

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E359	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/30/2012
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NAME OF PROVIDER OR SUPPLIER ST JOHNS HOME FOR THE AGED	STREET ADDRESS, CITY, STATE, ZIP CODE 1236 LINCOLN AVE EVANSVILLE, IN 47714
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: May 21-25, 29, 30, 2012</p> <p>Facility number: 000443 Provider number: 15E359 AIM number: 100289580</p> <p>Survey team: Diane Hancock, RN, TC Amy Wininger, RN Barbara Fowler, RN Vickie Ellis, RN Jodi Meyer, RN 5/21-5/25/12, 5/29/12</p> <p>Census bed type: NF: 44 Total: 44</p> <p>Census payor type: Medicaid: 42 Other: 2 Total: 44</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 6/5/12 Cathy Emswiller RN</p>	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F0166 SS=D	<p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>Based on interview and record review, the facility failed to provide prompt efforts to locate resident's personal items for 2 of 3 sampled residents who had lost personal property, in a sample of 3 who met the criteria for lost property, in that the residents lost a blouse and/or money in the past month. (Residents #8 and #38)</p> <p>Findings include:</p> <p>1. Resident #8 was interviewed on 5/21/12 at 11:10 a.m. She indicated she had lost an unspecified amount of money in the last month. She indicated she had told the workers of the loss and nothing else could be done. She also stated she kept money with the facility.</p> <p>2. Resident #38 was interviewed on 5/22/12 at 10:30 a.m. She indicated a blouse had been missing for more than one month. She indicated the employees on her floor, the laundry staff and volunteers were aware of the missing blouse. She hoped it would be returned</p>	F0166	<p>1. Corrective actions: A new log for missing items has been initiated and is being used, and efforts to help residents locate missing items are being promptly initiated and documented. 2. How other residents with potential to be affected will be identified and corrective actions to be taken: Missing item reporting was discussed in Resident Council on 6/12/12 so that other residents with this problem may be identified. Inservicing for all employees was held on 6/14/12 and 6/15/12 to review policy for reporting and promptly trying to locate lost items. 3. Measures or systemic changes to prevent recurrence: All new employees will be inserviced during the orientation process on reporting of missing items and making prompt efforts to find the items. Ongoing bi-annual all-staff inservices will be given on this topic. Residents who withdraw their statement about a missing item within the same conversation (i.e., cited resident #8, who said her money was missing but then recalled in the same conversation that she had spent it when she went out to eat) will be entered onto the log</p>	06/18/2012	

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	<p>sometime in the future. She had not given up on finding it. "I will know it if I see someone else wearing it."</p> <p>On 5/24/12 at 3:00 p.m., the log of lost items for the last six months was provided by the Administrator and reviewed at that time. Residents #8 and #38 did not have any items logged as missing in that time frame. During interview on 5/24/12 at 3:30 p.m., the Administrator indicated she was unaware of the above items that were missing.</p> <p>During an interview on 5/25/12 at 9:00 a.m., the Administrator indicated the facility policy was for the residents and/or staff to report the lost items to each Sister [Nun] in charge of the floor, they were to look for the items and record them in the log. "Most items were found right away."</p> <p>3.1-7(a)(2)</p>		<p>regardless. 4. <u>How corrective actions will be monitored/QA to be implemented:</u> Director of Nursing (DON) and Social Service Designee (SSD) will monitor compliance with missing items procedures and will report on this to the Quality Assurance (QA) committee quarterly for 1 year (through June of 2013).</p>		

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F0221 SS=D	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>Based on observation, interview and record review, the facility failed to utilize the least restrictive restraint in 1 of 1 resident reviewed for restraints in a sample of 3 that met the criteria for restraints, in that the resident failed to have a medical symptom for the restraint. (Resident #32)</p> <p>Finding includes:</p> <p>Resident #32's clinical record was reviewed on 5/23/12 at 9:54 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, mild mental retardation, anxiety, and depression.</p> <p>The MDS [Minimum Data Set] assessment dated 4/19/12, indicated Resident #32's BIMS [Basic Interview for Mental Status] score was a 9 out of 15, indicating problems with short and long term memory. The functional status of the resident was as follows: extensive assistance of two persons for transfer, unable to ambulate, locomotion on unit was with supervision, locomotion off unit was extensive assistance of one person,</p>	F0221	<p>1. Corrective actions: Resident's physical restraint elimination assessment dated 4/18/12 was reviewed. On 6/1/12, orders were received to release the seat belt at mealtime 3X daily. A new updated assessment was completed on 6/12/12 and order was obtained to discontinue the restraint and to get a physical therapy eval. Care plan has been updated. 2. How other residents with potential to be affected will be identified and corrective actions to be taken: Any resident with a restraint would have the potential to be affected (although there are none at present). Assistant Director of Nursing (ADON) has been inserviced on 6/12/12 regarding follow-through with assessment recommendations. 3. Measures or systemic changes to prevent recurrence: If restraints are used on any resident, the medical symptom will be documented and a restraint elimination assessment will be completed quarterly by the ADON. This will be reviewed by the DON for follow-through on any recommendations for restraint reduction. 4. How corrective actions will be monitored/QA to</p>	06/18/2012			

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	<p>dressings was extensive assistance of one person, toilet use was extensive assistance with two persons, personal hygiene was extensive assistance of one person, bathing was extensive assistance of two persons. Resident #32 was at risk for a pressure ulcer. The MDS assessment indicated Resident #32 had restraints which included bed rails that were used daily and a trunk restraint which was used daily.</p> <p>The current physician's recapitulation of orders dated 4/26/12, indicated the resident was to have a seat belt when she was in her wheelchair due to the resident leaning forward. The physician's order did not indicate a medical symptom for the restraint. The order indicated the seat belt was to be checked hourly and released every 2 hours.</p> <p>Resident #32 had a care plan dated 4/24/12, for the seat belt in her wheelchair. The goals listed in the care plan included placing the seat belt on Resident #32 when she was in her wheelchair, the staff was to check Resident #32 hourly, and the staff was to release the seat belt and reposition Resident #32 every 2 hours. The interventions included Resident #32 would have the least restrictive device necessary to keep her safe from falls or</p>		<p>be implemented: DON will review restraint assessments and follow-up, and will report results quarterly to the QA committee for one year (through June of 2013).</p>				

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	<p>injury.</p> <p>Resident #32 had fallen on 1/12/12. The care plan, dated 1/31/12, for the resident's fall included as an intervention the resident was to have a seat belt in use when she was in her wheelchair and a pad alarm used when she was in her recliner or bed. The seat belt was to be checked every hour and released every 2 hours. The pad alarm was to be checked every shift for proper working order and placement of the alarm box.</p> <p>Resident #32 had a quarterly restraint assessment completed to assess the need for the seat belt. The quarterly restraint assessments were completed on 8/11/11, 11/3/11, 1/26/12, and 4/18/12. The quarterly "Physical Restraint Elimination Assessment" dated 4/18/12, indicated the resident was a good candidate for restraint reduction or elimination, but there was no indication the seat belt had not been attempted to be reduced or eliminated.</p> <p>On 5/2/12 [no time], the nurse's notes documented on the weekly assessment indicated Resident #32 was no longer able to ambulate and a mechanical lift was required for transfers.</p> <p>The falls risk assessment dated 1/20/12, indicated Resident #32 had fallen on</p>						

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	<p>1/12/12 and the resident had a gait balance problem but the fall risk assessment did not specify the type of problem the gait balance was.</p> <p>On 5/14/12, the 3-11 p.m. shift nurse's notes indicated the resident had a seat belt in her wheelchair and it was released every 2 hours because she had times of leaning forward.</p> <p>Resident #32 was observed on 5/22/12 at 11:28 a.m., to be sitting in her wheelchair with a seat belt around her waist. The resident was sitting straight in her wheelchair and upon query of Resident #32, the resident was unable to unattach or remove her seat belt.</p> <p>The resident was observed on 5/22/12 at 3:16 p.m., sitting in her wheelchair with a seat belt on, sleeping in front of the television but was not leaning forward. Staff were noted to bring other residents into the area but did not offer to release her seat belt.</p> <p>The resident was observed on 5/23/12 at 8:25 a.m., feeding herself in the dining room while in her wheelchair with her seat belt on and was not leaning forward. On 5/23/12 at 11:04 a.m., Resident #32 was observed watching television with her seat belt around her waist. The</p>			

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	<p>resident was sitting in her wheelchair and was not leaning.</p> <p>On 5/23/12 at 1:39 p.m., CNA #1 and CNA #2 assisted the resident to her bathroom. CNA #1 placed the lift pad of the sit to stand mechanical lift under the resident's arms and applied a gait belt around her waist. CNA #1 indicated the resident refused to hold onto the mechanical lift's handles. Resident #32 was asked to hold onto handles but would not attempt to do this. The resident was lifted and placed onto the commode. When interviewing the CNAs regarding Resident #32's seat belt, CNA #2 indicated the resident had ambulated in the past with assistance but was now unable to get out of the chair. CNA #2 indicated the resident had not been able to get out of chair for approximately a year.</p> <p>The resident was observed on 5/24/12 at 9:00 a.m. in the dining room, sitting in her wheelchair with the seat belt around her waist. The resident was not leaning forward in her wheelchair. The resident was asked to remove the seat belt from around her waist and the resident was unable to remove it. The resident did not know the purpose for the seat belt.</p> <p>The policy for use of restraints provided by the Administrator on 5/23/12 at 8:00</p>						

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	<p>a.m. and dated 5/06, indicated the restraint was considered a temporary care modality that ensured protection and security for the resident. The procedure indicated the resident should have the least restrictive device tried first and the continued need for the restraint would be addressed by the interdisciplinary care team. It also indicated an assessment would continue every 90 days or more frequently if necessary by the nursing services and the physician.</p> <p>On interview with the DoN [Director of Nursing] on 5/24/12 at 9:14 a.m., she indicated the reason for the restraint was the resident had fallen in the past and the resident had restlessness. The DoN indicated the resident was assessed quarterly by the ADoN [Assistant Director of Nursing] for the continuation of the restraint. She indicated the benefit of the seatbelt was for safety of the resident and the risks were less movement for the resident and constipation. The DoN indicated the seat belt was checked every 1 hour and the seat belt was released and her position changed every 2 hours. She indicated the resident did not have a restraint when in bed and the resident had walked in the past with assistance of 2 persons but had become agitated. The DoN indicated the resident was receiving no therapy at this time.</p>						

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	<p>On interview of the ADoN on 5/24/12 at 9:14 a.m., she indicated the medical reason for the restraint was the resident leaned forward in her wheelchair. The ADoN indicated that a quarterly restraint assessment was completed on the resident by watching the resident, talking with the staff, and asking the resident to remove the belt. The ADoN indicated occasionally Resident #32 could remove the seat belt and occasionally she could not remove it. When queried of the ADoN regarding the quarterly assessments of the resident on 8/11/11, 1/26/12, and 4/18/12 which documented the resident was a good candidate for restraint reduction or elimination, the ADoN indicated the resident was actually not a good candidate for restraint reduction or elimination. The ADoN indicated the resident "slumps in her chair."</p> <p>The quarterly assessment dated 11/4/11, indicated the seat belt was continued as a reminder to the resident to have assistance with transfers and ambulation. The ADoN indicated she did not know why she had not indicated why the resident was not a good candidate on the "Restraint Assessment Form" on 8/11/11 and 4/18/12, but the reason originally was due to the resident leaning forward. The</p>			

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	<p>ADoN indicated the resident needed to be reminded not to get up without assistance. The ADoN indicated the care plan and the restraint assessment form were both updated at the same time.</p> <p>3.1-3(w) 3.1-26(o)</p>			

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F0225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review, the facility failed to report an allegation of</p>	F0225	<p>1. Corrective actions: Individual training was given to the Certified Nursing Assistant (CNA) whom</p>	06/18/2012			

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	<p>mistreatment to the State agency in 1 of 2 residents in a sample of 2 who met the criteria in that the facility failed to report an allegation of roughness to the State agency. [Resident #9]</p> <p>Finding includes:</p> <p>On 5/21/12 at 2:30 p.m., an interview was conducted with Resident #9. The Resident indicated a staff member, she did not wish to name, had been rough with her with a wash rag during ADL [Activities of Daily Living] care a week ago. Resident #9 stated, "one worker, one time, last week was really rough but she was nice today; she must have had a bad day." Resident #9 indicated when the unnamed staff member was assisting her out of bed and into her wheelchair, the staff member swung her legs too fast, making it painful for her. Resident #9 indicated she was moving slowly due to her arthritis [a degenerative joint disease].</p> <p>On 5/23/12 at 8:55 a.m., an interview was conducted with Resident #9. Resident #9 indicated the staff member who was rough with the wash rag in the previous week assisted her with ADL care during the morning of 5/23/12 and continued to be rough when washing with the wash rag. Resident #9 indicated the allegation of roughness with a wash rag by a staff</p>		<p>resident #9 reported as having "rubbed her hard when cleaning her" (as told to facility by the surveyor). Inservice was held 6/14/12 and 6/15/12 for all employees regarding facility abuse policies, reporting, and investigation, and instructing them that the incident of a CNA "rubbing hard when cleaning her"- -which the resident told the surveyor on 5/21/12 and which the surveyor reported to the facility two days later on 5/23/12, adding "We are not saying this is abuse, but we wanted the DON to be aware"--should have been deemed by the facility to be immediately reportable to the state agency. 2. <u>How other residents with potential to be affected will be identified and corrective actions to be taken:</u> Other residents with potential to be affected will be identified through Social Service visits and interviews, in addition to ongoing vigilance on the part of charge nurses and unit staff for indications of anything that might be considered possible mistreatment. Abuse/Neglect was reviewed with residents in Resident Council on 6/12/12 to further support efforts to identify those at risk to be affected. Any report of suspected or alleged abuse, neglect, or mistreatment will be reported to the state agency according to facility policy. A full investigation will be completed and action taken per:</p>				

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	<p>member during ADL care was not reported to anyone. Resident #9 said, "The lady is going to retire within a year, so I know she is on limited time." The resident also stated, "I have reported her one time in the past for something else and they talked to her." Resident #9 indicated she did not wish to report the roughness on 5/23/12 to the Director of Nursing [DoN].</p> <p>Record Review on 5/22/12 at 8:55 a.m., indicated Resident #9 had diagnoses of osteoarthritis and gout, and the Minimum Data Set [MDS] assessment dated 4/12/12 indicated Resident #9 had a BIMS [Basic Interview for Mental Status] score of 15 which indicated the resident did not have any short term or long term memory problems.</p> <p>In an interview with the DoN on 5/24/12 at 9:26 a.m., the DoN indicated she had investigated the issue of roughness by staff by selecting several residents and asking the residents if staff was rough with them. The DoN also indicated several family members of the residents were called and asked if any of the staff members had been rough with their family members who were residents at the facility.</p> <p>In an interview on 5/24/12 at 9:50 a.m.,</p>		<p>findings. 3. <u>Measures or systemic changes to prevent recurrence:</u> New employees will receive more intensive abuse/neglect training during orientation. For current employees, an all-staff inservice was held on June 14 and 15 and will be held every 6 months hereafter regarding alleged or suspected abuse, neglect, or mistreatment. Follow-up with Resident Council will take place monthly. 4. <u>How corrective actions will be monitored/QA to be implemented:</u> DON will monitor on an ongoing basis the information received from Resident Council, Social Worker, and staff, will keep administrator informed, and will bring results of monitoring to quarterly QA meeting for one year (through June 2013).</p>		

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	<p>the Administrator indicated a follow up to the investigation of the alleged roughness by staff members had been completed, but the state agency had not been notified when the facility learned of the allegation. The results indicated a resident had been identified through the investigation, but the roughness was not done intentionally and the resident did not feel any mistreatment took place. The Administrator indicated she had identified a CNA as the staff member of whom the allegation of roughness was made and that person was not there on the day of the investigation. The Administrator indicated the CNA would be educated and possibly disciplined. She indicated, she did not report the incident or investigation to the state because the allegation proved to be false. She indicated if mistreatment or abuse was proven, it would be reported to the state.</p> <p>At 10:58 a.m. on 5/24/12, the DoN provided a copy of the facilities investigation of rough treatment and explained the allegation of the rough treatment was not reported to the state, because it was not proven to be true.</p> <p>A document, titled "Prohibition, Reporting, and Investigation of Resident Abuse, Neglect and Mistreatment", dated 5/06, was provided by the DoN on</p>			

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	5/22/12 at 9:15 a.m. The document indicated the administrator would report any suspected abuse, neglect, or mistreatment to the state agency as soon as possible but within no more than 2 hours. 3.1-28(c)			

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F0226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to follow the facility policy of reporting allegations of mistreatment in 1 of 2 residents in a sample of 2 who met the criteria for abuse as the facility failed to report an allegation of roughness. [Resident #9]</p> <p>Finding includes:</p> <p>On 5/21/12 at 2:30 p.m., an interview was conducted with Resident #9. The Resident indicated a staff member, she did not wish to name, had been rough with her with a wash rag during ADL [Activities of Daily Living] care a week ago. Resident #9 stated, "one worker, one time last week, was really rough but she was nice today; she must have had a bad day."</p> <p>Resident #9 indicated when the unnamed staff member was assisting her out of bed and into her wheelchair, the staff member swung her legs too fast, making it painful for her. Resident #9 indicated she was moving slowly due to her arthritis [a degenerative joint disease].</p>	F0226	<p>1. Corrective actions: Inservice was held 6/14/12 and 6/15/12 for all employees regarding facility abuse policies, reporting, and investigation. This inservice clarified that a resident's report of a CNA's "rubbing hard when cleaning her"--which the resident told the surveyor on 5/21/12 and which the surveyor reported to the facility in those words 2 days later on 5/23/12, adding "We are not saying this is abuse, but we wanted the DON to be aware" —should have been deemed by the facility to be immediately reportable to the state agency. 2. How other residents with potential to be affected will be identified and corrective actions to be taken: Other residents with potential to be affected will be identified through Social Service visits and interviews, in addition to ongoing vigilance on the part of charge nurses and unit staff for indications of anything that might be considered possible mistreatment. Abuse/Neglect was reviewed with residents in Resident Council on 6/12/12 to further support efforts to identify those at risk to be affected. Any</p>	06/18/2012			

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	<p>On 5/23/12 at 8:55 a.m., an interview was conducted with Resident #9. Resident #9 indicated the staff member who was rough with the wash rag in the previous week assisted her with ADL care on the morning of 5/23/12 and continued to be rough when washing with the wash rag. Resident #9 indicated the allegation of roughness with a wash rag by a staff member during ADL care was not reported to anyone. Resident #9 said, "The lady is going to retire within a year, so I know she is on limited time." The resident also stated, "I have reported her one time in the past for something else and they talked to her." Resident #9 indicated she did not wish to report the roughness on 5/23/12 to the Director of Nursing [DoN].</p> <p>Record Review on 5/22/12 at 08:55 a.m. indicated Resident #9 had diagnoses of osteoarthritis and gout, and the Minimum Data Set [MDS] assessment, dated 4/12/12, indicated Resident #9 had a BIMS [Basic Interview for Mental Status] assessment score of 15, which indicated the resident did not have any short term or long term memory problems.</p> <p>In an interview with the DoN on 5/24/12 at 9:26 a.m., the DoN indicated she had investigated the allegation of roughness</p>		<p>report of suspected or alleged abuse, neglect, or mistreatment will be reported to the state agency according to facility policy. A full investigation will be completed and action taken per findings. 3. <u>Measures or systemic changes to prevent recurrence:</u> New employees will receive more intensive abuse/neglect training during orientation. For current employees, an all-staff inservice will be held on June 14-15 and every 6 months hereafter regarding suspected abuse, neglect, or mistreatment. Follow-up with Resident Council will take place monthly. Any report of alleged or suspected abuse, neglect, or mistreatment (including rubbing hard with a washcloth) will be deemed reportable, and the facility's policy will be followed for reporting such allegations/suspicious. A full investigation will be completed and action taken per findings. 4. <u>How corrective actions will be monitored/QA to be implemented:</u> Follow-up with Resident Council will take place monthly. DON will monitor on an ongoing basis the information received from Resident Council, Social Worker, and staff, will verify that allegations of abuse, neglect, or mistreatment (including rubbing hard with a washcloth) have been reported per: facility policy, and will keep administrator informed. DON will</p>				

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	<p>by the staff by selecting several residents and asking the residents if staff was rough with them. The DoN also indicated several family members of the residents were called and asked if any of the staff members had been rough with their family members who were residents at the facility.</p> <p>In an interview on 5/24/12 at 9:50 a.m., the Administrator indicated the follow up to an investigation of the alleged roughness by staff members had been done, but the state agency had not been notified when the facility learned of the allegation. The results were a resident had been identified through the investigation, but the roughness was not done intentionally and the resident did not feel any mistreatment took place. The Administrator indicated she had identified a CNA as the staff member of whom the allegation of roughness was reported, and that person was not there on that date. The Administrator indicated the CNA would be educated and maybe disciplined. She indicated she did not report the incident or investigation to the state, because the allegation proved to be false. She indicated if mistreatment or abuse was proven, it would be reported to the state.</p> <p>At 10:58 a.m. on 5/24/12, the DoN</p>		bring results of monitoring to quarterly QA meeting for one year (through June of 2013).				

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	<p>provided a copy of the facility's investigation of rough treatment and indicated the allegation of the rough treatment was not reported to the state, because it was not proven to be true.</p> <p>A document, titled "Prohibition, Reporting, and Investigation of Resident Abuse, Neglect and Mistreatment," dated 5/2006, was provided by the Administrator on 5/22/12 at 9:15 a.m. The document indicated it was the facility's policy the administrator would report any suspected abuse, neglect, or mistreatment to the state agency as soon as possible but within no more than 2 hours.</p> <p>3.1-28(a)</p>				

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F0272 SS=D	<p>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.</p> <p>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.</p> <p>Based on observation, interview, and record review the facility failed to ensure an MDS [Minimum Data Set Assessment] was accurate, in relation to a resident's behaviors and use of anti-anxiety medication, in that, the resident was using Xanax as needed daily and the MDS</p>	F0272	<p>1. Corrective actions: Resident #18 has had a new Minimum Data Set (MDS) done on 6/12/12 which more accurately captures information about antianxiety medication and behaviors. Her care plan has been updated accordingly and now indicates some non-pharmacological</p>	06/18/2012

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	<p>assessment indicated the resident did not have behaviors and did not use anti-anxiety medication for 1 of 2 residents reviewed for Activities of Daily Living. (Resident #18)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #18 was reviewed 05/24/12 at 9:07 a.m. The record indicated Resident #18 was admitted 06/29/11 with diagnoses that included, but were not limited to, anxiety.</p> <p>Resident #18 was observed on 05/21/12 at 9:00 a.m. to be sitting in her personal recliner watching television, no signs or symptoms of anxiety were observed. In an interview at that time, Resident #18 indicated, she was having a wonderful morning.</p> <p>Resident #18 was observed on 05/24/12 at 10:00 a.m. to be sitting in her personal recliner with her laptop computer on her lap, no signs or symptoms of anxiety were noted. During an interview at that time, she indicated, "sometimes I just get nervous... I feel so much better than when I first found out the Sisters were leaving."</p> <p>The most recent quarterly MDS [Minimum Data Set Assessment] dated 03/15/12 indicated Resident #18 had mild</p>		<p>interventions which should be attempted before administration of as-needed/pro re nata (PRN) antianxiety agents. 2. <u>How other residents with potential to be affected will be identified and corrective actions to be taken:</u> MDS Coordinator was inserviced on 6/14/12 on the importance of accurately capturing medication data and behaviors on the MDS, and care planning accordingly. Since any residents on antianxiety medications have the potential to be affected, MDSs and care plans on all residents on antianxiety agents have been reviewed and updated to assure that these medications are reflected and that suggestions are given for non-pharmacological interventions to utilize prior to administration of PRN anti-anxiety medications. 3. <u>Measures or systemic changes to prevent recurrence:</u> A new form is being utilized to assist with monitoring of psychotropic medications. This form monitors dosage and frequency of use. All dosage changes will be reflected. This form is used as a tracking tool. The form will be reviewed weekly by the DON. The SSD, DON, and ADON will review the usage of psychotropic medications monthly. The consulting pharmacist will continue to review all residents' medications monthly, with special emphasis on antianxiety agents. An inservice was held on 6/14/12</p>				

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	<p>to no cognitive impairment, had an active diagnosis of anxiety, and "experienced feeling down, depressed, or hopeless two to 6 days, feeling tired or having little energy two to six days, and trouble concentrating on things two to six days..."</p> <p>The MDS assessment further indicated a symptom frequency score of 03/27. The MDS assessment lacked any documentation of behaviors and also indicated Resident #18 had received no anti-anxiety medications.</p> <p>The most recent April 2012 Physician order recapitulation indicated orders for , "...Xanax [an anti-anxiety medication] 0.5 mg tab, take (1) (one) tablet by mouth (3) (three) times daily as needed for anxiety.."</p> <p>The May 2012 MAR [Medication Administration Record] for Resident #18 was reviewed on 05/23/12 and indicated the resident had received Xanax 26 times between 05/01/12 and 05/23/12 for anxiety. The record lacked any documentation of non-pharmacological interventions prior to the administration of the medication.</p> <p>The most recent care plan dated 05/11/12 indicated a problem of, "[Resident #18] has a dx [diagnosis] of depression. At risk for change in mood and/or cognitive</p>		<p>for all nurses and Qualified Medication Aides (QMAs) regarding non-pharmacological interventions to be attempted prior to administration of PRN antianxiety drugs . 4. <u>How corrective actions will be monitored/QA to be implemented:</u> DON will monitor PRN antianxiety drug usage and non-pharmacological interventions weekly, and will bring results of this monitoring to the QA committee every quarter for one year (through June of 2013).</p>				

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	<p>status. [Resident #18] receives...an antianxiety medication PRN [as needed]... with interventions of:</p> <p>"*observe [Resident #18] for increased confusion, withdrawal from daily routine, increased self-isolation, tearfulness, paranoia, increased drowsiness, hallucination, dizziness, irritability</p> <p>*Have Pharmacy check medications and possible interactions at least quarterly</p> <p>*[Resident #18] attends mass regularly and often visits the chapel on her own for quiet reflection/spiritual uplifting" The plan of care lacked any interventions prior to the administration of Xanax."</p> <p>The clinical record lacked any documentation that the use of Xanax prn was being monitored.</p> <p>In an interview on 05/24/12 at 10:25 a.m. with QMA #1 she indicated, "She is very nervous about the sisters leaving and a new owner coming in."</p> <p>In an interview on 05/24/12 at 11:25 a.m. with the Social Service Director she indicated, "I do not monitor psych and anti-anxiety medications for use and interventions...I do not have a care plan that specifically addresses behaviors and interventions...there is no assessment."</p> <p>In an interview with the DoN [Director of</p>			
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	<p>Nursing] on 05/24/12 at 11:30 a.m. she indicated, "the pharmacist reviews the use of all medications monthly and tells us what to do...nobody else monitors it...we do not use non-Pharm interventions, we just give her Xanax, that's what works." She further indicated at that time, there was no policy related to the monitoring of anti-anxiety medications.</p> <p>3.1-31(a)</p>			

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F0279 SS=E	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>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.</p> <p>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).</p> <p>Based on observation, interview and record review, the facility failed to ensure care plans were developed with measurable goals and objectives, for 6 of 25 residents reviewed for care plans, in the stage two sample of 25, in that the residents' care plans were either not developed for assessed needs, and/or did not have measurable objectives and goals. (Resident #32, #18, #12, #8, #24, #16)</p> <p>Findings include:</p> <p>1. Resident #32's clinical record was</p>	F0279	<p>1. Corrective actions: Interventions are initiated for all falls timely; the care plans of resident #32 and all residents with recent falls have been reviewed and updated as needed for fall interventions established. A new restraint assessment form has been completed on resident #32; on 6/1/12 orders were received to release the seat belt at mealtime 3X daily, and the care plan was reviewed and updated at that time. The restraint was discontinued on 6/12/12. An order has been obtained for resident #18's compression sleeve and</p>	06/18/2012	

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	<p>reviewed on 5/23/12 at 9:54 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, mild mental retardation, anxiety, and depression.</p> <p>Clinical record review on 5/23/12 at 2:00 p.m. indicated a nurse's note dated 1/12/12 at 7:50 p.m. Resident #32 had a fall on from her reclining chair. An alarm pad was in use when the resident fell from the foot of her recliner. The care plan, dated 1/31/12 and revised 4/24/12, did not indicate the resident had fallen on 1/12/12. The last documented fall on the care plan was on 6/20/11. The care plan indicated the intervention was to have a seat belt in use when the resident was in her wheelchair and a pad alarm when the resident was in her recliner or bed. The seat belt was to be checked every hour and released every 2 hours and the pad alarm was to be checked every shift for proper working order and placement of the alarm box, reinforce with the resident the need to call for assistance, have the resident wear proper and non-slip footwear, and bilateral top side rails up at all times when in bed for safety and enabling. There was no updating of either of the care plan's interventions or goals after the resident's fall on 1/12/12.</p> <p>The policy provided on 5/23/12 at 8:00 a.m. by the Administrator for falls</p>		<p>order was placed on the treatment book and care plan has been updated; a new MDS has also been done on this resident, reflecting current level of ADL assistance. Resident #12's care plan has been updated reflecting potential for bruising, as have the care plans of all other residents on Coumadin or Plavix. Resident #8's pain medication usage has been reviewed and new pain medication orders received; care plan was updated. A care plan for ROM was initiated for resident #24, and staff were made aware of the range-of-motion exercise record on the nursing unit which reflected the 3X/day range-of-motion exercises that had actually been done and documented on this resident for many months. Resident #16's pain medication usage was reviewed and discussed with resident; she reconsidered her previous decision and accepted to try pain medication, and new orders were received and the care plan was updated. 2. <u>How other residents with potential to be affected will be identified and corrective actions to be taken:</u> ADON has checked that new interventions implemented after a fall are updated in the care plan in a timely manner. There are currently no other restraints in the facility. Treatment orders--including items such as compression sleeves--will be checked for accuracy and</p>				

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	<p>management (undated), indicated following a fall the care plan will be reviewed and interventions implemented as appropriate.</p> <p>Physician's orders dated 4/26/12, indicated the resident was to have a seat belt when up in her wheelchair due to the resident leaning forward. The physician's order did not indicate a medical symptom for the restraint. The order indicated the seat belt was to be checked hourly and released every 2 hours.</p> <p>Resident # 32 had a quarterly restraint assessment completed to assess the need for the seat belt. The quarterly restraint assessments were completed on 8/11/11, 11/3/11, 1/26/12, and 4/18/12. The documentation of the physical restraint reduction/elimination assessment on 8/11/11 indicated the resident was to continue to have a seat belt on while in her chair. The quarterly restraint assessment for 11/4/11 indicated the seat belt was continued in the resident's wheelchair to remind to the resident she needed assistance with transfers and/or ambulation. There was no documentation for the use of why the reduction or elimination of the physical restraint was not being done on 1/26/12. The quarterly "Physical Restraint Elimination Assessment" dated 4/18/12, indicated the</p>		<p>completeness on admission; resident and family will be interviewed for any treatments not already included in admission orders. All residents receiving Coumadin or Plavix have been identified as having potential for bruising, and now have a care plan in place addressing bruising; any residents with new orders for Coumadin or Plavix in the future will also have a care plan developed for this. Pain assessments have been reviewed on residents triggering for pain, and care plans were updated as needed. Care plans were reviewed for all residents with contractures and limited movement, and were updated or initiated as needed. MDS Coordinator will carefully review each ADL grid on upcoming MDSs and reassess if grids are not correct. Range-of-motion (ROM) log is being reviewed weekly by MDS Coordinator and care plans initiated and updated if needed. 3. <u>Measures or systemic changes to prevent recurrence:</u> ADON was inserviced on 6/12/12 regarding timely update of care plans after a fall and need to identify the medical symptom if we receive an order for a restraint in the future. Treatments will be reviewed more carefully during monthly review of orders. Inservices were held 6/14/12 & 6/15/12 for nursing staff regarding correct coding of ADL grid. Inservices regarding</p>		

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	<p>resident was a good candidate for restraint reduction or elimination but the seat belt was not being reduced or eliminated.</p> <p>Resident #32 had a care plan dated 1/31/12 and 4/24/12, for the seat belt in her wheelchair. The goals listed in the care plan included placing a seat belt on the resident when she was in her wheelchair, the staff was to check the resident hourly, and the staff was to release the seat belt and reposition the resident every 2 hours. The interventions included Resident #32 would have the least restrictive device necessary to keep her safe from falls or injury. No further interventions or goals were listed on the care plan.</p> <p>During interview with the DoN [Director of Nursing] on 5/24/12 at 9:14 a.m., she indicated the reason for the restraint was the resident had fallen in the past and the resident has restlessness. The DoN indicated the resident is assessed quarterly by the ADoN [Assistant Director of Nursing] for the continuation of the restraint. She indicated the benefit of the seatbelt was for safety of the resident and the risks were less movement for the resident and constipation. The DoN indicated the seat belt was checked every 1 hour and the seat belt was released and her position changed every 2 hours. She</p>		<p>correct coding of ADLs will be scheduled every 6 months and as needed. New orders will be given to MDS Coordinator to update the care plan promptly. Pain assessments will be completed quarterly and PRN. The physician will be updated with reports of increased pain. An inservice was held on 6/14/12 for nurses regarding pain assessment and interventions (medication and non-pharmacological). An inservice was held 6/14/12 for nurses and QMAs and on 6/15/12 for other nursing staff reviewing residents on ROM and location of ROM log. ADON will review each resident's ADL grid for correct coding. MDS Coordinator was inserviced 6/14/12 regarding care plans for ROM and limited movement. 4. <u>How corrective actions will be monitored/QA to be implemented:</u> DON will monitor follow-through on all above corrective measures, and will report on results to QA committee quarterly for one year (through June of 2013).</p>				

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	<p>indicated the resident does not have a restraint when in bed and the resident had walked in the past with assistance of 2 persons but has now become agitated. The DoN indicated the resident was receiving no therapy at this time.</p> <p>During interview of the ADoN on 5/24/12 at 9:14 a.m., she indicated the medical reason for the restraint was the resident leans forward in her wheelchair. The ADoN indicated that a quarterly restraint assessment was completed on the resident by watching the resident, talking with the staff, and asking the resident to remove the belt. The ADoN stated that occasionally Resident #32 could remove the seat belt and occasionally she could not remove it. When queried of the ADoN regarding the quarterly assessments of the resident on 8/11/11, 1/26/12, and 4/18/12 which documented the resident was a good candidate for restraint reduction or elimination, the ADoN indicated the resident was actually not a good candidate for restraint reduction or elimination. The ADoN indicated the resident "slumps in her chair". The quarterly assessment dated 11/4/11, indicated the seat belt was continued as a reminder to the resident to have assistance with transfers and ambulation. The ADoN indicated she did not know why she had not indicated why</p>			

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	<p>the resident was not a good candidate on the "Restraint Assessment Form" on 8/11/11 and 4/18/12 but the reason originally was due to the resident leaning forward. The ADoN indicated the resident needed to be reminded not to get up without assistance. The ADoN indicated the care plan and the restraint assessment form are both updated at the same time.</p> <p>2. The clinical record of Resident #18 was reviewed on 05/24/12 at 9:07 a.m. The record indicated Resident #18 was admitted 06/29/11 with diagnoses that included, but were not limited to, lymphedema left arm s/p [status post] bilateral mastectomy.</p> <p>Resident #18 was observed on 05/21/12 at 9:00 a.m. to be sitting in her personal recliner with a compression sleeve on her left arm. In an interview at that time, Resident #18 indicated she dressed herself independently. She further indicated she wore the sleeve everyday and needed the help of staff to put it on.</p> <p>Resident #18 was observed on 05/24/12 at 10:00 a.m. to be sitting in her personal recliner with a compression sleeve on her left arm.</p> <p>The most recent quarterly MDS</p>						

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	<p>[Minimum Data Set Assessment] dated 03/15/12 indicated Resident #18 had mild to no cognitive impairment and required extensive assistance of one person for dressing,</p> <p>The most recent April 2012 Physician order recapitulation lacked an order for the compression sleeve.</p> <p>In an interview with the MDS Coordinator on 05/24/12 at 11:10 a.m. she stated, " I can't find an order anywhere for [Resident #18] compression stocking."</p> <p>The May 2012 TAR [Treatment Administration Record] of Resident #18 was reviewed on 05/23/12 and lacked any documentation that a compression sleeve was being used.</p> <p>The most recent care plan dated 05/11/12 lacked any documentation that a compression sleeve was being used.</p> <p>In an interview on 05/24/12 at 10:15 a.m. with QMA #1 she stated, "We help her apply that sleeve every morning, it helps keep the swelling down."</p> <p>In an interview with the MDS Coordinator on 05/24/12 at 10:33 a.m. she indicated, "I think all we do is help her with the compression sleeve...it really</p>				

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	<p>isn't part of her dressing...I don't know why it would be coded like that because she is completely independent with all aspects of ADL [Activities of Daily Living] care including dressing, she even takes her own shower. It is my fault for not following up on this further."</p> <p>In an interview with the DoN on 05/25/12 at 8:55 a.m. she indicated there was no specific policy related to obtaining an order for a treatment that was already being done. She further indicated it was their daily practice to obtain an order before providing a treatment.</p> <p>3. Resident #12 was observed on 5/21/12 at 2:35 p.m. sitting in her personal recliner with a bruise on her left hand. At that time, she indicated the bruise had occurred while trying to unlock a wheelchair.</p> <p>The clinical record of Resident #12 was reviewed on 05/22/12 at 2:55 p.m. The record indicated the diagnoses included, but were not limited to, atrial fibrillation.</p> <p>The most recent quarterly MDS [Minimum Data Set Assessment] dated April 5, 2012 indicated Resident #12 experienced no cognitive impairment.</p>				

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	<p>A Nursing note dated 05/21/12 at 7:00 p.m. indicated, "noted a 3 X 2 cm ecchymosed [sic] area posterior left hand between thumb and 1st finger. Resident stated it happened a couple of days ago while she was applying the brakes on a loaner wheelchair. She accidentally [sic] bumped it..."</p> <p>A Physician's telephone order dated 04/30/12 indicated Coumadin 1 mg [milligram] should be continued..."</p> <p>The most recent care plan dated 04/10/12 indicated, "[Resident #12] has potential for alteration skin integrity: occasional itching/rash bilateral lower extremities [sic] Legs on lower legs [sic] are very fragile, red and sensitive" with interventions that included, but not limited to, "perform skin assessments weekly and prn [as needed]." The plan of care lacked any specific care plan related to the potential for bleeding related to the use of Coumadin.</p> <p>In an interview with the DoN [Director of Nursing] on 05/24/12 at 11:35 a.m. she indicated, Resident #12 had received a bruise to her left hand while trying to unlock a wheelchair. She further indicated at that time, Resident #12 did not have a care plan for a bruise.</p>			

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	<p>4. Resident #8 was observed on 5/21/12 at 11:10 a.m. The resident complained of pain in her back and knees.</p> <p>On 5/24/12 at 9:00 a.m., the resident complained of "back pain, knees hurt all the time. Sometimes I get heat to my knees, sometime no one is there to give heat; my neck hurts too."</p> <p>The resident's clinical record was reviewed on 5/24/12 at 11:00 a.m. The resident's diagnoses included, but were not limited to, dementia, hypertension, history of sleep disturbance, osteoarthritis, atherosclerotic cardiovascular disease, fractured distal radius 2003, osteoporosis, ocular hypertension, and macular degeneration.</p> <p>The current physician's orders included, "moist heat joints prn [as needed] per RA [restorative aide] nursing, heating pad for 1 hour at the lowest setting only with supervision and staff to monitor." Medication for pain was "Oxycodone/APAP [acetaminophen] [narcotic pain medication] 5/500 mg [milligrams] take 2 capsules daily at 1 a.m." ordered 4/13/12. "Oxycodone/APAP 5/500 mg every 4 hours prn pain" ordered 3/15/12, and "Tylenol 325 mg 2 tablets every 4 hours as needed for pain ordered 1/19/09."</p>			

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	<p>In review of the March 2012 medication and/or treatment record, the resident had received the following: Capsaicin [topical pain medication] used 3 times to knees Lidocaine [topical pain medication] to back used 3 times, Lidocaine to knees one time, no moist heat, no heating pad used, Voltran [topical anti-inflammatory] not used for 6 days reason written "off the market"</p> <p>The April, 2012 medication and/or treatment record indicated the resident received the following: Capsaicin 0.025 % used 3 times to knees. Lidocaine to back 3 times Voltaren both knees ordered 2 times daily was used 23 days; there was no indication as to why the medication was not applied as ordered. Lidocaine to knees one time. The resident also received Oxycodone /Apap 5/500 mg 2 capsules every 4 hours as needed for pain ordered 3/15/12, twenty five times during the month of April.</p> <p>The May, 2012 medication and treatment records were as follows: Capsaicin cream not used 5/1-29/12</p>			

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	<p>Lidocaine to back not used 5/1-29/12 Voltaren used as ordered 2 times daily Lidocaine to both knees not used 5/1-29/12 Heating pad at the lowest setting for one hour only with supervision and staff monitoring was used on 5/27/12. Oxycodone was used 5 times and Tylenol 2 tablets every 4 hours as needed for pain ordered 1/19/09 was used 8 times.</p> <p>The restorative treatment record was reviewed for March, April and May 2012. The resident did not receive moist heat to painful joints in March. The resident received moist heat two times in April, and one time in May, 5/17/12.</p> <p>The resident's current care plan for pain, dated 6/30/11, indicated the following: Altered comfort d/t [due to] osteoarthritis, "[Resident's Name] will be as free of pain as possible." interventions: give --pain med as prescribed, offer heat pads and analgesic prn, apply lidocaine [topical pain medication] to knees, and back q 4 hrs prn, apply voltran gel both knees bid." The last review date of care plan was 3/13/12.</p> <p>The last quarterly Minimum Data Set [MDS] assessment was completed on 3/8/12. The pain assessment recorded the</p>			

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	<p>resident had received "prn" pain medications [as needed pain medications], had not received non medication interventions for pain, pain presence was yes, frequency was "almost constantly." The pain scale was 8/10, at that time. [10 being the worse coded pain.]</p> <p>The quarterly MDS assessment completed on 12/15/11 recorded the resident was in less pain 5/10.</p> <p>5. Resident #24 was observed on 5/22/12 at 9:26 a.m. The left hand appeared to be contracted and had a rolled wash cloth in it.</p> <p>Resident #24's clinical record was reviewed on 5/23/12 at 10:25 a.m. Diagnoses included, but were not limited to, arthritis, muscle disuse, atrophy, dysphagia, abnormality of gait, pacemaker, depression, hypothyroidism, atrial fibrillation, congestive heart failure [CHF], anemia, constipation, dementia, allergic rhinitis, mild renal insufficiency, and anxiety.</p> <p>The quarterly Minimum Data Set [MDS] assessment, dated 3/1/12, indicated the following: -Cognitive Skills for decision making severely impaired. Transfers extensive assistance of two staff, Bed mobility extensive assistance of</p>						

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	<p>two staff, unable to ambulate, Functional Limitation in Range of Motion, impairment on both sides, Personal Hygiene extensive assistance of two staff</p> <p>The resident's care plan for pain, dated 6/28/11, revised 3/2/12, indicated the use of Tylenol routinely. It also noted the hand rest splint was discontinued on 5/14/12 due to discomfort. It further Indicated an intervention of placing a rolled washcloth or palm grips in the resident's hands to prevent contraction of hands. There was no actual care plan for range of motion exercises.</p> <p>RN #1 was interviewed on 5/22/12 at 9:40 a.m. She indicated Resident #24 had a splint on the left hand, but it was painful for her so it was discontinued. She further indicated, "if they do range of motion, I don't know about it; there's no order for it."</p> <p>6. RN #1 indicated, during interview on 5/22/12 at 9:49 a.m., she was unsure whether or not Resident #16 had a contracture of one of her feet. She indicated it was shaped odd and the resident complained of pain.</p> <p>Resident #16's clinical record was reviewed on 5/23/12 at 1:55 p.m. Diagnoses included, but were not limited</p>			

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	<p>to, diabetes mellitus type II, postherpetic neuralgia, hypertension, coronary artery disease [CAD], glaucoma, gastroesophageal reflux disease [GERD], hypothyroidism, Paget disease, osteoarthritis, normocytic anemia, hyperlipidemia, chronic cholecystitis, and depressive disorder.</p> <p>Resident #16's annual Minimum Data Set [MDS] assessment, dated 4/5/12, indicated the resident had no short or long term memory problems, required extensive assistance of 1 for transfer, was unable to walk, limitation in range of motion on one side, and pain almost constantly at a severity level of 7 out of 10.</p> <p>The resident had a care plan for mobility, dated 8/2/11 and reviewed 4/10/12, for one person to assist her with ambulation every morning and evening and as needed. There was no care plan for range of motion and/or exercises.</p> <p>On 5/23/12 at 9:02 a.m., Resident #16 was observed in her room, in a wheelchair. She indicated legs hurt, especially her right leg. The resident's right leg was observed to be bending inward. During interview, she indicated they came in some afternoons and did exercises with her. Usually 2-3 times a</p>						

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	<p>week. She indicated she would not let them do her right leg due to it being uncomfortable.</p> <p>A rehab aide note, dated 4/3/12, indicated the following: "Up daily dressed with assist of 1 with ADLs [activities of daily living]. [Resident's name] is not ambulatory she pivots from w/c [wheelchair] to where she is going. Her w/c is used for all transportation.</p> <p>3.1-35(a) 3.1-35(b)(1)</p>			

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F0280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on interview, record review and observation , the facility failed to review and revise the care plans for pain, anxiety and depression, and/or ambulation status, for 2 of 25 residents sampled with care plans, in the stage 2 sample of 25, in that one resident had continuing problems with anxiety/depression and/or pain without revision of the care plan and one resident was no longer ambulatory without revision of the care plan. (Resident #43, #16)</p> <p>Findings include:</p> <p>1. Resident #43 was observed and</p>	F0280	<p>1. Corrective actions: Care plan on resident #43's pain and anxiety/depression was reviewed and updated, including non-pharmacological interventions as well as addressing treatment of other types of pain. Resident #16's care plan has been revised to reflect non-ambulation and exercise program, and all residents with contractures and limited movement had their care plans updated as needed. 2. <u>How other residents with potential to be affected will be identified and corrective actions to be taken:</u> Inservice for all nurses and QMAs was held 6/14/12 regarding identification of</p>	06/18/2012			

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	<p>interviewed on 5/23/12 at 9:50 a.m. The resident was having pain of her back at that time. She was observed to be lying in bed and indicated she had taken Tylenol for back pain. "I think I twisted it or something, I just cannot go. This is not the same pain I normally have in my back."</p> <p>The clinical record was reviewed at 10:30 a.m. on 5/23/12. The resident's diagnoses included, but were not limited to, anxiety, diabetes II, hypertension, hyperlipidemia, GERD [gastroesophageal reflux disease], metastatic breast cancer w/ bone pain, atrial fibrillation, renal failure, and depression.</p> <p>The physician's progress note indicated on 5/3/12, when the Oxycontin [narcotic pain medication] was increased, "It is difficult to tell if her pain is osteoarthritis or mets bone, will increase oxycontin to 30 mg [milligrams] bid [twice a day]." Another note, dated 3/15/12 indicated, "Trial of Cymbalta both for depression and for neuropathic pain." The note did not identify the length of time the trial would take place.</p> <p>The physician's orders included but were not limited to,</p> <p>Cymbalta [antianxiety/antidepressant</p>		<p>residents needing preventive measures for anxiety/depression and also interventions for pain management and exercise/mobility. MDS Coordinator was inserviced on 6/14/12 regarding care plan interventions for residents experiencing anxiety and depression including preventing occurrences, identifying increased anxiety, and providing interventions; also on pain and limited mobility. 3. <u>Measures or systemic changes to prevent recurrence:</u> MDS Coordinator will review with charge nurse/QMA residents' anxiety/depression, pain, and changes in mobility weekly and update care plan as needed. For all residents who trigger for anxiety, depression, or pain, plan of care will be reviewed, revised as necessary, and updated- -including non-pharmacological interventions. MDS Coordinator will review with rehab aide ambulation/functional status of residents receiving rehab services and update care plan on a weekly basis. 4. <u>How corrective actions will be monitored/QA to be implemented:</u> DON will review care plans for depression/anxiety and pain and also pain assessments quarterly. DON will review care plans for mobility quarterly as care plans are due. DON will bring the results of this monitoring to the quarterly QA</p>				

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	<p>medication] 60 mg q d ordered 3/15/12 Oxycontin 30 mg bid increased to 30 mg on 5/3/12. Klonopin [antianxiety medication] 0.5mg q [every] 6 hrs [hours] prn [as needed] anxiety ordered 8/1/11 Tylenol 325 mg 2 tabs q 6 hrs pain ordered 8/19/10</p> <p>The last care conference was held on 4/10/12. care plan for Pain- Altered comfort Mets breast bone pain-comfortable as possible and pain free, -Give Tamoxifen [anti-cancer agent], give Oxycontin q 12 hrs, give Tylenol 500 mg 2 q 6 hrs. The care plan did not include any type of non medication type intervention. It did not address the treatment of other pain, other than the breast bone.</p> <p>Diagnosis of anxiety disorder- Anxiety will be controlled through implementation of prescribed interventions AEB [as evidenced by] no signs of anxiety, agitation, wringing hands, crying, nervousness- monthly assessment of meds, by RPH [Registered Pharmacist], monitor s/s [signs/symptoms] of anxiety, monitor for episodes of increased anxiety enc to report monitor pulse ox weekly.</p>		committee meeting for one year (through June of 2013).				

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	<p>Diagnosis of depression and admits to being depressed- will continue to maintain her regular routine, going to the dr [doctor], for meals and going out with family-provide with opportunity to verbalize her concerns, feelings and fears. Administer Cymbalta, dly. [daily] observe for s/s of depression, isolation in room, refusal of food, crying, irritability.</p> <p>The care plans for anxiety and depression did not include interventions to prevent the occurrences, only to identify once the anxiety or depression was occurring.</p> <p>On 5/23/12 at 1:30 p.m., QMA [Qualified Medication Aide] #1 indicated the resident took Klonopin prn [as needed] almost every day usually two times per day, for anxiety. "She never explains her anxiety, I think it is associated with pain. She requests the drug, ends up taking most days 3 times a day that includes the bedtime dose. She took two Tylenol this morning for pain."</p> <p>2. RN #1 indicated, during interview on 5/22/12 at 9:49 a.m., she was unsure whether or not Resident #16 had a contracture of one of her feet. She indicated it was shaped odd and the resident complained of pain.</p> <p>Resident #16's clinical record was</p>						

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	<p>reviewed on 5/23/12 at 1:55 p.m.</p> <p>Diagnoses included, but were not limited to, diabetes mellitus type II, postherpetic neuralgia, hypertension, coronary artery disease [CAD], glaucoma, gastroesophageal reflux disease [GERD], hypothyroidism, Paget disease, osteoarthritis, normocytic anemia, hyperlipidemia, chronic cholecystitis, and depressive disorder.</p> <p>Resident #16's annual Minimum Data Set [MDS] assessment, dated 4/5/12, indicated the resident had no short or long term memory problems, required extensive assistance of 1 for transfer, was unable to walk, limitation in range of motion on one side, and pain almost constantly at a severity level of 7 out of 10.</p> <p>The resident had a care plan for mobility, dated 8/2/11 and reviewed 4/10/12, for one person to assist her with ambulation every morning and evening and as needed.</p> <p>A physical therapy reassessment/plan of progress, dated 2/10/12, indicated the resident was being discharged from therapy. The record indicated the resident required minimal assistance of one person for stand pivot transfers and did not bear weight on her right lower extremity.</p>			

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	<p>A rehab aide note, dated 4/3/12, indicated the following: "Up daily dressed with assist of 1 with ADLs [activities of daily living]. [Resident's name] is not ambulatory she pivots from w/c [wheelchair] to where she is going. Her w/c is used for all transportation. [Resident's name] has an order for moist heat P.R.N. She also has a follow up order from P.T. for exercises for lower extremity."</p> <p>The care plan had not been revised for care and interventions related to the resident's non-ambulatory status.</p> <p>3.1-35(d)(2)(B)</p>			
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F0282 SS=E	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview and record review, the facility failed to ensure care was provided by qualified persons in accordance with each resident's plan of care, for 6 of 25 residents reviewed for following care plans, in the stage 2 sample of 25, in that pain treatment was not effective and approaches were not changed to attempt to control the pain, range of motion was not provided, non-pharmacological interventions were not attempted before antianxiety medication use, and a medication aide gave as needed medication without consulting a licensed nurse. (Residents #43, #9, #24, #16, #18, #46)</p> <p>Findings include:</p> <p>1. Resident #43 was observed and interviewed on 5/23/12, at 9:50 a.m. The resident was having pain of her back at that time. She was observed to be lying in bed, indicated she had taken Tylenol for back pain. "I think I twisted it or something, I just cannot go. This is not the same pain I normally have in my back."</p>	F0282	<p>1. Corrective actions: Care plans were reviewed and revised for pain management on residents #9 and #43 and for ROM and mobility status on resident #24. A physical therapy evaluation has been ordered for residents #24 and #16 for more detailed exercise orders. IAn inservice was held 6/15/12 reviewing resident #16's home exercise program and documentation. An inservice was held 6/14/12 for nurses and QMAs regarding use of non-pharmacological interventions prior to the administration of medications for anxiety and documentation of interventions. Resident #18's care plan for depression has been updated to reflect use of non-pharmacological interventions prior to administration of medication for anxiety. On 5/25/12 QMA was reminded of needing to contact a nurse prior to administering any PRN medication, and document approval. An inservice was held 6/14/12 for nursing staff regarding QMA guidelines for giving PRN medications. 2. <u>How other residents with potential to be affected will be identified and</u></p>	06/18/2012			

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	<p>On 5/24/12 at 10:00 a.m., the resident indicated she felt a little better today that she was in bed all day the day before with the pain. She had only taken Tylenol when she could. "It hurt really bad, I just could not do anything." She indicated she did not attend activities on 5/23/12, that most of her day was spent in bed.</p> <p>On 5/23/12 at 1:30 p.m., QMA [Qualified Medication Aide] #1 indicated the resident took Klonopin [medication for anxiety] prn [as needed] almost every day usually two times per day, for anxiety. "She never explains her anxiety, I think it is associated with pain. She requests the drug, ends up taking most days 3 times a day and that includes the bedtime dose. She took two Tylenol this morning for pain." The QMA indicated she questioned the resident regarding the pain scale [1-10]. She indicated she reported the number to the nurse, but that it was not charted at the time.</p> <p>The QMA indicated the resident's pain intensity was 8 on a scale of 1 to 10 at the time of the Tylenol. Response or results of the medication was recorded as "helpful or effective."</p> <p>The clinical record was reviewed on 5/23/12 at 10:30 a.m. The resident' s</p>		<p><u>corrective actions to be taken:</u> Pain assessment will be reviewed on all residents triggered for pain on their MDS and care plans will be updated. Residents' physicians will be updated on residents' pain control as needed and care plan updated with change of pain medications. Pain assessments will be completed quarterly and PRN. New nursing staff will be oriented on ROM and a bi-annual inservice will be held on this topic for all nursing employees. CNAs were inserviced on ROM 6/15/12. The care plans of all residents with orders for PRN antianxiety drugs have been reviewed and updated to reflect non-pharmacological interventions that can be utilized prior to administration of medication for anxiety. Nurses and QMAs were inserviced on 6/14/12 regarding QMA guidelines for giving PRN medications. <u>3. Measures or systemic changes to prevent recurrence:</u> MDS Coordinator will review with charge nurse/QMA residents' pain management monthly and as needed, and update care plans. Home exercise program will be added to CNA ROM documentation record on nursing unit for easier accessibility. New documentation will be used to assist with monitoring of psychotherapeutic medication. ROM records will be reviewed weekly for compliance. Inservices</p>				

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	<p>diagnoses included, but were not limited to, anxiety, diabetes II, hypertension, hyperlipidemia, gastroesophageal reflux disease [GERD], metastatic breast cancer w/ bone pain, atrial fibrillation, renal failure, and depression.</p> <p>The physician's progress note on 5/3/12, when the Oxycontin [narcotic pain medication] was increased indicated, "It is difficult to tell if her pain is osteoarthritis or Mets [metastatic disease of] bone, will increase oxycontin to 30 mg [milligrams] bid [twice a day]." Another note dated 3/15/12 indicated, "Trial of Cymbalta both for depression and for neuropathic pain." [The note did not identify the length of time the trial would take place]</p> <p>The physician's orders included, but were not limited to, the following:</p> <p>Cymbalta 60 mg q d [daily] ordered 3/15/12 Oxycontin 30 mg bid increased to 30 mg on 5/3/12. Klonopin 0.5mg q 6 hrs prn anxiety ordered 8/1/11 Tylenol 325 mg 2 tabs q 6 hrs pain ordered 8/19/10</p> <p>The May, 2012 medication administration record listed the Tylenol given on 5/23/12 at 9:10 a.m., the results or response to the</p>		<p>will be held bi-annually reviewing QMA guidelines. 4. <u>How corrective actions will be monitored/QA to be implemented:</u> DON or her designee will monitor pain assessments, pain care plans, and ROM documentation weekly for compliance. The SSD, DON, and ADON will review the dose and usage of residents' PRN anti-anxiety medication monthly. Random Medication Administration Records and nurses' notes will be reviewed weekly for nurses' authorization for as-needed medications administered by QMAs. Results of all monitoring will be brought to the QA committee meeting by DON and ADON every quarter for one year (through June 2013).</p>				

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	<p>drug was recorded as "helpful." The resident was administered a Klonopin 0.5 mg for increased anxiety at 1:00 p.m. At 2:00 p.m. the response was recorded as "helpful."</p> <p>The nurse's note dated 5/26/12 at 7-3 p.m., indicated, "pt [[patient] requested a sick tray for breakfast due to severe back pain. 9 a.m. pt. requested and given Tylenol 500 mg 2 tabs for continued back pain..."</p> <p>A nurse's note on 5/28/12 9:20 p.m., indicated, "requested Tylenol 2 for complaints of Left side of body hurting 'states pain in various spots-don't know why. States left ankle feels sprained.' " "10:00 p.m. No further complaints."</p> <p>The quarterly assessment on 4/5/12 recorded the pain as almost constant, limited the day to day activity because of pain, and was rated at an intensity of 8 of 10 pain.</p> <p>The last care conference was held on 4/10/12. The care plan for Pain- Altered comfort Mets breast bone pain-comfortable as possible and pain free,-Give Tamoxifen [anti-cancer medication], give Oxycontin q 12 hrs, give Tylenol 500mg 2 q 6 hrs prn pain.</p>			

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	<p>2. An observation was made on 5/22 /12 at 03:00 p.m. of ADL [Activity of Daily Living] care being provided to Resident #9 by Certified Nursing Assistant [CNA] #3. CNA #3 was assisting the resident with peri care and off of the toilet. CNA #3 washed hands and gloved. CNA #3 then applied hot water and soap to clean peri area. The resident complained of pain when the CNA performed peri care.</p> <p>An observation on 5/24/12 at 1:25 p.m. was made of Resident #9 in her room waiting on CNA #2 to assist to bathroom. Resident # 9 was grimacing when CNA #2 assisted Resident #9 from recliner to wheelchair.</p> <p>In an interview with Resident #9 on 5/21/12 at 3:08 p.m., Resident #9 stated "My arms hurt all the time because of arthritis."</p> <p>Record Review on 5/23 at 10:30 a.m. indicated Resident #9 had a care plan dated 8/9/2011 and revised 4/18/2012 for potential for alteration in comfort due to diagnoses of osteoarthritis and chronic pain with interventions of encourage to report discomfort, give allopurinol [a gout medication] 200 milligrams [mg], apply voltaren gel [anti-inflammatory topical</p>			

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	<p>medication] topically to affected areas as needed, apply pennsaid</p> <p>[anti-inflammatory medication] drops to right shoulder and massage three times a day, Oxycontin [a narcotic pain medication] 20 mg by mouth every 12 hours and Oxycodone [a narcotic pain medication] 5/325 mg as need for pain, and encourage ambulation 1-2 times a day to exercise joints and possibly decrease pain.</p> <p>The medical record indicated Resident #9 had diagnoses of osteoarthritis [degenerative joint disease] and gout [swollen painful joints].</p> <p>A pain assessment dated 4/12/12 indicated Resident #9 had diagnoses of arthritis and gout. The assessment also indicated Resident #9 verbalized her pain as aching and throbbing with the pain being the worst at night with a frequent level of 8-10 on a 1-10 scale with 1 being the least and 10 being the worst.</p> <p>The Minimum Data Set [MDS] assessment, dated 10/27/11, indicated Resident #9 had a diagnosis of osteoarthritis. The MDS quarterly assessment dated 4/12/12 indicated Resident #9 had no non-medication interventions for pain, was in pain frequently with a pain level of 8, and was</p>						

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	<p>on scheduled pain medications.</p> <p>Resident #9 had a doctor's order dated 5/22/12 for MS contin [extended release narcotic pain medication] 15 mg 1 tablet by mouth 2 times a day.</p> <p>Resident #9 had a doctor's order dated 11/17/10 for percocet 5/325 mg take 1 tablet by mouth every 4 hours as needed for pain.</p> <p>Resident #9 had a doctor's order dated 5/11/12 to discontinue oxycontin 20 mg 1 tablet by mouth twice a day and add morphine ER [a narcotic pain medication] 30 mg 1 tablet by mouth twice a day.</p> <p>The Medication Administration Record indicated Resident #9 received the following pain medications as needed for pain in addition to scheduled pain medication:</p> <p>5/1/12 at 1:00 (no a.m. or p.m. noted) percocet 5/325 mg for assessed "back pain" with a follow up assessment charted as "helpful"</p> <p>5/8/12 at 1:55 a.m. percocet 5/325 mg assessed as complaint of "back pain" with a follow up assessment at 2:50 a.m. of "helpful"</p> <p>5/8/12 2:00 p.m. percocet (no dosage documented) assessed as complaint of "back pain" with a follow up assessment at 4:00 p.m. of "helpful"</p>			

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	<p>5/11/12 no time documented percocet 5/325mg assessed "as given in place of oxycontin" follow up assessment "helpful"</p> <p>5/17/12 at 09:30 (a.m. or p.m. not charted) percocet 5/325 mg assessed at an 8-10 level with a follow up assessment of "did not help"</p> <p>5/18/12 10:30 (no a.m. or p.m. documented) Percocet 5/325 mg assessed at an 8-10 on a 1-10 scale with a follow up assessment of "no further complaint"</p> <p>5/19/12 at 7:00 a.m. percocet 5/325 mg assessed as "break through pain" and a follow up assessment of "effective"</p> <p>5/22/12 at 9:00 p.m. percocet 5/325 mg assessed as "all over aches" with a follow up of assessment of "helpful"</p> <p>5/24/12 at 5:00 p.m. percocet 5/325mg assessed as " MS Contin 15 mg unavailable and no follow up assessment documented.</p> <p>In an interview with LPN #1 at 5/24/12 at 10:20 a.m., LPN #1 indicated she worked nights most times and takes care of Resident #9. LPN #1 indicated Resident #9 has pain all the time and Resident #9 usually rates her pain at a level of 8-10 on a 1-10 scale. LPN #1 indicated Resident #9 usually takes as needed pain medication 1 time on night shift and 1 time on day shift.</p>						

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	<p>In an interview on 5/24/12 at 1:30 p.m. CNA #2 indicated Resident #9 was "always in pain".</p> <p>3. Resident #24 was observed on 5/22/12 at 9:26 a.m. The left hand appeared to be contracted and had a rolled wash cloth in it.</p> <p>Resident #24's clinical record was reviewed on 5/23/12 at 10:25 a.m. Diagnoses included, but were not limited to, arthritis, muscle disuse, atrophy, dysphagia, abnormality of gait, pacemaker, depression, hypothyroidism, atrial fibrillation, congestive heart failure [CHF], anemia, constipation, dementia, allergic rhinitis, mild renal insufficiency, and anxiety.</p> <p>The quarterly Minimum Data Set [MDS] assessment, dated 3/1/12, indicated the following: -Cognitive Skills for decision making severely impaired. Transfers extensive assistance of two staff, Bed mobility extensive assistance of two staff, unable to ambulate, Functional Limitation in Range of Motion, impairment on both sides, Personal Hygiene extensive assistance of two staff.</p> <p>The resident's care plan for pain, dated</p>			

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	<p>6/28/11, revised 3/2/12, indicated the use of Tylenol routinely. It also noted the hand rest splint was discontinued on 5/14/12 due to discomfort. It further Indicated an intervention of placing a rolled washcloth or palm grips in the resident's hands to prevent contraction of hands. There was no care plan for range of motion exercises. Other than the evaluation by Occupational Therapy for the use of the resting hand splint, the record lacked any evaluation by Physical Therapy regarding the limited range of motion and recommendations.</p> <p>A care plan initiated on 6/28/11 and revised 3/2/12, indicated, "Ambulates with rolling walker/locomotion via wheelchair. Interventions indicated the resident required assist of one staff for long distance locomotion in wheelchair.</p> <p>RN #1 was interviewed on 5/22/12 at 9:40 a.m. She indicated Resident #24 had a splint on the left hand, but it was painful for her so it was discontinued. She further indicated, "if they do range of motion, I don't know about it; there's no order for it."</p> <p>CNAs #1 and #2 were interviewed on 5/23/12 at 11:19 a.m. They indicated their assignment sheets were at the nurse's station. The assignment sheets were</p>				

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	<p>reviewed at that time and consisted of lists of names, with blank areas labeled "B & B [bowel and bladder], R.O.M. [range of motion], AMB [ambulation], VS [vital signs], WT [weight], PT [physical therapy], I & O [intake and output], BATH, and ORAL CARE." The CNAs had notes regarding one shower done for a resident on the list, and 3 different residents' bowel movements. There was no indication of which residents received range of motion and/or ambulation.</p> <p>CNAs #1 and #2 were interviewed again on 5/23/12 at 2:05 p.m. They indicated they had a rehab aide 4-5 days a week. The rehab aide would do range of motion. CNA #2 indicated she was the rehab aide on 5/22/12. She indicated she would do gentle range of motion to Resident #24's hands, and some movements with arms. She indicated the resident "was pretty good with moving her legs, so they didn't have to do as much." She indicated CNAs would do some range of motion with her bath and getting her up, such as washing her hands, putting lotion on, moving her around some. She indicated documentation would be in the rehab book in the therapy room.</p> <p>On 5/23/12 at 2:15 p.m., the rehab book was reviewed. The Treatment Records</p>			

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	<p>for 4/1 through 4/30/12 and 5/1 through 5/31/12 were reviewed. The routine orders indicated Gentle ROM exercises to arms, legs and neck as tolerated. The ROM exercises were initialed as done on 5/2/12, 5/11/12, and 5/21/12. None were documented in April, 2012.</p> <p>4. RN #1 indicated, during interview on 5/22/12 at 9:49 a.m., she was unsure whether or not Resident #16 had a contracture of one of her feet. She indicated it was shaped odd and the resident complained of pain.</p> <p>Resident #16's clinical record was reviewed on 5/23/12 at 1:55 p.m. Diagnoses included, but were not limited to, diabetes mellitus type II, postherpetic neuralgia, hypertension, coronary artery disease [CAD], glaucoma, gastroesophageal reflux disease [GERD], hypothyroidism, Paget disease, osteoarthritis, normocytic anemia, hyperlipidemia, chronic cholecystitis, and depressive disorder.</p> <p>Resident #16's annual Minimum Data Set [MDS] assessment, dated 4/5/12, indicated the resident had no short or long term memory problems, required extensive assistance of 1 for transfer, was unable to walk, had limitation in range of motion on one side, and pain almost</p>			

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	<p>constantly at a severity level of 7 out of 10.</p> <p>The resident had a care plan for mobility, dated 8/2/11 and reviewed 4/10/12, for one person to assist her with ambulation every morning and evening and as needed. There was no care plan for range of motion and/or exercises.</p> <p>On 5/23/12 at 9:02 a.m., Resident #16 was observed in her room, in a wheelchair. She indicated legs hurt, especially her right leg. The resident's right leg was observed to be bending inward. During interview, she indicated they came in some afternoons and did exercises with her. Usually 2-3 times a week. She indicated she would not let them do her right leg due to it being uncomfortable.</p> <p>The rehab book was reviewed on 5/23/12 at 2:15 p.m. Resident #16 had a Treatment Record in the book with the following routine orders: "May have warm moist heat to painful joints PRN [as needed]," and "Special lower extremity exercises as indicated on rehab instruction sheets." The lower extremity exercises were documented as done on 5/2/12 and 5/21/12 only.</p> <p>A physical therapy reassessment/plan of</p>						

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	<p>progress, dated 2/10/12, indicated the resident was being discharged from therapy. "Pt. [patient] maintaining current functional abilities [with] transfers. She will benefit from continued HEP [home exercise program] daily [with] verbal cues. Instructed CNA to follow through [with] this." As per review of the rehab documentation and interviews, the exercises had not been completed daily as recommended.</p> <p>A rehab aide note, dated 4/3/12, indicated the following: "Up daily dressed with assist of 1 with ADLs [activities of daily living]. [Resident's name] is not ambulatory she pivots from w/c [wheelchair] to where she is going. Her w/c is used for all transportation. [Resident's name] has an order for moist heat P.R.N. She also has a follow up order from P.T. for exercises for lower extremity."</p> <p>5. The clinical record of Resident #18 was reviewed 05/24/12 at 9:07 a.m. The record indicated Resident #18 was admitted 06/29/11 with diagnoses that included, but were not limited to, anxiety.</p> <p>Resident #18 was observed on 05/21/12 at 9:00 a.m. to be sitting in her personal recliner watching television, no signs or</p>			

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	<p>symptoms of anxiety were observed. In an interview at that time, Resident #18 indicated, she was having a wonderful morning.</p> <p>Resident #18 was observed on 05/24/12 at 10:00 a.m. to be sitting in her personal recliner with her laptop computer on her lap, no signs or symptoms of anxiety were noted. During an interview at that time, she indicated, "sometimes I just get nervous... I feel so much better than when I first found out the Sisters were leaving."</p> <p>The most recent quarterly MDS [Minimum Data Set Assessment] dated 03/15/12 indicated Resident #18 had mild to no cognitive impairment, required extensive assistance of one person for dressing, had an active diagnosis of anxiety, and "experienced feeling down, depressed, or hopeless, feeling tired or having little energy, and trouble concentrating on things..."</p> <p>The most recent April 2012 Physician order recapitulation indicated orders for , "...Xanax 0.5 mg tab, take (1) (one) tablet by mouth (3) (three) times daily as needed for anxiety.."</p> <p>The May 2012 MAR [Medication Administration Record] for Resident #18 was reviewed on 05/23/12 and indicated</p>						

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	<p>the resident received Xanax 26 times between 05/01/12 and 05/23/12 for anxiety. The record lacked any documentation of non-pharmacological interventions prior to the administration of the medication for anxiety.</p> <p>The most recent care plan dated 05/11/12 indicated a problem of , "[Resident #18] has a dx [diagnosis] of depression. At risk for change in mood and/or cognitive status. [Resident #18] receives...an antianxiety medication PRN [as needed]... with interventions of: "*observe [Resident #18] for increased confusion, withdrawal from daily routine, increased self-isolation, tearfulness, paranoia, increased drowsiness, hallucination, dizziness, irritability *Have Pharmacy check medications and possible interactions at least quarterly *[Resident #18] attends mass regularly and often visits the chapel on her own for quiet reflection/spiritual uplifting"</p> <p>The clinical record lacked any documentation that non-pharmacological interventions were attempted before Xanax was administered.</p> <p>In an interview on 05/24/12 at 10:25 a.m. with QMA #1 she indicated, "She is very nervous about the sisters leaving and a new owner coming in"</p>			

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	<p>In an interview on 05/24/12 at 11:25 a.m. with the SSD [Social Service Designee] she stated, "I do not monitor psych and anti-anxiety medications for use and interventions...I do not have a care plan that specifically addresses behaviors and interventions...there is no assessment"</p> <p>In an interview with the DoN [Director of Nursing] on 05/24/12 at 11:30 a.m. she indicated, "the pharmacist reviews the use of all medications monthly and tells us what to do...nobody else monitors it...we do not use non-Pharm interventions, we just give her Xanax, that's what works."</p> <p>The policy and procedure for Psychoactive Drugs provided by the DoN [Director of Nursing] on 05/25/12 at 8:55 a.m. indicated, "Procedure: 1. a. Psychoactive drugs are initiated only after other methods of behavior modifications have been utilized without success..."</p> <p>6. During a random observation on 05/23/12 at 11:33 a.m. Resident #46 was observed walking in the hallway of Unit #2. At that time, QMA #1 was observed to be walking through a common area lounge and the SSD was observed to approach QMA #1. During an interview at that time, the SSD gave the following</p>						

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	<p>instructions to QMA #1, "[Resident #46] is short of breath, give her a puffer." QMA #1 was then observed to the Unit #2 medication room and return with a handheld inhaler and administer 2 [two] puffs from the inhaler. QMA #1 was not observed to contact the nurse before administering the medication.</p> <p>The clinical record of Resident #46 was reviewed on 05/24/12 at 9:40 a.m. The most recent May 2012 Physician recapitulation indicated an order for "Proventil [a respiratory medication] inhaler inhale 2 [two] puffs 4 [four] times daily as needed for shortness of breath"</p> <p>In an interview with QMA #1 on 05/24/12 at 9:35 a.m. she indicated she had administered Proventil prn yesterday afternoon to Resident #46 and it was effective with relief noted.</p> <p>During an interview with the ADoN [Assistant Director of Nursing] on 05/24/12 at 8:40 a.m. she indicated a QMA must get permission from a nurse before administering an as needed medication.</p> <p>The Policy and Procedure for Administering of PRN medication by Qualified Medication Aides provided by the DoN [Director of Nursing] on</p>			

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	05/25/12 indicated, "Authorization must be received from licensed nurses before prn medications can be Administered [sic] by a qualified medication aide." 3.1-35(g)(2)			

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F0309 SS=G	<p>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.</p> <p>Based on observation, interview and record review, the facility failed to provide pain management to 4 of 4 residents sampled for pain recognition and management, in a sample 4 residents who met the criteria for pain recognition and management, in that the residents complained of pain which affected their daily activities, available interventions for pain were not consistently implemented, and interventions were not updated/revised in an attempt to address the pain. (Residents #8, #43, #16, #9)</p> <p>Findings include:</p> <p>1. Resident #43 was observed and interviewed on 5/23/12, at 9:50 a.m. The resident was having pain of her back at that time. She was observed to be lying in bed, indicated she had taken Tylenol for back pain. "I think I twisted it or something; I just cannot go. This is not the same pain I normally have in my back."</p>	F0309	<p>1. Corrective actions: A new pain assessment has been completed on residents #8, 9, 16, and 43, and care plan interventions have been updated as needed and are being implemented. CNAs were inserviced on 6/15/12 regarding gentleness in peri-care and for providing exercise program per: PT recommendations. 2. <u>How other residents with potential to be affected will be identified and corrective actions to be taken:</u> Pain assessments have been reviewed for all residents triggered for pain. The physician will be updated with reports of unrelieved pain. An inservice was held 6/14/12 for nurses/QMAs regarding pain assessment and interventions. 3. <u>Measures or systemic changes to prevent recurrence:</u> ADON and DON will confer with charge nurse/QMA regarding any residents who are noted at shift report to have complained of unrelieved pain. Residents' pain will be documented using 1-10 scale. Response or results from PRN pain medication will be specific.</p>	06/18/2012			

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	<p>On 5/24/12 at 10:00 a.m., the resident indicated she felt a little better today, that she was in bed all day the day before with the pain. She had only taken Tylenol when she could. "It hurt really bad, I just could not do anything." She indicated she did not attend activities on 5/23/12, that most of her day was spent in bed.</p> <p>On 5/23/12 at 1:30 p.m., QMA [Qualified Medication Aide] #1 indicated the resident took Klonopin [antianxiety medication] prn [as needed] almost every day, usually two times per day, for anxiety. "She never explains her anxiety, I think it is associated with pain. She requests the drug, ends up taking most days 3 times a day; that includes the bedtime dose. She took two Tylenol this morning for pain." The QMA indicated she questioned the resident regarding the pain scale [1-10]. She indicated she reported the number to the nurse, but that it was not charted at the time. The QMA indicated the resident's pain was 8 at the time of the Tylenol. Response or results of the medication were recorded as "helpful or effective."</p> <p>The clinical record was reviewed on 5/23/12 at 10:30 a.m. The resident's diagnoses included, but were not limited to, anxiety, diabetes II, hypertension, hyperlipidemia, gastroesophageal reflux</p>		<p>DON will review quarterly pain assessments and follow up with physician as needed. 4. <u>How corrective actions will be monitored/QA to be implemented:</u> DON will monitor each resident's pain assessment and pain care plan quarterly per: care plan schedule, and will bring results of this monitoring to the QA committee each quarter for one year (through June of 2013).</p>				

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	<p>disease [GERD], metastatic breast cancer w/ bone pain, atrial fibrillation, renal failure, and depression.</p> <p>The physician's progress note on 5/3/12, when the Oxycontin was increased, indicated, "It is difficult to tell if her pain is osteoarthritis or Mets [metastasis] bone, will increase oxycontin to 30 mg [milligrams] bid [twice a day]."</p> <p>Another note, dated 3/15/12, indicated, "Trial of Cymbalta both for depression and for neuropathic pain." [The note did not identify the length of time the trail would take place.]</p> <p>The physician's orders included but were not limited to,</p> <p>Cymbalta 60 mg q d [daily] ordered 3/15/12 Oxycontin 30 mg bid increased to 30 mg on 5/3/12. Klonopin 0.5 mg q [every] 6 hrs [hours] prn [as needed] anxiety ordered 8/1/11 Tylenol 325 mg 2 tabs q 6 hrs pain ordered 8/19/10</p> <p>The May medication administration record listed the Tylenol given on 5/23/12 at 9:10 a.m.; the results or response to the drug was recorded as "helpful." The resident was administered a Klonopin 0.5</p>				

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	<p>mg for increased anxiety at 1:00 p.m. At 2:00 p.m. the response was recorded as "helpful."</p> <p>The nurse's note dated 5/26/12 at 7-3 p.m. indicated, "pt [[patient] requested a sick tray for breakfast due to severe back pain. 9 a.m. pt. requested and given Tylenol 500 mg 2 tabs for continued back pain..."</p> <p>A nurse's note on 5/28/12 9:20 p.m. indicated, "requested Tylenol 2 for complaints of Left side of body hurting 'states pain in various spots-don't know why. States left ankle feels sprained.'" "10:00 p.m. No further complaints."</p> <p>The quarterly assessment on 4/5/12 recorded the pain as almost constant, limited the day to day activity because of pain and the intensity was recorded as 8 on a scale of 1 to 10.</p> <p>The last care conference was held on 4/10/12, when the care plans were reviewed. The care plan for Pain at that time included the following: Altered comfort Mets breast bone pain-comfortable as possible and pain free,-Give Tamoxifen [anti-cancer agent], give Oxycontin q 12 hrs, give Tylenol 500mg 2 q 6 hrs prn pain.</p> <p>2. Resident #8 was observed on 5/ 21/12</p>						

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	<p>at 11:10 a.m. The resident complained of pain in her back, and pain of knees.</p> <p>On 5/24/12 at 9:00 a.m., the resident complained of "back pain, knees hurt all the time. Sometimes I get heat to my knees, sometime no one is there to give heat, my neck hurts too."</p> <p>The resident's clinical record was reviewed on 5/24/12 at 11:00 a.m. The resident's diagnoses included, but were not limited to, dementia, hypertension, history of sleep disturbance, osteoarthritis, atherosclerotic cardiovascular disease, fractured distal radius 2003, osteoporosis, ocular hypertension, and macular degeneration.</p> <p>The current physician's orders included, "moist heat joints prn [as needed] per RA [restorative aide] nursing, heating pad for 1 hour at the lowest setting only w/ supervision and staff to monitor." Medication for pain was "Oxycodone/Apap [narcotic pain medication] 5/500 mg [milligrams] take 2 capsules daily at 1 a.m. ordered 4/13/12. Oxycodone/APAP 5/500mg every 4 hours prn pain ordered 3/15/12, and Tylenol 325 mg 2 tablets every 4 hours as needed for pain ordered 1/19/09."</p> <p>In review of the March 2012 medication</p>			

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	<p>and/or treatment record, the resident had received the following: Capsaicin [topical pain cream] used 3 times on the knees Lidocaine [topical pain medication] to back used 3 times, Lidocaine to knees one time, no moist heat, no heating pad used, Voltran [topical anti inflammatory medication] not used for 6 days, reason written "off the market"</p> <p>The April 2012 medication and/or treatment record indicated the resident received the following: Capsaicin 0.025 % used 3 times to knees. Lidocaine to back 3 times Voltaren both knees ordered 2 times daily was used 23 days. There was no indication as to why the medication was not applied as ordered. Lidocaine to knees one time. The resident also received Oxycodone /Apap 5/500 mg 2 capsules every 4 hours prn pain ordered 3/15/12, 25 times during the month of April.</p> <p>The May 2012 medication and treatment records were as follows: Capsaicin cream not used 5/1-29/12 Lidocaine to back not used 5/1-29/12 Voltaren used as ordered 2 times daily Lidocaine to both knees not used</p>			

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	<p>5/1-29/12</p> <p>Heating pad at the lowest setting for one hour only with supervision and staff monitor was used on 5/27/12.</p> <p>Oxycodone was used 5 times and Tylenol 2 tablets every 4 hours prn for pain ordered 1/19/09 was used 8 times.</p> <p>The restorative treatment record was reviewed for March, April and May 2012. The resident did not receive moist heat to painful joints in March, received two times in April, and one time in May 5/17/12.</p> <p>The quarterly Minimum Data Set [MDS] assessment dated 3/8/12, recorded the resident did not receive non medication interventions for pain, the pain frequency was almost constantly and the pain intensity was 8 on a scale of 1-10.</p> <p>The resident's current care plan for pain, dated 6/30/11, was as follows:</p> <p>Altered comfort d/t [due to] osteoarthritis, " [Resident's Name] will be as free of pain as possible." interventions give --pain med as prescribed, offer heat pads and analgesic prn, apply lidocaine to knees, and back q 4 hrs prn, apply voltran gel both knees bid."</p> <p>The last review date of care plan was</p>			

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	<p>3/13/12.</p> <p>The last quarterly MDS assessment was completed on 3/8/12. The pain assessment recorded the resident had received "prn" pain medications [as needed pain medications], had NOT received non medication interventions for pain, pain presence was yes, frequency was "almost constantly." The pain scale was 8/10 at that time. [10 being the worse coded pain.] The quarterly MDS assessment, completed on 12/15/11, recorded the resident was in less pain 5/10.</p> <p>On 5/24/12 at 10:00 a.m., the Assistant Director of Nursing [ADON] was interviewed. She indicated the restorative person assigned to providing moist heat was not available daily; other staff members could provide that service when the resident needed a treatment.</p> <p>3. RN #1 indicated, during interview on 5/22/12 at 9:49 a.m., she was unsure whether or not Resident #16 had a contracture of one of her feet. She indicated it was shaped odd and the resident complained of pain.</p> <p>Resident #16's clinical record was reviewed on 5/23/12 at 1:55 p.m.</p>			

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	<p>Diagnoses included, but were not limited to, diabetes mellitus type II, postherpetic neuralgia, hypertension, coronary artery disease [CAD], glaucoma, gastroesophageal reflux disease [GERD], hypothyroidism, Paget disease, osteoarthritis, normocytic anemia, hyperlipidemia, chronic cholecystitis, and depressive disorder.</p> <p>Resident #16's annual Minimum Data Set [MDS] assessment, dated 4/5/12, indicated the resident had no short or long term memory problems, required extensive assistance of 1 for transfer, was unable to walk, had limitation in range of motion on one side, and pain almost constantly at a severity level of 7 out of 10.</p> <p>The resident's record included a pain assessment, dated 4/5/12, indicating, "Just pain." "Padgets disease causing (R) leg to be crooked." The intensity of the pain was documented as a 7 out of 10, with 10 being unbearable. Regarding relief of pain, the pain assessment indicated the pain was relieved by heat, the resident was not on any routine pain medication and the resident did not receive as needed medication. The record indicated, "Doesn't like taking medication." No conclusion was documented regarding any interventions being necessary or any</p>						

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	<p>changes in interventions from the pain assessment.</p> <p>A care plan, initiated 5/5/11 and reviewed 4/10/12, for alteration in comfort related to post herpetic neuralgia and Paget's disease, indicated a Goal, "will be as free of pain and comfortable as possible." The intervention: "Give Acetaminophen 325 mg [milligrams] 1-2 PO [by mouth] q [every] 6 hours PRN [as needed] for mild to moderate pain.</p> <p>Resident #16 indicated, during interview on 5/21/12 at 3:11 p.m., she had pain in both of her legs that was unrelieved.</p> <p>On 5/23/12 at 9:02 a.m., the resident was observed in her room, in a wheelchair. She indicated her legs hurt, especially the right leg. The right leg was observed to be bending inward. During interview she indicated they came in some afternoons and did exercises with her. Usually 2-3 times a week. She indicated she would not let them do her right leg due to it being uncomfortable.</p> <p>On 5-23-12 at 1:40 p.m., the resident was observed lying in bed. She indicated her right leg was hurting. She indicated, "nothing helps it."</p> <p>RN #1 was Interviewed on 5/24/12 at</p>			

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	<p>11:05 a.m. She indicated the resident had not complained to her about anything. She indicated the resident hadn't complained to her about pain lately. She indicated, "she probably has pain due to the Paget's disease, but she hasn't mentioned anything to me lately."</p> <p>The rehab book was reviewed on 5/23/12 at 2:15 p.m. Resident #16 had a Treatment Record in the book with the following routine orders: "May have warm moist heat to painful joints PRN [as needed]," and "Special lower extremity exercises as indicated on rehab instruction sheets." The warm moist heat was documented as provided only on the following dates: 5/2, 5/3, 5/9, 5/10, 5/11, and 5/22/12. The lower extremity exercises were documented as done on 5/2/12 and 5/21/12 only.</p> <p>Resident #16's Medication Administration Record for 5/2012 was reviewed on 5/23/12 at 2:35 p.m. No PRN [as needed] pain medication was given during May, 2012.</p> <p>4. An observation was made, on 5/22/12 at 03:00 p.m., of ADL [activity of daily living] care being provided by Certified Nursing Assistant [CNA] #3 to resident #9. CNA #3 was assisting the resident with peri care and off of the toilet. CNA</p>						

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	<p>#3 washed her hands and gloved. CNA #3 then applied hot water and soap to clean the peri area. The resident complained of pain when the CNA performed peri care.</p> <p>An observation on 5/24/12 at 1:25 p.m. was made of Resident #9 in her room, waiting on CNA #2 to assist her to the bathroom. Resident #9 was grimacing when CNA #2 assisted Resident #9 from recliner to wheelchair.</p> <p>In an interview with Resident #9 on 5/21/12 at 3:08 p.m., Resident #9 stated "My arms hurt all the time because of arthritis."</p> <p>Record Review on 5/23 at 10:30 a.m. indicated Resident # 9 had a care plan dated 8/9/2011 and revised 4/18/2012 for potential for alteration in comfort do to a diagnosis of osteoarthritis and chronic pain with interventions of encourage to report discomfort, give allopurinol [a gout medication] 200 milligrams [mg], apply voltaren gel topically to affected areas as needed, apply pennsaid drops to right shoulder and massage three times a day, Oxycontin [a narcotic pain medication] 20 mg by mouth every 12 hours and Oxycodone [a narcotic pain medication] 5/325 mg as need for pain, and encourage ambulation 1-2 times a day to exercise</p>			

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	<p>joints and possibly decrease pain.</p> <p>The medical record indicated Resident #9 had a diagnosis of osteoarthritis [degenerative joint disease] and gout [swollen painful joints].</p> <p>A pain assessment dated 4/12/12 indicated Resident #9 had diagnoses of arthritis and gout. The assessment also indicated Resident #9 verbalized her pain as aching and throbbing with the pain being the worst at night with a frequent level of 8-10 on a 1-10 scale with 1 being the least and 10 being the worst.</p> <p>The MDS assessment dated 10/27/11 indicated Resident #9 had a diagnosis of osteoarthritis. The MDS quarterly assessment dated 4/12/12 indicated Resident #9 had no non-medication interventions for pain, was in pain frequently with a pain level of 8, and was on scheduled pain medications.</p> <p>Resident #9 had a doctor's order dated 5/22/12 for MS contin [narcotic pain medication] 15 mg 1 tablet by mouth 2 times a day.</p> <p>Resident #9 had a doctor's order dated 11/17/10 for percocet 5/325 mg take 1 tablet by mouth every 4 hours as needed for pain.</p> <p>Resident #9 had a doctor's order dated</p>						

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	<p>5/11/12 to discontinue oxycontin 20 mg 1 tablet by mouth twice a day and add morphine ER [a narcotic pain medication] 30 mg 1 tablet by mouth twice a day.</p> <p>The Medication Administration Record indicated Resident #9 received the following pain medications as needed for pain in addition to scheduled pain medication:</p> <p>5/1/12 at 1:00 (no a.m. or p.m. noted) percocet 5/325 mg for assessed "back pain" with a follow up assessment charted as "helpful"</p> <p>5/8/12 at 1:55 a.m. percocet 5/325 mg assessed as complaint of "back pain" with a follow up assessment at 2:50 a.m. of "helpful"</p> <p>5/8/12 2:00 p.m. percocet (no dosage documented) assessed as complaint of "back pain" with a follow up assessment at 4:00 p.m. of "helpful"</p> <p>5/11/12 no time documented percocet 5/325mg assessed "as given in place of oxycontin" follow up assessment "helpful"</p> <p>5/17/12 at 09:30 (a.m. or p.m. not charted) percocet 5/325 mg assessed at an 8-10 level with a follow up assessment of "did not help"</p> <p>5/18/12 10:30 (no a.m. or p.m. documented) Percocet 5/325 mg assessed at an 8-10 on a 1-10 scale with a follow</p>						

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	<p>up assessment of "no further complaint" 5/19/12 at 7:00 a.m. percocet 5/325 mg assessed as "break through pain" and a follow up assessment of "effective" 5/22/12 at 9:00 p.m. percocet 5/325 mg assessed as "all over aches" with a follow up of assessment of "helpful" 5/24/12 at 5:00 p.m. percocet 5/325mg assessed as " MS Contin 15 mg unavailable and no follow up assessment documented.</p> <p>In an interview with LPN #1 at 5/24/12 at 10:20 a.m., LPN #1 indicated she worked nights most times and takes care of Resident #9. LPN #1 indicated Resident #9 has pain all the time and Resident #9 usually rates her pain at a level of 8-10 on a 1-10 scale. LPN #1 indicated Resident #9 usually takes as needed pain medication 1 time on night shift and 1 time on day shift.</p> <p>In an interview on 5/24/12 at 1:30 p.m. CNA #2 indicated Resident #9 is "always in pain".</p> <p>The policy and procedure for pain management, no date, was provided by the Director of Nurses on 5/25/12 at 8:55 a.m. The policy included, but was not limited to, the following: "All residents will be assessed for pain on admission, quarterly, and when there is a</p>			

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	<p>significant change...all healthcare staff will be responsible for the assessment of pain as well as the timely initiation of pain control measures..."</p> <p>The purpose of the policy included, "To recognize and treat appropriately any pain, acute or chronic, experienced by our Residents so that it may not impact negatively on their quality of life and daily functioning."</p> <p>The procedure included, but was not limited to, "all new admissions will have a Pain Assessment form completed upon admission, when a significant change occurs, and quarterly by the Nurse." "Resident complaint of pain will be reported to the nurse on duty promptly by the staff. The Nurse on Duty is responsible to take immediate action to effectively treat the Pain." "The Pain Assessment Form shall include the pain intensity measured with appropriate tool. a. A pain scale of 0-10 (0=no pain, 10=worst pain) should be utilized for Resident pain. b. Behaviors and or symptoms should be evaluated with regard to presence of pain for a Resident who is cognitively impaired or unable to communicate." "Administration of pain medications as ordered by the physician."</p>			

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	"Nursing staff will follow up with Resident to monitor effectiveness of treatments." 3.1-37(a)			

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F0318 SS=D	<p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>Based on observation, interview and record review, the facility failed to ensure range of motion exercises were provided to 2 of 3 sampled residents reviewed for range of motion, in the sample of 6 who met the criteria for range of motion. (Residents #24, #16)</p> <p>Findings include:</p> <p>1. Resident #24 was observed on 5/22/12 at 9:26 a.m. The left hand appeared to be contracted and had a rolled wash cloth in it.</p> <p>Resident #24 was observed in bed on her left side on 5/22/12 at 2:58 p.m.</p> <p>The resident was observed on 5-23-12 at 8:50 a.m. in the rehabilitation dining area in a geri chair.</p> <p>The resident was observed on 5/23/12 at 10:10 a.m., in a geri-chair in a common area, asleep. She had a pillowed neck support around her head.</p>	F0318	<p>1. Corrective actions: A care plan for ROM has been initiated for resident #24. Physical therapy (PT) has completed an evaluation and recommendations are being followed. Resident #16's mobility care plan has been revised and updated reflecting resident's inability to ambulate. The care plan has also been updated with the exercise program recommended by PT. 2. How other residents with potential to be affected will be identified and corrective actions to be taken: Residents showing a decline in ROM on their MDS will be assessed for an ROM program. Care plans were reviewed for all residents with contractures and limited ROM and updated as needed. CNAs were inserviced on ROM on 6/15/12. 3. Measures or systemic changes to prevent recurrence: ROM records will be reviewed weekly for compliance by the DON or her designee. New nursing staff will be inserviced on ROM during orientation and bi-annual inservice on ROM will be held for all nursing employees. 4. How corrective actions will</p>	06/18/2012

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	<p>Resident #24's clinical record was reviewed on 5/23/12 at 10:25 a.m. Diagnoses included, but were not limited to, arthritis, muscle disuse, atrophy, dysphagia, abnormality of gait, pacemaker, depression, hypothyroidism, atrial fibrillation, congestive heart failure [CHF], anemia, constipation, dementia, allergic rhinitis, mild renal insufficiency, and anxiety.</p> <p>The quarterly Minimum Data Set [MDS] assessment, dated 3/1/12, indicated the following: -Cognitive Skills for decision making severely impaired. Transfers extensive assistance of two staff, Bed mobility extensive assistance of two staff, unable to ambulate, Functional Limitation in Range of Motion, impairment on both sides, Personal Hygiene extensive assistance of two staff</p> <p>The resident's care plan for pain, dated 6/28/11, revised 3/2/12, indicated the use of Tylenol routinely. It also noted the hand rest splint was discontinued on 5/14/12 due to discomfort. It further Indicated an intervention of placing a rolled washcloth or palm grips in the resident's hands to prevent contraction of hands. There was no care plan for range of motion exercises.</p>		<p><u>be monitored/QA to be implemented:</u> DON will monitor follow-through and will bring results of monitoring to the QA committee each quarter for one year (through June of 2013).</p>				

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	<p>Other than the Occupational Therapy Evaluation regarding the use of the resting hand splint, the record lacked Physical Therapy evaluations of the resident or recommendations regarding range of motion exercises.</p> <p>A care plan initiated on 6/28/11 and revised 3/2/12, indicated, "Ambulates with rolling walker/locomotion via wheelchair. Interventions indicated the resident required assist of one staff for long distance locomotion in wheelchair.</p> <p>RN #1 was interviewed on 5/22/12 at 9:40 a.m. She indicated Resident #24 had a splint on the left hand, but it was painful for her so it was discontinued. She further indicated, "if they do range of motion, I don't know about it; there's no order for it."</p> <p>CNAs #1 and #2 were interviewed on 5/23/12 at 11:19 a.m. They indicated their assignment sheets were at the nurse's station. The assignment sheets were reviewed at that time and consisted of lists of names, with blank areas labeled "B & B [bowel and bladder], R.O.M. [range of motion], AMB [ambulation], VS [vital signs], WT [weight], PT [physical therapy], I & O [intake and output], BATH, and ORAL CARE." The</p>			

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	<p>CNAs had notes regarding one shower done for a resident on the list, and 3 different residents bowel movements. There was no indication of which residents received range of motion and/or ambulation.</p> <p>CNAs #1 and #2 were interviewed again on 5/23/12 at 2:05 p.m. They indicated they had a rehab aide 4-5 days a week. The rehab aide would do range of motion. CNA #2 indicated she was the rehab aide on 5/22/12. She indicated she would do gentle range of motion to Resident #24's hands, and some movements with arms. She indicated the resident "was pretty good with moving her legs, so they didn't have to do as much." She indicated CNAs would do some range of motion with her bath and getting her up, such as washing her hands, putting lotion on, moving her around some. She indicated documentation would be in the rehab book in the therapy room.</p> <p>On 5/23/12 at 2:15 p.m., the rehab book was reviewed. The Treatment Records for 4/1 through 4/30/12 and 5/1 through 5/31/12 were reviewed. The routine orders indicated Gentle ROM exercises to arms, legs and neck as tolerated. The ROM exercises were initialed as done on 5/2/12, 5/11/12, and 5/21/12. None were documented in April, 2012.</p>				

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	<p>2. RN #1 indicated, during interview on 5/22/12 at 9:49 a.m., she was unsure whether or not Resident #16 had a contracture of one of her feet. She indicated it was shaped odd and the resident complained of pain.</p> <p>Resident #16's clinical record was reviewed on 5/23/12 at 1:55 p.m. Diagnoses included, but were not limited to, diabetes mellitus type II, postherpetic neuralgia, hypertension, coronary artery disease [CAD], glaucoma, gastroesophageal reflux disease [GERD], hypothyroidism, Paget disease, osteoarthritis, normocytic anemia, hyperlipidemia, chronic cholecystitis, and depressive disorder.</p> <p>Resident #16's annual Minimum Data Set [MDS] assessment, dated 4/5/12, indicated the resident had no short or long term memory problems, required extensive assistance of 1 for transfer, was unable to walk, limitation in range of motion on one side, and pain almost constantly at a severity level of 7 out of 10.</p> <p>The resident had a care plan for mobility, dated 8/2/11 and reviewed 4/10/12, for one person to assist her with ambulation every morning and evening and as</p>						

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	<p>needed. There was no care plan for range of motion and/or exercises.</p> <p>On 5/23/12 at 9:02 a.m., Resident #16 was observed in her room, in a wheelchair. She indicated legs hurt, especially her right leg. The resident's right leg was observed to be bending inward. During interview, she indicated they came in some afternoons and did exercises with her. Usually 2-3 times a week. She indicated she would not let them do her right leg due to it being uncomfortable.</p> <p>The rehab book was reviewed on 5/23/12 at 2:15 p.m. Resident #16 had a Treatment Record in the book with the following routine orders: "May have warm moist heat to painful joints PRN [as needed]," and "Special lower extremity exercises as indicated on rehab instruction sheets." The lower extremity exercises were documented as done on 5/2/12 and 5/21/12 only.</p> <p>A physical therapy reassessment/plan of progress, dated 2/10/12, indicated the resident was being discharged from therapy. "Pt. [patient] maintaining current functional abilities [with] transfers. She will benefit from continued HEP [home exercise program] daily [with] verbal cues. Instructed CNA to follow through</p>			

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	<p>[with] this." As per interview and review of the Treatment Record in the rehab book, the resident was not receiving exercises as recommended daily.</p> <p>A rehab aide note, dated 4/3/12, indicated the following: "Up daily dressed with assist of 1 with ADLs [activities of daily living]. [Resident's name] is not ambulatory she pivots from w/c [wheelchair] to where she is going. Her w/c is used for all transportation. [Resident's name] has an order for moist heat P.R.N. She also has a follow up order from P.T. for exercises for lower extremity."</p> <p>3. The policy and procedure for Range of Motion Exercises, dated 5/2006, was provided on 5/25/12 at 8:55 a.m. by the Director of Nurses [DoN]. The policy indicated range of motion [ROM] exercises were used to maintain joint mobility, prevent deformities that limit function and stimulate circulation. The policy indicated range of motion could be performed either as active ROM [resident performs movements] or passive ROM [movements done by someone else].</p> <p>The procedure outlined exercises for shoulder joints, elbow joints, wrist joints, finger joints, thumb joints, hip joints, knee joints, ankle joints, and toes.</p>			

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	3.1-42(a)(2)			

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F0329 SS=D	<p>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.</p> <p>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.</p> <p>Based on observation, interview, and record review, the facility failed to ensure 2 of 10 residents reviewed for unnecessary medications had the medications monitored for indications for their use, for effectiveness, and with adequate monitoring, in that multiple pain medications were ordered without monitoring the appropriate use of each and monitoring effectiveness. (Residents #43, #38)</p> <p>Findings include:</p>	F0329	<p>1. Corrective actions: Resident #43's care plan for pain has been reviewed and updated including non-pharmacological interventions and the treatment of other pain (other than the breast). Care plans have also been updated for anxiety and depression to include interventions to prevent occurrences. A new pain assessment has been completed and physician updated with resident's pain control. Resident #38's pain medications have been reviewed, adjusted, and</p>	06/18/2012	

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	<p>1. Resident #43 was observed and interviewed on 5/23/12, at 9:50 a.m. The resident was having pain of her back at that time. She was observed to be lying in bed, indicated she had taken Tylenol for back pain. "I think I twisted it or something, I just cannot go. This is not the same pain I normally have in my back."</p> <p>The clinical record was reviewed on 5/23/12 at 10:30 a.m. The resident' s diagnoses included, but were not limited to, anxiety, diabetes II, hypertension, hyperlipidemia, gastroesophageal reflux disease [GERD], metastatic breast cancer w/ bone pain, atrial fibrillation, renal failure, and depression.</p> <p>The physician's progress note on 5/3/12, when the Oxycontin was increased, indicated, "It is difficult to tell if her pain is osteoarthritis or Mets [metastatic cancer] bone, will increase oxycontin to 30 mg [milligrams] bid [twice daily]." Another note dated 3/15/12, indicated, "Trial of Cymbalta both for depression and for neuropathic pain." [The note did not identify the length of time the trial would take place]</p> <p>The physician's orders included, but were not limited to, the following:</p>		<p>updated with specific pain condition orders. An inservice was held on 6/14/12 for nurses and QMAs regarding pain management and interventions to utilize prior to administration of PRN anti-anxiety drugs. Inservices will also be held bi-annually on these topics. 2. <u>How other residents with potential to be affected will be identified and corrective actions to be taken:</u> Pain assessments will be reviewed on all residents triggered for pain and physician updated as needed. Care plans have been updated to include non-pharmacological interventions.3. <u>Measures or systemic changes to prevent recurrence:</u> Anxiety symptoms will be monitored and documented. This documentation will be reviewed quarterly by DON. All new PRN pain orders will be monitored by ADON/DON for specific indicators regarding when to use the PRN pain medications 4. <u>How corrective actions will be monitored/QA to be implemented:</u> Each resident's pain assessment and PRN antianxiety drug use will be reviewed quarterly with care plan schedule, and the DON will bring results of this monitoring to the QA meeting each quarter for one year (through June of 2013).</p>		

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	<p>Cymbalta [antianxiety/antidepressant] 60 mg q d [daily] ordered 3/15/12 Oxycontin [narcotic pain medication] 30 mg bid increased to 30 mg on 5/3/12. Klonopin [for anxiety] 0.5 mg q 6 hrs prn anxiety ordered 8/1/11 Tylenol 325 mg 2 tabs q 6 hrs pain ordered 8/19/10</p> <p>The last care conference was held on 4/10/12. The care plan for pain was as follows: Altered comfort Mets breast bone pain-comfortable as possible and pain free,-Give Tamoxifen [anti-cancer medication], give Oxycontin q 12 hrs, give Tylenol 500 mg 2 q 6 hrs. The care plan did not include any type of non medication type intervention. It did not address the treatment of other pain, other than the breast bone.</p> <p>Diagnosis of anxiety disorder- Anxiety will be controlled through implementation of prescribed interventions AEB [as evidenced by] no signs of anxiety, agitation, wringing hands, crying, nervousness- monthly assessment of meds, by RPH [Registered Pharmacist],monitor s/s [signs/symptoms] of anxiety, monitor for episodes of increased anxiety enc [encourage] to report monitor pulse ox weekly.</p>						

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	<p>Diagnosis of depression and admits to being depressed- will continue to maintain her regular routine, going to the dr, for meals and going out with family- provide with opportunity to verbalize her concerns, feelings and fears. Administer Cymbalta, dly. [daily] observe for s/s of depression, isolation in room, refusal of food, crying, irritability.</p> <p>The care plans for anxiety and depression did not include interventions to prevent the occurrences, only to identify once the anxiety or depression was occurring.</p> <p>On 5/23/12 at 1:30 p.m., QMA [Qualified Medication Aide] #1 indicated the resident took Klonopin prn [as needed] almost every day, usually two times per day, for anxiety. "She never explains her anxiety, I think it is associated with pain. She requests the drug, ends up taking most days 3 times a day and that includes the bedtime dose. She took two Tylenol this morning for pain."</p> <p>Pharmacy recommendations dated 9/21/11 indicated, requested a GDR [gradual dose reductions] for Xanax; the physician recorded NO-" Benefit of therapy is currently greater than the risk of adverse drug reactions. The current dose is felt to be the lower clinically</p>			

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	<p>effective dose continue Xanax." At that time, the Xanax order was 0.5 mg at bedtime ordered 8/31/10.</p> <p>The pharmacy recommendation on 2/17/12 increased routine Xanax and d/c [discontinued] prn per pharmacy. According to the Assistant Director of Nursing [ADON], at 10:00 a.m. on 5/23/12, the medications were not changed.</p> <p>On 5/2/12 physician order "D/C Xanax after supply is depleted. Then start Clonazepam 0.5 mg po daily at bedtime, then continue the prn Clonazepam as ordered."</p> <p>2. Resident #38's clinical record was reviewed on 5/23/12 at 9:30 a.m. The resident's diagnoses included, but were not limited to, hypertension, low back pain, gastroesophageal reflux disease [GERD], hypothyroidism, congestive heart failure [CHF], irritable bowel syndrome [IBS], degenerative disc disease [DDD] osteoarthritis [OA], restless leg syndrome [RLS], anxiety, spinal stenosis, Malaga, digestive-genital tract fistula, disarticulates, atrial fibrillation, renal artery stenosis and status post colostomy.</p> <p>The resident had three oral pain medications ordered as follows: Tramadol-APAP [anti-inflammatory pain</p>						

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	<p>medication] 37.5 mg-325 mg one tablet by mouth every 8 hours as needed for pain ordered 10/3/11, Hydrocodone/ Acetaminophen [narcotic pain medication] 5/325 mg one tablet every 4 hours as needed for pain Hydrocodone/Acetaminophen 5/325 mg 2 tabs every 4 hours as needed for pain, both ordered 3/24/12.</p> <p>On 5/3/12, the physician visited the facility and ordered a physical therapy evaluation for right hip pain, and Lidocaine [topical pain medication] gel to right hip BID [twice daily]. There was no specific instructions regarding when to use the oral pain drugs, with multiple drugs ordered for the same non specific condition-pain.</p> <p>The QMA was interviewed on 5/23/12 at 1:30 p.m. She indicated she started with the least dose or strength. "If the drug doesn't help, I will ask the Director of Nurses [DON]. The prn drug we contact the [name of unit] nurse." The pain scale was used to find out what the severity of the pain was, but she indicated she did not record it anywhere.</p> <p>3.1-48(a)(3) 3.1-48(a)(4)</p>						

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F0371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, the facility failed to ensure foods were served under sanitary conditions, for 1 of 2 dining rooms, in that plates were handled without hand hygiene and the self serve salad bar was not monitored for sanitary use. This deficient practice had the potential to affect 36 residents who ate in the Main Dining Room.</p> <p>Findings include:</p> <p>On 5/21/12 at 12:00 p.m., residents were observed in the main dining room being served their lunch from staff. Staff were observed to be delivering the plates of food to each resident at a table. No sanitization or glove use by the staff serving was observed. QMA [Qualified Medication Aide] #1 was observed placing her hand into her apron pockets in between residents and no sanitization or glove use was observed.</p>	F0371	<p>1. Corrective actions: Servers wash hands before serving plates. If servers touch a resident, they will wash their hands before they serve another resident. Servers will refrain from putting their thumb or fingers on top of plate or lip of bowl/cup, or in apron pockets. Dietary staff will serve items off the salad bar. The dietary aide will place the scoop in a holder between passing drinks. Dining room aide will wash hands and apply gloves before proceeding with a new task that requires gloves. 2. How other residents with potential to be affected will be identified and corrective actions to be taken: Residents eating in the main dining room have potential to be affected. Inservices were held on 5/29/12, 6/4/12, and 6/6/12 for dietary staff and servers regarding correct placement of ice scoop, proper sanitation technique, infection control, glove use, and salad bar procedure. 3. Measures or systemic changes to prevent recurrence: Inservices will be held twice yearly and as needed regarding infection control/sanitation issues.</p>	06/18/2012	

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	<p>An observation was made on 5/21/12 at 11:50 a.m., during the lunch time meal, of a self serve salad bar for the residents of the facility, a spoon handle was noted to be laying in the tomatoes. A randomly observed diner picked the spoon up, put tomatoes on their plate, then put the spoon handle back into the tomatoes.</p> <p>During the same lunch meal, a resident's family member was making a salad for the resident. The family member spooned jello out and the resident decided they did not want the jello, so the family member put the jello back onto the salad bar.</p> <p>QMA #1 was observed passing plates to the residents. QMA #1 was carrying the plates with her thumb on the top surface</p>		<p>New staff will be inserviced on orientation. Registered Dietitian has been asked to monitor food service sanitation more closely.</p> <p>4. <u>How corrective actions will be monitored/QA to be implemented:</u> Dietary supervisor will monitor staff one time weekly for proper ice scoop placement, correct serving technique (not touching top or lip of plates or bowls, nor serving apron, residents, or wheelchairs), and salad bar sanitation. Dietary supervisor will bring results of this monitoring to the QA committee meeting quarterly for one year (through June of 2013).</p>		

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	<p>of the plate. QMA #1 was seen putting her hands in her apron, touching wheelchairs, and touching residents in between passing plates and no gloves, handwashing, or hand sanitizer was used.</p> <p>An observation on 5/24/12 at 11:27 a.m. of the lunch meal was made. Dining room assistant [DRA] #1 was filling resident's cups up with ice. When filling the cups with ice she place the handle of the ice scoop down in the ice bucket with the handle laying on the ice. She then continued by picking up the handle with her gloved hands after touching the juice carton, pitcher of water, and plastic cups with gloved hands and not removing gloves, washing hands, or re gloving.</p> <p>The policy for handwashing, dated 5/29/12, indicated all staff providing any physical contact with residents shall wash their hands between contacts with different residents.</p> <p>3.1-21(i)(3)</p>				

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F0431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review the facility failed to ensure that medications were stored, accounted for, and disposed of as required in 4 of 4</p>	F0431	<p>1. Corrective actions: An inservice was held 6/14/12 for nurses and QMAs regarding signing out narcotic medications when given, watching med expiration</p>	06/18/2012

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	<p>medication rooms [Unit 1 medication room 1, 2, 3 and Unit 2 medication room 1], in that, narcotic records were not kept accurately, expired medications were not disposed of, and medications of discharged residents were not returned to pharmacy timely. This affected 7 residents whose medications were randomly observed during the medication storage observation. (Resident #45, #8, #14, #33, #21, #32, #35)</p> <p>Findings include:</p> <p>1. During the medication storage observation on 05/22/12 at 10:40 a.m. of Unit #2 Medication Room #1 with RN #2 the following was observed:</p> <p>(A.) RN #2 signed and dated the Oxycontin [a medication for pain] narcotic sheet and the Klonopin [a medication for anxiety] narcotic sheet for Resident #45 and the Oxycodone/APAP [a medication for pain] narcotic sheet for Resident #8. During an interview at that time, RN #2 indicated she had administered the narcotics during the 9:00 a.m. medication pass. During an interview at that time, RN #2 further indicated, narcotics should be signed out when they were given.</p>		<p>dates, dating of insulins, eye drops, nasal solutions, and Nitroglycerin when opened, refusal of medication, and prompt disposal of discharge medications. Medication carts have been checked for expired drugs on all units.</p> <p>2. <u>How other residents with potential to be affected will be identified and corrective actions to be taken:</u> Training was given on 6/14/12 for nurses and QMAs regarding above items in order to safeguard all other residents who receive medications.</p> <p>3. <u>Measures or systemic changes to prevent recurrence:</u> Inservices will be held bi-annually on above-referenced topics. Nurses/QMAs will review bottles for dates opened when administering medications. Pharmacy techs will complete cart review quarterly for expired/expiring medications. Consulting pharmacist will spot-check insulins and drugs monthly. A list will be available in medication room of expiration timeframes for insulin, nasal solutions, eye drops, and other pertinent drugs. An assigned nurse will check expiration dates of opened insulin and ophthalmic and nasal solutions weekly. Pharmacy will spot-check bottles monthly for dates opened . Pharmacy techs will review medication carts every three months for compliance.</p> <p>4. <u>How corrective actions will</u></p>				

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	<p>(B) 1. An opened bottle of eye drops dated 03/30/12 for Resident #8. (Expiration of 04/27/12).</p> <p>2. An opened bottle of eye drops dated 12/05/11 for Resident #14. (Expiration of 01/02/12).</p> <p>3. An opened bottle of eye drops dated 11/03/11 for Resident #33 (Expiration of 12/01/12. During an interview on 05/22/12 at 10:55 a.m., RN #2 stated, "Those meds are good for 6 months."</p> <p>4. A preloaded syringe of Glucagon [a medication for diabetes] for Resident #21 with an expiration date of 04/12.</p> <p>During an interview with the DoN [Director of Nursing] on 05/23/12 at 2:22 p.m. she stated, "they are to date the medications when they open them".</p> <p>4. During the medication storage observation of Unit #1 medication room #2 on 05/23/12 at 2:30 p.m. with the DoN, the following was observed:</p> <p>(A.) A pharmacy return tote box containing a tube of Bacitracin [an antibiotic ointment] and an open bottle of Sorbitol [a stool softener] for Resident #45. During an interview at that time, the DoN</p>		<p><u>be monitored/QA to be implemented:</u> The Medication Administration Record will be reviewed by the DON or ADON immediately after completion of a medication pass 2X weekly X1 month, then 1X weekly for 1 year to monitor for compliance. The quarterly pharmacy tech report, monthly consulting pharmacist report, and weekly expired drug review will be monitored by ADON/DON. After discharge of residents, medication and treatment carts will be checked by nursing service for disposal of all medications and treatments. Medication pass will be monitored 1x weekly by the DON or her designee for compliance with appropriate documentation on Medication Administration Record. Results of the above monitoring will be reported by the DON to the QA committee once each quarter.</p>				

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	<p>indicated Resident #45 was discharged on 05/11/12.</p> <p>5. During the medication storage administration observation of Unit #2 medication room #1 on 05/24/12 at 3:36 p.m. the following was observed:</p> <p>(A.) An opened bottle of Novolog [insulin] for Resident #21 dated 04/25/12 (expiration of 05/23/12)</p> <p>2. During the medication storage observation on Unit #1 medication room #1 on 05/23/12 at 1:49 p.m. with RN #1 the following was observed:</p> <p>(A) An opened bottle of Lantus [insulin] for Resident #32 dated 04/19/12. (expiration of 5/17/12)</p> <p>3. During the medication storage observation on Unit #1 medication room #2 on 05/23/12 at 1:54 p.m. with RN #2 the following was observed:</p> <p>(A) A medication cup filled with medications was observed in the first drawer of the medication cart. RN #2 indicated the medications belonged to Resident #35 and identified the medications as those scheduled for 12:00 p.m. RN #2 further indicated Resident #35 had refused the medications and had</p>						

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	<p>requested to take them later. The MAR [Medication Administration Record] for May 2012 was observed at that time and lacked any documentation for the noon medication pass. During an interview at that time, RN #2 stated, "I don't handle it as a refusal, I just handle it like they will take them later."</p> <p>(B.) An opened and undated bottle of Nitroglycerin for Resident #35 with a delivery date of 11/01/11. (expiration of 04/01/11) During an interview on 05/23/12 at 1:54 p.m., RN #2 indicated medications are good for 6-12 months after being opened. At that time, RN #2 was observed to date the bottle of Nitroglycerin for 05/23/12 as the open date.</p> <p>In an interview with the DON on 5/23/12 at 3:48 P.M. she indicated there was no policy and procedure on expired medication. At that time, the DoN provided a document from the pharmacy that indicated the expiration dates as follows "...Lantus [an insulin]-28 days...Novolog-28 days...Nitroglycerin Sublingual tablets-6 months after opening...Ophthalmic [eye] Solutions-28 days..."</p> <p>3.1-25(j)</p>						

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	3.1-25(k) 3.1-25(l)			

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F0441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility failed to ensure</p>	F0441	1. Corrective actions: As soon as deficiency was reported to	06/18/2012	

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	<p>infection control procedures were followed for 1 of 2 residents observed for blood sugar testing and 1 of 2 residents observed for insulin administration in that, handwashing and glove use were not done as required. (Resident #21)</p> <p>Findings include:</p> <p>During an observation of an Accucheck [test to measure blood sugar] on 05/23/12 at 11:45 a.m., QMA #1 was observed to perform a fingerstick and obtain a blood sample from Resident #21 without applying gloves. RN #2 was then observed to enter the Unit #1 medication room #2, apply gloves, and administer insulin to Resident #21. RN #2 was not observed to perform handwashing or hand hygiene before applying gloves.</p> <p>The Infection Control-Universal Precautions provided by the HFA [Health Facilities Administrator] on 05/29/12 at 9:15 a.m. indicated, "2. Handwashing ...b. Hands should always be washed before and after contact with Residents, even when gloves have been used...3. Gloves...b. When it is reasonable to anticipate contact with blood...staff should routinely apply gloves..."</p> <p>In an interview with the DoN [Director of Nursing] on 05/25/12 at 2:00 p.m., she</p>		<p>facility, QMA and nurse were notified of their error and re-educated about proper procedures. 2. <u>How other residents with potential to be affected will be identified and corrective actions to be taken:</u> Any residents who have blood sugar checks or receive insulin have the potential to be affected. An inservice was held 6/14/12 for nurses and QMAs regarding correct procedures for washing hands and applying gloves before doing blood sugar checks or insulin administration. 3. <u>Measures or systemic changes to prevent recurrence:</u> Policy/procedure for applying gloves and washing hands has been made available at nurses' stations as a reminder. Med pass observations will include blood sugar checks and insulin administration at least 1-2X per quarter. 4. <u>How corrective actions will be monitored/QA to be implemented:</u> Random checks of nurses and QMAs for applying gloves and washing hands will be completed 1X weekly X1 month, then every two (2) weeks; this will be done by the DON or her designee. Results of this monitoring will be reported to the quality assurance committee quarterly for one year (through June 2013).</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E359	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/30/2012
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	<p>indicated the staff should have used gloves when performing an Accucheck and the staff should have performed handwashing before administering the insulin.</p> <p>3.1-18(b)</p>			