

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

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175356	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/16/2019
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - DECATUR COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 108 E ASH STREET OBERLIN, KS 67749		
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F 000	INITIAL COMMENTS	F 000			
F 557 SS=E	<p>The following citations represent the findings of a Health Resurvey. The 2567 was electronically sent on 5/21/19.</p> <p>Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2)</p> <p>§483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:</p> <p>§483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: The facility had a census of 41 residents. The sample included 12 residents. Based on observation, record review, and interview the facility failed to promote respect and dignity.</p> <p>Findings included:</p> <p>- On 5/13/19 at 2:00 PM in the Angel Lane dining room, observation revealed 3 certified nurse aides sat at a table and 2 residents in wheelchairs at another dining table. The 3 certified nurse aides were overheard speaking about different residents in the facility and their medical conditions.</p> <p>On 5/14/19 at 8:16 AM, observation revealed 21 residents sat at tables in the main dining room. Further observation revealed a direct care staff member propelled a rolling cart into the dining</p>	F 557			

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

TITLE

(X6) DATE

05/21/2019

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 557	<p>Continued From page 1</p> <p>room, containing a blood pressure cuff, oxygen saturation machine and accu-chek monitor (to check blood glucose by the use of a small needle device).</p> <p>On 5/14/19 at 8:25 AM, observation revealed the direct care staff member obtained Resident #36 and #10's blood sugar at the dining table, Resident #1's blood pressure and Resident #13 and #17's oxygen saturation.</p> <p>On 5/14/19 at 2:10 PM, in the Angel Lane dining room observation revealed 1 certified nurse aide standing with a clip board in his/her hand, 1 certified nurse aide sat at a table, 2 residents sat on dining chairs, and 1 resident sat in a wheelchair. Observation revealed the certified nurse aide with the clip board spoke loudly about which resident had a bowel movement and residents who had not had a bowel movement.</p> <p>On 5/16/19 at 11:00 AM, Administrative Staff A and Administrative Nurse D verified the direct care staff should not have obtained a blood pressure, accu-checks and oxygen saturations in the dining room. Administrative Staff A verified direct care staff are to discuss resident personal information in a private area.</p> <p>The facility's 2/2017 Dignity policy states the facility will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his/her individuality.</p>	F 557			

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F 557	Continued From page 2	F 557			
F 656 SS=D	<p>The facility failed to promote dignity and respect, for Residents #36, #10, #1, #13 and #17 when staff shared personal information in a non-private area, placing the residents at risk for a demeaning environment.</p> <p>Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)</p> <p>§483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -</p> <p>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and</p> <p>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and</p>	F 656			

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F 656	<p>Continued From page 3</p> <p>desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>The facility had a census of 41 residents. The sample included 12 residents. Based on observation, record review, and interview the facility failed to develop a comprehensive care plan for 2 of 12 sampled residents, Resident #36 for skin integrity, #23 for depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness).</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident #36's annual (MDS) Minimum Data Set assessment, dated 4/18/19, documented the resident had severely impaired cognition, unsteady gait, and upper and lower functional impairment on both sides. The MDS documented the resident required extensive assistance of 2 staff for bed mobility, transfers, dressing and toileting. <p>The 4/18/19 (CAA) Care Area Assessment documented the resident was unaware of safety issues and tried to walk independently resulting in falls.</p>	F 656			

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F 656	<p>Continued From page 4</p> <p>The 5/7/19 care plan documented the resident was at risk for falls and directed staff to monitor the resident for significant changes in cognition, safety awareness and decision making skills. The care plan lacked interventions for skin integrity for the resident to prevent bruises and skin tears.</p> <p>On 5/13/19 at 10:45 AM, observation revealed the resident sat in a chair by the dining room. Further observation revealed a large dark purple bruise on the outside of the resident's left lower leg.</p> <p>On 5/15/19 at 7:35 AM, observation revealed the resident sat in a chair by the dining room and had thin stockinettes (a woven material that is open at both ends and used to hold bandages in place or to protect a leg, finger or arm) on both of his/her legs.</p> <p>On 5/15/19 at 11:00 AM, Administrative Nurse F verified the resident did not have a care plan for skin integrity.</p> <p>On 5/15/19 at 11:30 AM, Administrative Nurse D stated the resident bruised easily and the care plan should have interventions to prevent bruises and skin tears.</p> <p>On 5/15/19 at 4:10 PM, observation revealed Administrative Nurse D measured the resident's left lower leg bruise at 13.5 (cm) centimeter x 16.5 cm, and stated he/she had placed heel protectors on the resident's wheelchair to protect his/her legs from bruising.</p> <p>The facility's 11/2016 Care Plan policy documented the comprehensive plan of care will be finalized during an interdisciplinary care team conference no later than seven days after</p>	F 656			

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F 656	<p>Continued From page 5</p> <p>completion of the comprehensive resident assessment. The care plan will emphasize the care and development of the whole person ensuring that the resident would receive appropriate care and services.</p> <p>The facility failed to develop a comprehensive plan of care for Resident #36, to instruct staff with individualized interventions to prevent bruises, placing the resident at risk for more bruises.</p> <p>- Resident #23's (POS) physician's order sheet, dated 5/2/19, documented the resident had a diagnosis of major depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness).</p> <p>The quarterly (MDS) Minimum Data Set assessment, dated 3/19/19, documented the resident had modified independence for decision making skills, with no mood or behavior problems. The assessment documented the resident required supervision of 1 staff for bed mobility, transfers, and extensive assistance of 1 staff for toileting. The assessment further documented the resident received antidepressant medication everyday of the 7 day look back period.</p> <p>The 3/19/19 care plan documented the resident had potential for impaired cognitive function and directed staff to monitor and document and report any changes in the resident's cognitive function. The care plan lacked interventions to assist staff when the resident had episodes of depression and that the resident received an antidepressant.</p> <p>The 3/7/19 physician's order directed staff to</p>	F 656			

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F 656	<p>Continued From page 6</p> <p>administer Celexa, (an antidepressant medication) 20 (mg) milligram, 1 tablet, by mouth, daily for the diagnosis of depression.</p> <p>On 5/14/19 at 7:45 AM, observation revealed the resident in the dining room eating breakfast, smiling and talking with tablemate's.</p> <p>On 5/15/19 at 11:00 AM, Administrative Nurse D stated the resident had a diagnosis of depression, received an antidepressant therefore he/she should had a depression care plan.</p> <p>On 5/15/19 at 11:15 AM, Administrative Nurse F verified the resident did not have a depression care plan.</p> <p>On 5/15/19 at 12:43 PM, Licensed Nurse G stated the resident had periods of forgetfulness, especially regarding his/her medication. Licensed Nurse G further stated the resident did not act depressed and was happy most of the time.</p> <p>On 5/15/19 at 3:00 PM, Nurse Aide M stated the resident was very social, went to a lot of activities and did not act depressed.</p> <p>The facility's 11/2016 Care Plan policy documented the comprehensive plan of care will be finalized during an interdisciplinary care team conference no later than seven days after completion of the comprehensive resident assessment. The care plan will emphasize the care and development of the whole person ensuring that the resident would receive appropriate care and services.</p> <p>The facility failed to develop a comprehensive plan of care for Resident #23, who had a</p>	F 656			

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F 656	Continued From page 7	F 656			
F 679 SS=D	<p>diagnosis of depression and received an antidepressant medication, placing the resident at risk for further depression.</p> <p>Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1)</p> <p>§483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: The facility had a census of 41 residents. The sample included 12 residents of with 1 reviewed for activities. Based on observation, record review, and interview the facility failed to develop an activity program to support the physical, mental, and psychosocial well-being, for 1 of 1 sampled residents. (#9)</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident #9 admission (MDS) Minimum Data Set assessment, dated 2/22/19, recorded the resident was admitted to the facility on 2/18/19, and had severely impaired cognition. The MDS recorded the resident required supervision and set up help for bed mobility and transfers, and was able to ambulate independently in room and corridor. The MDS recorded music, keeping up with the news, newspapers, activities with groups 	F 679			

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F 679	<p>Continued From page 8 of people and religious activities were all very important to the resident.</p> <p>The MDS lacked a (CAA) Care Area Assessment for activities.</p> <p>The 2/22/19 care plan recorded the resident liked music, news, the newspaper and visiting with others. The care plan directed the staff to invite and assist the resident to group activities and daily devotions.</p> <p>The 3/18/19 activity assessment, completed 30 days after the resident's admission to the facility, documented the assessment, "Getting to know you," consisted of resident past preferences, current preferences and personal history of the resident.</p> <p>On 5/14/19 at 8:20 AM, observation revealed the resident ambulated with his/her front wheeled walker to the dining room. Further observation revealed the resident stated to another resident at his/her table, "I guess we just go back to bed after we eat?"</p> <p>On 5/14/19 at 9:40 AM, observation revealed the resident lying on his/her bed with a blanket over his/her head, room dark and quiet. Further observation revealed a devotion group activity being held in the dining room.</p> <p>On 5/14/19 at 12:50 PM, observation revealed the resident lying on his/her bed with a blanket over his/her head, room dark and quiet. Further observation revealed residents sat in a group outside.</p> <p>On 5/15/19 at 7:50 AM, observation revealed the</p>	F 679			

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F 679	<p>Continued From page 9</p> <p>resident sat at the dining room table eating his/her breakfast. Observation revealed the resident finished eating breakfast, he/she ambulated to his/her room, sat down on the bed, and covered up his/her head with a blanket.</p> <p>On 5/15/19 at 9:30 AM, observation revealed the resident lying on his/her bed, eyes closed, and room dark. Further observation revealed some facility residents sat outside, and daycare children came and provided a music activity.</p> <p>On 5/15/19 at 3:10 PM, observation revealed the resident lying on his/her bed, while other resident's sat in the large dining room attending a religious activity.</p> <p>On 5/15/19 at 9:05 AM, Nurse Aide N verified the resident came out to meals and then rested on his/her bed most of the day.</p> <p>On 5/15/19 at 9:40 AM, Nurse H verified the resident stayed in his/her room most of the day and only came out to meals. Nurse H verified the resident had not attended any group activities and was unsure if he/she had been encouraged to go to activities.</p> <p>On 5/15/19 11:10 AM, Administrative Nurse D stated the resident spent most of his/her time in the room.</p> <p>On 5/15/19 at 4:00 PM, Activity Staff Z verified a completed activity assessment had not been completed until 3/18/19, 30 days after the resident's admission to the facility. Activity Staff Z verified the resident had not attended any group or religious activities, did not have music available in his/her room and</p>	F 679			

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F 679	Continued From page 10 stayed in his/her room in bed most of the day. The facility's 2/2019 Activity policy states the facility will enhance each resident's quality of life, encourage participation in meaningful activities of their choice, while respecting the resident's interests. Focusing on each resident as an individual. The facility lacked engaging activities for Resident #9, placing the resident at risk for boredom and loneliness.	F 679			
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: The facility had a census of 41 residents. The sample included 12 residents. Based on observation, record review, and interview the facility failed to provide necessary care and treatment for skin integrity for 1 sampled resident who had a large bruise (an injury appearing as an area of discolored skin on the body, caused by a blow or impact rupturing underlying blood vessels). (#36) Findings included:	F 684			

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F 684	<p>Continued From page 11</p> <p>- Resident #36's annual (MDS) Minimum Data Set assessment, dated 4/18/19, documented the resident had severely impaired cognition, unsteady gait, and upper and lower functional impairment on both sides. The MDS documented the resident required extensive assistance of 2 staff for bed mobility, transfers, dressing and toileting.</p> <p>The 4/18/19 (CAA) Care Area Assessment documented the resident was unaware of safety issues and tried to walk independently resulting in falls.</p> <p>The 5/7/19 care plan documented the resident was at risk for falls and directed staff to monitor the resident for significant changes in cognition, safety awareness and decision making skills. The care plan lacked interventions for skin integrity for the resident to prevent bruises and skin tears.</p> <p>On 5/13/19 at 10:45 AM, observation revealed the resident sat in a chair by the dining room. Further observation revealed a large dark purple bruise on the outside of the resident's left lower leg.</p> <p>On 5/15/19 at 7:35 AM, observation revealed the resident sat in a chair by the dining room and had thin stockinettes (a woven material that is open at both ends and used to hold bandages in place or to protect a leg, finger or arm) on both of his/her legs.</p> <p>On 5/15/19 at 11:30 AM, Administrative Nurse D stated he/she had not completed an investigation on the the bruise because he/she had thought the bruise was probably from a fall that happened on 5/12/19. Administrative Nurse D further verified the resident did not have any injuries at the time</p>	F 684			

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F 684	<p>Continued From page 12 of the fall and there were no skin observation sheets completed after the fall documenting the resident had any injuries.</p> <p>On 5/15/19 at 1:25 PM, Licensed Nurse E stated the resident moved around a lot when transferred. Licensed Nurse E stated he/she had not noticed any bruising until that morning when he/she placed stockinettes on the resident's legs.</p> <p>On 5/15/19 at 3:00 PM, Nurse Aide M stated the resident bruised easily and told the nurse when he/she noticed any bruising.</p> <p>On 5/15/19 at 4:10 PM, observation revealed Administrative Nurse D measured the resident's left lower leg bruise at 13.5 (cm) centimeter x 16.5 cm, and stated he/she had placed heel protectors on the resident's wheelchair to protect his/her legs from bruising.</p> <p>The 3/19 facility's Skin Assessment Prevention and Documentation Requirement policy documented a bruise or contusion is an injury when the skin is not broken, pain, swelling and discoloration are characteristics. If a bruise, contusion, abrasion, or skin tear was observed on the resident, this should be reported to the nurse immediately. The bruise, contusion, skin tear, abrasion should be monitored weekly and any changes and/or progress toward healing should be documented on the skin observation sheet and the resident's care plan.</p> <p>The facility failed to prevent a bruise on Resident #36, who was cognitively impaired, and had poor safety awareness, placing the resident at risk for further bruising.</p>	F 684			

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F 689	Continued From page 13	F 689			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility had a census of 41 residents. The sample included 12 residents. Based on observation, record review, and interview the facility failed to investigate bruising of unknown origin for 1 sampled resident. (#36) Findings included: - Resident #36's annual (MDS) Minimum Data Set assessment, dated 4/18/19, documented the resident had severely impaired cognition, unsteady gait, and upper and lower functional impairment on both sides. The MDS documented the resident required extensive assistance of 2 staff for bed mobility, transfers, dressing and toileting. The 4/18/19 (CAA) Care Area Assessment documented the resident was unaware of safety issues and tried to walk independently resulting in falls. The 5/7/19 care plan documented the resident was at risk for falls and directed staff to monitor the resident for significant changes in cognition, safety awareness and decision making skills. The	F 689 F 689			

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F 689	<p>Continued From page 14</p> <p>care plan lacked interventions for skin integrity for the resident to prevent bruises and skin tears.</p> <p>On 5/13/19 at 10:45 AM, observation revealed the resident sat in a chair by the dining room. Further observation revealed a large dark purple bruise on the outside of the resident's left lower leg.</p> <p>On 5/15/19 at 7:35 AM, observation revealed the resident sat in a chair by the dining room and had thin stockinettes (a woven material that is open at both ends and used to hold bandages in place or to protect a leg, finger or arm) on both of his/her legs.</p> <p>On 5/15/19 at 11:30 AM, Administrative Nurse D stated he/she had not completed an investigation on the the bruise because he/she had thought the bruise was probably from a fall that happened on 5/12/19. Administrative Nurse D further verified the resident did not have any injuries at the time of the fall and there were no skin observation sheets completed after the fall documenting the resident had any injuries.</p> <p>On 5/15/19 at 1:25 PM, Licensed Nurse E stated the resident moved around a lot when transferred. Licensed Nurse E stated he/she had not noticed any bruising until that morning when he/she placed stockinettes on the resident's legs.</p> <p>On 5/15/19 at 3:00 PM, Nurse Aide M stated the resident bruised easily and told the nurse when he/she noticed any bruising.</p> <p>On 5/15/19 at 4:10 PM, observation revealed Administrative Nurse D measured the resident's left lower leg bruise at 13.5 (cm) centimeter x 16.5 cm, and stated he/she had placed heel</p>	F 689			

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F 689	Continued From page 15 protectors on the resident's wheelchair to protect his/her legs from bruising. The facility's 10/2018 Abuse and Neglect policy documented the purpose of the policy was to identify events, such as suspicious bruising of residents, occurrences, patterns and trends that may constitute abuse and to determine the direction of the investigation. The charge nurse would be notified immediately to assess the situation to determine if any emergency treatment or action was required and complete an initial investigation. If an injury of unknown origin, he or she would attempt to determine the cause of the injury, and notify the physician and family. The facility failed to investigate cognitively impaired Resident #36's bruise of unknown origin, and had poor safety awareness, placing the resident at risk for further bruising.	F 689			
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: The facility had a census of 41 residents. The sample included 12 residents with 1 reviewed for social services. Based on observation, record review, and interview the facility failed to provide social services to attain or maintain the highest practicable physical, mental and psychosocial well-being for 1 of 1 sampled resident. (#9) Findings included:	F 745			

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F 745	<p>Continued From page 16</p> <p>- Resident #9's admission (MDS) Minimum Data Set assessment, dated 2/22/19, recorded the resident was admitted to the facility on 2/18/19 and had severely impaired cognition, required supervision and set up for bed mobility and transfers, and was able to ambulate independently in the room and corridor.</p> <p>The MDS lacked a (CAA) Care Area Assessment for psychosocial well-being.</p> <p>The 2/22/19 care plan recorded the resident had enhanced psychosocial well-being with an individualized daily routine, and directed staff to honor the resident's personal preferences.</p> <p>The social service admission assessment dated 2/18/19, recorded the resident's expected stay in the facility was 60 days, to receive Physical and Occupation therapy, and then be discharged back to the community.</p> <p>On 3/6/19 a Home Safety Check assessment was completed by Physical and Occupational Therapy. The results of the Home Safety Check assessment recorded it was unsafe to discharge the resident back to home setting or an Assisted Living due to poor cognition and lack of safety awareness.</p> <p>The medical record lacked documentation of discussion with the resident regarding changes in his/her discharge plans.</p> <p>The 3/22/19 nurse's note recorded the resident agitated and wanting to leave the facility. Staff able to re-direct the resident.</p>	F 745			

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F 745	<p>Continued From page 17</p> <p>The 4/11/19 nurse's note recorded the resident became agitated and mad at staff wanted to know why he/she had to stay in the facility.</p> <p>The medical record lacked a depression assessment.</p> <p>The 4/12/19 nurse's note recorded the resident was seen and examined by psychiatric services and the physician ordered Zoloft (an antidepressant medication) 25 (mg) milligrams, (PO) by mouth daily for one week then increase Zoloft to 50 mg daily, and recheck in 2 weeks. The Zoloft was discontinued on 5/2/19, due to the resident became dizzy and had a fall without injury.</p> <p>The medical record lacked follow up by a mental health provider after the Zoloft was discontinued.</p> <p>On 5/14/19 at 8:20 AM, observation revealed the resident ambulated with his/her front wheeled walker to the dining room. Further observation revealed the resident stated to another resident at his/her table, "I guess we just go back to bed after we eat?"</p> <p>On 5/14/19 at 9:40 AM, observation revealed the resident lying on his/her bed with a blanket over his/her head, room dark and quiet.</p> <p>On 5/14/19 at 12:50 PM, observation revealed the resident lying on his/her bed with a blanket over his/her head, room dark and quiet.</p> <p>On 5/15/19 at 7:50 AM, observation revealed the resident sat at the dining room table eating his/her breakfast. Observation revealed the resident finished eating breakfast, ambulated to</p>	F 745			

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F 745	<p>Continued From page 18</p> <p>his/her room, sat down on the bed, and covered up his/her head with a blanket.</p> <p>On 5/15/19 at 9:30 AM, observation revealed the resident lying on his/her bed, eyes closed, and room dark.</p> <p>On 5/15/19 at 3:10 PM, observation revealed the resident lying on his/her bed.</p> <p>On 5/15/19 at 9:05 AM, Nurse Aide N verified the resident came out to meals and then rested on his/her bed most of the day.</p> <p>On 5/15/19 at 9:40 AM, Nurse H verified the resident stayed in his/her room most of the day and only came out to meals.</p> <p>On 5/15/19 at 11:10 AM, Administrative Nurse E verified the resident was not currently receiving Zoloft. Administrative Nurse E stated the facility has not had a mental health provider for the past month, and the facility was in the process of finding a new psychiatrist.</p> <p>On 5/16/19 at 10:10 AM, Social Service Staff X verified the resident was to be in the facility for 60 days and the discharge plan had changed. Social Service X also verified the facility failed to provide psychosocial adjustment.</p> <p>The facility's 12/2014 social work support and objectives policy stated to assist residents in meeting emotional, spiritual, psychosocial, economic and environmental needs. To focus on the resident's strengths and have an understanding of the resident's life before entering the facility.</p>	F 745			

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F 745	Continued From page 19 The facility failed to provide social service support to Resident #9 placing the resident at risk for decline in mental and psychosocial health.	F 745			
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly	F 756			

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F 756	<p>Continued From page 20</p> <p>drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:</p> <p>The facility had a census of 41 residents. The sample included 12 residents with 5 reviewed for unnecessary medications. Based on observation, record review, and interview the facility failed to obtain an appropriate diagnosis for 1 of 5 residents reviewed for the use of Seroquel (an antipsychotic medication). (# 8)</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident #8's physician order sheet, dated 4/1/19, recorded the diagnosis Dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked memory disorder, personality changes and impaired reasoning) with behavioral disturbance, (behavioral abnormalities such as aggression and anxiety). <p>The quarterly (MDS) Minimum Data Set assessment, dated 3/2/19, recorded the resident had a (BIMS) Brief Interview for Mental Status score of 3, indicating severely impaired cognition. The MDS recorded the resident required extensive staff assistance with bed mobility and transfers. The MDS recorded the resident received antipsychotic medication (class of medications primarily used to manage a severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality).</p>	F 756			

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F 756	<p>Continued From page 21</p> <p>The 11/30/18 psychotropic drug use (CAA) Care Area Assessment recorded the resident received an antipsychotic medication for dementia. (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked memory disorder, personality changes and impaired reasoning).</p> <p>The 3/2/19 care plan recorded the resident received Seroquel and directed staff to monitor the residents for side effects, such as mood and behavior changes, constipation, drowsiness, and dizziness.</p> <p>The physician order, dated 11/30/17, directed the staff to administer Seroquel 100 (mg) milligrams, (PO) by mouth at bedtime for dementia with behavioral disturbance.</p> <p>The physician order, dated 1/25/18, directed the staff to administer Seroquel 50 mg, PO daily at noon for dementia with behavioral disturbance.</p> <p>Review of the consultant pharmacist recommendations/review for the months of March, April and May 2019, documented no irregularities in the resident's drug regimen.</p> <p>The Black Box warning (BBW) (strictest warning put in the labeling of prescription drugs or drug products by the Food and Drug Administration (FDA) when there is reasonable evidence of an association of a serious hazard with the drug) for Seroquel documented the medication was not approved for the treatment of dementia, and could increase mortality (death) risk and adverse side effects in the elderly.</p> <p>Review of the medical record lacked</p>	F 756			

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F 756	<p>Continued From page 22</p> <p>documentation for behavior monitoring and risk versus benefits for the use of Seroquel.</p> <p>On 5/14/19 at 8:20 AM, observation revealed the resident sat in his/her wheelchair at the dining table with his/her eyes closed.</p> <p>On 5/15/19 at 8:50 AM, Administrative Nurse E verified the resident received Seroquel two times a day and the diagnosis of Dementia with behavioral disturbance. Administrative Nurse E also verified the lack of behavior documentation for the use of the Seroquel, and no pharmacy recommendations for the use of the Seroquel.</p> <p>On 5/16/19 at 9:15 AM, Administrative Nurse D stated he/she was unsure if the resident had the correct diagnosis for the use of Seroquel, and if the facility should be monitoring the resident for the use of Seroquel.</p> <p>The facility's 6/2017 use of psychotropic medication policy stated staff were to evaluate resident behavior and use behavior interventions and alternatives before using a psychotropic medication. Antipsychotics are only to be used for specific diagnosis's and gradual dose reduction attempts should be used to assess whether the dose or medication can be discontinued. Mood and behavior documentation should be completed when an antipsychotic medication is used. If an antipsychotic medication is used to treat behavioral symptoms related to dementia this is clinically contraindicated.</p> <p>The facility's Pharmacy Consultant failed to recommend an appropriate diagnosis for the use of Resident #8's Seroquel, placing the resident at risk for mood and behavior changes,</p>	F 756			

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F 756	Continued From page 23 constipation, drowsiness, and dizziness.	F 756			
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: The facility had a census of 41 residents. The sample included 12 residents with 6 reviewed for unnecessary medications. Based on observation, record review, and interview the facility failed to provide adequate reasoning for the use of an as needed antianxiety (a medication that calmed and relaxed people with excessive anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) medication for 1 of 6 sampled residents. (#13)	F 757			

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F 757	<p>Continued From page 24</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident #13's (POS) physician order sheet, dated 3/28/19, documented the resident had diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), major depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and dementia with without behavior disturbances (a condition in which a person loses the ability to think, remember, learn, make decisions, and solve problems and may also include personality changes and emotional). <p>The annual (MDS) Minimum Data Set assessment, dated 3/5/19, documented the resident had a (BIMS) Brief Interview for Mental Status Score of 13 indicating intact cognition. The assessment documented the resident required supervision and set up assistance for transfers, ambulation, and set up assistance of 2 staff for dressing. The assessment further documented the resident had no behaviors and received anxiety medication everyday of the 7 day look back period.</p> <p>The 3/5/19 (CAA) Care Area Assessment for psychotropic medication documented the resident received an as needed anxiety medication.</p> <p>The 3/5/19 CAA for behaviors did not trigger.</p> <p>The 3/19/19 care plan documented the resident received anxiety medication and directed staff to monitor for side effects, effectiveness of the medication, consult with the pharmacy, and healthcare provider to consider dosage reduction</p>	F 757			

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F 757	<p>Continued From page 25</p> <p>when clinically appropriate. The care plan further directed staff to report any side effects to the nurse.</p> <p>The 4/13/18 physician order directed staff to administer Alprazolam (an antianxiety medication) 0.5 (mg) milligram, 1 tablet, by mouth, every 8 hours, as needed for the diagnosis of anxiety.</p> <p>The April 2019 (MAR) Medication Administration Record documented the resident received the as needed medication on 5, 6, 7, 20, 22, and 30 but lacked documentation why the resident received the medication.</p> <p>Review of the medical record progress notes lacked documentation the resident experienced anxiety or behaviors on the above dates he/she received the as needed medication.</p> <p>On 5/14/19 at 12:15 PM, observation revealed the resident in the dining room for the noon meal conversing with staff.</p> <p>On 5/15/19 at 11:30 AM, Administrative Nurse D stated staff documented in the progress note when the resident had behaviors and if the resident received medication.</p> <p>On 5/15/19 at 2:30 PM, Nurse Aide M stated the resident did not have behaviors and if he/she did, staff chart the behaviors and told the nurse.</p> <p>On 5/15/19 at 3:30 PM, Licensed Nurse G stated the resident experienced anxiety and occasionally had behaviors. Licensed Nurse G further stated the resident had as needed medication if he/she was anxious, and the behavior was charted in the progress notes.</p>	F 757		

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F 757	Continued From page 26 The facility's 6/2017 Psychotropic Medications policy documented throughout the administration of the psychotropic medications, mood and behavior documentation must continue in order to indicate the effect the medication has on the behavior, monitor for side effects, monitor for the effectiveness of the medication and the potential adverse consequences. The facility failed to document the need for an as needed antianxiety mediation for Resident #13, placing the resident at risk for potential side effects.	F 757			
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic	F 758			

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F 758	<p>Continued From page 27</p> <p>drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;</p> <p>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and</p> <p>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.</p> <p>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: The facility had a census of 41 residents. The sample included 12 residents with 5 reviewed for unnecessary medications. Based on observation, record review, and interview the facility failed to obtain an appropriate diagnosis for 1 of 5 residents reviewed for the use of Seroquel (an antipsychotic medication). (# 8)</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident #8's physician order sheet, dated 4/1/19, recorded the diagnosis of dementia with 	F 758			

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F 758	<p>Continued From page 28</p> <p>behavioral disturbance (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked memory disorder, personality changes and impaired reasoning, with behavioral abnormalities such as aggression and anxiety).</p> <p>The quarterly (MDS) Minimum Data Set assessment, dated 3/2/19, recorded the resident had a (BIMS) Brief Interview for Mental Status score of 3, indicating severely impaired cognition. The MDS recorded the resident required extensive staff assistance with bed mobility and transfers. The MDS recorded the resident received antipsychotic medication (class of medications primarily used to manage a severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality).</p> <p>The 11/30/18 psychotropic drug use (CAA) Care Area Assessment recorded the resident received an antipsychotic medication for dementia.</p> <p>The 3/2/19 care plan recorded the resident received Seroquel and directed staff to monitor the residents for side effects, such as mood and behavior changes, constipation, drowsiness, and dizziness.</p> <p>The physician order, dated 11/30/17, directed the staff to administer Seroquel 100 (mg) milligrams, (PO) by mouth at bedtime for dementia with behavioral disturbance.</p> <p>The physician order, dated 1/25/18, directed the staff to administer Seroquel 50 mg, PO daily at noon for dementia with behavioral disturbance.</p>	F 758			

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F 758	<p>Continued From page 29</p> <p>The Black Box warning (BBW) (strictest warning put in the labeling of prescription drugs or drug products by the Food and Drug Administration (FDA) when there is reasonable evidence of an association of a serious hazard with the drug) for Seroquel documented the medication was not approved for the treatment of dementia, and could increase mortality (death) risk and adverse side effects in the elderly.</p> <p>Review of the medical record lacked documentation for behavior monitoring and risk versus benefits for the use of Seroquel.</p> <p>On 5/14/19 at 8:20 AM, observation revealed the resident sat in his/her wheelchair at the dining table with his/her eyes closed.</p> <p>On 5/15/19 at 8:50 AM, Administrative Nurse E verified the resident received Seroquel two times a day and the diagnosis of Dementia with behavioral disturbance. Administrative Nurse E also verified the lack of behavior documentation for the use of the Seroquel.</p> <p>On 5/16/19 at 9:15 AM, Administrative Nurse D stated he/she was unsure if the resident had the correct diagnosis for the use of Seroquel, and if the facility should be monitoring the resident for the use of Seroquel.</p> <p>The facility's 6/2017 use of psychotropic medication policy stated staff were to evaluate resident behavior and use behavior interventions and alternatives before using a psychotropic medication. Antipsychotics are only to be used for specific diagnosis's and gradual dose reduction attempts should be used to assess whether the dose or medication can be discontinued. Mood</p>	F 758			

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F 758	Continued From page 30 and behavior documentation should be completed when an antipsychotic medication is used. If an antipsychotic medication is used to treat behavioral symptoms related to dementia this is clinically contraindicated. The facility failed to obtain an appropriate diagnosis and assessment for behaviors for Resident #8's use of Seroquel, placing the resident at risk for mood and behavior changes, constipation, drowsiness, and dizziness.	F 758		