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

PRINTED: 04/29/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A049	A. BUILDING _____ B. WING _____	04/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOSHEN CARE CENTER	2009 LARAMIE STREET TORRINGTON, WY 82240

(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 The following common abbreviations and acronyms are used throughout this document: RN-Registered Nurse LPN-Licensed Practical Nurse DON-Director of Nursing CNA-Certified Nursing Assistant MDS-Minimum Data Set CAA-Care Area Assessment ADL-Activities of Daily Living MAR-Medication Administration Record RAI-Resident Assessment Instrument GDR-Gradual Dose Reduction PRN-as needed mg-milligrams	F 000		
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure the development and ongoing implementation of an activity program that addressed individual activity needs for 3 of 4 sample residents (#65, #81, #87) who resided in the secure unit. The findings were: Review of the 1/13/11 quarterly MDS assessment for resident #87 showed s/he had moderately impaired cognitive skills and was totally dependent on staff for all ADLs, including	F 248	The facility will provide for an on-going program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental and psychosocial well-being of each resident. This will be accomplished by: Facility implemented a resident specific activity for residents #87, #65, and #81 that meet their individual needs. a. The Activity Professionals will complete the About Me form for each resident at Goshen Care Center. Prior to admission if able to obtain from family/resident. If not able to obtain information will complete on admission day.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 6/3/2011

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.

RECEIVED
Wyoming Dept of Health
JUN 03 2011
Office of Healthcare Licensing and Surveys

This POC accepted on 6/6/11 by [illegible] and Tony Madden. 6/6/11

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F 248	Continued From page 1 wheeling his/her wheelchair. Review of the 7/8/10 annual MDS assessment showed the resident's activity preferences were reading/writing, wheeling outdoors, talking, and music. Review of the care plan showed interventions that addressed activities for this resident that included: activity calendar posted in room, encourage to accept invitations to programs, and encourage family to join resident activities. The review of the care plan and assessment information showed television and movies were not identified as activity preferences for this resident. Review of the March 2011 activity progress notes showed the following: a. With the exception of one Saturday, there was no documentation of weekend activities; b. There were four one-to-one visits; and on thirteen of twenty-four days, the only activities provided were: sitting in the common area, television, and movies. Review of the April 2011 activity progress notes revealed there was no documentation of weekend activities. The only activities provided for the resident from 4/1/11 to 4/10/11 were movies, television, sleeping, and sitting in common areas. Observation on 4/11/11 from 2:10 PM to 4 PM revealed staff did not wheel the resident outdoors for the outdoor group activity. The resident was observed sleeping in his/her wheelchair in the television viewing area during that time. In addition, the resident continued to doze during the singing/music activity from 5 PM to 5:30 PM. Review of the 1/18/11 quarterly MDS assessment for resident #65 showed s/he had cognitive impairment due to dementia, but could walk independently. Review of the 10/26/10 annual MDS assessment, preferences for customary	F 248	The resident's individual activity interests will also be revisited every quarter following the MDS schedule and updated accordingly. b. The Activity Professionals will use the resident's About Me forms to write their care plans and will be available on the ADL C.N.A. resident care plan form on each hall, these will be updated quarterly. c. The Activity Professionals will ensure the resident's are offered the individual activities the resident's choose weekly. This will be reflected in the activities documentation. d. The Activity Professionals will provide stimulating activities on a daily basis. If residents are not actively engaged in activities, the activity professionals will change the activity to meet the resident's needs at the time. e. The Activity Professionals will invite every resident every time to activities that are about to begin. The only exception being if a resident is asleep the activity professionals will only wake them if it has been identified the resident would want to participate in the upcoming activity. f. The Social Services Manager will review the activity assessment log quarterly. Items A through F will be reviewed and reported quarterly at Performance Improvement Committee meeting by social services.	6/14/11

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F 248	Continued From page 2 routine and activities, showed the following activities were important to the resident: listening to music, being around pets, engaging in a favorite activity, religious services and going outside to get fresh air. Review of the care plan showed interventions that addressed activities for this resident included: an activity calendar posted in room, watching television in the unit lounge and encourage activity participation. Review of the April 2011 activity progress notes for this resident showed the following: daily activities of watching movies, the television and sitting in common areas. However, there was no documentation to show that any weekend activities were available. Observations on 4/11/11 from 2:10 PM to 4 PM revealed the resident participated in the afternoon outdoor group activity during that time. At 5 PM the resident was observed to be present at the singing/music activity; however, s/he slept the entire time. Observation on 4/12/11 from 8:30 AM until 7:30 PM revealed the only activity provided for the resident during that time was a ball toss activity from 2:15 PM to 3 PM. During this observed period of time, staff did not provide or encourage participation in additional activities; and the resident periodically slept in the television viewing area or walked in the halls. Review of the 4/3/11 quarterly MDS assessment for resident #81 showed s/he had moderately impaired cognitive skills and the ability to walk independently. Review of the 7/15/10 annual MDS assessment showed the resident's activity preferences included arts, crafts, music, television, plants, going outdoors, and religious activities. Review of the care plan showed interventions that addressed activities for this resident should have included: a. activity calendar posted in room,	F 248	This page left blank intentionally	

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F 248	Continued From page 3 b. encourage to watch television in the unit lounge c. encourage activity participation. Review of the March and April 2011 activity progress notes for this resident showed the following: except for one day when s/he engaged in baking and another day when a one-to-one visit was provided, daily activities were documented as watching movies, the television and sitting in common areas. In addition, there was no documentation of weekend activities. Observations on 4/11/11 from 2:10 PM to 4 PM revealed the resident participated in the afternoon outdoor group activity during that time. At 5 PM the resident was observed to be present at the singing/music activity; however, s/he slept during the activity. Observation on 4/12/11 from 8:30 AM until 7:30 PM revealed the only activity provided for the resident during that time was a ball toss activity from 2:15 PM to 3 PM. During this observed period of time, staff did not provide or encourage participation in additional activities. The observation also revealed the resident periodically slept in the television viewing area or walked in the halls. Interview on 4/12/11 at 4:30 PM with the activity aide revealed approximately one month prior to the survey she became responsible for the activity program for the residents residing in the secure unit. She stated she provided activities Monday through Friday; excluding evening hours and weekends. She stated the activity program did not include the posting of activity calendars, planned activities, or a system for identifying and addressing individualized activity needs. She stated information regarding activity participation was documented in the activities progress notes	F 248	This page left blank intentionally	

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F 248	Continued From page 4 for each resident. She further stated she was not aware of the activity approaches that had been identified in the individual care plans. During the interview she confirmed morning activities were not provided on 4/12/11. She stated sometimes she did not offer activities for the residents because when she arrived on the unit the residents were "laid back" and appeared to not need activities at that time. Interview on 4/12/11 at 4:36 PM with LPN #1 revealed the following activities were provided by the nursing staff when the activity aide was not on duty: movies on Saturday, religious services on Sunday, and occasional music and singing during the evening hours by volunteers from the community.	F 248		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status;	F 272	The facility will ensure that comprehensive assessments are completed with documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the MDS 3.0 and documentation of participation in assessment. This will be accomplished by: 1. Facility Interdisciplinary team will meet by May 31, 2011 to review residents # 1, 32, 37, 38, 39, 40, 52, 54, 64 and 65, to evaluate all triggered areas on the CAAs. A review of indicators and summary will be filled out to assure that adequate data has been collected to develop an individualized plan of care. 2. The Interdisciplinary team will document participation in the review of residents # 1, 32, 37, 38, 39, 40, 52, 54, 64 and 65 on the individual care plan by May 31, 2011.	

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F 272	Continued From page 5 Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of MDS 3.0 requirements, the facility failed to ensure comprehensive assessments were completed for 10 of 10 sample residents (#1, #32, #37, #38, #39, #40, #52, #54, #64, #65) who required these assessments. The findings were: 1. Record review for resident #1 revealed an 11/2/10 annual MDS assessment. Review of section V for this MDS assessment identified the following areas as triggered and requiring additional assessments: cognitive loss, visual function, communication, ADL function, urinary incontinence, behavioral symptoms, falls, nutritional status, dehydration, psychotropic drug use and pain. Review of the CAA summary showed the assessment information for the triggered areas was documented in the nutrition notes, nursing notes and ADL sheets. However,	F 272	Plan: All residents of the facility will have a comprehensive assessment of needs, using the resident assessment instrument specified by the State, documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the MDS and documentation of participation in assessment. This will be accomplished by: Action: 1. Education: All licensed staff will be educated on accurate documentation on the data gathering forms for comprehensive assessment. 2. Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the MDS will be entered into the chart by the licensed staff responsible for the assessment during the seven (7) day MDS look back. 3. Documentation in section V of the comprehensive assessment will be completed by the responsible licensed staff for the triggered area to show that adequate data was collected to provide an individualized plan of care. Audit: Will be conducted by the MDS Coordinator every 30 days for the previous month comprehensive and reported to Performance Improvement quarterly.	6/14/1

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F 272	Continued From page 6 review of the documented information failed to show a clear and complete evaluation of causes, contributing conditions, risk factors, and the impact on the resident's health. 2. Review of the 11/08/10 annual MDS assessment for resident #32 showed s/he required comprehensive assessments in the following areas: cognitive loss/dementia, vision, communication, ADLs, urinary incontinence, mood, falls, nutritional status, dehydration/fluid maintenance, dental care, pressure ulcers, and psychotropic medications. However, review of section V showed no evidence that adequate data was collected in these areas for analysis to provide information critical to the development o f an individualized plan of care. 3. Review of the 10/12/10 annual MDS assessment for resident #37 showed s/he required comprehensive assessments in the following areas: cognitive loss/dementia, communication, urinary incontinence, psychosocial well-being, behavior, activities, falls, nutritional status, pressure ulcers, psychotropic drug use, and pain. For the areas of cognitive loss/dementia, psychosocial well-being, and behavior, section V of the MDS referred to the data in the MDS that triggered the need for a CAA, and not an actual analysis. For the remaining section V required areas, there was no evidence that adequate data was collected for analysis to provide rationale for care planning. 4. Review of the 2/19/11 annual MDS assessment for resident #38 showed s/he required comprehensive assessments in the following areas: delirium, cognitive loss/dementia, communication, ADLs, urinary incontinence, falls,	F 272	This page left blank intentionally	

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F 272	Continued From page 7 dehydration/fluid maintenance, pressure ulcers, and psychotropic drug use. Review of section V showed no evidence that adequate data was collected in any of these areas for analysis prior to developing an effective plan of care. 5. Review of the 3/06/11 annual MDS assessment for resident #39 showed s/he required comprehensive assessments in the following areas: ADLs, urinary incontinence, falls, nutritional status, pressure ulcers, psychotropic drug use, and pain. However, review of section V showed no evidence that adequate data was collected in these areas for analysis to provide crucial information to ensure an effective care plan process. 6. Review of the 2/06/11 annual MDS assessment for resident #40 showed s/he required comprehensive assessments in the following areas: delirium, cognitive loss/dementia, communication, urinary incontinence, mood, falls, nutritional status, pressure ulcers, and psychotropic drug use. However, review of section V showed no evidence that adequate data was collected in these areas for analysis to provide rationale for care planning. 7. Review of the 10/12/10 annual MDS for resident #52 showed s/he required a comprehensive assessments in the following areas: cognitive loss, ADL function, urinary incontinence, falls, nutrition, and pressure ulcers. However, review of section V showed no evidence that adequate data was collected for any of these areas to ensure an effective care plan could be developed for this resident. 8. Review of the 2/16/11 significant change MDS	F 272	This page left blank intentionally	

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F 272	Continued From page 8 for resident #54 showed s/he required a comprehensive assessments in the following areas: cognitive loss, communication, ADLs, urinary incontinence, psychosocial well-being, mood state, behaviors, activities, falls, nutrition, dental care, pressure ulcer and psychotropic drug use. However, review of section V showed no evidence that adequate data was collected in these areas for analysis to develop an effective care plan. 9. Review of the 2/8/11 annual MDS assessment for resident #64 revealed section V identified the following areas that required additional assessments: cognitive loss, visual function, communication, urinary incontinence, behavioral symptoms, falls, nutritional status, dental care, pressure ulcer and psychotropic drug use. Review of the CAA summary showed the assessment information for the triggered areas was documented in the medication administration record, nursing notes, ADL sheets and intake book. However, review of the documented information failed to show a clear and complete evaluation of causes, contributing conditions, risk factors, and impact on the resident's health. 10. Review of the 10/26/10 annual MDS assessment for resident #65 revealed section V for this MDS assessment identified the following areas were triggered and required additional assessments: cognitive loss, communication, ADL function, urinary incontinence, falls, nutritional status, pressure ulcer, and psychotropic drug use. Review of the CAA summary showed the assessment information for the triggered areas was documented in the medication administration record, nursing notes, ADL sheets and intake book. However, review of	F 272	This page left blank intentionally	

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F 272	Continued From page 9 the documented information failed to show a clear and complete evaluation of causes, contributing conditions, risk factors, and impact on the resident's health. 11. During an interview with the MDS coordinator on 4/12/11 at 11:30 AM, she stated the facility had not completed CAAs for any residents since 10/1/10, when CAAs were required. She further stated the facility would change their MDS process because multiple staff members who did not understand MDS 3.0 were completing parts of them. According to CMS's RAI Version 3.0 Manual, "Nursing homes should ensure that whatever assessment and care planning resources are used are current, evidence-based or expert-endorsed research and clinical practice guidelines/resources." Review of the information provided by the facility showed this requirement was not met for the ten sample residents who required these assessments.	F 272		
F 278 SS=E	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. 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.	F 278	The facility will ensure that each resident's assessment accurately reflects the resident's status. This will be accomplished by: 1. Review of resident # 46 3/5/11 quarterly MDS section J was not blank but was answered that he did not have pain during the seven (7) day look back. Chart and MAR show no pain meds were administered during that time. Section N was not correctly documented. The nurse responsible for data input was educated on the necessity of complete and accurate data. Review and update of care plan completed by May 31, 2011.	

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F 278	Continued From page 10 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: Based on observation, medical record review, and staff interview, the facility failed to accurately assess 4 of 15 sample residents (#46, #52, #54, #65) for various MDS assessments due to inaccurate information. The findings were: During an interview on 4/14/11 at 10 AM, the MDS coordinator confirmed inaccuracies in the following MDS assessments: 1. Review of the 3/5/11 quarterly MDS section J for resident #46 showed the section that asked: "Should the staff assessment for pain be conducted?," was blank. Section N documented the resident was not receiving an antipsychotic. However, review of the April 2011 MAR showed the resident had been on resperidone (an antipsychotic) since 6/22/10. 2. Review of the 10/12/10 quarterly MDS for resident #52 showed, in section B, the resident understood others and could make him/herself	F 278	2. Review of resident # 52: Nurses responsible for data input were educated on the necessity of complete and accurate data. Review and update of care plan completed by May 31, 2011. 3. Review of resident # 54. Licensed staff educated on the necessity of complete and accurate data. Review of care plan Completed May 31, 2011. 4. Review of resident #65: 10/26/10 annual assessment was correct with information gathered from both the nurses and the CNAs. 01/18/11 quarterly assessment information differed from the perspective of the nurses and the CNAs. Education of nurse responsible on the necessity for complete and accurate data entry. Current review of resident care plan accuracy completed May 31, 2011. Plan: All residents of the facility will have assessments that accurately reflect the resident's status. This will be accomplished by: Action: 1. Staff education on proper, complete and accurate documentation on data gathering forms. 2. Summary documentation for each assessment will be entered into the chart by each individual discipline within the 7 day look back to ensure accurate data entry in the MDS.	

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F 278	Continued From page 11 understood. However, section J showed the pain assessment interview could not be conducted because the resident rarely understood. Review of the 3/22/11 quarterly MDS, section I, showed the resident had no active diagnoses and one "other' diagnoses. The 10/12/10 quarterly MDS, section I, documented the resident actually had five diagnoses including hip fracture and dementia. 3. Review of the 5/6/10 significant change MDS assessment showed that resident #54 experienced mild pain in hip and was on a routine medication for pain, naproxen. Review of the coding for the 1/25/11 quarterly MDS assessment showed the resident was not on a routine medication for pain and did not experience pain. Review of the 2/16/11 significant change MDS coding also showed the resident received a routine pain medication, naproxen. Review of the April 2011 MAR showed the resident had been on naproxen since 12/4/09. Further review of the 1/25/11 quarterly MDS, section B, showed the resident was able to make him-herself understood and usually understood others. Section J showed the pain assessment interview should not be conducted because resident could only rarely be understood. Review of the physician's progress notes dated 8/26/10 and 3/3/11 showed a diagnosis of depression. However, section I for active diagnoses revealed depression was not identified. Review of the 2/16/11 significant change MDS showed the same discrepancies in sections I and J as in the 1/25/11 MDS. Section F, preferences for customary routine and activities showed the interview was not conducted because the resident was rarely/never understood.	F 278	Audit: Will be conducted by the MDS Coordinator every 30 days for the previous month assessments and reported quarterly to the PI Committee for quality assurance.	6/14/11

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F 278	Continued From page 12 4. Review of the 10/26/10 annual MDS assessment for resident #65 showed the resident required extensive assistance with dressing, limited assistance with toilet use, and extensive assistance with personal hygiene care. Review of the 1/18/11 quarterly MDS assessment showed the resident was able to do dressing, toileting and personal hygiene care independently. Review of the care plan interventions that addressed ADLs included the following: provide assist of one for completion of ADLs; monitor for changes in condition that would alter the resident's ability to participate in ADLs; and required set-up help for grooming, oral and personal hygiene care. Interview on 4/12/11 at 9:30 AM with CNA #2 revealed the resident required minimal assistance and supervision with most ADLs. Periodic observations of the resident on 4/11/11 and 4/12/11 revealed the resident ambulated independently, required set-up assistance and cueing during meals, staff assistance with the toilet sometimes, which included cueing for hand washing. 5. Interview with the MDS coordinator on 4/12/11 at 11:30 AM multiple staff members, who did not understand MDS 3.0, were completing various sections of the assessment form.	F 278		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure acceptable standards of	F 281	The Facility will ensure pain medication is administered in accordance with physician's orders for resident. This will be accomplished by: 1. Resident # 19: Chart review and update completed 04/22/2011 Plan: The facility will ensure acceptable standards of nursing practice are followed for administering medication according to the	

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F 281	Continued From page 13 nursing practice were followed for administering medication according to the physician's orders for 1 of 15 sample residents (#19). The findings were: According to Smith, Duell, and Martin in "Clinical Nursing Skills: Basic to Advanced Skills," 7th Edition, 2008: "Skill and functions that professional nurses perform in daily practice include: ... Administer treatments per physician's order." Refer to F309 concerning the facility's failure to ensure pain medication was administered in accordance with physician's orders for resident #19.	F 281	physician's orders. This will be accomplished by: Action 1. Place standing orders for medications/treatments in MAR. (ongoing) Audit: Physician standing order placement in the MAR will be monitored and reported quarterly to PI team for quality assurance.	6/14/11
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure resident care plans were followed for 3 of 15 sample residents (#65, #81, #87). The findings were: 1. Refer to F248 for information regarding staff's failure to follow the care plan for posting activity calendars in resident rooms for #65, #81 and #87. 2. Refer to F309 for information regarding staff 's failure to follow the care plan for providing bowel incontinence care for resident #87.	F 282	The facility will ensure resident care plans are followed. This will be accomplished by: 1. Activities a. The Activity Professionals will post daily activities in the main living area on 500 hall for residents to view. b. The Activity Professionals will reflect this in the 500 hall resident's care plans. 2. Resident # 87: Staff educated on the necessity to follow plan of care for each individual resident to ensure the necessary care and services are provided. The facility will provide care/services for the highest well being. Education of staff on necessity to follow plan of care to provide adequate toileting by June 14, 2001. Audit: Random chart audits will be performed and reported to Performance Improvement quarterly to ensure staff have signed and familiarized themselves with the care plans.	6/14/11

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F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, resident interview, staff interview, and review of policies and procedures, the facility failed to provide the necessary assessments, monitoring, and nursing interventions to ensure adequate pain management for 1 of 10 sample residents (#19) who had pain. In addition, the facility failed to provide timely incontinence care for 1 of 8 sample residents (#87) who had bowel incontinence. The findings were: In regard to inadequate pain assessment: 1. Review of the medical record for resident #19 showed the resident had pain due to osteoarthritis and left knee surgery. According to the 3/7/11 quarterly MDS assessment, s/he received PRN frequently for moderate pain; and at times the pain limited his/her day to day activities. Review of the care plan showed interventions for pain included administer pain medication as needed. Review of the 2/8/11 pain assessment showed the resident's established pain goal was four to five (based on the one to ten pain scale) during the day and two to three at night. Review of the PRN MARs for February,	F 309	The facility will provide the necessary assessments, monitoring, and nursing interventions to ensure adequate pain management and provide timely incontinence care for residents who had bowel incontinence. This will be accomplished by: 1. Resident # 19: Review and update PRN pain medication to a routine order, standing orders, and review pre and post pain assessment records. Education to nurses to provide necessary assessments, monitoring and nursing interventions for adequate pain management and to administer treatments per physician's orders. 2. Resident # 87: Staff educated on the necessity to follow plan of care for each individual resident to ensure the necessary care and services are provided. Plan: Facility will ensure that services provided or arranged by the facility will meet professional standards of quality. The facility will provide care/services for the highest well being. This will be accomplished by: Action: 1. Education all licensed staff on one pain scale for the facility by June 14th, 2011. 2. Education all licensed staff on pain assessment, management and standing orders by pharmacist on May 18, 2011.	

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F 309	Continued From page 15 March and April 2011, showed the resident received a single dose of Tylenol 650 milligrams for knee pain on 2/10, 2/13, 2/14, 2/17, 3/17, 3/25 and 3/26/11. This review also showed the resident received one dose of Motrin 400 milligrams on 2/6, 3/26, 3/31, 4/4, 4/8, 4/9, and 4/10/11. A review of the documented administration times showed ten of the fourteen doses were administered between 7 PM and 8:30 PM. The following concerns were noted regarding the management of this resident's pain: a. Interview with the resident on 4/13/11 at 10:40 AM revealed the pain medications effectively relieved his/her pain if s/he took them as soon as s/he experienced the pain. She further stated that sometimes s/he waited too long before s/he asked for the pain medication. b. Reconciliation of the medications and physician's orders revealed an order for the PRN Tylenol dated 9/10/10; but there was no physician's order for the Motrin. Interview with LPN #2 on 4/14/11 at 12 :30 PM revealed she was unable to find evidence that the pain medication had been ordered by the physician. She stated staff had not noted the resident requested pain medications at approximately the same time each day. The LPN further stated that the nurses failed to talk with the physician about changing the resident's PRN pain medication to a scheduled medication. Phone interview with the DON on 4/20/11 at 4:35 PM confirmed staff had administered the Motrin without a physician's order. c. Review of the 2011 pain assessment and monitoring records showed areas for pre and post medication assessment were incomplete and information regarding the effectiveness of the medications was lacking.	F 309	3. Education of licensed staff on pre and post pain assessment with facility standard documentation by June 14, 2011 4. Education of staff on necessity to follow plan of care to provide adequate toileting by June 14, 2001. Audit: Random chart audits will be performed and reported quarterly to ensure staff have signed and familiarized themselves with the care plans.	6/14/11

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F 309	Continued From page 16 During an interview with the DON on 4/12/11 at 5:05 PM, she stated nursing staff relied on CNAs to tell them if residents appeared to be in pain. In regard to the lack of timely bowel incontinence care by staff: Review of the 1/13/11 quarterly MDS assessment for resident #87 showed s/he had moderately impaired cognitive skills, frequent episodes of bowel incontinence, and was totally dependent on staff for all ADLs, including personal hygiene and incontinence care. Review of the care plan showed interventions for continence included: check every two hours and watch for triggers that may indicate the need to use the toilet. Observation showed the resident remained in the wheelchair in the television viewing area and dining room after breakfast from 10:45 AM until 4 PM without ever being checked or changed for incontinence (five hours and fifteen minutes). At 4 PM when CNA's #3 and #4 wheeled the resident to the shower room; the CNA's removed the resident's soiled disposable brief. Interview with CNA #3 on 4/12/11 at 4:20 PM revealed the resident usually had a bowel movement before or after lunch and staff were expected to take the resident to the toilet every two hours. The CNA confirmed the resident had not been checked or changed since 9:30 AM that morning. The CNA further stated staff did not check or change the resident for the prolonged period of time because the resident had visitors after lunch.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an	F 315	Tag # F315 begins on page 18	

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F 315	Continued From page 17 indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure staff provided adequate toileting to promote continence for 1 of 8 sample residents (#87) who were incontinent of bladder. The findings were: Review of the 1/13/11 quarterly MDS assessment for resident #87 showed s/he had moderately impaired cognitive skills, frequent episodes of urinary incontinence, and was totally dependent on staff for all ADLs, including personal hygiene and incontinence care. Review of the care plan showed interventions for continence included: check every two hours and watch for triggers that may indicate the need to use the toilet. Continued observation showed the resident remained in the wheelchair in the television viewing area and dining room after breakfast from 10:45 AM until 4 PM without being checked or changed for incontinence (five hours and fifteen minutes). At 4 PM when CNA's #3 and #4 wheeled the resident to the shower room, the CNA's removed the resident's urine saturated disposable brief that was also soiled with feces. Interview with CNA #3 on 4/12/11 at 4:20 PM revealed the resident usually had a bowel movement before or after lunch and staff were expected to take him/her to the toilet every two hours. The CNA confirmed the	F 315	The facility will ensure resident care plans are followed. This will be accomplished by: 1. Resident #87: Staff will be educated on necessity to follow plan of care for each individual resident to ensure the necessary care and services are provided. The facility will provide care/services for the highest well being. Education of staff on necessity to follow plan of care to provide adequate toileting by June 14, 2011. Audit: Random chart audits will be performed and reported quarterly to Performance Improvement to ensure staff have signed and familiarized themselves with the care plans. Action: Education of staff on necessity to follow plan of care to provide adequate toileting by June 14, 2011.	6/14/11

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F 315	Continued From page 18 resident had not been checked or changed since 9:30 AM that morning. The CNA further stated staff did not check or change the resident for the prolonged period of time because the resident had visitors after lunch.	F 315		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of policy and procedure, the facility failed to ensure medication regimens for 7 of 15	F 329	Each resident's drug regimen will be free from unnecessary drugs. Pharmacist will review residents medications for risk/benefit of continuing their medications specified in the deficiency (Resident #39 and #41) done by May 13, 2011.Physicians will document assessment of Risk/benefit for continuing the medications for these residents (resident #39 and #41) by June 30, 2011 Nursing will assess patients (#39, 41) response to these medications in nursing notes by May 13, 2011 Pharmacist and physician recommended the medication be stopped (Resident # 46) done April 15, 2011 Nursing will assess resident # 54, #65 and document finding on Behavior and Monitoring forms, and in the nursing notes. Done by May 31, 2011 Physicians will document rationale and risk/benefit of continued use of their medications at the current dose or will initiate a Gradual Dose reduction for the following residents (#65, 81, and 87). Done by May 31, 2011.	

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F 329	Continued From page 19 sample residents (#39, #41, #46, #54, #65, #81, #87) were free from unnecessary medications. The findings were: 1. Based on medical record review the following residents had been prescribed medications with a psychological effect, but had no evidence of a pharmacy review or a physician's evaluation of the risks and benefits of continuing the medications or periodic nursing assessment of each patient's response to the drug in light of long term use: a. Resident #39 with a 7/10/09 order for amytryptyline (tricyclic antidepressant) 25 mg each night. b. Resident #41 with a 5/10/11 order for lorazepam (anti-anxiety) 1 mg twice daily. 2. Review of the April 2011 MAR for resident #46 showed s/he received resperidone (antipsychotic) 0.25 mg. Review of the admission orders dated 6/22/10 showed the resident was started on risperdal 0.25 mg at night for dementia. Review of the pharmacy monthly review dated 2/11/11 showed a recommendation for the consideration of stopping the resperidone. Review of the physicians' orders and medical record revealed no gradual dose reduction ordered or clinical contraindication for a reduction. 3. Review of the April 2011 MAR for resident #54 showed s/he received resperidone 0.5 mg each morning and 1.0 mg at night ordered 11/12/10. Further, the resident was on venlafaxine (antidepressant) 150 mg daily with a start date of 10/9/08, then started on paroxetine (an antidepressant) 20 mg once daily on 3/3/11 with a taper dose for venlafaxine. Review of the mood and behaviors monitoring form for 2/11 showed	F 329	Interdisciplinary team will evaluate residents #65, 81, and 87 and recommend a Gradual dose reduction or document continued need for these medications will be completed By May 31, 2011. Action Interdisciplinary team will develop a list of medications which have a higher risk of side effects which require more monitoring. This will be added to the medications which the regulations require gradual dose reductions. The team will then review all the residents with these medications for nursing assessments, physician documentation of continued need, and pharmacist review of risk/benefit of continued use of the medications. Policy and procedure updated by July 31, 2011, review of residents will be ongoing. Interdisciplinary team will review all residents on medications requiring a Gradual dose reduction and will recommend a gradual dose reduction or document the continued need. (Ongoing) Education program will be held for the physicians describing the process for the assessment and documentation of rationale, risk/benefit for continued need of chronic medications and the requirements for Gradual dose reductions for certain medications. (completed by July 2011) Education program will be done with nursing staff training them on the requirements for gradual dose reductions	

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F 329	Continued From page 20 s/he was assessed by nursing staff only one time and 4/1/11-4/11/11 showed the resident was assessed only one time. No documentation was found for monitoring mood and behavior for 3/11. Review of the nurses notes revealed on 3/3/11 orders were received from the physician and faxed to pharmacy. There was no documentation in the nursing notes, which included documentation for this issue, from 3/4/11- 4/4/11. 4. Medical record review showed resident #66 was admitted on 9/29/09 with diagnoses that included dementia and persistent mental disorders. Review of the April 2011 physicians order sheet showed Risperdal 0.5 mg twice daily was ordered on 1/10/10 for agitation and aggressive behaviors. Review of the pharmacy monthly medication reviews showed on 9/8/10 the pharmacist recommended the gradual dose reduction of the Risperdal be delayed. Further review of pharmacist notes, dated 12/20/10, showed the Risperdal administration times had been changed, the dose remained unchanged and the recommendation was to review for possible increase in dose. A review of the February, March, and April 2011 behavior monitoring records showed inconsistent documentation, and sections regarding specific behaviors were blank. Interview with LPN #1 on 4/12/11 at 4:46 PM and LPN #4 on 4/14/11 at 10:45 AM revealed they knew the nurses were responsible for completing the behavior monitoring records, but they did not have a clear understanding of the process. A review of the medical record showed the physician had not documented rationale, risk, or benefits of allowing continued use of the medication at the current dose. The review also showed no evidence the resident had failed a previously attempted dose	F 329	(done for Psychotropic agents on April 20, 2011), requirements for assessment and documentation of the behaviors and side effects (behavior monitoring forms), June and July 2011, requirements for assessment and documentation of effects of chronic medications (document response to new medications and ongoing monitoring for adverse effects), (July and August 2011). Audit Interdisciplinary team will conduct random chart audits to verify the nursing documentation of response to new medications, and possible adverse effects. (ongoing) The interdisciplinary team will report quarterly to the Performance Improvement team the results of our ongoing reviews of residents. The number of residents on medications listed in the policy for medication monitoring, the number with Gradual dose reductions, the results of random audits of nursing charting and behavior monitoring forms for compliance with monitoring. (ongoing)	6/14/11

6/16/11

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	53A049	A. BUILDING _____ B. WING _____	04/14/2011

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F 329	Continued From page 21 reduction of this medication. 5. Medical record review showed resident #81 was admitted on 7/20/09 with diagnoses that included Alzheimer's disease and anxiety disorders. Review of the 4/3/11 quarterly MDS assessment showed the resident has physical and verbal behavior symptoms directed toward others in addition to other behavioral symptoms that were not directed toward others. Review of the physician's 2011 order sheets showed Xanax (anxiolytic) 0.25 mg three times daily, Ativan 0.5 mg daily as needed and Seroquel 50 mg at bedtime was ordered on 7/20/09. This review also showed Geodon 20 mg daily was ordered on 9/3/09 because the resident had violent behaviors. Review of the pharmacist's notes showed Geodon was increased to 20 mg twice daily on 10/1/09; Ativan was decreased to 0.5 mg twice daily as needed on 12/8/09; Seroquel was discontinued on 10/13/10 and Xanax was decreased to twice daily on 11/11/10. Review of the pharmacy monthly medication reviews showed the pharmacist's recommendation on 10/13/10 was to continue the Geodon. Further review showed the pharmacist recommended a review of the medication for possible GDR on 4/7/11. A review of the medical record showed the physician had not documented rationale, risk, or benefits of allowing continued use of the medication at the current dose. The review also showed no evidence the resident had failed a previously attempted dose reduction of this medication. 6. Medical record review showed resident #87 was admitted on 7/20/09 with diagnoses that included dementia and anxiety disorders. This review also showed prior to and after admission	F 329	This page left blank intentionally	

6/6/11

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F 329	Continued From page 22 to the facility the resident received the following medications for combative behaviors, agitation and aggression related to the anxiety disorder: Zyprexa (antipsychotic) 2.5 milligrams twice daily, Zoloft (antidepressant) 25 mg twice daily, Ativan (anxiolytic) 0.5 mg twice daily, and Ativan increased to 1 mg twice daily on bath days. According to the physician's orders the following changes were made in the residents medication regime: on 10/1/09 Geodon (antipsychotic) 20 mg twice daily was added; on 10/14/09 Ativan was changed from 1 mg on bath days to 0.5 mg every eight hours as needed; on 12/8/09 Zoloft was discontinued, Zyprexa was reduced, and Celexa (antidepressant) 20 mg daily was added; on 12/15/09 Zyprexa was discontinued, on 9/13/10 the scheduled dose of Ativan was decreased to 0.5 mg daily dose; and on 10/23/10 Ativan was again changed to 1 mg twice daily. Review of the pharmacy monthly medication reviews showed the pharmacist recommended a review of the Geodon for possible GDR on 8/10/10, 10/13/10, 1/30/11 and 4/7/11 because the dosage had not been changed since 10/14/09. A review of the medical record showed the physician had not documented rationale, risk, or benefits of allowing continued use of the medication at the current dose. The review also showed no evidence the resident had failed a previously attempted dose reduction of this medication. 7. During an interview on 4/12/11 at 4:45 PM, the DON stated staff had not talked with the physician about this issue because they were not aware of the need for the dose reduction reviews for the residents. She also verified the physician had not documented rationale, risk, or benefits of allowing continued use of the medication at the current dose. During an interview with the DON on	F 329	This page left blank intentionally	

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F 329	Continued From page 23 4/13/11 at 11 AM, she stated that staff failed to monitor behaviors and side effects associated with those medications. 8. Review of the policy and procedure titled, "Chemical Restraints and Monitoring," last reviewed by the facility on 1/2005, showed the following requirements: "Residents admitted to the facility while using one of the drugs from the listed classes of drugs will be assessed by the Restraint Team of Interdisciplinary Care Plan Team...This policy applies to medications from the following classes: long-acting benzodiazepines, benzodiazepines and other anxiolytic/sedative drugs, antipsychotics, medications used for sleep induction, misc. hypnotic/sedative/anxiolytic drugs, antidepressants. A behavior monitoring form will be initiated documenting the indications or specific behaviors for which the resident is receiving the medications, or for which there is a potential need for such medication, along with outcomes and medication side-effects."	F 329		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 425	Pharmaceutical Services; Residents # 39 and 41 will be reviewed by the pharmacist for irregularities in the medication regimen by May 13, 2011. The policy and procedure for chemical restraints will be reviewed and updated to match current regulations and procedures. Completed by May 31, 2011 Action: All residents will be reviewed for irregularities monthly following the updated policy and procedures. (ongoing)	

4/6/11

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F 425	Continued From page 24 The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of policy and procedure, the facility failed to monitor irregularities in the medication regimen for 2 of 15 sample residents (#39, #41). The findings were: 1. Review of the April 2011 MAR for resident #39 showed s/he had a 7/10/09 order for amitriptyline (tricyclic antidepressant) 25 mg each night. Review of the pharmacy consultant monthly reviews showed the pharmacist identified the resident use of amitriptyline on 8/29/09 and documented, "will monitor." Continued review showed no further documentation concerning the resident's long term use of amitriptyline. 2. Review of the April 2011 MAR for resident #41 showed s/he had a 5/11/10 order for lorazepam (anti-anxiety) 1 mg orally twice daily. Review of the pharmacy consultant monthly reviews showed the pharmacist did not identify the resident's use of lorazepam or monitor the long term use. During an interview with the pharmacist on 4/14/11 at 1:45 PM, she confirmed the pharmacy consultant monthly reviews in each resident record have all of the medication monitoring that was completed by the pharmacist. The monthly	F 425	Audit: Random audits will be done by Nursing supervisors to document that monthly reviews for irregularities are being done. Results will be reported quarterly at the GCC quality improvement committee.	6/14/11

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F 425	Continued From page 25 reviews for residents #39 and #41 were done. However, the pharmacist confirmed that the amitriptyline for resident #39 and the lorazepam for resident #41 appear to have been missed. Review of the facility policy and procedure titled, "Chemical Restraints and Monitoring," last reviewed by the facility on 1/2006, showed the following requirements: "The consulting Pharmacist's monthly review of each resident's medication regiment will also include review/recommendations for psychotropic drugs. To include: 1. The continued appropriateness of the medication and dosage; 2. evidence of medication-related problems; 3. the effectiveness of and continued need for therapy; 4. inappropriate doses ordered or administered; and 5. the need to discontinue any medication."	F 425	This page left blank intentionally	

6/6/11