STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535045	A. BUILDING _____ B. WING _____	C 10/11/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWELL VALLEY CARE CENTER	777 AVENUE H POWELL, WY 82435

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F 157 SS=J	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policies, and staff interview, the facility failed to notify the physician immediately for four of four sample residents (#41, #87, #97, #98) who had a	F 157	F 157 The facility will ensure that the resident, resident's physician and resident's legal representative are notified when there is an accident involving the resident and has the potential for requiring physician intervention; a significant change in condition, a need to significantly alter treatment or a decision to transfer or discharge the resident from the facility by; A. Resident #98 is a closed record. A. Resident #97 is a closed record. A. Nursing staff have been instructed to notify the primary physician and resident's responsible party with any injury or significant change of condition that might require physician intervention for resident # 41. A. Nursing staff were re-educated that the Nursing/Physician Communication form is only to be used for non-emergent issues and never used for initial communication regarding falls with injury or significant changes of condition for resident #87. A. The Falls/Fall Risk Assessment procedure 2.11 will be revised to include physician notification guidelines.	11/15/06

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE CEO | (X6) DATE 10-30-06

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.

NOV 02 2006 Accepted w/Changes Reviewed w/ Cheri Benander LPN

DOC = 11/15/06 Loralee Rees 11/13/06

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F 157	Continued From page 1 fall with injury or change of condition which required physician intervention. Two of the residents (#97 and #98) were delayed in getting treatment which resulted in immediate jeopardy. The findings were: 1. Review of nursing notes dated 8/30/06 at 3:30 AM showed resident #98 was found lying on the floor. The resident complained of left hip and left shoulder pain. The nurse documented the left pupil was slow to react, and the resident was not able to put weight on the left leg. There lacked documentation of physician notification. Review of the neurology flow sheet showed the resident's left pupil was slow to react at 3:30 AM, 3:45 AM, 4 AM, 4:15 AM, and 4:45 AM. [Review of the facility procedure 6.1, revised 3/06, showed the facility used "Nursing Procedures", Edition IV, by Lippincott, Williams & Wilkins for nursing procedures. Review of "Nursing Procedures" showed when examining the pupils, the nurse tests for direct light response. "...Shine the light directly into the eye. Normally, the pupil constricts immediately. When you remove the penlight, the pupil should dilate immediately..."] The next nursing documentation was 8/30/06 at 6:15 AM (2 hours and 45 minutes after the fall with injury) which documented the certified nurse aide (CNA) came to the nurse and stated the resident was crying out, and complaining of pain in the left hip. The resident was pale, and crying it hurt. The nurse documented she called the resident's son, who said to take the resident to the emergency room. There lacked documentation of physician notification. The next documentation was on 8/30/06 at 6:45 AM (3 hours and 15 minutes after the fall) which documented the resident continued to cry out in pain. The emergency room was	F 157	B. All residents with injuries or significant changes of condition have the potential to be affected by the lack communication between the facility and primary or on-call physician and the responsible party, if appropriate. C. The facility will ensure that any resident accident resulting in injury, or change in condition, that has the potential for requiring physician intervention will be immediately reported to the primary physician or on-call physician, and the resident's legal representative. Nurse/Physician Communication forms will not be used for emergent issues and never used for initial communication regarding falls with injury or significant changes of condition. In an emergent situation, the resident may be transferred to the emergency room (ER), and the physician notified by facility staff as soon as possible. This will be accomplished by immediate staff education of the nurses, and formal in-service at October Odyssey, October 16-20, 2006. Written guidelines for physician and responsible party will be located at each nurse's station. The Falls/Fall Risk Assessment procedure 2.11 will be revised to include physician notification guidelines.	

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F 157	Continued From page 2 phoned, and the resident was then taken to the emergency room. Nursing documentation on 8/30/06 at 9:45 AM showed the emergency room nurse reported that the physician had been notified and x-rays taken. The resident had a fractured hip and the resident was admitted to the critical access hospital. A note dated 9/27/06 showed the resident expired on 9/1/06 and CVA (cerebral vascular accident, "stroke") was listed as the cause of death. Review of the quality improvement fall follow-up form in the medical record dated 8/30/06 showed at the time of the fall, the emergency room was called and the emergency room "staff" instructed the facility to wait until the morning. During an interview on 10/10/06 at 1:20 PM, the care center nursing director and quality improvement coordinator stated the nurse at the facility spoke to the nurse in the emergency room, but did not speak to a physician. The nursing director confirmed the facility did not notify the physician of the resident's fall with injury. The fall follow-up form showed the physician was not notified until 9:40 AM by the emergency room staff. 2. Review of the interdisciplinary progress notes in the medical record of resident #97 revealed staff heard the resident's personal alarm sounding on 8/18/06 at 3:15 AM. The CNA was documented as having found the resident lying on his/her right side on the floor. According to the documentation, the resident evidently had raised the electric recliner to its full upright height in order to facilitate and independent transfer. The resident initially complained of right shoulder pain and was noted to have a bump on the right lateral forehead. The resident was transferred to bed	F 157	D. The Nursing Directors will review 100% of all incidents of injury that had the potential for requiring physician intervention to ensure proper notifications were made to the physician and the resident's responsible party. The data will be aggregated quarterly and submitted to the Medical Director and the Quality Council.	11/15/06 ~~10/11/06~~

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F 157	Continued From page 3 and complained of right knee pain. Staff noted the resident could not straighten the right knee, but no right knee crepitation was felt or heard by the registered nurse (RN). There was no evidence that the facility attempted to notify the resident's physician. At 4:30 AM, the facility documented that the resident continued to complain of right knee pain. The resident called out in pain when the nurse attempted to move the resident's right leg. The RN heard a faint popping sound and telephoned the emergency room nurse and told her the RN was going to send the resident over for an evaluation. According to the record, the resident was transferred via a gurney to the emergency room of the critical access hospital at 4:45 AM. The progress notes documented that on 8/18/06 at 6:15 AM, the facility was notified by the emergency room nurse that the resident had sustained a right hip fracture. An entry in the progress notes on 8/23/06 at 1:55 PM revealed the resident had expired in the hospital on 8/18/06 at 10:35 PM. There was no evidence the facility attempted to contact this resident's physician at any time after the fall, prior to transfer to the critical access hospital in order to determine the need for further evaluation or treatment. Interview with the Care Center Nursing Director on 10/10/06 at 1:20 PM verified that staff was not necessarily expected to notify a resident's physician after an accident that might require further treatment. Review of the Consultation Report from the critical access hospital dictated by the surgeon on 8/19/06, revealed this patient had been experiencing pain since the injury happened and was an "extreme risk" for any type of surgical intervention. According to the documentation by the surgeon, the injury experienced by the resident as a result	F 157		

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F 157	Continued From page 4 of the fall sustained in the facility would have prevented the resident from being placed into a sitting position, would have required bed rest, and would have resulted in continued pain without surgical intervention. According to the Discharge Summary dictated by the surgeon on 8/23/06, an informed decision was made to pin the resident's hip. According to the physician's documentation, "We had no idea how long [the resident] would survive this particular injury. [The resident's] family, and I believe [he/she] understood, that the injury itself is a lifethreatening [sic] situation." 3. Review of nursing notes dated 7/7/06 at 11:30 PM showed resident #41 was found on the floor. The resident had a vertical laceration to the middle forehead. The note documented the resident was taken to the emergency room. There lacked evidence the physician was notified. A nursing note dated 7/7/06 at 11:10 PM stated the resident was brought back from the emergency room (ER). The note documented the resident briefly opened his/her eyes in the ER, but was non verbal. Review of the after care instruction from the ER showed "...watch for signs of head injury...". Review of the ER after care instructions for "head injuries" revealed the resident should return to the ER for "...confusion, unconsciousness...difficulty speaking...or any worsening of condition." The following concerns were identified: a. Review of nursing notes dated 7/8/06 at 12:15 AM showed the resident would not open his/her eyes and was non verbal, but did move his/her legs. Nurses notes dated 7/8/06 at 6:15 AM showed the resident kept his/her eyes closed and tried to speak, but the nurse was unable to	F 157		

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F 157	Continued From page 5	F 157		

understand the speech. The note further showed the resident had a slight hand grasp, and staff did not get the resident out of bed due to the resident being "sleepy". Nurses notes dated 7/8/06 at 3:35 PM showed the resident would not open his/her eyes or grasp the nurse's hand. The note further documented the resident had not spoken and remained in bed all shift; and did not eat lunch because "would not rouse."

b. Review of the neurology flow sheet showed on 7/7/06 at 9:30 PM, prior to going to the ER, the resident's EMV (eye opening, motor response, verbal response) score was 14 and both pupils were reactive. The neurology flow sheet showed the EMV scale was the "Glasgow" scale to assess brain damage, with scores ranging from 3 to 15. However, review of the neurology flow sheet after the resident returned from the ER revealed the following on 7/7/06 and 7/8/06: at 11:15 PM the Glasgow score was 3 and the right pupil was non reactive; at 12:15 AM the Glasgow score was 3 and the right pupil was non reactive; at 1:15 AM the Glasgow was 7 and the right pupil was non reactive; at 2:15 AM the Glasgow was 3 and the right pupil was non reactive; at 6:15 AM the Glasgow was 5 and the right pupil was non reactive; at 10:15 AM the Glasgow was 3; and at 2:15 PM the Glasgow was 3. Review of the facility procedure 6.1, revised 3/06, showed the facility used "Nursing Procedures", Edition IV, by Lippincott, Williams & Wilkins for nursing procedures. Review of "Nursing Procedures" showed changes in pupillary activity (....response to light) may signal increased intracranial pressure...when examining the pupils, the nurse tests for direct light response. "...Shine the light directly into the eye. Normally, the pupil constricts immediately. When you remove the penlight, the

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F 157	Continued From page 6 pupil should dilate immediately..". In addition, "The Glasgow Coma Scale provides a standard reference for assessing or monitoring level of consciousness...a score of 3 is the lowest and 15 is the highest. A score of 7 or less indicates coma...". In addition, "...if a previously stable patient suddenly develops a change in neurologic or routine vital signs, further assess his condition, and notify the physician immediately." c. Further record review showed no evidence the physician was notified of the above findings. 4. Review of nursing notes dated 9/20/06 at 6:45 PM showed resident #87 fell out of the wheelchair off the curb outside the front door. The resident was taken to the emergency room. Review of a nurse/communication sheet showed the physician was not made aware of the fall until the next day, on 9/21/06. During an interview on 10/11/06 at 8:45 AM, the quality improvement coordinator and Minimum Data Set (MDS) coordinator stated the communication form was only supposed to be used for non-emergency communication, and not used for falls with injuries. 5. Review of the facility's policy "Falls/Fall Risk Assessment" (procedure 2.11, revised 2/06) showed the nurse was to document when the physician was notified, but did not address when the physician was to be notified. On 10/10/06 at 4:50 PM, the care center nursing director stated the facility did not have a policy which stated when nursing staff was to notify the physician. On 10/10/06 at 1:20 PM, the care center nursing director stated he expected the physician to be notified as soon as possible. But then he stated that some nurses called the physicians, but some nurses would make the decision if the resident	F 157		

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F 157	Continued From page 7 needed to go to the emergency room without consulting the physician. During an interview on 10/10/06 at 5:05 PM, the medical director stated nurses should be notifying the physicians. When asked for a timeframe, the medical director replied it would depend on the injury, but for example if it was a suspected hip fracture, the physician should be notified as soon as possible. 6. On 10/10/06 at 4:44 PM, the care center nursing director was notified of the immediate jeopardy. On 10/11/06 at 11:25 AM, the immediate jeopardy was removed on-site by the following actions: the facility revised the falls policy and developed a new policy for physician notification; the facility educated all nurses working the shifts since the immediate jeopardy was called; and the facility submitted a plan to educate all remaining nurses. References: "Nursing Malpractice" by Ann Helm, RN, MS, JD, 2003, Lippincott, Williams & Wilkins states "As a nurse, you must communicate changes in the resident's condition to the physician, even if you aren't sure how important those changes may be....It's the nurse's duty and responsibility to keep the physician informed so that care may be directed appropriately..." "Nursing and the Law", sixth edition, Sheryl Feutz-Harter, PESI Healthcare, 1997 states "...Nurses are responsible for appropriately and adequately monitoring the condition of their patients so that proper care and treatment can be rendered...the nurse is also responsible for communicating any pertinent information to the applicable physician..notification of a physician	F 157		

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F 157	Continued From page 8 does not merely mean that a phone call is placed but rather that a physician is actually contacted and responds appropriately...". "Nursing and the Law" by Kammie Monarch, RN, MS, JD, 2002, states "...nurses are required to promptly communicate troublesome patient findings. Failure to properly communicate patient findings can be devastating for patients...".	F 157		
F 202 SS=E	483.12(a)(3) DOCUMENTATION When the facility transfers or discharges a resident under any of the circumstances specified in paragraph (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by the resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and a physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to assure there was physician documentation for four of four sample residents (#41, #87, #97, #98) who were transferred to the critical assess hospital (CAH) from the facility. The findings were: 1. Review of closed record for resident #97 revealed the resident sustained a fall with an injury at 3:15 AM on 8/18/06. A decision was made by the nurse on duty to transfer the resident	F 202	F 202 The facility will ensure that when the facility transfers or discharges a resident under any circumstance, documentation must be made by the resident's physician when transfer or discharge is necessary. This will be accomplished by, A. No further action resident #97 is a closed record. A. No further action resident #98 is a closed record. A. Nursing staff have been instructed to notify the primary or on-call physician informing him or her when any injury or significant change of condition that might require physician intervention for resident #41. A verbal or written order shall be obtained to transfer or discharge the resident to the appropriate facility.	✓ ✓

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F 202	Continued From page 9 to the emergency department of the critical access hospital on that same date at 4:30 AM. At 4:45 AM the resident was transferred from the facility. There was no documentation in the record by the resident's physician or physician extender as to the reason for the discharge. Interview with the care center nursing director on 10/10/06 at 1:20 PM verified that there was no other documentation to review and that the nursing department did not necessarily expect personal physicians to be notified prior to a transfer from the facility. 2. Review of nursing notes dated 8/30/06 at 3:30 AM showed resident #98 was found lying on the floor. The resident complained of left hip and left shoulder pain. Nurses notes showed on 8/30/06 at 6:45 AM the resident was taken to the emergency room. Nursing documentation on 8/30/06 at 9:45 AM showed the emergency room nurse reported the resident had a fractured hip and the resident was admitted to the critical access hospital. A note dated 9/27/06 showed the resident expired on 9/1/06. The medical record lacked physician documentation regarding the transfer to the emergency room at the CAH. 3. Review of nursing notes dated 7/7/06 at 11:30 showed resident #41 was found on the floor. The resident had a vertical laceration to the middle forehead. The note documented the resident was taken to the emergency room. There lacked physician documentation regarding the transfer to the emergency room. 4. Review of nursing notes dated 9/20/06 at 6:45 PM showed resident #87 fell out of the wheelchair off the curb outside the front door. The resident was taken to the emergency room. There lacked	F 202	B. Nursing staff have been instructed to notify the primary or on-call physician informing him or her when any injury or significant change of condition that might require physician intervention for resident #87. A verbal or written order shall be obtained to transfer or discharge the resident to the appropriate facility. B All residents have the potential to be affected by the lack of obtaining a verbal or written order by a physician prior to transfer or discharge of the resident to the appropriate facility. C. All residents will have a verbal or written order by a physician before transfer or discharge to another facility. In an emergent situation, the resident may be transferred to the emergency room (ER), and the physician notified by facility staff as soon as possible. This will be accomplished by immediate staff education of the nurses and a formal in-service at October Odyssey, October 16-20, 2006 and written guidelines for physician notification will be located at each nurse's station. D. The Nursing Directors will review 100% of all documentation in regards to transfer or discharged residents to ensure that physicians were notified appropriately. The data will be aggregated quarterly and submitted to the Medical Director and the Quality Council.	✓ ✓ ✓ ✓ 11/15/06 ~~11/6/06~~

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F 202	Continued From page 10 physician documentation regarding the transfer to the emergency room. 5. Interview with the care center nursing director on 10/10/06 at 1:20 PM revealed the nursing department did not necessarily expect personal physicians to be notified prior to a transfer from the facility.	F 202	F 250 The facility will provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident by; A. Resident # 97 is a closed record. A. Resident # 98 is a closed record. A. Social services will address inappropriate sexual behaviors with resident # 33 and the resident's legal representative if appropriate. Social services will also address inappropriate sexual behaviors on the Resident Assessment Protocol (RAPS) and the behavior will be included in the resident's plan of care. Nursing staff will be educated to notify social services of inappropriate sexual behaviors exhibited by resident # 33. B. All residents have the potential to be affected by adverse side affects such as altered sleep patterns, anxiety, and others behaviors with the use of psychotropic medications.	
F 250 SS=D	483.15(g)(1) SOCIAL SERVICES The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility did not ensure medically related social services were provided for three of three sample residents (#33, #97, #98) for whom social services needs were identified. Findings were: 1. Record review revealed resident #97 was admitted to the facility on 4/11/06. On 4/26/06 2.5 mg Valium was ordered to be administered by mouth "every night" secondary to the diagnosis of anxiety. Further medical record review revealed the following psychotropic medication changes: a. On 5/26/06 the physician changed the time the Valium was to be administered to every morning instead of at night. The physician added that if the resident was more alert at night and	F 250		

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F 250	Continued From page 11 sleeping more during the day, staff should call the physician. b. On 6/8/06 the pharmacist recommended the physician consider a short acting benzodiazepine such as Ativan in place of the Valium for this resident. On 6/13/06 an order was signed by the physician to discontinue the Valium and initiate Ativan at 1 mg by mouth, twice daily. c. A nurse/physician communication noted dated 6/19/06 stated that since 6/17/06 the resident had experienced increased anxiety, hollering out, restlessness, increased wakefulness at night, being afraid, and non-specific complaints of being sick. The nurse documented the resident was receiving Lexapro 10 mg, Effexor XR 150 mg, and Trazodone 50 mg. The nurse documented "wondering if Ativan is having the opposite effect." The physician's response, dated 6/20/06, consisted of an order to discontinue the Ativan and restart the resident's previous Valium order. d. On 6/29/06 a nurse/physician communication noted documented the resident was not sleeping and was having "near full blown if not full blown panic attacks over fear of dying...and being alone..." The nurse also noted that there was nothing currently ordered on an as needed basis (prn) and "Valium 2.5 mg is just not working..." The note also documented that the resident's fear was not making the resident's stomach any better..."maybe some Seroquel or Risperdal..." The physician's response, dated 7/5/06, to the communication note was to order the antipsychotic Risperdal 0.25 mg at night. e. On 7/17/06 the physician ordered 5 mg of Valium to be administered by mouth at bedtime (HS) in addition to the Risperdal, which was to continue at 0.25 mg at HS. In addition the order	F 250	B. All residents have the potential to be affected by sexually inappropriate behaviors exhibited by other residents. C. Social services will assess the changes resident's behavior for possible non-pharmacological interventions prior to the initiation of pharmacological interventions. Social services will discuss interventions with the resident, the resident's legal representative if appropriate and the interventions will be incorporated into the care plan. C. All nursing staff will be educated to notify social services of resident sexual behaviors at a nursing staff meeting November 8, 2006. D The Social Service Director will perform a random audit of charts to determine if appropriate behavior assessments were completed. The Social Service Director will meet with the primary nurse from each unit weekly to ensure that appropriate behaviors are being assessed. Information will be aggregated quarterly and submitted to the Medical Director and Quality Council.	11/15/06 11/8/06

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	535045	A. BUILDING _____ B. WING _____	C 10/11/2006

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F 250	Continued From page 12 showed that the morning dose of Valium at 2.5 mg was to be continued. f. On 7/30/06 a nurse/physician communication note documented the resident was not sleeping at night and wanting to sleep all day and was experiencing increase confusion, having increased difficulty swallowing pills and increased difficulty with transfers and the performance of activities of daily living. The physician responded on 7/31/06 with an order to change the resident's Effexor XR to 150 mg every night instead of in the morning and to double the resident's Risperdal dose given at bedtime. Despite all of the documentation related to concerns about the resident's sleep pattern, anxiety, and other behaviors, there was no evidence that the social worker assessed the resident's behaviors for possible alternative interventions to pharmacologic interventions. The initial Minimum Data Set (MDS) assessment for this resident with the assessment reference date of 4/20/06 and the quarterly assessment with the assessment reference date of 7/19/06 showed the resident had no problems with sleep cycle issues. In addition, review of the MDS documents verified the resident was not on any anti-anxiety or antipsychotic medications at the time of admission. The plan of care for this resident showed the problem of psychotropic drug use and a problem related to the resident's risk for falls. However, there were no plans to address specific behavior issues such as those described by the nurses in their communications to the residents's physician. A review of the behavior tracking forms showed	F 250		

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F 250	Continued From page 13 the resident was being monitored for hollering out and sticking a finder down the throat in the attempt to self-induce vomiting. There were no monitored behaviors related to sleep cycle issues, expression of fears, complaining of non specific illnesses, or panic attacks. There was no plan that addressed how this specific individual could best be redirected or otherwise have behaviors modified without the use of medication. Interview with the social worker on 10/10/06 at 3:55 PM verified that the social worker was not involved with assessing or planning alternative interventions to drug therapy related to this resident's behaviors. The social worker stated that, with regard to the MDS process, he had been more involved with behavior assessments and planning in the past, but was currently mostly involved with assessing the cognitive functions of residents.	F 250		
	2. Review of the 7/10/06 Minimum Data Set (MDS) assessment showed resident #98 had impaired long and short term memory, and had moderately impaired cognition. Review of a 2/21/06 physician note showed the resident was "progressively more demented" and was moved to the dementia unit (locked unit). Review of a 5/29/06 nursing note revealed "found male resident in room c [with] jeans down. Resident had her blouse up, breast bared. ..CNA reports resident stated " I don't want that man around me any more"...". Review of a 7/22/06 nursing note showed "found resident sitting in her recliner in her room. Male resident standing against her c [with] his penis out of his pants. Removed male			

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F 250	Continued From page 14 resident..". A note dated 7/24/06 showed "found male resident in [resident's] room c [with] his penis in [resident's] hand. Both standing up hugging." During an interview on 10/10/06 at 2:45 PM, the care center nursing director identified the male resident as resident #33. The nursing director stated the resident had a history of sexually inappropriate behaviors with other female residents, as well as staff. Review of the medical record for resident #33 and resident #98 showed no social service notes regarding the interactions between the two residents. Review of the 10/10/06 care plan for resident #33 showed the resident's sexually inappropriate behaviors were not addressed. During an interview on 10/10/06 at 3:55 PM, the social services director stated he could not ascertain if the relationship was consensual. He further stated there had not been an interdisciplinary team meeting to discuss the relationship between the two residents, nor was there evidence the family members had been notified. The social services director further stated he agreed that he should have been involved in the situation, but was not.	F 250		

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F 272 SS=D	483.20, 483.20(b) 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 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 through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to complete a comprehensive assessment of needed areas for two (#87, #97) of seven sample residents. The	F 272	F 272 The facility will ensure that an initial and periodic comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity is completed by; A. Resident # 97 is a closed record. A. Resident #87 was moved in the dementia care unit on 9/22/06 in collaboration with the responsible party and the physician to maintain her safety B. All residents have the potential to be affected by the lack of accurate initial and periodic comprehensive assessments. C. The comprehensive assessment will be completed on all residents and will include mood and behavior patterns. Non-pharmacological interventions will be attempted in place of or as an adjunctive therapy to pharmacological interventions as appropriate. D The Social Service Director will perform a random audit of charts to determine if behavior assessments were completed as appropriate. The Social Service Director will review assessments to ensure that behavior and mood elements are included. Information will be aggregated quarterly and submitted to the Medical Director and Quality Council. 11/15/06 11/08/06	

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F 272	Continued From page 16 findings were: 1. Closed record review for resident #97 revealed that on 4/26/06 a long-acting benzodiazepine was ordered to be administered by mouth "every night" secondary to the diagnosis of anxiety. On 5/26/06 the physician changed the time the drug was to be administered to every morning instead of at night. The physician added that if the resident was more alert at night and sleeping more during the day, staff should notify the physician. A nurse/physician communication note dated 6/19/06 documented that since 6/17/06 the resident had experienced increased anxiety, hollering out, restlessness, increased wakefulness at night, being afraid, and non-specific complaints of being sick. On 6/29/06 a nurse/physician communication note documented the resident was not sleeping and was having "near full blown if not full blown panic attacks over fear of dying...and being alone..." The nurse also noted that there was nothing currently ordered on an as needed basis (prn) and "Valium 2.5 mg is just not working..." The note also documented that the resident's fear was not making the resident's stomach any better. On 7/30/06 a nurse/physician communication note documented the resident was not sleeping at night and wanting to sleep all day and was experiencing increased confusion, having increased difficulty swallowing pills and increased difficulty with transfers and the performance of activities of daily living. Despite all of the documentation related to concerns about the resident's sleep pattern, anxiety, and other behaviors, there was no evidence that a thorough assessment of the resident's mood and behavior patterns was completed. The initial Minimum	F 272		

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F 272	Continued From page 17 Data Set (MDS) assessment for this resident with an assessment reference date of 4/20/06 and the quarterly assessment with the assessment reference date of 7/19/06 indicated the resident had no problems with sleep cycle issues. In addition, review of the MDS documents verified the resident was not on any anti-anxiety or antipsychotic medications at the time of admission, although by the date of the resident's transfer from the facility (8/18/06) the resident was receiving those types of medications on a daily basis to manage aberrant behaviors and sleep cycle issues. Refer to F250 related to the lack of medically related social services interventions to provide nonpharmacologic approaches and identify causative and contributing factors in the attempt to address these problems for this resident. In addition, interview with the social worker on 10/10/06 at 3:55 PM verified that the social worker did not use the Resident Assessment Instrument (RAI) process to assess resident behaviors. The social worker stated that he had been more involved with behavior assessments and planning in the past, but at this time primarily used the RAI to assess the cognitive function of residents. 2. Review of the 1/31/06 annual and 7/31/06 quarterly Minimum Data Set (MDS) assessments showed resident #87 had long and short term memory problems and moderately impaired cognitive skills. Review of a nursing note dated 3/18/06 at 10:45 PM showed the resident was found outside of the facility. Nursing notes showed on 7/8/06 the resident exited the facility out the front doors. On 7/9/06 a certified nurse aide (CNA) reported the resident was sitting by the front doors and stated he/she wanted to leave. A CNA note on 8/8/06 documented the	F 272		

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F 272	Continued From page 18 resident tried to leave the facility. Review of the medical record showed no assessment of the resident's elopement behavior. Nursing notes dated 9/20/06 at 6:45 PM revealed a CNA coming to work witnessed the resident falling out of the wheelchair off the curb out the front door. The resident was sent to the emergency room. Nursing notes dated 9/20/06 at 9:40 PM revealed the resident had a right humeral neck fracture. During an interview on 10/10/06 at 1:20 PM, the care center nursing director verified there was no assessment for the resident's elopement behavior.	F 272		

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F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to develop an individualized written plan of care of needed areas for three (#33, #87, #97) of seven sample residents. The findings were: 1. Review of patient #97's closed record revealed there was an interdisciplinary plan of care that addressed the use of psychotropic medications related to behaviors. An approach for the medication problem documented that the resident's behaviors were to be monitored as needed. The interdisciplinary notes dated 7/3/06	F 279	F279 Results of comprehensive assessments will be used to develop, review and revise care plans by; A. Resident #97 is a closed record. A. The Social Service Director will meet with Resident # 87 to discuss her elopement behavior . The resident was moved in the dementia care unit on 9/22/06 in collaboration with the responsible party and the physician to maintain her safety. A A care plan will be develop to addresses the behavior exhibited by Resident #33, & Resident #87 B. All residents have the potential to be affected by care plans that are not developed based on comprehensive assessments an individualized to the resident. C Care plans will be individualized for each resident and based on the comprehensive assessment. D. The MDS/Restorative Director will perform a random audit to determine if the resident's care plan is based on the comprehensive assessment and individualized to the specific resident needs. The data will be aggregated quarterly and reported to the Care Center Medical Director and the Quality Council.	11/15/06 11/8/06

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F 279	Continued From page 20 revealed the resident's June behavior record showed 2 "constant" episodes of repetitive hollering out, 6 episodes of attempting to induce vomiting, and 1 episode of "constant paranoid thoughts." The care plan did not address these behavioral symptoms, therefore there were no identified planned interventions to assist in understanding and managing this resident's behaviors. Refer to F250 related to the lack of medically related social services for this resident in order to assist in the development of alternatives to pharmacotherapy in managing behaviors. In addition, nurse/physician communication memos, dated 6/19/06, 6/29/06, and 7/30/06, revealed the resident was not sleeping at night and in each case the physician responded with either new or revised medication orders. The plan of care did not address the problem of sleep cycle disturbance for this resident. 2. Review of the 1/31/06 annual and 7/31/06 quarterly Minimum Data Set (MDS) assessments showed resident #87 had long and short term memory problems and moderately impaired cognitive skills. Review of a nursing note dated 3/18/06 at 10:45 PM showed the resident was found outside of the facility. Nursing notes showed on 7/8/06 the resident exited the facility out the front doors. On 7/9/06, a certified nurse aide (CNA) reported the resident was sitting by the front doors and stated he/she wanted to leave. A CNA note on 8/8/06 documented the resident tried to leave the facility. Review of the care plan showed elopement was not addressed. Nursing notes dated 9/20/06 at 1845 revealed a CNA coming to work witnessed the resident falling out of the wheelchair off the curb out the front door. The resident was sent to the	F 279		

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F 279	Continued From page 21 emergency room. Nursing notes dated 9/20/06 at 9:40 PM revealed the resident had a right humeral neck fracture. During an interview on 10/10/06 at 1:20 PM, the care center nursing director verified there was no care plan for the resident's elopement behavior. 3. Review of the 7/10/06 MDS assessment showed resident #98 had impaired long and short term memory, and had moderately impaired cognition. Review of a 2/21/06 physician note showed the resident was "progressively more demented" and was moved to the dementia unit (locked unit). Review of a 5/29/06 nursing note revealed "found male resident in room c [with] jeans down. Resident had her blouse up, breast bared. ..CNA reports resident stated " I don't want that man around me any more"...". Review of a 7/22/06 nursing note showed "found resident sitting in her recliner in her room. Male resident standing against her c [with] his penis out of his pants. Removed male resident..". A note dated 7/24/06 showed "found male resident in [resident's] room c [with] his penis in [resident's] hand. Both standing up hugging." During an interview on 10/10/06 at 2:45 PM, the care center nursing director identified the male resident as resident #33. The nursing director stated the resident had a history of sexually inappropriate behaviors with other female residents, as well as staff. Review of the 10/10/06 care plan for resident #33 showed the resident's sexually inappropriate behaviors were not addressed.	F 279		

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F 309 SS=J	483.25 QUALITY OF CARE 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: Based on medical record review, review of facility policies, and staff interview, the facility failed to assure prompt physician intervention for three of four sample residents (#41, #97, #98) who had a fall with injury or change of condition which required physician intervention. Two of the residents (#97 and #98) were delayed in getting treatment which resulted in immediate jeopardy. The findings were: 1. Review of nursing notes dated 8/30/06 at 3:30 AM showed resident #98 was found lying on the floor. The resident complained of left hip and left shoulder pain. The nurse documented the left pupil was slow to react, and the resident was not able to put weight on the left leg. There lacked documentation of physician notification. Review of the neurology flow sheet showed the resident's left pupil was slow to react at 3:30 AM, 3:45 AM, 4 AM, 4:15 AM, and 4:45 AM. [Review of the facility procedure 6.1, revised 3/06, showed the facility used "Nursing Procedures", Edition IV, by Lippincott, Williams & Wilkins for nursing procedures. Review of "Nursing Procedures" showed when examining the pupils, the nurse tests for direct light response. "...Shine the light directly into the eye. Normally, the pupil constricts	F 309	F309 The facility will ensure that each resident has the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being and in accordance with his or her established care plan by: A. Resident #98 is a closed record. A. Resident #97 is a closed record. A. Nursing staff have been instructed to notify the primary physician and resident' responsible party is appropriate with any injury or significant change of condition that might require physician intervention for resident #41. B. All residents have the potential to be affected by the lack of care and services to attain or maintain physical, mental and psychosocial well-being.	

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F 309	Continued From page 23 immediately. When you remove the penlight, the pupil should dilate immediately..."] The next nursing documentation was 8/30/06 at 6:15 AM (2 hours and 45 minutes after the fall with injury) which documented the certified nurse aide (CNA) came to the nurse and stated the resident was crying out, and complaining of pain in the left hip. The resident was pale, and crying it hurt. The nurse documented she called the resident's son, who said to take the resident to the emergency room. There lacked documentation of physician notification. The next documentation was on 8/30/06 at 6:45 AM (3 hours and 15 minutes after the fall) which documented the resident continued to cry out in pain. The emergency room was phoned, and the resident was then taken to the emergency room. Nursing documentation on 8/30/06 at 9:45 AM showed the emergency room nurse reported that the physician had been notified and x-rays taken. The resident had a fractured hip and the resident was admitted to the critical access hospital. A note dated 9/27/06 showed the resident expired on 9/1/06 and CVA (cerebral vascular accident, "stroke") was listed as the cause of death. Review of the quality improvement fall follow-up form in the medical record dated 8/30/06 showed at the time of the fall, the emergency room was called and the emergency room "staff" instructed the facility to wait until the morning. During an interview on 10/10/06 at 1:20 PM, the care center nursing director and quality improvement coordinator stated the nurse at the facility spoke to the nurse in the emergency room, but did not speak to a physician. The nursing director confirmed the facility did not notify the physician of the resident's fall with injury. The fall follow-up form showed the physician was not	F 309	C. This will be accomplished by immediate staff education of the nurses and formal in-service at October Odyssey, October 16-20, 2006. Written guidelines for physician notification will be located at each nurse's station. D. The Nursing Directors will review 100% of all related to resident incidents to ensure that physicians were notified appropriately. The data will be aggregated quarterly and submitted to the Medical Director and the Quality Council.	11/15/06 10/11/06

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	535045	A. BUILDING _____ B. WING _____	C 10/11/2006

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F 309	Continued From page 24 notified until 9:40 AM by the emergency room staff. 2. Review of the interdisciplinary progress notes in the medical record of resident #97 revealed staff heard the resident's personal alarm sounding on 8/18/06 at 3:15 AM. The CNA was documented as having found the resident lying on his/her right side on the floor. According to the documentation, the resident evidently had raised the electric recliner to its full upright height in order to facilitate and independent transfer. The resident initially complained of right shoulder pain and was noted to have a bump on the right lateral forehead. There resident was transferred to bed and complained of right knee pain. Staff noted the resident could not straighten the right knee, but no right knee crepitation was felt or heard by the registered nurse (RN). There was no evidence that the facility attempted to notify the resident's physician. At 4:30 AM, the facility documented that the resident continued to complain of right knee pain. The resident called out in pain when the nurse attempted to move the resident's right leg. The RN heard a faint popping sound and telephoned the emergency room nurse and told her the RN was going to send the resident over for an evaluation. According to the record, the resident was transferred via a gurney to the emergency room of the critical access hospital at 4:45 AM. The progress notes documented that on 8/18/06 at 6:15 AM, the facility was notified by the emergency room nurse that the resident had sustained a right hip fracture. An entry in the progress notes on 8/23/06 at 1:55 PM revealed the resident had expired in the hospital on 8/18/06 at 10:35 PM. There was no evidence the facility attempted to contact this resident's	F 309		

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F 309	Continued From page 25 physician at any time after the fall, prior to transfer to the critical access hospital in order to determine the need for further evaluation or treatment. Interview with the Care Center Nursing Director on 10/10/06 at 1:20 PM verified that staff was not necessarily expected to notify a resident's physician after an accident that might require further treatment. Review of the Consultation Report from the critical access hospital dictated by the surgeon on 8/19/06, revealed this patient had been experiencing pain since the injury happened and was an "extreme risk" for any type of surgical intervention. According to the documentation by the surgeon, the injury experienced by the resident as a result of the fall sustained in the facility would have prevented the resident from being placed into a sitting position, would have required bed rest, and would have resulted in continued pain without surgical intervention. According to the Discharge Summary dictated by the surgeon on 8/23/06, an informed decision was made to pin the resident's hip. According to the physician's documentation, "We had no idea how long [the resident] would survive this particular injury. [The resident's] family, and I believe [he/she] understood, that the injury itself is a lifethreatening [sic] situation." 3. Review of nursing notes dated 7/7/06 at 11:30 PM showed resident #41 was found on the floor. The resident had a vertical laceration to the middle forehead. The note documented the resident was taken to the emergency room. There lacked evidence the physician was notified. A nursing note dated 7/7/06 at 11:10 PM stated the resident was brought back from the emergency room (ER). The note documented the resident briefly opened his/her eyes in the ER, but was	F 309		

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F 309	Continued From page 26 non verbal. Review of the after care instruction from the ER showed "...watch for signs of head injury...". Review of the ER after care instructions for "head injuries" revealed the resident should return to the ER for "...confusion, unconsciousness...difficulty speaking...or any worsening of condition." The following concerns were identified: a. Review of nursing notes dated 7/8/06 at 12:15 AM showed the resident would not open his/her eyes and was non verbal, but did move his/her legs. Nurses notes dated 7/8/06 at 6:15 AM showed the resident kept his/her eyes closed and tried to speak, but the nurse was unable to understand the speech. The note further showed the resident had a slight hand grasp, and staff did not get the resident out of bed due to the resident being "sleepy". Nurses notes dated 7/8/06 at 3:35 PM showed the resident would not open his/her eyes or grasp the nurse's hand. The note further documented the resident had not spoken and remained in bed all shift; and did not eat lunch because "would not rouse." b. Review of the neurology flow sheet showed on 7/7/06 at 9:30 PM, prior to going to the ER, the resident's EMV (eye opening, motor response, verbal response) score was 14 and both pupils were reactive. The neurology flow sheet showed the EMV scale was the "Glasgow" scale to assess brain damage, with scores ranging from 3 to 15. However, review of the neurology flow sheet after the resident returned from the ER revealed the following on 7/7/06 and 7/8/06: at 11:15 PM the Glasgow score was 3 and the right pupil was non reactive; at 12:15 AM the Glasgow score was 3 and the right pupil was non reactive; at 1:15 AM the Glasgow was 7 and the right pupil was non reactive; at 2:15 AM the Glasgow was 3	F 309		

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 309	Continued From page 27 and the right pupil was non reactive; at 6:15 AM the Glasgow was 5 and the right pupil was non reactive; at 10:15 AM the Glasgow was 3; and at 2:15 PM the Glasgow was 3. Review of the facility procedure 6.1, revised 3/06, showed the facility used "Nursing Procedures", Edition IV, by Lippincott, Williams & Wilkins for nursing procedures. Review of "Nursing Procedures" showed changes in pupillary activity (....response to light) may signal increased intracranial pressure...when examining the pupils, the nurse tests for direct light response. "...Shine the light directly into the eye. Normally, the pupil constricts immediately. When you remove the penlight, the pupil should dilate immediately..". In addition, "The Glasgow Coma Scale provides a standard reference for assessing or monitoring level of consciousness...a score of 3 is the lowest and 15 is the highest. A score of 7 or less indicates coma...". In addition, "...if a previously stable patient suddenly develops a change in neurologic or routine vital signs, further assess his condition, and notify the physician immediately." c. Further record review showed no evidence the physician was notified of the above findings. 4. Review of the facility's policy "Falls/Fall Risk Assessment" (procedure 2.11, revised 2/06) showed the nurse was to document when the physician was notified, but did not address when the physician was to be notified. On 10/10/06 at 4:50 PM, the care center nursing director stated the facility did not have a policy which stated when nursing staff was to notify the physician. On 10/10/06 at 1:20 PM, the care center nursing director stated he expected the physician to be notified as soon as possible. But then he stated	F 309		

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F 309	Continued From page 28 that some nurses called the physicians, but some nurses would make the decision if the resident needed to go to the emergency room without consulting the physician. During an interview on 10/10/06 at 5:05 PM, the medical director stated nurses should be notifying the physicians. When asked for a timeframe, the medical director replied it would depend on the injury, but for example if it was a suspected hip fracture, the physician should be notified as soon as possible. 5. On 10/10/06 at 4:44 PM, the care center nursing director was notified of the immediate jeopardy. On 10/11/06 at 11:25 AM, the immediate jeopardy was removed on-site by the following actions: the facility revised the falls policy and developed a new policy for physician notification; the facility educated all nurses working the shifts since the immediate jeopardy was called; and the facility submitted a plan to educate all remaining nurses. References: "Nursing Malpractice" by Ann Helm, RN, MS, JD, 2003, Lippincott, Williams & Wilkins states "As a nurse, you must communicate changes in the resident's condition to the physician, even if you aren't sure how important those changes may be....It's the nurse's duty and responsibility to keep the physician informed so that care may be directed appropriately..." "Nursing and the Law", sixth edition, Sheryl Feutz-Harter, PESI Healthcare, 1997 states "...Nurses are responsible for appropriately and adequately monitoring the condition of their patients so that proper care and treatment can be rendered...the nurse is also responsible for	F 309		

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F 309	Continued From page 29 communicating any pertinent information to the applicable physician..notification of a physician does not merely mean that a phone call is placed but rather that a physician is actually contacted and responds appropriately...". "Nursing and the Law" by Kammie Monarch, RN, MS, JD, 2002, states "...nurses are required to promptly communicate troublesome patient findings. Failure to properly communicate patient findings can be devastating for patients...".	F 309	F324 The facility will ensure that each resident receives adequate supervision and assistance devices to prevent accidents by: A. Resident #87 has been moved into the locked dementia care unit in collaboration with the physician and the resident's responsible party and a care plan could be developed. B. All residents have the potential to be affected by inadequate supervision or assistive devices to prevent accidents. C. The Social Service Director will do a behavioral assessment on all residents who elope. The MDS/Restorative Director will review all falls in collaboration with the Falls Committee to determine adequate assistance devices for residents who are at risk. D. The Social Services Director will perform an audit all incident reports related to elopement to ensure that a behavior assessment was performed. The MDS/Coordinator will audit incident reports for injuries or potential injury conditions to ensure that appropriate assistance devices were initiated. The data will be aggregated quarterly and reported to the Care Center Medical Director and the Quality Council.	11/15/06 11/8/06
F 324 SS=G	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to provide supervision to prevent an accident for one (#87) of one sample resident with a history of elopement, which resulted in harm. The findings were: Review of the 1/31/06 annual and 7/31/06 quarterly Minimum Data Set (MDS) assessments showed resident #87 had long and short term memory problems and moderately impaired cognitive skills. The 2/7/06 care plan (and updated 5/1/06 and 7/31/06) showed the resident was at risk for falls, with an intervention of "stays in view of nursing staff in the living room area." Review of a nursing note dated 3/18/06 at 10:45	F 324		

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F 324	Continued From page 30 PM showed the resident was found outside of the facility. Nursing notes showed on 7/8/06 the resident exited the facility out the front doors. On 7/9/06 a certified nurse aide (CNA) reported the resident was sitting by the front doors and stated he/she wanted to leave. A CNA note on 8/8/06 documented the resident tried to leave the facility. Review of the medical record showed no assessment of the resident's elopement behavior. In addition, review of the care plan dated 2/7/6 (and updated 5/1/06 and 7/31/06) showed elopement was not addressed. Nursing notes dated 9/20/06 at 6:45 PM revealed a CNA coming to work witnessed the resident falling out of the wheelchair off the curb out the front door. The resident was sent to the emergency room. Nursing notes dated 9/20/06 at 9:40 PM revealed the resident had a right humeral neck fracture. Review of a 9/28/06 occupational therapy evaluation showed the resident had a shoulder immobilizer and required elbow exercises and "pendulum exercises". Review of the 9/06 and 10/06 medication administration records (MARs) showed the resident was medicated with Hydrocodone/APAP 5/500 milligrams (mg) (narcotic pain medication) for shoulder pain on 9/22/06, 9/23/06, twice on 9/30/06, 10/1/06, twice on 10/2/06, 10/5/06, and 10/6/06. Observation of the resident on 10/10/06 at 9:20 AM showed the resident had a shoulder immobilizer on the right arm. During an interview on 10/10/06 at 1:20 PM, the care center nursing director stated he was not aware the resident could get outside by himself/herself. The nursing director verified there was no assessment or care plan for the resident's elopement behavior.	F 324		

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F 330 SS=D	483.25(l)(2) ANTIPSYCHOTIC DRUGS 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. This REQUIREMENT is not met as evidenced by: Based on closed record review and staff interview, the facility failed to ensure that one of one sample resident (#97) who was started on an antipsychotic while at the facility received the drug for a specific condition that was quantitatively and objectively documented prior to the initiation of the drug therapy. Findings were: Record review revealed resident #97 was admitted on 4/11/06 with diagnoses that included depression. The resident was not receiving any antipsychotic medications at the time of admission. On 6/29/06 a nurse/physician communication note documented the resident was not sleeping and was having "near full blown if not full blown panic attacks over fear of dying...and being alone..." The nurse also noted there was nothing currently ordered on an as needed basis (prn) and "Valium [antianxiety medication] 2.5 mg is just not working..." The note also documented that the resident's fear was not making the resident's stomach any better..."maybe some Seroquel or Risperdal [both antipsychotic medications]..." The physician's response, dated 7/5/06, to the communication note was to order the antipsychotic Risperdal 0.25 mg at night. On 7/30/06 a nurse/physician	F 330	F330 The facility will 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 by: A. Resident #97 is a closed record. B. All residents have the potential to be affected by the unnecessary use of antipsychotic drugs. C. The Social Services Director will review the list of residents who are on Anti-psychotics to ensure that those residents who were recently started on those medications received alternative treatments if appropriate before initiation of therapy. D. The data will be aggregated quarterly and reported to the Care Center Medical Director and the Quality Council.	11/15/06 11/8/06

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F 330	Continued From page 32	F 330		

communication note documented the resident was not sleeping at night, was wanting to sleep all day, and was experiencing increased confusion. In addition the nurse documented the resident was having increased difficulty swallowing pills and increased difficulty with transfers and the performance of activities of daily living. The physician responded on 7/31/06 with an order that included doubling the resident's Risperdal dose given at bedtime. The following concerns were identified:

a. This resident's medical record showed the only behavioral monitoring in place was for hollering and attempting to self induce vomiting.

b. There was no record of any objective monitoring of behaviors related to sleep pattern issues, paranoia, or possible delusions, or hallucinations.

c. There was no evidence the behaviors exhibited by the resident were evaluated to determine causative or contributing factors or to rule out other possible reasons for the resident's behaviors.

d. The plan of care did not address the specific behaviors for this resident as described in the nurse/physician communication memos.

e. Interview with the social worker on 10/10/06 at 3:55 PM verified the social worker was not involved with assessing or planning alternative interventions to drug therapy related to this resident's behaviors. The social worker also stated that he was not currently involved in assessing behaviors or developing interventions to assist in managing behaviors for any residents.