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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	04/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	300 MAIN ST S VELVA, ND 58790

(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 survey started on 04/25/11 and completed on 04/28/11, the sample included 2 residents for complete review,8 residents for focused review, and 1 closed record for review. The sample included 2 additional residents added to the sample to verify specific concerns during the survey.	F 000	Preparation and Execution of this response and plan of correction does not constitute an admission of 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 section 7305 of the State Operations Manual.	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy and procedure, and staff interview, the facility failed to ensure 1 of 1 sampled resident with a wheelchair lap tray (Resident #6) was free from physical restraints imposed for convenience regarding failure to remove or release the lap tray. Failure to remove or release the lap tray had the potential to limit the resident's highest practicable well being and functional status. Findings include: Review of the facility policy and procedure "Physical Restraints," occurred on 04/28/11. This document, revised 08/08, stated "PURPOSE, To ensure appropriate use of restraints. DEFINITIONS, Convenience - any action taken by the center to control a resident's behavior or	F 221	Souris Valley Care Center (SVCC) is using a lap buddy instead of a lap tray for resident #6. SVCC will remove the lap buddy a minimum of every 2 hours while awake, for toileting, ambulation, dining, and repositioning. This will be documented on GSS form 250(Hourly flow sheet). Any resident who has a physical restraint has the potential to be affected.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 5/20/11

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

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F 221	Continued From page 1 manage a resident's behavior with a lesser amount of effort by the center and not in the resident's best interest. . . . Physical Restraints - any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's own body. Physical restraints may include . . . lap trays . . . that the resident cannot remove. . . . PROCEDURE . . . Non-Emergency Restraint Use . . . 3. Throughout utilization of the restraint, the following must be completed: a. Restraints must be released at least every two hours. . . ." Review of Resident #6's medical record occurred on April 25-28, 2011. The facility admitted the resident in 03/08. The resident's current diagnoses included a history of falls, history of hip fracture, and dementia. The resident's quarterly Minimum Data Set (MDS), dated 01/12/11, identified Resident #6 rarely or never understood others or made herself understood, had short and long term memory problems, continuous disorganized thinking and inattention, at risk for developing pressure sores, and required extensive assistance of two persons for bed mobility and transfers. Resident #6's physician orders, initiated 04/22/08 and updated with each renewal, included "Lap tray while up in wheelchair." Resident #6's Physical Restraint Review, dated 04/11/11, identified the facility attempted to reduce the restraint by having the resident seated in a recliner with a chair alarm which resulted in	F 221	The policy for restraint use is being reviewed. Hourly flow sheet has been put into use to document restraint removal by the nurses and CNAs. Staff will enter time and initials on front side of form and enter comments on the back describing when restraint was replied and removed. The Quality Assurance Committee will audit restraint use and removal on a monthly basis for 3 months and then every 3 months for a total of a year. Mandatory staff education will be provided on May 25, 2011 related to the facility policy on physical restraint use. The facility Director of Nursing will be responsible for ensuring compliance.	06/02/11

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F 221	Continued From page 2 the resident falling on 03/12/11. This review also identified the resident has dementia and no safety awareness. Resident #6's current care plan, dated 01/18/11, stated "Problems . . . Potential for injury r/t [related to] history of falls and (B) [bilateral] hips fractured. . . . Approaches . . . Lap top tray to w/c [wheelchair]. Release lap top every 2 hours and reposition . . ." Observation on 04/26/11 identified Resident #6 seated in a wheelchair, with a lap top tray table attached to the wheelchair. The resident remained in the wheelchair without repositioning or removal of the tray table from the beginning of observations at 8:05 a.m. to 10:35 a.m. (two and one half hours) and from 3:00 p.m. to the completion of observations at 5:30 p.m. (two and one half hours). It is unknown how long Resident #6 was in the wheelchair with the lap top tray table before 8:05 a.m. and after 5:30 p.m. During interview, on 04/28/11 at 5:45 p.m., an administrative nursing staff member (#2) and an administrative management staff member (#3) reported they expected facility staff to remove Resident #6's wheelchair lap top tray table and reposition her every two hours. The facility obtained a physician order for a wheelchair lap top tray table, assessed it as a restraint, attempted to reduce its use, and care planned for removal of the tray table every two hours. Failure to remove the tray table every two hours and reposition Resident #6 placed the resident at risk of the tray table being used for staff convenience, limited the resident's ability to	F 221		

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F 221	Continued From page 3 achieve her highest practicable well being, and placed the resident at risk for loss of mobility, development of skin breakdown, agitation, loss of dignity, and reduced quality of life.	F 221	The facility policy for bedmaking has been reviewed.The facility staff will make resident #13's bed every morning. The staff will make the bed while in the room providing morning cares. All residents who sleep in a bed have the potential to be affected. Mandatory staff education will be provided on May 25, 2011 related to the policy of making beds. Quality Assurance Committee will audit bed making for resident 13 and other residents in the facility on monthly basis for 3 months and quarterly for a total of one year. The Charge Nurse will be responsible for insuring compliance.	06/02/11
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview, and staff interview, the facility failed to provide care in a manner and environment that respected the right of 1 of 2 supplemental residents (Resident #13) to make a choice significant to the resident, regarding making the resident's bed on 3 of 3 days of observation. Failure to make Resident #13's bed did not recognize the resident's right to make choices that are significant to her. Findings include: Review of Resident #13's medical record occurred on 04/28/11. The facility admitted the resident on 04/20/11. The resident's initial/temporary care plan, dated 04/25/11, stated ". . . I am alert. I am able to make my needs /wishes known. . . ."	F 242		

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F 242	Continued From page 4 Observations of Resident #13's room identified the following: *04/25/11, 11:30 a.m., during the initial facility tour - Resident #13 out of the room and the resident's bed unmade with the blankets and top sheet thrown back. *04/25/11, 4:30 p.m. - Resident #13 seated in an arm chair in her room reading a book and her bed unmade with the blankets and top sheet thrown back. When questioned about the unmade bed, the resident stated it "bothers" her and the staff "usually make it." *04/26/11 - Observations throughout the day showed the resident out of the room and her bed unmade with the blankets and top sheet thrown back. *04/27/11, 3:00 p.m. - Resident #13 laying on her unmade bed with the blankets and top sheet thrown back. When asked if she asked the staff to not make her bed, the resident responded the bed was not made "Because they didn't make it and they should." The resident repeated it "bothers" her to have an unmade bed. During interview, on 04/27/11 at 5:45 p.m., a nursing management staff member (#2) and an administrative management staff member (#3) reported their expectation is that the facility staff would make Resident #13's bed each day.	F 242		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.	F 278		

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F 278	Continued From page 5 A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON MARCH 10, 2010. Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument User's Manual (Version 3.0), and staff interview, the facility staff failed to accurately complete the Minimum Data Set (MDS) for 1 of 7 sampled residents (Resident #2) identified with a behavioral symptom. Failure of the interdisciplinary team to validate the resident's behavior has the potential for inaccurate completion of the MDS, and does not allow the	F 278	The RAI manual has been reviewed for the completion of section E. The MDS for resident #2 will be corrected for question E0200C. Any resident who is documented for having a behavior during their assessment period has the potential to be affected. Prior to completion of MDS, the social worker completing section E of the MDS will review computerized behavior documentation. If there are episodes of behaviors documented, the social worker will ask the staff person who documented the behavior for specifics of the behavior. The social worker will also meet with the resident and ask the resident for specifics of the situation, if the resident is interviewable. This investigation will be included in the Interdisciplinary Assessement and Summary Review note for the MDS. Quality Assurance Committee will audit the accuracy of section E of the MDS for resident #2 quarterly. The QA committee will also audit 2 random MDSs a month for 3 months and quarterly for 3 quarters for a total of a year.	

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F 278	Continued From page 6 resident the opportunity to receive care consistent with their individual needs, problems, and strengths. Findings include: The Long-Term Care Facility Resident Assessment Instrument User's Manual (Version 3.0), page 2-1 states, ". . . The RAI process is the basis for the accurate assessment of each nursing home resident . . .", and page Z-6 states, ". . . The importance of accurately completing and submitting the MDS cannot be overemphasized. The MDS is the basis for the development of: * an individualized care plan * the Medicare Prospective Payment System * Medicaid reimbursement programs * quality monitoring activities, such as the quality indicator/quality measure reports * the data-driven survey and certification process * the quality measures used for public reporting * research and policy development . . ." Each person completing a section of the MDS is required to sign the Attestation Statement (Z0400) on page Z-6 that reads, "I certify that the accompanying information accurately reflects resident assessment information for this resident . . . I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds . . ." * Page E-1, states, "SECTION E: BEHAVIOR, Intent: The items in this section identify behavioral symptoms in the last seven days that may cause distress to the resident, or may be distressing or disruptive to facility residents, staff members, or the care	F 278	The facility social worker will be responsible for insuring compliance.	06/02/11

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F 278	Continued From page 7 environment. These behaviors may place the resident at risk for injury, isolation, and inactivity and may also indicate unrecognized needs, preferences, or illness. Behaviors included those that are potentially harmful to the resident himself or herself. The emphasis is identifying behaviors, which does not necessarily imply a medical diagnosis. Identification of the frequency and the impact of behavioral symptoms on the resident and on others is critical to distinguish behaviors that constitute problems from those that are not problematic. Once the frequency and impact of behavioral symptoms are accurately determined, follow-up evaluation and care plan interventions can be developed to improve the symptoms or reduce their impact." The MDS 3.0 describes "Other behavioral symptoms not directed toward others" as "e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds." - A roster provided by the facility on April 25, 2011, identified Resident #2 as an interviewable resident, and also with behaviors. Review of Resident #2's medical record occurred on April 25-27, 2011. The facility admitted Resident #2 in December of 2010. Resident #2's diagnoses included insulin dependent diabetes mellitus, peripheral vascular disease, mild mental retardation, metatarsal amputation on the left foot, and on 04/18/11, metatarsal amputation on the right foot.	F 278		

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F 278	Continued From page 8 Review of an admission Minimum Data Set (MDS), dated 12/28/10, and quarterly MDS, dated 03/17/11, identified Resident #2 with a Brief Interview for Mental Status (BIMS) score of 15, identifying the resident as cognitively intact for assessment purposes. The admission and quarterly MDS identified the resident with no mood and behaviors, nor depression indicators. The quarterly MDS identified an "Other behavioral symptom not directed toward others" occurred 1 to 3 days within that assessment period. An interdisciplinary assessment and summary review statement dated 03/17/11 completed by a supervisory social services staff member, stated the following: "Met [with] [resident] et [and] completed the MDS interview. [Resident] is alert and oriented x 3 [times three]. [Resident] . . . denied any mood issues. . . . No mood or behavior indicators noted on the electronic charting. . . . His independent activities include reading, computer games, and drawing. He also likes to go through catalogs and find items other people might like. . . . denied any needs or concerns. His goal remains to return to his apartment. . . ." An interdisciplinary assessment and summary review statement, dated 03/21/11, completed by the same supervisory social services staff member stated the following: "Addendum to 3/17/11 note. [Resident] was coded for a physical behavior toward others. I spoke [with] [certified nursing assistant-CNA] as she coded this behavior. She stated that [resident] showed her pictures of a sexual nature. She was able to [change] the subject. He did not make any gestures or comments. Coded to other behavior	F 278		

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F 278	Continued From page 9 on MDS." Review of the "Mood & Behavior Record" showed the behavior occurred on the day shift of 03/15/11, and the "Causes" of the behavior identified as "Other." An interview occurred on the afternoon of 04/26/11 with a supervisory staff member (#1) regarding the documented behavior. The staff member stated the coding on the MDS occurred based on the interaction with the resident and the CNA's interpretation of the incident. The staff member stated she did not question the resident regarding the pictures and agreed the resident should have been interviewed regarding what occurred before coding the behavior. Resident #2's behavior was coded based on the interpretation of one staff member, and no assessment by the interdisciplinary team. The facility failed to identify if what occurred was a behavior, and how it was problematic.	F 278		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: 1. Based on record review, review of facility	F 309		

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F 309	Continued From page 10 policy and procedure, and staff interview, the facility failed to ensure 1 of 1 sampled resident (Resident #7) who experienced a fall resulting in a hip fracture received the necessary care and services. Failure to ensure timely evaluation and treatment after the resident's fall resulted in Resident #7 experiencing unnecessary prolonged hip and leg pain while attempting to ambulate, and may have resulted in avascular necrosis of the right hip. Failure to monitor Resident #7's pain caused the resident unnecessary pain. Findings include: - Review of the facility policy and procedure "Pain Management - Resident Assistance," occurred on 04/28/11. This document stated "PURPOSE, To provide residents assistance in pain management. POLICY, All residents will receive interdisciplinary consultations on assistance in managing pain. . . . The registered nurse will assess current pain levels and develop with the physician and interdisciplinary team, interventions which may be non-pharmacological as well as pharmacological. . . ." Review of Resident #7's medical record occurred on April 25-28, 2011. The facility admitted the resident in November 2005. Current diagnoses included Parkinson's disease, constipation, mental impairment, and fractured right hip (03/16/11). Resident #7's quarterly Minimum Data Set (MDS), dated 02/23/11, identified he usually understood others and sometimes made himself understood, had unclear speech, had severe cognitive impairment, had continuous disorganized thinking, and required extensive	F 309	The facility policy for Resident Incidents has been reviewed. The facility obtained an xray on 3/31/11 for resident #7. Resident #7 is NWB on right side with transfers and no ambulation. Care plan has been updated to include these changes. Resident #7 was also started on a fiber supplement, which consists of benefiber mixed with fruit sauce, three times a day. This is to prevent constipation due to inactivity from fractured right hip. For resident #7, a Pain Data Collection Tool was completed and physician was updated. Resident #7 remains NWB to help decrease pain. Follow up appointment with orthopedic doctor has been arranged. All residents who fall are at risk of fractures, inactivity, constipation and pain. Any resident who falls will be assessed by a nurse and physician notified immediately of any signs and symptoms of injury or increased pain. Pain management will be addressed with physician. Any resident with a fracture and inactivity due to a fracture will have a bowel assessment	Bowel re-assessment TBD 5-31-11. Add to care plan! fluids offered with med pass & all cares added to care plan per T.C. with Jon Stoner Mike Hammer 9:15 a.m. 5/31/11 P Swenson

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F 309	Continued From page 11 assistance of one person and a walker to ambulate and transfer. Resident #7's Cognitive Care Area Assessment, dated 11/26/10, stated ". . . does not have a MR [mental retardation] diagnosis, but it is suspected. . . ." Resident #7's current care plan, dated 06/01/10, stated "Problems . . . I have a hard time communicating my needs. . . . My speech is garbled and mumbly. . . . Approaches . . . Give me the time to express myself, I may repeat myself. Help me out with Yes or No questions. Sometimes I give nonverbal clues (pointing) to get my point known. . . . Problems . . . Potential for alteration in comfort m/b [manifested by] has complaint of pain, arthritis. . . . Approaches . . . Adm [Administer] pres [prescribed] analgesic & [and] report unrelieved/persistent pain. Non-pharmacological interventions to be tried . . . Reposition for comfort as needed. . . ." Resident #7's physician orders included the following pain medications: Tylenol 1000 milligrams (mg) two times each day (BID) and Tylenol 650 mg every four hours (q4h), as needed (PRN). The resident's medication administration records (MARs) for the period March 01, 2011 through April 26, 2011 showed Resident #7 did not receive any of the PRN Tylenol during this period. Resident #7's medical record included the following entries: *Interdisciplinary Progress Notes (IDPN), dated 03/16/11 at 9:00 a.m., ". . . resident was on toilet [with] alarm on and took alarm off and self ambulate [sic] across bathroom. Lost balance and fell to buttocks. . . .	F 309	completed and dietary will be notified of status change. Dietary will assist in developing a bowel care plan. Mandatory staff education will be provided on May 25, 2011 related to policy regarding falls, pain management and communication with physician. Quality Assurance Committee will audit monthly for 3 months and quarterly for a total of one year to assess communication with physician and timeliness of intervention and development of bowel care plan. The facility Director of Nursing Services will be responsible for ensuring compliance.	06/02/11

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F 309	Continued From page 12 03/16/11, 6:00 p.m., "No c/o [complaints of] re: [regarding] fall this a.m. . . . 03/18/11, 11:00 a.m., "Fax sent to [physician] re: resident fall on 03/16/11 . . . Now c/o (R) [right] leg pain from hip to knee. Does bear some wt. [weight]. Refuses to ambulate because it hurts. Should we do an x-ray[?]" *Fax Communication To Physician, dated 03/18/11, 8:48 a.m., ". . . Concern: Resident fell on 03/16/11 self transfer from toilet. Now c/o (R) leg pain from hip to knee. Does bear some wt. Refuses to amb. [ambulate] because it hurts. Should we do an x-ray[?]" 03/21/11, 10:45 a.m., Fax response from the provider, "How is he today, 03/21/11?" Undated, untimed, unsigned response to the provider on the same fax form, "No further complaints from [Resident #7] over the weekend or today. Thanks." *Restorative Program notes included Ambulation Distance, for the period March 01-15, 2011, which varied from 0 feet (due to refusal unrelated to pain) to 300 feet; and, from March 16-30, included Ambulation Distance, as follows: 03/16/11 - 30 feet; 03/17/11 - 30 feet; 03/18/11 through 03/20/11 - none; 03/21/11 - 300 feet; 03/22/11 - none; 03/23/11 - 100 feet; 03/24/11 - 50 feet; 03/25/11 - 100 feet; 03/26/11 through 03/28/11 - none; 03/29/11 - 50 feet; and 03/30/11 - none. Ambulation attempts have been on hold since	F 309		

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F 309	Continued From page 13 03/31/11. * Restorative Program narrative notes, all untimed, stated: 03/18/11, "Resident attempt to ambulate. C/o of right leg hurting." 03/19/11, "Resident (R) leg hurts him." 03/20/11, "Resident still c/o (R) leg hurting." 03/22/11, "Resident still c/o (R) leg hurting." 03/26/11, "Resident attempted to ambulate. No success. Resident stated 'that he could not get moving.' " 03/27/11, "Resident still c/o hurt leg hurting. Resident stated his leg still hurts." 03/30/11, "[Resident #7] is not himself - just doesn't have any energy." * IDPN, 03/31/11, 2:30 p.m., "Res. [Resident] continues to c/o pain to his (R) leg. There is no shortening of the leg or bruising. Res. does have decreased ROM [range of motion] and strength in (R) leg. Physical Therapy reports that res. does not bear wt. on the (R) leg. Called [provider] @ [at] [clinic] and received order to do x-ray on (R) leg tomorrow @ [clinic]." * IDPN, 04/01/11, 10:30 a.m., "Resident to [clinic] for x-ray of (R) leg as ordered/noted above. . . . Upon questioning this a.m., resident denied pain. Resident receives scheduled ES [Extra Strength] Tylenol X [times] 2 BID. Has not requested nor received any additional prn doses in past month." * IDPN, 04/04/11, 9:35 a.m., "Spoke [with] [provider]. Hip is fractured. . . ." * IDPN, 04/05/11, no time, "Resident to . . . [orthopedic surgeon] to consult re: above. . . ."	F 309		

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F 309	Continued From page 14 Resident #7's medical record included an orthopedic surgeon's note, dated 04/05/11, which identified an "impacted subcapital fracture" of the right hip with "early nonunion and avascular necrosis" and advised surgical repair. Surgical repair was scheduled for 04/26/11 and cancelled on the instruction of the resident's power of attorney. An Internet site, medilexicon.com, "Stedman's Online Medical Dictionary," 2006, Lippincott, Williams & Wilkins defines a subcapital femur fracture as "at the point where the neck of the femur joins the head" and avascular necrosis as tissue death "resulting from deficient blood supply." During interview, on 04/27/11 at 3:05 p.m., a restorative therapy staff member (#4), who authored the Restorative Program Notes of March 18-27, 2011, reported Resident #7 complained of right hip and leg pain and pointed to his right hip and leg during attempted ambulation on March 18-20, 2011. This staff member (#4) reported she did notify the charge nurse of the resident's leg pain and inability to ambulate. This staff member (#4) also reported she notified the charge nurse of Resident #7's leg pain and inability to ambulate on March 22, 26 and 27, 2011. During interview, on 04/27/11 at 5:45 p.m., a nursing management staff member (#2) and an administrative management staff member (#3) reported they were not aware of Resident #7's complaints of pain to the restorative therapy staff. During interview, on 04/28/11 at 8:15 a.m., staff	F 309		

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F 309	Continued From page 15 members (#2) and (#3) reported the facility staff should have contacted the provider by phone on 03/18/11 to obtain orders for Resident #7's hip x-ray instead of waiting for a response to the fax. These staff members did not know why the charge nurse, who the restorative therapy member informed on multiple occasions of Resident #7's pain, did not assess and document the resident's reported pain in the IDPN. It is unknown why the facility staff did not administer PRN Tylenol to Resident #7. The facility failed to follow-up with Resident #7's provider in a timely manner following a fall which resulted in a hip fracture. Record review identified the following: evidence of right leg pain extending from his hip to his knee causing discomfort with ambulation two days after the fall; fax communication of this pain to the medical provider, which staff waited over three days for a reply; and staff failure to provide the provider with accurate information regarding Resident #7's complaints of right hip and leg pain as documented and reported by the restorative therapy staff member beginning on 03/18/11. These failures resulted in a 13 day delay in receiving an order for an x-ray of Resident #7's right hip, and a delay in diagnosing the hip fracture. Due to this delay, the facility staff continued to attempt weight bearing ambulation on the right leg and Resident #7 continued to experience untreated pain. This delay may have resulted in the orthopedic diagnosis of early "avascular necrosis," and may have increased impaction of the fracture. 2. Based on observation, record review, review of facility policy and procedure, and staff interview,	F 309		

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F 309	Continued From page 16 the facility failed to ensure 1 of 1 sampled resident with reduced bowel function and who experienced increased pain and inactivity after a fall and fracture (Resident #7) received the necessary care and services regarding dietary interventions to promote bowel function. Failure to provide dietary interventions may have resulted in reduced bowel function and an increased use of bowel medications. Findings include: Review of the facility policy and procedure "Bowel Assessment," occurred on 04/28/11. This document, revised 09/10, stated "PURPOSE, To assess bowel function appropriately; To identify effective bowel management programs. DEFINITIONS, Constipation: If the resident has two or fewer bowel movements during the seven-day look-back period . . . PROCEDURE, Assessment . . . 4. Use the following assessment data to determine the need for a program: a. Physical and Mental Status: Need to look at the nature of neurological alteration; cognition; ability to communicate; presence of related physical and emotional conditions. b. Bowel History: Consider past and present bowel history. Look at . . . episodes of constipation . . . c. Nutritional History: Food preferences . . . fiber and fluid adequacy . . . d. Functional Ability: . . . assistance for bowel management and for eating; energy/endurance level and joint diseases that limit mobility. e. Medications: What has been used in the past . . . Possible Interventions and Modifications, 1. Plan	F 309		

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F 309	Continued From page 17 interventions based on the individual resident and the assessment: a. Diet: Add fiber to the diet . . . b. Fluid Intake . . . c. Activity . . . 2. The care plan interventions should be individualized based on the CAA [Care Area Assessment] assessment and modify the plan as appropriate based on an assessment of the resident's unique bowel elimination pattern. . . ." Review of Resident #7's medical record occurred on April 25-28, 2011. The facility admitted the resident in November 2005. Current diagnoses included Parkinson's disease, constipation, mental impairment, and fractured right hip. The resident's quarterly Minimum Data Set (MDS), dated 02/23/11, identified the resident required extensive assistance of one person with toileting, frequently incontinent of bowel, and on a toileting program. The resident's Dehydration/Fluid Maintenance CAA, dated 11/26/10, stated, ". . . will say that is enough when it comes to fluids. He will not take more when encouraged. . . ." Resident #7's Nutrition Assessment, dated 11/16/10, stated ". . . Hx. [History] constipation. Tried pears 1 X [time] day [with] no change. Bowel regular meds [medications]." Resident #7's Interdisciplinary Assessments and Summary Reviews stated the following: 11/19/10, Nursing, ". . . He is on scheduled/prompted toileting program to promote bowel continency. . . . He does have some problems [with] constipation. . . ." 11/23/10, Dietary, ". . . Receives Benefiber daily. Was recommended to give pears daily to promote regularity, did not change bowel pattern	F 309		

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F 309	Continued From page 18 for past 3 weeks. . . ." 01/24/11, Nursing, ". . . He does use bowel aids. . . . He has potential for dehydration d/t [due to] refusal to drink all his fluids @ meals et [and] was offered during the day." Resident #7's current care plan, dated 06/01/10, stated, "Problems . . . I will not drink all of my fluids. . . . Approaches . . . Refuses drink [sic] supplements. Verbal reminders to finish fluids at meals. . . . [updated 08/24/10] Problems . . . Take me to BR [bathroom] per approach to promote bowel continency. . . . Approaches . . . Assist me to the toilet upon rising, one hr. [hour] [with] in meals, bedtime, when I state/gesture. . . ." Resident #7's current physician orders included orders for Lactulose (laxative) 30 milliliters at bedtime, with an original order date of 11/30/05; Senokot S (stool softener and laxative combination) three tablets two times each day, and two tablets at 12:00 noon daily, with an original order date of 06/27/07; Dulcolax (stool softener) 10 milligrams (mg) oral or suppository daily, as needed (PRN); and Benefiber (soluble fiber) in juice at breakfast. Review of Resident #7's PRN medication administration records (MARs) for January 2011 through 04/23/11 identified the resident received the Dulcolax, orally or suppository, as follows: January: 6 times February: 6 times March: 7 times April: 9 times Review of Resident #7's BM [Bowel Movement] Record for the period October 27, 2010 through April 27, 2011 showed a frequency of bowel	F 309		

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F 309	Continued From page 19 movements approximately every two to four days. Bowel frequency in November 2010, during the trial of pears, was approximately every three to four days. During the period April 02-09, 2011, the resident did have PRN Dulcolax on 04/06/11 and 04/08/11, and did not have a bowel movement until 04/09/11. Resident #7's medical record identified he experienced a fall on 03/16/11 with complaints of pain and further reduced activity beginning on 03/18/11 and this continued through 04/28/11. Observation of Resident #7 during the breakfast and noon meals on 04/26/11 and the breakfast meal on 04/27/11 showed he received juice with Benefiber added, water, coffee, and milk and consumed approximately half of these fluids at each meal. During interview, on 04/27/11 at 4:30 p.m., a dietary management staff member (#5) reported Resident #7 does not consume fluids well and pears were provided for three weeks in 11/10 for bowel assistance without change in his bowel pattern. This staff member reported she was not aware of any further communication with other facility staff regarding Resident #7's bowel frequency, including since his fall on 03/16/11 and reduced activity. This staff member (#5) confirmed the only additional dietary fiber Resident #7 receives is the Benefiber in his juice. This staff member agreed since Resident #7 does not consume all his juice, he does not receive the full amount of Benefiber. During interview, on 04/28/11 at 8:15 a.m. a nursing management staff member (#2) and an	F 309		

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F 309	Continued From page 20 administrative management staff member (#3), agreed the facility's dietary interventions for Resident #7's bowel management had been limited. These staff members also agreed Resident #7's reduced physical activity and potential increase in pain and pain medications placed him at increased risk of constipation and did require re-assessment and intervention. These staff members reported the facility staff added pears to Resident #7's daily diet on 04/27/11. The facility identified Resident #7's fluid intake was poor and has a history of constipation. The resident received the same oral laxatives since 06/27/07, nearly four years. Dietary interventions remained limited to fiber added to his juice (which the resident consumed poorly) and a three week trial of pears in November 2010). Resident #7's fall with injury on 03/16/11, reduced activity, pain, and increased pain with activity places him at increased risk of constipation. The resident's bowel records show a reduced frequency of bowel activity and increased use of PRN laxative since the fall. Continued use of laxatives and stool softeners may have resulted in Resident #7 being dependent on these medications for bowel movements. Failure to provide dietary interventions placed him at increased risk of dependence on these medications and at risk of constipation. Failure to provide dietary interventions after his fall and reduced activity has resulted in increased constipation and increased use of laxatives.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

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F 323	Continued From page 21 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 and procedure, and staff interview, the facility failed to ensure 1 of 1 sampled resident with a history of falls and non-surgically repaired hip fracture (Resident #7) received adequate supervision and assistance devices to prevent accidents regarding chair alarms during 2 of 2 days of observations (April 26-27, 2011). Failure to ensure use of the chair alarms placed the resident at risk of injury while attempting to independently ambulate or transfer. Findings include: Review of the facility policy and procedure, Alarms: Bed, Chair and Door, occurred on 04/28/11. This document, revised 10/08, stated "PURPOSE, To ensure a system is in place for center bed, chair and door alarms; To identify the process used to check these center alarms; To determine appropriate use of these alarms. POLICY, The center will ensure that a system is in place for all . . . chair . . . alarms . . . Alarms will be installed . . . PROCEDURE . . . 2. Each shift of nursing staff will be responsible for visually checking	F 323	The facility policy for alarms has been reviewed. The facility has placed a sensor alarm which is automatically activated in resident #7's wheelchair. A TABS alarm will be used whenever resident # 7 is in a recliner. All residents with cognitive impairment and/or a history of falls have the potential to be affected. Mandatory staff education will be provided on May 25, 2011 regarding importance and use of alarms to prevent falls. Nursing and activity staff will make rounds to be sure alarms are in use where necessary. 3x daily + 2 weeks, then 1x/wk for 1 month Quality Assurance Committee will audit alarm use once a month for three months and quarterly for three quarters for a total of a year. The charge nurse will be responsible for insuring compliance.	per T.C. with Jon Stone + Mike Herman @ 9:15 am 5/31/11 PSwenson 06/02/11

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F 323	Continued From page 22 placement of alarms. . . . 5. A system will be in place to determine which residents have a need for alarms. This can be done utilizing the pre-defined resident notes area on the physician's orders or through a center list. Use of an alarm will be documented on the resident's care plan and will be included on Certified Nursing Assistant flow sheets. . . ." Review of Resident #7's medical record occurred on April 25-28, 2011. The facility admitted the resident in 11/05. Current diagnoses included Parkinson's disease, arthritis, history of falls, and fracture right hip (03/16/11). The resident's quarterly Minimum Data Set (MDS), dated 02/23/11, identified the resident usually understood others, had severe cognitive impairment, and required extensive assistance of one person for transfers. Resident #7's Interdisciplinary Progress Notes (IDPN), dated 03/16/11 at 9:00 a.m., stated ". . . resident was on toilet [with] alarm on and took alarm off and self ambulate [sic] across bathroom. Lost balance and fell to buttocks. . . ." On 04/04/11, a provider identified a fractured right hip on x-ray. Resident #7's Falls Care Area Assessment (CAA), dated 11/26/10, stated ". . . lacks safety awareness. He has alarms to . . . chair. He will self transfer . . . He needs assist with transfers . . ." Resident #7's current care plan, dated 06/01/10, stated "Problems . . . I have difficulty walking and transferring because of my Parkinson's. I have fallen before transferring myself. I need a w/c	F 323		

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F 323	Continued From page 23 [wheelchair] for mobility. [undated handwritten modification] My last fall was 03/16/11 [with] fx [fracture] hip resulting . . . Goals . . . Hold amb. [ambulation] d/t [due to] (R) [right] hip fx . . . Approaches . . . Help me to transfer with assist of one and my walker. . . . [undated handwritten modification] I am needing more help. I fx my hip 03/16/11. . . .. . . TABS alarm applied when up in a chair and to w/c. . . . " Resident #7's care plan lacked weight bearing instructions during transfers following identification of his right hip fracture on 04/04/11. - Observation identified Resident #7 seated in a wheelchair in the dining room or activities as follows: *04/26/11, 8:00 a.m. to 9:00 a.m. and 12:10 p.m. to 3:35 p.m. *04/27/11, 7:55 a.m. to 11:20 a.m. While seated in the wheelchair, Resident #7 did not have a wheelchair alarm. Observation at 11:20 a.m. identified the resident seated in a recliner, without a chair alarm, in the activities area. It is unknown how long he remained in the activities area. During these observations facility staff were intermittently in the areas, leaving Resident #7 unsupervised for extended periods of time. During interview, on 04/27/11 at 5:45 p.m., a nursing management staff member (#2) and an administrative management staff member (#3) reported their expectation facility staff would ensure Resident #7 had a chair alarm in place in his wheelchair and recliner. The facility identified Resident #7 required assistance with transfers and ambulation and	F 323		

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F 323	Continued From page 24 used a chair alarm before his fall and fracture on 03/16/11. Failure to ensure the chair alarm was used, as care planned, placed Resident #7 at risk of fall and additional injury.	F 323	Facility policy regarding psychotropic medication has been reviewed. The Seroquel for resident #5 has been discontinued after provider education with family.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of policy and procedure, review of professional reference, and staff interview, the facility failed to	F 329	Facility will request to attempt a reduction of Seroquel for resident #6. Nursing staff will document daily regarding any change in behavior for resident #5 and #6. Behavior committee will review any documentation and update physician. All residents who receive antipsychotic medication(s) have potential to be affected. All residents who receive antipsycotic medications will be reviewed by the Behavior Committee. The committee will consult with the pharmacist and physician regarding any recommended antipsychotic medication reduction(s). The facility will use the Antipsychotic Checklist(GSS 475) prior to initiating any antipsychotic medication and to follow procedure for reduction of antipsychotics. The behavior committee will be responsible to insure compliance.	monthly pm T.C. with J. Stone, Adm 5/31/11 @ 1:30 pm P. Swenson see next page for QA 06/02/11

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F 329	Continued From page 25 ensure the medication regimens for 2 of 4 sampled residents receiving antipsychotics (Resident #5 and #6) remained free of unnecessary medications regarding inadequate indications for their use and failure to attempt a gradual dose reduction (GDR) (Resident #6). Use of antipsychotics without adequate indications and failure to attempt GDR placed the residents at risk of receiving unnecessary medications, experiencing adverse consequences, and failing to achieve their highest level of well being. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding indications for use of antipsychotic medication and GDR. Tapering may be indicated when the resident's clinical condition has stabilized or the underlying causes of the original target symptoms have resolved. Often the only way to know whether the dose remains appropriate is to reduce the dose and monitor the resident closely for improvement, stabilization, or decline. For antipsychotic medication, within the first year the facility must attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. A GDR may be clinically contraindicated if the physician has documented the clinical rationale for why an attempted dose reduction would be likely to impair the resident's function or increase distressed behavior. Review of the facility policy "Psychopharmacological Medications and Sedative/Hypnotics," occurred on 04/28/11. This policy, revised 01/07, stated ". . . DEFINITIONS .	F 329	Quality Assurance Committee will audit monthly for 3 months and quarterly for a total of one year dose reductions of anti psychotic medications. per T.C. with Jon Stone, Adm. 5/31/11 1:30 p.m. P. Swenson	

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F 329	Continued From page 26 . . Convenience - any action taken by the center to control a resident's behavior or manage a resident's behavior with a lesser amount of effort by the center and not in the resident's best interest. . . . Gradual Dose Reduction - the stepwise tapering of a dose to determine if symptoms, conditions or risks can be managed by a lower does [sic] or if the dose or medication can be discontinued. . . . Review of the facility procedure "Psychopharmacological Medications and Sedative/Hypnotics," occurred on 04/28/11. This procedure, revised 09/10, stated ". . . PROCEDURE . . . Gradual Dose Reductions . . . c. Clinically contraindicated means: 1) For a resident who is receiving an antipsychotic medication to treat behavioral symptoms related to dementia the GDR may be clinically contraindicated if: a) the resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility and b) The physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or increase distressed behavior. . . ." - Review of Resident #6's medical record occurred on April 25-28, 2011. The facility admitted the resident in 03/08. Current diagnoses included a history of falls, dementia, and depression. The resident's quarterly Minimum Data Set (MDS), dated 01/12/11, identified the resident was rarely or never understood or understands others, had severely impaired cognitive skills for daily decision making, did not have verbal or physical behaviors directed	F 329		

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F 329	Continued From page 27 towards others, had other behaviors not directed towards others for one to three days in the seven day assessment period, required extensive assistance of two or more persons for transfers, and did not ambulate. Resident #6's physician orders included Celexa (antidepressant) 5 milligrams (mg), daily (QD) and Seroquel (antipsychotic) 25 mg, QD initiated on 01/15/10. Resident #6's medication administration record (MAR) for the period January 01, 2011 through April 26, 2011 identified the resident received Seroquel on a daily basis. Resident #6's Behavior Resident Assessment Protocol Summary (RAPS), dated 04/12/10, stated ". . . was upset and threatened to and attempted to hit at staff when they were trying to provide cares. . . . This behavior occurred one time. Staff was unable to determine what may have contributed to this, as it is out of character for [Resident #6]. . . ." Resident #6's Social Services Interdisciplinary Assessment and Summary Review, dated 04/12/11, did not identify any behaviors. Resident #6's Mood and Behavior Record for the period October 01, 2010 through April 26, 2010 identified the following behaviors: *Physical or verbal behaviors directed toward others - 10/22/10 and 02/03/11 *Other behaviors not directed toward others - 02/02/11, 02/03/11, 02/18/11, and 02/23/11 *Rejection of cares - 11/04/10, 03/18/11, 03/28/11, 04/11/11, and 04/14/11. *Wandering - 02/23/11	F 329		

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F 329	Continued From page 28 Resident #6's current care plan, dated 01/18/11, stated "Problems . . . is restless at times. . . . Sometimes I will lick or spit on my hands and throw it. I have become upset and swore at others. I have attempted to hit and kick others. . . . Approaches . . . Administer antipsychotic, monitor for side effects . . . Document behaviors . . . If I am upset, move me to a quieter area to decrease stimulation. . . ." Resident #6's medical record included a Fax Communication To Physician, dated 02/01/11 at 5:12 p.m., included the following: *Resident #6's medication regimen review (MRR) by the facility's consultant pharmacist, dated 01/31/11. The MRR stated ". . . Recommendation Type: Antipsychotic therapy recommendation . . . Resident satrted [sic] Seroquel 25mg po [by mouth] qd 01/08/10 r/t [related to] licking behavior. No behaviors charted recently. MD [Physician] may consider a dose reduction of Seroquel. Thanks." *A facility staff member's note, dated 02/01/11, which stated "Pharmacy recommends. What would you like? Resident continues [with] this behavior." *Response from a provider, dated 02/02/11 at 11:42 a.m., which stated "Cont. [Continue] current dose. However please chart behaviors." Observation, on April 25-27, 2011, identified Resident #6 seated in a wheelchair with a lap top tray table throughout each day. The resident did move her arms about in a random fashion and reach for objects and persons nearby. Observations did not identify any hand licking or spitting behaviors.	F 329		

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F 329	Continued From page 29 Resident #6 has received the same dose of Seroquel since 01/15/10. The medical record lacked evidence of an attempted GDR. The facility's behavior documentation for Resident #6 showed 12 incidents of behaviors in an approximate 7 month period. Two of the behaviors were directed towards others. The provider continued the antipsychotic, Seroquel, without evidence of a clinical contraindication or a GDR. - Review of Resident #5's medical record occurred on April 25-27, 2011. The facility admitted the resident in 02/10. Current diagnoses included dementia, anxiety, and Parkinson's disease. The resident's annual MDS, dated 02/17/11, identified fluctuating inattention and disorganized thinking behaviors, delusions, verbal behaviors directed towards others occurred one to three days of the seven day assessment period, and behaviors interfered or disrupted the resident's care and that of others. Resident #5's physician orders included Ativan (anti-anxiety medication) 0.5 mg, two times each day (BID), as needed (PRN), initiated 02/23/10; and, Seroquel 25 mg, QD, initiated 03/24/11. Review of Resident #5's MARs for the period November 01, 2011 through March 31, 2011 showed the resident received the PRN Ativan as follows: *March 2011 - 11 times *February 2011 - 9 times *January 2011 - 9 times *December 2010 - 13 times *November 2010 - 14 times Resident #5's Behavioral Care Area Assessment	F 329		

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F 329	Continued From page 30 (CAA), dated 02/24/11, stated ". . . has a strong personality. If she believes something, she is difficult to reassure or redirect. [Family member] comes up if we are unable to calm her. . . . When she is upset, she becomes restless . . . No set pattern noted with her behaviors. She can go weeks without behaviors and then will have a stretch of days where she has several. She can take Ativan prn. She has taken the Ativan 7 times this month. On average, she uses the prn Ativan about 10 times a month. . . ." Resident #5's Mood and Behavior Record for the period October 01, 2010 through April 27, 2010 identified the following behaviors: *Physical or verbal behaviors directed toward others - 10/26/10, 01/12/11, and 02/13/11 *Other behaviors not directed toward others - 10/26/10 and 01/02/11 *Wandering - 12/03/10, 01/06/11, and 01/25/11 *Short tempered, easily annoyed - 10/23/10, 10/26/10, 01/02/11, 01/06/11, 01/25/11, 02/13/11, and 02/24/11 *Rejection of cares - 02/24/11 and 04/15/11 Resident #5's current care plan, dated 11/23/10, stated "Problems . . . I do get tearful. I worry that people are in my home. I think my daughter has been 'taken.' [updated 02/24/11] I might get upset when you try to reassure me. . . . Approaches . . . If I am upset, take me to an area where I cannot see a large group of people. Reassure me that you will help. . . . Help me call my daughters. Walk with me to help me decrease restlessness. . . ." The care plan lacked information regarding use of Seroquel and Ativan and monitoring side effects of these medications.	F 329		

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F 329	Continued From page 31 Resident #5's medical record included a physician's progress note, dated 03/24/11, which stated ". . . The patient's daughter is here with her today and is complaining that she has noticed that her mom is more agitated, especially after she has been on Ativan and it begins to wear off. She has been requiring almost daily dosages of Ativan at approximately 2:00 to 3:00 in the afternoon every today [sic]. The daughter states that by late afternoon or early evening it seems to be losing its effectiveness and the patient is becoming much more agitated. The nurses report similar findings, although the nurses do not feel like it is quite as dramatic as the patient's daughter seems to think it is. The nurses would like to have something scheduled routinely in the afternoons such as the Ativan. However, the daughter does not want her on any scheduled Ativan. She would like to try something different. . . . PLAN: 1. Continue with the lorazepam [Ativan] on a p.r.n. basis. 2. We will schedule Seroquel 25 mg in the mid afternoon and see if we cannot take care of some of the afternoon agitation and get a little bit better response than we were getting with the lorazepam. 3. . . . We will adjust the Seroquel based upon effectiveness of the initial dosage. . . ." The Mood and Behavior record showed 10 episodes of behaviors directed towards others in the seven month period reviewed. The MARs showed the following frequency of Ativan use: *March 2011 - 11 times (less than daily) *February 2011 - 9 times *January 2011 - 9 times *December 2010 - 13 times	F 329		

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F 329	Continued From page 32 *November 2010 - 14 times The medical record lacked a medical diagnosis for use of the antipsychotic, Seroquel; and, lacked evidence Resident #5's behaviors posed a danger to herself or others. During interview, on 04/28/11 at 8:15 a.m., with a nursing management staff member (#2) and an administrative management staff member (#3), these staff members reported Resident #6 continued to have licking and spitting behaviors, which were not documented. These staff members confirmed the facility did not attempt a GDR for Resident #6's Seroquel. These staff members also reported the facility called Resident #5's family member more frequently in March to assist with the resident's behaviors, however, this is also not documented.	F 329		