

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

PRINTED: 12/02/2013
FORM APPROVED
OMB NO. 0938-0391

1372

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505086	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2013
NAME OF PROVIDER OR SUPPLIER LANDMARK CARE AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 710 NORTH 39TH AVENUE YAKIMA, WA 98902	
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F 000	<p>INITIAL COMMENTS</p> <p>This report is a result of an unannounced Off-Hour Quality Indicator Survey conducted at Landmark Care and Rehabilitation on 11/07/13, 11/08/13, 11/12/13, 11/13/13, 11/14/13, 11/15/13 and 11/18/13. The survey included data collection on 11/13/13 from 7:00 p.m. to 9:00 p.m. A sample of 27 residents was selected from a census of 87. The sample included 20 current residents and 7 former and/or discharged residents.</p> <p>The survey was conducted by:</p> <p style="text-align: right;">Received Yakima ROS DEC 12 2013</p> <p> RD  RN  RN  RN</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging and Long-Term Support Administration Residential Care Services, District 1, Unit D 3611 River Road, Suite 200 Yakima, WA 98902</p> <p>Telephone: (509) 225-2800 Fax: (509) 574-5597</p> <p> 12/3/13 Residential Care Services Date</p>	F 000	<p>ADDENDUM TO PLAN OF CORRECTION</p> <p>Submission of the Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingly, the Facility has prepared and submitted this Plan of Correction solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in the Title 18 and Title 19 programs. The submission of the Plan of Correction within this time frame should in no way be considered or construed as agreement with the allegations of non compliance or admissions by the facility.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE **12-12-13**

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

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F 225 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>	F 225	<p>F 225</p> <ol style="list-style-type: none"> Resident #124: Identification and assessment [REDACTED] with physician notification, family notification, and treatment orders with daily monitoring completed 10/28/13. Resident denied abuse/neglect. Resident #124 re-assessed 11/13/13 with [REDACTED] in healing process without complications. Care plan revisions and staff education related to specific interventions for resident #124 completed 11/14/13. Residents with injuries will all be reported immediately and investigated within appropriate time frames. Direct care staff education related to "Abuse, Neglect, reporting" policy. * All skin incidents will be reviewed weekly with skin/weight committee to ensure thorough investigations with interventions in place to prevent future occurrences. <ul style="list-style-type: none"> Direct care staff education related to "Abuse, Neglect, reporting" policy. Licensed nurse staff education related to completion of incident investigations, including staff interviews, written statements, etc. 		

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F 225	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to thoroughly investigate incidents involving potential neglect or abuse for 1 of 4 sampled residents (#124) with accidents/injuries of unknown origin as required by 42 CFR 483.13(c)(3). Failure to thoroughly investigate bruises of unknown origin disallowed opportunities for possible discovery of the etiology of the bruises, implementation of additional protective measures, and evaluation of whether care was delivered in accordance with the resident's plan of care to rule out neglect or abuse. Findings include but were not limited to:</p> <p>Resident #124: Review of the medical record revealed the resident had multiple diagnoses including [REDACTED] with [REDACTED] on one [REDACTED] of her [REDACTED] and generalized [REDACTED]</p> <p>The resident's plan of care identified she was cognitively impaired with memory impairment, required staff assistance to turn in bed, and was transferred between her bed and wheelchair with a mechanical lift. The resident also had fragile skin and received daily [REDACTED] and [REDACTED] medication, potentially causing her to bruise more easily. Her plan of care also noted she was at risk for falling due to her balance problems.</p> <p>Observation of Resident #124 on 11/08/13 at approximately 9:05 a.m. noted the resident had a grayish bruise on her [REDACTED] cheek approximately [REDACTED] inches in diameter.</p> <p>Review of the November 2013 Treatment Record on 11/13/13 noted daily monitoring of a bruise on the [REDACTED] side of the resident's face, daily beginning</p>	F 225	<p>4. All incidents will be reviewed for trends and reported to the QA committee and Medical Director monthly.</p> <p>5. Corrective action will be completed by 12/17/13</p> <p>6. Director of Nursing will be responsible to ensure correction.</p>	12-17-13

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F 225	<p>Continued From page 3 on 10/28/13 and continuing.</p> <p>A nursing entry, dated 10/28/13, documented there was a bruise on the resident's cheek. At that time the cognitively impaired resident stated she didn't know how it happened.</p> <p>Interviewed on 11/12/13 at approximately 1:23 p.m. Staff Member F, a Licensed Nurse (LN) stated the bruise on the [redacted] cheek was monitored daily. The cognitively impaired resident had told the LN she was in a car wreck.</p> <p>On 11/12/13 at approximately 1:25 p.m. Staff Member E, a LN, stated she thought the bruise was possibly related to a hooyer (mechanical lift) transfer.</p> <p>Review of the 10/28/13 facility investigative documents, noted there was a bruise to [redacted] side of the resident's face [redacted] by [redacted] cm, discovered prior to care delivery.</p> <p>An interview was conducted on 11/12/13 at approximately 4:00 p.m. with Staff Member H, a Nursing Assistant. Staff Member H recalled Resident #124 was not her assigned resident on 10/28/13 but she and another Nursing Assistant were helping a co-worker. Staff Member H recalled seeing a light greenish bruise on the resident's [redacted] cheek prior to putting her to bed via the mechanical lift with her co-worker's assistance. She reported the bruise to the LN on-duty. "She (the resident) is scared of the hooyer (the mechanical lift)." They tried to calm her first and have her hold her weak arm with her other arm to ensure there was no resistance and no incidents. At other times the resident was observed hitting herself in the face on both sides,</p>	F 225			

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F 225	<p>Continued From page 4 "rarely."</p> <p>When interviewed on 11/12/13 at approximately 4:10 p.m., Staff Member I, Staff Member H's partner on 10/28/13, stated the resident had experienced various bruises, on the forehead and face in the past. On 10/28/13 they reported the bruise to the LN. Staff Member I stated the resident was fearful and at times would push against the hoyer bar. She stated the resident probably bumped her head during the hoyer transfer but not while they were transferring her that evening.</p> <p>On 11/13/13 at approximately 12:35 p.m., Staff Member J, a LN, stated she had assisted as the second person with the hoyer transfer that morning. For the resident it was "90% caregiver approach" and the remainder was the mood the resident was in that day impacting how the transfer went.</p> <p>Review of the facility investigation pertaining to the discovery of the 10/28/13 bruise on the resident's face identified only data pertaining to the time of discovery and did not include any interviews about care prior to discovery to attempt to discover the etiology of the bruise, to ensure care was appropriate, and to aid in implementing protective measures to prevent recurrence.</p> <p>When interviewed on 11/13/13 at approximately 2:45 p.m., Administrative/Investigative LNA stated she did not have any other interviews from caregivers on previous shifts and had not identified who they were (to evaluate their care and any incidents). LNA was unable to identify any changes made to the care plan pertaining to the lift transfers following the bruising incident.</p>	F 225		

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F 241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide care in a manner that promoted resident dignity or personal privacy for 5 of 26 sampled residents (#21, #29, #36, #62, & #124). Deficient practice included inappropriate comments about residents, signage, and caregiver intrusions during resident showers. Findings include:</p> <p>Resident #36: Review of the medical record revealed the resident had multiple diagnoses including [REDACTED] and [REDACTED] issues. A 10/22/13 comprehensive assessment documented the resident was [REDACTED] intact. He required staff assistance for bathing and dressing.</p> <p>When interviewed on 11/07/13 at approximately 2:30 p.m. about staff maintenance of privacy during care, Resident #36 stated that staff did not maintain his privacy during showers. The resident was able to complete most of his shower by himself but needed some help from the Shower Aide to wash his back. However, while he was in the shower, Nursing Assistants (NAs) working on the floor would enter the shower room, pull back the privacy curtain, and check to see if someone was in there. "A little embarrassing sometimes." He further stated he guessed it was "part of</p>	F 241	<p>F241</p> <p>1. Resident # 21</p> <ul style="list-style-type: none"> Staff member L interviewed and provided education related to promoting resident dignity 11/8/13 Resident #21 interviewed on 12/04/13 to ensure he is being treated with dignity and respect with no concerns noted. <p>Resident # 29</p> <ul style="list-style-type: none"> All staff education related to privacy during showers completed on 11/14/13 Privacy signs posted on shower room door 11/14/13 Privacy curtains in shower replaced to increase resident privacy <p>Resident # 36</p> <ul style="list-style-type: none"> All staff education related to privacy during showers completed on 11/14/13 Privacy signs posted on shower room door 11/14/13 Privacy curtains in shower replaced to increase resident privacy <p>Resident #62: Permission from resident's [REDACTED] received when sign placed in bathroom related to preventing skin breakdown. Resident's [REDACTED] POA confirmed this again on 11/18/13 that he gives permission for</p>		

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F 241	<p>Continued From page 6</p> <p>elderly life" but he thought that perhaps the Shower Aide could prevent other NAs from being "nosey." Resident #36 stated the facility had group meetings to discuss issues but it was too private of an issue for him to bring up in a group setting.</p> <p>Observations on 11/13/13 at approximately 12:30 p.m. revealed a shower room on the resident's wing. Prior to entry into the shower area itself, there was an corridor area where a large scale was located. A privacy curtain separated the area with the scale and the shower area.</p> <p>On 11/14/13 at approximately 9:00 a.m., Staff Member K, a NA/Shower Aide, stated Resident #36 received the first shower of the morning on his scheduled day. Staff Member K stated she typically assisted the resident with undressing and a transfer into the shower chair. He was able to complete much of his shower and she assisted him in washing his back and feet. Staff Member K mentioned there were a number of residents who required daily weights on the unit. Twelve names were identified on the list for daily weights at that time. Floor staff attempted to weigh those residents first thing in the morning and would bring the residents into the scale area adjacent to the shower area. Floor staff would open the privacy curtain to obtain the calculator (kept on a ledge in the shower stall) even while residents were in the shower. She was aware Resident #36 had experienced staff intrusions while he was in the shower and it had happened to other residents as well during their showers. Staff Member K was often unable to prevent the staff intrusions, depending on where she was in the room. In addition, Staff Member K stated therapy staff would also pull back the privacy curtain on</p>	F 241	<p>the sign. Resident #62 is aware that sign is in bathroom also.</p> <p>Resident # 124:</p> <ul style="list-style-type: none"> ● Staff member L interviewed and provided education related to promoting resident dignity 11/8/13 ● Resident #21 interviewed on 12/04/13 to ensure he is being treated with dignity and respect with no concerns noted. <p>2. Privacy signs posted on shower room doors 11/14/13</p> <ul style="list-style-type: none"> ● Direct care staff education related to promoting dignity completed ● Direct care staff education related to privacy with showers completed 11/14/13. ● Staff member L interviewed and educated related to promoting dignity 11/8/13. <p>3. ● Policy revision with staff education related to "promoting/maintaining resident dignity"</p> <ul style="list-style-type: none"> ● Direct care staff education related to promoting resident dignity. ● Effective 12/5/13 resident council meeting includes guidance for voicing privacy concerns. 	

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F 241	<p>Continued From page 7</p> <p>occasion stating, "Who do you have in there?" and "some also peek." Additionally, the privacy curtain was approximately 21 1/2 inches off the floor. A resident's bare legs and feet could potentially be viewed from the hallway if the door was opened.</p> <p>On 11/14/13 at approximately 9:10 a.m. cognitively alert Resident #29 reported staff had opened the privacy curtain exposing her during her showers on occasion.</p> <p>On 11/14/13 at approximately 9:12 a.m. Resident #36 stated, "Some people don't care if they are exposed to the world but I'm not one of them."</p> <p>Resident #62: Review of the medical record revealed the resident had multiple diagnoses including a disorder of her [REDACTED] and [REDACTED]. The resident's plan of care noted she had [REDACTED] required caregiver assistance for her activities of daily living, and had fragile [REDACTED] with recent [REDACTED] issues.</p> <p>Observations on 11/07/13 at approximately 1:55 p.m. noted a sign posted on the wall over the toilet in the resident's bathroom stating, "Do not use wipes on (the resident's name)!!!!" The sign could potentially be viewed by the resident, her roommate if taken into the bathroom, or by visitors entering the bathroom.</p> <p>On 11/08/13 at approximately 9:14 a.m., Staff Member L, a NA, entered Resident #62's room with two Physician Students and stated, "(The resident's nickname) is very continent. She likes to wear those girlie pads." The comment was spoken in front of Resident #62, her roommate (Resident #124), the Physician Students, and the</p>	F 241	<p>4. • Continue with resident quality of life interviews to ensure care is being provided in a manner that promotes dignity & respect. Interviews are being reviewed by Administrator</p> <p>5. Corrective action will be completed by 12/17/13</p> <p>6. Director of Nursing will be responsible to ensure correction.</p>		

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F 241	<p>Continued From page 8 Surveyor.</p> <p>Resident #124: Review of the resident's medical record revealed the resident had multiple diagnoses including history of a [REDACTED] and recent [REDACTED] issues. An 08/19/13 comprehensive assessment documented the resident had significant [REDACTED] impairment, scoring [REDACTED] out of a possible score of [REDACTED] on the [REDACTED] test. The resident's plan of care also noted the resident had some [REDACTED] problems as well as a [REDACTED] in her [REDACTED] functioning with a deficit in [REDACTED] and [REDACTED] making.</p> <p>On 11/08/13 at approximately 9:12 a.m., Staff Member L was overheard from the hallway telling two Physician Students that Resident #124 had [REDACTED] problems. As Staff Member L entered the room and approached Resident #124 with the Physician Students she made a statement that the resident did not know her address. Resident #124 stated, "I do know my address!" and she recited an address. The interaction took place in front of her roommate (Resident #62), the Physician Students, and the Surveyor.</p> <p>On 11/08/13 at approximately 9:00 a.m., Staff Member M, nursing assistant (NA) entered Resident #21's room without knocking on the door and was accompanied by 4 physician students. The NA was explaining the resident's daily cares and ability to perform them. There was no introduction of the physician students nor was there an introduction or permission asked to the resident by Staff Member M.</p> <p>On 11/08/13 at approximately 9:30 a.m., Staff Member A, the director of nursing, stated that</p>	F 241		

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F 241	Continued From page 9 Staff Member M was to introduce the resident to the physician students and was to ask permission from the resident to allow information to be discussed. about the resident.	F 241			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide sufficient supervision to prevent falls for 1 of 4 sampled residents (#68) with falls/accidents. Resident #68 frequently received anti-anxiety medication in excess of the total daily dose threshold resulting in an increased risk for falls/accidents. The facility failed to provide a sufficient level of supervision to mitigate the known risk. Thus, the resident remained at risk for falls and potential injury. Findings include: Resident #68: A review of the medical record revealed the resident was admitted on [REDACTED]/13 with multiple diagnoses including a [REDACTED] in her [REDACTED] a [REDACTED], an [REDACTED] [REDACTED] and [REDACTED]. Admission orders, dated 9/04/13, included an order for [REDACTED] twice daily to address the resident's anxiety. The resident	F 323	F 323 1. Resident #68: Resident discharged [REDACTED]/2013. Consent for [REDACTED] medication obtained 9/4/13 plan of care established 9/4/13 with ongoing revisions, bims completed 9/10, 9/17, 9/20, 9/30, 10/7, 11/1 with severe [REDACTED] noted. Pharmacy consultant reviews completed 9/14 and 10/14 with documentation included. "Patient looks awake with [REDACTED] QID". In house physician visits with resident & family with reviews of medications 10/22/2013. Dr. Brady on 9/30/13 notes additional diagnosis includes; [REDACTED] that include [REDACTED] and [REDACTED] and on 11/18/13 validates the necessity of her ordered medications and diagnosis related to [REDACTED] risk assessed with care plan implemented 9/4/13; care plan included "initiate 1:1 care as needed for safety". Wander guard bracelet in place, anti-roll-back mechanism placed on wheelchair for safety, fall alarm in place on bed and wheelchair. Her level of supervision included keeping her in		

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F 323	<p>Continued From page 10</p> <p>received daily blood thinning medication and pain medication as needed. During the course of the resident's stay she received [REDACTED] medication at or above the daily recommended dosages. In addition, an [REDACTED] medication was added.</p> <p>The facility's 09/04/13 consent form for the anti-anxiety medication [REDACTED] noted potential side effects such as sedation, muscle relaxations, a potential for falls, a loss of inhibition, confusion, and disorientation.</p> <p>The plan of care documented the resident required assistance for transfers and ambulation. The resident experienced anxiety and fearfulness often about her family and was at risk for elopement. A specific intervention included "1:1 (one-on-one) care as needed for safety of herself or others." The resident was at risk for falls/injury related to her poor balance, non-compliance with mobility aid use, and impaired cognition.</p> <p>A 09/18/13 comprehensive assessment documented the resident had significant cognitive impairment, scoring [REDACTED] out of a possible [REDACTED] on a [REDACTED] test.</p> <p>Refer to F329 for a discussion pertaining to the dosing ranges and the addition of an anti-psychotic medication beginning on 10/18/13 with additional potential impact on mobility and cognition.</p> <p>According to nursing entries and facility investigative documents, the resident experienced two non-injury falls shortly after admission. On 09/08/13 the resident bent over in her wheelchair and fell to the floor. On 09/09/13</p>	F 323	<p>needed. Review of falls again on 11/18/13 substantiate that the increase in [REDACTED] from 10/4/13-10/14/13 did not result in an increased number of falls. #68 medication management was on going and determined by the physicians.</p> <ol style="list-style-type: none"> Fall and Safety risk assessment are complete and interventions currently in place are appropriate for identified residents. • Revision of "Accidents & Supervision" policy to include "levels of supervision" to ensure each resident receives adequate supervision. Revision of 1:1 form to include levels of supervision documentation. In-service to direct care staff of policy "accidents & supervision", 1:1 form, and completion of logs. Quality Assurance Committee will review any residents requiring level of supervision beyond standard including one-on-one, 30 minute checks, etc. to ensure residents are provided the sufficient level of supervision to prevent known risks. Director of nursing will be responsible to ensure correction. 		

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F 323	<p>Continued From page 11</p> <p>the resident was sitting near the nurses' station and started to stand. However, the resident failed to lock her brakes and she fell to the floor.</p> <p>A 09/29/13 nursing entry documented the resident "does not respond to redirection or orientation. Resident is generally calm when engaged 1-on-1 with someone else, but will often direct conversation to finding her family members, and 'I have to get out of here.'..."Resident continually stands up and attempts to ambulate independently."</p> <p>Nursing documentation on 10/01/13 nursing entry recorded the resident was extremely fearful and anxious. The Licensed Nurse kept the resident at the nurses' station off and on to keep her calm. On 10/02/13 the resident was noted to wander over to her roommate's bed to attempt to urinate on the bed. Later that day, one-on-one was initiated. On 10/04/13 the resident was exit seeking and made an attempt to leave the building but staff were able to assist her successfully.</p> <p>On 10/04/14 there was a physician's order to increase the resident's [REDACTED] medication dose to [REDACTED] times the previous dose with extra as needed medication as an option as well.</p> <p>A 10/06/13 nursing entry documented the resident requested water, received the water, and then was trying to pour water down another resident's mouth stating, 'It's OK shes (sic) had it before.' One-on-one was initiated after the incident (for an interval).</p> <p>A 10/07/13 nursing entry and investigative documents recorded that at 7:07 a.m. the</p>	F 323	6. Corrective action will be completed by 12/17/13	12/17/13

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	<p>Continued From page 12</p> <p>resident had reportedly gotten up out of bed, was attempting to dress herself, and fell on the floor. No injuries were identified. A safety alarm was re-initiated.</p> <p>Documentation from a care conference, a late entry on 10/08/13, revealed a discussion about a plan to decrease the resident's [REDACTED] and pain medication because the resident was not responding well to the increased [REDACTED]. On occasion the resident had one-on-one staff assigned.</p> <p>On [REDACTED]/13 the nursing entry noted the resident fell out of her recliner onto the floor bumping her head. There was a [REDACTED] centimeter "goose egg on her forehead." The resident was sent to the hospital for an evaluation. No further injuries were identified.</p> <p>Per the investigative documentation, on [REDACTED]/13 the resident was at the nurses' station with staff nearby and the resident self-transferred and fell. A nursing entry later that day noted the resident was experiencing some changes in her speech and was unable to maintain her balance when walking even with assistance. She was sent to the hospital for an evaluation but returned to the facility thereafter without abnormal findings.</p> <p>According to a 10/16/13 nursing entry, the resident made decisions without thinking of the consequences or personal safety. "Staff monitors for falls because she will self-transfer." A 10/19/13 nursing entry documented the resident was found on the floor next to her bed. No injuries were noted.</p> <p>Nursing entries documented the resident</p>			

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F 323	<p>Continued From page 13</p> <p>experienced falls on 10/23/13 and on 10/26/13 due to self-transferring. An 11/01/13 incident note (pertaining to the 10/26/13 fall) documented, "As interventions we are continuing to provide as much 1:1 supervision as we can, family is also assisting with this, and she (the resident) has had multiple medication changes."</p> <p>A fall investigation, dated [REDACTED]/13 at 4:00 p.m., documented another self-transfer and fall to the floor without injury. A [REDACTED]/13 incident note (referencing the 10/29/13 4:00 p.m. fall) documented that the resident's assigned one-on-one caregiver exited the room to ask the Charge Nurse if she should stay in the room or return to her other scheduled work since the resident was sleeping. The resident's alarm sounded and staff member returned to find the resident falling. No injuries were identified but the resident was sent to the hospital for an evaluation because the resident's lab work was elevated, increasing her bleeding risk. After return from the hospital on [REDACTED]/13, the nursing entry recorded the resident fell again in her room at approximately 7:30 p.m. No injuries were identified. Two days later, on 10/31/13 at 8:21 p.m., the nursing entry documented the resident's alarm was sounding and the resident was on the floor in her room. No injuries were identified. The resident had three falls in three days.</p> <p>Investigative documentation noted on 11/03/13 at 10:39 p.m. staff responded to the alarm sounding and found the resident on the floor. The resident was unable to state what had happened. No injuries were observed.</p> <p>Finally, an 11/06/13 investigative summary documented Resident #68 was in her room sitting</p>	F 323		

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F 323	<p>Continued From page 14</p> <p>on her roommate, refusing to get off her. Staff intervened and the resident was sent to the hospital.</p> <p>When interviewed on 11/15/13 at approximately 1:20 p.m., Staff Member E, a Licensed Nurse (LN), stated the Charge Nurse would keep the resident at the nurses' station to monitor her. On 10/29/13 the resident fell asleep and the one-on-one staff member left the room to ask if it was okay to leave the resident because she was sleeping and the resident fell. Staff member E stated the (psychoactive medication) was not helpful "it made her less stable on her feet". The resident would self-transfer. She had [REDACTED] and was [REDACTED]</p> <p>On 11/18/13 at approximately 8:32 a.m., Staff Member C, a LN, stated "If we didn't do one-on-ones she would be on the ground." From 1:00 p.m. to bedtime was her worst time. Earlier she would visit with other residents. Staff had to try to keep her busy. She was always fearful and afraid of the dark. The resident thought she should be cleaning the house and caring for others. The [REDACTED] (anti-anxiety medication) never really worked for her." and made her fall, her balance was worse. The resident was always saying 'please don't leave me alone.' Her son would come around noon and try to get her to nap. "She needed constant attention." "As long as she had someone to comfort her she was OK." If there was a staff member on light duty they would assign them to her. We told the family they would have to do one-on-ones but they didn't. If one-on-ones were not provided then they would have to do fall reports. Staff Member C recalled having to instruct the staff not to talk loudly. If they talked loudly it would set her off.</p>	F 323		

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F 323	Continued From page 15	F 323			
F 325 SS=D	<p>Although the facility recognized the resident's fall risk, they failed to provide the necessary ongoing level of supervision to prevent recurrent falls typically related to self-transfers. The resident was at increased risk of falls due to her psychoactive medications.</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to ensure 1 of 4 residents (#184) sampled for nutrition and/or weight loss did not experience significant unintentional body weight loss. Failure to provide adequate calories and protein for Resident #184 resulted in potential for poor wound healing and continued weight loss. Findings include:</p> <p>Resident #184 was admitted [redacted] 11/13 from a hospital with diagnoses including recent [redacted] to [redacted] a [redacted] that had [redacted] and become [redacted]. The most recent</p>	F 325	<p>F325</p> <ol style="list-style-type: none"> 1. Resident # 184: On 11/14/13 a physician's order for [redacted] initiated per order. Registered dietician reassessed the nutritional status of resident #184 on 11/15/2013. Revisions to care plan with interventions reviewed with staff. On 11/15/13, 11/8, 11/13, 11/22. assessment of [redacted] & [redacted] with no concerns noted. 2. Dietician developed communication log to ensure needs are documented with interventions in place. 3. Dietician with in-service to licensed nurses r/t "dietician communication log" placed at nurses stations to address concerns with interventions in place. 4. Communication log will be reviewed weekly at "Skin/Weight Committee" to ensure interventions in place and residents are receiving adequate [redacted] intake 		

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F 325	<p>Continued From page 16</p> <p>comprehensive assessment noted the resident was cognitively alert and had no chewing or swallowing problems.</p> <p>Per record review, Resident #184 weighed [redacted] pounds (lbs.) on 10/30/13. On 11/02/13, he weighed [redacted] lbs. (a [redacted] lb. [redacted] and a [redacted] [redacted] in body weight from admission). On 11/06/13, the resident weighed [redacted] lbs. (a [redacted] lb. [redacted] and a [redacted] decrease in weight from admission). On 11/13/13, he weighed [redacted] lbs. (a [redacted] lb. [redacted] and a [redacted] decrease in weight from admission).</p> <p>Review of the resident's care plan revealed he was identified as being at nutrition risk on 11/06/13 due to unintentional weight [redacted] poor intake and an infected [redacted] hip. Interventions identified on the care plan included a general diet, a [redacted] per cubic centimeter (cc) supplement three times a day with medications, multiple [redacted] and [redacted] supplementation, health [redacted] (high [redacted] and high [redacted] supplement designed to resemble a milkshake) with lunch and dinner and having the dietary manager meet with him for food preferences.</p> <p>On 11/06/13, a nutrition assessment completed by Staff Member B, Registered Dietitian, noted [redacted] weight and the resident "is not eating adequately for wound healing needs." She assessed his ideal body weight to be [redacted] lbs. plus or minus [redacted]. The assessment recommended starting the [redacted] per cc supplement with medications.</p> <p>On 11/14/13 at approximately 11:40 a.m., Staff Member C, licensed nurse, stated Resident #184 was "super picky" about his food and the</p>	F 325	<p>5. Director of nursing will be responsible to ensure correction completed.</p> <p>6. Corrective action will be completed by 12/17/2013</p>	<p>12-13-17</p>

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F 325	Continued From page 17 resident's private caregiver sometimes brought in food for him. Staff Member C stated he could not find a physician order for the [REDACTED] supplement recommended by the dietitian in the assessment. On 11/14/13 at approximately 12:40 p.m., Resident #184 was observed in his room with his lunch on a tray on his bedside table. On the tray was a partly eaten sandwich, an unopened container of yogurt, an empty container of chocolate health shake, and approximately 6 ounces pink fluid in a glass. It appeared that none of the pink fluid had been taken from the glass. The resident stated he thought the pink fluid in the glass was [REDACTED] (a brand name for a high calorie, high protein [REDACTED]). He further stated "Today is the first day I've seen the health shake and the [REDACTED]" On 11/15/13 at approximately 3:00 p.m. Staff Member B stated when she makes a nutrition recommendation for a supplement, she typically writes an order for the physician to approve, which initiates implementation of the recommendation. In the case of Resident #184, she stated that it appeared she did not follow through with the physician order, thus supplements were not offered to the resident. Failure to implement recommended supplementation placed the resident at risk of poor wound healing, continued weight [REDACTED] and a decline in nutrition health.	F 325			
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from	F 329	F 329	1. Resident # 68 admitted 09/4/13 with primary DX including phlebitis,	

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F 329	<p>Continued From page 18</p> <p>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>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure 2 of 6 sampled residents (#68 & #184) received medications with adequate indication for use, without an excessive dosage, and/or without evidence of adverse consequences as required by 42 CFR 483.25(l)(1)(i)(iv)&(v). Failure to comply with the noted parameters placed the residents at potential risk for negative outcomes related to receiving unnecessary medications. Findings include:</p> <p>Resident #68: A review of the medical record</p>	F 329	<p>with [REDACTED] related to her advance [REDACTED]. •: Consent for [REDACTED] medication obtained 9/4/13 plan of care established 9/4/13 with ongoing revisions, bims completed 9/10, 9/17, 9/20, 9/30, 10/7, 11/1 with severe [REDACTED] noted. Pharmacy consultant reviews completed 9/14 and 10/14 with documentation included. "Patient looks awake with [REDACTED] QID". In house physician visits with resident & family with reviews of medications 10/22/2013. Dr. Brady on 9/30/13 notes additional diagnosis includes; [REDACTED] that include [REDACTED] and [REDACTED] problems" and on 11/18/13 validates the necessity of her ordered medications and diagnosis related to medications. fall risk assessed with care plan implemented 9/4/13; care plan included "initiate 1:1 care as needed for safety". Wander guard bracelet in place, anti-roll-back mechanism placed on wheelchair for safety, fall alarm in place on bed and wheelchair. Her level of supervision included keeping her in view at nursing station and 1:1 when needed. Review of falls again on 11/18/13 substantiate that the increase in [REDACTED] from 10/4/13-10/14/13 did not result in an increased number of falls. #68 medication management was on going and determined by the</p>	

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F 329	<p>Continued From page 19</p> <p>revealed the resident was admitted on [REDACTED]/13 with multiple diagnoses including a [REDACTED] in her [REDACTED] a [REDACTED], an [REDACTED] condition not based in [REDACTED], [REDACTED], and [REDACTED]. Admission orders, dated [REDACTED]/13, included an order for [REDACTED] twice daily to address the resident's [REDACTED]. The resident received daily [REDACTED] medication and [REDACTED] medication as needed.</p> <p>Per guidelines, the resident was admitted with orders for [REDACTED] at the total daily threshold, a total of [REDACTED] a day, for the [REDACTED] medication (to minimize adverse side effect potential for the elderly resident).</p> <p>A review of a [REDACTED]/13 Consent for [REDACTED] Treatment identified the facility had sought permission from a family member to use [REDACTED] for treatment of the resident's [REDACTED]. No specific dosage was referenced. The family member signed on [REDACTED]/13 granting permission for use of [REDACTED]. Risks for the use of the medication included sedation, muscle relaxation, potential for falls, vertigo (dizziness), syncope (fainting), confusion, dependence on the medication, loss of inhibition, disorientation, depression, insomnia, and increase in aggression related to disinhibition.</p> <p>On 09/05/13 there was a physician's order for [REDACTED] orally every 6 hours daily as needed, in addition to the routine [REDACTED] administered most days. Behavioral monitoring for the use of the anti-anxiety medication included incidents of impulsive behaviors with transfers/self transfers, restlessness, agitation, and anxious behaviors.</p>	F 329	<p>physicians. Resident discharged 11/06/13.</p> <p>Resident #184-Admitted [REDACTED]/13 with dx of recent [REDACTED] with [REDACTED] of [REDACTED]. Sleep monitor initiated upon admission resident discharged [REDACTED]/13.</p> <ol style="list-style-type: none"> Immediate review of current residents ordered [REDACTED] to ensure physician documentation includes rationale, dx, dosage side effects, and tapers as needed. Weekly psychotropic meetings will review all new residents with orders for antipsychotics and antianxiety medications to ensure appropriate documentation in place, Aims if applicable, consent from completed, care plan with effective interventions. Scheduling will ensure all residents reviewed at least quarterly & as needed. Audit tool created to ensure review of medication to ensure appropriate care planning & documentation. LN's in-service r/t documentation and interventions prior to medication administered for behaviors, anxiety & 	

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F 329	Continued From page 20 A review of the September 2013 medication administration record (MAR) noted the resident received as needed doses of [REDACTED] of the 25 remaining days in the month. Thus, the resident received [REDACTED] of [REDACTED] on 09/05/13, 09/07/13, 09/21/13, and 09/22/13, the days she received both routine doses and as needed doses). The resident received [REDACTED] of [REDACTED] on 09/29/13 (twice the daily recommended daily total). A 09/18/13 comprehensive assessment documented the resident had significant [REDACTED] impairment, scoring [REDACTED] out of a possible [REDACTED] on the [REDACTED] test. Additionally, the resident required assistance for bed mobility, transferring, and walking. According to nursing entries and facility investigative documents, on 09/08/13 the resident bent over in her wheelchair and fell to the floor. No injuries were sustained. On 09/09/13 the resident was sitting near the nurses' station and started to stand. The resident failed to lock her brakes and fell to the floor. No injuries were observed. A review of a 10/04/13 physician's order revealed the daily dose of [REDACTED] went from [REDACTED] daily in two divided doses to [REDACTED] four times a day ([REDACTED] times the previous dosage.). No justification was noted to explain why the previous dosage was insufficient or why the prescribed dose was the lowest therapeutic dose. The 09/05/13 as needed [REDACTED] every 6 hours was also available for administration. Documentation from a care conference, a late	F 329	or insomnia etc. and completion of behavior monitor flow sheets. • Random audits of charts for residents with antipsychotics antianxiety etc. will be completed every two weeks x 2 months to ensure the facility is monitoring the effectiveness of medications and appropriate care planning in place, tapers in place as required. • Quality Assurance Committee will review monthly the minutes from weekly meetings with Medical Director/Pharmacist. 5. Director of Nursing will be responsible to ensure correction. 6. Corrective action will be completed by 12/17/2013		

12-17-13

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

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F 329	<p>Continued From page 21</p> <p>entry on 10/08/13, revealed a discussion about a plan to decrease the resident's [REDACTED] and pain medication because the resident was not responding well to the increased [REDACTED]</p> <p>On 10/10/13 the Pharmacist requested documentation about the [REDACTED] four times a day and why it was necessary. The Pharmacist's Consultation Report, signed 10/15/13, also advised the facility of the high [REDACTED] dose and requested documentation about why it was necessary to use that dosage to improve her anxiety.</p> <p>The October 2013 MAR noted the resident received [REDACTED] on 10/05/13 and 10/06/13, the four routine doses and an additional as needed dose.</p> <p>On 10/14/13 there was an order to decrease the [REDACTED] to [REDACTED] four times a day. An anti-psychotic medication, [REDACTED] was added on 10/18/13 at [REDACTED] twice daily and increased on 10/24/13 to [REDACTED] twice daily (both [REDACTED] dosages exceeding the daily recommended dosage of [REDACTED] for behavioral management with [REDACTED] although [REDACTED] was also noted). The "as needed" [REDACTED] dose option continued. On 10/22/13 the [REDACTED] was decreased to [REDACTED] every eight hours.</p> <p>A review of nursing entries and investigative documents revealed multiple falls usually related to self-transfers or accidents during the month of October 2013 and November 2013 on: 10/07/13 (fall), 10/09/13 (dropped her foot while being pushed in her wheelchair causing it to be dragged), 10/10/13 (fall with a bruise on her [REDACTED]), 10/14/13 (fall), 10/19/13 (fall),</p>	F 329		

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F 329	<p>Continued From page 22</p> <p>10/23/13(fall), 10/26/13 (fall), 10/29/13 (two falls), 10/31/13 (fall), and 11/03/13 (fall). The falls were all non-injury falls except the fall resulting in a bruise on her [REDACTED].</p> <p>On 11/15/13 at approximately 1:20 p.m. Staff Member E, a Licensed Nurse (LN), reviewed the resident's behaviors and falls. The [REDACTED] medications were initially managed by one physician then later by another. The medication reportedly "made her less stable on her feet."</p> <p>11/18/13 at approximately 8:32 am Staff Member C, a LN, stated the "[REDACTED] never really worked for her".... "[REDACTED] made her worse, it made her fall." After the [REDACTED] her balance was worse. She was lethargic (at times) but it never zonked her...She had [REDACTED] in her [REDACTED] as well, walked some. She was less able to walk over time.</p> <p>On 11/15/13 at approximately 2:00 p.m. and on 11/18/13 at approximately 9:35 a.m. Staff Member D, a Licensed Nurse (LN), was interviewed. Staff Member D stated the resident was on "a lot of [REDACTED] the dose seemed high" but she had very high [REDACTED]. On 11/18/13 Staff Member D stated she was unable to locate any physician documentation/justification for the dosage of [REDACTED] exceeding the daily maximum dosage. She had notified the physician's office to seek documentation if available.</p> <p>A review of Physician documentation, received on 11/19/13, revealed documentation that the resident experienced episodes of "agitated [REDACTED]" and some calming effect on her agitation was required. The dose selected "reflects the severity of her [REDACTED]"</p>	F 329		

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F 329	<p>Continued From page 23</p> <p>condition frequently causing confusion) and agitation. The dose varies with her level of confusion."</p> <p>Although helpful in identifying the rationale for treatment, the documentation did not discuss the the specific medication prescribed, specific doses, risk of side effects, and why a specific lower dose was insufficient in managing symptoms especially in relation to the increase in the daily dose from [REDACTED] to [REDACTED] (with additional medication available as needed).</p> <p>The facility failed to show evidence of a specific analysis of the effectiveness and impact of the [REDACTED] and later the [REDACTED] and [REDACTED] on the resident especially in light of the significant number of falls, mobility concerns, and behavioral issues.</p> <p>Resident #184. Admitted on [REDACTED]/13 with diagnoses to include recent [REDACTED] to [REDACTED] and [REDACTED].</p> <p>Review of the physician orders revealed an order dated 11/01/13 for the medication [REDACTED] (a drug used to treat anxiety) [REDACTED] and to give [REDACTED] tablet orally up to [REDACTED] a day as needed for [REDACTED] or [REDACTED]. Review of the MAR revealed between 11/01/13 and 11/14/13, [REDACTED] [REDACTED] was given twice on eight days (11/01,11/02,11/04,11/05,11/08,11/10,11/11 and 11/12/13). [REDACTED] was given once on 11/06/13. All doses were administered in the evening and night hours,</p> <p>Review of the care plan revealed the use of the anti-anxiety medication was to be monitored and documented for side effects and effectiveness.</p>	F 329		

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F 329	<p>Continued From page 24</p> <p>Occurrences of target behavior were also to be monitored and documented.</p> <p>Review of the "Behavior Monthly Flow Sheet" for November 2013 revealed documentation began on 11/12/13. Between 11/12/13 and 11/15/13, there were no documented episodes of insomnia.</p> <p>On 11/14/13 at approximately 4:10 p.m., Staff Member N, Licensed Nurse (LN), stated the resident asked for [REDACTED] for insomnia. She further stated they do not offer non-medicinal alternatives before giving the [REDACTED], though she does usually asked him if he is in pain. She stated her usual documentation on the MAR for this medication is "[REDACTED]"</p> <p>On 11/14/13 at 4:30 p.m., Staff Member C, LN, stated usually they would document in the MAR non-medicinal interventions offered before the medication was given. He said he did not see from looking at the chart that "we are doing that for Resident #184."</p> <p>On 11/15/13 at 2:45 p.m., Staff Member O, Social Services, stated she did not start behavior monitoring documentation for Resident #184 until 11/12/13.</p> <p>Failure to try non-medicinal alternatives before administering medication, failure to monitor the target behavior the medication was intended for and failure to monitor the effectiveness of the medication placed the resident at risk of receiving medication without adequate indication for use.</p>	F 329			