STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	376034	A. BUILDING _____ B. WING _____	C 12/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD CARE CENTER	6202 EAST 61ST STREET TULSA, OK 74136

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification/relicensure survey was conducted on 12/09/13 through 12/13/13 and 12/16/13 through 12/17/13. Complaints #OK00043512, #OK00043448, #OK00043468, #OK00043443, #OK00043458, and #OK00043539 were investigated in conjunction with this survey. The following abbreviations/symbols were used in this text: ADON - Assistant Director of Nursing CMA - certified medication aide CNA - certified nurse aide DON - director of nursing LPN - licensed practical nurse RN - registered nurse DA - dietary aide DM - dietary manager SS - social services adl - activities of daily living A-fib - atrial fibrillation BID - twice daily bil - bilateral BLE - bilateral lower extremities c - with CHF - congestive heart failure c/o - complaint of cont - continue COPD - chronic obstructive pulmonary disease dc - discontinue DVT - deep vein thrombosis dx - diagnosis fx - fracture L - left med - medication	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Onya Maness — TITLE: LNHA — (X6) DATE: 1-17-14

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 000	Continued From page 1 mg - milligram N/O - New order NS - normal saline po - by mouth ppm - parts per million prn - as needed q - every qd - every day r or rt - right sq - subcutaneous s/sx - signs and symptoms TAR - treatment administration record T/O - telephone order tx - treatment vac - vaccum w/c - wheelchair wk - week w/o - without x - times	F 000		
F 157 SS=H	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in	F 157	**Without admitting or denying the validity or existence of the alleged deficiencies, Maplewood Care Center provides the following plan of correction.** F157 1. On 12/14/13, resident #3's physician was notified of her pain. The physician ordered her to begin on dilaudid 1mg per peg q 4 hours routinely at this time. 2. All residents receiving routine and/or as needed pain medications have the potential to be affected. A pain screen was completed on these residents by 01/17/14	1/31/14

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F 157	Continued From page 2 §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to notify the physician of increased pain for one (#3) of thirteen sampled residents who were reviewed for pain. This resulted in actual harm for resident #3. The facility identified 72 residents as receiving routine and/or as needed pain medications. Findings: The facility's policy on pain, dated 04/2013, documented, "...Assessment and Recognition...Includes a review of known diagnoses or conditions that commonly cause or predispose residents to pain...Review for any treatments that the resident currently is receiving for pain...Assessments should occur on admission to the facility, at each quarterly review, whenever there is a significant change in condition and at any time pain is suspected...The staff will reassess the individual's pain and consequences of pain at regular intervals..."	F 157	3. Nursing staff were inserviced by the Risk Manager on 12/17/13 regarding notification of physicians with increased or uncontrolled pain. 4. Audits will be completed to ensure residents are effectively treated for pain weekly x 4, monthly x 3 and quarterly x 1 and finding reported in the Quality Assurance Meeting.	

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F 157	Continued From page 3 Resident #3 was admitted to the facility on 09/14/11 with diagnoses that included multiple sclerosis (MS), chronic pain, dysarthria, joint contractures, multiple pressure ulcers, diabetes, and myalgia. The resident received all medications via a percutaneous gastrostomy tube. Physicians orders, dated 02/2013, documented the resident was to receive Norco 7.5/325 mg, two tablets every eight hours for pain, Baclofen 10 mg every six hours for muscle spasms, Zanaflex 4 mg every six hours for spasms, and acetaminophen 640 mg every fours hours as needed for pain. A physician's order, dated 02/08/13 at 7:00 p.m., documented to decrease the resident's Norco to 7.5/325 mg every eight hours for pain. A physician's order, dated 02/17/13, documented the resident could receive Norco 7.5/325 mg every eight hours as needed for pain. A nurse's note, dated 02/19/13, documented, "... [Name withheld] [complains of] pain...[one] tab Norco does not relieve pain...Requested to have it back to 2 tab [sic]..." A physician's order, dated 02/19/13, documented to increase the pain medication back to Norco 7.5/325 mg two tablets every eight hours routinely for pain. Physician's orders, dasted 05/2013, documented the resident was to receive Norco 7.5/325 mg, two tablets every eight hours, acetaminophen 640 mg every eight hours, and naproxen 250 mg	F 157		

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F 157	Continued From page 4 every twelve hours as needed for pain Resident #3 was hospitalized on 05/20/13 and re-admitted to the facility on 06/11/13. The facility admission/start-up orders, dated 06/11/13, documented the resident was to receive Norco 7.5/325 mg two tablets every eight hours for pain and acetaminphen 650 mg every four hours as needed for pain. The diagnosis description included Sacral ulcer stage IV, multiple sclerosis, dysarthria, left leg contracture, and contracture of the hand. Another facility admission/start-up order, dated 06/11/13, documented the resident was to receive Norco 5/325 mg every four hours as needed for pain and naproxen 250 mg every 12 hours as needed for pain. A physician order, dated 06/14/13, documented to increase the resident's Norco 7.5/325 to two tablets every six hours. A quarterly assessment, dated 06/18/13, documented the resident was cognitively intact, required total assistance from staff for bed mobility, transfers, and all ADLs. It was documented the resident's upper and lower extremity range of motion was impaired due to joint contractures. It was documented the resident was on a scheduled pain medication regimen and had received as needed pain medication. It was also documented the resident's pain was frequent with an intensity of eight, on a pain scale of one to ten.	F 157		

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F 157	Continued From page 5 It was also documented the resident had three stage III pressure ulcers and one stage four pressure ulcer. There were three unstaged slough/eschar pressure ulcers. A physician order, dated 06/18/13, documented to increae the resident's Norco7.5/325 mg to two tablets every four hours. An assessment of contracture risk was completed on 06/20/13. The total score was ten. This indicated the resident was at risk and required a regular positioning schedule for both bed and chair. Predisposing factors were documented as bilateral upper and lower extremity flexion contractures. It was also documented the resident's hands were contracted. The resident was hospitalized on 07/25/13 for non-healing pressure ulcers and re-admitted to the facility on 08/09/13. The facility admission/start-up orders, dated 08/09/13, documented the resident was to receive acetaminophen 640 mg every four hours as needed for pain and Norco 5/325 mg two tablets every four hours as needed for pain. A routine pain medication was not ordered on readmission. A facility pain assessment was completed on 08/09/13. The assessment documented the resident had experienced pain daily in the last seven days in both legs and feet. The assessment revealed that pain was increased upon movement.	F 157		

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F 157	Continued From page 6 A medication administration record, dated 08/2013, documented the resident received Norco 5/325 mg, two tablets almost daily. On 08/24/13, the resident was hospitalized for non-healing pressure ulcers and re-admitted to the facility on 09/16/13. The facility admission/start-up orders, dated 09/16/13, documented the resident was to receive Norco 7.5/325 mg every four hours as needed for pain and naproxen 220 mg daily. The diagnosis description on re-admission included multiple pressure ulcers, multiple sclerosis, depression, and neuropathy. A nurse's note, dated 09/16/13 at 1:46 p.m., documented, "...Res arrived at facility via hospital transportation...Multiple wounds to legs, both feet [and] both hips...Wound nurse to assess [and] treat...Res in too much pain to allow nurse to turn [and] assess skin on back [and] coccyx..." A pain assessment was completed on 09/16/13. The assessment documented the resident rated her pain at six on a scale of one to ten. It was documented the resident's pain was located in both knees and hips. The pain was described as sharp and increased with activities. An annual assessment, dated 09/17/13, documented the resident was on a scheduled pain medication regimen and received as needed pain medication. The assessment revealed the resident's pain was frequent and rated at six on a scale of one to ten. It was documented the pain made it hard for the resident to sleep.	F 157		

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F 157	Continued From page 7 A nurse's note, dated 09/20/13, documented, "...Dr.[Name withheld] in the building [new order] to [increase] baclofen to QID, Flexeril 10 mg TID..." On 10/03/13, the resident was hospitalized for non-healing pressure ulcers and re-admitted to the facility on 10/08/13. The diagnosis description on re-admission included multiple sclerosis, depression, and pressure ulcers on the low back, hip, and heel. A pain assessment was completed on10/08/13. The assessment revealed the resident's diagnosis of multiple sclerosis and conditions of contractures and pressure ulcers that would likely cause pain. It was documented the resident received routine and as needed pain medication. It was also documented the resident had described the pain as dull, burning, tingling, pins and needles. The pain involved both upper and lower extremities, occurred daily, and was intermittent. The intensity was rated seven on a pain scale of one to ten and affected the resident's sleep. Repositioning and movement made the pain worse. The facility resident-data collection, dated 10/08/13, documented the resident experienced constant, severe pain in both lower extremities, rating the pain a five on a pain scale of one to ten. Monthly physician orders, dated 10/2013, documented the resident was to receive Aleve 220 mg every day for pain. There was no documentation of any other pain medications being ordered.	F 157		

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F 157	Continued From page 8 Monthly physician orders, dated 11/2013, documented the resident was to receive Aleve 200 mg one tablet every day for pain and Norco 7.5/325 mg two tablets every four hours as needed for pain. A Peg Tube facility form, dated 11/2013, documented the resident received Norco 7.5/325 mg one tablet every four hours as needed for pain. The resident's care plan, updated 11/25/13, documented, "...Problem/Need...She will be monitor [sic] for any and all pain, using pain scale if appropriate...Medicate with ordered medication call physician if no relief obtained...Goal...Receive medication as ordered...she will be comfortable and achieve her goal of pain level 4...Approaches...If relief is not obtained consult physician to change or add to medication ordered..." Monthly physician orders, dated 12/2013, documented the resident was to receive Aleve 220 mg every day for pain and Norco 7.5/325 mg two tablets every four hours as needed for pain. Medication administraton records, dated 12/2013, documented, "...Norco 7.5-325 Tablet 2 Tabs Per Peg Tube Every 4 Hrs As Needed..." There was a slash mark through the two in the administration directions of the Norco, and the numeral "1" was written in. Review of narcotic count sheets, dated 12/01/13 through 12/09/13, revealed documentation the resident requested, on a daily basis, Norco 7.5/325 tablets with each tube feeding, at 9:00	F 157		

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F 157	Continued From page 9 a.m., 12:00 p.m., and 4:00 p.m. On 12/10/13 at 9:25 a.m., LPN #3 was observed administering pressure ulcer care to resident #3. The resident was observed to be severely contracted in the hips and knees. The resident's torso was twisted to the left from the waist down with both legs drawn and crossed at the ankles which caused contact in areas creating high risk pressure points. The LPN stated the resident had been administered pain medication 30 minutes prior to the wound care beginning. The resident was asked to rate her pain on a scale of one to ten. She stated, "Eight." The resident was unable to relax due to muscle spasms. When the LPN would touch the resident, she would begin having muscle spasms. With each manipulation of the resident's lower extremities the resident would yell out, "Oh, Oh." The resident was very flushed, her cheecks were red, and her eyes were wide. She had a grimace on her face with a fearful look when she knew she would be moved. At 10:05 a.m., the resident was asked if she had received pain medication prior to wound care. She stated, "Yes." She was asked if she felt the pain medication was effective. She stated, "They tell me I take the strongest pain medication they can give me, but I could stand a stronger one."	F 157		

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F 157	Continued From page 10 She was asked if she ever refused repositioning. She stated, "Sometimes. It hurts. They can't get me comfortable." At 10:17 a.m., LPN #2 was asked if she felt the resident's pain medication was effective when administering wound care. She stated, "She has muscle spasms when you touch or move her." At 10:55 a.m., CNA #2 was asked how she knew the resident was in pain when administering care. She stated, "She yells." She was asked what she did when she saw the resident was in pain. She stated she would tell the medication aide or reposition the resident. She stated the medication aide will give her a pain pill. She stated, "She lets us move her but she doesn't want to." She stated, "She hates showers, she cries." She was asked what causes the resident pain. She stated, "Touching and moving her." She was asked who she had told about the resident's pain. She stated, "Everyone knows." She was asked if the charge nurses were aware. She stated, "Yea." She was asked if it appeared the resident's pain medication was effective in relieving the resident's pain. She stated, "No, nothing changes." On 12/12/13 at 9:44 a.m., LPN #2 was asked who was responsible for resident #3's pain management. She stated, "Dr. [name withheld] and each nurse."	F 157		

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F 157	Continued From page 11 She was asked what was done with the information obtained during pain assessments. She stated, "Chart it and medicate according to the assessment." She was asked what caused resident #3 to have pain. She stated, "She has MS and is super contracted." She was asked what she did to minimize the resident's pain during activities known to cause pain. She stated she tried to make sure the resident had her pain medication, and she assessed to see if it worked. She stated the resident requested pain medication be given before each tube feeding. She was asked what the resident's pain medications were. She stated, "Norco and Aleve, Baclofen, Neurontin." She was asked when the last time the resident's pain medication had been adjusted. She stated, "I don't know. As long as I been taking care of her they've been the same." She stated she had been at the facility less than six months. She was asked why those specific medications were chosen. She stated, "I don't know." She was asked why the resident had been told that she was on the strongest pain medication she could be on. She stated, "I don't know who told her that." On 12/12/13 at 11:00 a.m., the medication administration record was reviewed It was documented the resident had received Baclofen	F 157		

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F 157	Continued From page 12 20 mg, Aleve 220 mg, and one tablet of Norco 7.5/325 mg at 9:00 a.m. On 12/13/13 at approximately 9:50 a.m., Dr. [name withheld] was asked if staff had informed him that the resident had increased pain with pressure ulcer dressing treatment. He stated, "I'm not too sure about that." The physician stated the resident's pain would never be completely relieved due to her diagnoses. He stated that sometimes, just breathing on the resident could cause her excruciating pain. He stated because of the resident's diagnoses, her pain was extremely difficult to manage. He was informed that the resident's routine pain medication was Aleve. He stated, "That's nothing." He was asked what he would have done if he had known the resident was having increased pain with her pressure ulcer treatments. He stated, " I would have increased her pain medication." He was asked if he depended on staff to inform him of resident's pain levels and issues with pain. He stated, "Yes I do, they are my eyes and my ears. I depend on them." The physician was asked if he knew why someone had decreased the resident's as needed Norco 7.5/325 mg from two tablets every four hours to one tablet, when it was known that one tablet did not control her pain. He stated, "No, I don't."	F 157		
F 224 SS=E	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN	F 224		

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F 224	Continued From page 13 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to prohibit verbal mistreatment for one (#30) of one resident who was observed to be verbally mistreated and failed to prohibit misappropriation of resident property for one (#14) of 29 sampled residents whose clinical records were reviewed. This had the potential to affect 163 residents who resided at the facility. Findings: The facility's undated policy on abuse documented, "...all residents entrusted into our care have an inherit right to be free from verbal, physical, and mental abuse, corporal punishment and involuntary seclusion. Therefore, this facility shall not use or condone, nor shall we tolerate any form of abuse towards our residents including, but not limited to: verbal, sexual, physical or mental abuse, mistreatment, neglect, corporal punishment, misappropriation of resident funds or involuntary seclusion..." 1. Resident #14 was admitted to the facility on 08/20/13 with diagnoses that included Alzheimer's disease. A resident personal belongings list, dated	F 224	F224 1a. On 11/21/13 , Resident #14 several items that were reported missing were found and returned to him. The additional items were replaced on 1/16/14. 1b. On 12/14/13, resident #30's care plan was updated to reflect that she had a age progression of 4yo and responds well to hand gestures. 2a. All residents have the potential to be affected. Resident and family interviews were conducted to determine if any additional property was missing or any unreported allegations of abuse on 1/20/14. 3. CNA #3 was in-serviced by the Risk Manager nurse regarding residents rights, dignity, and abuse on 12/19/13. All other staff was in-serviced on 1/20/14 by the DON. 4. Random interviews with residents and families to identify missing items or abuse will be conducted weekly x 4, monthly x 3 and quarterly thereafter. Results will be reported in the Quality Assurance meeting.	1/21/14

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	375034	A. BUILDING _____ B. WING _____	C 12/17/2013

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F 224	Continued From page 14 08/20/13, documented the resident had five t-shirts, 6 trousers, two polo shirts, six pairs socks, six underwear, two pajamas, and a mesh laundry basket. Resident council meeting minutes, dated 09/26/13, documented, "...Biggest problem is with the return of laundry. Too often items are missing...When asked to look for things, they often reappear. Where were they in the meantime? This is especially true of undergarments...Can there be some sort of system with checks and balances?..." Resident council meeting minutes, dated 10/24/13, documented, "...Laundry occasionally returned to wrong resident. Please check more carefully..." An interdisciplinary meeting form, dated 11/21/13, documented, "...Care plan meeting held c team and [family member and family member], clothing is laundered by the family but clothing is missing on a frequent basis. States some things have returned, not knowing where they may be going..." The form was signed by RN #3, SS #2, the family members, and an unknown staff member. On 12/10/13 at 1:43 p.m., the resident's room was checked for clothing. Two pajamas bottoms and one t-shirt were hanging in his closet. One pair of pajama bottoms and one t-shirt were observed in the mesh laundry basket. On 12/16/13 at 8:15 a.m., the resident's representative was asked if the resident had missing clothing items. She stated, "Yes." She was asked if the issue had been resolved. She	F 224		

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F 224	Continued From page 15	F 224		

stated, "They said they would take care of it, but it hasn't been resolved." She stated, "Some were found. They said they are working on it." The representative was asked how many clothing items were missing. She stated, "We have been replacing clothes every week or so." She stated the family had taken six new sets of clothing on the previous Saturday night because the resident only had one pants and one shirt left.

The representative was asked if they had reported the missing items. She stated, "Yes." The representative stated the family had talked with staff just the previous day about the missing clothing items and that they had been instructed to file a complaint. The representative stated the issue had also been brought up in the care plan meeting.

On 12/16/13 at 8:34 a.m., MDS coordinator #2 was asked what she did if a family complained of missing clothing during a care plan meeting. She stated she would reassure them, report the missing items to the housekeeping supervisor, and if there was no resolution, she would go and look for the missing items herself.

The MDS coordinator was asked how she informed the administrator of the complaints. She stated she would write the complaint up and social services would write a statement. She stated there was a meeting once a week and the social services department was good about following through.

She was asked if the resident's family had complained of missing clothing items. She stated she was not aware of that. She stated if they had, she would instruct them to go to social

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F 224	Continued From page 16 services. On 12/16/13 at 8:49 a.m., social services #2 was asked what he did when he received complaints of missing clothing. He stated, "Talk with the laundry. Do your best to track down the clothes. Try to find them." He stated, "I have gone to the laundry myself." Social services #2 was asked how he informed the administrator of any missing items. He stated, "Bring it to her attention." Social services #2 was asked what the administrator would do. He stated a list of the missing items would have to be taken to the administrator. Social services #2 was asked if the resident's family had complained of missing clothing items. He stated, "I don't remember." On 12/16/13 at 9:16 a.m., the resident's family member was asked if the resident had any missing clothing items. She stated, "Yes, quite a lot." She was asked if it had been reported. She stated she had told whoever the nurse was when it was identified items were missing and the laundry. She stated she had also addressed the concern in the care plan meeting. The family member was asked if the issue had been addressed to her satisfaction. She stated, "I was told they were either in the laundry or the outside source [for laundry]." She stated, "Stuff has been missing from the very beginning. A few things will show up now and then." The family member was asked if she brought new clothing on the previous Saturday. She stated, "Yes." She stated, "I brought six pants and	F 224		

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F 224	Continued From page 17 matching shirts on Saturday." She was asked if she had laundry now. She stated, "Yes, two pair of pants and shirts." On 12/16/13 at 9:27 a.m., CNA #15 was asked who did the resident's laundry. She stated, "The family." She was asked what she did when there were complaints of missing laundry. She stated, "Normally go to the housekeeper." When asked what she would do if the resident had no clothes in their room, CNA #15 stated she would normally go to the rack in the laundry and get some. On 12/16/13 at 9:28 a.m., the resident was observed to have five sets of clothing in his drawer. There were no clothes hanging in the resident's closet. On 12/16/13 at 9:48 a.m., the housekeeping supervisor was asked what she did when she received complaints about missing clothing items. She stated she would go straight to the laundry aide, do closet searches, and speak with the outside laundry company. The housekeeping supervisor was asked if she received complaints about the resident's clothing being missing. She stated, "All the time." She stated the facility did not do the resident's laundry but the aides put it in the laundry bins anyway. She stated, "You never know who's doing it and they're not going to say." The housekeeping supervisor stated signs were posted but it did not always make a difference. She stated, "Sometimes it will recycle itself and get back." The housekeeping supervisor was asked what she was told to do when she reported missing items to the administrator. She stated, "All I can	F 224		

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F 224	Continued From page 18 do is tell her and they just say to go look through the closets." She was asked if she had informed the administrator specifically about the missing clothing items belonging to resident #14. She stated, "No." On 12/16/13 at 10:13 a.m., the administrator was asked how staff notified her if there were complaints of missing laundry. She stated they would send an email or communication form and they talked about it in morning meetings. The administrator was asked how she monitored the laundry to ensure residents got their clothes. She stated the clothing was supposed to marked. She stated, "[Laundry supervisor] and I check on the laundry people. Any issues that come up we take care of." The administrator was asked how she handled complaints regarding missing laundry. She stated, "Try to find it. Sometimes it turns up. If not, replace it." The administrator was asked had there been complaints of the resident's clothing being missing. She stated, "Just once." 2. Resident #30 was admitted to the facility on 06/20/13 with diagnoses that included intellectual disabilities. The resident's care plan, dated 06/20/13, documented, "...is aphasic and cannot participate in or initiate conversation. She yells, screams and grunts and this upsets other residents. She has dx of mental retardation and depression/anxiety. She receives routine medication for this...cannot easily be redirected or	F 224		

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F 224	Continued From page 19 respond to 1:1 intervention..." The goal was, "...will receive medications as ordered and minimize her risk for increase in behaviors or mood changes thru next review..." Approaches included, "...Observe behavior pattern. Watch for ability to control behavior and expressions of needs and feelings...Recognize stressors that may precipitate problem behavior...Use calm approach when inappropriate behavior is exhibited..." On 12/09/13 at 3:31 p.m., CNA #3 and SS #2 were observed having a conversation in the north dining room. They were standing in front of resident #30. Resident #30 was yelling out and having verbal behaviors. CNA #3 turned, faced the resident, and stated, "Shush." At 3:35 p.m., CNA #3 was asked if she told the resident to shush. She stated, "No." At 3:45 p.m., SS #2 was asked if he heard CNA #3 tell the resident to shush. He stated, "Yes. I was standing right there. I've never heard that shush before." At 4:25 p.m., the administrator was asked if any one had reported an allegation of verbal mistreatment to her that afternoon. She stated, "No."	F 224		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 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	F 225	F225 1a. The abuse allegation for resident #30 was reported to the Administrator by the surveyor. The accused CNA was placed on immediately suspension until the completion of the investigation	1/31/14

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F 225	Continued From page 20 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. 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). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to: A. Report an incident of verbal mistreatment to the administrator for one (#30) of one resident	F 225	1b. A grievance form was completed for Resident #14 regarding his missing clothing and an investigation initiated on 11/21/13. 1c. Resident #24 no longer resides in this facility. Resident #34 has had no further injuries of unknown origin. Resident #21 has had no further complaints of mistreatment. 2. All residents have the potential to be affected. Resident and family interviews were conducted to identify any other residents with complaints of mistreatment or injuries of unknown origin on 1/20/14. 3. All staff was in-serviced regarding resident rights, dignity, abuse and misappropriation of property on 1/3/14. 4. Random interviews with residents and families to identify missing items or abuse will be conducted weekly x 4, monthly x 3 and quarterly thereafter. Results will be reported in the Quality Assurance meeting.	

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F 225	Continued From page 21 who was observed to be verbally mistreated; B. Report to the administrator and thoroughly investigate allegations of misappropriation of resident property for one (#14) of 25 sampled residents who were reviewed for misappropriation of property; and C. Failed to conduct thorough investigations related to resident to resident abuse or staff to resident verbal mistreatment for three (#21, #24, and #34) of four residents whose abuse investigations were reviewed. This had the potential to affect 163 residents who resided at the facility. Findings: The facility's undated policy on abuse documented, "...all residents entrusted into our care have an inherit right to be free from verbal, physical, and mental abuse, corporal punishment and involuntary seclusion. Therefore, this facility shall not use or condone, nor shall we tolerate any form of abuse towards our residents including, but not limited to: verbal, sexual, physical or mental abuse, mistreatment, neglect, corporal punishment, misappropriation of resident funds or involuntary seclusion... Training: employees will be orientated at the time of employment and have on-going in-services through the year on issues related to abuse prohibition practices:...how staff should report their knowledge related to allegations without fear of reprisal...	F 225		

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F 225	Continued From page 22 Prevention: facility will provide to residents, families and staff information on how and to whom they may report concerns...This may include the following:...assessment, care planning, and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as...residents with communication disorders, those that require heavy nursing care and/or are totally dependent on staff... Investigation: facility will conduct a thorough investigation and document all findings..." 1. Resident #14 was admitted to the facility on 08/20/13 with diagnoses that included Alzheimer's disease. A resident personal belongings list, dated 08/20/13, documented the resident had five t-shirts, 6 trousers, two polo shirts, six pairs socks, six underwear, two pajamas, and a mesh laundry basket. An interdisciplinary meeting form, dated 11/21/13, documented, "...Care plan meeting held c team and [family member and family member], clothing is laundered by the family but clothing is missing on a frequent basis. States some things have returned, not knowing where they may be going..." The form was signed by RN #3, SS #2, the family members, and an unknown staff member. On 12/10/13 at 1:43 p.m., the resident's room was checked for clothing. Two pajamas bottoms and one t-shirt were hanging in his closet. One pair of pajama bottoms and one t-shirt were observed in the mesh laundry basket.	F 225		

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F 225	Continued From page 23 On 12/16/13 at 8:15 a.m., the resident's representative was asked if the resident had missing clothing items. She stated, "Yes." She was asked if the issue had been resolved. She stated, "They said they would take care of it, but it hasn't been resolved." She stated, "Some were found. They said they are working on it." The representative was asked how many clothing items were missing. She stated, "We have been replacing clothes every week or so." She stated the family had taken six new sets of clothing on the previous Saturday night because the resident only had one pants and one shirt left. The representative was asked if they had reported the missing items. She stated, "Yes." The representative stated the family had talked with staff just the previous day about the missing clothing items and that they had been instructed to file a complaint. The representative stated the issue had also been brought up in the care plan meeting. On 12/16/13 at 8:34 a.m., MDS coordinator #2 was asked what she did if a family complained of missing clothing during a care plan meeting. She stated she would reassure them, report the missing items to the housekeeping supervisor, and if there was no resolution, she would go and look for the missing items herself. The MDS coordinator was asked how she informed the administrator of the complaints. She stated she would write the complaint up and social services would write a statement. She stated there was a meeting once a week and the social services department was good about following through.	F 225		

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F 225	Continued From page 24 She was asked if the resident's family had complained of missing clothing items. She stated she was not aware of that. She stated if they had, she would instruct them to go to social services. On 12/16/13 at 8:49 a.m., social services #2 was asked what he did when he received complaints of missing clothing. He stated, "Talk with the laundry. Do your best to track down the clothes. Try to find them." He stated, "I have gone to the laundry myself." Social services #2 was asked how he informed the administrator of any missing items. He stated, "Bring it to her attention." Social services #2 was asked what the administrator would do. He stated a list of the missing items would have to be taken to the administrator. Social services #2 was asked if the resident's family had complained of missing clothing items. He stated, "I don't remember." On 12/16/13 at 9:16 a.m., the resident's family member was asked if the resident had any missing clothing items. She stated, "Yes, quite a lot." She was asked if it had been reported. She stated she had told whoever the nurse was when it was identified items were missing and the laundry. She stated she had also addressed the concern in the care plan meeting. The family member was asked if the issue had been addressed to her satisfaction. She stated, "I was told they were either in the laundry or the outside source [for laundry]." She stated, "Stuff has been missing from the very beginning. A few things will show up now and then."	F 225		

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F 225	Continued From page 25 The family member was asked if she brought new clothing on the previous Saturday. She stated, "Yes." She stated, "I brought six pants and matching shirts on Saturday." She was asked if she had laundry now. She stated, "Yes, two pair of pants and shirts." On 12/16/13 at 9:27 a.m., CNA #15 was asked who did the resident's laundry. She stated, "The family." She was asked what she did when there were complaints of missing laundry. She stated, "Normally go to the housekeeper." When asked what she would do if the resident had no clothes in their room, CNA #15 stated she would normally go to the rack in the laundry and get some. On 12/16/13 at 9:28 a.m., the resident was observed to have five sets of clothing in his drawer. There were no clothes hanging in the resident's closet. On 12/16/13 at 9:48 a.m., the housekeeping supervisor was asked what she did when she received complaints about missing clothing items. She stated she would go straight to the laundry aide, do closet searches, and speak with the outside laundry company. The housekeeping supervisor was asked if she received complaints about the resident's clothing being missing. She stated, "All the time." She stated the facility did not do the resident's laundry but the aides put it in the laundry bins anyway. She stated, "You never know who's doing it and they're not going to say." The housekeeping supervisor stated signs were posted but it did not always make a difference. She stated, "Sometimes it will recycle itself and get back."	F 225		

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F 225	Continued From page 26 The housekeeping supervisor was asked what she was told to do when she reported missing items to the administrator. She stated, "All I can do is tell her and they just say to go look through the closets." She was asked if she had informed the administrator specifically about the missing clothing items belonging to resident #14. She stated, "No." On 12/16/13 at 10:13 a.m., the administrator was asked how staff notified her if there were complaints of missing laundry. She stated they would send an email or communication form and they talked about it in morning meetings. The administrator was asked how she monitored the laundry to ensure residents got their clothes. She stated the clothing was supposed to marked. She stated, "[Laundry supervisor] and I check on the laundry people. Any issues that come up we take care of." The administrator was asked how she handled complaints regarding missing laundry. She stated, "Try to find it Sometimes it turns up. If not, replace it." The administrator was asked had there been complaints of the resident's clothing being missing. She stated, "Just once." 2. Resident #30 was admitted to the facility on 06/20/13 with diagnoses that included intellectual disabilities. The resident's care plan, dated 06/20/13, documented, "...is aphasic and cannot participate in or initiate conversation. She yells, screams	F 225		

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	375034	A. BUILDING _____ B. WING _____	C 12/17/2013

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F 225	Continued From page 27 and grunts and this upsets other residents. She has dx of mental retardation and depression/anxiety. She receives routine medication for this...cannot easily be redirected or respond to 1:1 intervention..." The goal was, "...will receive medications as ordered and minimize her risk for increase in behaviors or mood changes thru next review..." Approaches included, "...Observe behavior pattern. Watch for ability to control behavior and expressions of needs and feelings...Recognize stressors that may precipitate problem behavior...Use calm approach when inappropriate behavior is exhibited..." On 12/09/13 at 3:31 p.m., CNA #3 and SS #2 were observed having a conversation in the north dining room. They were standing in front of resident #30. Resident #30 was yelling out and having verbal behaviors. CNA #3 turned, faced the resident, and stated, "Shush." At 3:35 p.m., CNA #3 was asked if she told the resident to shush. She stated, "No." At 3:45 p.m., SS #2 was asked if he heard CNA #3 tell the resident to shush. He stated, "Yes. I was standing right there. I've never heard that shush before." At 4:25 p.m., the administrator was asked if any one had reported an allegation of verbal mistreatment to her that afternoon. She stated, "No." 3. A resident occurrence report, dated 09/30/13, documented, "...[resident #34]...bruising to [right] arm [and] chest...aid came to this nurse, bruising to [right upper] arm, bruising to chest..."	F 225		

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F 225	Continued From page 28 An incident report, dated 09/30/13, detailing an incident between resident #24 and #34, documented, "...Bruising (purple/blue) noted to [resident #34]'s chest, she states that last night a white man with brown hair pushed her in her chair. [Resident #24] is white with dark hair pulled back (like it is short). There are no white men that work this hallway. Residents separated, [resident #24] placed on 1:1 supervision, investigation initiated... [Resident #24] is alert with confusion at times, she is ambulatory ad lib and requires minimal assistance with adl's. Her dx include: paranoid schizophrenia, psychosis, anxiety and depression. [Resident #34] is alert and oriented x 1, she is up as tolerated in a gerichair, she is dependent on staff for all adl's. Her dx include: dementia, w/o behavior, depression, late effect cv[a] and macular degeneration..." Review of the incident investigation revealed a statement from employee #1 and a statement from CNA #17. There was no documentation any other employees were interviewed or that any residents or family members were interviewed. A final state reportable incident report, with a fax date of 10/04/13, documented, "...[Resident #24] has been transferred to a behavioral unit for evaluation and treatment. [Resident #34]: the bruising remains, no complaints of pain..." On 12/17/13 at 11:37 a.m., the quality assurance nurse was asked if she had completed the investigation for residents #24 and #34. She stated, "Yes."	F 225		

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F 225	Continued From page 29 The quality assurance nurse was asked who she had interviewed as part of the investigation. She stated she had interviewed resident #34 and the aides. She was asked how many staff had been interviewed. She stated there should have been statements from all the aides on that shift. The quality assurance nurse was asked if any other residents or family members had been interviewed. She stated, "Yes." She was asked to review the investigation and show where the interviews had been documented. She reviewed the record and stated the documentation might be in another folder and she would look. At 12:29 p.m., the quality assurance nurse was asked if she had found any other documented interviews. She stated, "I couldn't find any other documentation." 4. Resident #21 was re-admitted to the facility on 09/08/13 with diagnoses that included depressive disorder. An incident report, dated 05/14/13, documented, "...This resident reported to a staff member that she,...asked for pain medication. When the nurse brought them in, the resident told her she was 1 1/2 hrs late. The nurse said 'go to hell' and left the room. Employee has been suspended...The resident is alert [and] oriented. She is independent c transfers [and] self propelled [sic] in her w/c..." A final incident report, dated 05/22/13, documented, "...We have been unable to substantiate this allegation. The nurse refused to give a statement. No other residents had any complaints about the nurse..."	F 225		

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F 225	Continued From page 30 Review of the investigative file revealed no documentation of resident, staff, or family interviews. Review of staff rosters revealed the nurse was no longer employed at the facility. On 12/17/13 at 11:37 a.m., the quality assurance nurse was asked if she had completed the investigation for resident #21. She stated, "Yes." The quality assurance nurse was asked who she had interviewed as part of the investigation. She stated she had interviewed residents and staff. She was asked to review the investigation and show where the interviews had been documented. She reviewed the record and stated the documentation might be in another folder and she would look. At 12:29 p.m., the quality assurance nurse was asked if she had found any documented interviews. She stated, "I couldn't find any other documentation."	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 226	F226 1a. The abuse allegation for resident #30 was reported to the Administrator by the surveyor. The accused CNA was placed on immediately suspension until the completion of the investigation 1b. A grievance form was completed for Resident #14 regarding his missing clothing and an investigation initiated on 11/21/13.	1/21/14

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F 226	Continued From page 31 review, it was determined the facility failed to follow their abuse policy when: A. Staff did not report an incident of verbal mistreatment for one (#30) of one resident who was observed to be verbally mistreated; B. Staff failed to report and investigate allegations of misappropriation of resident property for one (#14) of 25 sampled residents who were reviewed for misappropriation of property; and C. Staff failed to conduct thorough investigations related to resident to resident abuse and/or staff to resident verbal mistreatment for three (#21, #24, and #34) of four residents whose abuse investigations were reviewed. This had the potential to affect 163 residents who resided at the facility. Findings: The facility's undated policy on abuse documented, "...all residents entrusted into our care has an inherit right to be free from verbal, physical, and mental abuse, corporal punishment and involuntary seclusion. Therefore, this facility shall not use or condone, nor shall we tolerate any form of abuse towards our residents including, but not limited to: verbal, sexual, physical or mental abuse, mistreatment, neglect, corporal punishment, misappropriation of resident funds or involuntary seclusion... Training: employees will be orientated at the time of employment and have on-going in-services	F 226	1c. Resident #24 no longer resides in this facility. Resident #34 has had no further injuries of unknown origin. Resident #21 has had no further complaints of mistreatment. 2. All residents have the potential to be affected. Resident and family interviews were conducted to identify any other residents with complaints of mistreatment or injuries of unknown origin on 1/20/14. 3. All staff was in-serviced regarding resident rights, dignity, abuse and misappropriation of property on 1/3/14. 4. Random interviews with residents and families to identify missing items or abuse will be conducted weekly x 4, monthly x 3 and quarterly thereafter. Results will be reported in the Quality Assurance meeting.	

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F 226	Continued From page 32 through the year on issues related to abuse prohibition practices:...how staff should report their knowledge related to allegations without fear of reprisal... Prevention: facility will provide to residents, families and staff information on how and to whom they may report concerns...This may include the following:...assessment, care planning, and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as...residents with communication disorders, those that require heavy nursing care and/or are totally dependent on staff... Investigation: facility will conduct a thorough investigation and document all findings..." 1. Resident #14 was admitted to the facility on 08/20/13 with diagnoses that included Alzheimer's disease. A resident personal belongings list, dated 08/20/13, documented the resident had five t-shirts, 6 trousers, two polo shirts, six pairs socks, six underwear, two pajamas, and a mesh laundry basket. An interdisciplinary meeting form, dated 11/21/13, documented, "...Care plan meeting held c team and [family member and family member], clothing is laundered by the family but clothing is missing on a frequent basis. States some things have returned, not knowing where they may be going..." The form was signed by RN #3, SS #2, the family members, and an unknown staff member. On 12/10/13 at 1:43 p.m., the resident's room	F 226		

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was checked for clothing. Two pajamas bottoms and one t-shirt were hanging in his closet. One pair of pajama bottoms and one t-shirt were observed in the mesh laundry basket.

On 12/16/13 at 8:15 a.m., the resident's representative was asked if the resident had missing clothing items. She stated, "Yes." She was asked if the issue had been resolved. She stated, "They said they would take care of it, but it hasn't been resolved." She stated, "Some were found. They said they are working on it." The representative was asked how many clothing items were missing. She stated, "We have been replacing clothes every week or so." She stated the family had taken six new sets of clothing on the previous Saturday night because the resident only had one pants and one shirt left.

The representative was asked if they had reported the missing items. She stated, "Yes." The representative stated the family had talked with staff just the previous day about the missing clothing items and that they had been instructed to file a complaint. The representative stated the issue had also been brought up in the care plan meeting.

On 12/16/13 at 8:34 a.m., MDS coordinator #2 was asked what she did if a family complained of missing clothing during a care plan meeting. She stated she would reassure them, report the missing items to the housekeeping supervisor, and if there was no resolution, she would go and look for the missing items herself.

The MDS coordinator was asked how she informed the administrator of the complaints. She stated she would write the complaint up and

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social services would write a statement. She stated there was a meeting once a week and the social services department was good about following through.

She was asked if the resident's family had complained of missing clothing items. She stated she was not aware of that. She stated if they had, she would instruct them to go to social services.

On 12/16/13 at 8:49 a.m., social services #2 was asked what he did when he received complaints of missing clothing. He stated, "Talk with the laundry. Do your best to track down the clothes. Try to find them." He stated, "I have gone to the laundry myself."

Social services #2 was asked how he informed the administrator of any missing items. He stated, "Bring it to her attention." Social services #2 was asked what the administrator would do. He stated a list of the missing items would have to be taken to the administrator.

Social services #2 was asked if the resident's family had complained of missing clothing items. He stated, "I don't remember."

On 12/16/13 at 9:16 a.m., the resident's family member was asked if the resident had any missing clothing items. She stated, "Yes, quite a lot." She was asked if it had been reported. She stated she had told whoever the nurse was when it was identified items were missing and the laundry. She stated she had also addressed the concern in the care plan meeting.

The family member was asked if the issue had

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F 226	Continued From page 35 been addressed to her satisfaction. She stated, "I was told they were either in the laundry or the outside source [for laundry]." She stated, "Stuff has been missing from the very beginning. A few things will show up now and then." The family member was asked if she brought new clothing on the previous Saturday. She stated, "Yes." She stated, "I brought six pants and matching shirts on Saturday." She was asked if she had laundry now. She stated, "Yes, two pair of pants and shirts." On 12/16/13 at 9:27 a.m., CNA #15 was asked who did the resident's laundry. She stated, "The family." She was asked what she did when there were complaints of missing laundry. She stated, "Normally go to the housekeeper." When asked what she would do if the resident had no clothes in their room, CNA #15 stated she would normally go to the rack in the laundry and get some. On 12/16/13 at 9:28 a.m., the resident was observed to have five sets of clothing in his drawer. There were no clothes hanging in the resident's closet. On 12/16/13 at 9:48 a.m., the housekeeping supervisor was asked what she did when she received complaints about missing clothing items. She stated she would go straight to the laundry aide, do closet searches, and speak with the outside laundry company. The housekeeping supervisor was asked if she received complaints about the resident's clothing being missing. She stated, "All the time." She stated the facility did not do the resident's laundry but the aides put it in the laundry bins anyway.	F 226		

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F 226	Continued From page 36 She stated, "You never know who's doing it and they're not going to say." The housekeeping supervisor stated signs were posted but it did not always make a difference. She stated, "Sometimes it will recycle itself and get back." The housekeeping supervisor was asked what she was told to do when she reported missing items to the administrator. She stated, "All I can do is tell her and they just say to go look through the closets." She was asked if she had informed the administrator specifically about the missing clothing items belonging to resident #14. She stated, "No." On 12/16/13 at 10:13 a.m., the administrator was asked how staff notified her if there were complaints of missing laundry. She stated they would send an email or communication form and they talked about it in morning meetings. The administrator was asked how she monitored the laundry to ensure residents got their clothes. She stated the clothing was supposed to marked. She stated, "[Laundry supervisor] and I check on the laundry people. Any issues that come up we take care of." The administrator was asked how she handled complaints regarding missing laundry. She stated, "Try to find it. Sometimes it turns up. If not, replace it." The administrator was asked had there been complaints of the resident's clothing being missing. She stated, "Just once." 2. Resident #30 was admitted to the facility on 06/20/13 with diagnoses that included intellectual	F 226		

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F 226	Continued From page 37 disabilities. The resident's care plan, dated 06/20/13, documented, "...Is aphasic and cannot participate in or initiate conversation. She yells, screams and grunts and this upsets other residents. She has dx of mental retardation and depression/anxiety. She receives routine medication for this...cannot easily be redirected or respond to 1:1 intervention..." The goal was, "...will receive medications as ordered and minimize her risk for increase in behaviors or mood changes thru next review..." Approaches included, "...Observe behavior pattern. Watch for ability to control behavior and expressions of needs and feelings...Recognize stressors that may precipitate problem behavior...Use calm approach when inappropriate behavior is exhibited..." On 12/09/13 at 3:31 p.m., CNA #3 and SS #2 were observed having a conversation in the north dining room. They were standing in front of resident #30. Resident #30 was yelling out and having verbal behaviors. CNA #3 turned, faced the resident, and stated, "Shush." At 3:35 p.m., CNA #3 was asked if she told the resident to shush. She stated, "No." At 3:45 p.m., SS #2 was asked if he heard CNA #3 tell the resident to shush. He stated, "Yes. I was standing right there. I've never heard that shush before." At 4:25 p.m., the administrator was asked if any one had reported an allegation of verbal mistreatment to her that afternoon. She stated, "No."	F 226		

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F 226	Continued From page 38 3. A resident occurrence report, dated 09/30/13, documented, "...[resident #34]...bruising to [right] arm [and] chest...aid came to this nurse, bruising to [right upper] arm, bruising to chest..." An incident report, dated 09/30/13, detailing an incident between resident #24 and #34, documented, "...Bruising (purple/blue) noted to [resident #34]'s chest, she states that last night a white man with brown hair pushed her in her chair. [Resident #24] is white with dark hair pulled back (like it is short). There are no white men that work this hallway. Residents separated, [resident #34] placed on 1:1 supervision, investigation initiated... [Resident #24] is alert with confusion at times, she is ambulatory ad lib and requires minimal assistance with adl's. Her dx include: paranoid schizophrenia, psychosis, anxiety and depression. [Resident #34] is alert and oriented x 1, she is up as tolerated in a gerichair, she is dependent on staff for all adl's. Her dx include: dementia, w/o behavior, depression, late effect cv[a] and macular degeneration..." Review of the incident investigation revealed a statement from employee #1 and a statement from CNA #17. There was no documentation any other employees were interviewed or that any residents or family members were interviewed. A final state reportable incident report, with a fax date of 10/04/13, documented, "...[Resident #24] has been transferred to a behavioral unit for evaluation and treatment. [Resident #34]: the bruising remains, , no complaints of pain..."	F 226		

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F 226	Continued From page 39 On 12/17/13 at 11:37 a.m., the quality assurance nurse was asked if she had completed the investigation for residents #24 and #34. She stated, "Yes." The quality assurance nurse was asked who she had interviewed as part of the investigation. She stated she had interviewed resident #34 and the aides. She was asked how many staff had been interviewed. She stated there should have been statements from all the aides on that shift. The quality assurance nurse was asked if any other residents or family members had been interviewed. She stated, "Yes." She was asked to review the investigation and show where the interviews had been documented. She reviewed the record and stated the documentation might be in another folder and she would look. At 12:29 p.m., the quality assurance nurse was asked if she had found any other documented interviews. She stated, "I couldn't find any other documentation." 4. Resident #21 was re-admitted to the facility on 09/08/13 with diagnoses that included depressive disorder. An incident report, dated 05/14/13, documented, "...This resident reported to a staff member that she...asked for pain medication. When the nurse brought them in, the resident told her she was 1 1/2 hrs late. The nurse said 'go to hell' and left the room. Employee has been suspended...The resident is alert [and] oriented. She is independent c transfers [and] self propelled [sic] in her w/c..."	F 226		

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F 226	Continued From page 40 A final incident report, dated 05/22/13, documented, "...We have been unable to substantiate this allegation. The nurse refused to give a statement. No other residents had any complaints about the nurse..." Review of the investigative file revealed no documentation of resident, staff, or family interviews. Review of staff rosters revealed the nurse was no longer employed at the facility. On 12/17/13 at 11:37 a.m., the quality assurance nurse was asked if she had completed the investigation for resident #21. She stated, "Yes." The quality assurance nurse was asked who she had interviewed as part of the investigation. She stated she had interviewed residents and staff. She was asked to review the investigation and show where the interviews had been documented. She reviewed the record and stated the documentation might be in another folder and she would look. At 12:29 p.m., the quality assurance nurse was asked if she had found any documented interviews. She stated, "I couldn't find any other documentation."	F 226		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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.	F 241	F241 1a. Resident #27, #30, #35, #37, #39, #40 and #41 are asked each morning by the CNA what time they wish to get out of bed.	1/31/14

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F 241	Continued From page 41 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to: A. Treat seven (#27, #30, #35, #37, #39, #40, and #41) of fifteen residents who were observed for wake up times with dignity and respect when staff awakened the residents and got them out of bed beginning at 4:30 a.m. This had the potential to affect fifteen residents identified by the facility as being awakened on the 11-7 shift; and B. Treat three (#30, #31, and #34) of eleven residents who were observed being fed with dignity during the dining experience. The facility identified 17 residents as being dependent with eating. Findings: The facility's policy on dignity, dated 10/2009, documented, "...Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality... Residents shall be treated with dignity and respect at all times...Demeaning practices and standards of care that compromise dignity are prohibited...Staff shall treat cognitively impaired residents with dignity and sensitivity..." The facility's policy on assistance with meals, dated 10/2009, documented, "...Residents shall receive assistance with meals in a manner that meets the individual needs of each resident...Residents who cannot feed themselves will be fed with attention to safety, comfort and	F 241	1b. Residents #30, #31 and #34 are now fed by a staff member who remains seated throughout the duration of the resident's meal. 1c. The dining room was cleaned and cleared from the previous meal. 2. All residents who are dependent during meals have the potential to be affected. Dining room supervisors were immediately notify to correct any issues with dependent diners regarding dignity during meals. 3. Nursing staff was inserviced regarding dignity during meals on 1/3/14. 4. Random audits of dining room during and after meals will be conducted weekly x 4, monthly x 3 and as needed. Results will be reviewed in the Quality Assurance Meeting.	

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F 241	Continued From page 42 dignity, for example...Not standing over residents while assisting them with meals...All employees who provide resident assistance with meals will be trained and shall demonstrate competency in the prevention of foodborne illness, including personal hygiene practices and safe food handling..." 1. On 12/09/13 at approximately 11:00 a.m., a note titled 11-7 get-up list was noted to be taped on the southeast nurses' station. Included on that list was resident #39. Five resident names were on the list. An 11-7 get up list was noted in the ADL book located on the center hall. Five residents were named on the list. An 11-7 get up list was noted in the ADL book located on the north hall. It was documented to wake resident #35, dress him, and leave him in bed. Seven additional resident names were on the list. 2. On 12/11/13 at 5:10 a.m., residents #27, #30, and #37 were observed to be dressed and sitting in their chairs in the north dining room. They had no fluids available to them. Resident #35 was observed to be lying in his bed with his eyes closed. On 12/11/13 at 6:25 a.m., CNA #14 was asked what time she started getting residents up in the mornings. She stated, "Around 5 [a.m.]." She was asked if the residents were asleep. She stated, "Yes." CNA #14 was asked what time she woke resident	F 241		

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F 241	Continued From page 43 #37 and got her out of bed. She stated, "5:00 [a.m.]." She was asked what time she woke resident #27 and got her out of bed. She stated, "Around 5." She was asked if the resident was asleep when she went to get her out of bed. She stated, "Sometimes." CNA #14 was asked what time she woke resident #30 and got her out of bed. She stated, "Around 5." She was asked if the resident was asleep when she went to get her out of bed. She stated, "She will be pretty sleepy." CNA #14 was asked if she had woke resident #35 to dress him. She stated, "Yes." CNA #14 was asked why the residents were gotten up so early. She stated it was so they would be ready for breakfast on the 7-3 shift. On 12/16/13 at 11:30 a.m., LPN #4 was asked why staff started getting residents up so early. She stated, "That's a good question. They say so day shift doesn't have to come in here and start getting them up." LPN #4 was asked why resident #35 was awakened, dressed, and left in bed. She stated, "Because he doesn't want to sit in the chair that long." LPN #4 was asked what time breakfast was served. She stated, "Between 7:30 and 8:00 [a.m.]." On 12/17/13 at 9:25 a.m., the DON and administrator were asked what the reason was for staff to get residents up so early. The administrator stated, "I wasn't aware they were getting them up that early." They were asked how staff knew the residents were agreeable to	F 241		

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F 241	Continued From page 44 getting up so early. The administrator stated social services talked with the residents and asked them what time they would like to get up. The administrator was asked if residents #27, #30, and #37 could tell staff they did not want to get up that early. She stated, "No." The administrator and DON were asked why resident #35 was dressed at 4:30 a.m. and left in bed. There was no comment. The administrator and DON were asked why the residents were not provided fluids when they were taken to the dining. The administrator stated, "They should be." She was asked when breakfast was served. She stated, "Between 7:30 and 8:00 [a.m.]." 3. On 12/11/13 at 5:05 a.m., the southeast dining room was observed. Pitchers of warm water, warm juice, and cold coffee were observed on a cart in the dining room. The assisted feeding table was observed with two plates that contained chicken, potatoes, rolls. These items were on the previous evening's menu. Resident #40 was observed in her wheelchair with her head resting on the dining room table. She was asked if she wanted to get up at this time. She stated, "No." She was asked if she would rather be in bed. She stated "Yes." At 5:43 a.m., CNA #5 brought resident #39 into the dining room. At 5:49 a.m., resident #39 was observed with her eyes closed. She was asked if the staff got her	F 241		

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F 241	Continued From page 45 up. She stated, "Yes." She was asked if she wanted to get up this early. She stated, "No." She was asked if she would rather be in bed. She stated, "Yes." She was asked if staff got her up early everyday. She stated, "Yes." At 6:00 a.m., resident #41 was observed in a wheelchair at a feeding table in the dining room. The resident was talking to himself. At 6:18 a.m., LPN #1 was asked why resident #41 was up at 6:00 a.m. She stated he was on the get up list which meant he was to be woke up anytime after 5:00 a.m. She stated the list was comprised most of residents who required assistance feeding. At 7:49 a.m., resident #39 received her breakfast. At 7:57 resident #41 received his breakfast. 4. On 12/09/13 at 12:05 p.m., observations of the noon meal in the north dining room were made. CNA #4 began feeding resident #31. She stood as she fed the resident. At 12:11 p.m., CNA #8 began feeding resident #34. She stood as she fed the resident. CNA #4 began feeding resident #30 as well as resident #31. She continued to stand. At 12:12 p.m., CNAs #4 and #8 began talking about personal issues between themselve at the dining room table while they fed the residents. At 12:15 p.m., CNA #8 sat down. CNA #4 continued to stand.	F 241		

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F 241	Continued From page 46 On 12/17/13 at 9:33 a.m., the DON and administrator were asked who monitored the dining rooms. The DON stated there was a licensed staff member who was supposed to monitor each dining room and the dietary manager monitored sometimes. The DON and administrator were asked where the aides were supposed to position themselves while feeding. The DON stated, "Next to the residents." She was asked why the staff were not supposed to stand while feeding. She stated staff would be unable to see if the residents were choking if they were standing up. The administrator stated, "It's a dignity issue."	F 241		
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to answer call lights in a timely manner and/or ensure call lights were accessible for four (#15, #18, #42, and #43) of 27 residents who were observed for call light concerns. This had the potential to affect 140 residents identified by the facility as being able to use the call light. Findings:	F 246	F246 1. Resident #18s call light was placed within reach on 12/11/13 immediately after she was assisted with incontinent care. 1b. Residents #33, 42, and 43 call lights were answered. 1c. Resident #15s call light was answered. 2. All residents who use call lights have the potential to be affected. All unanswered lights were answered. 3. All staff were inserviced on 1/3/14 by the DON regarding promptly answering call lights. 4. Call light logs will be reviewed weekly x 4, monthly x 3 and as needed to ensure timely answering of call lights. Results will be reviewed in the Quality Assurance Meeting.	1/21/14

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F 246	Continued From page 47 The facility's policy and procedure titled Answering the Call Light, dated October 2010, documented, "...General guidelines...Answer the resident's call as soon as possible..." 1. Resident #18 was admitted to the facility on 11/18/13 with diagnoses that included a stage III pressure ulcer and colostomy. On 12/11/13 at 5:03 a.m., a very strong smell of feces was noted from the hallway to be coming from the resident's room. The resident's light was off and the surveyor entered the resident's room. The resident asked, "Ma'am, can you help me? My colostomy needs to be changed out, and I can't do it." The surveyor asked the resident if she had pushed her call button for assistance. The resident asked, "Where is it?" The call light was observed to be between the resident's mattress and the left upper side rail. It was out of the resident's reach. The call light was given to the resident, and she pushed the button. The resident was noted to have dried feces covering her left hand. The resident's gown and bed linens were covered with feces. The resident's abdomen was exposed and feces was noted to cover her abdomen. At 5:08 a.m., CNA #1 entered the resident's room. The resident informed the CNA she required assistance with her colostomy. CNA #1 turned on the light. Liquid feces was puddled in the juncture of the resident's legs. The resident's urinary catheter tubing was in the feces. The colostomy bag was expanded with air and feces, and feces was noted to be draining between the skin and the seal of the colostomy bag.	F 246		

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F 246	Continued From page 48 At approximately 5:10 a.m., CNA #1 was asked how often she checked on the resident. She stated, "Every two hours." She was asked when the resident was checked last. She stated, "I don't know the exact time. Between 3:00 and 3:30 [a.m.]." CNA #1 was asked if she checked the resident's colostomy bag. She stated, "No, I didn't." She stated, "When I come in I check the bags and colostomy." CNA #1 was asked when she started her shift. She stated 11:00 p.m. She was asked when she emptied the colostomy. She stated at the beginning and end of her shift. On 12/17/13 at 2:39 p.m., the DON was asked what the average call light response time was. She stated, "Five to eight minutes." She was asked where call lights were supposed to be located. She stated, "Within residents' reach." 2. On 12/16/13 at 4:01 p.m., the ADON was noted to be sitting at the north nurses' station. She was looking at her cell phone. The call lights for residents #33, #42, and #43 were observed to be going off. A pager was noted on the desk at the nurses' station. It was noted to beep. The ADON put her phone down and began looking through a chart on the desk. The call lights continued to go off. At 4:05 p.m., MDS coordinator #1 was observed walking down the north hall. She stopped and assisted resident #43. LPN #4 exited the room for resident #33 and de-activated the call light. The ADON remained seated at the nurses' station. At 4:06 p.m., an unidentified CNA was observed to walk down the hall, notice the call light for	F 246		

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F 246	Continued From page 49 resident #42, and enter the room to assist the resident. At 4:07 p.m., the ADON was asked what her title was. She stated she was the ADON. She was asked how staff would know if call lights were going off. She picked up a pager off the desk and stated there was a pager system for call lights. As she picked up the pager, it beeped. The ADON was asked if she was aware that while sitting at the nurses' station, three call lights had been going off. She stated, "No, I wasn't. I was looking at a chart." On 12/17/13 at 2:39 p.m., the DON was asked what the average call light response time was. She stated, "Five to eight minutes." She was asked where call lights were supposed to be located. She stated, "Within residents' reach." The DON was asked how staff knew if a call light had been activated. She stated the facility used a pager system and through observations. The DON was asked what her expectation was for all staff members if a call light was noted to be going off. She stated, "Any staff member is supposed to answer the lights." 3. Resident #15 was admitted to the facility on 08/09/13 with diagnoses that included multiple sclerosis, chronic pain, muscular disuse atrophy, paraplegia, and colostomy. The care plan, dated 08/09/13, documented, "...Problem/ Need...ADLs...Has dx of MS and is extensive or total assist with ADLs...Approaches...Call light within easy reach at all times...Answer promptly..."	F 246		

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F 246	Continued From page 50 A quarterly assessment, dated 11/06/13, documented the resident was cognitively intact and was totally dependent on staff for transfers, toilet use, and bathing. On 12/16/13 at 2:33 p.m., when the surveyor knocked on resident #15's door, her call light came on. When the surveyor entered, the resident was sitting in her wheelchair next to her bed. She stated she had just turned her call light on to get juice. The resident was asked how long it usually took staff to respond to her call light. She stated, "20 to 30 minutes, sometimes over an hour." She was asked if she felt there was enough staff to meet her needs. She stated, "No, this place is full to the max and there are only three people for the center hall and this hall." She stated, "It's shift change. Evenings is always short staffed." At 3:24 p.m., the DON entered resident #15's room and asked, "[Name withheld] you need something?" The resident stated, "I just wanted some apple juice." It was observed that it took 51 minutes for staff to respond to resident #15's call light. On 12/17/13 at 2:39 p.m., the DON was asked what the average call light response time was. She stated, "Five to eight minutes." The DON was asked how staff knew if a call light had been activated. She stated the facility used a pager system and through observations. The DON was asked what her expectation was for all	F 246		

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F 246	Continued From page 61 staff members if a call light was noted to be going off. She stated, "Any staff member is supposed to answer the lights." The DON was asked why it took 50 minutes to answer the call light for resident #15. She stated,"I do not know." She was asked how she monitored to ensure call lights were answered timely. She stated she audited the call light logs on the computer. She stated it seemed to be the same residents who had the issues.	F 246		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to complete a significant change assessment for one (#1) of 29 sampled residents whose assessments were reviewed. This had the potential to affect 163 residents who resided at the facility. Findings:	F 274	F274 1. A significant change in status assessment was completed on Resident # 1 on 12/17/13. 2. All residents with a significant change in staus have the potential to be affected. A review of the residents within the facility to identify resident with significant changes was completed on 12/17/13. 3. MDS coordinators were in serviced on 12/20/13 by the Director of Clinical Reimbursement regarding significant change in status criteria. 4. Audits will be completed to ensure that significant change in status assessments are completed when indicated weekly x 4, monthly x 3 and as needed. Results will be reviewed in the Quality Assurance Meeting.	1/31/14

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 274	Continued From page 52 Resident #1 was admitted to the facility on 05/24/13 with diagnoses that included respiratory failure, anxiety, and osteoarthritis. Review of the clinical record revealed documentation the resident had been re-admitted to the facility on 10/01/13 following hospitalization at a psychiatric unit. A nurse's note, dated 11/07/13 at 8:00 p.m., documented, "...Res [up] walking by nurses' desk s [oxygen] on. She lost her balance and fell into another resident and onto floor. res c/o pain unable to move [left] hip..." A nurse's note, dated 11/15/13 at 4:00 p.m., documented, "...Res returned to facility c [left] hip fx surgery..." Review of the resident's record revealed no significant change assessment had been completed for the resident after having a psychiatric in-patient hospital stay and a fall with fracture that required surgical repair. On 12/16/13 at 9:57 a.m., MDS Coordinator #1 was asked if the resident had suffered a fall and sustained a hip fracture on 11/07/13. She stated yes. She was asked if the resident had been hospitalized during October due to a psychiatric concern. She stated yes. She was asked if a significant change assessment had been completed for the resident. She stated,"No." MDS Coordinator #1 stated, "One should have been done."	F 274		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	F 278		

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F 278	Continued From page 53 The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure assessments were accurate related to wounds and antipsychotic medications for two (#1 and #16) of 29 sampled residents whose assessments were reviewed. This had the potential to affect 163 residents who resided at	F 278	F278 1. A modification to resident #16 and #1s MDS was completed on 12/16/13. 2. All residents have the potential to be affected. MDS were reviewed to ensure that coding was accurate on 01/16/14. 3. MDS coordinators were in serviced on 12/20/13 by the Director of Clinical Reimbursement regarding MDS coding. 4. Audits will be conducted to ensure that MDS's are coded accurately weekly x 4, monthly x 3 and as needed. Results will be reviewed in the Quality Assurance Meeting.	1/31/14

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F 278	Continued From page 54 the facility. Findings: 1. Resident #16 was admitted to the facility on 10/02/13 with diagnoses that included lower limb wounds, depression, bipolar disease, and chronic pain. The resident's admission assessment, dated 10/11/13, documented the resident was cognitively intact and did not have any skin conditions. A care area trigger worksheet on pressure ulcers, dated 10/11/13, documented, "...Resident's wound causes are unknown at this time. History obtained from the [family member] stated that resident had surgery and follow up care was not adequate, pressure does not appear to be the problem to extremity where wounds are present..." On 12/09/13 at 12:20 p.m., the resident showed the surveyor three wounds on her lateral right ankle. The resident stated the wounds were due to inadequate care following surgery. On 12/16/13 at 11:35 a.m., the MDS Coordinator was why it was documented the resident had no skin conditions. She reviewed the assessment and stated the wounds should have been coded has surgical wounds. She stated the assessment was inaccurate and would be fixed. 2. Resident #1 was re-admitted to the facility on 10/01/13 with diagnoses that included depression. Admission orders, dated 10/01/13, documented the resident was to receive Abilify, an	F 278		

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F 278	Continued From page 55 antipyschotic medication, 2.5 mg daily for depression. MARs, dated 10/02/13 and 10/03/13, documented the resident received the medication as ordered by the physician. A quarterly assessment, dated 10/03/13, documented the resident did not receive any antipsychotic medications in the previous seven days. On 12/16/13 at 9:57 a.m., MDS Coordinator #1 was asked how she received the information regarding medications the resident took during the previous seven days. She stated, "From the orders." She was asked why the use of Abilify was not identified on the resident's assessment. She stated, "It says zero and it should have been marked."	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under	F 279	F279 1a. Resident #1 care plan was updated on 12/16/13 to reflect antipsychotic use. 2. All residents have the potential to be affected. Audit will be done of current residents care plans to ensure they are accurate and reflect the residents' current plan of care by 01/16/14. 3. MDS was in-serviced by the Director of Clinical Reimbursement regarding updating care plans daily on 12/20/13.	1/31/14

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F 279	Continued From page 56 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to develop comprehensive care plans related to a diagnosis of anxiety and the use of antipsychotic medications for one (#1) of 29 sampled residents whose care plans were reviewed. This had the potential to affect 163 residents who resided at the facility. Findings: Resident #1 was re-admitted to the facility on 10/01/13 with diagnoses that included depression. Admission orders, dated 10/01/13, documented the resident was to receive Abilify, an antipyschotic medication, 2.5 mg daily for depression. It was also documented the resident was to receive Ativan, an anxiolytic, 0.5 mg twice daily for anxiety. Review of the resident's care plan, last updated 12/05/13, revealed no problem of anxiety. There was no goal, and there were no interventions. It was only documented the resident was to receive Ativan for anxiety. There was no problem related to the use of an antipsychotic medication. There was no goal and	F 279	4. Random audits of care plans will be done by DON/designee weekly X 4 weeks, then monthly X 3, then quarterly to ensure care plans accurately reflect the residents current plan of care & findings will be reported through the QA process.	

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F 279	Continued From page 57 there were no interventions. On 12/16/13 at 10:06 a.m., MDS coordinator #2 was asked why the use of Abilify was not identified as a problem on the resident's care plan, with goals and interventions identified. She stated, "I don't have an answer." MDS coordinator #2 was asked why anxiety was not identified as a problem on the resident's care plan, with goals and interventions, including the use of Ativan, identified. She stated, "I'll fix it. We'll double check from now on."	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 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. 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.	F 280	F280 1. Resident #15s care plan was updated on 12/16/13 to reflect the colostomy care. 2. All residents have the potential to be affected. Audit will be done of current residents care plans to ensure they are accurate and reflect the residents' current plan of care by 01/16/14. 3. MDS was in-serviced by the Director of Clinical Reimbursement regarding updating care plans daily on 12/20/13. 4. Random audits of care plans will be done by DON/Designee weekly X 4 weeks, then monthly X 3, then quarterly to ensure care plans accurately reflect the residents current plan of care & findings will be reported through the QA process.	1/16/14

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F 280	Continued From page 58 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to update a care plan to have resident-specific approaches related to colostomy care for one (#15) of four sampled residents with colostomies whose care plans were reviewed . The facility identified eight residents as having colostomies. Findings: The facility's policy and procedure on colostomy/ileostomy Care, dated October 2010, documented, "...Purpose...The purpose of this procedure is to provide guidelines that will aid in preventing exposure of the resident's skin to fecal matter..." Resident #15 was admitted to the facility on 08/09/13 with diagnoses that included multiple sclerosis, muscular disuse atrophy, paraplegia, and colostomy. The resident's care plan, dated 08/09/13, documented, "...Problem...Colostomy functioning without difficulty...Skin intact..." The approaches did not include rinsing the colostomy bag after emptying or proper folding and clipping the end of the bag to prevent leakage of feces onto the resident's skin in order to maintain skin integrity. A facility form, labeled skin and dated 10/10/13, documented, "...Colostomy care [every] shift per protocol...Frequency: 7-3; 3-11; 11-7..." A quarterly assessment, dated 11/06/13,	F 280		

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F 280	Continued From page 59 documented the resident was cognitively intact and was totally dependent on staff for transfer, toilet use, and bathing. Bowel continence documented, "...Appliances: ostomy..." On 12/16/13 at 2:33 p.m., resident #15 was asked who was responsible for emptying her colostomy bag. She stated, "A lot of them try." She stated the staff did not rinse the colostomy bag after emptying it. She stated staff sometimes used a "baby wipe" to clean inside the end of the bag. At 2:45 p.m., resident #15's colostomy bag was observed to have a moderate amount of formed stool and air in the bag. The colostomy bag had a copious amount of feces lining the inside of the bag to the very end which was folded over once and clipped. Approximately one inch of the end of the bag was exposed past the clip. The bag's end that had been left exposed had not been cleansed of feces. The bag's end was stuck together with dried feces. She was asked if the colostomy bag was usually folded once with the end exposed with feces after staff has emptied it. She stated, "Yes. I've had it drip down my side." She stated feces often got on her clothes. On 12/17/13 at 9:18 a.m., the DON was asked what training the CNAs received on colostomy bags. She stated, "I need to look into that." She was asked how they were taught to clean the colostomy bag. She stated, "We just know to rinse with soap and water."	F 280		
F 282	483.20(k)(3)(ii) SERVICES BY QUALIFIED	F 282		

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F 282 SS=D	Continued From page 60 PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to implement interventions identified on the care plan related to pain, colostomy care, and/or pressure ulcers for three (#3, #12, and #18) of 25 sampled residents whose care plans were reviewed. This had the potential to affect 163 residents who resided at the facility. Findings: 1. Resident #3 was admitted to the facility on 09/14/11 with diagnoses that included multiple sclerosis (MS), chronic pain, dysarthria, joint contractures, multiple pressure ulcers, diabetes, and myalgia. The resident received all medications via a percutaneous gastrostomy tube. Physicians orders, dated 02/2013, documented the resident was to receive Norco 7.5/325 mg, two tablets every eight hours for pain, Baclofen 10 mg every six hours for muscle spasms, Zanaflex 4 mg every six hours for spasms, and acetaminophen 640 mg every fours hours as needed for pain. A physician's order, dated 02/08/13 at 7:00 p.m., documented to decrease the resident's Norco	F 282	F282 1. Resident # 3, #12, and #18s care plans were reviewed to ensure individualizes interventions were provided in accordance with each resident written plan of care. 2. All residents have the potential to be affected. Staff was in-serviced on following care plans by the DON/designee on 1/17/14. 3. All staff was inserviced on following care plans on 1/17/14 by the DON. 4. Audits to ensure staff is following the care plans will performed weekly x 4, monthly x 3 and as needed. Results will be reviewed in the Quality Assurance Meeting.	1/31/14

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F 282	Continued From page 61 7.5/325 mg every eight hours for pain. A physician's order, dated 02/17/13, documented the resident could receive Norco 7.5/325 mg every eight hours as needed for pain. A nurse's note, dated 02/19/13, documented, "... [Name withheld] [complains of] pain...[one] tab Norco does not relieve pain....Requested to have it back to 2 tab [sic]..." A physician's order, dated 02/19/13, documented to increase the pain medication back to Norco 7.5/325 mg two tablets every eight hours routinely for pain. A quarterly assessment, dated 06/18/13, documented the resident was cognitively intact, required total assistance from staff for bed mobility, transfers, and all ADLs. It was documented the resident's upper and lower extremity range of motion was impaired due to joint contractures. An annual assessment, dated 09/17/13, documented the resident was on a scheduled pain medication regimen and received as needed pain medication. The assessment revealed the resident's pain was frequent and rated at six on a scale of one to ten. It was documented the pain made it hard for the resident to sleep. On 10/03/13, the resident was hospitalized for non-healing pressure ulcers and re-admitted to the facility on 10/08/13. The diagnosis description on re-admission included multiple sclerosis, depression, and	F 282		

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F 282	Continued From page 62 pressure ulcers on the low back, hip, and heel. A pain assessment was completed on 10/08/13. The assessment revealed the resident's diagnosis of multiple sclerosis and conditions of contractures and pressure ulcers that would likely cause pain. It was documented the resident received routine and as needed pain medication. It was also documented the resident had described the pain as dull, burning, tingling, pins and needles. The pain involved both upper and lower extremities, occurred daily, and was intermittent. The intensity was rated seven on a pain scale of one to ten and affected the resident's sleep. Repositioning and movement made the pain worse. The facility resident-data collection, dated 10/08/13, documented the resident experienced constant, severe pain in both lower extremities, rating the pain a five on a pain scale of one to ten. Monthly physician orders, dated 10/2013, documented the resident was to receive Aleve 220 mg every day for pain. There was no documentation of any other pain medications being ordered. Monthly physician orders, dated 11/2013 documented the resident was to receive Aleve 200 mg one tablet every day for pain and Norco 7.5/325 mg two tablets every four hours as needed for pain. A Peg Tube facility form, dated 11/2013 documented the resident received Norco 7.5/325 mg one tablet every four hours as needed for pain.	F 282		

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F 282	Continued From page 63 The resident's care plan, updated 11/25/13, documented, "...Problem/Need...She will be monitor [sic] for any and all pain, using pain scale if appropriate...Medicate with ordered medication call physician if no relief obtained...Goal...Receive medication as ordered...she will be comfortable and achieve her goal of pain level 4...Approaches...If relief is not obtained consult physician to change or add to medication ordered..." Monthly physician orders, dated 12/2013, documented the resident was to receive Aleve 220 mg every day for pain and Norco 7.5/325 mg two tablets every four hours as needed for pain. Medication administraton records, dated 12/2013, documented, "...Norco 7.5-325 Tablet 2 Tabs Per Peg Tube Every 4 Hrs As Needed..." There was a slash mark through the two in the administration directions of the Norco, and the numeral "1" was written in. Review of narcotic count sheets, dated 12/01/13 through 12/09/13, revealed documentation the resident requested, on a daily basis, a Norco 7.5/325 tablets with each tube feeding, at 9:00 a.m., 12:00 p.m., and 4.00 p.m. On 12/10/13 at 9:25 a.m., LPN #3 was observed administering pressure ulcer care to resident #3. The resident was observed to be severely contracted in the hips and knees. The resident's torso was twisted to the left from the waist down with both legs drawn and crossed at the ankles which caused contact in areas creating high risk pressure points.	F 282		

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F 282	Continued From page 64 The LPN stated the resident had been administered pain medication 30 minutes prior to the wound care beginning. The resident was asked to rate her pain on a scale of one to ten. She stated, "Eight." The resident was unable to relax due to muscle spasms. When the LPN would touch the resident, she would begin having muscle spasms. With each manipulation of the resident's lower extremities the resident would yell out, "Oh, Oh." The resident was very flushed, her cheecks were red, and her eyes were wide. She had a grimace on her face with a fearful look when she knew she would be moved. At 10:05 a.m., the resident was asked if she had received pain medication prior wound care. She stated, "Yes." She was asked if she felt the pain medication was effective. She stated, "They tell me I take the strongest pain medication they can give me, but I could stand a stronger one." She was asked if she ever refused repositioning. She stated, "Sometimes. It hurts. They can't get me comfortable." At 10:17 a.m., LPN #2 was asked if she felt the resident's pain medication was effective when administering wound care. She stated, "She has muscle spasms when you touch or move her." At 10:55 a.m., CNA #2 was asked how she knew	F 282		

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F 282	Continued From page 65 the resident was in pain when administering care. She stated, "She yells." She was asked what she did when she saw the resident was in pain. She stated she would tell the medication aide or reposition the resident. She stated the medication aide will give her a pain pill. She stated, "She lets us move her but she doesn't want to." She stated, "She hates showers, she cries." She was asked what causes the resident pain. She stated, "Touching and moving her." She was asked who she had told about the resident's pain. She stated, "Everyone knows." She was asked if the charge nurses were aware. She stated, "Yea." She was asked if it appeared the resident's pain medication was effective in relieving the resident's pain. She stated, "No, nothing changes." On 12/12/13 at 9:44 a.m., LPN #2 was asked who was responsible for resident #3's pain management. She stated, "Dr. [name withheld] and each nurse." She was asked what was done with the information obtained during pain assessments. She stated, "Chart it and medicate according to the assessment." She was asked what caused resident #3 to have pain. She stated, "She has MS and is super contracted." She was asked what she did to minimize the	F 282		

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F 282	Continued From page 66 resident's pain during activities known to cause pain. She stated she tried to make sure the resident had her pain medication, and she assessed to see if it worked. She stated the resident requested pain medication be given before each tube feeding. She was asked what the resident's pain medications were. She stated, "Norco and Aleve, Baclofen, Neurontin." She was asked when the last time the resident's pain medication had been adjusted. She stated, "I don't know. As long as I been taking care of her they've been the same." She stated she had been at the facility less than six months. She was asked why those specific medications were chosen. She stated, "I don't know." She was asked why the resident had been told that she was on the strongest pain medication she could be on. She stated, "I don't know who told her that." On 12/12/13 at 11:00 a.m., the medication administration record was reviewed. It was documented the resident had received Baclofen 20 mg, Aleve 220 mg, and one tablet of Norco 7.5/325 mg at 9:00 a.m. On 12/13/13 at approximately 9:50 a.m., Dr. [name withheld] was asked if staff had informed him that the resident had increased pain with pressure ulcer dressing treatment. He stated, "I'm not too sure about that." The physician stated the resident's pain would never be completely relieved due to her diagnoses. He stated that sometimes, just breathing on the	F 282		

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F 282	Continued From page 67	F 282		

resident could cause her excruciating pain. He stated because of the resident's diagnoses, her pain was extremely difficult to manage.

He was informed that the resident's routine pain medication was Aleve. He stated, "That's nothing."

He was asked what he would have done if he had known the resident was having increased pain with her pressure ulcer treatments. He stated, " I would have increased her pain medication."

He was asked if he depended on staff to inform him of resident's pain levels and issues with pain. He stated, "Yes I do, they are my eyes and my ears. I depend on them."

The physician was asked if he knew why someone had decreased the resident's as needed Norco 7.5/325 mg from two tablets every four hours to one tablet, when it was known that one tablet did not control her pain. He stated, "No, I don't."

On 12/17/13 at 9:00 a.m., the DON was asked who was responsible for the pain management program. I stated, "I am." She was asked how she monitored the program. She stated the quality assurance team audited and looked at the CMA and nurse pain assessments.

The DON was asked how she ensured residents' pain was controlled effectively and to the best level possible. She stated she expected staff to ask the resident about their pain after taking pain medication and if it was not controlled, she expected the nurses to follow up. She stated morning rounds were made with the nurses and

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F 282	Continued From page 68 she reviewed the twenty-four hour reports. The DON was asked what she did if she identified the pain program was not being effective either as a system or for a specific resident. She stated all aspects of care would be reviewed and a solution would be found., She stated she would continue to monitor. 2. Resident #18 was admitted to the facility on 11/18/13 with diagnoses that included a stage III pressure ulcer and colostomy. The resident's care plan, dated 11/18/13, documented a problem, "...requires extensive to total assist with bathing, bed mobility, toileting, dressing..." The goal was, "...will have assistance with all her ADL functions to have her needs/wants met on a daily basis thru next review..." Approaches included, "...Empty foley catheter and colostomy pouch with each shift and as needed when noted that is is full...Place call light within easy reach when in room, answer promptly when activated..." Another problem was, "...has diverting colostomy in place...is bedfast and nonambulatory..." One goal was, "...will not develop stoma complication/obstruction..." Approaches included, "...Empty colostomy pouch q shift and prn, do not let colostomy pouch become full...Change colostomy pouch as needed..." Another problem was, "...has multiple medical condition[s]..." One goal was, "...s/sx of exacerbation of COPD, CHF, A-Fibb [sic] will be identify [sic] thru nursing assessment..." Approaches included, "...Encourage to avoid gas forming foods beans, cabbage, cauliflower,	F 282		

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F 282	Continued From page 69 onions..." The resident's admission assessment, dated 11/26/13 documented the resident was cognitively intact, required extensive assistance with bed mobility and toilet use and limited assistance with personal hygiene. It was documented the resident had a colostomy and urinary catheter. On 12/11/13 at 5:03 a.m., a very strong smell of feces was noted from the hallway to be coming from the resident's room. The resident's light was off and the surveyor entered the resident's room. The resident asked, "Ma'am, can you help me? My colostomy needs to be changed out, and I can't do it." The surveyor asked the resident if she had pushed her call button for assistance. The resident asked, "Where is it?" The call light was observed to be between the resident's mattress and the left upper side rail. It was out of the resident's reach. The call light was given to the resident, and she pushed the button. The resident was noted to have dried feces covering her left hand. The resident's gown and bed linens were covered with feces. The resident's abdomen was exposed and feces was noted to cover her abdomen. At 5:08 a.m., CNA #1 entered the resident's room. The resident informed the CNA she required assistance with her colostomy. CNA #1 turned on the light. Liquid feces was puddled in the juncture of the resident's legs. The resident's urinary catheter tubing was in the feces. The colostomy bag was expanded with air and feces, and feces was noted to be draining between the skin and the seal of the colostomy bag.	F 282		

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F 282	Continued From page 70 CNA #1 removed the resident's soiled gown and the top sheet. She bundled them up, and without bagging the linens, left the room, went down the center hall, and placed them in the soiled linen hamper. She stopped at room #30 on the center hall and requested CMA #7's help. CNA #1 told CMA #7 the resident's colostomy had burst. The surveyor asked CNA #1 if the bag burst or was it full. CNA #1 stated, "It's full. It's coming out." CNA #1 was asked how often she checked on the resident. She stated, "Every two hours." She was asked when the resident was checked last. She stated, "I don't know the exact time. Between 3:00 and 3:30 [a.m.]." CNA #1 was asked if she checked the resident's colostomy bag., She stated, "No, I didn't." She stated, "When I come in I check the bags [urinary catheter bags] and colostomy." CNA #1 was asked when she started her shift. She stated 11:00 p.m. She was asked when she emptied the colostomy. She stated at the beginning and end of her shift. At 5:58 a.m., CNA #1 was observed to be finishing placing a new colostomy bag on the resident. CNA #1 gathered the soiled linens from the bed bath, placed them in a bag, and without washing her hands, left the room. She went down the center hall, placed the bag of soiled linens in the hamper, and went into room #62 and washed her hands. CNA #1 was asked if she had put the new colostomy bag on the resident. She stated, "Yes." She was asked if she had been trained to replace colostomy bags. She stated, "No. That was my first one ever." CNA #1 was asked if there was enough staff on her shift to meet the residents'	F 282		

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F 282	Continued From page 71 needs. She stated, "Usually. That's the worst thing that's happened. I was trying to get people up and that consumed all my time. The resident had to wait." On 12/12/13 at approximately 6:30 a.m., the corporate nurse stated she had reviewed the cameras. She stated the aide had been in the resident's room seven times during her shift. The corporate nurse provided documentation of the times the CNA had entered the room. The time the CNA spent in the room on each visit ranged from two to six minutes. It was documented another staff member, either an RN or CMA, entered the room at 4:44 a.m. and spent 12 minutes in the room. The surveyor explained the aide had stated she had not checked the resident's colostomy bag since the beginning of the shift. The corporate nurse stated the resident had ate beans and cabbage for the previous evening meal, causing increased gas. She stated some nursing homes did not check the colostomy bags but once per shift. On 12/17/13 at 9:18 a.m., the DON was asked what training the aides received regarding colostomy bags. She stated, "I need to look into that, They are trained to empty every shift." She was asked how the staff would know if the resident had gas-causing foods. She stated the menu was documented on the board by the nurses' station. She was asked what staff was expected to do if they knew a resident had consumed gas producing food. She stated they should check the colostomy more often.	F 282		

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F 282	Continued From page 72 The DON was asked who was responsible for changing the bag. She stated, "The nurse helps the CNA unless the nurse has instructed the CNA on how to do it." 3. Resident #12 was admitted to the facility on 11/15/13 with diagnoses that included diabetes mellitus type II, osteomyelitis, chronic pain, and cervical spinal stenosis. A resident data collection form, dated 11/15/13, documented, "...skin intact no skin breakdown noted neck surgical incisions intact..." A body audit form, dated 11/17/13, documented no skin problems. The resident's care plan, dated 11/19/13, documented, "...Problem: Potential for skin breakdown...decrease in mobility secondary to generalize[d] muscle weakness, he requires assistance with toileting and incontinent care...He noted [sic] fragile skin...has Dx of Diabetes...Approaches: Weekly skin audit. Document all new skin condition and report to PCP...Reposition [resident] every 2 hours as needed..." An initial assessment, dated 11/22/13, documented the resident was cognitively intact, needed extensive assistance with ADLs, had an indwelling urinary catheter, was incontinent of bowel, and had no pressure ulcers. A Braden scale for predicting pressure sore risk, dated 11/22/13, documented the resident scored a 16. This indicated the resident was at risk to developing pressure ulcers.	F 282		

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F 282	Continued From page 73 A body audit, dated 11/24/13, documented the resident did not have a skin problem. A daily skilled nurses' note, dated 11/24/13 at 7:00 p.m., documented, "Resident noted to have redness to buttocks. N/O to apply calmoseptine to buttocks q shift until resolved..." A body audit form, dated 12/05/13, documented, "...sacrum red, excoriated..." A body audit form, dated 12/08/13, documented, "...2 small open superficial areas to sacrum..." A physician's order, dated 12/08/13, documented, "...calmoseptine to buttocks q shift & prn. Dx: open areas..." An update to the care plan, dated 12/08/13, documented, "...Calmoseptine to buttocks Q shift & prn. Dx open area..." A daily skilled nurses notes, dated 12/08/13 at 9:30 p.m., documented, "...Wound nurse noted superficial open areas to buttocks. N/O calmoseptine Q shift prn. Bedpan provided as order..." Medication administration records, dated 12/08/13 and 12/09/13, documented the calmoseptine was applied three times each day. On 12/10/13 at 2:16 p.m., a resident interview was conducted. The resident stated the staff did not answer his call light. He also stated staff would put him on the bed pan and not come back. He was asked how long staff left him on the bed	F 282		

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F 282	Continued From page 74 pan. He stated, "One time it was two hours. I timed it once, and it was one hour and fifty minutes." He was asked if he had turned his call light on. He stated, "Yes, it was on the whole time." On 12/11/13 at 8:03 a.m., the resident was asked if he had any problems with his skin. He stated, "Yes." He rolled over onto his right side and three stage II pressure ulcers, approximately 1cm x 0.5cm each, were observed on his upper buttocks and left buttock. The ulcers were in an arched pattern, similar to the outline of a bed pan. He stated, "They are starting to itch." At 8:55 a.m., the resident was asked when he had been left on the bed pan. He stated, "An hour this week." He stated it was either Monday, Tuesday, or Sunday. He stated he had been left on the bed pan for "a couple of times" for two hours or more. He was asked when he had been left of the bed pan for two hours or more. He stated, "It was in this room, two weeks ago in the afternoon. It was [CNA #16]. She told me they were busy. I knew she wasn't because I heard her talking to people in the hall." On 12/11/13 at 9:02 a.m., LPN #9 was asked if the resident had a treatment for his stage II pressure ulcers. She stated, "They have a facility cream that they put on when a bottom is red." LPN #9 pulled a tube of cream out of the treatment cart. It was labeled "skin repair cream."	F 282		

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F 282	Continued From page 75 She was asked who used this cream. She stated the nurses had to put it on. She stated it was supposed to be documented on the resident's chart. On 12/11/13 at 9:17 a.m., the resident was asked if staff had applied a cream to his bottom. He stated, "They use some kind of salve." He was asked who applied the salve, CNAs or LPNs. He stated, "Both." He was asked when they had applied the cream. He stated when he had a bowel movement. He was asked how many times a day the cream had been applied. He stated, "I only have a bowel movement one time a day." On 12/11/13 at 10:45 a.m., CNA #6 was asked what she did to help prevent pressure ulcers. She stated, "I turn them and keep them dry." She was asked when she placed someone on a bed pan, what she did to make sure she did not forget them. She stated, "I just know." She was asked if resident #12 had any skin breakdown. She stated, "Yes." She was asked how long he had breakdown. She stated about two weeks. On 12/11/13 at 11:05 a.m., CNA #10 was asked what he did to help prevent pressure ulcers. He stated, "I turn residents at least every two hours and I assist them out of bed if the resident is able. He was asked what he did when he placed someone on a bed pan to make sure he did not	F 282		

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F 282	Continued From page 76 forget about them. He stated he usually just stepped out the door until they are finished. He was asked if resident #12 had any skin breakdown. He stated he did not know because he had just started working the hall the resident was on two days previously. On 12/11/13 at 11:10 a.m., LPN #9 was asked if resident #12 had any skin breakdown. She stated he had "redness" to his bottom. She was asked if he had any open areas. She stated, "A couple of areas were open today." She was asked how she monitored the CNAs to ensure they were implementing interventions to aid in prevention of skin breakdown. she stated, "I usually have to do it myself or I ask the CNAs." She was asked how she ensured CNAs were providing quality care. She stated, "I make rounds and ask them if there are changes." On 12/17/13 at 9:00 a.m., the DON was asked who was responsible for identifying interventions to aid in the prevention and healing of pressure ulcers. She stated, "Everyone." She stated input was obtained from the charge nurses, physical therapy, and the weekly wound meetings. She was asked how she monitored to ensure interventions were identified and implemented. She stated through the quality assurance process. On 12/17/13 at 9:53 a.m., the DON was asked how she ensured residents were not left on bed pans for prolonged periods of time. She stated	F 282		

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F 282	Continued From page 77 the aides were supposed to check frequently and that she was unaware of any problems with this. She stated she reviewed the call light response times on the computer. She was asked if she was aware the resident had breakdown on his coccyx area. She stated she was aware of two red and opened areas. The DON was asked who applied the medication to the opened areas. She stated the nurses were to apply the medication on each shift. She was asked if she was aware it was documented the resident was receiving the cream on each shift but the resident stated it was only being applied once a day. She stated no. She stated the amount of medication left when the resident discharged from the facility showed it was being applied more than once per shift. The DON was asked how often skin checks were performed. She stated weekly by the wound team on the weekends. She stated the aides also documented any concerns on the bath sheets.	F 282		
F 283 SS=E	483.20(l)(1)&(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative.	F 283	F283 1. Resident #25 no longer resides in this facility. 2. All residents discharged have the potential to be affected. Discharge summaries will be reviewed to ensure accuracy and completeness 3. Nursing supervisors will be in serviced by the DON/Designee on 1/20/14 regarding completing discharge summaries.	1/21/14

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F 283	Continued From page 78 This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to complete a discharge summary for one (#25) of three sampled residents whose closed records were reviewed. This had the potential to affect 163 that resided in the facility. Findings: A facility policy on discharge summaries and planning, dated 12/2012, documented, "...The discharge summary will include a recapitulation of the resident's stay at this facility and a final summary of the resident's status at the time of the discharge in accordance with established regulations ... The discharge summary shall include a description of the resident's:.. Medically condition and prior medical history entering the facility and current medical diagnoses... Physical and mental functional status... Sensory and physical impairments... Nutritional status and requirements... Cognitive status... Drug therapy... A copy of the post-discharge plan and summary will be provided to the resident and receiving facility and a copy will be filed in the resident's medical records..." Resident #25 was admitted to the facility on 11/11/13 with diagnoses that included subarachnoid hemorrhage and chronic kidney disease stage IV.	F 283	4. Audits will be completed to ensure discharge summaries are complete and accurate weekly x 4, monthly x 4 and as needed. Results will be reviewed in the Quality Assurance meeting.	

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	375034	A. BUILDING _____ B. WING _____	C 12/17/2013

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F 283	Continued From page 79 A interdisciplinary discharge summary, dated 12/03/13, documented, "...Admission date: 11/11/13...Discharge date: 12/3/13...Treatment provided: general nursing care c PT, OT therapy..." The discharge summary did not include a synopsis of the resident's stay, disposition of medications, or disposition of the resident's possessions. On 12/16/13 at 10:08 a.m., the administrator, DON, and corporate nurse were shown the resident's discharge summary. They were asked where is the synopsis of the resident's stay was documented. The administrator stated, "It's too general." They were asked if the resident's medications were dispensed to him upon discharge. No response was given. They were asked what happened to the resident's personal belongings. No response was given.	F 283		
F 309 SS=H	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.	F 309	F309 1a. On 12/14/13, resident #3's physician was notified of her pain. The physician ordered her to begin on dilaudid 1mg per peg q 4 hours routinely at this time. 1b. Resident #16 was interviewed and feels that her pain medication are effective on 12/17/13. She was educated to report pain that is not controlled on 12/17/13.	1/1/14

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F 309	Continued From page 80 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to: A. Recognize pain, develop and/or implement pain management interventions, and/or monitor the effectiveness of pain management interventions for two (#3 and #16) of thirteen sampled residents who were reviewed for pain. The facility's failure to manage pain resulted in actual harm for residents #3 and #16. The facility's Census and Conditions report identified 110 residents as being on a pain management program. The facility identified 72 residents as receiving routine and/or as needed pain medications; B. Provide bladder retraining as ordered by the physician for one (#12) of one sampled resident with a urinary catheter and physician's orders for bladder retraining. The facility identified 18 residents as having a urinary catheter; and C. Ensure an edema glove was worn as ordered by the physician for one (#5) of one sampled resident with physician orders for an edema glove. This had the potential to affect 163 residents who resided in the facility. Findings: The facility's policy on pain, dated 04/2013, documented, "...Assessment and Recognition...Includes a review of known diagnoses or conditions that commonly cause or predispose residents to pain...Review for any treatments that the resident currently is receiving for pain...Assessments should occur on	F 309	1c. Resident #12 no longer resides at this facility 1d. Resident #5 order was clarified to apply in am and remove in pm on 12/12/13. 2a & b. All residents receiving routine and/or as needed pain medications have the potential to be affected. A pain screen was completed on these residents by 01/17/14. 2c. All residents with urinary catheters have the potential to be affected. All resident with a catheter were reviewed to determine the need for bladder retraining by 12/17/13. 2d. All residents with orthotics have the potential to be affected. A review of residents with orthotics was conducted on 12/17/13 to ensure they were being applied per physician order. 3. All nursing staff were inserviced by the DON on 1/20/14 regarding pain, bladder retraining and application of orthotics. 4. Audits will be completed to ensure residents are treated effectively for pain, bladder retraining is performed as ordered and orthotics applied as ordered	

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F 309	Continued From page 81 admission to the facility, at each quarterly review, whenever there is a significant change in condition and at any time pain is suspected...The staff will reassess the individual's pain and consequences of pain at regular intervals..." 1. Resident #3 was admitted to the facility on 09/14/11 with diagnoses that included multiple sclerosis (MS), chronic pain, dysarthria, joint contractures, multiple pressure ulcers, diabetes, and myalgia. The resident received all medications via a percutaneous gastrostomy tube. Physicians orders, dated 02/2013, documented the resident was to receive Norco 7.5/325 mg, two tablets every eight hours for pain, Baclofen 10 mg every six hours for muscle spasms, Zanaflex 4 mg every six hours for spasms, and acetaminophen 640 mg every fours hours as needed for pain. A physician's order, dated 02/08/13 at 7:00 p.m., documented to decrease the resident's Norco to 7.5/325 mg every eight hours for pain. A physician's order, dated 02/17/13, documented the resident could receive Norco 7.5/325 mg every eight hours as needed for pain. A nurse's note, dated 02/19/13, documented, "... [Name withheld] [complains of] pain...[one] tab Norco does not relieve pain...Requested to have it back to 2 tab [sic]..." A physician's order, dated 02/19/13, documented to increase the pain medication back to Norco 7.5/325 mg two tablets every eight hours routinely for pain.	F 309	weekly x 4, monthly x 3 and as needed and finding reported in the Quality Assurance Meeting.	

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F 309	Continued From page 82 Physician's orders, dated 05/2013, documented the resident was to receive Norco 7.5/325 mg, two tablets every eight hours, acetaminophen 640 mg every eight hours, and naproxen 250 mg every twelve hours as needed for pain Resident #3 was hospitalized on 05/20/13 and re-admitted to the facility on 06/11/13. The facility admission/start-up orders, dated 06/11/13, documented the resident was to receive Norco 7.5/325 mg two tablets every eight hours for pain and acetaminphen 650 mg every four hours as needed for pain. The diagnosis description included Sacral ulcer stage IV, multiple sclerosis, dysarthria, left leg contracture, and contracture of the hand. Another facility admission/start-up order, dated 06/11/13, documented the resident was to receive Norco 5/325 mg every four hours as needed for pain and naproxen 250 mg every 12 hours as needed for pain. A physician order, dated 06/14/13, documented to increase the resident's Norco 7.5/325 to two tablets every six hours. A quarterly assessment, dated 06/18/13, documented the resident was cognitively intact, required total assistance from staff for bed mobility, transfers, and all ADLs. It was documented the resident's upper and lower extremity range of motion was impaired due to joint contractures. It was documented the resident was on a	F 309		

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F 309	Continued From page 83 scheduled pain medication regimen and had received as needed pain medication. It was also documented the resident's pain was frequent with an intensity of eight, on a pain scale of one to ten. It was also documented the resident had three stage III pressure ulcers and one stage four pressure ulcer. There were three unstaged slough/eschar pressure ulcers. A physician order, dated 06/18/13, documented to increase the resident's Norco 7.5/325 mg to two tablets every four hours. An assessment of contracture risk was completed on 06/20/13. The total score was ten. This indicated the resident was at risk and required a regular positioning schedule for both bed and chair. Predisposing factors were documented as bilateral upper and lower extremity flexion contractures. It was also documented the resident's hands were contracted. The resident was hospitalized on 07/26/13 for non-healing pressure ulcers and re-admitted to the facility on 08/09/13. The facility admission/start-up orders, dated 08/09/13, documented the resident was to receive acetaminophen 640 mg every four hours as needed for pain and Norco 5/325 mg two tablets every four hours as needed for pain. A routine pain medication was not ordered on readmission. A facility pain assessment was completed on 08/09/13. The assessment documented the	F 309		

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F 309	Continued From page 84 resident had experienced pain daily in the last seven days in both legs and feet. The assessment revealed that pain was increased upon movement. A medication administration record, dated 08/2013, documented the resident received Norco 5/325 mg, two tablets almost daily. On 08/24/13, the resident was hospitalized for non-healing pressure ulcers and re-admitted to the facility on 09/16/13. The facility admission/start-up orders, dated 09/16/13, documented the resident was to receive Norco 7.5/325 mg every four hours as needed for pain and naproxen 220 mg daily. The diagnosis description on re-admission included multiple pressure ulcers, multiple sclerosis, depression, and neuropathy. A nurse's note, dated 09/16/13 at 1:45 p.m., documented, "...Res arrived at facility via hospital transportation...Multiple wounds to legs, both feet [and] both hips...Wound nurse to assess [and] treat...Res in too much pain to allow nurse to turn [and] assess skin on back [and] coccyx..." A pain assessment was completed on 09/16/13. The assessment documented the resident rated her pain at six on a scale of one to ten. It was documented the resident's pain was located in both knees and hips. The pain was described as sharp and increased with activities. An annual assessment, dated 09/17/13, documented the resident was on a scheduled pain medication regimen and received as	F 309		

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F 309	Continued From page 85 needed pain medication. The assessment revealed the resident's pain was frequent and rated at six on a scale of one to ten. It was documented the pain made it hard for the resident to sleep. A nurse's note, dated 09/20/13, documented, "...Dr.[Name withheld] in the building [new order] to [increase] baclofen to QID, Flexeril 10 mg TID..." On 10/03/13, the resident was hospitalized for non-healing pressure ulcers and re-admitted to the facility on 10/08/13. The diagnosis description on re-admission included multiple sclerosis, depression, and pressure ulcers on the low back, hip, and heel. A pain assessment was completed on 10/08/13. The assessment revealed the resident's diagnosis of multiple sclerosis and conditions of contractures and pressure ulcers that would likely cause pain. It was documented the resident received routine and as needed pain medication. It was also documented the resident had described the pain as dull, burning, tingling, pins and needles. The pain involved both upper and lower extremities, occurred daily, and was intermittent. The intensity was rated seven on a pain scale of one to ten and affected the resident's sleep. Repositioning and movement made the pain worse. The facility resident-data collection, dated 10/08/13, documented the resident experienced constant, severe pain in both lower extremities, rating the pain a five on a pain scale of one to ten.	F 309		

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F 309	Continued From page 86 Monthly physician orders, dated 10/2013, documented the resident was to receive Aleve 220 mg every day for pain. There was no documentation of any other pain medications being ordered. Monthly physician orders, dated 11/2013 documented the resident was to receive Aleve 200 mg one tablet every day for pain and Norco 7.5/325 mg two tablets every four hours as needed for pain. A Peg Tube facility form, dated 11/2013 documented the resident received Norco 7.5/325 mg one tablet every four hours as needed for pain. The resident's care plan, updated 11/25/13, documented, "...Problem/Need...She will be monitor [sic] for any and all pain, using pain scale if appropriate...Medicate with ordered medication call physician if no relief obtained...Goal...Receive medication as ordered...she will be comfortable and achieve her goal of pain level 4...Approaches...If relief is not obtained consult physician to change or add to medication ordered..." Monthly physician orders, dated 12/2013, documented the resident was to receive Aleve 220 mg every day for pain and Norco 7.5/325 mg two tablets every four hours as needed for pain. Medication administraton records, dated 12/2013, documented, "...Norco 7.5-325 Tablet 2 Tabs Per Peg Tube Every 4 Hrs As Needed..." There was a slash mark through the two in the administration directions of the Norco, and the	F 309		

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F 309	Continued From page 87 numeral "1" was written in. Review of narcotic count sheets, dated 12/01/13 through 12/09/13, revealed documentation the resident requested, on a daily basis, Norco 7.5/325 tablets with each tube feeding, at 9:00 a.m., 12:00 p.m., and 4:00 p.m. On 12/10/13 at 9:25 a.m., LPN #3 was observed administering pressure ulcer care to resident #3. The resident was observed to be severely contracted in the hips and knees. The resident's torso was twisted to the left from the waist down with both legs drawn and crossed at the ankles which caused contact in areas creating high risk pressure points. The LPN stated the resident had been administered pain medication 30 minutes prior to the wound care beginning. The resident was asked to rate her pain on a scale of one to ten. She stated, "Eight." The resident was unable to relax due to muscle spasms. When the LPN would touch the resident, she would begin having muscle spasms. With each manipulation of the resident's lower extremities the resident would yell out, "Oh, Oh." The resident was very flushed, her cheecks were red, and her eyes were wide. She had a grimace on her face with a fearful look when she knew she would be moved. At 10:05 a.m., the resident was asked if she had received pain medication prior wound care. She	F 309		

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F 309	Continued From page 88 stated, "Yes." She was asked if she felt the pain medication was effective. She stated, "They tell me I take the strongest pain medication they can give me, but I could stand a stronger one." She was asked if she ever refused repositioning. She stated, "Sometimes. It hurts. They can't get me comfortable." At 10:17 a.m., LPN #2 was asked if she felt the resident's pain medication was effective when administering wound care. She stated, "She has muscle spasms when you touch or move her." At 10:55 a.m., CNA #2 was asked how she knew the resident was in pain when administering care. She stated, "She yells." She was asked what she did when she saw the resident was in pain. She stated she would tell the medication aide or reposition the resident. She stated the medication aide will give her a pain pill. She stated, "She lets us move her but she doesn't want to." She stated, "She hates showers, she cries." She was asked what causes the resident pain. She stated, "Touching and moving her." She was asked who she had told about the resident's pain. She stated, "Everyone knows." She was asked if the charge nurses were aware. She stated, "Yea." She was asked if it appeared the resident's pain medication was effective in relieving the resident's pain. She stated, "No, nothing	F 309		