STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515151	A. BUILDING _____ B. WING _____	04/23/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANT REHABILITATION AND CARE CENTER	127 EARLY AVENUE Petersburg, WV 26847

(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 151 SS=B	483.10(a)(1)&(2) EXERCISE OF RIGHTS 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. Based on random observation and facility staff interview, it was determined that the facility failed to assure that fifty-six (56) of one hundred nine (109) facility residents were informed and gave permission for nurse aide students to provide nursing related services. Resident identifier #s: 1, 2, 3, 5, 7, 10, 11, 17, 18, 20, 21, 23, 26, 27, 29, 31, 32, 36, 37, 38, 40, 41, 43, 44, 45, 47, 48, 49, 52, 56, 58, 60, 66, 67, 68, 69, 72, 73, 74, 75, 76, 79, 80, 81, 83, 84, 86, 87, 90, 91, 92, 94, 98, 100, 101, and 107. Findings include: a) During random observations of the facility on 04/22/04 at 1:45 p.m., a group of females in blue uniforms were present in the resident hallway. When inquiry was made, members of the group identified themselves as nursing assistant students. The instructor for the students was interviewed at 2:20 p.m. on 04/22/04, and was unable to provide information as to how permission was obtained from residents and legal representatives for the students to provide resident care. An interview with the administrator, on 04/22/04	F 151		06/04/04

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 05/14/2004

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515151	A. BUILDING _____ B. WING _____	04/23/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANT REHABILITATION AND CARE CENTER	127 EARLY AVENUE Petersburg, WV 26847

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	at 2:30 p.m., revealed that the facility had not assured that facility had informed the above residents/legal representatives that certified nursing assistants would be providing care, nor was permission obtained for the students to render care. The administrator provided the list of the residents identified as not being informed nor providing permission for care to be provided by the students.			
F 157 SS=D	483.10(b)(11) NOTIFICATION OF RIGHTS AND SERVICES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in s483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in s483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157	PLEASE SUBMIT CREDIBLE EVIDENCE IN ADDITION TO AN ACCEPTABLE PLAN OF CORRECTION FOR THIS CITATION.	05/25/04

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515151	A. BUILDING _____ B. WING _____	04/23/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANT REHABILITATION AND CARE CENTER	127 EARLY AVENUE Petersburg, WV 26847

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The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

Based on record review, observation, and staff interview, the facility failed to notify the attending physician of resident's incidents and accidents that had the potential for requiring physician intervention. The facility also failed to notify the physician of a significant change in a resident's behavior. This was found with one (1) of twenty-two (22) residents sampled. Resident identifier: #108.

Findings include:

a) Resident #108

1. Review of Resident #108's medical record, on 04/24/04, revealed five (5) incident reports (dated 04/01/04, 04/07/04, 04/08/04, 04/12/04, and 04/21/04). Each report contained the question "Was attending physician notified?" On each report, the response box was checked "no".

Per the incident reported dated 04/07/04, the resident hit his/her head on the wheelchair, and a reddened area was noted on back. Per the incident report dated 04/12/04, the resident received "a small reddened area on back". Per the incident report dated 04/21/04, the resident received "a skin tear 1 cm by 1 cm on left arm surrounded with bruise 5.5 cm by 1.5 cm." In review of nursing notes corresponding to the dates of the incident reports (on dated 04/01/04, 04/07/04, 04/08/04, 04/12/04, and 04/21/04), no documentation was found that the physician was notified.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515151	A. BUILDING _____ B. WING _____	04/23/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANT REHABILITATION AND CARE CENTER	127 EARLY AVENUE Petersburg, WV 26847

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	The director of nursing was interviewed on 04/24/04, and she was not able to demonstrate that resident's physician was notified. 2. Further review of Resident #108's medical record revealed a physician's history and physical and progress notes written on 04/07/04. Following this visit, no documentation could be found notifying physician about subsequent changes in the resident's behaviors. In review of nurses notes dated 04/08/04, "resident very restless and striking out at staff." Notes dated 04/10/04 stated, "very physical and abusive." Notes dated 04/12/04 stated, "verbal and physical abusive to staff." Notes dated 04/16/04 stated, "resident not cooperative with staff very abusive-physical and verbally." Notes dated 04/21/04 stated, "combative hitting, kicking, yelling" and "combative, delusional thinking paranoid hitting-physical and verbally abusive." No documentation was found to reflect that the attending physician was notified of these events.			
F 225 SS=E	483.13(c)(1)(ii) STAFF TREATMENT OF RESIDENTS 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	F 225	PLEASE SUBMIT CREDIBLE EVIDENCE IN ADDITION TO AN ACCEPTABLE PLAN OF CORRECTION FOR THIS CITATION.	05/27/04

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515151	A. BUILDING _____ B. WING _____	04/23/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANT REHABILITATION AND CARE CENTER	127 EARLY AVENUE Petersburg, WV 26847

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or licensing authorities.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

Based on medical record review, review of facility abuse reporting records, and staff interview, it was determined that the facility failed to ensure that allegations of abuse, for one (1) of twenty-two (22) sampled residents, were reported immediately to the facility administrator, protection provided to the resident, and the allegation thoroughly investigated and reported to state agencies as required by state law, because the resident's cognitive status was in question. This practice has the potential to affect all residents on 100 hall. Resident identifier: #12.

Findings include:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515151	A. BUILDING _____ B. WING _____	04/23/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANT REHABILITATION AND CARE CENTER	127 EARLY AVENUE Petersburg, WV 26847

(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

a) Resident #12

Medical record review revealed a nursing note, on 03/11/04 at 8:00 a.m., recording that the resident's physician called the nursing home to report that the resident's family had called him, indicating that the resident had told her family the facility staff had been mean to her. The nursing note further indicated that this resident had alleged that staff had twisted her arm, causing pain.

During a review of facility abuse investigations, a report of this incident could not be found.

During an interview with the facility social worker at 10:30 a.m. on 04/22/04, it was revealed that this incident had not been reported to her. It was also revealed during this interview that she had recently discovered another allegation of abuse, when reviewing nursing notes on another resident, that had not been reported and investigated.

During an interview with the director of nursing at 11:00 a.m. on 04/22/04, it was revealed that she was aware of this incident, but it had not been reported and investigated due to the resident's cognitive status.

The director of nursing also stated that this resident, and others who reside on the 100 hall, make frequent allegations of abuse, but the allegations made by these residents were not investigated due to their cognitive status. She also indicated it would take too many staff hours to report and complete the paper work.

During an interview with the facility administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515151	A. BUILDING _____ B. WING _____	04/23/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANT REHABILITATION AND CARE CENTER	127 EARLY AVENUE Petersburg, WV 26847

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	at 10:50 a.m. on 04/23/04, it was revealed that this allegation of abuse had not been reported to him immediately and investigated as required.			
F 241 SS=D	483.15(a) QUALITY OF LIFE The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on random observation, facility staff interview, and medical record review, it was determined that the facility failed to assure that one (1) of twenty-two (22) sampled residents was provided care in a manner which enhanced that resident's dignity and respect. A member of the nursing staff was overheard to state to Resident #67 that she couldn't have anything to drink. Facility census 109. Findings include: a) During random observation of the facility on 04/21/04 at 9:00 a.m., a resident was overheard to tell a member of the nursing staff, "I want a drink. I want something to drink." It was noted that the staff member was transporting the resident via a wheelchair from the main dining room. The staff member was heard to state to the resident, "You can't have anything else to drink. You can have a drink when you get your pills." The staff member was observed to transport the resident to a resident room and return to the hallway. The staff member was asked why she had refused to allow the resident something to drink. The staff member stated that the resident	F 241	PLEASE SUBMIT CREDIBLE EVIDENCE IN ADDITION TO AN ACCEPTABLE PLAN OF CORRECTION FOR THIS CITATION.	05/25/04

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515151	A. BUILDING _____ B. WING _____	04/23/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANT REHABILITATION AND CARE CENTER	127 EARLY AVENUE Petersburg, WV 26847

(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
	was on fluid restrictions. A review of the medical record found a physician's order to monitor the resident's fluid intake each shift. The record contained no instructions for staff members to limit the amount of fluids consumed by the resident. The director of nursing (DON) agreed, during an interview conducted on 04/21/04 at 10:15 a.m., that the staff member's response to the resident's request was inappropriate.			
F 279 SS=E	483.20(k) RESIDENT ASSESSMENT The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following: 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 s483.25; and Any services that would otherwise be required under s483.25 but are not provided due to the resident's exercise of rights under s483.10, including the right to refuse treatment under s483.10(b)(4). d) Resident #34 Record review revealed the facility failed to develop a comprehensive care plan to maintain the resident's highest practicable physical,	F 279	PLEASE SUBMIT CREDIBLE EVIDENCE IN ADDITION TO AN ACCEPTABLE PLAN OF CORRECTION FOR THIS CITATION.	06/11/04

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515151	A. BUILDING _____ B. WING _____	04/23/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANT REHABILITATION AND CARE CENTER	127 EARLY AVENUE Petersburg, WV 26847

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mental and psychological well-being. Doctors orders were written on 11/03/03, for oxycodone one (1) tablet every four (4) hours as needed for pain. On 03/30/04, Duragesic was discontinued due to pruritus. On 04/06/04, the resident stated to physician, "I need my pain patch back," and the doctor ordered Duragesic 25 mcg topically changed every seventy-two (72) hours. Following this order was a additional order for Ultram 50 mg TID (three times a day) PRN (as needed). During this time period, the resident's care plan was not updated to address the resident's problem of pain.
b) Resident #81

Review of the 04/13/04 minimum data set assessment (MDS) found that the facility had assessed the resident as requiring total assistance with bed mobility.

A review of the current care plan found that staff were instructed to turn/reposition the resident every two (2) to three (3) hours.

Review of literature from the National Pressure Ulcer Advisory Panel (NPUAP) found that, "...two hours in a single position is the maximum duration of time recommended for patients with normal circulatory capacity.

The facility failed to develop and implement a care plan to meet this resident's nursing needs in accordance with accepted standards of practice.
c) Resident #49

During the medical record review and observations on 04/21/04, it was discovered that this resident was totally dependent on staff for all activities of daily living.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515151	A. BUILDING _____ B. WING _____	04/23/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANT REHABILITATION AND CARE CENTER	127 EARLY AVENUE Petersburg, WV 26847

(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

It was also discovered, during the medical record review, that this resident had a history of pressure ulcers on both heels.

During a review of comprehensive care plan, dated 01/22/03, it was revealed that the resident was to be turned and repositioned by staff every two (2) to three (3) hours.
Based on observation, record review and staff interview, it was determined that the facility failed to develop care plans for three (3) of twenty-two (22) sampled residents (Residents #39, #81, #49), to specifically describe the care and services to be provided to attain and maintain each resident's physical, mental, and psychosocial well-being. The facility also failed to update the care plan of Resident #34, when the resident had a significant change in condition. Facility Census 109.

Findings include:

a) Resident #39

During the review of Resident #39's medical record on 04/21/04, a doctor's order, dated 12/04/02, stated "No CPR (cardiopulmonary resuscitation) - Full Code Otherwise." A second document, signed and notarized, was found in the record, titled Option II - Coding (CPR for Resident) also stated, "No CPR but full code otherwise."

Interviews were conducted on the morning of 04/23/04, with the assistant director of nurses (ADON) and the director of nurses (DON), regarding the exact meaning of the order. Two (2) other nurses, chosen randomly the same morning, were asked what they would do for Resident #39, in the case he would stop

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515151	A. BUILDING _____ B. WING _____	04/23/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANT REHABILITATION AND CARE CENTER	127 EARLY AVENUE Petersburg, WV 26847

(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
	breathing. The four (4) nurses described four (4) different procedures they would carry out as a result of this order. Further discussion with the staff revealed the order was interpreted to mean different things by each of them. Review of the resident's current care plan, dated 02/11/04 through 05/11/04, revealed the resident's code status was not addressed. No evidence was found that explained the exact meaning of the resident's code status. According to the medical record, the resident lacked capacity to make his own decisions regarding his medical care, and a health care surrogate was appointed by the physician on 09/30/02.			
F 281 SS=E	483.20(k)(3)(i) RESIDENT ASSESSMENT The services provided or arranged by the facility must meet professional standards of quality. Based on record review and staff interview, the facility failed, for four (4) of twenty-two (22) sampled residents, to have clear and complete physician orders, which could lead to the potential of over-medication, and/or lack of quality care (#93, #39, #54, and #107; facility failed to follow its own pain management protocol for two (2) sampled residents (#93 and #34); and failed to follow physician orders for two (2) sampled residents (#54 and #98). Facility census 109. Findings include: a) Resident #93 1. In record review of Resident #93's physician orders, the following orders were noted: Atarax	F 281	PLEASE SUBMIT CREDIBLE EVIDENCE IN ADDITION TO AN ACCEPTABLE PLAN OF CORRECTION FOR THIS CITATION.	06/11/04

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515151	A. BUILDING _____ B. WING _____	04/23/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

10 mg po (by mouth) q hs (at bedtime); Atarax 10 mg po TID (three times a day) PRN (as needed); Ativan 1 mg po q hs, and Ativan 1 mg po TID PRN. Both Atarax and Ativan ordered to be given at bedtime were scheduled to be administered at 2100 (9:00 p.m.) by default. The Atarax and Ativan ordered as needed could be administered at any time of day. The orders did not specify the minimum amount of time that must lapse before administering the next does, nor did the orders specify the maximum dosage Ativan or Atarax that could be safely administered within a twenty-four (24) hour period; this could lead to over-medication.

2. In record review of Resident #93, and review of facility's pain protocol, the facility failed to follow own policy with respect to adequate pain assessment, documentation, and monitoring of effectiveness of the pain medications when given. A complete assessment was not documented during episodes of pain. Nursing notes did not address assessment or evaluation. The resident's forms for pain assessment and monitoring were not completed or updated.

b) Resident #34

In record review of Resident #34, and review of facility's pain protocol, the facility failed to follow own policy with respect to adequate pain assessment, documentation, and monitoring of effectiveness of the pain medications when given. A complete assessment was not documented during episodes of pain. Nursing notes did not address assessment or evaluation. The resident's forms for pain assessment and monitoring were not completed or updated.
d) Resident #54

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515151	A. BUILDING _____ B. WING _____	04/23/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANT REHABILITATION AND CARE CENTER	127 EARLY AVENUE Petersburg, WV 26847

(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

1. During random observations of the medication administration pass on 04/21/04 at 8:40 a.m., it was noted that Resident #54's medication administration record (MAR) contained an order, dated 04/07/04, for Lasix 20 mg each day as needed for increased edema. The order contained no parameters or instructions as to what constituted "increased edema".

Review of the medical record found that nursing staff administered the Lasix 20 mg on 04/14/04. The medical record contained no information as to the circumstances present which necessitated the administration of the Lasix.

There was no evidence that the nursing staff member contacted the physician for clarification of the order prior to administering the Lasix 20 mg.

2. During random observations of the medication pass on 04/21/04 at 8:40 a.m., a member of the nursing staff was noted to prepare morning medications for Resident #54. The staff member removed a 160 mg tablet of Inderal from the medication cart and compared the medication with the existing order. The physician's order present on the medication administration record (MAR) specified Inderal 60 mg. The staff member stated that the MAR was wrong and gave the resident the 160 mg tablet of Inderal without verifying the order with the resident's medical record.

A review of the medical record at 9:00 a.m. found that the resident's medical record contained a 01/29/04 physician's order for Inderal 60 mg.

An interview with the director of nursing (DON), the assistant director of nursing (ADON), and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515151	A. BUILDING _____ B. WING _____	04/23/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANT REHABILITATION AND CARE CENTER	127 EARLY AVENUE Petersburg, WV 26847

(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

registered nurse supervisor was conducted at 10:10 a.m. on 04/21/04. The interview revealed that the resident had been receiving the wrong dose of Inderal on a daily basis as of 03/29/04.

There was no indication from review of the resident's blood pressure records for this time period that the resident sustained harm from these medication errors.

e) Resident #98

A review of the resident's medical record, on the afternoon of 04/21/04, noted a 04/20/04 physician's order which specified that the resident was to receive nectar thickened liquids with all meals, medications, and supplements.

Random observations of the morning meal, on 04/22/04 at 8:45 a.m., noted that staff members were providing liquids to the resident which had not been thickened to a nectar consistency. When the staff member was asked if the resident was ordered thickened liquids, she indicated that the resident's tray card did not specify thickened liquids.

An interview with a member of dietary management, on 04/22/04 at 9:10 a.m., revealed that the dietary department had "missed" placing instructions on the tray card for the meal that morning

f) Resident #107

Review of the medical record, on 04/21/04, found a 12/23/02 physician's order to irrigate both ears each month. Further review found that nursing staff members were instilling Debrox into the resident's ears and irrigating them each month.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515151	A. BUILDING _____ B. WING _____	04/23/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANT REHABILITATION AND CARE CENTER	127 EARLY AVENUE Petersburg, WV 26847

(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
	The physician's order was brought to the attention of the DON at 3:30 p.m. on 04/21/04. The DON stated that the physician's order was incomplete. The facility could provide no evidence that nursing staff members had contacted the physician to clarify the order prior to performing the irrigation. c) Resident #39 During the review of Resident #39's medical record on 04/21/04, a doctor's order, dated 12/04/02, stated, "No CPR - Full Code Otherwise." Interviews were conducted, on the morning of 04/23/04, with the assistant director of nurses (ADON) and the director of nurses (DON) regarding the exact meaning of the order. Two (2) other nurses, chosen randomly the same morning, were asked what they would do for Resident #39, in the case he would stop breathing. The four (4) nurses described four (4)different procedures they would carry out as a result of this order. Further discussion with the staff revealed the order was interpreted to mean different things to each of them.			
F 322 SS=D	483.25(g)(2) QUALITY OF CARE Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.	F 322	PLEASE SUBMIT CREDIBLE EVIDENCE IN ADDITION TO AN ACCEPTABLE PLAN OF CORRECTION FOR THIS CITATION.	06/11/04

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	515151	A. BUILDING _____ B. WING _____	04/23/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANT REHABILITATION AND CARE CENTER	127 EARLY AVENUE Petersburg, WV 26847

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Based on random observation, medical record review, and facility staff interview, it was determined that the facility failed to assure that the facility was free of medication error rates of five percent (5%) or greater. It was determined that five (5) medication errors occurred with forty-five (45) opportunities for error. The medication error rate was determined to be 11.1 percent (11.1%). This deficient practice directly affected two (2) sampled residents (#54 and #108). Facility census 109.

Findings include:

a) Resident #54

A nursing staff member was observed to administer Inderal 160 mg to Resident #54 at 8:35 a.m. Review of the medication administration record (MAR) and the medical record found that the physician had ordered the resident to receive 60 mg of Inderal.

At 8:40 a.m., the nursing staff member was observed to prepare a 30 cc dose of Milk of Magnesia (MOM). A review of the physician's order present on the MAR noted that staff were to hold the MOM if the resident had more than two (2) bowel movements.

When the nurse handed the medication cup of MOM, the resident stated, "Can't they cut this stuff in half? I went four times yesterday." The nurse stated that the physician wanted her to have the MOM. The resident took the MOM.

The nurse was asked why she had not held the MOM in accordance with physician's orders. The nurse stated that she only held the MOM if the resident had diarrhea.

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	515151	A. BUILDING _____ B. WING _____	04/23/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANT REHABILITATION AND CARE CENTER	127 EARLY AVENUE Petersburg, WV 26847

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	b) Resident #108 A random observation of the medication administration pass was conducted at 9:45 a.m. on 04/21/04. A member of the nursing staff was observed to administer 1000 mg of Depakote Sprinkles, 20 mg of Prozac, and 25 mg of HCTZ. A review of the medical record found that the above medications were scheduled to be given to the resident at 8:00 a.m. daily. The medication was administered one (1) hour and forty-five (45) minutes after the scheduled time. The director of nursing (DON) stated, during an interview conducted on 04/21/04 at 10:00 a.m., that the staff member did not administer the medications in accordance with the guidelines.			
F 329 SS=E	483.25(l)(1) QUALITY OF CARE 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. f) Resident #93 In record review of Resident #93, there was a lack of documentation to reflect that the facility had adequately monitored the resident with respect to the use of the following medications:	F 329	PLEASE SUBMIT CREDIBLE EVIDENCE IN ADDITION TO AN ACCEPTABLE PLAN OF CORRECTION FOR THIS CITATION.	06/11/04

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515151	A. BUILDING _____ B. WING _____	04/23/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANT REHABILITATION AND CARE CENTER	127 EARLY AVENUE Petersburg, WV 26847

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- Ultram 50 mg po (by mouth) q hs (at bedtime) and Ultram 50 mg po q 4 hours PRN (every 4 hours as needed).

- Ativan 1 mg po q hs and Ativan 1 mg po TID PRN (every 3 hours as needed).

- Atarax 10 mg po q hs and Atarax 10 mg po TID PRN.

The resident was ordered to receive each medication routinely at bedtime, as well as several times a day as needed. Each of the above medications, if used each time in the above dosage and frequency, have the potential to sedate or over-medicate the resident. The above medications, when used in combination, also have the potential to sedate or over-medicate resident.

Evidence of the resident's response, with respect to the improvement or maintenance the resident's functional status, was not documented.
e) Resident #67

A review of the medical record found a 2/05/04 physician's order for the antipsychotic medication Seroquel 50 mg, to be administered twice-a-day (bid). Further review noted that the resident was receiving this antipsychotic medication for yelling out and repetitive verbalizations.

The medical record contained a lack of information concerning how the resident's "yelling out" and "repetitive verbalizations" were negatively impacting her quality of life. Additionally, the medical record contained no statements or assessments as to how the administration of this antipsychotic assisted the

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	515151	A. BUILDING _____ B. WING _____	04/23/2004

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GRANT REHABILITATION AND CARE CENTER	127 EARLY AVENUE Petersburg, WV 26847

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resident in reaching her highest level of physician and mental functioning.

There was a lack of evidence that adequate indications for the use of Seroquel were present for this resident.
Based on medical record review, observation, and staff interview, it was determined that the facility failed to ensure that the drug regimens of six (6) of twenty-two (22) sampled residents were free from unnecessary drugs. Antianxiety and antipsychotic drugs were being used without an appropriate diagnosis for use, for excessive duration, without adequate indications for use, and with the potential for excessive dosage. Resident identifiers: Residents #10, #49, #24, #3, #67, and #93. Facility census 109.

Findings include:

a) Resident #10

During the medical record review, it was discovered that this resident was receiving the antipsychotic drug Zyprexa 2.5 mg every HS (hour of sleep) for dementia with behaviors since 02/04/03.

Further review of the medical record revealed that she was also receiving Ativan 0.5 mg three (3) times a day for anxiety since 04/17/01.

During a review of behavior monitoring records, it was discovered that the behaviors being monitored for the use of Zyprexa was excessive cursing and for the use of Ativan was yelling.

During a review of physician orders, progress notes, and pharmacy documentation, it was discovered that gradual dosage reductions had

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	515151	A. BUILDING _____ B. WING _____	04/23/2004

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GRANT REHABILITATION AND CARE CENTER	127 EARLY AVENUE Petersburg, WV 26847

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not been attempted as required.

During observations of this resident on 04/21/04 at 8:00 a.m., it was observed that the resident was sleeping, and staff could not arouse her for breakfast.

On 04/21/04 at 9:30 a.m., the resident was again observed to be sleeping soundly in the 100 wing activity room.

During an interview with the director of nursing at 11:00 a.m. on 04/22/04, it was verified that the gradual dose reductions for the Zyprexa and Ativan had not been attempted.

b) Resident #49

During the medical record review, it was discovered that this resident had been receiving Ativan 0.5 mg every HS since 07/99 for anxiety.

Further review of the medical record revealed that a gradual dose reduction had not been attempted in an effort to discontinue the Ativan.

During a review of the physician's progress notes, it was discovered that, on 09/16/03, the physician indicated that he planned to continue the Ativan at the family's request.

During observations of this resident on 04/21/04, it was observed that the resident is alert but non-responsive.

During interviews with the nursing staff that take daily care of the resident, on 04/21/04 at 4:20 p.m., it was revealed that the resident is totally dependent on staff for all activities of daily living. It was also revealed that the resident would open

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	515151	A. BUILDING _____ B. WING _____	04/23/2004

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GRANT REHABILITATION AND CARE CENTER	127 EARLY AVENUE Petersburg, WV 26847

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her eyes but did not respond verbally to staff or family.

During a review of behavior monitoring records for the months of November and December 2003, and January through March 2004, it was discovered that no episodes of anxious "behaviors" had been documented.

During an interview with the director of nursing at 4:30 p.m. on 04/21/04, it was verified that gradual dose reductions had not been attempted.

c) Resident #24

During the medical record review, it was discovered that this resident was receiving Xanax 1 mg every day for anxiety since 04/29/03, and Ambien 5 mg at HS for sleep since 05/27/03.

Further review of the medical record revealed that gradual dose reductions had not been attempted, in an effort to decrease the dose, or discontinue the drugs.

During observations of this resident from 04/20/04 to 04/22/04, it was observed that the resident was dressed appropriately, ate in the dining area of 100 hall, attended activities, and was social with visitors, staff, and other residents.

During an interview with the director of nursing at 2:30 p.m. on 04/22/04, it was verified that the gradual dose reductions had not been attempted.

d) Resident #3

During the medical record review, it was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515151	A. BUILDING _____ B. WING _____	04/23/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANT REHABILITATION AND CARE CENTER	127 EARLY AVENUE Petersburg, WV 26847

(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
	discovered that this resident had been receiving the antipsychotic drug Zyprexa 5 mg every day since 12/24/02, for anxiety, restlessness, and striking out. Further review of the medical record revealed that no gradual dose reductions had been attempted, in an effort to reduce the dose or discontinue the drug. During an observation of this resident on 04/21/04 at 8:30 a.m., it was observed that the resident was sleeping soundly in a wheelchair in the dining room. It was also observed that staff were unable to arouse the resident to eat breakfast and put her back to bed. During an interview with the director of nursing at 2:00 p.m. on 04/21/04, it was verified that no dose reductions had been attempted.			