STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365531	A. BUILDING _____ B. WING _____	07/28/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LANCIA VILLA ROYALE	1852 SINCLAIR AVENUE STEUBENVILLE, OH 43953

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0157 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to notify a psychiatrist of a consulting physician's concerns regarding one resident's lethargy (Resident #63) in a timely manner. This affected one of nine residents records reviewed. The facility census was 63. Findings include: Review of Resident #63's medical record revealed [DIAGNOSES REDACTED]. Review of a transfer sheet for an appointment with a consulting physician dated 04/01/14 revealed Resident #63 was extremely lethargic and difficult to arouse. The transfer form indicated the physician spoke with the nurse from the facility and asked the psychiatrist to evaluate Resident #63's medications. Review of the report to the attending physician from the consulting physician related to the visit on 04/01/14 indicated Resident #63's visit was a follow up visit for his [MEDICAL CONDITION]. The report indicated Resident #63 was severely lethargic and was minimally arousable but, had no associated symptoms. The consulting physician indicated the altered mental status was possibly related to psychiatric medications. The report indicated a nurse from the facility was contacted and was to call the psychiatrist and ask him to address the lethargy and possibly change medications. A nursing note dated 04/04/14 timed 11:00 A.M. revealed the nurse practitioner for the psychiatrist was made aware of the consulting physician's concerns regarding Resident #63's lethargy. On 07/22/14 at 10:00 A.M., the director of nursing (DON) was interviewed regarding the consulting physician's documentation on 04/01/14 indicating he was concerned regarding Resident #63's lethargy and possible correlation with psychiatric medication use with no evidence indicating the psychiatrist's office was notified until 04/04/14. The DON indicated there had been two nurses working Resident #63's unit on 04/01/14, with one of the nurses being in training. The DON stated the nurses were unable to recall who spoke to the consulting physician's office. The DON indicated on 04/04/14 they became aware the issue had not been addressed and that was when notification of the psychiatrist's office was completed. This deficiency substantiates Complaint Number OH 413.
F 0272 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Conduct initial and periodic assessments of each resident's functional capacity.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to assess residents need for toileting programs in a timely manner for five residents (Resident #14, #21, #29, #49 and #63) and failed to document assessment of all skin impairments for one resident (Resident #63). This affected five of nine residents reviewed for assessments. The facility census was 62. Findings include: 1. Review of Resident #63's medical record revealed [DIAGNOSES REDACTED]. A plan of care initiated on 12/17/13 revealed Resident #63 had bladder incontinence related to his inability to make his toileting needs known as a result of [MEDICAL CONDITION]. The plan of care indicated Resident #63 was frequently incontinent of bladder with the urinal offered every two hours during waking hours and every two hours at night if awake. The plan of care revealed Resident #63 did urinate in the urinal at times with at least one episode of continence voiding within a seven day period. The plan of care was updated on 03/15/14 to reveal a seven day voiding diary was initiated and Resident #63 would be assessed for a possible toileting program if appropriate. The care plan did not reveal the evaluation was ever completed or if Resident #63 required a change in his toileting program. Review of a Bowel/Bladder Continence assessment dated [DATE] revealed the assessment was initiated but the staff member doing the assessment was waiting for the wet/dry diary in order to complete the assessment. Data regarding Resident #63's patterns of continence and incontinence was scheduled to begin 03/14/14. The information was blank for that date. Tracking information was recorded between 03/15/14 and 03/20/14 but the assessment was not completed. On 07/22/14 at 10:00 A.M., the director of nursing (DON) was interviewed regarding the incomplete bowel and bladder assessment for Resident #63. No additional information was provided. At 10:30 A.M., the DON verified the bowel and bladder assessments were incomplete. On 07/22/14 at 10:44 A.M., Restorative Nurse #27 verified after the voiding diary was complete for Resident #63 in March, 2014; no one finished the bowel and bladder assessment, determined Resident #63's type of incontinence or the appropriateness of a toileting program as indicated in the plan of care. 2. Review of Resident #14's medical record revealed [DIAGNOSES REDACTED]. Review of a bowel and bladder tracking record dated 04/22/14 through 04/28/14 revealed no evidence an evaluation of the tracking information was completed. The Bowel/Bladder Continence Assessment was completed on 07/17/14 based on the April, 2014 tracking log. On 07/21/14 at 6:35 P.M. the DON verified the assessments and toileting programs for Resident #14 were based on bowel and bladder tracking completed three months prior. The DON verified Resident #14's incontinence needs could have changed over that three month timeframe. 3. Review of Resident #29's medical record revealed [DIAGNOSES REDACTED]. Resident #29's Bowel and Bladder Collection Form revealed the facility monitored for patterns from 04/25/14 through 04/30/14. The Bowel/Bladder Continence Assessment form was dated 06/26/14. An undated Bladder/Bowel Restorative Scheduled Toileting Program indicated Resident #29 was to be assisted with toilet use after breakfast, after lunch, after dinner, and as necessary. The form contained no documentation the program was enacted. 4. Review of Resident #49's medical record revealed [DIAGNOSES REDACTED]. Bowel and bladder tracking was completed from 03/14/14 through 03/20/14. A continence assessment based on the tracking was dated 06/26/14. Documentation for the restorative bowel and bladder toileting program was blank. 5. Review of Resident #21's medical record revealed [DIAGNOSES REDACTED]. Bowel and bladder tracking was completed from 04/22/14 through 04/28/14. The assessment based on the tracking was not completed until 06/25/14. 6. Review of the weekly skin integrity review form dated 04/03/14 revealed Resident #63 had redness of the bilateral inner buttocks and the ischial folds. The review contained no assessment of the size of the reddened areas or the cause/type of skin breakdown. Review of the weekly skin integrity forms dated 04/08/14 and 04/15/14 indicated the buttocks were red. The weekly skin integrity forms dated 04/22/14 indicated Resident #63's scrotum was red. The skin integrity forms contained no information regarding assessment of the areas or causative factors. Review of a nursing note dated 04/27/14 timed 10:15 A.M. and indicating it was a late entry for 04/26/14 indicated an emergency room transfer report for Resident #63 included that Resident #63 had a right heel pressure ulcer and a scab on the second toe of the right foot. On 07/22/14 at 10:30 A.M. the DON verified there were no comprehensive wound assessments or documentation for the skin breakdown of the buttocks, scrotum, toe, or ischium for Resident #63. This deficiency substantiates Complaint Number OH 413.
F 0314 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, and staff interview, the facility failed to implement a physician ordered pressure reduction device for one resident (Resident #29). This affected one of three residents reviewed for skin

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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

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F 0314 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) impairment. The facility identified six residents with pressure ulcers. Findings include: Review of Resident #29's medical record revealed [DIAGNOSES REDACTED]. Resident #29 was admitted on [DATE] with a Stage II pressure ulcer to the coccyx measuring 1.0 centimeters (cm) by 0.7 cm by 0.2 cm. A physician order [REDACTED]. A weekly wound evaluation flow sheet revealed an assessment on 07/17/14 which revealed the pressure ulcer on the coccyx remained a Stage II ulcer and measured 0.8 cm x 0.2 cm x 0.1 cm. Resident #29 was observed sitting in a chair in the common area of the secure unit on 07/21/14 at 2:42 P.M., 3:45 P.M., 5:03 P.M. and 6:43 P.M. with no pressure reducing device observed in the chair. On 07/22/14 at 11:58 A.M. Resident #29 was observed sitting in a chair in the common area with no pressure reducing cushion under her buttocks. On 07/22/14 at 1:13 P.M., Sitter #31 was interviewed and stated the only pad she was aware of that Resident #29 used was the pressure alarm pad in the chair. Sitter #31 verified Resident #29 had no pressure relief cushion in the chair in the common area on 07/21/14 or the morning of 07/22/14. Sitter #31 was present with Resident #29 during all observations. On 07/22/14 at 1:15 P.M. State tested Nurse Aide (STNA) #33 was interviewed and stated the only cushion used in Resident #29's chair was when staff would sometimes fold an incontinence pad and place it under the resident. On 07/22/14 at 1:33 P.M. Registered Nurse (RN) #35 was interviewed and stated Resident #29 used to have a foam cushion. She asked STNA #33 if she knew where it was located. STNA #33 responded she had not seen the cushion. Staff checked Resident #29's room but were unable to locate the cushion. This deficiency substantiates Complaint Number OH 413.
F 0323 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, policy review, review of facility admission packet, resident interview and staff interview, the facility failed to ensure Resident #40 was provided appropriate staff assistance and supervision to prevent unrestrained forward motion down an outdoor incline leading to a rock patch and a two lane highly traveled highway while in a wheelchair. This resulted in Immediate Jeopardy for one resident (Resident #40) of four residents identified by the facility that utilized the front entrance in a wheelchair. In addition one resident sustained [REDACTED].#21) and the facility failed to secure a narcotic medication out of the reach of five confused, independently mobile residents (Resident #24, #29, #36, #59 and #60). The facility census was 62. The administrator and director of nursing (DON) were notified on 07/23/14 at 5:00 P.M. that Immediate Jeopardy began on 07/22/14 at 1:40 P.M. when the receptionist was observed opening the secured front door to permit exit from the facility for Resident #40 who was seated in a wheelchair. Resident #40 was observed being unable to maintain control of the wheelchair and swerved to the right and down an incline toward a raised concrete curb that separated the path from a rock and boulder patch and a two lane highly traveled highway. Resident #40 reported increased pain and drainage from a recently repaired fractured ankle site and emotional trauma as a result of the incident. The immediate Jeopardy was removed on 07/25/14 at 1:30 when the facility implemented the following corrective actions: ? On 07/24/14 at 3:13 P.M. the administrator and DON reported four residents known to go outside independently in wheelchairs were informed of the need to use the rear doors where the exit was flat. ? On 07/24/14 the facility implemented a policy in which residents would get on and off the activity van in the rear of the building where the surface was flat. All staff were inserviced on this policy and residents were notified as they prepared to load the bus for activities. ? On 07/24/14 the facility began assessing residents to determine each resident's need for outdoor supervision and assistance. As of 4:55 P.M. on 07/24/14, 25 residents had been assessed. Thirty seven residents that were either independent for mobility or resided on the secure unit had not been assessed. ? On 07/24/14 the facility revised the policy entitled 'Resident's Right to Go Outside the Building'. The policy indicated any resident who wished to go outside the front entrance of the building was required to have supervision. Staff training on the new policy began on 07/24/14. As of 5:55 P.M. on 07/24/14, all but three employees had received training. These employees were to be inserviced on 07/25/14 when they came to the facility to pick up their paycheck. Although the Immediate Jeopardy was removed the facility remained out of compliance at a severity Level 2 (no actual harm with the potential for more than minimal harm that was not Immediate Jeopardy) as all residents were not assessed for outdoor supervision and not all staff were in-serviced on the revised resident outdoor policy. In addition the facility failed to apply an alarm to Resident #21 as care planned to alert staff of attempts of unassisted transfers, failed to ensure medications were secured and out of reach of confused and independently mobile residents (Residents #24, #29, #36, #59, and #60) and one resident sustained [REDACTED]. Findings include: 1. Review of the medical record revealed Resident #40 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #40 was admitted with orders for physical and occupational therapy following surgical repair of a left ankle fracture. Review of the admission record revealed Resident #40 experienced coughing episodes where she reportedly became dizzy and blacked out. Resident #40 had experienced four falls in the month prior to admission and had sustained injuries including a left ankle fracture as a result of those falls. Review of an occupational therapy progress note dated 07/18/14 revealed Resident #40 presented to therapy with a decrease in functional transfers and mobility. She was non-weight bearing on the left extremity and was assessed as high risk for falls. On 07/22/14 at 1:40 P.M., Receptionist #12 was observed opening the secured front door to permit exit of the building by Resident #40 while she was seated in a wheelchair. The entrance to the facility is on an incline. Resident #40 was unable to maintain control of the wheelchair as it swerved to the right down the hill and forward toward a raised concrete curb that separated the path from a rock and boulder patch and a two lane highly traveled highway. Resident #40's wheelchair was approximately one inch from the concrete curb when it was stopped by Resident #35 who had run out of the lobby chasing Resident #40, and then lunged forward to stop the wheelchair from hitting the curb. Resident #35 fell and sustained an 11 centimeter (cm) by two cm by 0.3 cm abrasion to his arm. Review of a nurses' note dated 07/22/14 timed 2:20 P.M. indicated Resident #40 went to the front doors and stated she wanted to sit out under the canopy. The note indicated Resident #40 was let out the door by the receptionist. Resident #40 began to wheel sideways and was stopped. The note indicated Resident #40 reported she put her left foot down to catch herself, along with her right foot and stated she may have bumped her left leg on the foot pedal. The nurses' note indicated a moderate amount of yellow serous drainage was noted to the left foot dressing. The dressing was removed and both lateral incisions were intact with sutures. A small amount of edema was noted to the mid-foot between the surgical pin insertion sites. On 07/22/14 at 3:13 P.M. Licensed Practical Nurse (LPN) #14 was interviewed and stated although Resident #40 was alert and oriented, she was very sick. LPN #14 stated she did not believe Resident #40 had the strength to independently maneuver the wheelchair outside. On 07/22/14 at 4:40 P.M. Receptionist #12 was interviewed and verified she was the staff member who opened the door for Resident #40. Receptionist #12 stated it was the first time she had met Resident #40. Receptionist #12 stated Resident #40 had stated she was outside the day before but failed to tell her she had two people with her while outdoors. Receptionist #12 verified she knew nothing else about Resident #40 and stated she should have asked if the resident was safe to go outside independently. Receptionist #12 stated she did not realize Resident #40 was not safe to be outside independently until she saw her start rolling down the hill. Receptionist #12 verified Resident #40's wheelchair was stopped from missing the curb due to the action taken by Resident #35. On 07/23/14 at 7:00 A.M., Licensed Physical Therapy Assistant (LPTA) #16 was interviewed and stated she had completed Resident #40's physical therapy evaluation. LPTA #16 stated she would not have recommended Resident #40, or any resident in a wheelchair, exit the facility using the front entry door without assistance due to the hill. On 07/23/14 at 4:30 P.M., Certified Occupational Therapist Assistant (COTA) #18 was interviewed and stated she only assessed Resident #40 for wheelchair mobility indoors. COTA #18 stated she had observed Resident #40 propel on flat surfaces and over doorway thresholds in the facility. COTA #18 stated Resident #40 had not been assessed for the ability to propel her wheelchair on an inclines or hills. COTA #18 stated she would not recommend Resident #40 go outside with less than supervision. On 07/23/14 at 4:33 P.M., Resident #40 was interviewed and reported on 07/22/14 she went to the front lobby to wait on a visitor but saw a cat on the chair. She stated since she was allergic to cats, she decided to wait outside. Resident #40 stated she was outside the day before with two other residents. Resident #40 stated one of the other residents propelled her in the wheelchair and she did not pay attention to the surroundings. Resident #40 stated she did not realize the steepness of the hill or realize how many cracks or crevices were in the pavement. Resident #40 stated when she told the receptionist she wanted to go outside, nobody provided any instruction or warning that there was an inclined area outdoors. Resident #40 stated when she went to exit the building there was a man in the doorway. Resident #40 stated she tried to turn left but the wheelchair got away from her. Resident #40 stated she believed it was related to the incline. She stated she was not prepared for the incline and did not think she would be going down as fast as she did. Resident #40 stated she was so fearful she thought

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F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) about jumping off the wheelchair. She stated it happened so fast she did not know how to react. Resident #40 remembered trying to stop the wheelchair and believed she may have tried to use both feet to stop the wheelchair. Resident #40 stated her left foot, which was already fractured, had increased pain following the incident and she noticed drainage that was not there before. Resident #40 stated if it were not for Resident #35, she could see herself lying in the morgue. Resident #40 verified she was only an inch or two away from the wheelchair hitting the curb prior to it being stopped. On 07/23/14 at 4:50 P.M., the administrator reported all five staff members that had receptionist duties had received training informing them not to permit residents to go outside without checking with medical staff to ensure they were safe to do so. Review of the facility's policy entitled 'Residents' Right to go Outside the Building', revised June, 2014, indicated a policy was in place to ensure the safety for residents who wanted to go outside without a staff member. The policy indicated residents who wanted to go outside the building without a staff member must be alert and oriented and the resident was to inform a staff member they were going outside. Staff were to check on the residents according to a frequent check protocol that stated check every 30 to 60 minutes. Review of the facility's admission packet revealed prior to allowing a resident to participate in any outside activity, nursing reviewed the resident's physical and mental condition to make certain there was nothing that would preclude the resident from participating in the activity. The policy indicated the facility would take every precaution to ensure the safety and welfare of the resident. An observation was made on 07/24/14 following the wheelchair incident, of the activity van and a visitor being directed to the flat area in the back of the building to load and unload residents. Interviews conducted with Laundry Personnel #41, LPN #14 and State tested Nurse Aide (STNA) #39 on 07/24/14 revealed knowledge of the facility's revised policy for residents going outdoors. Interviews with Office Staff #26, Housekeeper #43, STNA #45 and STNA #47 on 07/25/14 indicated knowledge of the revised policy. Observation was made of Residents #14, #35 and #40 in the common area discussing the revised policy on 07/25/14 at 10:30 A.M. Observations conducted on 07/25/14 revealed no residents outside without supervision. 2. Review of Resident #35's medical record revealed [DIAGNOSES REDACTED]. Review of a fall risk evaluation dated 05/27/14 indicated Resident #35 was at risk for falls. Review of the Minimum Data Set 3.0 ((MDS) dated [DATE] revealed Resident #35 was cognitively intact. On 07/22/14 at 1:40 P.M., Resident #35 attempted to stop a wheelchair occupied by Resident #40, from propelling down an incline toward a rocky path and a heavily traveled two lane highway. Resident #35 fell to the ground onto his right side and sustained an abrasion to the right forearm measuring 11 centimeters (cm) by 2.0 cm. by 0.3 cm. as well as abrasions to the right palm and middle finger. On 07/23/14 the physician was notified and an X-Ray was obtained in the facility that was negative for fracture or dislocation. Neosporin ointment and a dressing were initiated. On 07/24/14 the treatment was changed to Aquacel and an adhesive dressing. Interview on 07/23/14 at 6:55 A.M. with Registered Nurse (RN) #37 indicated Resident #35 was in pain and was sore during the night. RN #37 stated she administered Tylenol 325 milligrams (mg) and Ativan 0.5 mg. Review of the medication administration record (MAR) verified the administration. RN #37 revealed Resident #35 seldom asked for any pain medication. On 07/23/14 at 9:38 A.M., Resident #35 was observed lying on his bed on his left side holding onto his right shoulder. A bandage was on his right forearm. On 07/24/14 at 10:20 A.M. Resident #35's right forearm was observed during a dressing change. Resident #35 had irregular shaped abrased areas with well-defined edges on the right forearm with two large and one small open area within the 11 cm by 2.0 cm abrasion. Interview with Resident #35 revealed his right arm was sore. 3. On 07/21/14 at 4:57 P.M., Licensed Practical Nurse (LPN) #25 was observed administering medication to Resident #36, who resided on a secure unit. While preparing the medication for administration, LPN #25 removed a card of Vicodin (narcotic pain medication) from the cart and placed the card with one pill in a notebook on top of the cart which was located in the common area. Resident #59 walked over to the medication cart and stood in front of it. LPN #25 turned and walked away from the cart toward Resident #36's room. LPN #25 saw staff exiting the room with Resident #36, walked back to the medication cart and informed staff they would need to return Resident #36 to her room. LPN #25 once again walked away from the medication cart down the hall toward Resident #36's room, leaving the narcotic pain pill on the top of the cart. LPN #25 was stopped and asked if Resident #59 would attempt to do anything with the Vicodin left on the medication cart in the front of the notebook. LPN #25 insisted the card was empty and there was no medication in it. When informed she had not been observed removing the Vicodin from the card, LPN #25 looked at the medication cup she was holding and verified the Vicodin was not in the cup and was in the card on top of the unattended medication cart. On 07/24/14 at 12:10 P.M., LPN #14 identified independently mobile, confused residents on the secured unit as Residents #24, #29, #36 #59, and #60. 4. Review of Resident #21's medical record revealed [DIAGNOSES REDACTED]. A nursing note dated 05/02/14 timed 6:10 A.M. revealed Resident #21 was assessed as a high risk for falls after being found on the floor. Review of the physician order [REDACTED].#21 was ordered a bed sensor alarm and an alarm pad in the chair. On 07/21/14 at 4:22 P.M., Resident #21 was observed propelling herself in a wheelchair toward the receptionist's desk. An alarm pressure pad was observed in the wheelchair but the Velcro sleeve for securing the alarm box was empty. No alarm box was observed anywhere in the wheelchair. On 07/22/14 at 7:40 A.M., Resident #21 was observed sitting in her wheelchair in the dining room. No alarm box was observed. On 07/22/14 at 4:45 P.M., Resident #21 was observed sitting in the wheelchair in the hall by the nursing station. The pressure pad was observed on the wheelchair but no alarm box was observed. At 4:48 P.M. the director of nursing (DON) confirmed no alarm box was attached to the pad in resident #21's wheelchair. This deficiency substantiates Complaint Number OH 413.
F 0332 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Keep the rate of medication errors (wrong drug, wrong dose, wrong time) to less than 5%.** Based on observation, review of physician's orders and staff interview, the facility failed to ensure medications were administered according to physician orders. Two medication errors of 28 opportunities were identified resulting in a 7.14 percent medication error rate. The facility census was 62. Findings include: 1. On 07/21/14 at 4:57 P.M., LPN #25 was observed administering medication to Resident #36. Donepezil 10 mg. was included with the medication administered. LPN #25 verified all medication administered. Review of physician orders revealed donepezil 10 mg was to be administered at bedtime for dementia. Review of the facility's Medication Administration Pass policy (revised 01/13/14) revealed medications were to be administered to the resident according to physician orders. 3. On 07/22/14 at 7:23 A.M., LPN #14 was observed administering medication to Resident #38. Among the medication administered was one tablet of one gram of sodium chloride. Review of physician orders revealed two tablets of one gram of sodium chloride were ordered twice a day. On 07/22/14 at 8:10 A.M., LPN #14 was interviewed and verified she had only administered one tablet of the sodium chloride. This deficiency was an incidental finding at the time of the Complaint Investigation.
F 0428 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**At least once a month, have a licensed pharmacist review each resident's medication(s) and report any irregularities to the attending doctor.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure pharmacy recommendations were addressed in a timely manner. This affected six of seven residents sampled for pharmacy drug regimen review (Resident #21, #29, #36, #38, #49, and #63). The facility census was 62. Findings include: 1. Review of Resident #36's medical record revealed [DIAGNOSES REDACTED]. Review of a pharmacy recommendation dated 05/07/14 revealed Resident #36 did not have a [DIAGNOSES REDACTED]. Review of the pharmacy review dated 06/04/14 revealed there had been no response to the review and recommendations dated 05/07/14. The director of nursing (DON) signed and responded to the recommendation on 06/17/14. 2. Review of Resident #38's medical record revealed [DIAGNOSES REDACTED]. Review of the pharmacy review dated 06/04/14 indicated the recommendation from 05/07/14 had not been responded to. The DON signed the recommendation on 06/18/14 with a note the recommendation was accepted via a telephone order. The physician signed the recommendation on 06/25/14. 3. Review of Resident #29's medical record revealed [DIAGNOSES REDACTED]. Review of the pharmacy review dated 05/07/14 revealed Resident #29 was due for an abnormal involuntary movement assessment and requested orders for laboratory tests related to the use of thyroid medication and Lasix (diuretic). The pharmacy review dated 06/04/14 indicated the recommendation was not responded to. The recommendations were responded to by the DON on 06/17/14 and signed by the physician on 06/30/14. 4. Review of Resident #21's medical record revealed [DIAGNOSES REDACTED]. Review of the pharmacist medication regimen review dated 04/16/14 revealed a request had been made on 03/10/14 which had not been addressed. The request was for the physician

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0428 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 3) to consider a trial dose reduction of Ativan (anti-anxiety) 0.5 mg ordered as needed on a daily basis. The request was not responded to until 06/13/14. 5. Review of Resident #63's medical record revealed [DIAGNOSES REDACTED]. The pharmacy review dated 04/16/14 requested the physician change the order for Namenda five milligrams (mg) twice a day to an extended release form of the medication, Namenda 's. In addition the pharmacist recommended an attempt at discontinuation of Zyprexa (anti-psychotic) five mg once a day and a [DIAGNOSES REDACTED]. On 06/13/14, the DON documented the resident was no longer at the facility. 6. Review of Resident #49's medical record revealed [DIAGNOSES REDACTED]. Review of a pharmacy review dated 06/04/14 revealed the pharmacist inquired if Resident #49 would benefit from the addition of a cholinesterase inhibitor or Namenda XR due to a [DIAGNOSES REDACTED].#49 had an order for [REDACTED]. On 06/17/14, the DON documented the psychiatrist or his nurse practitioner were to address the recommendation during their next rounds. Resident #49 was last seen by the nurse practitioner on 05/28/14. On 07/25/14 at 10:29 A.M., the DON was interviewed and verified Resident #49 had not been seen by the psychiatrist or nurse practitioner since 05/28/14 and the recommendation had not been addressed. On 07/22/14 at 10:00 A.M., the director of nursing (DON) verified the pharmacist's recommendations were not responded to in a timely manner. This deficiency was an incidental finding at the time of the Complaint Investigation.
F 0441 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Have a program that investigates, controls and keeps infection from spreading.** Based on observation, staff interview, and policy review, the facility failed to ensure ice was distributed in a sanitary manner. This had the potential to affect 57 of 62 residents. Findings include: On 07/23/14 at 9:44 A.M., a cart was observed on C hall with an ice chest and supplies for passing ice water including trays, pitchers and lids. A cat was observed with its front paws and face in the bin containing the trays, pitchers and lids on the bottom shelf. The cart was not in view of any staff members. On 07/23/14 at 9:45 A.M., Housekeeper #29 obtained trays, pitchers and lids from the ice cart and put three trays and pitchers on the top of the ice chest. Housekeeper #29 verified the supplies had been obtained from the bottom shelf of the cart and she intended to use the pitchers. The cat was laying on the floor across the hall. Housekeeper #29 was informed of the observations of the cat contaminating the articles. At 9:47 A.M., Housekeeper #29 resumed preparing ice for distribution. Housekeeper #29 verified she changed the pitchers but she had not washed her hands after handling the items the cat had contaminated. Review of the facility's Hand Washing policy (revised 10/17/13) revealed hands should be washed after contact with a source of microorganisms. This deficiency was an incidental finding at the time of the Complaint Investigation.