

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

PRINTED: 04/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025025	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/04/2016
NAME OF PROVIDER OR SUPPLIER PRESTIGE CARE & REHAB CENTER OF ANCHORAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 9100 CENTENNIAL DRIVE ANCHORAGE, AK 99504		
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F 000	INITIAL COMMENTS The following deficiencies were noted during an unannounced standard Medicare/Medicaid recertification and State Licensing survey conducted 2/29/15 to 3/4/16. The sample included 16 active residents, 3 closed records and 9 non-sampled residents were reviewed. In addition, the was a FOSS survey. STATE OF ALASKA Department of Health & Social Services Division of Health Care Services 4501 Business Park Blvd. Ste. 24, Bldg L Anchorage, Alaska 99503	F 000			
F 151 SS=E	483.10(a)(1)&(2) RIGHT TO EXERCISE RIGHTS - FREE OF REPRISAL The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure residents were afforded the information and the opportunity to vote. Specifically, the facility failed to inform 8 out of 9	F 151	Resident #11 and family have had voting information reviewed with them. Residents with desire and ability to vote	4/12/16	

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

TITLE

(X6) DATE

Electronically Signed

04/04/2016

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 151	<p>Continued From page 1</p> <p>residents present at the group interview of how and when to vote in the most current election. Furthermore, 1 additional resident (#11) who was interviewed was not informed or assisted in exercising his/her voting rights. The total facility census was 81 residents. This failed practice denied residents the opportunity to exercise their rights as citizens, specifically their right to vote. Findings:</p> <p>During the group interview on 03/1/16 at 1:05 pm, when asked by the surveyors if any of the Residents exercised their right to vote, 1 Resident indicated that he/she has voted in the past while residing in the facility. The other Residents (8 out of 9) present during the group interview indicated that they did not know it was time to vote. During the time of the survey, the presidential primaries were taking place.</p> <p>Record review from 2/29/16 to 3/4/16 revealed Resident #11 was admitted to the facility for rehabilitation after an extended hospital admission for congestive heart failure.</p> <p>During an interview on 3/1/16 at 11:45 am Resident #11 was asked if the facility had offered to assist him with voting. The Resident and his daughter stated the facility had not discussed the possibility of voting and the resident stated he would like to vote.</p> <p>During an interview on 3/3/16 at 11:45 am the Social Services Director (SSD) stated the facility did not have an effective process in place to assist Residents with registering to vote.</p> <p>Review of the facility's "Resident's Rights" section in the admission packet stated, "Each resident,</p>	F 151	<p>have the potential to be affected.</p> <p>Residents were given verbal and written information regarding voting rights. Voter applications were offered/assisted with completion as applicable.</p> <p>To ensure on-going compliance voter rights and upcoming election opportunities will be added to the monthly resident council agenda and reviewed during the monthly meeting.</p> <p>Administrator to audit monthly resident council meeting minutes and review plans per election cycle to ensure all appropriate residents were given the opportunity to exercise their rights to vote.</p> <p>Copy of audit(s) with findings (negative outcomes/trends/patterns) will be provided the QAPI team. Issue will be reviewed during monthly Performance Improvement Meeting for 3 months or until resolved to ensure continued compliance.</p>		

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F 151	Continued From page 2 and legal representative as appropriate, has the following rights: The right of citizenship. Nursing home residents do not lose any of their rights of citizenship, including the right to vote..."	F 151			
F 154 SS=D	483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure 2 residents (#s 1 and 14) and/or their representatives were fully informed of the potential risks and benefits concerning the use of medications, out of 16 residents reviewed. Specifically, the resident and/or their representatives were not notified fully of the risks and benefits regarding the use of an antipsychotic medication for 1 resident (#1) and an anticholinergic medication for resident (#14). This failed practice denied the residents' and/or their representatives the right to be fully informed of risks and benefits prior to initiating the use of	F 154	Resident #1 is no longer at facility. Resident #14 medication regimen was fully reviewed with family and medical records were updated. Residents receiving antipsychotic and/or anti-cholinergic medication have the potential to be affected. Residents receiving antipsychotic and/or anti-cholinergic medication have been reviewed to ensure risk/benefit review has been completed with resident/responsible	4/12/16	

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F 154	<p>Continued From page 3 these medications. Findings:</p> <p>Resident #1</p> <p>Record review on 2/29/16 to 3/4/16 revealed Resident #1 was admitted with a diagnosis of Parkinson's with dementia and hallucinations.</p> <p>Review of the "Psychoactive Drug Review" dated 6/17/15 revealed the antipsychotic medication Seroquel was started on 3/19/15.</p> <p>Further review of the most current "Psychotropic Drug Consent" dated 3/19/15, revealed no documentation of the FDA (Federal Drug Administration) black box warnings for the antipsychotic medication.</p> <p>The FDA black box warning indicated for the antipsychotic medication Seroquel states, "Increased Mortality in Elderly Patients with Dementia-Related Psychosis: Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Seroquel is not approved for the treatment of patients with dementia-related psychosis."</p> <p>According to "Identifying Medications that Older Adults Should Avoid or Use with Caution: the 2012 American Geriatrics Society Updated Beers Criteria, "Antipsychotic drugs"...may increase risks of confusion, sleepiness, blurred vision, difficulty urinating, dry mouth, constipation, stroke, and death in people with dementia. Avoid using these drugs to treat behavioral problems in older people with memory disorders unless non-drug options haven't worked and the patient is a threat to himself or herself or others."</p>	F 154	<p>party. It was discovered that an out dated form had been used for previous consent in question. Out dated forms were removed and destroyed, and all resident charts were reviewed and updated consents completed as needed.</p> <p>Licensed Nurses and Resident Care Managers were re-educated regarding policy and procedure regarding medications and risk/benefit documentation.</p> <p>To ensure on-going compliance, consent completion for risk/benefit will be reviewed daily during MACC (Managing Acute Condition Changes) meeting.</p> <p>Copy of audit(s) with findings (negative outcomes/trends/patterns) will be provided to the Administrator for review and follow-up as necessary. Issue will be reviewed during monthly Performance Improvement Meeting for 3 months or until resolved to ensure continued compliance.</p>		

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F 154	<p>Continued From page 4 Resident #14</p> <p>Record review on 3/3-4/16 revealed Resident #14 had a diagnosis of status post cerebral vascular accident (stroke) and had family members that made decisions for him.</p> <p>Review of the most recent Minimum Data Set (MDS), an assessment dated 12/22/15, revealed the Resident had a BIMS (brief interview of mental status) score of 3 out of 15, which indicated severe cognitive impairment.</p> <p>Review of the medical record revealed on the date of 2/24/16, a physician's order for Benadryl 25mg [by mouth] at bedtime for [complaints of] itchiness... There was no information in the medical record the family, responsible for the Resident's medical care, was notified of the new medication.</p> <p>During an interview on 3/3/16 at 2:00 pm, Resident Care Manager #1, confirmed the nurse had not documented that the Resident's family was notified of the new medication.</p> <p>During an interview on 3/4/16 at 8:15 am, when asked who provided the risk and benefits education to Residents and interested parties, the Resident's Physician stated "The nurses will. If they are not comfortable [the nurses], they will ask him to do it."</p> <p>Record review from 3/1-4/16 of the "Psychoactive Medication" policy, dated 1/15, revealed "The risk/benefit of the drug use and informed consent will be obtained...prior to administration of any psychoactive medication."</p>	F 154			

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F 154	Continued From page 5 Review of the 2012 American Geriatric Society Updated Beers Criteria source; the medication Benadryl was listed, and included the following information: "These drugs cause many side effects in older adults, including confusion, drowsiness, blurred vision, difficulty urinating, dry mouth and constipation, Safer medications are available...Use of Benadryl in special situations-such as treating severe allergic reactions-may be appropriate."	F 154			
F 164 SS=F	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.	F 164		4/12/16	

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F 164	<p>Continued From page 6</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>.</p> <p>Based on observation, interview and record review the facility failed to ensure medical information was protected for 3 sampled residents (#s 1, 5, and 10), and 2 non-sampled residents (#s 21 and 22) out of 81 residents residing in the facility. This failed practice had the potential to affect all all residents and denied them of personal privacy of their medical record. Findings:</p> <p>Resident Information Visible</p> <p>Observation on 3/2/16 from 8:30 am to 8:50 am revealed an unattended desktop computer screen displaying the in-room care plan for Resident #1. The computer was located in the common area on Unit #1 and was trafficked by residents, visitors, and staff from all disciplines. The in-room care plan contained personal information about Resident's care needs.</p> <p>MACC Information Sheet</p> <p>During an interview on 3/2/16 at 8:35 am, the Director of Nursing (DON) stated there is a MACC (Managing Acute Condition Changes) meeting with the Resident Care Managers (RCMs) in the mornings of Monday through</p>	F 164	<p>Reviewed issues for Res #1, 5, 10, 21, and 22. No negative impact related to review.</p> <p>All residents have the potential to be affected by this citation.</p> <p>MACC information sheet notification was corrected during survey and is only shared with appropriate staff.</p> <p>IT has been contacted to ensure sleep mode on all computers/monitors is set appropriately. All staff were re-educated regarding protecting medical information, with focus on examples of cited issues.</p> <p>Administrator and Dept. Managers will perform management rounds to ensure medical information is kept private. Rounds will be done daily for two weeks and then weekly for four weeks.</p> <p>Copy of audit(s) with findings (negative outcomes/trends/patterns) will be</p>		

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F 164	<p>Continued From page 7</p> <p>Friday throughout the week. The DON stated after the MACC meetings, an information sheet which contained follow-up information was routinely emailed to all the department heads, including the business office. During the interview the DON stated the information sheet contained clinical information about the Residents.</p> <p>Review of the MACC information sheet that had been sent to the managers on 3/1/16 revealed the sheet listed the following information:</p> <p>"[Resident #5] hydrochlorothiazide d/c [discontinued]; [Resident #21] dig level; and [Resident #22] d/c Novolog"</p> <p>Blister Pack</p> <p>Record review from 3/1-4/16 revealed Resident #10 was admitted to the facility with diagnoses that included major depressive disorder and anxiety disorder.</p> <p>Further review of the Medication Administration Record (MAR) revealed Resident #10 was taking Lexapro daily.</p> <p>Observation on 3/3/16 at 11:15 am of Unit #1 revealed empty medication blister cards in the trash can next to the medication cart. Further observation, after picking up one of the blister cards, revealed one of the cards included personal and clinical information regarding Resident #10.</p> <p>During an interview on 3/4/16 at 10:15 am, LN # 5 stated the name should be removed off of the medication blister card before throwing the card in the trash.</p>	F 164	<p>provided to the Administrator for review and follow-up as necessary.</p> <p>Issue will be reviewed during monthly Performance Improvement Meeting for 3 months or until resolved to ensure continued compliance.</p>		

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F 164	Continued From page 8	F 164			
F 167 SS=C	<p>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility .</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to post signage for the location of survey results. This failed practice denied ready access to the survey results by all residents, visitors and staff. Findings:</p> <p>Observations from 2/29/16 - 3/4/16 at the entrance and visitor check-in counter revealed the survey results, though located on the desk, had no signage to alert residents, family, or visitor of the survey results location.</p> <p>In addition, the survey results were not posted or readily accessible to Residents who lived on the second floor.</p>	F 167	<p>Residents/responsibly parties are at risk related to this citation.</p> <p>Notice was posted at reception desk and foyer of dining room on second floor, identifying where survey results are posted.</p> <p>To ensure on-going compliance Administrator and Dept. Managers will complete monthly Pulse rounds to ensure notice and survey results are posted correctly.</p> <p>Copy of audit(s) with findings (negative outcomes/trends/patterns) will be</p>	4/12/16	

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F 167	Continued From page 9 During an interview on 2/29/16 at 2:30 pm Receptionist #1 stated if someone wants to review the survey results they have to ask. During an interview on 3/4/16 at 7:50 am, the Administrator confirmed there should have been a posted notice identifying where the survey results were.	F 167	provided to the Administrator for review and follow-up as necessary. Issue will be reviewed during monthly Performance Improvement Meeting for 3 months or until resolved to ensure continued compliance.		
F 223 SS=E	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure residents were free from verbal abuse and physical intimidation. This failed practice directly affected 1 resident (#7), and had the potential to affect all other residents living in Unit #1 (11 residents), as the verbal abuse and physical intimidation occurred in the common space of that unit. Findings: Record review on 3/1-4/16 revealed Resident #7 was admitted to the facility on 8/26/15 with	F 223	Incident between resident #7 and 12 was re-investigated based on new information identified in the 2567. Residents with verbal altercations have the potential to be affected. We have reviewed event reports for previous 30 days to ensure policies and procedures were followed. Updates were made as necessary. All Staff were re-educated regarding	4/12/16	

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F 223	<p>Continued From page 10</p> <p>diagnoses that include dementia with behavior disturbance.</p> <p>Continuous observation on 3/2/16 from 12:25 - 12:34 pm during the lunch time meal in the common area of Unit #1, revealed Resident #7 sitting in a wheelchair for lunch. Resident's (#10 and #20), were present and eating lunch at the dining table during the event. During the meal, Resident #7 called out loudly "Stop, no" while being fed by CNA #2. Resident #12 then moved his wheel chair to his room doorway and stated loudly to CNA #5, "she needs to go somewhere else... she needs to stop... Just stop it. Next time she screams I'm going over there and take care of it. It's not right especially at dinner. She's an animal." Resident #12 was referring to Resident #7.</p> <p>During the same observation Resident #7 continued to cry out, while Resident #12 continued to sit in a wheelchair at the doorway of his room and watch Resident #7. When Resident #7 again began to call out "Why! Stop! Stop!" repetitively, Resident #12 wheeled out of the doorway and into the common space towards Resident #7 and began staring at Resident #7. When Resident #7 called out "Ugh!" repetitively, Resident #12 would repeat "Ugh, Ugh, Ugh" multiple times in a mimicking high pitched voice. Resident #12 proceeded to stare at Resident #7 with his face scrunched up and frowning while pushing out his chest. This continued for the next 6 minutes, until CNA #s 2 and 5 assisted Resident #7 to bed in her room. During the exchange Resident #10 and #20 were present in the common area.</p> <p>Observation on 3/2/16 at 12:34 pm revealed the</p>	F 223	<p>abuse, and specific focus on survey citation and review policies and procedures.</p> <p>Interdisciplinary team will audit per MACC process to ensure all reported issues were handled appropriately. Audits will occur daily for two weeks and then weekly for four weeks.</p> <p>Copy of audit(s) with findings (negative outcomes/trends/patterns) will be provided to the Administrator for review and follow-up as necessary. Issue will be reviewed during monthly Performance Improvement Meeting for 3 months or until resolved to ensure continued compliance.</p>		

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F 223	Continued From page 11 Social Services Director (SSD) arrived on Unit #1 and engaged in conversation with Resident #12. During an interview on 3/2/16 at 1:20 pm, Resident #20 stated, "That [Resident #12] over there, thinks he owns that room. He came out here [common area] one time and raised hell with a girl about 3 months ago. It looked like he was going to hit her." Review of the progress note after the incident, dated 3/2/16 at 1:36 pm, revealed "This writer came upstairs and resident was sitting on court, every time other resident would make a noise, this Resident [#12] would respond by making a similar noise." Review of the Facility Policy on Abuse screening, training, identification, investigation, reporting and protection revealed "...It is the policy of this center to:... 6) Protect our residents from abuse... Any staff member observing resident to resident conflict, verbal and/or physical abuse will immediately separate residents, ensuring residents' safety ...Verbal abuse is defined as the use of oral, written or gestured communication to a resident to visitor that describes a resident(s) in disparaging or derogatory terms; Mental abuse includes humiliation, harassment, threats or punishment or deprivation directed toward the resident..."	F 223			
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	F 225		4/12/16	

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

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F 225	<p>Continued From page 12</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 225			

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F 225	<p>Continued From page 13</p> <p>Based on record review, observation and interview the facility failed to ensure 2 suspected abuse and neglect incidents were initially reported to the State agency within 24 hours, and the final reporting within 5 days. The first incident involved 1 resident-to-resident interaction with verbal ridicule and harassment towards a resident (#7). There were 11 residents residing in the unit where the first incident took place who were at risk. The second incident involved a situation in which a resident (#14), with known elopement behaviors, eloped outside the facility for 15-30 minutes. There were 4 residents with known elopement behaviors (utilizing the wander guard system) living in the facility. These failed practices had the potential to affect 15 residents. In addition, the facility's investigation failed to ensure systemic measures were implemented to help mitigate the risk for further abuse and potential neglect.</p> <p>Findings:</p> <p>Resident #7</p> <p>Record review on 3/1-4/16 revealed Resident #7 was admitted to the facility with diagnoses that included dementia, anxiety and depression.</p> <p>Continuous observation on 3/2/16 from 12:25 - 12:34 pm during the lunch time meal in the common area of Unit #1, revealed Resident #7 sitting in a wheelchair for lunch. Resident's (#10 and #20), were present and eating lunch at the dining table during the event. During the meal, Resident #7 called out loudly "Stop, no" while being fed by CNA #2. Resident #12 then moved his wheel chair to his room doorway and stated loudly to CNA #5, "she needs to go somewhere else... she needs to stop... Just stop it. Next time</p>	F 225	<p>Res #7 incident was re-investigated and reported to state based on new information received in 2567. This incident was responded to at time of event, and residents on unit interviewed and all denied concern. The event was reported to DNS.</p> <p>Res #14 elopement was reported to State during survey upon discovery that it had not been reported previously.</p> <p>Residents with state reportable events have the potential to be affected. We have reviewed event reports for previous 30 days to ensure state reports were made as needed.</p> <p>Topic of state reporting was reviewed with IDT and policies and procedures reviewed. All staff were re-educated on policies and procedures surrounding elopement and how to respond during an elopement investigation. Reviewed with staff completion of elopement checklist with all elopements, to ensure all information is gained at time of elopement, and to ensure all residents at risk for elopement are accounted for at time of. Elopement drill was practiced with all three shifts.</p> <p>Facility had security firm review all doors to ensure proper function with use of wander guard</p> <p>Administrator and Dept. Managers will perform rounds and review of MACC</p>		

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F 225	<p>Continued From page 14</p> <p>she screams I'm going over there and take care of it. It's not right especially at dinner. She's an animal." Resident #12 was referring to Resident #7.</p> <p>During the same observation Resident #7 continued to cry out, while Resident #12 continued to sit in a wheelchair at the doorway of his room and watch Resident #7. When Resident #7 again began to call out "Why! Stop! Stop!" repetitively, Resident #12 wheeled out of the doorway and into the common space towards Resident #7 and began staring at Resident #7. When Resident #7 called out "Ugh!" repetitively, Resident #12 would repeat "Ugh, Ugh, Ugh" multiple times in a mimicking high pitched voice. Resident #12 proceeded to stare at Resident #7 with his face scrunched up and frowning while pushing out his chest. This continued for the next 6 minutes, until CNA #s 2 and 5 assisted Resident #7 to bed in her room. During the exchange Resident #10 and #20 were present in the common area.</p> <p>During an interview on 3/2/16 at 1:20 pm, Resident #20 stated, "That [Resident #12] over there, thinks he owns that room. He came out here [common area] one time and raised hell with a girl about 3 months ago. It looked like he was going to hit her."</p> <p>Review of the progress note after the incident, dated 3/2/16 at 1:36 pm, revealed "This writer came upstairs and resident was sitting on court, every time other resident would make a noise, this Resident [#12] would respond by making a similar noise."</p> <p>During an interview on 3/2/16 at 3:45 pm, the</p>	F 225	<p>information to ensure all items were reported/investigated appropriately. Audits will be daily for two weeks and then weekly for four weeks.</p> <p>Copy of audit(s) with findings (negative outcomes/trends/patterns) will be provided to the Administrator for review and follow-up as necessary. Issue will be reviewed during monthly Performance Improvement Meeting for 3 months or until resolved to ensure continued compliance.</p>		

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F 225	<p>Continued From page 15</p> <p>Social Services Director (SSD) stated staff called her about the above episode and she responded and spoke to Resident #12. The SSD further stated staff "should be intervening if [Resident #12] threatens a resident." When asked by the surveyor if this should be reported as potential resident-to-resident abuse, the SSD stated it was reported to her.</p> <p>During an interview on 3/3/16 at 11:03 am, nearly 20 hours after the confrontation, the Director of Nursing (DON) stated she had not received notice from the SSD or anyone else that Resident #12 threatened he was going to go over to Resident #7.</p> <p>Resident #14</p> <p>Record review on 3/3-4/16 revealed Resident #14 had diagnoses that included stroke and aphasia (a communication disorder resulting from damage to the brain). The Resident used a wheel chair for mobility.</p> <p>Review of the most recent Minimum Data Set (a quarterly assessment), dated 12/22/15, revealed the Resident had scored a 3 out of 15 on the BIMS (brief interview for mental status). A score of 7 or below can indicate severe cognitive impairment.</p> <p>Review of an "Elopement Risk Evaluation," completed 1/4/15, revealed Resident #14 was at risk for elopement.</p> <p>During a telephone interview on 3/3/16 at 12:18 pm, Resident #14's spouse stated the Resident had eloped outside about 3 weeks ago without the staffs' knowledge. The spouse stated the</p>	F 225			

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F 225	<p>Continued From page 16</p> <p>facility did not know how long the Resident was outside.</p> <p>During an interview on 3/3/16 at 2:00 pm, Resident Care Manager (RCM) #1 stated she was out of town when it happened but per report the Resident had eloped outside for 15-30 minutes on Sunday 2/14/16 in the evening. The Receptionist had gone to another door which was alarming after Resident #13 had attempted to elope. Someone had shut off the alarm to the court yard door (where the smoking area was located) which had gone off frequently that day. The RCM stated someone driving to the facility had seen Resident #14 outside. The Resident had opened the latch on the gate, exited the yard, and became stuck outside in his/her wheelchair.</p> <p>Review of the Resident's medical record revealed on 2/14/16 at 11:25 pm, "Resident attempted to get out from exit door on the front door for a few minutes at 5:45 pm, assisted resident with 3 staff to come back inside, and Resident was cooperative, he [complained of] Right hand and right foot pain..." There was no documentation in the medical record or the behavior log about the Resident being found outside.</p> <p>Review of the investigation, completed 2/20/16, revealed on 2/14/16 at 5:15 pm "Concerned Citizen from the neighborhood reported to the receptionist that she found a resident in a wheelchair in front yard of Prestige Care, asked another staff to look for him. 3 staff went outside including this writer and assisted [him/her] to come back on our facility. Resident was cooperative with the staff, one staff member reported that the resident caught right foot on wheel chair footrest; further assessment done.</p>	F 225			

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F 225	<p>Continued From page 17</p> <p>No skin issue incident, Resident [complained of] pain to right foot and right hand, skin cold to touch. Alert and oriented to self and to the staff. Vital signs BP 131/86, T98.3..."</p> <p>Further review of the same elopement investigation revealed notes that stated, "Resident is s/p [status post] CVA and wanders around the building all day long and can open doors within the facility. On this occasion both this resident and another wandering resident were alarming the doors continuously in the afternoon. Staff had retrieved the other wandering resident who did not get outside, and reset the alarm thinking the other wandering resident had set the alarm off because when the alarm was reset there was no other alarm. Receptionist had heard the other alarm was no longer ringing so she thought that someone else had gone to the courtyard door and shut off the alarm there, not realizing the resident had gone outside. Staff is to check on resident's whereabouts frequently to reduce the risk for reoccurrence, per resident assessment and per investigation. Staff is to ensure gate to courtyard is locked to reduce the risk for reoccurrence. Abuse and neglect ruled out per witness statements and per investigation."</p> <p>During an interview on 3/4/16 at 11:30 am, the ADON stated the event involving Resident #14 had not been reported to the State agency as potential neglect.</p> <p>The Complaints Coordinator at the State agency confirmed the elopement on 2/14/16 with Resident #14 had not been reported until 3/4/16, 19 days after the incident.</p> <p>Review of the facility policy, "Abuse, Screening,</p>	F 225			

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F 225	Continued From page 18 Training, Identification, Reporting, and Protection," reviewed 1/15, revealed "Mental Abuse includes humiliation, harassment, threats of punishment or deprivation directed towards the resident." The policy did not contain a definition of neglect. Further review of the document revealed "Who to report to: If, in the performance of their duties, any of the above [mandatory reporters] has cause to believe that a vulnerable adult suffers from abandonment, exploitation, abuse, neglect, or self-neglect a report shall be made not later than 24 hours after first having cause for the belief to the departments central information and referral service for vulnerable adults." Review of the "Prestige Care, Inc. Building a Legacy of Caring New Employee Manual, "dated 2012, revealed "Neglect occurs when a person through his/her action or inaction, deprives a vulnerable adult of the care necessary to maintain the vulnerable adult's physical or mental health." The employee manual goes on to say, "Elder neglect or failure to fulfill a caretaking obligation constitutes more that half of all reported cases of elder abuse. It can be active (intentional) or passive (unintentional, based on factors such as ignorance or denial that an elderly charge needs as much care as he or she does)."	F 225			
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a	F 241		4/12/16	

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F 241	<p>Continued From page 19</p> <p>manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review the facility failed to ensure care was provided in a manner to promote dignity for 1 sampled resident (#7) of 12 residents observed during bathing and/or cares. This failed practice had the potential to negatively affect the resident's self-esteem and quality of life in general. Findings:</p> <p>Dignity during bathing</p> <p>Resident #7</p> <p>Observation on 2/29/16 at 3:20 pm revealed Resident #7 undressed and sitting on a shower chair in her room. The Resident was draped with a covering that did not cover the sides of her upper thighs/buttocks. The shower chair seat resembled that of a toilet seat, with a hole in the middle. (The shower chair seat can also be used as a commode when a bucket is placed underneath. When the bucket is not present, the buttocks of the individual sitting on the seat can be exposed to air).</p> <p>Continued observation revealed CNA #7 wheeling Resident #7 from her room to the elevator on Unit #1 and then to the downstairs (Unit #4) bathroom, passing other Residents and staff along the way.</p> <p>Additional observation on 2/29/16 at 3:35 pm</p>	F 241	<p>Res #7 care plan was updated with interventions to ensure dignity is maintained during shower.</p> <p>Residents transported in shower chair have the potential to be affected. Resident Care Managers reviewed all residents that are transported for showers to ensure privacy and dignity is maintained.</p> <p>Staff were re-educated regarding shower transfer process and maintaining resident privacy and dignity at all times.</p> <p>Licensed Nurses/RCM/SDC will perform rounds to ensure shower transfers are completed and dignity is maintained. Audits will be done daily for two weeks and then weekly for four weeks.</p> <p>Copy of audit(s) with findings (negative outcomes/trends/patterns) will be provided to the Administrator for review and follow-up as necessary. Issue will be reviewed during monthly Performance Improvement Meeting for 3 months or until resolved to ensure continued compliance.</p>		

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F 241	Continued From page 20 revealed Resident #7 in the hallway on Unit #4 after her shower. The Resident was draped in a covering that again exposed her upper thighs/buttocks. CNA #7 wheeled Resident #7 from the shower on Unit #4, through the common area to the elevator and back to Unit #1 passing many other Residents and staff on the way back to the Resident's room. During an interview on 3/4/16 at 9:45 am, the Administrator stated he ordered ponchos to cover the Resident's while being transported in the shower chair. The administrator further stated there is a bucket that should also be placed underneath the seat of the shower chair. Record review on 3/4/16 of the facility's admission packet received from the facility on 2/29/16 revealed the facility's "Resident's Rights" information included: "The right to dignity. Residents of nursing homes are honored guests and have the right to be so treated.	F 241			
F 246 SS=D	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.	F 246		4/12/16	

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F 246	<p>Continued From page 21</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, observation and interview the facility failed to accommodate resident needs for a call light for 1 resident (#1) out of 16 sampled residents whose environments were reviewed. This failed practice placed the resident at an increased risk for urinary tract infections, incontinence, social isolation, and had the potential to adversely affect the resident's sense of dignity and enjoyment of life in general. Findings:</p> <p>Record review on 2/29/16 to 3/4/16 revealed Resident #1 was admitted with a diagnosis of Parkinson's with dementia and hallucinations.</p> <p>Observation on 2/29/16 at 2:00 pm revealed Resident #1 in his room in a wheelchair. The Resident had no visible urinal in the room and the touch pad call light was attached to the call light cord on the wall, out of reach of the Resident.</p> <p>Observation on 3/1/16 at 7:45 am revealed both touch pad call lights were on the floor when staff went into the room for morning cares.</p> <p>Observation on 3/1/16 at 2:10 pm revealed the Resident in his wheelchair in his room with a bedside table between him and the bed. The touch call light was on the foot of the bed, out of the Resident's reach.</p> <p>During an interview on 3/3/16 at 9:35 am the Director of Nursing (DON) stated the call light is to be in reach of the residents when in their rooms.</p>	F 246	<p>Res #1 is no longer at the facility.</p> <p>Residents able to use call light have the potential to be affected. Residents were reviewed by RCMs to ensure call light placement while in room is correct.</p> <p>Staff re-educated regarding call light placement for resident use.</p> <p>Dept. Managers will perform rounds to ensure call lights and in and accessible to residents. Audits will be daily for two weeks, then weekly for four weeks.</p> <p>Copy of audit(s) with findings (negative outcomes/trends/patterns) will be provided to the Administrator for review and follow-up as necessary. Issue will be reviewed during monthly Performance Improvement Meeting for 3 months or until resolved to ensure continued compliance.</p>		

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F 246	Continued From page 22 Review of the "In room care plan," dated 3/1/16 revealed, "keep call light within reach at all times... "keep frequently used items, (i.e. urinal) within reach... toileting assist..." Review of the most current Minimum Data Set (MDS) dated 12/6/15 revealed the Resident was occasionally incontinent and required a 1 person assist for all balance type activities.	F 246			
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		4/12/16	

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F 280	<p>Continued From page 23</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, observation and interview the facility failed to ensure daily and/or compressive care plans were revised to reflect the current care provided for 2 residents (#s 3 and 8) out of 12 sampled residents. This failed practice placed the residents at risk for not receiving necessary care and services. Findings:</p> <p>Resident #3</p> <p>Record review on 3/1-4/16 revealed Resident #3 had a diagnosis that included dementia.</p> <p>Review of the In Room Care Plan, updated 7/23/15, revealed "Dentures upper/lower...pureed [and] nectar thick [dated] 12/14/15...and wander guard on w/c [wheel chair] d/c [discontinued] 2/19/16."</p> <p>Review of the comprehensive care plan dated 2/23/16 revealed, "Regular mechanical soft texture [diet]...Encourage Resident to use Denture...Cognitive loss/Dementia: Monitor for exit seeking behaviors, wandering into unsafe areas and entering other resident rooms uninvited."</p> <p>During an observation on 3/1/16 at 8:40 am, the Resident did not have her dentures put in during or after morning care. During the breakfast meal at 9:00 am the Resident received a pureed meal with thickened liquids.</p> <p>During an interview on 3/1/16 at 8:45 am, when asked about the dentures, CNA #1 stated the</p>	F 280	<p>Res #3 and 8 care plans were reviewed at updated at the time of survey.</p> <p>Residents with care plan changes have the potential to be affected. Resident care plans were reviewed and updated as needed.</p> <p>The issue with smoking was re-educated with staff while surveyors were still in facility, and additional re-education was completed regarding care plan accuracy and updates, with specific focus on diet, dentures, wandering and smoking as examples cited.</p> <p>This issue was identified by facility QAPI team and process improvement was underway, staff to continue with care plan reviews and process improvement plan via QAPI. Policies and procedures reviewed for care plan updates, and no changes necessary. Process reviewed with IDT and to ensure changes are made timely to care plan will audit via MACC process for order changes, and follow up to ensure care plan has been updated. Resident Care Managers will make care plan updates as necessary.</p> <p>To ensure on-going compliance DNS will audit for care plan changes and updates during MACC review and random</p>		

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F 280	<p>Continued From page 24</p> <p>Resident no longer wore them.</p> <p>During an interview on 3/2/16 at 11:30 am the Speech-Language Pathologist (SLP) confirmed the Resident was on a pureed diet with thickened liquids. When asked about the Resident's dentures, the SLP stated the Resident was supposed to wear full dentures but no longer recognized she needed to wear them.</p> <p>During an interview on 3/2/16 at 12:00 pm, Resident Care Manager (RCM) #2 stated Resident #3 no longer exhibited wandering behaviors.</p> <p>Resident #8</p> <p>Record review from 2/29/16 to 3/4/16 revealed Resident #8 had diagnoses that included end stage renal disease with hemodialysis and nicotine dependence.</p> <p>Smoking</p> <p>Record review of Resident #8's Smoking Evaluation, conducted on 3/2/16, revealed the Resident was able to smoke independently and did not require supervision with smoking.</p> <p>Record review of the comprehensive care plan updated on 1/11/16, revealed "Problem: Smoker with disregard for safety...Approach: Resident to be observed with all smoking..."</p> <p>Record review of the In-Room Care Plan, updated on 2/17/16, revealed no information regarding the Resident's ability to smoke.</p> <p>During an interview on 3/1/16 at 9:00 am CNA #3</p>	F 280	<p>sampling of full care plans. Audits will be daily for two weeks and then weekly for four weeks.</p> <p>Copy of audit(s) with findings (negative outcomes/trends/patterns) will be provided to the Administrator for review and follow-up as necessary. Issue will be reviewed during monthly Performance Improvement Meeting for 3 months or until resolved to ensure continued compliance.</p>		

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F 280	<p>Continued From page 25</p> <p>stated he assumed Resident #8 was independent with smoking because he carried his own cigarettes and lighter. When asked where the CNA could find information regarding the Resident's smoking ability, the CNA stated "I don't know. I don't even think it is on the care plan."</p> <p>During an interview on 3/2/16 at 8:49 am CNA #2 stated the In-Room Care plan should let staff know the Residents smoking status. The CNA reviewed the In-Room Care Plan and it did not address the residents smoking.</p> <p>During an interview on 3/2/16 at 2:11 pm, CNA # 2 stated the comprehensive care plan should reflect the latest smoking assessment.</p> <p>During an interview on 3/3/16 at 2:25 pm, the DON stated after reviewing the care plans neither addressed the Residents smoking status and both care plans should have smoking on them.</p> <p>Review of the facility's "Care Conference" policy dated 1/2015, revealed "During the interdisciplinary team review, care plans developed, goals dates and interventions will be reviewed to ensure they reflect the resident's current status."</p> <p>Review of the facility's policy "Care Plan-In Room,"dated 1/2015, revealed "Information/interventions related to the resident...will be provided on the In Room Care Plan...care plan, revisions will be made on both copies."</p>	F 280			

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F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, observation and interview the facility failed to consistently assess pain and determine the effectiveness for resident (#4) out of 10 sampled residents reviewed with pain. Without appropriate assessment, care plan interventions, and monitoring, residents were placed at risk for not receiving the necessary and/or appropriate care and services to ensure optimal outcomes. Findings:</p> <p>Resident #4</p> <p>Record review from 3/1-4/16 revealed Resident #4 was admitted to the facility with diagnoses that included chronic right shoulder and hip pain.</p> <p>During an observation on 2/29/16 at 12:48 pm, revealed Physical Therapist (PT) #1 and Occupational Therapist (OT) #1, attempted therapy with Resident #4 in his room. This was the second attempt at PT per CNA #6, as he was "not cooperating during his PT session earlier." The team cued the Resident to sit up, scoot, and to stand up while gripping his walker. While grimacing and moaning, the Resident stated it</p>	F 309	<p>Res #4 pain assessment updated and care plan was updated as well.</p> <p>Residents receiving therapy and having pain have the potential to be affected. Current therapy patients were reviewed to ensure all pain issues have been addressed.</p> <p>Therapy staff were re-educated on reporting pain issues to licensed nurse immediately as well as use of reporting tool to ensure all issues have been reported and appropriate follow up has been completed.</p> <p>To ensure on-going compliance IDT will review therapy report daily during stand up meeting to ensure all items appropriately reported and followed up upon. Audits will be daily for two weeks then weekly for four weeks.</p> <p>Copy of audit(s) with findings (negative outcomes/trends/patterns) will be</p>	4/12/16	

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F 309	<p>Continued From page 27</p> <p>hurt too much and that he could not continue. When asked, the Resident reported his pain level, to the right hip, was a 6 out of 10. LN #6 also cued the Resident to participate with PT activity. After 15 minutes, the Resident verbally escalated stating his shoulder and hips hurt too much and could not scoot and stand.</p> <p>During an interview on 2/29/16 at 2:15-2:30 pm, LN #7 was asked how PT/OT communicated Resident progress and pain. Stated PT has not communicated any issues with pain for any of the residents. When asked about #4's pain assessment, she stated the last dose of pain medication was Tylenol around 11:30 am and did not have a pain assessment for the Resident.</p> <p>During a follow up interview on 3/2/16 at 9:35 am PT #1 stated Resident #4's activity of daily living (ADL) had declined in the last two weeks, reporting, it seemed to always hurt during his PT sessions and he had been refusing to participate. When asked if she conveys these findings to the nurse, she stated no, because she assumed Resident is on a pain regimen.</p> <p>During an interview on 3/2/16 at 10:00 am, Resident Care Manager (RCM) #4 and LN #8 stated the physical therapy team had not communicated that Resident #4 had painful PT sessions.</p> <p>Review of the physician orders report revised 2/1/16 revealed "... 1/12/16... Resident to participate in PT 5-6 x week for 12 wks... oxycodone-acetaminophen-Schedule II tablet, 5-325mg for pain every 4 hours, PRN..."</p> <p>Review of Resident #4's care plan dated 2/6/16,</p>	F 309	<p>provided to the Administrator for review and follow-up as necessary.</p> <p>Issue will be reviewed during monthly Performance Improvement Meeting for 3 months or until resolved to ensure continued compliance.</p>		

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F 309	Continued From page 28 revealed: 1. "Problem: Actual pain on R hip and R shoulder...verbalization related to frozen shoulder and chronic pain issues..." 2. "Goals...Resident pain will be controlled with current management...increased participation in activities of daily living (ADL)" 3. "Approach to problem: Administer pain medications as ordered and validate effectiveness and assess intensity, location, duration and frequency of pain." Record review of medication administration record (MAR) on 2/29/16 revealed one dose of Tylenol had been given in the last 7 days. In addition, the last dose of oxycodone had been given on 2/20/16. Review of the facility's policy "Pain Management," last revised 1/2015, revealed "It is the policy of this facility that residents will receive care to ensure that they attain and maintain the highest quality of care and life ...Residents who are having signs and symptoms of pain, will have a comprehensive assessment completed by the R.C.M. [Resident Care Manager] to identify location, severity and related factors ...plan will be re-assessed for effectiveness until an optimal plan is established."	F 309			
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		4/12/16	

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F 323	<p>Continued From page 29</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>.</p> <p>Based on record review, interview, observation the facility failed to: 1) fully evaluate an elopement incident involving 1 resident (#14) and did not identify and implement systemic changes to reduce the risk of harm or injury to the resident; 2) ensure alarmed exit doors were monitored and staff response was adequate; 3) ensure a large knife was kept secure; and 4) ensure hygiene products with caustic effects, if misused or mishandled, were kept in a secured location. These failed practices placed 4 residents (resident #s 13, 14, 15 and 28), out of 4 residents with a known history of elopement and/or wandering, at risk for harm from injury. Findings:</p> <p>According to the Agency for Healthcare Research and Quality, accessed 3/9/16 at www.psnet.ahrq.gov <http://www.psnet.ahrq.gov>, the definition of elopement is a resident with "decreased mental capacity related to dementia, or temporary delirium, or intermittent status changes related to medication, disease, or traumatic injury" who leaves the building with intent and without permission. The definition of wandering is "a resident that strays beyond the view or control of</p>	F 323	<p>Res #14 incident was reviewed and care plan reviewed and updated. TAR was updated to include every shift check for function and placement of wanderguard.</p> <p>All residents are at risk related to this citation.</p> <p>Elopement policy and procedures were reviewed with staff. Knife issue was resolved and staff re-educated at time of discovery during survey. Locks were placed on all hygiene supply closets at time of survey and will be replaced with code locks.</p> <p>Basement door alarm procedures were reviewed with all staff.</p> <p>General orientation was updated to include specific information regarding basement door alarm and wanderguard alarm as well as appropriate staff response.</p> <p>Department Managers and members of IDT will complete audits to ensure elopement incidents completed</p>	

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F 323	<p>Continued From page 30</p> <p>staff without intent of leaving (cognitive impairment)." Both elopement and wandering can place residents at risk for serious harm.</p> <p>The facility utilized a resident wander guard system that allowed residents to wander in the facility and reduced the risk of unsafe elopement, a bracelet with a signal attached to the resident's wheelchair or extremity. When the resident approached an exit door, a musical alarm (The Happy Wanderer) would play and the exit doors locked so a confused resident could not leave the facility without the staff's knowledge.</p> <p>Elopement - Resident #14</p> <p>Record review on 3/3-4/16 revealed Resident #14 had diagnoses that included a stroke and aphasia (a communication disorder resulting from damage to the brain). The Resident used a wheel chair for mobility.</p> <p>Review of the most recent Minimum Data Set, a quarterly assessment, dated 12/22/15, revealed the Resident had scored a 3 of 15 on the BIMS (brief interview for mental status). A score of 7 or below can indicate severe cognitive impairment.</p> <p>Review of an "Elopement Risk Evaluation," completed 1/4/15, revealed Resident #14 was at risk for elopement.</p> <p>During a telephone interview on 3/3/16 at 12:18 pm, Resident #14's spouse stated the Resident had eloped outside about 3 weeks ago without the staffs' knowledge. The spouse stated the facility did not know how long the Resident was outside.</p>	F 323	<p>appropriately, knives are secured, basement alarms are responded to appropriately, and hygiene closets are kept locked.</p> <p>Audits will be daily for two weeks and weekly for four weeks.</p> <p>Copy of audit(s) with findings (negative outcomes/trends/patterns) will be provided to the Administrator for review and follow-up as necessary.</p> <p>Issue will be reviewed during monthly Performance Improvement Meeting for 3 months or until resolved to ensure continued compliance.</p>		

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F 323	<p>Continued From page 31</p> <p>During an interview on 3/3/16 at 2:00 pm, Resident Care Manager (RCM) #1 stated she was out of town when it happened but per report the Resident had eloped outside for 15-30 minutes on Sunday 2/14/16 in the evening. The Receptionist had gone to another door which was alarming after Resident #13 had attempted to elope. Someone had shut off the alarm to the court yard door (where the smoking area was located) which had gone off frequently that day. The RCM stated someone driving to the facility had seen Resident #14 outside. The Resident had opened the latch on the gate, exited the yard, and became stuck outside in his wheelchair.</p> <p>Review of the Resident's medical record revealed on 2/14/16 at 11:25 pm, "Resident attempted to get out from exit door on the front door for a few minutes at 5:45 pm, assisted resident with 3 staff to come back inside, and Resident was cooperative, He [complained of] Right hand and right foot pain..." There was no documentation in the medical record or the behavior log about the Resident being found outside.</p> <p>Review of the investigation, completed 2/20/16, revealed on 2/14/16 at 5:15 pm "Concerned Citizen from the neighborhood reported to the receptionist that she found a resident on wheelchair in front yard of Prestige Care, asked another staff to look for him. 3 staff went outside including this writer and assisted him to come back on our facility. Resident was cooperative with the staff. Resident was cooperative with the staff, one staff member reported that the resident was caught his right foot on wheel chair footrest; further assessment done. No skin issue incident, Resident [complained of] pain to right foot and right hand, skin cold to touch. Alert and oriented</p>	F 323			

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F 323	<p>Continued From page 32 to self and to the staff. Vital signs BP 131/86, T98.3..."</p> <p>Further review of the same elopement investigation revealed notes that stated, "Resident is s/p [status post] CVA and wanders around the building all day long and can open doors within the facility. On this occasion both this resident and another wandering resident were alarming the doors continuously in the afternoon. Staff had retrieved the other wandering resident who did not get outside, and reset the alarm thinking the other wandering resident had set the alarm off because when the alarm was reset there was no other alarm. Receptionist had heard the other alarm was no longer ringing so she thought that someone else had gone to the courtyard door and shut off the alarm there, not realizing the resident had gone outside. Staff is to check on resident's whereabouts frequently to reduce the risk for reoccurrence, per resident assessment and per investigation. Staff is to ensure gate to courtyard is locked to reduce the risk for reoccurrence. Abuse and neglect ruled out per witness statements and per investigation."</p> <p>Review of the Resident's care plan, edited 1/4/2016, revealed "Category: Behavioral Symptoms Resident at risk for elopement related to exit seeking behavior." The goal included "Resident will remain in building through next review." The Approaches listed were "Check on Resident's whereabouts frequently" and "Wanderguard placed, check wander guard [every] shift to ensure it works." There was no evidence the care plan was reviewed or revised and how the Resident would be kept safe.</p> <p>Review of the physician's orders, dated 1/25/16,</p>	F 323			

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

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F 323	<p>Continued From page 33</p> <p>revealed "Wanderguard on for safety related to elopement risk." There was no information on the treatment administration record (TAR) that instructed the nurses' document the wander guard was checked for functionality every shift.</p> <p>During an interview on 3/3/16 at 12:30 pm, Receptionist #1 showed the surveyors the book kept at the front desk which contained information and pictures about the residents at risk for elopement and becoming lost. Review of the book revealed Resident #14 did not have a picture and information in the elopement book.</p> <p>During an interview on 3/4/16 at 1:00 pm, the Assistant Director of Nursing (ADON) stated Resident #14 had a lot family members visiting that day (2/14/16) and was wandering from door to door. Because the alarmed doors were supposed to lock when a resident wearing the wander guard bracelet approached the doors, the Resident may have followed someone out of an open door, which would have set off the alarm. The facility was unable to determine who shut off the alarm and if they checked to see if the Resident was outside. The ADON stated no new education had been provided to staff following the incident.</p> <p>Review of the education provided to facility staff on general and job specific orientation revealed the education did not instruct staff what to do if they heard the alarm sounding and did not see a resident attempting to leave the premises.</p> <p>During an interview on 3/4/16 at 11:45 RCM #1 stated after the Resident had eloped, the facility increased Unit #6's staff to 3 CNAs. The RCM stated if the facility was short staffed, the staffing</p>	F 323			

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F 323	<p>Continued From page 34</p> <p>would be reduced to 2. The RCM confirmed the Unit had 2 CNAs working last Sunday when Resident #13 exited out the front door. Because the staff were in rooms caring for other residents and the receptionist was not there yet, it took a couple of minutes to retrieve the Resident from outside. The RCM stated 1 CNA was to stay on the court but confirmed there was no assignment for ensuring a CNA, or another staff member was always watching the 2 Residents that wander off unit #6 and are at high risk for elopement.</p> <p>During an interview on 3/4/16 at 2:00 pm Staff #1 stated he didn't know what the musical wander guard alarm was on his first day.</p> <p>Basement Exit Doors</p> <p>During an observation on 3/4/16 at 9:01 am the door labeled E004 was opened by the Surveyor to test for exit egress. When the door was opened, a chime rang out approximately 5 times and suddenly stopped. Continued observation at 9:03 am revealed a staff member from laundry services peeked around the laundry entrance door and quickly went back into central laundry. No additional staff arrived at door E004 from 9:01 am to 9:06 am.</p> <p>During an interview on 3/4/16 at 9:03 am, the Corporate Facilities Supervisor (CFS) stated the facility needed to conduct drills and test the staff response on doors such as E004. In addition, the CFS stated it appeared staff need education on how to respond to exit alarms like the one located on E004. When asked to explain the expected response, CFS stated staff should arrive at the alarmed door and investigate the reason for is activation. In addition, staff should walk outside</p>	F 323			

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F 323	<p>Continued From page 35</p> <p>and inspect the area to ensure residents have not exited the building into unsafe situations.</p> <p>During an observation on 3/4/16 at 11:21 am the door labeled E004 was opened by the Surveyor to test the alarm system response. When door was opened, a chime rang out for 27 seconds and suddenly stopped. Continuous observation until 11:24 am revealed no staff arrived to evaluate the door opening for 3 minutes and 30 seconds. During observation staffs were heard talking in the physical therapy department. At 3 minutes and 30 seconds after door was opened, the Surveyor walked to the alarm panel located on the 1st floor near the ADON's office. When the Surveyor arrived at panel, the ADON and Medical Records staff were reviewing the panel and attempting to locate door E004.</p> <p>During an interview on 3/4/16 at 11:25 am the ADON stated when the panel alarms, someone will acknowledge the alarm by pressing a button. As a result, the button will silence the alarm. At that time, a secondary staff member will go to the alarmed door and evaluate the reason for the activation of the alarm. The ADON stated there was difficulty locating door E004.</p> <p>During an interview on 3/4/16 at 11:46 am the Social Services Director (SSD) was asked what a staff is supposed to do during a door alarm. In response, the SSD stated staffs are to acknowledge the alarm at the panel and physically go and look at the alarmed door. In addition, SSD stated staffs are to go to the exterior door and look out the window to make sure a resident did not exit the facility.</p> <p>Unsecured knife</p>	F 323			

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F 323	<p>Continued From page 36</p> <p>Record review on 2/29/16 - 3/4/16 revealed Resident #1 was admitted with a diagnosis of Parkinson's with dementia and hallucinations.</p> <p>Review of the Resident's most current care plan, dated 3/1/16, revealed the Resident required extensive assistance of 1 staff to transfer. In addition, the Resident was not independently mobile in the wheelchair.</p> <p>Observations on 3/1/16 at 8:25 am revealed a sharp edged cutlery knife lying on a towel at the hand sink in Resident #1's room. The blade appeared to be 6 inches long.</p> <p>During an interview on 3/1/16 at 8:40 am CNA #4 was asked why there was a knife at the sink and she stated "it shouldn ' t be there, it must have been left by the family last evening." When asked if there were any concerns that the Resident would use it she stated no, he needed assistance to move about in his room.</p> <p>During an interview on 3/1/16 at 8:40 am LN #5 stated there were no residents that wandered on Unit #1 (upstairs).</p> <p>During an interview on 3/1/16 at 10:55 am the DON was asked if Resident #1 had been assessed for the use of a sharp knife. The DON stated no residents were to have any sharps in their rooms, especially knives and scissors.</p> <p>Unlocked Hygiene Supplies</p> <p>Observation on 2/29/16 between 9:40 - 10:40 am on Unit's #'s 1 and 2 revealed multiple unsecured Daily care items in the unlocked employee only</p>	F 323			

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F 323	Continued From page 37 cabinet and closet. Daily care items that included razors, super sani-cloths, body wash, perineal cleaner, derma-septin (a moisture barrier for the skin), derma wound cleanser, dental adhesive and Banophen (anti-itch/topical anesthetic). A number of these care items contained warning labels cautioning ingestion of the substance, as well as, the instruction to contact Poison Control if ingested. During an interview on 3/3/16 at 9 am LN #10 stated they keep the daily care supply cabinets unlocked for easy access. She acknowledged that it was possible for residents or families to inadvertently use the products. In addition, the LN stated there were wanderers. Record review of the medical record for the residents who have been known to wander, revealed the risk for consumption of caustic products was not assessed. During an interview on 3/3/16 at 1:50 pm, the Assistant Director of Nursing (ADON) acknowledged the closets were unlocked and items contained warnings.	F 323			
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections;	F 328		4/12/16	

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F 328	<p>Continued From page 38</p> <p>Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>.</p> <p>Based on record review, observation and interview the facility failed to ensure specialty care was provided for a resident receiving enteral feeding. Specifically, the facility failed to maintain 1 resident's (#23) head of bed (HOB) greater than 30 degrees inclined while the resident received tube feeding through a gastric tube (g-tube). This practice affected 1 out of 1 resident whose g-tube feeding was observed. This failed practice placed the resident at risk for aspiration. Findings:</p> <p>Record review from 3/1-4/16 revealed Resident #23 had a g-tube (a tube inserted into the abdomen to provide nutrition directly into the stomach) and received continuous feeding for 20 hours daily.</p> <p>Observation on 3/1/16 at 6:58 am revealed upon entry into the room, the Resident's HOB was observed to be nearly flat. A tube feeding pump was located at the bedside and the pump was running. The pump indicated that tube feeding was being administered at 65ml per hour. The resident showed no signs of distress.</p> <p>Record review on 3/1/16 of Resident #23 in-room care plan indicated the resident's HOB should be</p>	F 328	<p>Res #23 care plan was reviewed, no changes necessary. No negative outcome to resident based on this event.</p> <p>Residents receiving nutrition via g-tube have the potential to be affected. Residents were reviewed to ensure standards of care are being met.</p> <p>Staff re-educated regarding standards of care for residents receiving nutrition via g-tube.</p> <p>Administrator and Dept. Managers will perform rounds to ensure residents receiving g-tube nutrition are properly positioned. Rounds will be daily for two weeks and then weekly for four weeks.</p> <p>Copy of audit(s) with findings (negative outcomes/trends/patterns) will be provided to the Administrator for review and follow-up as necessary. Issue will be reviewed during monthly</p>		

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F 328	Continued From page 39 greater than 30 degrees while the resident is lying in bed. During an interview on 3/3/16 at 1:35 pm, Resident Care Manager (RCM) #3 stated the HOB for Residents receiving tube feeding should be greater than 30 degrees. Review of the facility's "Gastrostomy Feeding Tube" policy, last reviewed 01/15, indicated "The resident's head of bed should be elevated a minimum of 30-45 degrees during administration of enteral feedings. Should the resident be required to be in the supine position for any reason during a tube feeding, the tube feeding shall be stopped and then restarted once the procedure is completed."	F 328	Performance Improvement Meeting for 3 months or until resolved to ensure continued compliance.		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug	F 329		4/12/16	

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F 329	<p>Continued From page 40</p> <p>therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>.</p> <p>Based on record review and interview the facility failed to: 1) adequately monitor behaviors to determine medication effectiveness for 3 residents (#1, 3 & 12) and, 2) initiate dosage reductions in an attempt to decrease or eliminate the need for a psychotropic medication or document why a decrease in medication would be clinically contraindicated, for 1 resident (#10) of 5 residents reviewed who received psychotropic medications. These failed practices placed the residents at risk for less than optimal results from prescribed medications and created an increased risk for serious harm from potential complications related to medication administration. Findings:</p> <p>Behavior monitoring</p> <p>Resident #1</p> <p>Record review on 3/1-4/16 revealed Resident #1 was admitted with a diagnosis of Parkinson's (a neuromuscular illness that causes abnormal movements) with dementia and hallucinations.</p>	F 329	<p>Resident #1 is no longer at facility. Res #3,10 and 12 have had medication regimens and care plans reviewed and updated as needed with specific focus on cited issues and behavior monitoring.</p> <p>Residents with behaviors and/or use of psychotropic medication are at risk related to this citation, and have been reviewed and updated as appropriate.</p> <p>Staff were re-educated regarding psychotropic policies and procedures and behavior monitoring policies and procedures.</p> <p>RCM, SSD and DNS will audit via the MACC process to ensure medications are monitored and reviewed and behavior monitoring is complete. Audits will be done daily for two weeks and then weekly for four weeks.</p> <p>Copy of audit(s) with findings (negative</p>		

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F 329	Continued From page 41 Review of the physician's orders dated 2/1-29/16 revealed an order for the antipsychotic medication Seroquel. Review of the most recent "Psychotropic Drug Consent," dated 3/19/15, for the antipsychotic medication Seroquel revealed no documentation of targeted behaviors to monitor. Review of the Resident's care plan, revised 12/9/15, revealed "Behavior Symptoms" as evidence by "Alteration in mood/behaviors related to [history] of hallucinations and delusions." Review of the daily nursing notes in the medical record from 10/1/15 - 3/3/16, revealed sporadic documentation of behaviors. There was no consistent tracking or trending of behavioral episodes. Review of the most current "Psychoactive Drug Review," dated 2/10/16, revealed no documentation of behavior frequency or targeted behaviors. Review of the "Psychoactive Drug Review" dated 1/7/16, revealed under the heading of behavior frequency: "said he saw ants on food tray." Further review revealed: "No new behaviors reported or observed this month." Review of the "Psychoactive Drug Review" dated 6/17/15, revealed the Seroquel dose was increased [on 6/4/15] due to family concerns of night terrors. Further review revealed: "No new behaviors reported or observed this month." During an interview on 3/2/16 at 1:35 pm, the	F 329	outcomes/trends/patterns) will be provided to the Administrator for review and follow-up as necessary. Issue will be reviewed during monthly Performance Improvement Meeting for 3 months or until resolved to ensure continued compliance.		

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F 329	<p>Continued From page 42</p> <p>Director of Nursing (DON) was asked for the behavior documentation to include the targeted behaviors for Resident #1 and stated she was not able to find a behavior log for the Resident.</p> <p>Resident #3</p> <p>Record review on 3/1-4/16 revealed Resident #3 was admitted with diagnoses that included psychosis and dementia. The Resident's current medication regime included Thorazine (an antipsychotic medication), Cogentin (used to treat tremors and muscle stiffness from antipsychotic medications), and Remeron (antidepressant).</p> <p>Random observations at mealtimes on 3/1-3/16 revealed Resident #3 seated in a wheel chair in the common area. The Resident's head was tilted back so her chin was pointed at the ceiling and the Resident continuously shifted her hips.</p> <p>Review of the Resident's comprehensive care plan, edited 2/18/16, revealed the problem "Resident receives antipsychotic medication R/T [related to] dementia with past history of psychotic behavioral disturbances." Approaches included "Assess/record effectiveness of drug treatment. Monitor and report signs of sedation, anticholinergic and/or extrapyramidal symptoms ...Monitor resident's behavior and response to medication per facility protocol."</p> <p>During an interview on 3/2/16 at 11:45 am, LN #3 was asked where behaviors were documented and what behaviors were being monitored for Resident #3. The LN stated staff were to monitor the Resident for fatigue, restlessness, and sedation behaviors and were to document the</p>	F 329			

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F 329	<p>Continued From page 43 behaviors on the behavior sheet.</p> <p>During an interview on 3/2/16 at 12:00 pm, when asked why Resident #3 was on Thorazine and what behaviors had been exhibited, Resident Care Manger (RCM) #2 stated the Resident used to have unsafe wandering (towards the stairwells), was combative with staff, and had exhibited self-injurious behaviors such as biting herself and chewing on her skin. The RCM confirmed the Resident no longer had teeth, no longer wandered, and the facility was working on dose reductions for the Resident.</p> <p>Review of the "Behavior Monitoring Log," dated February 2016, revealed "Behaviors to look for (document behaviors)" included "Restlessness; Yelling/cursing; Refusal of Cares; and Striking out." The actions taken by staff included "Wander guard, Elopement book at front reception desk and back door Admin office, redirect to activities of interest ELOPEMENT RISK."</p> <p>Review of the "Behavior Monitoring Log," dated March 2016, revealed Resident #3 had a "wander guard" [a device attached to bracelet worn by the resident]. Further review of the monitoring log revealed "Behaviors to look for (Document below) Non adherent to cares and change in routine; Combative behaviors; Wanders aimlessly 'Elopement risk'; and, S/Sx [signs and symptoms] Depression."</p> <p>There were no behaviors documented in the behavior log for February and March and the Resident's current response to the medication reduction had not been consistently documented. There was no consistent tracking or trending of either behavioral episodes or</p>	F 329			

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F 329	<p>Continued From page 44 non-pharmacological interventions.</p> <p>Review of the "Psychoactive Drug Review," dated February 12, 2016, revealed the behavior type and frequency was not targeted for the Thorazine and Remeron ...The "Committee Comments" revealed "...no significant change in residents mood, and the behaviors appear to be the same ...rocking of the pelvis and frequent shifting of her lower extremities are visible at times ...Resident with occasional period of anxiety noted by staff members during which she is easily redirected or accepting of non-pharmacological interventions..."</p> <p>According to the Food and Drug Administration, accessed 3/9/16, at www.FDA.gov <http://www.FDA.gov>, side effects of Thorazine include extrapyramidal reactions (e.g., Parkinson-like symptoms, muscle stiffness and involuntary movements), drowsiness, dizziness, skin reactions or rash, dry mouth, orthostatic hypotension, amenorrhea, galactorrhea, weight gain. The side effects of Cogentin included, among others, aggressive behavior, forgetfulness, dizziness, difficulty speaking and swallowing, and weight loss.</p> <p>Resident #12</p> <p>Record review from 3/2-4/16 revealed Resident #12 had diagnoses that included major depressive disorder.</p> <p>Further review of the MAR, revealed Resident #12 was receiving Zoloft daily for depression.</p> <p>Additional review of the Resident's comprehensive care plan revealed, under the</p>	F 329			

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F 329	<p>Continued From page 45</p> <p>problem created 5/22/15, "Behavioral Symptoms ...Observe and report socially inappropriate and disruptive behaviors when around others."</p> <p>Review of the "Behavior Monitoring Log" for 1/1/16 - 3/3/16 revealed the behaviors identified to monitor included "Inappropriate verbalizations towards caregivers and staff ...Cursing ...Derogatory comments to caregivers, S/SX (signs and symptoms) Depression." Additional review revealed the log had only 1 entry for January, on 1/2/16; 1 entry for February, on 2/6/16 and no entries from 3/1-3/16.</p> <p>Review of the nursing progress notes from 1/1/16 - 3/3/16, revealed multiple entries for inappropriate behaviors.</p> <p>During an interview on 3/3/16 at 3:00 pm, the Pharmacist confirmed he does not review a behavior monitor log specific to a resident, he relies on the RCM's to provide that information at the meeting.</p> <p>During an interview on 3/4/16 at 12:30 pm, when asked about the behavior logs, Social Service Director stated the logs were not utilized effectively.</p> <p>Review of the policy "Behavior Monitor Policy and Procedure," revised 1/15, "It is the policy of this facility to monitor resident behaviors, precipitating factors, interventions, and effectiveness. Monitoring will be done on residents displaying behavioral symptoms and residents medications."</p> <p>Gradual Dose Reduction</p> <p>Resident #10</p>	F 329			

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

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F 329	Continued From page 46 Record review from 3/1-4/16 revealed Resident #10 was admitted to the facility with diagnoses that included major depressive disorder and anxiety disorder. Further review of the MAR revealed the Resident had a medication order for Lexapro (an anti-depressant) with a start date of 1/27/15. Review of Resident #10's "Psychoactive Drug Review," with dates of 7/23/15; 8/19/15; 9/17/15 and 1/8/16, revealed the facility did not address tapering of the anti-depressant or addressed whether tapering was clinically contraindicated. No other "Psychoactive Drug Reviews" were provided by the facility prior to exit. During an interview on 3/3/16 at 3:05 pm, the Pharmacist was asked how it was determined a particular medication was effective or not, and he stated the team sits down and talks during the psychoactive drug review meeting and the RCM provided the data regarding the number of behaviors a resident might have. During an interview on 3/4/15 at 8:15 am the Medical Director, who also functioned as many of the Residents' physician, stated he relied on anecdotal information from the RCM's when making a determination about a psychotropic medication.	F 329			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		4/12/16	

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F 371	<p>Continued From page 47</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>·</p> <p>Based on observation and interview the facility failed to ensure: 1) storage of food products in a safe manner; 2) cleanliness of kitchen area; 3) kitchen staff were able to demonstrate proper technique in creating and maintaining sanitation buckets; 4) staff were knowledgeable in the process of sanitation concentrations; 5) dishwashing was conducted in a manner to prevent cross contamination; and 6) equipment and utensils were in good repair. These failed practices placed all residents receiving food from the kitchen (based on a census of 81) at risk for food borne illnesses. Findings:</p> <p>Observations during the initial kitchen tour on 2/29/16 from 9:40 am to 10:00 am revealed:</p> <ul style="list-style-type: none"> · Debris on storage shelf of the serve line; · Apple sauce cake in refrigerator unit - not covered; · 2 bags of frozen baked chicken - bag open, large accumulation of frozen crystals; · 4 chocolate cookies in freezer - open to air; · 3 gallon carton of ice cream with broken 	F 371	<p>Identified issues were corrected during survey.</p> <p>Residents receiving food from facility kitchen have the potential to be affected.</p> <p>Dietary manager re-educated staff regarding storage, cleanliness, sanitation buckets, process of sanitation concentrations, dishwashing to prevent cross contamination, ensuring equipment and utensils are in good repair.</p> <p>RD and DSM to complete audits to ensure on-going compliance, audits to be daily for two weeks and weekly for four weeks.</p> <p>Copy of audit(s) with findings (negative outcomes/trends/patterns) will be provided to the Administrator for review and follow-up as necessary. Issue will be reviewed during monthly Performance Improvement Meeting for 3 months or until resolved to ensure</p>		

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F 371	<p>Continued From page 48</p> <p>lower seal;</p> <ul style="list-style-type: none"> · Multiple stalks of wilted celery; · Soft and wrinkled bell peppers; · Wilted lettuce; · 21.6 lb box of cookie dough with use by date of 7/2015; · Fan with excessive dust accumulation blowing on clean dishes; and · A deteriorated rubber spatula with multiple cracks and missing rubber pieces. <p>During an interview on 3/2/16 at 3:15 pm, the Dietary Manager (DM) acknowledged the findings from the initial kitchen tour and stated they should not have occurred.</p> <p>Sanitation Solution:</p> <p>During an interview and observation on 3/2/16 at 9:19 am Dietary Aide (DA) #2 when asked to demonstrate and test the sanitation solution used to wipe counters, the DA #2 quickly dipped the strip and read the strip. The DA further stated the chlorine test strip should be around 200 parts per million (ppm).</p> <p>During an interview and observation on 3/2/16 at 9:41 am, the Cook #1 stated the sanitation buckets were to be around 200 ppm, however then stated the cook's sanitation buckets were to be around 300 to 400 ppm. When asked to test the solution, the Cook quickly dipped the QT-10 Hydrion strip and then read the strip to be 300 ppm.</p> <p>Review of the QT-10 Hydrion dispenser on 3/2/16 at 9:25 am revealed instructions to dip test paper into solution for 10 seconds and quickly compare to chart on the dispenser itself.</p>	F 371	continued compliance.		

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F 371	<p>Continued From page 49</p> <p>During an interview on 3/2/16 at 3:15 pm the Dietary Manager (DM) stated all sanitation buckets should be between 200-400 ppm. Staff checks the sanitation buckets by dipping a test strip into the solution for 10 seconds. The DM added, briefly dipping the test strip could result in an incorrect reading that results in an incorrect known concentration.</p> <p>Dietary Aides demonstrated inconsistent knowledge of using test strips and the manufacturer's recommendations to check for proper sanitizer concentrations.</p> <p>Dishwashing:</p> <p>An observation of dishwashing on 3/2/16 at 9:30 am revealed Dietary Aide (DA) #1 dropping one glove on the kitchen floor, s/he retrieved the glove, put in on and continued to work.</p> <p>Observations on 3/2/16 at 9:31 am revealed DA #2 spray rinsing dirty dishes and the water and food debris was splashing on the sanitized cart and clean dishes.</p> <p>Continued observation on 3/2/16 from 9:50 -10:06 am revealed DA's # 1 and 2 used the dishwasher and cross contaminated dirty and clean processes by repetitive touching of the same dishwashing handle and handling of clean dishes with soiled gloves.</p> <p>Observation on 3/2/16 at 10:50 am revealed DA#2 rinsed soiled dishes and placed them into the dishwasher and then moved to clean side and removed and put away clean dishes with same gloved hands.</p>	F 371			

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F 371	<p>Continued From page 50</p> <p>Observation on 3/2/16 at 10:54 am revealed DA #3 brought in a gray cart with dirty dishes. After the dirty dishes were removed, and without cleaning the cart, DA #2 placed clean trays and dishes on the dirty cart for the lunch meal.</p> <p>During a second observation on 3/2/16 at 11:01 am DA #3 brought in a soiled dish cart, placed clean dishes atop the cart and DA #1 took the clean dishes from atop the cart to the cooking area for use.</p> <p>Observation on 3/2/16 at 11:16 am revealed Cook #2 carrying cutting boards under his/her arms from the back of the kitchen and placed them on the cooks counter.</p> <p>During an interview on 3/2/16 at 3:15 pm the Dietary Manager (DM) stated, 1 staff member needs to remain on the dirty side of the dishwashing area to prevent contamination of clean dishes that were removed from the dishwasher. In addition, stated cutting boards should not be carried under the arm and should have been cleaned before use.</p> <p>Equipment Integrity/Cleanliness:</p> <p>An observation on 3/2/16 at 10:40 am revealed Cook #1 using the cracked and deteriorated spatula to make mashed potatoes. Further observation revealed two additional cracked rubber spatulas in the sink.</p> <p>During an interview on 3/2/16 at 10:40 am Cook #1 stated the three observed deteriorated spatulas were the only ones the kitchen had on hand to use.</p>	F 371			

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F 371	Continued From page 51 Observation on 3/2/16 at 11:31 am revealed a significant amount of dust accumulation under the steam table. During an interview on 3/2/16 at 3:15 pm the DM stated the rubber spatulas were the only spatulas in the kitchen and had been around for a significant amount of time.	F 371			
F 386 SS=E	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure the physician visits were documented for 5 residents (#'s 7; 8; 9; 10; and 11) of 12 sampled residents whose records were reviewed for this documentation. Failure to document physician visits placed residents at risk for their health concerns not being fully known by the health care team. Findings:	F 386	Physician visits completed and up to date for Res #7,8,9,10 and 11. All residents have the potential to be affected, and were reviewed and physician visits brought up to date. This issue had been identified via facility QAPI and Physician Assistant was hired	4/12/16	

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F 386	<p>Continued From page 52</p> <p>Resident #7</p> <p>Record review on 3/1-4/16, revealed Resident #7 was admitted to the facility with diagnoses that included dementia with behavior disturbance .</p> <p>Further review of the medical record revealed the last documented physician progress note was on 10/29/15.</p> <p>Resident #8</p> <p>Record review on 3/1-4/16, revealed Resident #8 was admitted with diagnoses that included end stage renal disease on dialysis, chronic obstructive pulmonary disease, and chronic pain. The Resident's drug regimen included Fentanyl Patch (pain medication) & Norco (opiate pain medication).</p> <p>Further review of the medical record revealed the last documented physician progress note was on 9/26/15.</p> <p>During an interview on 3/2/16 at 2:49 pm, Medical Records Staff confirmed the last visit documented by the physician was on 9/26/15.</p> <p>Resident #9</p> <p>Record review on 3/1-4/16, revealed Resident #9 was admitted to the facility on 1/13/16 with diagnoses that include A-fib (an irregular and often rapid heart rate), diabetes, and parenchymal lung disease (also known as interstitial lung disease, which affects the tissue and space around the air sacs of the lungs).</p>	F 386	<p>to assist Physician, but had not started prior to survey. He has since started and assisting Physician with coverage. Physician visit timelines reviewed with MD and PA. Medical Records Director to keep MD aware of visits due to ensure all completed timely.</p> <p>Medical Records Director to audit completion and timeliness of physician visits. Audits will be completed daily for two weeks then weekly for four weeks.</p> <p>Copy of audit(s) with findings (negative outcomes/trends/patterns) will be provided to the Administrator for review and follow-up as necessary. Issue will be reviewed during monthly Performance Improvement Meeting for 3 months or until resolved to ensure continued compliance.</p>		

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F 386	<p>Continued From page 53</p> <p>Review of Resident #9's medical record revealed the last documented physician progress note was the admission note on 1/13/16.</p> <p>During an interview on 3/4/16 at 12:40 pm, Medical Records Staff stated there were no physician progress notes on this Resident.</p> <p>Resident #10</p> <p>Record review on 3/1-4/16 revealed Resident #10 was readmitted to the facility on 10/16/15 with diagnoses that included urinary tract infection, chronic obstructive pulmonary disease, and diabetes.</p> <p>Further review of the medical record revealed the last documented physician progress note was on 10/16/15.</p> <p>Resident #11</p> <p>Record review on 3/1-4/16, revealed Resident #11 was admitted to the facility with diagnoses to include heart disease and lower leg edema (fluid retention).</p> <p>Further review of the medical record revealed the last documented physician progress note was on 10/31/15.</p> <p>During an interview on 3/4/16 at 10:15 am, Medical Records Staff confirmed the last visit documented by the physician was on 10/31/15.</p> <p>During an interview on 3/4/16 at 8:15 am the Medical Director, who also the primary physician for the vast majority of the residents' residing in the facility, stated he is aware he should be</p>	F 386			

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F 386	Continued From page 54 documenting progress notes on resident visits. In addition, he stated both the Administrator and the Medical Records Director have spoken to him regarding the lack of documentation.	F 386			
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: . Based on record review, observation and interview the facility failed to ensure each resident	F 425	Res #7 issues were reviewed and no negative outcome to resident. Resident #10 did not miss dose of Lexapro, it was	4/12/16	

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F 425	<p>Continued From page 55</p> <p>had medications readily available when ordered by the physician for 2 residents (#7 and 10) of 12 sampled residents. This failed practice placed residents at risk of not receiving timely treatment for their medical conditions. Findings:</p> <p>Resident #7</p> <p>Record review on 3/1-4/16 revealed Resident #7 was admitted to the facility with diagnoses that included dementia and had a recent pneumonia infection.</p> <p>Further review of the physician order dated 2/1/16 revealed an order for Augmentin (an antibiotic) to be given twice a day by mouth.</p> <p>Review of the Medication Administration Record (MAR) dated 2/2/16, revealed only one dose of the antibiotic had been given at 10:15 am; no second dose of antibiotic was given.</p> <p>Further review of the MAR, dated 2/8/16 revealed the facility had ran out of the Augmentin. The 8:00 pm dose had a "Comment: had to be pulled from E-kit (emergency kit)."</p> <p>Further review of the Resident's MAR revealed on 2/1/16 at 8:04 pm the medication Albuterol Sulfate solution was "...not given due to dosage not available in E-Kit."</p> <p>Resident #10</p> <p>Record review from 3/1-4/16 revealed Resident #10 was admitted to the facility with diagnoses that included a depression disorder.</p> <p>Further review of the MAR revealed, Resident</p>	F 425	<p>administered upon arrival later the same day.</p> <p>Residents receiving medication have the potential to be affected.</p> <p>Staff re-educated regarding medication availability, use of e-kit and medication re-ordering to ensure no delay in administration.</p> <p>RCM and DNS to audit during MACC meeting to ensure all prescribed meds and treatments were received as ordered. Audits will be daily for two weeks and then weekly for four weeks.</p> <p>Copy of audit(s) with findings (negative outcomes/trends/patterns) will be provided to the Administrator for review and follow-up as necessary. Issue will be reviewed during monthly Performance Improvement Meeting for 3 months or until resolved to ensure continued compliance.</p>		

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F 425	<p>Continued From page 56</p> <p>#10 was taking Lexapro daily at 10:00 am.</p> <p>Observation on 3/2/16 at 3:00 pm of the medication cart on Unit #1 revealed Resident #10's blister card for Lexapro was empty.</p> <p>During an interview on 3/2/16 at 3:01 pm, LN #9 stated the medication was reordered and should arrive tonight.</p> <p>Observation on 3/3/16 at 10:30 am of the medication cart on Unit #1, revealed no Lexapro medication for Resident #10.</p> <p>During an interview on 3/3/16 at 10:30 am, LN #3 confirmed there was no Lexapro medication for Resident #10 this morning and therefore Resident #10 missed her daily dose. When asked what the process was for refilling medication, LN #3, stated the medication should have been ordered since the reorder label was removed from the blister card. LN #3, then checked the pharmacy faxed orders and confirmed the order was faxed to the pharmacy on 2/22/16.</p> <p>During a subsequent interview on 3/3/16 at 10:34 am, LN #3, stated she called the facility's pharmacy and the pharmacy satellite was going to send over the Lexapro today.</p> <p>During an interview on 3/3/16 at 11:03 am, the Director of Nursing (DON) stated the nurse should have verified the status of the medication order when she used the last dose of the medication. The DON further stated, "I would have called yesterday."</p> <p>Review on 3/8/16 of the drug insert for Lexapro from the webpage <http://druginserts.com>, with</p>	F 425			

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F 425	Continued From page 57 the last revision date of 11/2014, disclosed the following, "...there have been spontaneous reports of adverse events occurring upon discontinuation of these drugs, particularly when abrupt, including the following: dysphoric mood [sad], irritability, agitation, dizziness, sensory disturbances, ...anxiety, confusion, headache, lethargy, emotional lability, insomnia an hypomania [mild form of mania]. While these events are generally self-limiting, there have been reports of serious discontinuation symptoms." During an interview on 3/3/16 at 3:15 pm, the Pharmacist stated the satellite pharmacy is only for emergency medications and the nurses should follow up scheduled medications to make sure medications do not run out. The Pharmacist confirmed Residents should never have a missed dose or go without a medication.	F 425			
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428		4/12/16	

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F 428	<p>Continued From page 58</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview the facility failed to ensure pharmacist's concerns and recommendations were addressed by the physician for 1 resident (#4) out of 12 sampled residents. This failed practice had the potential for the resident to receive unnecessary and or ineffective antibiotic medications. Findings:</p> <p>Record review from 3/1-3/4 revealed Resident #4 was admitted with a diagnosis to include heart failure and bacteremia (a blood infection).</p> <p>Review of the "Note to Attending Physician/Prescriber" written by the Pharmacist, dated 12/10/15, revealed a recommendation that "ORAL vancomycin...will not treat [his/her]his bacteremia... I do not like the instruction to use oral vancomycin." The physician/Prescriber Response" section of the form had no acknowledgement from the physician.</p> <p>Review of the physician orders from 12/10-30/15 revealed no new vancomycin orders by the physician.</p> <p>Review on 3/4/16 of the policy "Medication Regimen Review/Pharmacy Recommendations" dated 1/15 revealed: "...the consultant pharmacist to provide physicians with... therapeutic recommendations... Through a written report... recommendations will be mailed, faxed or reviewed in the facility by the physician within 7 days... the physician will indicate on the recommendation if they choose to accept or decline the recommendation..."</p>	F 428	<p>Res #4 received all ordered doses of IV antibiotics. Facility staff did not document on pharmacy recommendation as resident had a PICC line and we would obtain replacement if it failed.</p> <p>Residents receiving pharmacy recommendations have the potential to be affected. Recent pharmacy recommendations reviewed to ensure all documentation is complete.</p> <p>Reviewed pharmacy policies and procedures with RCMs, and educated to document all changes and information on pharmacist rec form and review with MD.</p> <p>DNS to audit completion of follow up for all monthly pharmacist recs. Audits will be monthly for three months.</p> <p>Copy of audit(s) with findings (negative outcomes/trends/patterns) will be provided to the Administrator for review and follow-up as necessary. Issue will be reviewed during monthly Performance Improvement Meeting for 3 months or until resolved to ensure continued compliance.</p>		

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F 428	Continued From page 59	F 428			
F 441 SS=F	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and</p>	F 441		4/12/16	

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F 441	<p>Continued From page 60</p> <p>transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>.</p> <p>Based on record review, observation and interview, the facility failed to ensure: 1) staff performed hand hygiene according to accepted professional practices during the provision of care and services; 2) staff performed a bed change in a sanitary manner; 3) oversight of indwelling urinary catheters; 4) appropriate use of antibiotics; and 5) the Infection Control Committee (ICC) documented and communicated concerns with surveillance data to the Medical Director and Pharmacist and that action plans were developed for the data collected. These failed practices increased the risk for the development and transmission of disease and infection in a vulnerable population of all residents based on a current census of 81.</p> <p>Findings:</p> <p>Hand Hygiene</p> <p>Resident #1</p> <p>Record review on 3/1-4/16 revealed Resident #1 was admitted to the facility with a diagnosis of Parkinson's with dementia and hallucinations.</p> <p>Observation on 3/1/16 at 8:20 am revealed, the Resident's bed was saturated with urine. CNA #2 removed the soiled bed linen and then placed clean linen on the bed. During the observation</p>	F 441	<p>Res #1 is no longer at the facility. Res #9 and 10 issues were reviewed and addressed with staff at time of survey. Resident #17 was discharged from facility prior to survey.</p> <p>Residents receiving assistance with ADLs, use of indwelling catheters and/or treated with antibiotics have the potential to be affected. Residents with indwelling catheters and/or receiving antibiotics were reviewed and care plans/orders updated as necessary.</p> <p>Staff were re-educated regarding hand washing, infection control practices, indwelling catheter use and standards of care, antibiotic stewardship, and Infection Control Committee were completed with staff.</p> <p>Infection Control policies and procedures were reviewed and standards were developed for Infection Control Committee to include what information will be collected by Infection Preventionist and how information will be reviewed with ICC members , to include Medical Director and Pharmacist. Standards will include infection rates, antibiotic stewardship, foley catheter appropriate use, infection</p>		

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F 441	<p>Continued From page 61</p> <p>CNA #5 did not remove the contaminated gloves or perform hand hygiene before making the bed with clean linens.</p> <p>Additional observations on 3/1/16 from 8:20 to 8:35 am, revealed CNA #4 did not offer hand hygiene to the Resident after toileting and before going to the table for breakfast. CNA #4 also did not remove contaminated gloves or perform hand hygiene until after the Resident was assisted to the dining table for breakfast.</p> <p>Continuous observation on 3/1/16 between 10:00 am and 1:50 pm, on Unit #2, revealed nonsampled Residents #s 24, 25, 26, and 27 sitting at the dining table. The Residents were not offered hand hygiene before or after lunch.</p> <p>During an interview on 3/2/16 at 11:10 am the Assistant Director of Nursing (ADON)/Infection Control Coordinator (ICC) stated hand hygiene should occur after toileting, after removal of dirty gloves and before eating. Additionally, she stated gloves should be changed after a dirty task and before moving to a clean task.</p> <p>Review on 3/4/16 of the facility's policy and procedure, "Standard Precautions" dated 11/09, revealed "Change gloves during resident care... (when moving from a dirty site to a clean site)... wash hands immediately after removing gloves."</p> <p>Additional review of the facility's policy and procedure, "Hand Hygiene" dated 10/11, revealed "Situations that require hand hygiene... before & after eating... assisting a resident with personal care... after toileting and after assisting a resident with toileting."</p>	F 441	<p>control standards and updates. Based on results of information collected the ICC will complete and document action plans for triggered issues and report the information monthly to facility QAPI committee.</p> <p>Administrator and Dept. Managers will perform rounds to ensure hand washing and infection control measures are appropriately followed. Items will also be audited via MACC regarding indwelling catheters and antibiotic stewardship. DNS to audit ICC meeting minutes to ensure areas are fully reviewed and documented. Audits will be daily for two weeks and then weekly for four weeks.</p> <p>Copy of audit(s) with findings (negative outcomes/trends/patterns) will be provided to the Administrator for review and follow-up as necessary. Issue will be reviewed during monthly Performance Improvement Meeting for 3 months or until resolved to ensure continued compliance.</p>		

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F 441	<p>Continued From page 62</p> <p>Bed Changes</p> <p>Resident #1</p> <p>Record review on 3/1-4/16 revealed Resident #1 was admitted to the facility with a diagnosis of Parkinson's with dementia and hallucinations.</p> <p>Observations on 3/1/16 at 8:20 am revealed, the Resident's bed was saturated with urine. CNA #5 removed the soiled bed linen and then placed clean linen on the bed without first wiping down the mattress.</p> <p>Indwelling Urinary Catheter</p> <p>Resident #9</p> <p>Observation on 2/29/16 at 2:15 pm revealed Resident #9 had an indwelling urinary catheter (a flexible tube that drains urine from the bladder).</p> <p>Record review 3/1-4/16 revealed Resident #9 was admitted to the facility with a indwelling urinary catheter.</p> <p>Record review of the "Referral form" written by the Urologist, dated 1/21/16, indicated an order which stated "Foley [indwelling urinary] catheter, change monthly."</p> <p>Further record review on 3/2/16 of the Resident's treatment administration record revealed an order which stated to change the indwelling urinary (Foley) catheter on the 19th of each month.</p> <p>During an interview on 3/4/16 at 8:15 am the ADON/ICC stated she had not been collecting data on the number or appropriateness of</p>	F 441			

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F 441	<p>Continued From page 63 indwelling urinary catheter use.</p> <p>During an interview on 3/2/16 at 11:15 am the Director of Nursing (DON) was asked if the facility had a policy to reflect the monthly replacement of indwelling urinary catheters. She stated routine replacement of an indwelling urinary catheter was not best practice and the facility did not have a policy.</p> <p>Review of the facility's policy "Indwelling Urinary Catheter," last reviewed 01/15, stated, "Within 14 days of admission, the ongoing use of indwelling catheter will be evaluated..."</p> <p>Review on 3/12/16 of the 2009 Centers for Disease Control (CDC) guidelines from the website <http://www.cdc.gov>, revealed "Changing indwelling catheters or drainage bags at routine, fixed intervals is not recommended. Rather, it is suggested to change catheters and drainage bags based on clinical indications such as infection, obstruction, or when the closed system is compromised."</p> <p>Antibiotic Use</p> <p>Resident #10</p> <p>Record review on 3/1-4/16 revealed Resident #10 had diagnoses that included urgency of urination and urinary tract infection (UTI), not otherwise specified.</p> <p>Further review of the nursing progress note dated 2/6/16 at 10:23 pm, revealed the physician ordered a urine analysis and levofloxacin (an antibiotic) for a possible UTI.</p>	F 441			

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F 441	<p>Continued From page 64</p> <p>Review of the urine culture results dated 2/8/16, revealed "...mixed contaminating flora. No further workup [no culture and sensitivity to antibiotics was indicated]." The physician was notified of the results on 2/9/16. Neither the physician orders nor progress notes revealed a reason to continue the antibiotic.</p> <p>In addition, review of the Resident's medication administration record (MAR), revealed the Resident was also receiving sulfamethoxazole-trimethoprim (an antibiotic) daily since 10/16/15 for prophylaxis (prevention) of chronic UTI's.</p> <p>During an interview on 3/1/16 at 2:00 pm, the DON stated the facility is in the process of reviewing prophylactic antibiotic use for UTI's.</p> <p>Resident #17</p> <p>Record review on 3/3-4/16 revealed Resident #17 was admitted to the facility on 10/23/15 with diagnoses that included a UTI.</p> <p>Further record review of the MAR revealed Resident #17 had a physician's order for ciprofloxacin (an antibiotic) ordered on 11/30/15 to be given 7 days for a UTI. The antibiotic was completed on 12/7/15.</p> <p>Review of the laboratory results for a urine analysis, dated 11/30/15, revealed "No further workup, probable contaminate." A handwritten note on the lab results revealed, "Notified Dr. Thomas 12/4/15. No new order for repeat UA (urinalysis)." In addition, no physician notes were provided by the facility or in the electronic medical record (EMR) regarding the continued use of</p>	F 441			

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F 441	<p>Continued From page 65 antibiotics.</p> <p>Review of the facility's infection control plan policy titled "Infection Reporting and Tracking" dated 11/09, revealed "The infection control coordinator will...review monthly printouts of antibiotic use from the pharmacy..."</p> <p>Infection Control Committee</p> <p>Record review on 3/2-4/16 of the documentation provided for the infection prevention committee revealed several surveillance data graphs. No documentation was provided to support data analysis goals, action plans, or communication with the Medical Director or Pharmacist.</p> <p>Review of the CMS 672 form completed on survey by the facility revealed 10 Residents had indwelling urinary catheters. No surveillance data was included in the documents provided for the appropriateness of urinary catheter use.</p> <p>During an interview on 3/2/16 at 11:15 am the ADON/ICC stated the committee had minimal attendance by the Pharmacist or the Medical Director.</p> <p>Review of the surveillance data "% Antibiotics ordered vs Criteria Met[for UTI]," dated January - December 2015 revealed several months where there was a high discrepancy between when antibiotics had been given and UTI criteria had not been met.</p> <p>During the same interivew the ADON/ICC was asked if any action plans had been discussed or implemented during an infection control meeting after reporting the surveillance data and she had</p>	F 441			

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

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F 441	Continued From page 66 no comment. During an interview on 3/3/16 at 2:50 pm the Pharmacist was asked if he attended the infection control committee meetings or participated on an antibiotic stewardship committee, he said he did not. During an interview on 3/4/16 at 8:15 am the Medical Director stated he has not attended the infection control committee or quality meetings for some time. Review of the facility infection control plan policy titled "Infection Reporting and Tracking" dated 11/09, revealed "...maintain a record of infections and corrective actions related to infections...the infection control coordinator will monitor residents with infections to evaluate effectiveness of treatment plan...will analyze data collected and implement corrective action as needed...will report outcomes...trending, analysis and corrective actions related to facility infections and staff education provided to the Infection Control Committee as part of the Quality Assurance Committee meeting."	F 441			
F 501 SS=F	483.75(i) RESPONSIBILITIES OF MEDICAL DIRECTOR The facility must designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies; and the	F 501		4/12/16	

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F 501	<p>Continued From page 67 coordination of medical care in the facility.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview the facility's Medical Director failed to provide oversight of the attending physician responsible for the quality of care and quality of life of the residents, based on a census of 81. Specifically, the Medical Director failed to ensure the following:</p> <ol style="list-style-type: none"> 1) Best practice standards for the replacement of indwelling catheters had been implemented (Refer to F441); 2) Review and provide guidance to the infection control committee on the surveillance data collected (Refer to F441); 3) Review data provided from the pharmacist and the infection control and quality assurance committee 's to ensure appropriate use of antibiotics for urinary infections that did not meet infection criteria (Refer to F441); <p>During an interview on 3/4/16 at 8:15 am the Medical Director stated he has not attended the infection control committee or quality meetings for some time.</p> <ol style="list-style-type: none"> 4) Ensure the documentation of behaviors for residents on antipsychotic medications were complete, targeted toward the behaviors to be monitored, and were easily and readily accessible for the Physician and Pharmacists evaluation of 	F 501	<p>Facility residents have the potential to be affected by this citation.</p> <p>Medical Director responsibilities were reviewed, with specific focus on indwelling catheters, Infection Control Committee, antibiotic stewardship, behavior management and antipsychotic medication use, discharge summaries and physician visits.</p> <p>Administrator and Dept. Managers will perform audits to ensure Medical Director documentation is complete and up to date and full involvement in Medical Director duties has been completed. Audits will be daily for two weeks and then weekly for four weeks.</p> <p>Medical Director reviewed all audit tools and in agreement with audit schedule. Medical Records Director and DNS to follow up with MD regarding audit results to ensure all items are completed timely and accurately.</p> <p>Copy of audit(s) with findings (negative outcomes/trends/patterns) will be provided to the Administrator for review and follow-up as necessary. Issue will be reviewed during monthly</p>		

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F 501	<p>Continued From page 68 effectiveness (Refer to F329);</p> <p>During an interview on 3/4/15 at 8:15 am the Medical Director stated he relied on anecdotal information from the RCM's when making a determination about a psychotropic medication.</p> <p>5) Ensure the discharge summaries had been documented (Refer to F514);</p> <p>During an interview on 3/4/16 at 8:30 am, Medical Records Staff stated that the Resident Care Managers are the individuals who complete the Discharge Summary/ Recapitulation of stay. Then, the physician reviews and signs the document.</p> <p>6) Ensure the required physician visit summaries were documented (Refer to F386).</p> <p>During an interview on 3/4/16 at 8:15 am the Medical Director stated he is aware he should be documenting progress notes on resident visits. In addition, he stated both the Administrator and the Medical Records Director have spoken to him regarding the lack of documentation.</p> <p>Review of the "Medical Director Agreement," dated 5/14/15, revealed " ...Medical Director will also serve on Facility committees, which include the Quality Assurance/Continuance Quality Improvement Committee ...Collaborate with Facility leadership ...and evaluate resident care policies and procedures that reflect current</p>	F 501	<p>Performance Improvement Meeting for 3 months or until resolved to ensure continued compliance.</p>		

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F 501	Continued From page 69 standards of practice ...Continue educational efforts to increase knowledge of current standards of practice in resident long-term care ...Establish and apply effective monitoring systems, documentation, and results of findings to improve physician compliance with regulations, including required visits ..."	F 501			
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: . Based on record review and interview the facility failed to ensure the resident's clinical records were complete. This failed practice affected 4 Residents (#s 14, 17, 18 and 19) out of 19 residents whose clinical records were reviewed. Specifically, the physician failed to fully complete	F 514	Resident #14 medical record was corrected to include documentation of elopement. Resident 17, 18, 19 have all discharged from center prior to survey, but discharge summaries completed and signed by MD.	4/12/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025025	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/04/2016
NAME OF PROVIDER OR SUPPLIER PRESTIGE CARE & REHAB CENTER OF ANCHORAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 9100 CENTENNIAL DRIVE ANCHORAGE, AK 99504		
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F 514	<p>Continued From page 70</p> <p>discharge documentation on 3 residents #'s (17, 18 and 19). In addition, 1 resident (#14) elopement was not documented in the medical record or behavior log. These failed practices placed the residents at risk for incomplete documentation surrounding their discharge and behaviors charting. Findings:</p> <p>Resident #14</p> <p>Record review on 3/3-4/16 revealed Resident #14 had diagnoses that included stroke and aphasia (a communication disorder resulting from damage to the brain). The Resident used a wheel chair for mobility.</p> <p>During a telephone interview on 3/3/16 at 12:18 pm, Resident #14's spouse stated the Resident had eloped outside about 3 weeks ago without the staffs' knowledge. The spouse stated the facility did not know how long the Resident was outside.</p> <p>During an interview on 3/3/16 at 2:00 pm, Resident Care Manager (RCM) #1 stated she was out of town when it happened but per report the Resident had eloped outside for 15-30 minutes on Sunday 2/14/16 in the evening. The Receptionist had gone to another door which was alarming after Resident #13 had attempted to elope. Someone had shut off the alarm to the court yard door (where the smoking area was located) which had gone off frequently that day. The RCM stated someone driving to the facility had seen Resident #14 outside. The Resident had opened the latch on the gate, exited the yard, and became stuck outside in his wheelchair.</p> <p>Review of the Resident's medical record revealed</p>	F 514	<p>Residents that have eloped and/or residents that have discharged from center are at risk related to this citation. Reviewed elopements for last 30 days and discharges for last 30 days to ensure documentation is accurate and complete.</p> <p>RCM and Medical Director were re-educated regarding completion of discharge summaries. RCM's and Licensed Nurses were re-educated regarding completion of elopement documentation in the medical record.</p> <p>IDT to audit during MACC and stand up to ensure elopement events are fully documented in medical record. To ensure discharge summaries are completed accurately and timely by RCM and MD, Medical Records Director to review daily and work with RCM and MD for timely completion. Audits will occur daily for two weeks then weekly for four weeks.</p> <p>Copy of audit(s) with findings (negative outcomes/trends/patterns) will be provided to the Administrator for review and follow-up as necessary. Issue will be reviewed during monthly Performance Improvement Meeting for 3 months or until resolved to ensure continued compliance.</p>		

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F 514	<p>Continued From page 71</p> <p>on 2/14/16 at 11:25 pm, "Resident attempted to get out from exit door on the front door for a few minutes at 5:45 pm, assisted resident with 3 staff to come back inside, and Resident was cooperative, He [complained of] Right hand and right foot pain..." There was no documentation in the medical record or the behavior log about the Resident being found outside.</p> <p>During an interview on 3/4/16 at 11:30 am, the Assistant Director of Nursing (ADON) stated the nurse should have charted the incident in the medical record.</p> <p>Resident #17</p> <p>Record review on 3/3-4/16 revealed Resident #17 was admitted to the facility on 10/23/15 and discharged on 12/11/15. Further review of the Resident's medical record revealed no discharge summary.</p> <p>During a telephone interview on 3/4/16 at 8:15 am the Resident's physician confirmed he does not always do discharge summaries. The physician further stated he should do a discharge summary.</p> <p>Resident # 18</p> <p>Record review on 3/3-4/16 revealed Resident #18 was admitted to the facility on 11/5/15 and expired on 12/5/15.</p> <p>Review of Resident #18's "Discharge Summary/Recapitulation of Stay," dated 12/16/15, revealed the "Physicians Use Only" section was incomplete. Specifically, the sections titled "Prognosis/Condition on Discharge" and "Final Diagnosis/Cause of Death" was found</p>	F 514			

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F 514	<p>Continued From page 72 blank.</p> <p>Resident #19</p> <p>Record review on 3/3-4/16 revealed Resident #19 was admitted to the facility on 12/21/15 and discharged to home on 1/8/16.</p> <p>Review of Resident #19's "Discharge Summary/Recapitulation of Stay," dated 1/8/16, revealed the "Physicians Use Only" section was incomplete. The sections on the form that requested the Resident's "Prognosis/Condition on Discharge" and "Final Diagnosis/Cause of Death" were found blank. The Physician's signature was the only section completed by the physician.</p> <p>During an interview on 3/4/16 at 8:30 am, Medical Records Staff stated that the Resident Care Managers are the individuals who complete the Discharge Summary/Recapitulation of stay. Then, the physician reviews and signs the document.</p>	F 514			