STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355122	A. BUILDING _____ B. WING _____	01/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHARDTON HEALTH CENTER INC	212 3RD AVENUE WEST RICHARDTON, ND 58652

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on January 28, 2013 and completed on January 31, 2013 the sample included two (2) residents for complete review, five (5) residents for focused review, and one (1) closed record for review.	F 000		
F 272 SS=C	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care	F 272	On future MDS assessments for residents #1, 2, 3, 4, 5, 6, & 7: Section V of the MDS will include the date and location of the information used for that assessment. CAA documentation will be completed for resident #4. All facility residents have the potential to be affected by this deficient practice. Section V of the MDS will include the date and location of the information used for that assessment on future MDS assessments for all facility residents. CAA documentation will be completed for all residents. We are in the process of converting to the MATRIX computer documentation system facility wide. During the conversion, initial documentation will be found in the paper chart and transferred by MDS coordinator and/or designee into the MATRIX system. After complete conversion, the documentation will carry over to the MDS automatically.	

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

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 272	Continued From page 1 areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual Version 3.0, and staff interview, facility staff failed to identify information used in support of the clinical decision making or the location of the information for 7 of 7 sampled residents records (Resident #1, #2, #3, #4, #5, #6, and #7) and 1 of 1 closed record (Resident #8) reviewed, failed to identify the care plan decision for 6 of 7 sampled resident records (Resident #1, #2, #3, #4, #5 and #6) and 1 of 1 closed record (Resident #8) reviewed, and failed to provide Care Area Assessment (CAA) documentation for 1 of 7 sampled resident record (Resident #4) and 1 of 1 closed record (Resident #8) reviewed. Failure to complete the CAA process does not allow staff the opportunity to thoroughly review individual resident areas triggered, to assess the nature of the problem, and determine the specific causes for each individual triggered area. Findings include: The Long-Term Care Facility RAI User's Manual, Version 3.0, dated April 2012, page 4-7, stated, ".	F 272	Quality Improvement audit will be completed every month for the first 3 months, then quarterly thereafter for one year, as long as improvement is found to be sustained. (Attachment A) Time line for go live date with Matrix computer documentation facility wide is June 1st.	03/01/13

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F 272	Continued From page 2 . . Use the 'Location and Date of CAA Documentation' column on the CAA Summary (Section V of the MDS [Minimum Data Set]) to note where the CAA information and decision making documentation can be found in the resident's record. Also indicate in the column 'Care Planning Decision' whether the triggered care area is addressed in the care plan." Page 4-3, stated, "They [CAAs] are required only for Omnibus Budget Reconciliation Act of 1987 (OBRA) comprehensive assessments (Admission, Annual, Significant Change in Status . . .) . . . the CAAs must be completed in order to meet the requirements of the OBRA comprehensive assessment." - Review of Resident #1, #2, #3, #4, #5, #6, #7, and #8's medical records occurred on January 28-31, 2013. The CAA Summaries for the above residents failed to identify the specific location on the "Location and Date of CAA Information" column where the CAA information could be located in the medical record and failed to identify the facility's care plan decision on the "Care Planning Decision" column. The following CAA Summaries lacked the required information: Resident #1 - Admission MDS dated 09/03/12 and a Significant Change MDS dated 12/03/12 Resident #2 - Admission MDS dated 08/26/12 Resident #3 - Annual MDS dated 05/25/12 Resident #4 - Annual MDS dated 06/29/12 Resident #5 - Admission MDS dated 12/04/12 Resident #6 - Annual MDS dated 11/30/12 Resident #7 - Annual MDS dated 1/14/13, did include the facility's care plan decision Resident #8 - Admission MDS dated 07/20/12, and Significant Change MDSs dated 10/14/12	F 272		

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F 272	Continued From page 3 and 01/13/13 - The annual MDS for Resident #4, dated 06/29/12, identified nine care areas triggered from the MDS. The medical record lacked completed CAAs for eight triggered care areas: cognitive loss/dementia; communication; urinary incontinence and indwelling catheter; psychosocial well-being; behavioral symptoms; falls; pressure ulcer and psychotropic drug. - The admission MDS for Resident #8, dated 07/20/12, identified 10 care areas triggered from the MDS. The medical record lacked completed CAAs for all 10 triggered care areas: cognitive loss/dementia; visual function; communication; urinary incontinence and indwelling catheter; falls; nutritional status; dehydration/fluid maintenance; dental care; pressure ulcer and psychotropic drug. During an interview on 01/30/13 at 4:00 p.m., a managerial nurse (#6) confirmed the facility failed to complete the information regarding location/date of CAA documentation and failed to identify the facility's care plan decision. This same nurse (#6) could not provide CAAs for Resident #4 or #8.	F 272		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed	F 280	On current Care Plans for residents #1. 4, & 5: The use of and need for anxiolytic, psychotropic, and hypnotic medications will be care planned.	

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F 280	Continued From page 4 within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to review and revise the care plans for 3 of 7 sampled residents (Resident #1, #4, and #5). Failure to revise the care plan as the residents' status changes has the potential to affect staff's understanding of the residents' problems and required interventions, limits the staff's ability to communicate resident care issues, and may lead to lack of, or inconsistency in, the care provided. Findings include: - Review of Resident #1's medical record occurred January 28-31, 2013. The facility admitted the resident in August of 2012 with diagnoses including bipolar disorder, hallucinations, psychotropic adverse effect, and history of poisoning by a psychotropic agent. Resident #1's significant change Minimum Data Set (MDS), dated 12/03/12, identified the resident received five doses of an anxiolytic medication	F 280	All facility residents have the potential to be affected by this deficient practice. So, on future Care Plans for all facility residents: The use of and need for anxiolytic, psychotropic, and hypnotic medications will be care planned. We are in the process of converting to the MATRIX computer documentation system facility wide. During this conversion, initial documentation will be found in the paper chart and transferred by nursing staff into the MATRIX system. After complete conversion, the Care Plans will be used and updated as necessary and at least quarterly during the MDS completion process. Quality Improvement audit will be completed every month for the first 3 months, then quarterly thereafter for one year, as long as improvement is found to be sustained. (Attachment B) Completed by QA staff The other residents are currently being converted into MATRIX with a completion date for Care Plan conversion of April 1. As MDS assessments are completed during this time, all Care Plans will be reviewed to ensure they include the use of and need for anxiolytic, psychotropic, and hypnotic medications for all the residents affected by the use of these medications. MDS Staff Education completed by 3-1-13	03/01/13

Per TC 3-14-13 HS

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F 280	Continued From page 5 and no antipsychotic medications in the seven day assessment period. The current physician order sheet showed Resident #1 received the following central nervous system medications: * Ativan [an anxiolytic] 1mg [milligram] every four hours as needed. * Haldol [a psychotropic] 5 mg every four hours as needed. * Seroquel [a psychotropic] 100 mg every morning and Seroquel 200 mg at bedtime. The care plan, dated 12/16/12, identified, "Problem, Risk for decreased cognition d/t [due to] antianxiety medication." The care plan lacked information regarding psychotropic medications despite Resident #1's history of complications directly related to a psychotropic medication. - Review of Resident #4's medical record occurred January 28-31, 2013. Diagnoses included anxiety state, alcohol induced psychotic disorder with delirium, and episodic mood disorder. Resident #4's quarterly MDS, dated 12/28/12, and an annual MDS, dated 06/29/11, each identified Resident #4 received seven doses of an anxiolytic and seven doses of an antipsychotic medication in respective the seven-day assessment period. The current physician order sheet showed Resident #4 received the following central nervous system medications: * Ativan 0.5 mg every 4-6 hours as needed. * Lorazepam [an anxiolytic] 0.5 mg three times daily. * Risperdal [antipsychotic] 1 mg two times daily	F 280		

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F 280	Continued From page 6 and at bedtime. The current care plan, revised 12/16/12, failed to identify Resident #4 took anxiolytics and an antipsychotic. The care plan addressed behaviors with an approach, "Administer medication as ordered." The care plan lacked a problem, goal, and approaches to monitor side effects of the medications. - Review of Resident #5's medical record occurred on all days of survey. The resident's diagnosis included insomnia. An admission MDS, dated 12/04/12, identified the resident received seven doses of a hypnotic medication during the seven day assessment period. Resident #5's current physician's orders listed Ambien (a hypnotic medication for sleep) 10 mg at night. A review of Resident #5's current plan of care failed to identify a problem area for insomnia, that the resident received a sleeping medication nightly, or any of the side effects that may require monitoring.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	For resident #1: Following the survey, the nursing staff/CNAs were immediately educated regarding the need to elevate his head to 90 degrees as per the Speech Therapy evaluation recommendations. Education regarding what 90 degrees looks like was provided. (Attachment D)	

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F 309	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional literature, and staff interview, the facility failed to ensure 1 of 1 sampled resident (Resident #1), identified as having dysphagia and weight loss, received the care and services necessary to attain the highest degree of safety possible when assisted with fluids while in bed. Failure to adequately assess, and provide services based on assessment, has the potential to affect the resident's overall swallow safety, and placed him at greater risk of aspiration. Findings include: Nancy B. Swigert, The Source for Dysphagia: Third Edition, LinguiSystems, Inc, 2007, pages 9, 15-16 and the educational handouts identified the following: * "Signs and Symptoms of Dysphagia: . . . Weight loss . . . Coughing/Choking . . ." * "What are some signs of dysphagia?: Signs of pharyngeal dysphagia are coughing or choking during a meal . . ." * "What good are postural changes?: Some postural changes [being as close to 90 degrees as possible] can provide increased airway protection . . . " * "Why is it important for patients to sit at 90 [degrees] when eating? Many patients with dysphagia have decreased back of tongue control. This condition allows food and liquid to fall over the back of the tongue with risk of it entering the airway. Even a slightly reclined position while eating greatly increases the risk of premature loss of food over the back of the tongue."	F 309	All facility residents who have swallowing issues have the potential to be affected by this deficient practice. All facility residents who have swallowing issues will follow the Speech Therapy recommendations when being assisted with dining. Ongoing nursing/CNA education will be provided. The interdisciplinary team will see if the beds reach true 90 degrees. Education regarding how to prop up the residents to insure maintaining 90 degrees during dining will be provided. Nurses will observe throughout the day as care is provided and ongoing education will occur. Quality Improvement audit will be completed every month for the first 3 months, then quarterly thereafter for one year, as long as improvement is found to be sustained. (Attachment C) Completed by QA staff Immediate education was provided with all staff signing off as educated. Nursing education regarding what true 90 degrees looks like and how to prop up residents to insure maintaining true 90 degrees will occur during the end of February, all of March, ~~and be completed by April 1, 2013.~~ Maintenance will complete an assessment on the beds to assist with this education. Completed by March 1-2013	03/01/13

per E admin
TC on 3-14-13

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F 309	Continued From page 8 - Review of Resident #1's medical record occurred January 28-31, 2013. Diagnoses included dysphagia, and gastrostomy/Percutaneous Endoscopic Gastrostomy (PEG) tube. Resident #1's admission Minimum Data Set (MDS), dated 09/03/12, identified a cognitive summary score of nine (moderate impairment), total assistance of one person for eating, the resident held food in his mouth, and experienced coughing and choking while eating/drinking. A significant change MDS, dated 12/03/12, identified severely impaired cognitive skills, total assistance of one person for eating, and received tube feedings. Review of the weight log for Resident #1 showed the resident experienced a 45-pound weight loss since admission in August 2012. The current care plan, dated 11/27/12, identified, ". . . Problem: risk for aspiration pneumonia from use of feeding tube. Goal: Will maintain adequate nutritional intake via feeding tube and risk for aspiration will be minimized. . . .Approach: . . . Give oral liquids, as tolerated, per diet order. . . . Problem: Feeding tube must be utilized to maintain nutritional status. . . . Approach: . . .Oral diet per providers [physician] order as resident tolerates." A physician order, dated 12/15/12, stated, "Pureed diet [with] nectar thickened liquids if resident requests something orally." A "Speech Therapy Plan of Treatment for Dysphagia", dated 08/13/12, "Outcome: Res [Resident] will safely tolerate pureed diet [with] nectar liquids [with] no s/sx [sign/symptoms] of	F 309		

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F 309	Continued From page 9 asp [aspiration]. . . . Summary: Res needed max [maximum] assist of the head to remain @ [at] a 90 [degree]. . . . Res high aspiration/choking risk, as he does not remain alert [and] has poor positioning. . . ." This form also identified Resident #1 as being at risk for aspiration, with positioning needs of "Upright, 90 Degree Hip Flexion." Observations revealed the following: * On 01/28/13 at 1:30 p.m., following cares, Resident #1 requested water. The CNA (#1) raised the resident's bed to a 60-70 degree angle, and provided Resident #1 with thickened water using a straw. After drinking, the resident began to cough. * On 01/29/13 at 1:55 p.m., following cares, Resident #1 requested water. The CNA (#2) raised the resident's bed to a 55-60 degree angle, and provided Resident #1 with thickened water using a straw. * On 01/30/13 at 8:49 a.m., following cares, Resident #1 requested water. The CNA (#1) raised the resident's bed to a 60 degree angle, and provided Resident #1 with thickened water using a straw. During an interview, on 01/31/13 at 8:00 a.m., an administrative nurse (#3) identified staff are to follow the speech therapist's recommendations for providing food and fluids to Resident #1. The facility failed to ensure Resident #1 received the care and services necessary to attain the highest degree of safety possible while providing fluids in bed by not elevating the head of the bed to a 90-degree angle as identified by the speech	F 309		

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F 309	Continued From page 10 therapist.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, review of manufacturers' recommendations, and staff interview, the facility failed to assess the safety of an assistive device (sit to stand mechanical lift) and failed to lock the wheelchair brakes during a transfer for 2 of 5 sampled residents (Resident #4, and #5) who were observed during transfers. Failure to assess for continued safety of the sit to stand lift for Resident #4 placed the resident at risk for potential injury. Failure to lock the wheelchair brakes prior to transferring Resident #5 causing the wheelchair to move and the resident to fall to the floor, created the potential for an avoidable accident to occur for Resident #5. Findings include: - Observation on 01/29/13 at 12:45 p.m. showed Resident #5 sitting in her wheelchair in her room with a bedside table in front of her. A CNA (certified nurse aide) (#2) entered the room to assist the resident to use the bathroom. The CNA	F 323	For resident #4: PT/OT evaluations (Attachment E & F) will be completed at this time and quarterly to insure resident is able to use the EZ stand lift. If the evaluation shows he cannot, he will use the Hoyer for transfers, per their recommendation. For resident #5: The multi-disciplinary team met and reviewed all incident reports since resident admission. We will use the Hoyer lift for her for all transfers during the day and use either the Hoyer lift or bedpan on the night shift, depending on how awake she is. The provider feels she came to us overmedicated and is decreasing her medication. Orders received within first month to decrease Ambien by half and to continue medication reduction throughout the year. Resident is obese and is on a strengthening and weight loss plan. She has lost approximately 20 pounds since since admission here in late 2012. Will move from Hoyer, to EZ stand, to ambulation as she tolerates. PT assessments quarterly to evaluate safe transfers and progress with ambulation. OT education regarding use of W/C brakes and chair features documented in the resident record. (Attachment E-1)	

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F 323	Continued From page 11 (#2) moved the bedside table and placed a front wheeled walker in front of the resident. The CNA then applied the gaitbelt around Resident #5. The CNA held the walker with one hand and the gaitbelt with the other, the resident raised halfway to a standing position, lost her balance, and attempted to sit back on the wheelchair. The wheelchair rolled back and the resident sat on the floor. The CNA (#2) stated, "I did not check the brakes." Resident #5 stated "I did not check them either." Another CNA (#4) entered the room and said she would get the nurse. A staff nurse (#9) and 2 other staff members entered the room. The nurse (#9) assessed the resident for injury, vitals, and pain before they used a total body lift, to lift the resident from the floor and placed her on the bed. - Review of Resident #5 medical record occurred on all days of survey. Diagnoses include history of falls, morbid obesity, peripheral neuropathy and pain; and an admission date in November 2012. An admission Minimum Data Set (MDS) dated 12/04/12, identified Resident #5 as cognitively intact, needing extensive assistance of 2 persons for transfer, and walk in room assistance of 1 person. A review of Resident #5's Care Area Assessments (CAAs), dated 12/04/12, stated, ". . . ADL [activities of daily living] Function . . . [resident's name] and direct care staff believe that she is capable of increased independence . . . Falls . . . is not stable and only able to stabilize with staff assistance for balance during transition and walking. . . [resident name] stated that she	F 323	All facility residents who have transfer issues have the potential to be affected by this deficient practice. Nursing staff/CNAs were immediately educated regarding how to use the Hoyer effectively with resident #5 and how to safely transfer resident #4 with the EZ stand per PT/OT recommendations. They were educated to look for residents having safe transfer issues and report them to the Director of Nursing. Any reports will be evaluated by the DON or designee and PT/OT consults will be ordered as needed. Nurses will observe throughout the day as care is provided and report needs to the Director of Nursing. Quality Improvement audit will be completed every month for the first 3 months, then quarterly thereafter for one year, as long as improvement is found to be sustained. (Attachment G) Completed by QA staff. Immediate education was provided with all staff signing off as educated by March 1, 2013. Nursing education regarding the use of Hoyer and EZ stand will occur during the end of February, all of March and ~~be completed by April, 2013.~~ 4/1/13 3-1-13	

Per TC
Eadim on 3-14-13
KS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 12 had fallen about twice a week for almost 6-8 weeks; however, the falls never resulted in any fractures. She had not fallen since admission. . . ." Resident #5's current care plan stated the following: "Problem(s) High risk for falls related to obesity, deconditioning, and unsteady gait. (6 falls within 2 months prior to NH [nursing home] admission) . . . Approach . . . Teach proper use of assistive devices (walker, W/C) [wheelchair] . . . tip prevention bars on back of w/c, bed in low position when in bed, mat at bedside when in bed. . . Problem(s) Mobility impaired related to: Obesity, deconditioning, pain . . . Approach . . . Assist with all transfers . . . instruct in wheelchair mobility and safety . . . Small walker in room for toileting. . . " A review of Resident #5's Occupational Therapy (OT) notes stated the following: "1-25-13 Pt's [patient's] new w/c arrived . . . Pt educated to sit all the way back in w/c to avoid pelvic thrust and sliding out . . " "1-29-13 Pt reports new w/c going well only complaint is w/c is hard to turn. OT educated Pt on as width of w/c is increased, the [arrow up] difficulty [with] turns. OT encouraged Pt to be up in w/c for more than meals . . . " A review of Resident #5's "Nurses Notes"stated the following: "1/6/13 @ [at] 0400 [4:00 a.m.] Responded to residents call light. Resident was found [with] 3/4 of buttocks hanging off bed while attempting to get out of bed . . . Assisted resident to standing position [with] FWW [front wheeled walker]. While	F 323		

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F 323	Continued From page 13 standing @ bedside resident began pulling pillows from recliner beside her. Resident's L [left] knee gave out. Resident unable to move. Resident lowered to floor [with] no injuries . . . 0410 [4:10 a.m.] Resident hoyered [a total body lift] back to bed . . . [no] injury or bruising noted . . ." "1/15/13 @ 0445 [4:45 a.m.] Resident was attempting to pivot transfer from bed to wheelchair [with] FWW, gait belt and assist x [times] 1. As she sat on the wheelchair, she did not move her buttocks back into the seat far enough and bent her knees. She then stated 'I have to sit on the floor' Resident lowered to the floor [with] gaitbelt. Moved to bed [with] hoyer and assist x 2. Denies injury or pain. . . " "1-29-12 @1245 Res [resident] transferring from w/c to go to the BR [bathroom] [with] walker et [and] during transfer CNA had gait belt on res et had lowered res to floor. Res states she thought she had the w/c brakes engaged all the way but they were not et the w/c started to slip et she was then lowered to the floor by CNA, denies pain or injury, @ 1250 I was called to the room . . . Res gotten up [with] [4] assist et hoyer to bed. Res denied vertigo when asked. Back observed et no redness or injury seen. Note a spot of blood on lift pad of unknown origin but resident wanting to rest @ this time et will observe rest of body when out of bed, et res states she is ok [with] that as has no pain [sic] c/o [compliant of]. Does have existing open area to coccyx . . . " "1-29-13 @1530 [3:30 p.m.] note R [right] middle buttock has 12.5 cm [centimeter] x 0.3 cm pinch [with] small open superficial area, Bacitracin to open area per S.O. [standing order] . . . " - Review of the Manufacturer's operation manual	F 323		

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F 323	Continued From page 14 for the EZ Way Smart Stand, dated 08/26/09, stated, ". . . Patients should be able to bear some weight, have upper body strength and be able to follow simple commands. If a patient does not meet each of these three criteria, an EZ Way total body lift must be used." Page 5-6, stated, "Transferring the patient: . . . 3) Have patient place feet (help patient if needed) on foot plate and position their shins into the shin pad. The shin pad should be positioned below the knees. Use of Shin Strap: If a care giver deems it necessary to keep a patient's shins or feet on the foot plate, secure the strap around the patient's legs." Review of the facility policy/procedure titled "Safe Lifting and Movement of Residents" occurred on 01/31/13. This policy, dated August 2009, stated, ". . . 3. Nursing staff, in conjunction with the rehabilitation staff, shall assess individual residents' needs for transfer assistance on an ongoing basis. Staff will document resident transferring and lifting needs in the care plan. . . ." - Review of Resident #4's medical record occurred January 28-31, 2013. A quarterly MDS, dated 12/28/12, identified the resident as severely impaired, required extensive assistance of two or more staff members for transfers, and had functional limitation in range of motion to both legs. Resident #4's care plan, dated, 12/16/12, identified the problem of "High risk for falls related to cognitive impairments and immobility and poor balance" with approaches including, "Use EZ Stand when needed for transfers or assist of 1-2 persons [with] gait belt; Provide walker and one	F 323		

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F 323	Continued From page 15 person assistance with ambulation; and Provide wheelchair for mobility - front [and] back tippers." The facility identified the problem, "Mobility impaired related to cognitive impairments and poor balance" with approaches including, "Transfer with assistance of 1-2 with gait belt or EZ stand." The care card provided daily to the CNAs stated the following for Resident #4, "Transfers: 1-2 assist [with] walker, gait belt, w/c [wheelchair] PRN [as needed] E-Z stand (1-2)." Observations of Resident #4 utilizing a mechanical lift showed the following: * On 01/28/13, at 2:31 p.m., two CNAs (#1 and #2) used a mechanical lift to stand the resident while providing cares. The CNAs (#1 and #2) positioned Resident #4 in the lift harness, placed the resident's feet on the foot plate, buckled the shin pad strap, and attached the lift harness to the lift. One CNA (#1) placed her hand on Resident #4's knees and both CNAs (#1 and #2) told the resident to keep his feet on the foot plate as a CNA (#2) used the lift to assist the resident to a standing position. As the lift raised, Resident #4 held tightly to the handles, but only the tips of his shoes made contact with the footplate. Throughout the care, Resident #4 maintained this position in the lift. When the CNAs (#1 and #2) lowered Resident #4 into his wheelchair and directed him to let go of the handles, he did not. The CNAs (#1 and #2) assisted the resident to open his hands to release the handles. * On 01/29/13 at 10:27 a.m., two CNAs (#2 and #4) transferred Resident #4 from his bed to his wheelchair. The CNAs (#2 and #4) positioned the lift harness, placed the resident's feet on the foot plate, buckled the shin pad strap, and attached the lift harness to the lift. Both CNAs (#2 and #4)	F 323		

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F 323	Continued From page 16 told the resident to stand on his feet as the CNAs (#2 and #4) used the lift to assist the resident to standing. As he stood Resident #4's feet came up off the foot plate, the shin pad strap failed to hold Resident #4's legs securely to the shin pad, and he knelt on top of the shin pad. A CNA (#4) stated the resident does this all the time. One CNA (#4) positioned the wheelchair behind the resident and the other CNA (#2) manipulated the controls of the lift lowering the resident into his wheelchair. When told to let go of the handles, Resident #4 did not let go. The CNAs (#2 and #4) assisted the resident to open his hands to release the handles. * On 01/30/13 at 9:20 a.m., two CNAs (#1 and #8) transferred Resident #4 from his bed to a shower chair. The CNAs (#1 and #8) positioned the lift harness on Resident #4, placed the resident's feet on the foot plate, buckled the shin pad strap, and attached the lift harness to the lift. The CNA (#1) placed her hand on Resident #4's knees, told the resident to keep his feet down, and using the lift, raised Resident #4 to a standing position. At first, the tips of Resident #4's toes stayed in contact with the foot plate, but as the CNAs (#1 and #8) moved the lift and the shower chair together, one foot came up off the foot plate despite the shin pad strap. When the CNAs (#1 and #8) lowered Resident #4 onto the shower chair and directed him to let go of the lift handles, he did not. The CNAs (#1 and #8) assisted the resident to open his hands to release the handles. * On 01/30/13 at 9:50 a.m., two CNAs (#1 and #8) transferred Resident #4 from the bath chair to his wheelchair. The CNAs (#1 and #8) positioned the lift harness on the resident, placed the resident's feet on the foot plate, buckled the shin	F 323		

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F 323	Continued From page 17 pad strap, and attached the lift harness to the lift. The CNAs (#1 and #8) told the resident to keep his feet down as they engaged the lift. As Resident #4 stood, his feet came up off the foot plate, the shin pad strap failed to hold Resident #4's legs securely to the shin pad, and he knelt on top of the shin pad. After the CNAs (#1 and #8) lowered Resident #4 into his wheelchair, they directed him to let go of the lift handles, he did not. The CNAs (#1 and #8) assisted the resident to open his hands to release the handles. Observation showed Resident #4 failed to meet two of the three manufacturer's guidelines for safe use of the EZ stand lift. The resident failed to bear weight and to follow simple commands. The facility failed to reevaluate the resident's ability to safely transfer in this manner.	F 323		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the	F 431	Specific residents were not identified in this tag. All residents receiving insulin have the potential of being affected by this deficient practice. Nursing staff was immediately educated regarding the need to throw away or send home all opened insulin brought to the facility. All opened insulin will be kept in the med cart, date when opened and discarded in 28 days, unless it is Levemer. Levemer can be discarded in 42 days when kept at room temperature after being opened. All insulin syringes that are not in the labeled prescription box, needs to be labeled with resident label. (Attachment D)	

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F 431	Continued From page 18 facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of manufacturer's guidelines, and staff interview, the facility failed to store in-use insulin pens as directed by the manufacturer, failed to label/date multi-use insulin pens and failed to discard insulin when stored beyond the recommended time period for 5 of 5 insulins (vials/pens) observed in the medication room. Failure to properly store, label, and discard opened in-use insulin has the potential to affect the potency and efficacy of the medication. Findings include: The manufacturer's insert for NovoLog insulin stated, "NovoLog in use: Vials, Keep in the refrigerator or at room temperature below 86 [degrees] F [Fahrenheit] for up to 28 days. . . . Throw away an opened vial after 28 days of use, even if there is insulin left in the vial. . . . NovoLog	F 431	The insulin that was opened and not labeled was discarded per facility policy. The opened insulin was moved to the med cart and labeled appropriately with resident label, date of opening and date to discard. The unopened insulin will remain in the prescription container in the refrigerator until it is opened and moved to the med cart. Quality Improvement audit will be completed every month for the first 3 months, then quarterly thereafter for one year, as long as improvement is found to be sustained. (Attachment H) Immediate education was provided with all staff signing off as educated by March 1, 2013. (Attachment D-1) Initial QI will occur in March to insure compliance by April 1, 2013. Per TC T edem on 3-14-13 dls.	~~4/1/13~~ 3-1-13

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F 431	Continued From page 19 FlexPen, Keep at room temperature below 86 [degrees] F for up to 28 days. Do not store a . . . NovoLog FlexPen that you are using in the refrigerator. . . . Throw away a used . . . NovoLog FlexPen after 28 days, even if there is insulin left in the cartridge or syringe." The manufacturer's insert for Levemir insulin stated, ". . . FlexPen . . . After initial use, . . . a prefilled syringe (including FlexPen . . .) may be used for up to 42 days if it is kept at room temperature, below 30 [degrees] C [Celsius] (86 [degrees] F). In-use cartridges and prefilled syringes in-use must NOT be stored in a refrigerator . . ." The facility's consulting pharmacist provided guidelines from the manufacturer of Lantus insulin, which stated, ". . . How should I store Lantus? . . .Open (in-use) vial: Once a vial is opened, you can keep it in a refrigerator or at room temperature (below 86 [degrees] F) . . . Opened vial, either kept in a refrigerator or at room temperature, should be discarded 28 days after the first use even if it still contains Lantus. . . ." - Observation of the facility's medication room occurred on 01/30/13 at 2:30 p.m. with an administrative nurse (#3). The refrigerator contained the following insulins: * One Lantus multi-use vial identified opened on 01/01/13 and to be discarded on 01/28/13 * One NovoLog multi-use vial identified opened on 12/31/12 and to be discarded on 01/28/13 * One Levemir FlexPen lacked a label and date opened * One NovoLog FlexPen, in-use lacked a date	F 431		

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F 431	Continued From page 20 opened * One NovoLog FlexPen lacked a resident's name and date opened The nurse (#3) identified facility staff label the insulin vials when opened. The nurse (#3) verified the Lantus and NovoLog vials were beyond their use by date by two days. This same nurse (#3) identified staff should label the insulin pens with the resident's name and indicated staff could use the pens until the expiration date on the pen. This conflicts with the manufacturer's guidelines which state NovoLog pens should be discarded 28 days after opened. - Observation of the storage of insulin on 01/31/13, at 10:10 a.m., with a nurse (#5) showed three Levemir FlexPens and one NovoLog FlexPen, all in-use, stored in the refrigerator. Interview with the nurse (#5) confirmed the facility stores all in-use insulins in the refrigerator. This conflicts with the manufacturer's guidelines which stated in-use pens should not be stored in a refrigerator.	F 431		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment	F 520	Specific residents were not identified in this tag. All residents have the potential of being affected by this deficient practice.	

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F 520	Continued From page 21 and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on review of the facility's Quality Assessment and Assurance (QA) program and staff interview, the facility failed to ensure a physician actively participated as a member of the QA committee for 3 of 4 quarters during 2012 and failed to provide information prior to April 2012 to demonstrate an active QA program. Failure to have a physician participate in the facility's quality assurance activities deprives the committee of the unique contribution a physician provides for analysis of quality concerns and assistance with decision making based on identified concerns. Findings include: During an interview on the morning of 01/31/13, a managerial nurse (#6) identified the facility has a QA committee, which should meet quarterly. The staff member (#6) reported the committee consists of the multiple disciplines including the	F 520	QI meetings will be held on a day when the medical director is in the clinic. Time will be scheduled into his schedule for a meeting so he can attend. Meetings will be scheduled quarterly and routinely on the same days and times so department heads can work them routinely into their schedules. Quality Improvement audit will be completed every then quarterly for one year as long as improvement is found to be sustained. (Attachment I) Initial QI will occur in March. per TC c adm on 3-14-13 HS.	~~4/1/13~~ 3-1-13

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F 520	Continued From page 22 medical director/physician. Review of the rosters from meetings held in 2012, indicated the medical director only attended the meeting held on 05/22/12. Further information provided by an administrative staff member (#7), showed the QA committee met on 05/22/12, 07/02/12, 10/01/12, and 12/24/12. The staff member (#7) could not provide information regarding QA meetings prior to April 2012. During an interview on the afternoon of 01/30/13, an administrative nurse (#3), identified the facility was not reviewing their Quality Measures reports.	F 520		