

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

September 11, 2012

Mr. Dane Rank, Administrator
Thompson House Nursing Home
80 Maple Street
Brattleboro, VT 05302

Dear Mr. Rank:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **August 8, 2012**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,



Pamela M. Cota, RN
Licensing Chief

PC:jl



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

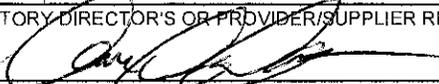
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Division of
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PRINTED: 08/22/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475050	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	Licensing and Protection	(X3) DATE SURVEY COMPLETED 08/08/2012
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NAME OF PROVIDER OR SUPPLIER THOMPSON HOUSE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 80 MAPLE STREET BRATTLEBORO, VT 05302
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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
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F 000	INITIAL COMMENTS	F 000		
F 279 SS=D	<p>An unannounced on-site recertification survey was conducted by the Division of Licensing and Protection between 08/06/2012 and 08/08/2012. The following regulatory deficiencies were identified:</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>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.</p> <p>The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to develop a plan of care for the use of an anti-anxiety medication for one Resident (#35). This affected one (#35) of 10 records reviewed for unnecessary medication use in the stage 2</p>	F 279	<p>F 279</p> <p>Resident #35's care plan was updated to monitor and address the indications for the use of lorazepam.</p> <p>All resident care plans were reviewed to ensure that all identified needs are addressed.</p> <p>Policies regarding care planning were reviewed and updated as necessary.</p> <p>DNS/SDC provided education to staff involved in care planning.</p> <p>DNS or designee will perform audits of 5 resident care plans per quarter to ensure that all identified needs are addressed</p> <p>Results will be reported at QA meetings. DNS to monitor for compliance.</p> <p><i>F279 POC accepted 9/11/12 G Coleman Pmc</i></p>	<p>8/9/12</p> <p>9/6/12</p> <p>8/31/12</p> <p>9/6/12</p> <p>Ongoing</p> <p>Ongoing</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 9/14/12
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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.

pmc

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F 279	<p>Continued From page 1 sample. Findings include:</p> <p>Per review of the clinical record, Resident #35 was admitted 03/29/10 with a diagnoses of vertebrobasilar cerebrovascular accident (stroke), basilar artery thrombosis, depression, anxiety, cognitive stimulation with Ritalin, chronic pain, and chronic muscle spasms. A plan of care for potential for adverse side effects related to the use of psychotropic medication was dated 04/15/10 and the target date was updated quarterly. A handwritten notation on the plan of care indicated that on 12/09, Resident #35 was taking Zoloft 150 milligrams daily and lorazepam (Ativan - an anti-anxiety medication) as needed (no dose indicated). The plan of care directs staff to monitor for side effects of orthostatic hypotension, increased confusion, decline in function, gait disturbances, restlessness, lethargy and movement disorders, to monitor for signs of dystonia (rigid, unnatural posture of the neck or trunk), akinesia (decrease in spontaneous movement), and tardive dyskinesia (tongue thrusting, movement of lips, chewing, puckering movements), to monitor for signs of constipation, urinary retention, dry mouth, hallucinations/delusions, to document behaviors and side effects on the monitoring sheet, to monitor for the effectiveness of the medication, taper drug as indicated, to monitor laboratory results and to report changes to the medical doctor.</p> <p>The plan of care does not indicate what symptoms are being addressed with the use of lorazepam. A plan of care was noted for pain related to stroke, contractures and muscle spasms, dated 04/15/10. It does not indicate if</p>	F 279		

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F 279	Continued From page 2 Resident #35 displays any behaviors related to pain. No plan of care was located that indicated Resident #35 displayed any behaviors, and no non-pharmacological interventions were identified that staff should attempt prior to medicating Resident #35 with anti-anxiety medication. Interview of the Registered Nurse (RN) charge nurse on 08/08/12 at approximately 10:00 A.M. revealed that s/he often worked the evening and night shifts and frequently administered the pain medication and anti-anxiety medication together related to pain. When queried regarding behaviors, the RN stated that Resident #35 cries for long periods and had a recent history of severe dental issues. The RN stated that Resident #35 was having teeth extracted one at a time over a period of a few months. The RN verified that the plan of care does not indicate the resident cries, does not address dental pain, provides no guidance to nursing staff related to when to administer as needed pain medication or when to give as needed anti-anxiety medication, and does not provide any insight to any non-pharmacological interventions that may alleviate the crying or the dental pain. The RN indicated the Resident had difficulty communicating needs at times and stated, "if [s/he] is crying and can't indicate pain, I give both medications. It calms [him/her] down". Interview of the Director of Nursing (DNS) at 3:30 P.M. on 08/08/12 verified that Resident #35 displays periods of crying and no plan of care was developed for behaviors, crying or dental pain.	F 279			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged	F 280			

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F 280	<p>Continued From page 3</p> <p>incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to revise the plan of care for two Residents (#35 and #42) to reflect current symptoms related to dental pain and anxiety/behaviors. This affected two (#35 and #42) of 24 stage 2 sampled residents. Findings include:</p> <p>1. Per review of the clinical record, Resident #35 was admitted 03/29/10 with diagnoses of vertebrobasilar cerebrovascular accident (stroke), basilar artery thrombosis, depression, contractures to both feet, anxiety, cognitive stimulation with Ritalin, chronic pain, and chronic muscle spasms. Review of the nurses notes for</p>	F 280	<p>F 280</p> <p>Resident #35's care plan was updated to include dental pain.</p> <p>Resident #42's care plan was updated to include agitation/ anxiety related to transfers.</p> <p>All resident care plans were reviewed to ensure resident specific issues are included.</p> <p>Policies regarding care planning were reviewed and updated as necessary.</p> <p>DNS/SDC provided education to staff involved in care planning.</p> <p>DNS or designee will perform audits of 5 resident care plans per quarter to ensure that all identified needs are addressed</p> <p>Results will be reported at QA meetings. DNS to monitor for compliance.</p> <p><i>F300 POC accepted 9/11/12 Gedemann/ Pmc</i></p>	<p>8/9/12</p> <p>8/9/12</p> <p>9/6/12</p> <p>8/31/12</p> <p>9/6/12</p> <p>Ongoing</p> <p>Ongoing</p>

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F 280	<p>Continued From page 4</p> <p>03/18/12 through 08/07/12 revealed that Resident #35 had frequent episodes of crying that staff frequently attribute to dental pain. A plan of care was noted for pain related to stroke, contractures and muscle spasms, dated 04/15/10. It did not indicate if Resident #35 displays any behaviors related to pain. No plan of care was located that indicated Resident #35 displayed any behaviors or symptoms of dental pain or discomfort.</p> <p>Interview of the Registered Nurse (RN) charge nurse on 08/08/12 at approximately 10:00 A.M. revealed that s/he often worked the evening and night shifts and frequently administered the pain medication and anti anxiety medication together related to pain. The RN stated that Resident #35 cries for long periods and had a recent history of severe dental issues. The RN stated that Resident #35 was having teeth extracted one at a time over a period of a few months. The RN verified that the plan of care does not address dental pain and provides no guidance to nursing staff related to when to administer as needed pain medication or when to give as needed anti anxiety medication, and does not provide any alternative non-pharmacological interventions that may alleviate the pain and crying. The RN indicated the Resident had difficulty communicating needs at times and stated, "if [s/he] is crying and can't indicate pain, I give both medications together. It calms [him/her] down".</p> <p>Interview of the Director of Nursing (DNS) at 3:30 P.M. on 08/08/12 verified the plan of care does not indicate Resident #35 suffers from dental pain or is having tooth extractions completed over a period of time and does not indicate what interventions may alleviate the dental pain.</p>	F 280			

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F 280	<p>Continued From page 5</p> <p>2. Review of the record for Resident #42 revealed an admission date of 12/19/11 and diagnoses of osteoarthritis, anxiety/restlessness, dementia, major depressive disorder, and Parkinson's disease. The annual Minimum Data Set assessment (MDS) dated 7/19/12 indicates moderately impaired decision making skills and impaired short and long term memory. Physical and verbal behaviors directed towards others were documented. Resident #42 requires extensive assistance with all activities of daily living including extensive assistance of two staff to transfer using a mechanical lift. Review of the nurses notes revealed one page for 5/24/12 through 08/07/12. On 05/20/12 the notes indicate the Resident was "a bit uptight during the day". On 06/20/12 the Resident became "agitated", yelling and calling out.</p> <p>Review of a behavior/intervention monthly flow record for July 2012 and August 2012 indicated the staff tracked episodes of biting and none were recorded during those 38 days. Review of the plan of care revealed a page titled potential for adverse side effects r/t psychotropic drug use. The page indicated the Resident receives Zoloft (an antidepressant) 25 milligrams daily. It does not indicate the Resident uses an anti-anxiety medication. Interventions include reassure as needed and reapproach if refusing care, meds or meals or is combative. An entry dated 01/13 indicates calling out "come, come, now, come" may mean the Resident needs to be toileted, offer toileting. There is no mention in any of the plan of care of biting, or agitation caused by transfers or the use of a mechanical lift.</p>	F 280		

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F 280	<p>Continued From page 6</p> <p>Just before and after dining observations of the noon meal on 08/06/12 in the main dining room, Resident #42 frequently stopped staff, other residents and visitors, stating come on now, come on and reaching for their hands. The resident was unable to state what was needed and was directed back to the table several times. During observations on 8/7/12 at 3:45 P.M., screaming was noted to be coming from Resident #42's room. During interview, after exiting the room, the Licensed Nursing Assistant (LNA) indicated that Resident #42 had just been transferred using a stand up lift and the Resident does not like the lift or to be transferred and is often resistant to care in the late afternoons. During interview of the second LNA, near the Resident to allow supervision, the Resident was observed to clench and shake his/her fists and mumble. The resident calmed after a few minutes.</p> <p>During interview of the Director of Nursing Services (DNS), responsible for care planning, on 08/07/12 at approximately 4:30 P.M., s/he stated that a few behaviors and issues are addressed on the potential for adverse side effects related to psychotropic medication use plan of care. The DNS verified that the plan of care does not address any issues with using the mechanical lift and the lingering frustration displayed after transfers, or wheeling her/him self out of the dining room at meal time.</p>	F 280		
F 281 SS=E	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p>	F 281		

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F 281	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, record reviews and staff interviews, the facility failed to provide services that met professional standards of care for 2 of 24 residents in the sample (Residents #2 & #20) Findings include: 1. Per review of the medical record for Resident #20 on 8/8/12, he/she was admitted to the facility on 6/6/11 with diagnoses that included history of reoccurring pressure areas on the left foot and ankle. Per review of the nurses notes dated 6/25/12, Resident #20 had an open area to the left ankle. Per review of the physicians orders dated 6/25/12, the primary physician wrote an order that indicated that a wound treatment was to be done to the left ankle. The order indicated to apply Mepilex AG (a type of wound treatment) covered with Allevyn (a type of bandaging) every three days and as needed. Per direct observation on 8/8/12 at 1:14 PM, the primary nurse for Resident #20 removed the dressing that was on the left ankle of Resident #20. The nurse indicated that he/she would need to leave the room after removing the dressing because the nurse verbalized that under the dressing there was a piece of AG (a type of wound dressing) which he/she had not brought into the room and must go get it. The nurse returned to the room and verbalized that he/she had checked the order in the Treatment Record and the order indicated that the wound was to be covered with Mepilex only. The primary nurse	F 281	F 281 Resident #20's MD order was transcribed properly to the treatment record. The outdated insulin vial was discarded, and all insulin vials checked for expiration dates. All resident care plans were reviewed to ensure MD orders are included and accurate. Policies regarding care planning, order transcription and medication storage were reviewed and updated as necessary. DNS/SDC provided education to staff involved in care planning, order transcription and medication storage DNS or designee will perform audits of 5 resident records per quarter to ensure that all identified needs are addressed, and orders are properly transcribed. Results will be reported at QA meetings. DNS to monitor for compliance. <i>F281 POC accepted 9/7/12 G Coleman/PMC</i>	8/8/12 8/6/12 9/6/12 8/31/12 9/6/12 Ongoing Ongoing

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F 281	<p>Continued From page 8 completed the dressing change.</p> <p>Per interview with the primary nurse on 8/8/12 at 1:28 PM he/she reviewed the written physicians order in the medical record and confirmed that he/she had not performed the treatment as the physician had written it on 6/25/12. The primary nurse confirmed that he/she had not looked the treatment up in the treatment record or the medical record and had asked another nurse who indicated that there was no AG needed for Resident #20's dressing change. The primary nurse confirmed that the treatment dated 6/25/12 by the physician was "apply Mepilex AG covered with Allevyn every three days and as needed". Per interview with the primary nurse, he/she reviewed the order written on 6/25/12 and compared the order to the transcription of the order on the June, July and August treatment record and confirmed that the transcription on the treatment record on these months was not the order that was written on 6/25/12 by the facility physician. The primary nurse confirmed that the 6/25/12 order was the most recent order and the June, July and August treatment record indicated that a "Mepilex AG Border dressing is to be applied to the left ankle every three days and as needed". The primary nurse confirmed the transcribed order did not include that after application of the Mepilex AG, Allevyn was to be applied. The primary nurse confirmed that he/she had not followed the physicians order as written.</p> <p>The DNS also indicated that the nurses signing for the treatment were doing a wound dressing that was not ordered by the physician.</p>	F 281		

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F 281	Continued From page 9 2. Per observation during a medication pass on 8/6/2012 at 12:20 PM the nurse, after checking the blood sugar for Resident #2 and after receiving an elevated blood sugar which required insulin coverage, drew up and administered 5 units of Novolog Insulin. The nurse, after pulling the Novolog insulin bottle from the box, drew up and administered the 5 units without checking the panned date on the side of the bottle indicating that it had been opened on 6/28/12. Per the facility pharmacy drug handbook instructions, 28 days after a bottle of insulin is opened it should be discarded. The open insulin bottle was to be discarded on 7/26/12 and was 11 days after the discard date when the nurse administered the Novolog insulin. On 8/6/12 at 12:40 P.M. the nurse confirmed that s/he had failed to look at the panned date on the insulin bottle which would have indicated the date it was opened. In addition, s/he confirmed that all open insulin bottles should be discarded in 28 days and that s/he failed to look at the date on the bottle which would have indicated that the insulin bottle should have been discarded by 7/26/12. *Phar Merica specialized long-term care nursing drug handbook, 2012 (facility pharmacy). Page 559 states, 'Insulin: once punctured (in use) vials may be stored under refrigeration or at room temperature-use within 28 days.'	F 281		
F 282 SS=E	See also F314 and F425. 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in	F 282		

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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
F 282	Continued From page 10 accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to implement interventions by qualified persons in accordance with the written plan of care for 3 of 24 residents, (#23, #39, and #4) identified in the sample. The findings include: 1. Per review of the medical record on 8/8/12, Resident #4 was admitted on 2/22/11 with diagnoses that include Alzheimer's dementia with agitation. Per review of the physician's orders, Resident #4 was receiving Ativan 0.5 milligrams (mg) by mouth (po) every 4 hours as needed (prn) for mild to moderate anxiety and agitation. Per review of the medication administration record on 8/8/12, nursing staff administered Ativan 0.5 mg by mouth for agitation and/or anxiety from April 1 to July 1st, 47 times. Per record review, there is a comprehensive plan of care titled "potential for adverse side effects related to antipsychotic drug use", initiated on 3/7/11. The care plan indicates that the behavior monitoring flow sheet is to be completed every shift by staff and note side effects. Per review of the behavior monitoring flowsheets for the time frame of April 1st though July 1st, there was no documentation on any shift for the months of April, May, or June reflecting any behaviors, interventions used to reduce behaviors, outcome of the interventions and any noted side effects. Per interview with the Director of Nursing Services (DNS) on 8/8/12, he/she	F 282	F 282 Resident #23, 39, and 4's care plans were updated to include interventions for behavior. All resident care plans were reviewed to ensure interventions for behavior are included. Policies regarding care planning, and behavior monitoring were reviewed and updated as necessary. DNS/SDC provided education to staff involved in care planning, and behavior monitoring documentation. DNS or designee will perform audits of 5 resident care plans per quarter to ensure that all identified needs are addressed Results will be reported at QA meetings. DNS to monitor for compliance. <i>F282 POC accepted 9/11/12 G. Coleman RN/ PMK</i>	8/9/12 9/6/12 8/31/12 9/6/12 Ongoing Ongoing

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F 282	<p>Continued From page 11</p> <p>confirmed that the nursing staff had administered Ativan 0.5 mg by mouth to Resident #4, 47 times during the time frame of April 1 to July 1. The DNS confirmed that the plan of care indicated that the behavior monitoring flow sheet is to be completed every shift by staff, and that the behavior monitoring flowsheet is used by staff to indicate what behavior a resident may have, interventions used to reduce the behavior, effectiveness (outcome) of interventions utilized and any noted side effects of the medication utilized. The DNS confirmed on 8/8/12 that the care plan had not been followed and that there was no documentation on the behavior flow sheets for the months of April, May, or June reflecting any behaviors, interventions used to reduce behaviors, outcome of the interventions and any noted side effects.</p> <p>2. Per review of the medical record on 8/8/12, Resident #23 was admitted on 12/06/11 with diagnoses that include dementia, depression and hallucinations. Per review of the physician's orders, Resident #23 was receiving Ativan 0.5 milligrams (mg) by mouth (po) twice a day as needed (prn) for anxiety. Per review of the medication administration record on 8/8/12, nursing staff administered Ativan 0.5 mg by mouth for anxiety from April 1 to August 7th, 67 times. Per review of the comprehensive plan of care titled "potential for adverse side effects related to antipsychotic, antianxiety drug use" and initiated on 12/20/11, the care plan indicates that the behavior monitoring flow sheet is to be completed every shift by staff and note side effects.</p> <p>The facility behavior monitoring flowsheet</p>	F 282		

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F 282	<p>Continued From page 12</p> <p>indicates what behavior a resident may have, interventions used to reduce the behavior , effectiveness (outcome) of interventions utilized and any noted side effects of the medication utilized. Per review of the behavior monitoring flowsheets for the time frame of April 1st to August 7th, there was no documentation on any shift reflecting any behaviors, interventions used to reduce behaviors, outcome of the interventions and any noted side effects. Per interview with the Director of Nursing Services (DNS) on 8/8/12, he/she confirmed that the nursing staff had administered Ativan 0.5mg by mouth to Resident #23, 67 times during the time frame of April 1 to August 7th for anxiety. The DNS confirmed that the plan of care indicated that the behavior monitoring flow sheet is to be completed every shift by staff, and that the behavior monitoring flowsheet is used by staff to indicate what behavior a resident may have, interventions used to reduce the behavior , effectiveness (outcome) of interventions utilized and any noted side effects of the medication utilized. The DNS on 8/8/12 indicated that the care plan had not been followed and that there was no documentation on the behavior flow sheets for the months of April, May, June, July or August reflecting any behaviors, interventions used to reduce behaviors, outcome of the interventions and any noted side effects.</p> <p>3. Per review of the medical record on 8/8/12, Resident #39 was admitted on 10/20/10 with diagnoses that include Advanced dementia with periodic agitation and anxiety. Per review of the physician's orders, Resident #39 was receiving Ativan 0.5 milligrams (mg) by mouth (po) every four hours as needed (prn) for agitation. Per review of the medication administration record on</p>	F 282			

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F 282	Continued From page 13 8/8/12, nursing staff administered Ativan 0.5 mg by mouth for agitation on 5/16, 5/17, 5/22, 6/4, 6/9 and 6/17. Per review of the comprehensive plan of care titled "potential for adverse side effects related to antipsychotic medications" and initiated on 12/02/10, the care plan indicates that the behavior monitoring flow sheet is to be completed for behaviors and side effects. Per review of the behavior monitoring flowsheets for the time frame of April 1st to August 7th, there was no documentation on any shift reflecting any behaviors, interventions used to reduce behaviors, outcome of the interventions and any noted side effects. Per interview with the Director of Nursing Services (DNS) on 8/8/12, he/she confirmed that the nursing staff had administered Ativan 0.5 mg by mouth to Resident #39, 6 times during the time frame of May and June for agitation. The DNS confirmed that the plan of care indicated that the behavior monitoring flow sheet is to be completed every shift by staff, and that the behavior monitoring flowsheet is used by staff to indicate what behavior a resident may have, interventions used to reduce the behavior, effectiveness (outcome) of interventions utilized and any noted side effects of the medication utilized. The DNS on 8/8/12 indicated that the care plan had not been followed and that there was no documentation on the behavior flow sheets for the months of May and June reflecting any behaviors, interventions used to reduce behaviors, outcome of the interventions and any noted side effects.	F 282		
F 314 SS=E	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a	F 314		

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F 314	<p>Continued From page 14</p> <p>resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview on 8/8/12, the facility failed to ensure that one resident of 1 (Resident # 20) received necessary treatments and services to promote healing and prevent infection and prevent new sores from developing. The findings include:</p> <p>1. Per review of the medical record for Resident #20 on 8/8/12, he/she was admitted to the facility on 6/6/11 with diagnoses that included history of reoccurring pressure areas on the left foot and ankle. Per review of the nurses notes dated 6/25/12, Resident #20 had an open area to the left ankle.</p> <p>Per review of the physicians orders dated 6/25/12 the primary physician wrote an order that indicated that a wound treatment was to be done to the left ankle, the order indicated to apply Mepilex AG (a type of wound treatment) covered with Allevyn (a type of bandaging) every three days and as needed.</p> <p>Per direct observation on 8/8/12 at 1:14 PM the primary nurse for Resident #20 removed the dressing that was on the left ankle of Resident</p>	F 314	<p>F 314</p> <p>Resident #20's MD order was transcribed properly to the treatment record.</p> <p>A skin risk assessment was completed for Resident #20.</p> <p>Policies regarding Pressure Ulcer Risk Assessment and Order Transcription were reviewed and updated as necessary.</p> <p>DNS/SDC will provide education to all nursing staff regarding Pressure Ulcer Risk Assessment and Order Transcription.</p> <p>DNS or designee will audit 5 resident records each quarter to ensure that assessments are complete.</p> <p>Results will be reported at QA meetings. DNS to monitor for compliance.</p> <p><i>F314 POC accepted 9/11/12 G.Coleman RN J Pme</i></p>	<p>8/8/12</p> <p>8/9/12</p> <p>8/31/12</p> <p>9/6/12</p> <p>Ongoing</p> <p>Ongoing</p>

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F 314	<p>Continued From page 15</p> <p>#20. The nurse indicated that he/she would need to leave the room after removing the dressing because the nurse verbalized that under the dressing there was a piece of AG (a type of wound dressing) which he/she had not brought into the room and must go get it. The nurse returned to the room and verbalized that he/she had checked the order in the Treatment Record and the order indicated that the wound was to be covered with Mepilex only. The primary nurse completed the dressing change.</p> <p>Per interview with the primary nurse on 8/8/12 at 1:28 PM he/she reviewed the written physicians order in the medical record and the confirmed that he/she had not performed the treatment as the physician had written it on 6/25/12. The primary nurse confirmed that he/she had not looked the treatment up in the treatment record or the medical record and had asked another nurse who indicated that there was no AG needed for Resident #20's dressing change. The primary nurse confirmed that the treatment dated 6/25/12 by the physician was "apply Mepilex AG covered with Allevyn every three days and as needed". Per interview with the primary nurse, he/she reviewed the order written on 6/25/12 and compared the order to the transcription of the order on the June, July and August treatment record and confirmed that the transcription on the treatment record on these months was not the order that was written on 6/25/12 by the facility physician.</p> <p>The primary nurse confirmed that the 6/25/12 order was the most recent order and the June, July and August treatment record indicated that a "Mepilex AG Border dressing is to be applied to</p>	F 314		

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F 314	<p>Continued From page 16</p> <p>the left ankle every three days and as needed". The primary nurse confirmed the transcribed order did not include that after application of the Mepilex AG, Allevyn was to be applied. The primary nurse confirmed that he/she had not followed the physicians order as written.</p> <p>Per interview with the Director of Nursing Services (DNS) on 8/8/12, he/she confirmed that the order dated 6/25/12 by the facility physician was not the order that was transcribed to the treatment records for June, July and August. The DNS also indicated that the nurses signing for the treatment were doing a wound dressing that was not ordered by the physician.</p> <p>Per review of the comprehensive assessment (MDS) dated 5/24/12, Resident #20 has a Stage 2 open area. Review of the Braden Assessments completed, Resident #20 is at high risk for skin breakdown. Review of the Braden Assessments indicates the last assessment was on 12/9/11.</p> <p>Per review of the facility "Pressure Ulcer Risk Assessment Policy " a skin assessment is to be completed by the nurse upon admission or readmission, with each MDS assessment and with a clinical change in status. Per review of the facility policy titled "noting physician orders" treatments for an open area are to be marked off on the treatment record once a week for the area to be measured, this will aid in assessing the efficacy of the treatment.</p> <p>Per review of the treatment records for June, July and August on 8/8/12 there was no evidence that the nurses had marked off the measurements of the open area of the Stage 2 wound on Resident</p>	F 314		

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F 314	Continued From page 17 #20's left lateral ankle. Per review of the nurses notes for June, July and August there was no evidence that the nurses documented weekly measurements to assess the efficacy of the ordered treatment. Per interview with the Director of Nursing Services (DNS) on 8/8/12 at 2:55 PM he/she confirmed the expectation of the nurses is that the Braden Assessment is to be done by the nurse upon admission or readmission, with each MDS assessment and with a clinical change in status. The DNS confirmed that the last Braden scale was done 12/9/11. The DNS also confirmed that there was no weekly documentation on the treatment record or in the nurses notes of weekly measurements to determine efficacy of the ordered treatment. See also F281.	F 314	F 329 Resident #4, 23, 35, 39, and 42's care plan was updated to include non-pharmacological interventions. All residents who receive psychoactive Medications were reviewed to ensure behavior monitoring sheets are in place. Policies regarding psychoactive medications were reviewed and updated as necessary. DNS/SDC provided education to staff involved in behavior monitoring. DNS or designee will perform audits of 5 resident records per quarter to ensure that behavior monitoring is completed.	8/9/12 9/6/12 8/31/12 9/6/12 Ongoing
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition	F 329	Results will be reported at QA meetings. DNS to monitor for compliance. <i>F329 POC accepted 9/7/12 C Coleman RN/ PNC</i>	Ongoing

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F 329	<p>Continued From page 18</p> <p>as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions; and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide adequate monitoring and failed to utilize non-pharmacological interventions in the management of behavior issues prior to the administration of an "as needed" antipsychotic medication for 5 residents of 10 residents (#4, #23, #35, #39, #42) in the sample. The findings include:</p> <p>1. Per review of the medical record on 8/8/12, Resident #4 was admitted on 2/22/11 with diagnoses that include Alzheimer's dementia with agitation. Per review of the physician's orders, Resident #4 was receiving Ativan 0.5 milligrams (mg) by mouth (po) every 4 hours as needed (prn) for mild to moderate anxiety and agitation. Per review of the medication administration record on 8/8/12, the nursing staff administered Ativan 0.5 mg by mouth for agitation and/or anxiety from April 1st to July 1st, 47 times.</p> <p>Per review of the comprehensive plan of care titled "potential for adverse side effects related to antipsychotic drug use" and initiated on 3/7/11, the care plan indicates that the behavior</p>	F 329		

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F 329	<p>Continued From page 19</p> <p>monitoring flow sheet is to be completed every shift by staff and that side effects are to be noted. The facility behavior monitoring flow sheet indicates what behavior a resident may have, interventions used to reduce the behavior, effectiveness (outcome) of interventions utilized and any noted side effects of the medication utilized. Per review of the behavior monitoring flow sheets for the time frame of April 1st through July 1st, there was no documentation on any shift for the months of April, May, or June reflecting any interventions used to reduce behaviors, outcome of the interventions and any noted side effects.</p> <p>Per review of the nurses notes from April 1st through July 1st, there was no documentation in the nurses notes indicating any non-pharmacological interventions utilized to reduce Resident #4's combative behaviors, anxiety and agitation prior to the administration of Ativan 0.5 mg. Per review of the facility policy titled; "Psychotropic Drug Monitoring" last updated 12/2011, the policy indicates that "the charge nurse will monitor for behaviors and side effects daily on the behavior/intervention monthly flow record."</p> <p>Per interview with the Director of Nursing Services (DNS) on 8/8/12, he/she confirmed that the nursing staff had administered Ativan 0.5 mg by mouth to Resident #4, 47 times during the time frame of April 1 to July 1. The DNS confirmed in interview on 8/8/12 at 4:20 PM that there was no documentation within the nurses notes indicating any non-pharmacological interventions utilized to reduce Resident #4's combative behaviors, anxiety and agitation prior to the administration of</p>	F 329		

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F 329	<p>Continued From page 20</p> <p>Ativan 0.5 mg. The DNS also confirmed in interview on 8/8/12 that the plan of care indicated that the behavior monitoring flow sheet is to be completed every shift by staff, and that the behavior monitoring flowsheet is used by staff to indicate what behavior a resident may have, interventions used to reduce the behavior , effectiveness (outcome) of interventions utilized and any noted side effects of the medication utilized. The DNS confirmed on 8/8/12 that the care plan had not been followed and that there was no documentation on the behavior flow sheets for the months of April, May or June reflecting any behaviors, interventions used to reduce behaviors, outcome of the interventions and any noted side effects.</p> <p>2. Per review of the medical record on 8/8/12, Resident #23 was admitted on 12/06/11 with diagnoses that include Dementia, depression and hallucinations. Per review of the physician's orders, Resident #23 was receiving Ativan 0.5 milligrams (mg) by mouth (po) twice a day as needed (prn) for anxiety. Per review of the medication administration record on 8/8/12, nursing staff administered Ativan 0.5 mg by mouth for anxiety from April 1 to August 7th, 67 times.</p> <p>Per review of the comprehensive plan of care titled "potential for adverse side effects related to antipsychotic, antianxiety drug use" and initiated on 12/20/11, the care plan indicates that the behavior monitoring flow sheet is to be completed every shift by staff and note side effects. The facility behavior monitoring flow sheet indicates what behavior a resident may have, interventions used to reduce the behavior , effectiveness</p>	F 329		

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F 329	<p>Continued From page 21</p> <p>(outcome) of interventions utilized and any noted side effects of the medication utilized. Per review of the behavior monitoring flow sheets for the time frame of April 1st to August 7th, there was no documentation on any shift reflecting any behaviors, interventions used to reduce behaviors, outcome of the interventions and any noted side effects.</p> <p>Per review of the facility policy titled; "Psychotropic Drug Monitoring" last updated 12/2011, the policy indicates that "the charge nurse will monitor for behaviors and side effects daily on the behavior/intervention monthly flow record." Per review of the nurses notes from April 1st through August 7th, there was no documentation in the nurses notes indicating any non-pharmacological interventions utilized to reduce Resident #23's anxiety prior to the administration of Ativan 0.5 mg.</p> <p>Per interview with the Director of Nursing Services (DNS) on 8/8/12, he/she confirmed that the nursing staff had administered Ativan 0.5 mg by mouth to Resident #23, 67 times during the time frame of April 1 to August 7th for anxiety. The DNS confirmed in interview on 8/8/12 at 4:20 PM that there was no documentation within the nurses notes indicating and non-pharmacological interventions utilized to reduce Resident #23's anxiety prior to the administration of Ativan 0.5 mg. The DNS confirmed that the plan of care indicated that the behavior monitoring flow sheet is to be completed every shift by staff, and that the behavior monitoring flow sheet is used by staff to indicate what behavior a resident may have, interventions used to reduce the behavior, effectiveness (outcome) of interventions utilized</p>	F 329		

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F 329	<p>Continued From page 22</p> <p>and any noted side effects of the medication utilized. The DNS on 8/8/12 indicated that the care plan had not been followed and that there was no documentation on the behavior flow sheets for the months of April, May, June, July or August reflecting any behaviors, interventions used to reduce behaviors, outcome of the interventions and any noted side effects.</p> <p>3. Per review of the medical record on 8/8/12, Resident #39 was admitted on 10/20/10 with diagnoses that include Advanced dementia with periodic agitation and anxiety. Per review of the physician's orders, Resident #39 was receiving Ativan 0.5 milligrams (mg) by mouth (po) every four hours as needed (prn) for agitation. Per review of the medication administration record on 8/8/12, nursing staff administered Ativan 0.5 mg by mouth for agitation on 5/16, 5/17, 5/22, 6/4, 6/9 and 6/17.</p> <p>Per review of the comprehensive plan of care titled "potential for adverse side effects related to antipsychotic medications" and initiated on 12/02/10, The care plan indicates that the behavior monitoring flow sheet is to be completed for behaviors and side effects. The facility behavior monitoring flow sheet indicates what behavior a resident may have, interventions used to reduce the behavior, effectiveness (outcome) of interventions utilized and any noted side effects of the medication utilized. Per review of the behavior monitoring flow sheets for the time frame of Aprils to August 7th, there was no documentation on any shift reflecting any behaviors, interventions used to reduce behaviors, outcome of the interventions and any noted side effects.</p>	F 329			

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F 329	Continued From page 23 Per review of the facility policy titled; "Psychotropic Drug Monitoring" last updated 12/2011, the policy indicates that "the charge nurse will monitor for behaviors and side effects daily on the behavior/intervention monthly flow record." Per review of the nurses notes from May and June, there was no documentation in the nurses notes indicating any non-pharmacological interventions utilized to reduce Resident #39's agitation prior to the administration of Ativan 0.5 mg. Per interview with the Director of Nursing Services (DNS) on 8/8/12, he/she confirmed that the nursing staff had administered Ativan 0.5 mg by mouth to Resident #39, 6 times during the time frame of May and June for agitation. The DNS confirmed in interview on 8/8/12 at 4:2) PM that there was no documentation within the nurses notes indicating and non-pharmacological interventions utilized to reduce Resident #39's agitation prior to the administration of Ativan 0.5 mg. The DNS confirmed that the plan of care indicated that the behavior monitoring flow sheet is to be completed every shift by staff, and that the behavior monitoring flow sheet is used by staff to indicate what behavior a resident may have, interventions used to reduce the behavior, effectiveness (outcome) of interventions utilized and any noted side effects of the medication utilized. The DNS on 8/8/12 indicated that the care plan had not been followed and that there was no documentation on the behavior flow sheets for the months of May and June reflecting any behaviors, interventions used to reduce behaviors, outcome of the interventions and any noted side effects.	F 329			

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F 329	<p>Continued From page 24</p> <p>4. Per review of the clinical record, Resident #35 was admitted 03/29/10 with diagnoses of vertebrobasilar cerebrovascular accident (stroke), basilar artery thrombosis, depression, contractures to both feet, anxiety, constipation, cognitive stimulation with Ritalin, chronic pain, and chronic muscle spasms. Review of the nurses notes for 03/18/12 through 08/07/12 revealed that Resident #35 had frequent episodes of crying that staff attributed to dental pain. A behavior/intervention monthly flow record indicated that staff tracked episodes of crying and nothing was noted on these dates. One episode of crying was documented on 08/08/12.</p> <p>A plan of care was noted for pain related to stroke, contractures and muscle spasms, dated 04/15/10. It did not indicate if Resident #35 displayed any behaviors or behaviors related to pain. No behaviors other than crying were noted in the clinical record. Review of the medication administration record revealed that Resident #35 received lorazepam (Ativan - an anti anxiety medication) 0.5 milligrams (mg) on August 1 and 5, 2012 for anxiety/agitation and also received Dilaudid (pain medication) at the same time for complaints of mouth pain. Further review of the medication record revealed the same medications for pain and for anxiety were administered together on July 1, 2, 6, 10, 17, 24, and 30.</p> <p>Per review of the facility policy titled; "Psychotropic Drug Monitoring" last updated 12/2011, the policy indicates that "the charge nurse will monitor for behaviors and side effects daily on the behavior/intervention monthly flow</p>	F 329		
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F 329	Continued From page 25 record." Interview of the Registered Nurse (RN) charge nurse on 08/08/12 at approximately 10:00 A.M. revealed that s/he often worked the evening and night shifts and frequently administered the pain medication and anti anxiety medication together related to pain. When queried regarding behaviors, the RN stated that Resident #35 cries for long periods and had a recent history of severe dental issues. The RN stated that Resident #35 was having teeth extracted one at a time over a period of a few months. The RN verified that the plan of care does not address dental pain and provides no guidance to nursing staff related to when to administer as needed pain medication or when to give as needed anti anxiety medication, and does not provide any insight to non pharmacological interventions that may alleviate the pain and crying. The RN indicated the Resident had difficulty communicating needs at times and stated, "if [s/he] is crying and can't indicate pain, I give both medications together. It calms [him/her] down". Interview of the Director of Nursing (DNS) at 3:30 P.M. on 08/08/12 verified that Resident #35 has orders for lorazepam for anxiety and dilaudid for pain and that the records indicate staff are frequently administering these medications together without documenting on the monthly log that the resident is crying. The DNS indicated the Resident has no behaviors but is crying due to pain related to dental extractions. The DNS verified the plan of care does not indicate Resident #35 suffers from dental pain or is having tooth extractions completed over a period of time and does not indicate when the lorazepam should	F 329		

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F 329	<p>Continued From page 26</p> <p>be used or provide alternatives to anti anxiety medication to address the mouth pain.</p> <p>5. Review of the record for Resident #42 revealed an admission date of 12/19/11 and diagnoses of anxiety/restlessness, dementia, and major depressive disorder. The annual Minimum Data Set assessment (MDS) dated 7/19/12 indicates moderately impaired decision making skills and impaired short and long term memory. Physical and verbal behaviors directed towards others were documented. Review of a behavior/intervention monthly flow record for July 2012 through August 7, 2012 indicated the staff tracked episodes of biting and none were recorded during those 38 days.</p> <p>Review of the medication administration record for the same 38 days indicated that Resident #42 received lorazepam (an anti anxiety medication) 0.5 milligrams (mg) one half tablet (0.25 mg) on eight occasions, on July 8, 14, 19, 20, 24, 27, 31 and August 7, 2012. Review of the nurses notes revealed one page of notes for 5/24/12 through 08/07/12. On 05/20/12 the notes indicate the resident was "a bit uptight during the day". On 06/20/12 the resident became "agitated", yelling and calling out. No notes were made during July or August 2012 related to behaviors or agitation. There was no documentation of any signs of agitation or anxiety, or non pharmacological interventions used to address any symptoms prior to the administration of medication on those eight occasions. There was no evidence that the staff attempted to reapproach or toilet the resident prior administering medications. Review of the plan of care revealed a page titled potential for</p>	F 329		

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F 329	<p>Continued From page 27</p> <p>adverse side effects related to psychotropic drug use. The page indicated the Resident receives Zoloft (an antidepressant) 25 milligrams daily. Interventions include reassure as needed and reapproach if refusing care, meds or meals or is combative. An entry dated 01/13 indicates calling out "come, come, now, come" may mean the Resident needs to be toileted, offer toileting. There is no mention in the plan of care of biting, specific symptoms of anxiety or agitation displayed by this resident or any non medication interventions that might lessen the residents' anxiety.</p> <p>Per review of the facility policy titled; "Psychotropic Drug Monitoring" last updated 12/2011, the policy indicates that "the charge nurse will monitor for behaviors and side effects daily on the behavior/intervention monthly flow record."</p> <p>Just before and after dining observations of the noon meal on 08/06/12 in the main dining room, Resident #42 frequently stopped staff, other residents and visitors, stating come on now, come on and reaching for their hands. The resident was unable to state what was needed and was directed back to the table several times. During observations on 08/07/12 at 3:45 P.M. screaming was noted to be coming from Resident #42's room. During interview, after exiting the room, the Licensed Nursing Assistant (LNA) indicated that Resident #42 had just been transferred using a stand up lift and the Resident does not like the lift or to be transferred and is often resistant to care in the late afternoons. During interview of the second LNA, near the Resident to allow for supervision, the Resident</p>	F 329		

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F 329	Continued From page 28 was observed to clench and shake his/her fists and mumble. The resident calmed after a few minutes. During interview of the Director of Nursing Services (DNS), responsible for care planning, on 08/07/12 at approximately 4:30 P.M., s/he stated that a few behaviors and issues were addressed on the potential for adverse side effects related to psychotropic medication use plan of care. The DNS verified that the plan of care does not address the issues with the lift and the Residents' lingering frustration after transfers, or wheeling herself out of the dining room at meal time. The DNS verified that these behaviors were not indicated on the behavior tracking logs which tracked only biting, and that the anti anxiety medication had been administered for "agitation" with no description of the behaviors displayed or documentation of any attempts to calm Resident #42 with non pharmacological measures.	F 329	F 412 Resident #17's care plan was updated to include a dental problem with interventions. Resident #17 had a follow up dental visit. All resident care plans were reviewed to ensure dental interventions are included. All residents were assessed for dental needs, and services offered if indicated. Policies regarding dental services were reviewed and updated as necessary. DNS/SDC provided education to staff involved in care planning.	8/9/12 8/27/12 9/6/12 9/6/12 8/31/12 9/6/12
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by:	F 412	Residents will be assessed for dental needs on a quarterly basis in care planning meeting using the "Care Conference Summary Notes" form. Dental services will be offered if indicated. DNS or designee will perform audits of 5 resident care plans per quarter to ensure that all identified needs are addressed Results will be reported at QA meetings. DNS to monitor	Ongoing Ongoing Ongoing

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F 412	<p>Continued From page 29</p> <p>Based on resident, family and staff interviews and review of medical records, the facility failed to obtain from an outside resource routine dental services to meet the needs of 1 of 2 residents in the applicable sample (Resident # 17). Findings include:</p> <p>Per medical record review begun on 08/07/2012 and completed on 08/08/2012 there is no evidence to indicate that Resident #17 was offered the services of a dentist since his/her admission on 02/15/2006. Assessments are current but other than to specify that Resident #17 uses an electric toothbrush for providing self mouth care, there is no mention in the care plan that s/he is missing several teeth nor that a dental consult was offered.</p> <p>Per review of care plan and confirmation with the DNS during interview in the afternoon of 08/08/2012, Resident #17 provides his/her own mouth care and requests name brand mouth care products that s/he purchases for him/herself. This is also not evident in the care plan. The DNS states during interview in the afternoon of 08/08/2012 that unless dental issues are "triggered by the Minimum Data Set (MDS) assessments there are no issues to add to the care plan."</p> <p>During interview on 08/06/2012 at 3:42 PM Resident #17 and her/his family indicated that s/he has not asked anyone on the staff for help in making a dental appointment but that s/he thinks that a dentist visit would be "helpful."</p>	F 412	<p>for compliance.</p> <p><i>F412 POC accepted 9/7/12 G Coleman RN / Pmc</i></p>	
F 425 .SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH	F 425		

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F 425	<p>Continued From page 30</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to discard open medication per pharmacy drug handbook recommendations prior to administration for 1 of 2 residents in the sample. (Resident #2) Findings include:</p> <p>Per observation during a medication pass on 8/6/2012 at 12:20 PM the nurse, after checking the blood sugar for Resident #2 and after receiving an elevated blood sugar which required insulin coverage, drew up and administered 5 units of Novolog Insulin. The nurse, after pulling the Novolog insulin bottle from the box, drew up and administered the 5 units without checking the</p>	F 425	<p>F 425</p> <p>The outdated insulin was discarded.</p> <p>All insulin vials were checked to ensure none are outdated.</p> <p>Policies regarding medication storage were reviewed and updated as necessary.</p> <p>DNS/SDC provided education to staff involved in medication storage.</p> <p>DNS or designee will perform audits of medication storage monthly to ensure that all medications are dated properly.</p> <p>Results will be reported at QA meetings. DNS to monitor for compliance.</p> <p><i>F425 POC accepted 9/7/12 G Coleman RN/PMC</i></p>	<p>8/6/12</p> <p>8/6/12</p> <p>8/31/12</p> <p>9/6/12</p> <p>Ongoing</p> <p>Ongoing</p>	

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F 425	<p>Continued From page 31</p> <p>penned date on the side of the bottle indicating that it had been opened on 6/28/12. Per the facility pharmacy drug handbook instructions, 28 days after a bottle of insulin is opened it should be discarded. The open insulin bottle was to be discarded on 7/26/12 and was 11 days after the discard date when the nurse administered the Novolog insulin.</p> <p>On 8/6/12 at 12:40 P.M. the nurse confirmed that s/he had failed to look at the penned date on the insulin bottle which would have indicated the date it was opened. In addition, s/he confirmed that all open insulin bottles should be discarded 28 days and that s/he failed to look at the date on the bottle which would have indicated that the insulin bottle should have been discarded by 7/26/12.</p> <p>*Phar Merica specialized long-term care nursing drug handbook, 2012 (facility pharmacy). Page 559 states, 'Insulin: once punctured (in use) vials may be stored under refrigeration or at room temperature-use within 28 days.'</p> <p>See also F281.</p>	F 425			