STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E003	A. BUILDING _____ B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL HOME	300 S AZTEC ST MONTEZUMA, KS 67867

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a health facility resurvey.	F 000		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E003	A. BUILDING _____ B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL HOME	300 S AZTEC ST MONTEZUMA, KS 67867

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F 272	Continued From page 1	F 272		

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 54 residents with 10 sampled for review.

Based on observation, interview and record review, the facility failed to conduct a periodic comprehensive, accurate assessment for 3 of the 10 sampled residents.
(#19, #38, #36)

Findings included:

- Resident #19's diagnoses from signed 1-17-12 physician's order sheet included general osteoarthrosis, edema, hypertension, trigeminal neuralgia, insomnia, idioperipheral neuropathy, cervical disc degeneration, constipation, depressive disorder, dysthymic disorder, diplopia, tear film insufficiency, stomach dysfunction, gastritis without hemorrhage, anemia, and limb pain.

The Significant change 4-11-12 MDS (minimum data set) identified resident #19 with BIMS score (brief interview for mental status) at 7 which indicated moderately impaired cognition, inattention, disorganized thinking, psychomotor retardation, and acute onset of mental status change. The assessment also identified the resident required limited assist with bed mobility, transfers, walking in room, locomotion on unit,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E003	A. BUILDING _____ B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL HOME	300 S AZTEC ST MONTEZUMA, KS 67867

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 2	F 272		

toileting, unsteady with balance, used a walker and wheelchair for mobility, and had falls since admission or prior assessment.

The CAAS (care area assessment summaries) dated 4-11-12 triggered for delirium, cognitive loss/dementia, and falls. The facility completed none of the CAA assessments at this time and also did not complete a recent fall assessment with the last one dated 1-18-12.

During an observation on 5-2-12 at 4:55 p.m., resident #19 sat in the straight back chair across the room from the bed. A fall mat laid on the floor under his/her feet with a motion sensor connected to it and a call light connected to the right arm of the chair within the resident's reach.

During an interview on 5-3-12 at 10:00 a.m., direct care staff E reported resident #19 fell recently, will push the fall mat under his/her bed intentionally, and will not call staff for help. Staff E reported the resident will ambulate independently in the hallways without allowing staff to help him/her.

During an interview on 5-2-12 at 5:10 p.m., licensed nurse C confirmed the resident had declined in many areas and the CAAS had not been completed on time.

The facility failed to complete the CAA assessments and a quarterly fall assessment in a timely manner for resident #19.

- Resident #36's May 2012 physician order sheet had diagnoses of osteoarthritis, constipation, anemia, seborrheic dermatitis, congestive heart

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E003	A. BUILDING _____ B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL HOME	300 S AZTEC ST MONTEZUMA, KS 67867

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 3	F 272		

failure, hypo-osmolality, cataract, fluid overload, pain, edema, and abdominal aortic aneurysm.

Resident #36's 3/13/12 Annual MDS (Minimum Data Set) identified the resident had severe cognitive impairment, obvious or likely broken natural teeth and he/she had difficulty chewing.

CAAs (Care Area Assessment Summary) dated 3/27/12 did not include any information related to dental care or resident #36's missing natural teeth and need for chopped or soft meat.

The 3/22/12 Care Plan indicated resident #36 had only a few natural teeth. Resident #36 needed soft food, weekly weights, and monitored for mouth pain/chewing problems.

Review of the 2011 " Dental Orders and Progress Notes" indicated resident #36 had five dental exams for extraction of bad teeth.

During an observation on 5/3/12 at 7:30 a.m., resident #36 had a few visible teeth in his/her mouth and ate 100% of the sausage links, eggs, and French toast without complaints of chewing difficulty or mouth pain.

During an interview on 5/3/12 at 11:45 a.m., administrative nursing staff C stated resident #36's 3/27/12 CAAs (Care Area Assessment Summary) lacked a complete assessment related to the resident's dental issues.

The facility failed to complete a comprehensive assessment of resident #36's dental issues and needs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E003	A. BUILDING _____ B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL HOME	300 S AZTEC ST MONTEZUMA, KS 67867

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 4	F 272		

- Resident #38's May 2012 physician order sheet had diagnoses of debility, Alzheimer's disease, dementia without behavior disturbance, hypertension, osteoarthrosis, backache, memory loss, constipation, cardiac dysrhythmia, edema, and gastritis.

Resident #38's 2/15/12 Quarterly MDS (Minimum Data Set) identified the resident had moderately impaired cognition, disorganized thinking, and moderate depression/delusional. The resident weighed 96 pounds and had no weight loss noted. Resident #38 received anti-anxiety and anti-psychotic medications during the assessment period.

CAAs (Care Area Assessment Summary) dated 11/23/11 did not include any information related to nutrition, cognitive loss/dementia, psychosocial well-being, mood state, or behavioral symptoms related to resident #38's weight, appetite issues, behaviors and psychoactive drug use.

The 2/23/12 Care Plan indicated the resident had paranoid thoughts of the staff poisoning his/her food and refused to eat at times. Resident #38 exhibited anger and mistrust and yelled at the staff that they kidnapped him/her.

Review of May 2012 physician orders indicated resident #38 received Seroquel XR for dementia with psychosis and Ativan for anxiety.

During an observation on 5/2/12 at 12:00 p.m., resident #38 ate 95% of the salad, fried chicken, mashed potatoes with gravy, cooked baby carrots, and dinner roll. Resident #38 visited with staff and other residents without delusions or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E003	A. BUILDING _____ B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL HOME	300 S AZTEC ST MONTEZUMA, KS 67867

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 5 behavior issues. During an interview on 5/3/12 at 10:45 a.m., administrative nursing staff C stated resident #38's 11/23/11 CAAs (Care Area Assessment Summary) lacked a complete assessment related to nutrition and psychoactive drug use. The facility failed to complete a comprehensive assessment for resident #38 related to nutrition issues with his/her weight/appetite, and behavior issues with his/her use of Ativan for anxiety and Seroquel for dementia with psychosis.	F 272		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility reported a census of 54 residents with 10 sampled for review. Based on observation, interview and record review, the facility failed to ensure that 1 of 3 residents sampled for accidents received adequate supervision and assistance to prevent accidents. (#19) Findings included:	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E003	A. BUILDING _____ B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL HOME	300 S AZTEC ST MONTEZUMA, KS 67867

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 6	F 323		

- The 1-17-12 signed physician order sheet for resident #19 had diagnoses that included general osteoarthrosis, edema, hypertension, trigeminal neuralgia, insomnia, idioperipheral neuropathy, cervical disc degeneration, constipation, depressive disorder, dysthymic disorder, diplopia, tear film insufficiency, stomach dysfunction, gastritis without/ hemorrhage, anemia, and limb pain.

The 4-11-12 Significant Change MDS (minimum data set) identified resident #19 with vision highly impaired, moderately impaired cognition, inattention, disorganized thinking, psychomotor retardation and an acute onset of mental status changes with hallucinations and delusions. The assessment revealed the resident required limited assist with bed mobility, transfers, walking in room, locomotion on unit, toileting, and unsteady balance. The resident used a walker and wheelchair for mobility and had experienced falls since the prior assessment.

The 4-11-12 CAAs (care area assessment summary) for falls had not been completed by staff.

The last fall assessment dated 1-18-12 identified resident #19 as high risk.

Review of the facility fall policy and procedure dated November 2011 identified staff would "document date and time of fall, occurrence of the fall including causes (if known), condition of the resident, complete a fall risk assessment form before end of shift and update interventions as needed after each fall."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E003	A. BUILDING _____ B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL HOME	300 S AZTEC ST MONTEZUMA, KS 67867

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 7	F 323		

Review of resident #19's nursing care plan related to falls revealed the interventions placed to prevent falls following the 4-9-12 fall had previously been implemented and the interventions placed following the 4-22-12 fall had also been previously implemented.

Observation on 5-3-12 at 7:00 a.m. showed the resident laying on his/her back in bed with eyes closed and the head of the bed elevated 30 degrees. The call light hung on the wall at the foot of the bed, not in the resident's reach, and the fall mat laid underneath the bed.

During an interview with resident #19 on 5-2-12 at 1:00 p.m., he/she reported falling two nights ago after getting his/her toe "hooked on the alarm pad....I have had several narrow escapes like that, I get dizzy when turning my head too fast or looking side to side quickly."

During an interview on 5-3-12 at 2:00 p.m. licensed nurse C reported that following a resident fall, licensed staff must assess the situation, check the interventions already in place and see if they helped prevent the occurrence and if they did not cover the fall, new ones should be applied.

During an interview on 5-2-12 at 5:10 p.m., licensed nurse C confirmed the interventions staff put into place on resident #19's care plan reflected no new attempts to help prevent future falls.

The facility failed to ensure resident #19 received adequate supervision and assistance to prevent accidents when the facility failed to thoroughly

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E003	A. BUILDING _____ B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL HOME	300 S AZTEC ST MONTEZUMA, KS 67867

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 8 evaluate each fall and implement appropriate interventions to prevent accidents.	F 323		
F 329 SS=D	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 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. This REQUIREMENT is not met as evidenced by: The facility reported a census of 54 residents and 10 sampled for unnecessary medication use. Based on observation, interview and record review, the facility failed to ensure each resident's	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E003	A. BUILDING _____ B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL HOME	300 S AZTEC ST MONTEZUMA, KS 67867

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 9	F 329		

drug regimen remained free from unnecessary drugs when the facility failed to adequately monitor for effectiveness and potential side effects for 2 of 10 residents reviewed for unnecessary medication use. (#42 for lack of monitoring for effectiveness of a stool softener and #19 for lack of monitoring for potential side effects related to low blood pressures/falls)

Findings included:

- The signed 5-2012 physician order sheet for resident #42 had diagnoses that included dementia, atrial fibrillation, hypertension, sleep apnea, chronic obstructive pulmonary disease, coronary artery disease, hyperlipidemia, pulmonary hypertension secondary to sleep apnea, anterior value replacement, benign prostatic hypertropy, osteoporosis, dry eyes, allergies and pain.

The 2-16-12 Quarterly MDS (minimum data set) showed resident #42 with severely impaired cognition, independent with all ADL's (activities of daily living) except required supervision with set up help from staff for personal hygiene and locomotion off the unit.

The 8-23-11 CAAs (Care Area Assessment summary) regarding resident #42's behaviors informed staff his/her behaviors occur provoked or unprovoked, remain inappropriate, and encourage staff to minimize harsh reactions to help them feel in control when they provide cares for him/her.

The revised 4-5-12 care plan directed staff to check resident #42 every 2 hours to offer toileting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E003	A. BUILDING _____ B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL HOME	300 S AZTEC ST MONTEZUMA, KS 67867

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 10	F 329		

and check on any other needs.

The May 2012 MAR (medication administration record) showed resident #42 received Colace (stool softener) 100 mg. (milligrams) daily.

Review of resident #42's bowel record from 4-16-12 through 4-25-12 revealed no staff documentation of bowel movements. The record indicated continent or incontinent, but did not specify if urine or bowel.

Observation of resident #42 on 5/2/12 at 2:26 p.m. showed him/her sitting in recliner in the front commons area with legs crossed with eyes closed.

During an interview on 5-2-12 at 2:45 p.m., direct care staff G reported with female assistance during toileting, the resident required 2 staff, but only required assistance of one male CNA (certified nurse aide) for cares.

During an interview on 5-7-12 at 11:19 a.m., Administrative nurse B confirmed after resident #42 returned from the hospital, staff failed to resume documentation regarding his/her bowel movements and only recorded the incontinence aspect.

The facility failed to ensure resident #42's drug regimen remained free from unnecessary medication when staff failed to adequately monitor for the effectiveness of the use of a stool softener for resident #42. The facility failed to adequately document resident #42's bowel movements for a period of 9 days.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E003	A. BUILDING _____ B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL HOME	300 S AZTEC ST MONTEZUMA, KS 67867

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 11	F 329		

- The 1-17-12 physician order sheet for resident #19 showed diagnoses that included general osteoarthrosis, edema, hypertension, trigeminal neuralgia, insomnia, idioperipheral neuropathy, cervical disc degeneration, constipation, depressive disorder, dysthymic disorder, diplopia, tear film insufficiency, stomach dysfunction, gastritis without hemorrhage, anemia and limb pain.

The 4-11-12 Significant Change Assessment identified #19 with moderately impaired cognition and disorganized thinking. The resident received a diuretic (water pill that also had a blood pressure lowering effect) daily.

The 2-22-12 updated care plan directed staff to monitor resident #19's blood pressure twice weekly.

Review of the May 2012 MAR (medication administration record) showed resident #19 received Metoprolol (a blood pressure lowering medication) XL 25 mg. (milligrams), 1/2 tab daily and Lasix (a water pill that also has a blood pressure lowering effect) 20mg. daily. The Target Value Range, located on the Vital Sign flow sheet, for blood pressures identified a low reading at 100/60 to a high reading of 160/100.

Review of the 12th Edition LexiComp GERIATRIC DOSAGE HANDBOOK directed monitoring parameters for blood pressure, including orthostatic hypotension (sudden drop in blood pressure when sitting or standing) for persons taking Metoprolol and/or Lasix.

Review of the clinical record revealed two

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E003	A. BUILDING _____ B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL HOME	300 S AZTEC ST MONTEZUMA, KS 67867

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 12	F 329		

significantly low blood pressure readings for resident #19. On 2-22-12, staff recorded a low pressure of 99/66 and on 2-29-12 another low reading of 84/55. Staff did not recheck the resident on these dates to ensure the accuracy of the reading and did not notify the physician.

Review of the November 2011 facility policy for blood pressure measurement directed staff to notify the charge nurse if the systolic number is greater than 150 or less that 100, the diastolic number is greater than 100 or less than 50, and then the charge nurse will notify the physician by fax or phone call.

Observation of resident #19 on 5-3-12 at 1:00 p.m. showed him/her sitting and talking with staff in his/her room with rambling conversation and refused a bath at this time. A fall mat laid on the floor in front of the chair with a motion sensor alarm in place.

During an interview with the resident on 5-2-12 at 10:30 a.m., he/she reported a recent fall, and reported feeling dizzy if he/she turned his/her head too fast.

During an interview on 5-7-12 at 12:30 p.m., Administrative nurse B confirmed nurse aides take routine vitals, licensed staff take vital signs for neuro-checks following falls, and confirmed the licensed staff were required to recheck significantly high or low blood pressures and stated it had been difficult to incorporate the practice.

The facility failed to ensure resident #19 remained free from unnecessary drugs by failure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E003	A. BUILDING _____ B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL HOME	300 S AZTEC ST MONTEZUMA, KS 67867

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 13 to adequately monitor for potential side effects related to significantly low blood pressure readings while receiving medications, including Metoprolol and Lasix, that had the potential to lower the blood pressure.	F 329		
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. This REQUIREMENT is not met as evidenced by: The facility reported a census of 54 residents with 10 residents sampled for unnecessary medication use. Based on observation, interview and record review, the facility failed to ensure the pharmacy consultant reported irregularities, including low blood pressure readings, to the attending physician, the director of nursing, and failed to ensure the reports were acted upon for 1 of 10 sampled residents. The resident received Metoprolol and Lasix, both of which had a potential side effect of hypotension (low blood pressure). (#19) Findings included:	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E003	A. BUILDING _____ B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL HOME	300 S AZTEC ST MONTEZUMA, KS 67867

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 14	F 428		

- The 1-17-12 physician order sheet for resident #19 showed diagnoses that included general osteoarthrosis, edema, hypertension, trigeminal neuralgia, insomnia, idioperipheral neuropathy, cervical disc degeneration, constipation, depressive disorder, dysthymic disorder, diplopia, tear film insufficiency, stomach dysfunction, gastritis without hemorrhage, anemia and limb pain.

The 4-11-12 Significant Change Assessment identified #19 with moderately impaired cognition and disorganized thinking. The resident received a diuretic (water pill that also had a blood pressure lowering effect) daily.

The 2-22-12 updated care plan directed staff to monitor resident #19's blood pressure twice weekly.

Review of the May 2012 MAR (medication administration record) showed resident #19 received Metoprolol (a blood pressure lowering medication) XL 25 mg. (milligrams), 1/2 tab daily and Lasix (a water pill) 20mg. daily. The Target Value Range for blood pressures, located on the facility Vital Sign Flow Sheet, identified a low reading of 100/60 to a high reading of 160/100.

Review of the 12th Edition LexiComp GERIATRIC DOSAGE HANDBOOK directs monitoring parameters for blood pressure, including orthostatic hypotension (sudden drop in blood pressure when sitting or standing) for persons taking Metoprolol and/or Lasix.

Pharmacy consultant notes on 3-6-12 identified

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E003	A. BUILDING _____ B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL HOME	300 S AZTEC ST MONTEZUMA, KS 67867

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 15	F 428		

resident #19 had a low blood pressure of 84/55 on 2-29-12 and directed staff to recheck blood pressures within one hour when significantly higher or lower than usual with a follow up to the physician if the recheck remained abnormal.

Review of the 4-4-12 pharmacy consultant notes failed to identify low blood pressure readings for resident #19 on 3-18-12 of 93/61, 95/55, and 91/55.

Observation of the resident on 5-3-12 at 1:00 p.m. showed him/her sitting and talking with staff in his/her room with rambling conversation and refused a bath at this time. A fall mat laid on the floor in front of the chair with a motion sensor alarm in place.

During an interview with the resident on 5-2-12 at 10:30 a.m., he/she reported a recent fall, and reported feeling dizzy if he/she turned his/her head too fast.

During an interview on 5-7-12 at 1:50 p.m., consultant staff F confirmed he/she did not review vital signs on neuro-check sheets, and did not note the low blood pressures on resident #19 on 2-22-12 or 3-8-12.

The facility failed to ensure the pharmacist reported irregularities, including significantly low blood pressure readings for resident #42, to the attending physician and the director of nursing and that these reports were acted upon.