable to locate the missing items. She received compensation for her loss by receiving new clothing on 10/12/10. Resident expressed satisfaction with the resolution. Her personal care items are clearly marked with her name.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: David Carda — TITLE: Administrator — (X6) DATE: 10-25-10

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 166	Continued From page 2 member (#2) on 09/23/10 at 8:30 a.m., the staff member recalled Resident #10's complaint of missing clothing items. She stated, "We don't always replace missing clothing items. . . . I think laundry and the resident's daughter went through her things to look for the missing blouses." The staff member (#5) was unable to provide any documentation related to the reported missing clothing. An interview occurred on 09/23/10 at 8:50 a.m. with an administrative nursing staff member (#2). The staff member stated, "We do replace misplaced resident's clothing."	F 166	one month, monthly for three months, and quarterly to assure procedure is followed for all missing articles. The results of the audit will be reported to the QA/CQI committee for further recommendations. Date certain 10-28-10	10-28-10
F 224 SS=D	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, resident interview, resident group interview, review of policy and procedure, and staff interview, the facility failed to ensure each resident was free from verbal, physical, and mental abuse by another resident, for 1 of 1 sampled physically aggressive resident (Resident #12) who struck another resident (Resident #10) and who caused other residents to be fearful. Failure to ensure residents are free from abuse by another resident placed all facility residents at risk of verbal, physical, and mental abuse and risk of injury.	F 224	1. Resident #10's individual needs have been met by providing a cordless call light. Resident #12 moved to 400 wing on 9-29-10, and was moved in dining room so his back was toward #10 on 9-23-10. Resident #12 medications have been reviewed by a psychiatrist and primary care physician. His mood is currently stable with no further incidents. Care plans have been updated to reflect the interventions put into place. 2. All residents have the potential to be affected in this area.	

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F 224	Continued From page 3 Findings include: Review of the facility policy, Abuse and Neglect, occurred on September 22-23, 2010. This policy, issued in 11/99, stated "PURPOSE, To assure that staff are knowledgeable regarding the reporting and investigative process of abuse and neglect allegations in the center. POLICY, The resident has the right to be free from verbal . . . physical and mental abuse . . . Residents must not be subjected to abuse by anyone, including, but not limited to . . . other residents . . ." - During an individual resident interview, on 09/22/10 at 9:45 a.m., Resident #10 reported Resident #12 "harasses" her at all times. Resident #10 reported Resident #12 stops the "harassment" when facility staff are in the area and Resident #12 resides in a room near hers. She also reported Resident #12 was in her room, uninvited, the previous evening. She reported she told Resident #12 to leave, which he did, and she did not inform the facility staff. - During interview with a group of facility residents identified by the facility as interviewable, on 09/22/10 at 3:00 p.m., Resident #10 reported Resident #12 struck her in the back and Resident #10 reported continued fear of Resident #12. During this interview, Resident #22 reported she witnessed Resident #12 strike Resident #10. - Review of Resident #10's medical record occurred on September 21-23, 2010. The facility admitted the resident in 09/05. Current diagnoses included anxiety, depression, psychosis, panic disorder, and back pain. Resident #10's annual	F 224	3. No other resident to resident incidents have occurred. A Staff in-service scheduled for October 26th & 27th, will alert all staff to be aware and intervene on all forms of abuse, such as harassment, mimicking, or fearful actions. Social Worker will interview other residents who verbalized they might be fearful of resident #12. A list of female residents was reviewed and 10% of them were chose to audit for any uncomfortable feelings from resident #12 behaviors. Review policy and procedures related to resident to resident abuse. After three incidents have been reviewed at the Incident Committee meeting, a care plan will be scheduled with family and entire Care Plan team for further review. 4. LSW or her designee will do an audit to ensure that the new system is operational. Audits will be done to monitor resident #10's fears, and resident #12's behaviors, and to identify any other residents that have any uncomfortable feelings about resident #12's behaviors. Audits will be done three times per week for one month, two times per week for one month and one time per week for one	

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F 224	Continued From page 4 Minimum Data Set (MDS), dated 09/06/10, identified short term memory problem, no long term memory problem, independent daily decision making, expressions of what appear to be unrealistic fears up to five days per week and repetitive health complaints daily that are easily altered, and no change in mood. Resident #10's current care plan, dated 09/15/10, stated "Problems . . . Altered mood state . . . Voice fear of male resident bothering her up to 5 days a week. . . . Plans . . . Reassure staff are aware and male resident has been talked to. Check on her frequently. Encourage her to discuss her feelings with staff." Resident #10's Physicians Progress Notes, dated 04/28/10, stated ". . . Patient states that she has been feeling very weak for the past two days. . . . Nurses indicate that this maybe to some extend [sic] related to anxiety as there have been certain problems with other residents, especially at mealtime and patient has been very sensitive to these comments. . . . She will be observed to see if there is a change in status. . . ." Resident #10's physician orders, dated 07/27/10, included "Ativan 1 mg [milligram] BID [two times each day]" for "Anxiety." This is an increase from 1 mg as needed each morning and 1 mg each evening. Ativan is an anti-anxiety medication. Resident #10's Interdisciplinary Progress Notes identified the following: *02/22/10, 9:00 p.m. - Resident #12 staring at her, making comments, Resident #10 uncomfortable. *09/01/10, 7:00 p.m. - Resident #10 "thumped" in the back by Resident #12. Resident #10 fearful of	F 224		

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F 224	Continued From page 5 Resident #12. During interview, on 09/23/10 at 9:05 a.m., a social work staff member (#5) reported the facility lacked a written report or investigation of the incident of 09/01/10 at 7:00 p.m. This staff member (#5) provided a "Suggestion or Concern" form dated 09/02/10 regarding Resident #10 which stated ". . . Report of Concern: Res. [Resident] asked me to stay with her because [Resident #12] was walking by. She told me he harassed her every meal. She also said she was scared he'd come into her room at night. She said she had told him that she did not like him. I reassured [her] that there was staff here to make sure he did not come to her room. Investigation: [Resident #12] can be overly friendly. We have told him this is socially unacceptable. He states he understands. Improvement had been noted [with] Lexapro [anti-depressant medication]. 2 weeks ago medication decreased. We have seen him increasingly more 'friendly' with other residents. Resolution: We will notify primary physician of residents [sic] behavioral changes. . . ." - Review of Resident #12's medical record occurred on September 22-23, 2010. The facility admitted the resident in 03/07. Current diagnoses included dementia, macular degeneration, and anxiety. The quarterly MDS, dated 09/17/10, identified short term memory problems, no long term memory problems, moderately impaired daily decision making, no change in cognitive status, persistent anger with self or others up to five days per week and easily altered, and independent in locomotion. The MDS, dated 03/17/10 identified socially inappropriate/ disruptive behaviors 1 to 3 days in 7 days, not	F 224		

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F 224	Continued From page 6 easily altered and deteriorated behavior symptoms. Resident #12's Behavioral Resident Assessment Protocol Summary (RAPS), dated 03/17/10, stated ". . . Teasing other residents and yelling at resident in the ding [sic] room. . . . yelled at opther [sic] in the ding [sic] room, not easily altered. He talks to someone not there and behaviors are sometimes present/sometimes not. Receives meds [medications] as ordered. Was annoyed with staff and other residents up to 5 days/week. Heas [sic] encouraged to attend activities and is provided reassurance as needed. Dx [Diagnosis] of depression, receives meds as ordered. He saw [consulting psychiatrist] 01/12/10 and his meds were increased. [Resident #12's] condition/diseases make his mood/behavior patterns unstable. . . . Charge nurse is notofoied [sic] of behaviors and they are charted as they occur. He is encouraged to play cards and attend activities. . . ." Resident #12's current care plan, dated 06/23/10, stated "Problems . . . Altered mood state r/t: Alzheimer's . . . m/b: . . . Needs to be observed. Makes faces at other residents. Annoyed with residents/staff up to 5 days/week. Easily altered. . . . Plans . . . Reassure. Remind it is not appropriate. . . . Continue to remind him to stay out of female resident rooms. . . . Problems . . . Altered behavior r/t: Alz. [Alzheimer's] dementia m/b: h/o [history of] socially inappropriate sexual behaviors. H/o yelling at and teasing other residents in dining room and hallways. Makes faces at other residents. . . . Plans . . . Inform/remind of other residents rights/feelings. Followed by psychiatrist.	F 224		

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F 224	Continued From page 7 Chart behaviors and notify charge nurse. . . . Charge nurse notify Unit Coordinator, SS [Social Services], or DON [Director of Nursing] of sexual behaviors. Notify MD [physician] of sexual behaviors. Encourage to play cards and attend activities. Notify POA [Power of Attorney] of any unappropriate [sic] behavior. Redirect inappropriate sexual behaviors with conversation topics such as farming/weather. . . . Gently redirect away from area of outbursts. Resident not to push residents. Redirect when he is talking in female resident's face. Remind of residents rights and feelings. Monitor residents behavior in dining room. Redirect if inappropriateness of behavior. . . ." Resident #12's current physician orders included the following medications and accompanying diagnoses: *Depakote 250 mg, BID - reactive confusion *Aricept 10 mg, daily (QD) - Alzheimer's dementia *Namenda 10 mg, BID - Alzheimer's dementia *Lexapro 10 mg, QD - depression (started 09/03/10) On request of the surveyor, on 09/23/10, social services staff member (#5) provided the facility Behavior Management Meeting minutes for the period September 2009 through August 2010. Review of these minutes included the following regarding Resident #12: *October, November, and December 2009 minutes lacked reference to Resident #12. *01/12/10 - "Was seen by [psychiatrist] today and he increased his antidepressant d/t [due to] his behaviors of getting into other residents space and scaring women residents in the dining room over the weekend. He had 1 outburst in the dining room and staff report he has been wandering to	F 224		

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F 224	Continued From page 8 the west side a little more than he did." [Resident #12's room was on the east side.] *02/11/10 - "He continues to mimick [sic] residents/staff. He makes faces at other residents. He likes to be in the center of attention and is followed by [psychiatrist]. On 01/12/10 his Lexapro was increased to 15 mg. Continue to redirect when these behaviors occur." *03/09/10 - "Has had several behaviors, teasing other residents and making faces. We are to monitor his behaviors in the DR [dining room] and anyone who hears or sees his behaviors needs to redirect him immediately about the inappropriateness of his behaviors." *04/13/10 - "Continues to make fun of another resident who falls asleep while playing cards. Another female resident is requesting a cordless call light in case he should enter her room when she is asleep in her recliner." *05/11/10 - "His behaviors continue. He has slammed his walker down hard on the floor, calling other female res. [residents] inappropriate names, staring at them - one res. in particular. He c/o her talking too much, mimicking her. . . . He was seen by [psychiatrist] today who started him on Depakote. His Lexapro was decreased by [primary physician] on 04/28/10 when he was c/o wt. [weight] gain. We will cont. [continue] to monitor and report any behaviors." *06/08/10 - "Continues to mock other residents and talk about them. He gets upset with a table of female residents in the dining room that like to visit and he thinks they shouldn't be 'cackling and talking' like they do. We will check with [dietary staff member (#13)] to see what was discussed when he was approached the last time to change places in the dining room." *07/20/10 - "Continues to mimic some residents in the DR, but no confrontation from it. Staff will	F 224		

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F 224	Continued From page 9 intervene when this happens." *08/10/10 - "Continues to minick [sic] other residents but there's been less reports of it. He was seen by [psychiatrist] today with no medication changes." Resident #12's Interdisciplinary Progress Notes for the period January 01, 2010 through September 22, 2010 identified the number of incidents of inappropriate behaviors towards other residents per month and specific examples, as follows: *January 2010 - 9 incidents - 01/05/10, 12 noon - "Noted rubbing a female resident's back. When redirected, continued to do. Lady requested he not do this. -01/07/10, 9:00 a.m. - "Sitting by desk. Talking to a female resident. 'Asked her do you have to pee pee?' reminded him of others rights et [and] to give her her space. Continued to sit by her et play [with] her food." *February 2010 - 10 incidents - 02/21/10, 6:30 p.m. - "Female resident complained that [Resident #12] was 'staring and pointing' at her during supper, making her feel uncomfortable. Reassured her that staff will monitor his behavior. No further incidents at this time." *March 2010 - 3 incidents - 03/20/10, 6:00 p.m. - "Was harassing women at dining room table. Would not leave when asked. Swung at CNA [certified nursing assistant] and cursed at her when she tried to redirect him. Spoke with him about this behavior. Says 'Yeah, yeah, OK.' Will monitor." *April 2010 - 3 incidents	F 224		

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F 224	Continued From page 10 - 04/24/10, 5:40 p.m. - "West side nurse reported [Resident #12] was pounding his walker on the floor in the dining room. She proceeded to say to him 'Stop it, stop it right now.' He then turned to one of the female residents and called her a 'bitch.' Nurse instructed him that this was inappropriate. CMA [Certified medication aide] redirected him . . . He was then taken to his table to eat [with] no further behaviors. . . ." *May 2010 - 7 incidents - 05/08/10, 7:30 a.m. - "Went from table to table bothering ladies. When redirected him, he turned around et flipped CNA off. Then went to another ladies [sic] table and made faces at her. Redirected again. When he got to his table he started waving his arms @ [at] nurse. Reminded him this behavior was inappropriate in dining room or anywhere." *June 2010 - 5 incidents - 06/02/10, 11:30 a.m. -"Bothering ladies at table b/4 [before] dinner. Gets his face up to there's [sic] and then has to touch them. Reminded him of others rights et to keep moving up to his table." *July 2010 - 3 incidents - 07/19/10, 6:30 p.m. - "CNA reports resident was arguing with a female resident after supper. He is outside on the swing now. Will continue to monitor." *August 2010 - 5 incidents - 08/13/10, 7:00 p.m. - "Sitting @ desk talking to another male resident. [Resident #12] states 'How do you like those boobies?' " *September 2010 - 6 incidents - 09/01/10, 7:00 p.m. - "Female resident reports [Resident #12] 'thumped' her on the back after she told him 'leave me alone' and 'I don't like you.' See GSS [Good Samaritan	F 224		

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F 224	Continued From page 11 Society] Form #401. [Incident Investigation Report]." Observation, on 09/23/10 at 8:55 a.m., identified Resident #12 seated in a recliner at the nurse's station and hallway intersection with his eyes closed. Resident #10 entered the intersection and greeted the surveyor, staff, and visited with another resident. Resident #10 spent approximately ten minutes in the intersection. During this time period, observation showed Resident #12 opened his eyes as Resident #10 voiced her greeting and followed her the entire time she remained in his sight. During interview, on 09/23/10 at 11:00 a.m., a supervisory nursing staff member (#6) reported she was not aware of Resident #12 entering Resident #10's room, uninvited. This staff member identified Resident #12's dementia and memory loss limited his awareness of his actions. Residents expressed fear of Resident #12 to facility staff because of his unwanted physical contact, striking Resident #10, gestures, and inappropriate behaviors towards other residents. Resident #10 expressed fear of Resident #12 which the facility staff and physician attributed, in part, to "anxiety" and increased her anti-anxiety medication. The facility staff monitored Resident #12's behaviors towards other residents and redirected him with variable success. The facility identified Resident #12 had a history of sexually inappropriate behaviors. The facility's interventions failed to reduce Resident #12's behaviors and the facility failed to modify the interventions. Failure to develop and implement behavior	F 224		

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F 224	Continued From page 12 interventions for Resident #12 resulted in Resident #12 striking Resident #10. The facility failed to address Resident #10's fear of Resident #12; the facility may have provided Resident #10 an unnecessary increase in her anti-anxiety medication; and, facility residents experienced continued verbal, mental, and physical abuse by Resident #12.	F 224		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 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 record review, review of facility policy and procedure, resident interview, resident group interview, and staff interview, the facility failed to implement policies and procedures regarding investigation of incidents of mistreatment or abuse of residents by another resident, for 1 of 1 sampled physically aggressive resident (Resident #12) who struck another resident (Resident #10) and caused other residents to be fearful. Failure to report and investigate the incident of striking another resident, as identified in the facility's policy, limited the facility's ability to implement the appropriate interventions to prevent a reoccurrence, left residents in fear of Resident #12, and placed all facility residents at risk of injury. Findings include: Review of the facility policy, Abuse and Neglect,	F 226	1. Resident #10 agreed with Good Samaritan Society Oakes decision to move Resident #12 to 400 Wing closer to the Nurse's station on 9-29-10, and was moved in dining room so his back was toward #10 on 9-23-10. 2. All residents have the potential to be affected in this area. 3. GSS #401 was completed with investigation on 10-27-10, on-going since survey. Review of all concerns over the past quarter identified no other resident to resident concerns. When any alleged abuse occurs, the resident being abusive will be removed from the situation. All alleged abuse incidents need to be reported to the charge nurse who will complete an Incident Report (GSS #401). The family/responsible party and	

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F 226	Continued From page 13 occurred on September 22-23, 2010. This policy, issued in 11/99, stated "PURPOSE, To assure that staff are knowledgeable regarding the reporting and investigative process of abuse and neglect allegations in the center. POLICY . . . Residents must not be subjected to abuse by anyone, including, but not limited to . . . other residents . . . Alleged or suspected violations involving any mistreatment . . . abuse . . . will be reported immediately to the center administrator . . . The center will have evidence that all alleged or suspected violations are thoroughly investigated and will prevent further potential abuse while the investigation is in progress. Results of all investigations will be reported to the administrator or designated representative . . ." - During an individual resident interview, on 09/22/10 at 9:45 a.m., Resident #10 reported Resident #12 "harasses" her at all times. Resident #10 reported Resident #12 stops the "harassment" when facility staff are in the area and Resident #12 resides in a room near hers. She also reported Resident #12 was in her room, uninvited, the previous evening. She reported she told Resident #12 to leave, which he did, and she did not inform the facility staff. - During interview with a group of facility residents identified by the facility as interviewable, on 09/22/10 at 3:00 p.m., Resident #10 reported Resident #12 struck her in the back and Resident #10 reported continued fear of Resident #12. During this interview, Resident #22 reported she witnessed Resident #12 strike Resident #10. - Review of Resident #10's medical record occurred on September 21-23, 2010. Resident	F 226	physician of the resident doing the abuse will be notified of the residents' actions. This incident report will be discussed at the next incident meeting. Investigation of the alleged abuse will be conducted by the LSW, DON, ADM. or their designees' immediately when an emergency situation arises. The Physician will also review medications. All staff will be in serviced on Oct. 26 & 27th on how to identify potential abusive behavior and the importance of reporting any abuse to the charge nurse. The LSW or her designee will meet weekly (or sooner if needed) with the residents who have complaints of being abused. If the resident who is being abused continues to have concerns after interventions have been completed, the family/responsible party of the resident doing the abuse will be notified to have a care conference with the IDT (inter-disciplinary team) and administrator or his designee about the alleged abuse.	

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F 226	Continued From page 14 #10's Interdisciplinary Progress Notes, dated 09/01/10 at 7:00 p.m., identified Resident #12 "thumped" Resident #10 in the back and Resident #10 was fearful of Resident #12. On request for evidence of an investigation for the incident of 09/01/10, an administrative nursing staff member (#2) reported a social work staff member (#5) maintains these files. During interview, on 09/23/10 at 9:05 a.m., staff member (#5) provided a "Suggestion or Concern" form dated 09/02/10 regarding Resident #10 which stated ". . . Report of Concern: Res. [Resident] asked me to stay with her because [Resident #12] was walking by. She told me he harassed her every meal. She also said she was scared he'd come into her room at night. She said she had told him that she did not like him. I reassured [her] that there was staff here to make sure he did not come to her room. Investigation: [Resident #12] can be overly friendly. We have told him this is socially unacceptable. He states he understands. Improvement had been noted [with] Lexapro [anti-depressant medication]. 2 weeks ago medication decreased. We have seen him increasingly more 'friendly' with other residents. Resolution: We will notify primary physician of residents [sic] behavioral changes. . . ." - Review of Resident #12's medical record occurred on September 22-23, 2010. The facility admitted the resident in 03/07. Current diagnoses included dementia, macular degeneration, and anxiety. The quarterly MDS, dated 09/17/10, identified short term memory problems, no long term memory problems, moderately impaired daily decision making, no change in cognitive status, persistent anger with self or others up to	F 226	4. LSW or her designee will do an audit to ensure that the new system is operational. Audits will be done to review all resident to resident concerns or incident of abuse to ensure facility policy is followed. Audits will be done three times per week for one month, two times per week for one month and one time per week for one month. Audit results will be reported to the QA/CQI committee for further recommendations. Audits will be done per Q.A. Coordinator and or designee. Date certain 10-28-10	10-28-10

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F 226	Continued From page 15 five days per week and easily altered, and independent in locomotion. The MDS, dated 03/17/10 identified socially inappropriate/disruptive behaviors 1 to 3 days in 7 days, not easily altered and deteriorated behavior symptoms. Review of the facility's monthly Behavior Management Meeting Minutes for the 12 month period September 2009 through August 2010 showed the facility staff discussed Resident #12's inappropriate behaviors at the 8 consecutive meetings, January through August 2010. Review of Resident #12's Interdisciplinary Progress Notes identified the resident's continued inappropriate behaviors towards facility residents, including the following: *09/01/10, 7:00 p.m. - "Female resident reports [Resident #12] 'thumped' her on the back after she told him 'leave me alone' and 'I don't like you.' During interview with an administrative management staff member (#1), on 09/22/10 at 6:00 p.m., this staff member reported he was not aware of the incident on 09/01/10. Resident #12 demonstrated inappropriate behaviors for an extended period of time. Resident #22 witnessed Resident #12 "thump" Resident #10 on the back on 09/01/10. The facility staff documented the incident in Resident #12's and Resident #10's medical records. The facility staff identified an Incident Investigation Report in the medical record, however the facility was unable to provide evidence the form had been completed. Resident #12 continued to "harass" Resident #10 and demonstrated inappropriate behaviors towards other residents.	F 226		

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F 226	Continued From page 16 It is unknown if the facility staff completed the Incident Investigation Report form. The facility did not have a record of the investigation, and administrative management staff were not aware of the incident. Failure to investigate the incident resulted in Resident #12's continued harassment of Resident #10, Resident #12's continued inappropriate behaviors towards other residents, limited the facility's ability to prevent further abuse during the investigation, and limited the facility's ability to implement appropriate corrective action.	F 226		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policies, review of professional literature, and staff interview, the facility failed to provide an ongoing program of activities for 2 of 2 sampled residents (Resident #3 and Resident #4) placed in isolation. Activities are an integral component of residents' lives and failure to implement an individualized activity program to respond to the interests and current capabilities of the residents has the potential to affect their physical, cognitive and emotional health. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice	F 248	1..For Resident # 3 Care Plan was updated on 10-18-10 to meet the resident's physical, mental and psychosocial well-being. Resident #3's choice is to stay in her room and never was on strict Isolation. Resident # 4 expired on 10-15-10. 1. All residents in Isolation have the potential to be affected by being isolated and not getting their Physical, Mental and psychosocial well-being met. 2. The activity staff will be educated about a new Activity Program for Isolation Residents, by the Activity Director and the Nursing staff will be educated on the importance of the resident's Physical, Mental and Psychosocial needs. In service	

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F 248	Continued From page 17 regarding activities which states the facility must identify each resident's interests and needs, and involve the resident in an ongoing program of activities that is designed to appeal to his/her interests and to enhance the resident's highest practicable level of physical, mental, and psychosocial well-being. Review of the facility's policy, titled "Philosophy and Objectives of Activity Services" occurred on 09/23/10. This policy, revised 01/04, stated, ". . . Objectives: 1. To reach every resident with individualized consideration. . . . 4. To provide meaningful socialization. 5. To provide mental activities to stimulate . . . cognitive ability. . . . 7. To provide opportunities for the resident to participate in personal choice programs. . . ." - Observation identified the following: * 09/21/10 at 4:45 p.m., Resident #4 sitting in wheelchair facing the door to the room. (The resident requires extensive-to-total assistance with transfers and locomotion.) The window to room behind the resident's wheelchair. Lights dimmed and drapes closed. Silence in room. * 09/22/10 at 8:00 a.m., 8:20 a.m., 8:35 a.m., 8:50 a.m., and 9:30 a.m., Resident #4 sitting in wheelchair facing the door to the room. The window to room behind the resident's wheelchair. Lights dimmed and drapes closed. Silence in room. Untouched breakfast tray on bedside table. Review of Resident #4's medical record on September 21-23, 2010 identified the resident's diagnoses included cataracts, anxiety, depression, deconditioning, and extended-spectrum beta lactamase (ESBL) [infection resistant clinically to all penicillins]. The resident wears glasses and hearing aides. The	F 248	is scheduled for Oct.26th & 27th. 3. Activity Supervisor or Designee will complete audits on the care plan and charting of the Isolation residents to see that they are receiving adequate social interactions to meet their Physical, Mental and Psychosocial well-being. Audits will be done weekly for three months, then quarterly. Audit results will be reported to the QA/CQI committee for further recommendations. Audits will be done per Q.A. Coordinator and or designee. 4. This is our allegation of compliance as of 10-28-10 3	10-28-10

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F 248	Continued From page 18 significant change Minimum Data Set (MDS), dated 08/10/10, identified short term memory impairment, moderately impaired daily decision making skills, loss of interest, awake morning and afternoon, involved in activities 1/3 to 2/3 of time, and general activity preferences: cards/other games, music, reading/writing, spiritual/religious activities, walking/wheeling outdoors, watching tv and talking/conversing. The Psychiatry Report, dated 08/10/10, indicated the psychiatrist increased Resident #4's Prozac (anti-depressant medication) from 20 mg to 30 mg [milligrams] po [by mouth] qd [daily]. Resident #4's comprehensive care plan, dated 08/18/10, stated, ". . . Problems . . . Diversional Activity Deficit . . . Approaches . . . Invite, assist and encourage to attend activities, Set-up activity, 1:1 visits 1 x weekly, Religious/musical therapy and functions/games/movies/lady functions, Special entertainment/social hour as desires, Outside/van rides as desires, Assist in w/c to activities, and Fold towels as desires." The facility did not update the resident's activity care plan after she was placed in isolation. Resident #4's Activity Participation Record, dated 08/01/10 - 09/23/10, identified the following: August 2010 * No activities on 6 of 31 days September 2010 * No activities on 11 of 23 days * No activities on 5 of 9 days in contact isolation (September 14-22, 2010) * Unable to attend on 2 of 9 days in contact isolation (September 14-22, 2010) * 1:1 only activity of day on 2 of 23 days * 1:1 only activity of day on 2 of 9 days in contact isolation (September 14-22, 2010)	F 248		

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F 248	Continued From page 19 Weekend Days * No activities on 7 of 15 weekend days (Saturday or Sunday) - Review of Resident #3's medical record on September 21-23, 2010 identified the resident's diagnoses included anxiety, psychosis, and ESBL. The quarterly MDS, dated 08/17/10, identified short term memory impairment, some difficulty with daily decision-making in new situations, awake morning and afternoon, involved in activities 1/3 to 2/3 of time, and general activity preferences: music, reading/writing, spiritual/religious activities, trips/shopping, walking/wheeling outdoors, watching tv and talking/conversing. Resident #3's Activity Participation Record, dated 08/01/10 - 09/23/10, identified the following: August 2010 * No activities on 15 of 31 days * No activities on 6 of 9 days in contact isolation (August 10-18, 2010) * 1:1 only activity of day on 5 of 31 days * 1:1 only activity of day on 1 of 9 days in contact isolation (August 10-18, 2010) September 2010 * No activities on 12 of 23 days * 1:1 only activity of day on 7 of 23 days Weekend Days * No activities on 11 of 15 weekend days (Saturday or Sunday) During an interview on 09/23/10 at 11:35 a.m., a management activity staff member (#8) stated, "One-to-one visits mean we talk to the residents, turn on the tv, have music on in their room, give them things to read or read to them. . . . One-to-one visits usually take 5-10 minutes."	F 248		

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F 248	Continued From page 20 The facility staff failed to provide a meaningful activity program responsive to Resident #3 and Resident #4's medical needs.	F 248		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, resident group interview, and staff interview, the facility failed to provide medically related social services to ensure each resident attained or maintained the highest practicable physical, mental, and psychosocial well-being, for 1 of 1 sampled resident (Resident #12) with physically aggressive and inappropriate behaviors towards other residents. Failure to provide services resulted in Resident #12 striking Resident #10, Resident #12's continued inappropriate behaviors, and facility residents being fearful. Findings include: - During an individual resident interview, on 09/22/10 at 9:45 a.m., Resident #10 reported Resident #12 "harasses" her at all times. Resident #10 reported Resident #12 stops the "harassment" when facility staff are in the area and resides in a room near hers. She also reported Resident #12 was in her room, uninvited, the previous evening. She reported she told	F 250	1. Resident #10 individual needs have been met by moving resident #12 to a different table in the dining on 9-23-10 and was moved to a different room away from resident #12's room, and closer to the nurse's station on 9-29-10. Care plan changes ongoing to reflect resident #12's behavioral status. Family was made aware and will be kept informed of resident #12's behaviors. Ongoing review of Resident #12's medications will be done per psychiatrist and physician. 2. All residents of Good Samaritan Society Oakes have the potential to be affected by this practice. 3. All staff educated to monitor resident #12's whereabouts and to report any noted behaviors to charge nurse. All	

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F 250	Continued From page 21 Resident #12 to leave, which he did, and she did not inform the facility staff. - During interview with a group of facility residents identified by the facility as interviewable, on 09/22/10 at 3:00 p.m., Resident #10 reported Resident #12 struck her in the back and Resident #10 reported continued fear of Resident #12. During this interview, Resident #22 reported she witnessed Resident #12 strike Resident #10. Review of Resident #10's medical record occurred on September 21-23, 2010. Resident #10's current care plan, dated 09/15/10, stated "Problems . . . Altered mood state . . . Voice fear of male resident bothering her up to 5 days a week. . . . Plans . . . Reassure staff are aware and male resident has been talked to. Check on her frequently. Encourage her to discuss her feelings with staff." Resident #10's Physicians Progress Notes, dated 04/28/10, stated ". . . Patient states that she has been feeling very weak for the past two days. . . . Nurses indicate that this maybe to some extend [sic] related to anxiety as there have been certain problems with other residents, especially at mealtime and patient has been very sensitive to these comments. . . . She will be observed to see if there is a change in status. . . ." Resident #10's physician orders, dated 07/27/10, included "Ativan 1 mg [milligram] BID [two times each day]" for "Anxiety." This is an increase from 1 mg as needed each morning and 1 mg each evening. Ativan is an anti-anxiety medication. Resident #10's Interdisciplinary Progress Notes identified the following:	F 250	concerns brought forth by residents, toward other residents will be reviewed at daily Incident meetings as they occur, and then reviewed at the monthly behavior meeting. We are starting a behavior trending and tracking log for resident #12 and for any other residents who have behavioral tendencies toward other residents to be reviewed at monthly behavior meeting. When any alleged abuse occurs, the resident being abusive will be removed from the situation. All alleged abuse incidents need to be reported to the charge nurse who will complete an Incident report (GSS #401). The family/responsible party and physician of the resident doing the abuse will be notified of the residents' actions. This incident report will be discussed at the next Incident meeting. Investigation of the alleged abuse will be conducted by the LSW, DON, ADM. or their designees' immediately when an emergency situation arises. Social Worker will interview	

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F 250	Continued From page 22 *dated 02/22/10, 9:00 p.m. - Resident #12 was staring at her, making comments to her, Resident #10 was uncomfortable. *dated 09/01/10, 7:00 p.m. - Resident #12 "thumped" Resident #10 in the back. Resident #10 expressed fear of Resident #12, to staff. During interview, on 09/23/10 at 9:05 a.m., a social work staff member (#5) reported the facility lacked a written report or investigation of the incident of 09/01/10 at 7:00 p.m. This staff member (#5) provided a "Suggestion or Concern" form dated 09/02/10 regarding Resident #10 which stated ". . . Report of Concern: Res. [Resident] asked me to stay with her because [Resident #12] was walking by. She told me he harassed her every meal. She also said she was scared he'd come into her room at night. She said she had told him that she did not like him. I reassured [her] that there was staff here to make sure he did not come to her room. Investigation: [Resident #12] can be overly friendly. We have told him this is socially unacceptable. He states he understands. Improvement had been noted [with] Lexapro [anti-depressant medication]. 2 weeks ago medication decreased. We have seen him increasingly more 'friendly' with other residents. Resolution: We will notify primary physician of residents [sic] behavioral changes. . . ." Refer to F224 and F226 for information regarding Resident #12's behavioral concerns and record review. During interview, on 09/23/10 at 11:00 a.m., a supervisory nursing staff member (#6) reported she was not aware of Resident #12 entering Resident #10's room, uninvited. This staff	F 250	other residents who verbalize they might be fearful of resident #12. State agency notification as required by Good Samaritan Society's policy. 4. All staff will be in serviced on Oct. 26th & 27th on how to identify potential abusive behavior and the importance of reporting any abuse to the charge nurse. The LSW or her designee will meet weekly (or sooner if needed) with the residents who have complaints of being abused. If the resident who is being abused continues to have concerns after interventions have been completed, the family/responsible party of the resident doing the abuse will be notified to have a care conference with the IDT (inter-disciplinary team) and administrator or his designee about the alleged abuse. 5. LSW or her designee will do an audit to ensure that the new system is operational. Audits	

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F 250	Continued From page 23 member identified Resident #12's dementia and memory loss limited his awareness of his actions. The facility identified Resident #12 with a history of sexual behaviors and identified the resident's inappropriate behaviors towards other residents. The resident's care plan identified monitoring and redirection as approaches for staff. Resident #12's Interdisciplinary Progress Notes identified recurrent inappropriate behaviors and staff redirection. The facility's Behavior Management Meeting minutes identify Resident #12's continued inappropriate behaviors. The facility's response to Resident #12's behaviors had been to continue monitoring, continue redirection, and increase his anti-depressant, Lexapro, on 09/03/10 after he struck Resident #10 on 09/01/10. Resident #12's behaviors continued towards residents and staff. The facility attributed Resident #10's expression of fear and increased anxiety related to Resident #12 as her own sensitivity and responded by increasing her anti-anxiety medication. The facility failed to consider Resident #12's increased behaviors and the close proximity of Resident #10's and Resident #12's rooms at the end of the hall away from the nurse's station as causes of her increased fear and anxiety. The facility failed to provide approaches and interventions to limit Resident #12's inappropriate behaviors. Failure to modify existing approaches and provide effective approaches to deal with Resident #12's inappropriate behaviors resulted in Resident #12 striking Resident #10, residents being fearful of Resident #12, and may have resulted in Resident #10 receiving unnecessary	F 250	will be done three times per week for one month, two times per week for one month and one time per week for one month. Audit results will be reported to the QA/CQI committee for further recommendations. Audits will be done per Q.A. Coordinator and or designee. Date certain 10-28-10	10-28-10

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355095	A. BUILDING _____ B. WING _____	C 09/23/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - OAKES	213 N 9TH ST OAKES, ND 58474

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F 250 F 323 SS=E	Continued From page 24 anti-anxiety medication and possible side effects. 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 review of facility policies and procedures, record review, and staff interviews, the facility failed to provide adequate supervision and monitoring to safeguard 1 of 2 sampled residents (Resident #2) exhibiting wandering and elopement risk. The failure of the facility to provide adequate supervision and monitoring resulted in Resident #2 leaving the facility unattended and without the facility's knowledge on multiple occasions and resulted in Resident #2 experiencing a fall with injury from his wheelchair. - Review of facility procedure titled "Elopement" occurred on 09/23/10. The procedure, revised September 2010, stated, "PURPOSE: to assess and identify residents at risk for elopement. To clearly define . . . residents at risk for elopement. These include identifying environmental hazards and individual resident risk, including the need for supervision; evaluating/analyzing hazards and risks; implementing interventions, including adequate supervision, consistent with a resident's needs, goals, plan of care and current standards of practice and monitor/modifying interventions as	F 250 F 323	1. For Resident # 2 the Life Line door alarm system has been installed and is in working order. Res. #2 was assessed for elopement and now has a bracelet on and his care plan has been amended. 2. All residents at an elopement risk have the potential to be affected by this practice. 3. A new door alarm system was fully installed on 9-24-10. New System Change: All Elopements will be notified to the Administrator at the time they happen according to Good Samaritan Society policy. In service to all staff about elopement, what constitutes elopement, and proper notification of Administration as per Good Samaritan Society policy will be held on Oct. 26th & 27th. The elopement risk worksheet will be completed prior to each new admission. Care plan will alert staff to the	

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F 323	Continued From page 25 needed. To provide a system of documentation for the prevention of and in the event of elopement. To minimize risk for elopement through individualized interventions. . . . To identify a plan in the event of resident elopement. PROCEDURE: . . . 2. At the time of admission, identify all residents who are at risk for elopement on the Initial/Temporary Narrative Care Plan (GSS #280A), Initial/Temporary Care Plan (GSS #280B or Comprehensive Care Plan (GSS #280C) with interventions specific to the resident to minimize individual risk. . . . 4. Care plan team members should consider the following when assessing risk of elopement: a. Wandering behavior . . . b. History of elopement c. Cognitive impairment d. Attempts to leave center . . . 6. Wander alert bracelets are to be checked daily by rehab or nursing to determine if they are in working order. . . . 10. In the event of a resident elopement: a. Notify the administrator, charge nurse . . . immediately. . . . d. In all cases, family will be notified of the incident. e. Notify the physician. f. The Resident/Visitor Incident Report (GSS #401) will be completed. . . . 12. After an elopement has occurred, use the Elopement Checklist Worksheet . . . to ensure all required steps were followed. . ." "Elopement Checklist Worksheet . . . 3. Have previous elopement attempts been documented by center staff: 4. Was the risk for elopement addressed on the Comprehensive Care Plan? 5. After elopement, was resident's care plan updated for appropriate interventions? 6. Were individualized interventions from the care plan implemented? 7. Was there adequate supervision? . . . 8. Is an individual resident safety alarm, . . . wander alert bracelet, used?	F 323	risk of elopement for each new admission. 4. Audits on the incident reports to ensure that the new system is operational will be done three times per week for one month, two times per week for one month and one time per week for one month. Audit results will be reported to the QA/CQI committee for further recommendations. Audits will be done per Q.A. Coordinator and or designee. Date certain 10-28-10	0-28-10

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F 323	Continued From page 26 9. If resident has an individual safety alarm, was it in working order? 10. Was the exit door alarm activated when the resident eloped? 11. If the exit door did not have an alarm, is the door within the sight of a staff member at all times? 12. Is the exit door alarm in working order?" The facility policy "Elopement" included a sample care that stated the following: "PROBLEM: Potential for elopement r/t previous history of wandering behavior, elopement attempts. GOAL: Resident will not elope from center. INTERVENTION: 1) Account for residents at risk for elopement every 15-30 minutes . . . 6) Use of door alarms 7) Use of video cameras or mirrors 8) Use of resident safety alarms 9) Provide appropriate activities, individualized to resident choice . . ." Review of Resident #2's medical record occurred on September 21-23, 2010. The resident's diagnoses included: Alzheimer disease, dementia, anxiety, and agitation. The resident's current medication administration record stated, "Aricept [dementia/Alzheimer] 10mg [milligrams] po [orally] q [every] day, Ativan [anxiety] 0.25mg qd prn [as needed], and Trazodone [anxiety/agitation] 25mg po tid [three times daily]". The Minimum Data Set (MDS) indicated short/long term memory problems, impaired decision making, and difficulty understanding others/making self understood. Resident #2's current care plan, dated 09/08/10, stated "PROBLEM: Alteration in mobility . . . falls INTERVENTIONS: secure care bracelet check for working order weekly and prn. Check for	F 323		

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F 323	Continued From page 27 irritation/edema from bracelet. PROBLEM: altered behaviors . . . sexual comments . . . goes in female friends room west unit . . . wanders hallways . . . INTERVENTIONS: . . . redirect him out of female's room, to stay 3 feet away from female resident, wears sensor to alert staff if close to female residents . . ." Resident #2's September 2010 medication record included "Secure care bracelet due to attempts of leaving facility per self 6:00 a.m." Review of facility "Incident Details" reports regarding Resident #2's elopements included: * 11/29/09 4:15 p.m.: "Resident noted sitting on ground with w/c [wheelchair] tipped on it's side, secure care did not set off alarm @ [at] door." . . . Section F. Type of Alleged Injury: "puncture to 1-4 fingertips, abrasion to forehead + knees bil. [bilaterally]." Section G of this report asked, "What immediate interventions have been put in place to prevent this incident from happening again?" with the response, "Update the care plan with these interventions . . ." Nursing documentation stated, "secure care bracelet replaced." The record indicated the administrator and the physician were not notified. * 01/12/10 3:00 p.m. and 3:45 p.m.: "Resident got out the sun room door on the East wing x [times] 2. Security alarm sounded but door did not lock. Staff retrieved him both times." Section G., (regarding assessment/evaluation and interventions for prevention of incident procurance), remained blank. * 06/13/10 6:00 p.m.: "Resident went out the sun porch door on the east side and came around to the front of the building . . . door alarm sounding." Section G. stated, "None needed." Immediate	F 323		

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F 323	Continued From page 28 interventions placed to prevent the incident from happening again stated, "Monitoring sun porch door more closely . . ." * 06/20/10 3:00 p.m.: "Resident found out in front parking lot by staff . . ." Section G. remained blank. Immediate interventions stated, "New secure care placed on residents arm." The record indicated the administrator and physician were not notified. * 07/03/10 10:35 a.m.: "Found [resident] out in parking lot by street. A visitor stopped him. . . . Took 4 people to get him into building. Kicking at CNA's. . ." Section G. stated, "Make sure secure bracelet is turned to outer wrist." Immediate interventions stated, "gave PRN [as needed] Lorazepam". The record indicated the administrator was not notified. * 08/15/10 4:25 a.m.: "Found on lawn/ w/c tipped over . . . sensor sounding - sun porch. Heard him yelling "it's cold." Section G. stated, "laying on lt [left] side. w/c tipped over on lawn. States 'he's going uptown.'" Immediate interventions stated, "Reassurance. . . ." The record indicated the administrator was not notified. * 08/21/10 6:15 p.m.: "Found this resident out on road on north side of GSS-O [Good Samaritan Society - Oakes]." Section G. remained blank. The record indicated the administrator was not notified. * 08/24/10 2:30 p.m.: "Wanders in w/c. Went out West/South door." Section D.,(regarding Personal Alarm System), indicated the alarm did not sound, and stated, "West door doesn't work". Section G. stated, "Told west nurse - turn him around when on west as doors don't work." The immediate interventions section remained blank. The record indicated the administrator was not notified. An interview with an administrative staff member	F 323		

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F 323	Continued From page 29 (#1) occurred on 09/23/10 at 1:50 p.m. The staff member agreed the elopement prevention process, interventions and documentation was unsatisfactory. The record lacked evidence the facility had assessed Resident #2 for risk of elopement prior to and following these incidents. In addition, the care plan had an entry "07/03/10 Elopement" crossed off the problem list even though Resident #2 eloped from the facility three more times after that date. Failure of the facility to provide adequate supervision and monitoring resulted in Resident #2 leaving the facility unattended and without the facility's knowledge on multiple occasions and resulted in Resident #2 experiencing a fall with injury from his wheelchair. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 09/10/09. 2. Based on observation, record review, review of the mechanical lift operating instructions, and staff interview, the facility failed to ensure residents received adequate supervision and assistance to prevent accidents for 4 of 8 sampled residents (Resident #4, #7, #11, and #16) observed during transfers with a sit to stand mechanical lift. This practice placed the residents at risk for injury and/or pain during the transfers. Findings include: Review of the EZ Stand mechanical lift operating instructions occurred on 09/23/10. The instructions stated ". . . TRANSFERRING THE PATIENT: APPLY HARNESS 1) Position the top	F 323	1. Res. # 4 expired on 10-15-10 Resident #11's safety needs have been met by getting a large enough chest strap to go around him. Resident #16's safety needs have been met by adding to the care plan "if resident is drowsy a gait belt and two person transfer will be used". Resident #7's safety needs have been met by ensuring that the staff is educated on proper foot placement on the platform and that the straps are fastened.	

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F 323	Continued From page 30 of the harness . . . around the upper body of the patient (approximately 4-5 inches below the underarm) . . . 2) For the safety of the patient, securely fasten the safety strap around the patient's chest. 3) On harnesses with the plastic buckles, secure the buckle and pull the loose strap to tighten . . . POSITION EZ STAND IN FRONT OF PATIENT . . . 3) Have patient place feet (help patient if needed) on foot plate and position their shins into the shin pad . . . NOTE: If necessary to keep patient's shins or feet on the foot plate, secure the shin straps around the patient's legs . . . RAISE THE PATIENT 1) Position patient's arms on the outside of the harness and place their hands on the padded handles. . . ." - Observations made on 09/22/10 identified the following: *1:30 p.m., a certified nursing assistant (CNA) (#9) transferred Resident #4 onto the toilet using a sit-to-stand mechanical lift. The CNA assisted Resident #4 to a standing position by raising the harness. The top lifting straps pulled upward into Resident #4's axillae (armpits), while the safety strap around her waist remained loose. Resident #4 moaned as the CNA raised the harness. The CNA (#9) asked the resident if she was in pain, and she responded "Yes." Resident #4 stopped moaning when the CNA (#9) lowered the harness slightly. *1:50 p.m., a CNA (#9) transferred Resident #4 into bed using a sit-to-stand mechanical lift. The CNA assisted Resident #4 to a standing position by raising the harness. The top lifting straps pulled upward into Resident #4's axillae (armpits), while the safety strap around her waist remained loose. Resident #4 moaned as the CNA raised the harness. She stopped moaning when the	F 323	2. All residents that are transferred with a transfer lift have the potential to be affected by this practice. 3. We will identify residents who use mechanical transfer lifts to be able to observe proper usage of the chest strap and foot placement. The Nursing staff will be in-serviced on Oct. 26th & 27th about the proper use of lift, usage of straps, foot placement and how to transfer residents who are drowsy or not holding on. 4. Audits will be conducted on the transfer lifts to ensure proper usage. Audits will be done three times per week for one month, two times per week for one month and one time per week for one month. Audit results will be reported to the QA/CQI committee for further recommendations. Audits will be done per Q.A. Coordinator and or designee. Date certain 10-28-10	10-28-10

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F 323	Continued From page 31 CNA (#9) lowered her into bed. Review of Resident #4's medical record on September 21-23, 2010 identified the resident's diagnoses included right below-knee-amputation (BKA), right hemiparesis, deconditioning, osteoarthritis, and pain. A significant change Minimum Data Set (MDS), dated 08/10/10, identified short-term memory impairment, moderately impaired daily decision-making skills, extensive assistance of one person with transfers, a fall within the past 30 days, and unstable condition. Resident #4's Resident Assessment Protocol (RAP) summary, dated 08/17/10, stated, ". . . ADL Function . . . Due to h/o [history of] right BKA [and] depression she has needed more assist with adls [activities of daily living]. She is nonambulatory [and] receives extensive assist of one with transfers with sit to stand lift . . ." Resident #4's current comprehensive care plan, dated 08/18/10, stated, ". . . Problems . . . Alteration in mobility . . . Approaches . . . Transfers with sit to stand lift for all transfers. Sling size small-medium. Do not use left leg shin strap per PT [physical therapy]. During an interview on 09/23/10 at 8:00 a.m., a management nursing staff member (#6) stated, "We will reevaluate her [Resident #4]. I didn't know she was having pain with transfers. She does have shoulder pain too. Maybe she has that hanging posture because of her leg." - Review of Resident # 11's medical record occurred on all days of survey. Medical diagnoses included traumatic spinal cord injury with	F 323		

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F 323	Continued From page 32 paraplegia, past cervical spine fracture, osteoarthritis, and muscle spasms. The current quarterly MDS, dated 08/03/10, identified the resident experienced mild pain less than daily in his soft tissues and "other" pain. The current MDS identified the resident required total assistance of two or more staff members to transfer. Observation on 09/21/10 at 4:45 p.m. showed a CNA (#3) transferred Resident #11 onto the toilet with a sit-to-stand mechanical lift. The CNA (#3) failed to fasten the safety strap around the resident's chest during the transfer and stated the facility did not have a sling with a strap big enough to fit around his chest. Observation of additional transfers with Resident #11 showed other CNAs used a sling with a chest strap that fastened around the resident's chest. During an interview on 09/23/10 at 11:15 a.m., an administrative staff member (#2) stated they have a larger sling available with chest straps to fit around Resident #11's chest and she expected all staff members to fasten the chest straps when transferring the resident with the sit-to-stand mechanical lift. - Review of Resident #16's medical record occurred on 09/23/10. Medical diagnoses included arthritis and peripheral neuropathy. The current quarterly MDS, dated 07/06/10, identified the resident required total assistance of one staff member to transfer. Observation on 09/23/10 at 8:30 a.m. showed two CNAs (#4 and #7) transferred Resident #16 from her wheelchair onto the toilet, and from the toilet to her bed, with a sit-to-stand mechanical lift. Resident #16 was drowsy and closed her eyes	F 323		

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F 323	Continued From page 33	F 323		

during the entire transfer. During the transfer a CNA (#7) stated, "She is really sleepy this morning." The resident failed to hold on to the handle bar on the lift with her right hand during the transfer both on and off the toilet. The strap around the resident's back slipped upward into her axillae, causing Resident #16's shoulders to shrug upward and her elbows to bow outward. Resident #16 bent her knees and failed to stand up straight during the transfer.

On 09/23/10 at 10:45 a.m., observation showed a CNA (#7) transferred Resident #16 with a sit-to-stand mechanical lift. Resident #16 opened her eyes and was more alert. The transfer went smoothly without concerns. A CNA (#7) stated when Resident #16 is tired they use a gait belt and transfer her with two staff members. The CNA (#7) stated, "We should have done that this morning since she was so drowsy."

During an interview on 09/23/10 at 11:15 a.m., an administrative staff member (#2) stated it is unacceptable for staff to transfer Resident #16 with the mechanical lift when she is drowsy and unable to utilize the mechanical lift properly.

- Review of Resident #7's medical record occurred on September 21-23, 2010. Current diagnoses included a history of left great toe ulcer (healed 06/11/10), edema, and long standing right below knee amputation. The resident's current MDS, dated 08/22/10, identified extensive assistance of two or more persons for transfers and falls in the past 180 days.

Resident #7's current care plan, dated 09/01/10, stated "Problems, Alteration in mobility and potential for injury r/t [related to]: right below knee

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F 323	Continued From page 34 amputation m/b [manifested by]: h/o [history of] falls. . . . Plans . . . Transfers with sit to stand PRN [as needed] as condition indicates. . . ." Observations of facility staff transferring Resident #7 with the sit to stand lift included the following: *09/22/10, 11:00 a.m. - CNAs (#11) and (#12) transferred the resident from the toilet to a wheelchair. The resident's left heel was positioned off the back of the lift platform with weight bearing on the raised lip of the platform, the thoracic strap and calf straps unbuckled. After returning the resident to the wheelchair, the CNAs determined he was in his roommate's wheelchair. The CNAs buckled the thoracic strap, left the calf strap unbuckled, the left heel remained off the back of the lift platform with weight bearing on the raised lip of the platform, brought the resident to a standing position with weight bearing on the left leg, and moved him to another wheelchair. *09/22/10, 12.25 p.m. - CNA (#12) transferred the resident from the wheelchair to his bed. The CNA placed the resident's left foot on the lift platform with his toes in a hyperextended position (bent backward) at the front of the lift platform, left the calf strap unbuckled, brought the resident to a standing position weight bearing on the left leg, and positioned him at the edge of the bed. During interview, on 09/23/10 at 11:00 a.m., a supervisory nursing staff member (#6) agreed the staff members should buckle the thoracic and calf straps and position the left foot on the lift platform, for Resident #7's transfers. Failure to buckle the lift straps placed Resident #7 at risk of falls from the lift during transfers. The absence of Resident #7's right leg increases the support necessary from the left leg. The	F 323		

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F 323	Continued From page 35 resident's history of falls identified the potential lack of stability of the left leg. In addition to Resident #7's history of healed left great toe ulcer, the facility's failure to ensure proper positioning of the resident's left foot on the lift platform placed him at risk of skin breakdown.	F 323		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review, review of professional reference, review of policy and procedure,	F 329	1.Resident #1's individual needs have been met by having the medications reviewed by the consultant pharmacist with recommendations made and accepted by the primary care physician to decrease the Xanax. Resident # 3's individual needs have been met by having the medications reviewed by the consultant pharmacist with recommendations made and accepted by the primary care physician to decrease the Buspar gradually. Resident #5's individual needs have been met by having the medications reviewed by the consultant pharmacist with recommendations made and accepted by the primary care physician to decrease the Clonoazapam. Resident #10's individual needs have been met by having the medications reviewed by the	

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F 329	Continued From page 36 resident interview, and staff interview, the facility failed to ensure the drug regimen remained free from unnecessary drugs regarding potential excessive dose, for excessive duration, without adequate monitoring, and in the presence of adverse consequences, for 4 of 16 (Resident #1, #3, #5, and #10) sampled residents. Failure to provide adequate monitoring and failure to attempt a gradual dose reduction (GDR) may have resulted in development of adverse consequences, including tardive dyskinesia, for Resident #10. Failure to provide these services placed all residents at risk of receiving unnecessary medications and potential side effects. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding the tapering of a medication dose/GDR which states the purpose of tapering a medication is to find an optimal dose or to determine whether continued use of the medication is benefiting the resident. Tapering may be indicated when the resident's clinical condition has improved or stabilized or the underlying causes of the original target symptoms have resolved. Often, however, the only way to know whether a medication is needed indefinitely and whether the dose remains appropriate is to try reducing the dose and to monitor the resident closely for improvement, stabilization, or decline. For antipsychotic medications, after the first year, a GDR must be attempted annually, unless clinically contraindicated. CMS identified "tardive dyskinesia" refers to abnormal, recurrent involuntary movements that	F 329	consultant pharmacist with recommendations made. The primary care physician did not decrease Seroquel or Ativan and add Cogentin after AIM's review. Will review at next house call. A dictated note was made for her reason not to decrease medications at this time. 2. All residents that receive antipsychotic medications have the potential to be affected in this area. 3. A list of residents currently receiving antipsychotic medications will have their AIMS score and their medications reviewed by a consulting physician and/or attending physician. A licensed nurse meeting will be held on Oct 26th & 27th to review the Procedure for gradual dose reduction on antipsychotic medications per Federal regulations. 4. Pharmacy consultant has developed a spreadsheet to monitor the use of antipsychotic medications including start/end date, date of last dosage reduction attempt, and AIMS score. Audits will be done three times per week for one month, two	

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F 329	Continued From page 37 may be irreversible and typically present as lateral movements of the tongue or jaw, tongue thrusting, chewing, frequent blinking, brow arching, grimacing, and lip smacking, although the trunk or other parts of the body may be affected. Review of the facility's policy, titled "Unnecessary Medications" occurred on 09/23/10. This policy, issued 01/07, stated, ". . . An unnecessary drug is any drug when used: a. in excessive dose including duplicate therapy or b. for excessive duration or c. without adequate monitoring . . . " Review of the facility's policy, titled "Psychopharmacological Medications and Sedative/Hypnotics" occurred on 09/23/10. This policy, revised 09/10, stated, ". . . Gradual Dose Reductions: The purpose of tapering medication is to . . . determine if continued use of the medication is benefiting the resident. . . . 3. Other Psychopharmacological Medications: a. . . . After the first year, a tapering should be attempted annually unless clinically contraindicated. . . . 10. e. Gradual dose reductions must be done according to federal regulations . . ." - Review of Resident #10's medical record occurred on September 21-23, 2010. Current diagnoses included back pain, arthritis, depression, and psychosis. The resident's current Minimum Data Set (MDS), dated 09/06/10, identified short term memory problems, no long term memory problems, expressions of what appear to be unrealistic fears up to five days per week and repetitive health complaints daily that are easily altered, no change in mood, and moderate degree of back, hip, and other joint pain on a daily basis. The MDSs, dated 06/08/10,	F 329	times per week for one month and one time per week for one month. Audit results will be reported to the QA/CQI committee for further recommendations. Audits will be done per Q.A. Coordinator and or designee. Date certain 10-28-10	10-28-10

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F 329	Continued From page 38 03/09/10, 12/08/10, and 09/07/10 identified repetitive health complaints daily that were easily altered, did not identify any other behaviors, and no change in mood identified. The facility identified the resident as interviewable. Resident #10's current physician orders, dated 09/15/10, included the following, with the current medication and dosage, the date prescribed, and the medication class: *Seroquel 25 mg, twice daily - 04/18/07 (antipsychotic) *Ativan 1 mg, twice daily - 07/27/10 (antianxiety), (increased from 1 mg, daily and 1 mg, morning, as needed - 01/19/07) "Nursing 2009 Drug Handbook," 29th edition, Lippincott, Williams and Wilkins, Philadelphia, regarding Seroquel, pages 669-671, states ". . . INTERACTIONS, Drug-drug. . . . Lorazepam [Ativan]: May decrease lorazepam clearance. Monitor patient for increased CNS [central nervous system] effects. . . . NURSING CONSIDERATIONS . . . Monitor patient for tardive dyskinesia, which may occur after prolonged use. It may not appear until months or years later and may disappear spontaneously or persist for life, despite ending drug. . . .;" Resident #10's Cognitive Resident Assessment Protocol Summary (RAPS), dated 09/06/10, stated ". . . She takes Ativan for anxiety & Celexa & Effexor for depression. . . . She takes Seroquel for her psychosis. . . .;" and, the Mood RAPS, dated 09/06/10, stated ". . . Her family has chosen not to have her seen for her psych [psychoactive] medication use. . . . " Resident #10's current care plan, dated 09/15/10,	F 329		

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F 329	Continued From page 39 identified anti-anxiety, anti-depressant, and anti-psychotic medications as "Problems" and "Side Effects, Physician to Follow, and Monitor Side Effects" as "Plans" for these medications. Resident #10's Physicians Progress Notes identified the following: *09/16/09 - ". . . takes Celexa 10 mg daily as well as Seroquel 25 mg. b.i.d. [two times daily] and Ativan 1 mg daily . . . Plan at this time is to continue her on the same medications. . . ." *01/06/10 - ". . . Her main concern is that of pain and she states that on some days it is not as bad, but overall methadone appears to be helping. Patient's pharmacy has requested that the Effexor be switched, however, she is on methadone and Celexa as well as Effexor, gabapentin, and Seroquel. At this time, I do believe that changing her medications would probably require adjustment of multiple other medications. Patient has been stable on this. . . ." *04/28/10 - ". . . patient states that she has been feeling very weak . . . Nurses indicate that this maybe to some extend [sic] related to anxiety as there have been certain problems with other residents, especially at mealtime and patient has been very sensitive to these comments. She does have a history of chronic back pain for which she takes methadone. Patient also has had a history of depression as well as anxiety. She takes Celexa 10 mg daily, Effexor 75 mg daily, Seroquel 25 mg b.i.d. as well as Ativan 1 mg daily. Patient has in the past done well on this combination and it appears to have controlled her symptoms. . . . We will continue to observe at this time. . . . Patient will continue on the current medications." *09/01/10 - ". . . The patient was having some problems with nausea for about 3 weeks;	F 329		

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F 329	Continued From page 40 however, she states that this has resolved, and she has not been feeling the nausea recently. She, however, has been having some problems with fatigue, and the patient states that he [sic] she is trying to get around a little bit more. The patient is on several pain medications, but this has appeared to control her problems of significant osteoarthritis. She seems comfortable from this, although I suspect that some of the nausea is related to these medications. . . . The patient will continue on her current dosage of methadone for pain control. . . ." The progress note did not include any changes in Resident #10's medication regimen. Resident #10's Abnormal Involuntary Movement Scale (AIMS), dated 06/07/10 and 09/07/10, showed scores of "2, mild" for lower extremity and trunk movements; were noted as "positive;" and, were signed by the resident's physician. The AIMS dated 09/02/09, 12/08/09, and 03/09/10 are identified as "negative." During interview, on 09/22/10 at 9:45 a.m., with Resident #10, observation identified the resident moved her trunk or extremities nearly continuously. When asked about this, the resident reported this is of recent onset but did not provide an approximate date. The resident reported "I get used to it and don't even notice it now." During interview, on 09/23/10 at 11:00 a.m., a supervisory nursing staff member (#6) reported Resident #10 complained of pain at times with the current medication regimen. This staff member was not aware of any attempt to reduce or change the resident's pain medications, antipsychotics, or antidepressants since the dates previously identified.	F 329		

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F 329	Continued From page 41 The facility provided Resident #10 with the same dosage of antipsychotic medication for more than two years. The physician's progress notes identify the number of medications, duration of these medications, potential interactions, and negative side effects. The facility continued to provide the same medications, failed to address the potential interactions, failed to address the negative side effects, and failed to address the positive AIMS test results. The facility failed to attempt a GDR on Resident #10's psychotropic medications in the absence of psychotic symptoms and after the resident demonstrated "positive" AIMS on 06/07/10 and 09/07/10. The facility has continued the same antipsychotic (Seroquel) since 2007, and increased the resident's antianxiety medication (Ativan) after providing the same dosage for more than three years. Failure to consider alternatives or reductions in these medications may have resulted in Resident #10 developing tardive dyskinesia, negative side effects, and receiving unnecessary medications in excessive doses with potential risk for drug interactions and additional negative side effects. - Review of Resident #3's medical record on September 21-23, 2010 identified diagnoses which included anxiety and psychosis. Resident #3's Resident Assessment Protocol (RAP) summary, dated 08/13/10, stated, ". . . Psychotropic Drug Use . . . BuSpar 15 mg [milligrams] po [by mouth] is taken bid [twice daily] for anxiety disorder. . . . This was started on 11/24/04. . . ."	F 329		

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F 329	Continued From page 42 Resident #3's current comprehensive care plan, dated 08/25/10, stated, ". . . Problems . . . Potential for adverse side effects r/t [related to]: anti-anxiety medication: . . . need to monitor . . . Approaches . . . Assess for consequences of med [medication] . . ." Resident #3's current Physician Orders identified the following: * "BuSpar 15 mg po bid (anxiety disorder)" During an interview on 09/23/10 at 8:00 a.m., a management nursing staff member (#6) confirmed the facility failed to attempt a GDR within the past year. Resident #3's medical record failed to provide clinical rationale for the continued use of BuSpar or the contraindications for a dose reduction attempt. - Review of Resident #5's medical record occurred on September 21-22, 2010. The facility admitted the resident on 06/09. Medical diagnoses included anxiety. Physician's Orders identified Resident #5's current medications include Clonazepam (an anticonvulsant medication) 0.5 mg at bedtime for anxiety initiated on 06/29/09. The medical record identified the facility hospitalized Resident #5 July 16-17, 2010 for a cerebral vascular accident (CVA) with left hemiparesis. Review of Resident #5's MDSs, since admission, identified the following: - Admission MDS, dated 07/05/09, identified repetitive physical movements are present and easily altered. No behaviors exhibited. - Quarterly MDS, dated 06/24/10, identified no	F 329		

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F 329	Continued From page 43 indicators of depression, anxiety, or sad mood. No behaviors exhibited. - Quarterly MDS, dated 07/21/10 (following the hospital stay) identified persistent anger with self or others is present and easily altered. Verbally abusive behaviors exhibited that were easily altered. Review of Physician's Orders identified no changes to the Clonazepam dosage since admission to the facility on 06/29/09. The Physician's Progress Notes, reviewed since admission, do not address the use of the Clonazepam by Resident #5 even after Resident #5 experienced a CVA and exhibited changes in her mood and behavior. An interview occurred with an administrative nursing staff member (#2) on 09/22/10 at 4:15 p.m. This staff member confirmed Resident #5 has received the same dose of Clonazepam since admission to the facility, with no attempts at a gradual dose reduction. - Review of Resident #1's medical record occurred on September 21-23, 2010. Resident #1's diagnoses included anxiety disorder. Resident #1's current medication regimen included, Xanax 0.5 mg every morning and at bedtime, dated 03/24/08. The current care plan, dated 07/29/10, stated, "PROBLEM: Potential for adverse side effects r/t [related to]: anti-anxiety medication . . . need to monitor . . . will be maintained on minimum therapeutic dose per MD orders/recommendations. Anxiety will be less by next review . . ." Record review failed to show a dose reduction had been attempted since 03/24/08 and failed to	F 329		

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F 329	Continued From page 44 identify a need for Resident #1 to remain on this same medication/same dose for over two years. An interview with an administrative nursing staff member (#6) occurred the morning of 09/23/10. The staff member confirmed a dose reduction had not been attempted within the past two years.	F 329		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review, review of professional reference, review of policy and procedure, and staff interview, the facility's consultant pharmacist failed to identify and report irregularities to the attending physician and director of nursing for 4 of 16 sampled residents (Resident #1, #3, #5, and #10) receiving psychopharmacological medications. Failure to attempt a GDR may have resulted in development of adverse consequences, tardive dyskinesia, for Resident #10. Failure to identify the presence of tardive dyskinesia as an adverse consequence may have limited the physician's ability to limit these effects. Failure to provide these services placed all residents at risk of receiving unnecessary	F 428	1. Resident #1's individual needs have been met by having the medications reviewed by the consultant pharmacist with recommendations made and accepted by the primary care physician to decrease the Xanax. Resident # 3's individual needs have been met by having the medications reviewed by the consultant pharmacist with recommendations made and accepted by the primary care physician to decrease the Buspar gradually. Resident #5's individual needs have been met by having the medications reviewed by the consultant pharmacist with recommendations made and accepted by the primary care physician to decrease the Clonoazapam.	

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F 428	Continued From page 45 medications and potential side effects. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined the the standards of practice regarding the drug regimen review which states the facility's intent should be to maintain the resident's highest practicable level of functioning and prevent or minimize adverse consequences related to medication therapy by providing a licensed pharmacist's review of each resident's regimen of medication. The pharmacist should identify and report irregularities to the attending physician and the director of nursing. Review of the following facility policies occurred on 09/23/10: *"Pharmaceutical Services," revised 01/09, stated, ". . . A licensed Pharmacist will be employed or services obtained to: . . . 4. Review the medication regime of each resident at the time of Change of Condition . . . 5. Report any irregularities to the attending physician or the director of nursing services or both. (These reports must be acted upon and follow-up documentation maintained.)" *"Psychopharmacological Medications and Sedative/Hypnotics," revised 09/10, stated: ". . . Non-Emergency Administration: . . . 10. e. Gradual dose reductions must be done according to federal regulations. . . ." *"Unnecessary Medications," issued 01/07, stated, ". . . 2. . . . the center and consultant pharmacist are responsible for . . . determining the use of unnecessary medications. . . ."	F 428	Resident #10's individual needs have been met by having the medications reviewed by the consultant pharmacist with recommendations made. The primary care physician determined not to decrease Seroquel or Ativan and add Cogentin after AIM's review. Dictation to note reason for decision. 2. All residents that receive antipsychotic medications have the potential to be affected in this area. 3. Consultant pharmacist review will be monitored by DNS and reduction meeting monthly. A list of residents currently receiving antipsychotic medications will have their AIMS score reviewed by consulting pharmacist and/or attending physician. Consultant pharmacist to set up a Spread sheet for following anti-psychotic medications. A licensed nurse meeting will be held on Oct 26th & 27th to review the procedure for antipsychotic medications to include tardive dyskinesia, gradual dose	

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F 428	Continued From page 46 The facility failed to ensure reporting of drug irregularities and gradual dose reductions occurred according to federal regulations for Resident #1, #3, #5, and #10. Refer to F329. - Review of Resident #10's medical record occurred on September 21-23, 2010. Resident #10's current physician orders, dated 09/15/10, included the following, with the start date of the current medication dosage, and the medication class: *Seroquel 25 mg, twice daily - 04/18/07 (antipsychotic) *Ativan 1 mg, twice daily - 07/27/10 (antianxiety), (increased from 1 mg, daily and 1 mg, morning, as needed - 01/19/07) Resident #10's Abnormal Involuntary Movement Scale (AIMS), dated 06/07/10 and 09/07/10, showed scores of "2, mild" for lower extremity and trunk movements; evaluated as "positive;" and, signed by the resident's physician. The facility staff evaluated the AIMS, dated 09/02/09, 12/08/09, and 03/09/10, as "negative." Resident #10's monthly pharmacy reviews, for the period January 23, 2009 through September 15, 2010, showed "Recommendations" for generic Effexor on 04/17/09 and 05/22/09 as "cheaper." The remainder of monthly "Recommendations" are "None." The facility's consultant pharmacist's monthly recommendations failed to address the positive AIMS test results, potential drug irregularities, and potential drug interactions. During interview, on 09/23/10 at 11:00 a.m., a supervisory nursing staff member (#6) reported she was not aware of any attempt to reduce or change the resident's antipsychotic medications	F 428	reduction, AIM's Screenings. Potential drug irregularities, and drug interactions will be reported to DNS for review and evaluation. 4. Audits done per Q.A. Coordinator to determine proper usage of antipsychotic medications including start/end date, date of last dosage reduction attempt, and AIMS score. Audits will be done three times per week for one month, two times per week for one month and one time per week for one month. Audit results will be reported to the QA/CQI committee for further recommendations. Audits will be done per Q.A. Coordinator and or designee. Date certain 10-28-10	10-28-10

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F 428	Continued From page 47 since initiated on 04/18/07. The facility's consultant pharmacist failed to identify the need for the GDR, the potential for medication interactions, or the positive AIMS. Resident #10 developed tardive dyskinesia, an adverse side effect of prolonged Seroquel use, and may have developed other negative side effects related to unnecessary medications in excessive doses over a prolonged period of time. Failure to identify the positive AIMS test results as an adverse consequence limited the resident's quality of life, limited the resident's ability to achieve the highest practicable level of functioning, and may have limited the physician's ability to prevent or minimize these adverse effects. - Review of Resident #3's medical record on September 21-23, 2010. The resident's diagnoses included anxiety and psychosis. Resident #3's current Physician Orders identified the resident on BuSpar 15 mg two times a day (anxiety disorder) with an initial start date of 11/24/04. Review of the consultant pharmacist's monthly medication reviews from September 2009 - August 2010 failed to show recommendations for a dose reduction attempt of Resident #3's BuSpar. During an interview on 09/23/10 at 11:48 a.m., an administrative nursing staff member (#2) confirmed the facility failed to attempt a GDR within the past year, and failed to provide information indicating the pharmacist had addressed the BuSpar.	F 428		

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F 428	Continued From page 48 - Review of Resident #5's medical record occurred on September 21-22, 2010. The facility admitted the resident in 06/09 with medical diagnoses which included anxiety. Physician's Orders identified Resident #5's current medications include Clonazepam (an anticonvulsant medication) 0.5 milligrams at bedtime for anxiety initiated on 06/29/09. Review of Resident #5's monthly pharmacy reviews occurred on 09/22/10. This review included pharmacy records from the time the facility admitted Resident #5 in June 2009 until September 2010. These records lacked evidence to indicate the pharmacist recommended a GDR in regard to Resident #5's continued use of Clonazepam. An interview occurred with the an administrative nursing staff member (#2) on 09/22/10 at 4:15 p.m. This staff member confirmed Resident #5 received the same dose of Clonazepam since admission to the facility, with no attempts at a GDR. - Review of Resident #1's medical record occurred on September 21-23, 2010. Resident #1's current medication regimen, dated 03/24/08, included Xanax (anti-anxiety medication) 0.5 mg every morning and at bedtime. Review of the consultant pharmacist's medication reviews from September 2009 through 09/23/10 failed to show recommendations for a GDR of Resident #1's Xanax. The facility failed to attempt a dose reduction since 03/24/08 .	F 428		

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F 428	Continued From page 49 An interview with an administrative nursing staff member (#6) occurred the morning of 09/23/10. The staff member confirmed a dose reduction had not been attempted within the past two years and failed to provide any information indicating the pharmacist had addressed the Xanax.	F 428		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	1. Resident #3 was not on strict Isolation, but Isolation cabinet remained in room for dressing change purposes only. September 22, 2010. Resident #4 was discontinued from isolation on September 22, 2010. Resident #21 was discontinued from isolation on September 22, 2010. 2. All resident, staff, and visitors have the potential to be affected in this area. 3. An all staff in-services has been scheduled for Oct 26th & 27th. Education will be provided on the procedures for ESBL and Contact Precautions. Visits may continue to isolation rooms using Good Samaritan	

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F 441	Continued From page 50 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, review of the facility's infection control program, review of facility policy, review of professional literature, and staff interview, the facility failed to establish and maintain an infection control program designed to prevent the development and transmission of disease and infection within the facility for 2 of 2 sampled residents (Resident #3 and Resident #4) and 1 of 1 supplemental resident (Resident #21) requiring contact precautions during August and September. Failure to establish and maintain an infection control program has the potential to affect the health and safety of all facility residents, staff, and visitors. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding infection control which includes developing, implementing and maintaining an Infection Prevention and Control Program in order to prevent, recognize, and control, to the extent possible, the onset and spread of infection within the facility. Program development and oversight emphasizes the prevention and management of infections. This includes developing and implementing appropriate infection control policies and procedures. The PPE should be readily available near the entrance to the	F 441	Precautions. E. coli is bacteria found in the normal human bowel and is necessary for digestion. System change: The center has developed isolation organizers that will be kept at the entrance of a resident room for residents with an infectious organism. A sign will be posted to "Please stop at the nurse's station before entering this room." 4. The QA Coordinator or designee will develop an audit to monitor isolation techniques in the center. Monitoring will be done for the appropriate PPE equipment availability and usage. Audits will be done three times per week for one month, two times per week for one month and one time per week for one month. Audit results will be reported to the QA/CQI committee for further recommendations. Audits will be done per Q.A. Coordinator and or designee. Date certain 10-28-10	10-28-10

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F 441	Continued From page 51 resident's room. Signage can be posted on the resident's door instructing visitors to see the nurse before entering. Maintaining an environment in which there are no signs posted in resident rooms does not include the CDC isolation precaution transmission based signage for reasons of public health protection, as long as the sign does not reveal the type of infection. Review of the facility's policy, titled "Multidrug-Resistant Organisms" occurred on 09/23/10. This policy, effective date 07/03, stated: ". . . Contact Precautions . . . are indicated for the following: . . . *Residents with . . . urinary carriage of multidrug-resistant organisms . . ." Review of the facility's policy, titled "Contact Precautions" occurred on 09/23/10. This policy, effective date 07/09, stated: ". . . 3. Use of Personal Protective Equipment . . . Don gloves upon entry into the room . . . Don gown upon entry into the room . . ." Review of the facility's policy, titled "Visits to Residents with Transmission Precautions" occurred on 09/23/10. This policy, effective date 07/09, stated: ". . . Procedure . . . 4. A sign will be posted instructing visitors to report to the nurses' station before entering a resident's room with transmission precautions. . . ." - Observations during the Initial Tour on 09/21/10 identified the following: * Resident #21 watched television in her room. Resident #21 responded to the knock on her door by stating, "You can't come in here. No one can come in here." A nursing staff member (#10), who was walking down the hallway at the time, overheard her comment and stated, "She is in	F 441		

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F 441	Continued From page 52 strict isolation. She has ESBL [extended-spectrum beta lactamase - an infection resistant clinically to all penicillins]." * Resident #3 watched television in her room. The nursing staff member (#10) stated, "She has ESBL. She just finished her medication. She is no longer in isolation." * Resident #4 sat in her room facing the door. She did not respond to the knock on her door. The nursing staff member (#10) stated, "She also has ESBL." When asked how a visitor would know the resident was in isolation, she stated, "Can't you see the red bag in the closet or the isolation cart?" When asked how a visitor would know the resident was in isolation if the closet door was closed or if they did not realize the cart in the middle of her room contained isolation items, she stated, "They wouldn't know." She further stated, "We can't put a sign on the door due to privacy." Review of Resident #3, #4 and #21's medical records, on September 21-23, 2010, identified each resident had diagnosis of ESBL. During an interview on 09/23/10 at 10:25 a.m. and 1:45 p.m., a management nursing staff member (#6) reported Resident #3 was in contact isolation from August 10-18, and Resident #4 and #21 were in contact isolation from September 14-22. She further stated, "We have a board in the nutrition center which shows who is in isolation and it's also marked on the group CNA [certified nurse assistants] sheets. We used to have the isolation carts right outside the door. We don't now, due to privacy. I put the isolation carts right inside the door. We can't keep a sign on the door either. It's a privacy issue. If they [visitors] come up to visit, we tell them [the Resident is in	F 441		

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F 441	Continued From page 53 Isolation]." During an interview on 09/23/10 at 11:48 a.m., an administrative nursing staff member (#2) stated, "We don't restrict visitors. This is their [the resident's] home. If we see them [visitors] going in, we tell them not to touch anything." The facility was asked to provide a policy and procedure regarding EBSL. No policy was provided. Failure of the facility to establish and maintain an infection control program that included written policies and procedures for new multidrug-resistant organisms, having PPE readily available near the entrance to the resident's room and/or having signage posted on the resident's door instructing visitors to see the nurse before entering, has the potential to affect the health and safety of all facility residents, staff, and visitors.	F 441		
F 454 SS=E	483.70 LIFE SAFETY FROM FIRE The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. This REQUIREMENT is not met as evidenced by: Based on observation, review of professional reference, review of facility policy and procedure, and staff interview, the facility failed to comply with Life Safety Code requirement NFPA 99 for Health Care Facilities to protect the health and safety of residents, personnel, and the public, regarding oxygen storage in 2 of 2 oxygen storage areas (East and West Wings). This failure could result in an oxygen tank falling and becoming a projectile, placing residents, staff, and visitors in the area at risk of injury.	F 454	1. No residents, staff or visitors were directly affected. 2. All residents, staff and Visitors could have been affected by this practice. 3. All staff education to cover storage and hazards of oxygen was held Oct 26 & 27th. Any thing that needs repair, must be put on the Maintenance Fix It sheet, or brought to Maintenance during maintenance hours. Extra cylinders have been removed from the facility as of 9-24-10 and only the number and correct size of cylinders that	

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F 454	Continued From page 54 Findings include: Life Safety Code requirements state, "Nonflammable medical gas systems and equipment used for the administration of inhalation therapy and for resuscitative purposes comply with National Fire Protection Association (NFPA) 99, 13-5.1, 7-1.2, NFPA 70." Standard for Storage, Use, and Handling of Compressed Gases and Cryogenic Fluids in Portable and Stationary Containers, Cylinders, and Tanks, NFPA 55, 7.1.4.4 states, "Securing Compressed Gas Containers, Cylinders and Tanks. Compressed gas containers, cylinders, and tanks in use or in storage shall be secured to prevent them from falling or being knocked over by corralling them and securing them to a cart, framework, or fixed object by use of a restraint, unless otherwise permitted by 7.1.4.4.1 and 7.1.4.4.2.7." Review of the facility policy and procedure, Oxygen Use Safety, occurred on 09/23/10. This document, revised in 01/09, stated "PURPOSE, To administer and store oxygen in a safe manner. GUIDELINES . . . 13. All oxygen cylinders should be chained in place, racked or stored in stable carts at all times. . . ." During the environmental tour, on 09/22/10 at 2:15 p.m., observation identified the following: *East Wing Oxygen Store Room-one oxygen cylinder wedged in an upright, unsecured position between two similar size cylinders secured in a rack; and, one oxygen cylinder in a cart with the wheels and part of one wheel attachment missing, making it unstable.	F 454	on the O2 storage areas to ensure that the O2 is stored safely and securely. These audits will be done three times per week for one month, two times per week for one month and one time per week for one month. Then quarterly, then as deemed necessary. Audit results will be reported to the QA/CQI committee for further recommendations. Audits will be done per Q.A. Coordinator and or designee. Date certain 10-28-10	10-28-10

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F 454	Continued From page 55 *West Wing Oxygen Store Room-one oxygen cylinder wedged in an upright, unsecured position between two larger cylinders secured in a rack. A maintenance management staff member (#) present during the tour, confirmed the unsecured cylinders in the East Store Room were "E" size and the unsecured cylinder in the West Store Room was a "D" size. This staff member agreed these cylinders were not secured and should have been secured. Observation on 09/23/10 at 9:48 a.m. revealed oxygen tanks stored in a bi-fold door closet in a hallway across from the nurse's station on the East Unit. A storage rack contained multiple oxygen tanks in a secure manner. One tank stood upright on the floor, unsecured, near the storage rack. An unidentified staff member stated, "The one oxygen tank is sitting on the floor because it doesn't fit in the storage rack." This staff member replaced an oxygen tank from the rack with the unsecured tank from the floor. She then placed the oxygen tank removed from the rack onto the floor where it remained unsecured. On 09/23/10 at 9:55 a.m., observation of the East Wing Oxygen Store Room identified one "E" size oxygen cylinder upright on the floor next to the storage rack, unsecured; and, one "E" size oxygen cylinder in a cart with the wheels and part of one wheel attachment missing, making it unstable. These storage areas are adjacent to the nurse's stations and hallways used by residents, staff, and visitors. Failure to properly secure the oxygen cylinders placed residents, staff, and visitors in these areas at risk of injury.	F 454		

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F9999	FINAL OBSERVATIONS Based on observation, record review, resident and staff interview, the complaint investigated in conjunction with the standard Medicare/Medicaid survey was not substantiated.	F9999		