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F 000	INITIAL COMMENTS Annual Certification Survey.	F 000		
F 283 SS=B	483.20(l)(1)&(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to complete a discharge summary for one of three closed records reviewed (R18) in the sample of 19. Findings include: R 18's closed record review showed the discharge summary sheet was not filled out. R18 was admitted on 9/30/11 and discharged to home on 10/15/11. The discharge summary sheet has areas including medical history, recapitulation of stay, prognosis and diagnosis for the physician to complete. Z2 the corporate nurse consultant said on 11/18/11 at 11:00am that the facility has a hard time getting the doctors to complete discharge summary.	F 283		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must	F 309		

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

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F 309	Continued From page 1 provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to develop and implement individualized pain management programs for two of nine residents (R4, R5) identified with pain in the sample of 19 and one resident (R27) in the supplemental sample. Findings include: 1. According to the medical record R5 is an 85 year old alert and oriented female who was admitted to the facility on 10/28/11. R5's diagnoses include Hypertension, Peripheral Vascular Disease, Osteoporosis and aftercare following surgery for a fracture of the vertebrae from a recent fall. R5 was first observed alone in her room on 11/15/11 at approximately 11:00 AM. R5 was sitting stiffly in a chair and appeared to be uncomfortable. R5 was asked if she was in pain. R5 stated she always has pain when she moves. R5 further stated the nurses don't ask her about her pain, they just give her pain medicine; she doesn't know what it is and it doesn't help much anyhow. R5 also stated she is afraid she will become dependent on the medication.	F 309		

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R5's pain medications were reviewed in the medication administration record (MAR) and current orders included: Fentanyl 25 mcg. (micrograms), 1 patch topically every 72 hours and norco 7.5 mg. (milligrams) / 325mg. 1 tab by mouth every 4 hours as needed for pain. There was an entry for a numeric pain score to be recorded every shift. The MAR also did not include a numeric pain goal that was to be attained after the Norco was administered. The location of R5's pain was also not noted on the MAR. R5's admission assessment dated 10/29/11 also did not include a thorough pain assessment and there was no Care Area Assessment for pain completed until 11/17/11, (during the survey.)

R5's care plan initiated on 10/28/11 notes R5 will meet pain goal of 2-3 but does not list R5's medications or parameters to follow to meet her pain management goal.

On 11/14/11 the medical record reflected R5 was seen by Z1(physician). Z1 documented R5's pain was a 6 out 10 in severity. Z1 wrote an order to increase R5's Fentanyl patch to 50 mcg. every 72 hours. However, when the chart was reviewed on 11/16/11 the physician's order had not been signed off by the nurse. E7 RN (Registered Nurse) was made aware of the order at approximately 1:00 PM on 11/16/11. Upon review of the MAR on 11/17/11 it was noted that the Fentanyl patch was initiated that morning, 11/17/11. E7 verbally confirmed on 11/17/11 the medication was started on the morning of 11/17/11.

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2. On 11/16/11 at 8:30 a.m. during the medication pass observation, E3 (nurse) administered two extra strength acetaminophen to R27. E3 returned to the medication cart and documented the medication was administered. E3 documented in the box for , "Pain Score" a zero for 11/16/11 the 7-3 shift. E3 was queried why she documented zero when R27 was not asked if she had pain during the observation of the administration of the medication. E3 admitted she did not ask R27 if she was in pain because she never has pain.

E2 (Director of nurses) on 11/16/11, was informed that staff did not inquire about R27's pain before administration. E2 stated on 11/17/11 that the facility's procedure is for the nurses to always ask the patient to rate his pain daily prior to giving pain medication and with each medication pass.

3. R4 complained of lower left arm pain during the initial tour on 11/15/11 at 11 a.m. R4 said , "my arm hurts all the time, had shingles seven years ago and the pain is always there". R4 said the medication they use a , "gel" only works for a few moments. R4 said she wished she could have something that works. R4 said she told them it did not work. R4 could not remember who the person was.

During the medication pass observation, R4 was observed in bed. E5(nurse) administered R4's medication and scored R4's pain as a 4 on a scale of 1 to 10. R4 when interviewed after E5 had given the medication on 11/16/11 (8 a.m.),

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was complaining of pain to the lower left arm. R4 said the pain is always there.

Interview with E5(LPN) and E6(RN) on 11/16/11 said R4 has used other medications for pain.

The care plan for R4 was reviewed for pain. The care plan was dated
8/4/10. The focus area is R4's, left arm pain evidenced by patients statements of pain related to history of shingles. The goal is to express pain management is within acceptable limits. There is no indications that the facility has changed interventions since the development of this care plan. .

On 11/18/11 R4 was in bed completing breakfast at 9 a.m.. R4 said her arm was really hurting bad. R4 was asked to rate the pain on a scale of 1 to 10 and 10 being the worst. R4 said it was a nine. R4 said she can relieve her pain by twisting the skin on her lower left arm and holding it tight. R4 showed how she was able to do this. R4 said that makes it go away. R4 asked if there was something else she could use and injection anything. R4 said the pain is always there. R4 was told would ask nursing to see her.

E6 (Director of clinical services) was informed of R4's pain on 11/18/11 at 9 a.m. and told of her continued complaints that the medication was not helping her.

E11 (nurse) was asked if R4 had pain when she administered R4's 8 a.m. medication. E11 said yes. R4's pain was a 7 on a scale of 10. The pain score scale on the medication administration record was reviewed. The scores were 1-4= mild

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pain, 5-7 = moderate pain and 8-10 = severe pain.

The medication administration record was reviewed with E11 . E11 documented a score of 7 in the box for pain score (7-3) shift. The pain score goal evaluated by the facility was documented in the pain score box as a score of 4 .

E11 stated that R4 received GCK GEL medication(for pain) routinely that it is scheduled for every 8 hours, (5 a.m., 1p.m. , 9p.m.). The medication record for this medication was reviewed with E11. The medication record documented the medication was given at 5 a.m. on 11/18/11. The pain score for the shift (11-7) documented a pain score of zero. R4 exhibited increased pain from a score of zero to 7 on the morning of 11/18/11.

The medication record and physicians order document a prn (give whenever necessary) every four hours for pain was ordered to be given. This medication was not offered to R4 when E11 assessed R4's pain at a score of 7 during the medication administration on 11/18/11 for 8 a.m..

E6(RN) entered the bathroom of R4 to ask if she needed anything. R4 yelled out and said " , Oh my arm hurts, oh, oh, my arm hurts." R4 complained of having pain in the right leg at this time. E11 was observed to administer the prn pain medication spray at this time.

A review of R4's medication administration record pain score documentation was done. The facility staff documented for the 3-11 shift, 11-7 shift all

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F 309	Continued From page 6 zeros for the dates 11/1/11 through 11/17/11. The 7-3 shift documented for 7 days R4 had a pain score of 4. R4 on 11/15/11 stated she always has pain and the pain it only leaves for a few minutes after the pain gel is applied and returns. E2 and E6 was queried on 11/16/11, as to how the nursing staff evaluate the effectiveness of the pain medications used for R4. There was no documentation before or after the pain medication was given to determine the effectiveness of the medication being used for R4.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to develop and implement specific and individualized interventions to prevent falls for two of four residents (R2 and R10) at risk for falls in the sample of 19. Findings include:	F 323		

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On 11/15/11 at Noon, R10 was in his bed at the edge.
R10's family was at his bed side and stated, R10 fell twice while in the facility. The only thing that saved R10 was his helmet when he fell to the ground on 11/3/11.

The facility had two documented incidents for R10 11/3/11 and 11/8/11.

The incident dated 11/3/11 7:30 pm, documents (E9) Nurse found R10 on the floor in his room. The incident investigation report indicates (E10) Certified Nurse Aide (CNA) transferred E10 using the total mechanical lift by her self

In the process, E10 failed to connect the sling to the lift hooks. R10 fell three feet down to the floor from the sling while lifting him from his chair with the mechanical lift.

On 11/17/11 at 1:30 pm, E10 states she usually transfers R10 by herself with the total mechanical lift, but now she knows she has to have two staff present when transferring with mechanical lift.

E10 also stated R10's family some times assists with the transfer of R10. On 11/3/11, R10's family was also present, but she was on the other side of the bed.

E10 states, she did not connect the sling properly to the lift hooks which resulted in R10 sliding from the sling head down to the floor.

The facility sent R10 to the Hospital on 11/3/11 and R10 returned to the facility on 11/4/11 at 2:00

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F 323	Continued From page 8 am. R10's clinical records did not indicate the 11/3/11 fall occurred when E10 transferred R10 with a mechanical lift by herself. R10's plan of care for falls dated 9/29/11, which was updated on 11/4/11, did not specify how many staff are required to transfer R10 with the total mechanical lift or what type of sling R10 is to use. R10's nurses notes indicate R10 fell from his bed to the floor and sustained abrasions to his face at the Craniotomy site. The facility failed to transfer safely and monitor R10 to prevent him from falling. 2) A facility incident report of 11/07/11 notes R2 was found on the floor of his room at 10:00 AM. R2 was noted to have a laceration of the occipital region of the head, (back of the head). R2 was transferred to the hospital where he received sutures. R2 was admitted for further treatment and was found to have a urinary tract infection. The final report of the facility's investigation of 11/07/11 completed by E1 (administrator) documented that R2 attempted to stand up to move back in his chair and fell. The investigation concluded that " it is likely that the patient failed to lock his wheelchair prior to attempting to stand. Upon return to the facility the patient's careplan will be revised." R2's careplan dated 11/02/11 (prior to his fall)	F 323		

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F 323	Continued From page 9 notes R2 was a fall risk due to the use of psychotropic medications, impaired balance/poor coordination, unsteady gait, syncope/vertigo. R2's careplan of 11/13/11 (after his return from the hospital) contained the same information as the careplan he had prior to his fall. E2, DON (Director of nursing) was asked on 11/17/11 if the facility made any changes to R2's careplan upon his readmission. E2 stated R2 probably fell because he had a urinary tract infection and no revisions to the careplan have been implemented at this time.	F 323		
F 328 SS=E	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, record review and facility staff interview the facility failed to follow their procedure for monitoring the Peripherally inserted Central Catheter (PICC) lines to prevent complications and reduce risk such as catheter migration.	F 328		

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This is for 2 of 19 sampled residents (R1 and R18) and 7 residents in the supplemental sample (R20, R21, R22, R23, R24,R25 and R26) who have PICC lines inserted.

Findings include:

R1 was readmitted to the facility with a right upper arm PICC line on 8/23/11. R1 was observed on 11/15/11 seated in a wheelchair wearing a bandage to the right lower arm. R1's right hand was edematous
R1 stated her arm was swollen from the IV (intravenous) tube that was in her right arm.

R1 pointed to the right arm and said it was now in the left arm. R1 said the PICC caused the arm to be like this. R1 was observed to have a PICC line in the left arm.

There was no supporting documentation provided to show how the facility was monitoring, (measuring the circumference of R1's arm or measuring the length of the external catheter) to assess risk and complications of the catheter.

Interview with E2 showed the facility did not document the
measurements of R1's right arm.

Review of R1's nurses notes documents R1's had a PICC line in the right arm. On 10/29/11 at 19:50 , Right arm PICC...complain of right arm pain, pain med's given. On 10/30/11 at 14:50 right upper arm noted to be swollen, reddish and warm to touch, painful especially when moving the arm...10/30/11 at 19;08 TPN (total parenteral nutrition) infusing...right arm, no intolerance

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noted, no swelling , still complain of pain on right upper arm.

The 10/31/2011 at 08:45 note states: complaining of severe pain in right upper extremity where PICC line is placed, area is swollen and warm to touch

R1's right PICC line was discontinued and a new PICC line was inserted in the left arm on 11/1/11.

Review of the Peripheral Inserted Central Catheter policy and Procedure for the management of PICC lines directs the nursing staff to follow specific guidelines. One of the guidelines instructs the staff to take and document external catheter measurements every dressing change (measure mid upper arm circumference and measure external catheter centimeters PICC line).

Interview with E2 stated the measurements for the PICC line are to be recorded on the medication administration record.

There were no measurements recorded for R1. The administration/parenteral nutrition record for R1 shows the facility was not taking and recording the measurements of R1's upper arm or the external catheter length during dressing change . The facility did not establish a baseline for the length of the external catheter upon admission.

Interviews with E1 (administrator) and discussion with E2 (director of nurses) on 11/15/11 indicated the facility is not following the procedure for measuring upper arm circumference or

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F 328	Continued From page 12 measuring the external catheter length for migration for residents who use PICC lines. The administration/parenteral records for seven residents in the facility who have PICC lines inserted were reviewed with E2. The review showed there were no measurements recorded for any of these residents, R20, R21, R22, R23, R24, R25 and R26. E2 stated on 11/16/11, the facility will inservice the nursing staff and follow the procedure as per facility protocol. None of the resident's care plans have addressed the measurements of upper arm and external catheter length of the catheter. R18's closed record indicates he was admitted from the hospital on 9/30/11 with an order for vancomycin through a PICC line. The Parenteral Nutrition Administration Record dated 9/30/11 has a location where the measurement of the external CM PICC should be recorded. This record is blank, there was no measurement recorded in the record.	F 328		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure a significant medication error did not occur for (R5), 1 of 19 sampled residents Findings include:	F 333		

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F 333	Continued From page 13 According to the medical record R5 is an 85 year old alert and oriented female who was admitted to the facility on 10/28/11. R5's diagnoses include Hypertension, Peripheral Vascular Disease, Osteoporosis and aftercare following surgery for a fracture of the vertebrae from a recent fall. R5 was first observed alone in her room on 11/15/11, at approximately 11:00 AM., R5 was sitting stiffly in a chair and appeared to be uncomfortable. R5 was asked if she was in pain. R5 stated she always has pain when she moves. On 11/16/11, R5's pain medications were reviewed in the medication administration record (MAR) and the current orders included: Fentanyl 25 mcg. (micrograms), 1 patch topically every 72 hours and Norco 7.5 mg. (milligrams) / 325mg. 1 tab by mouth every 4 hours as needed for pain. On 11/14/11, R5 was seen by Z1(physician). Z1 documented R5's pain was a 6 out 10 in severity. Z1 wrote an order to increase R5's Fentanyl patch to 50 mcg. every 72 hours. However, when the chart was reviewed on 11/16/11, the physician's order had not been signed off by the nurse. E7, RN (Registered Nurse) was made aware of the order at approximately 1:00 PM on 11/16/11. Upon review of the MAR on 11/17/11 it was noted the Fentanyl patch was initiated the morning, of 11/17/11. E7 verbally confirmed on 11/17/11 that the medication was not started until the morning of 11/17/11.	F 333		
F 498 SS=D	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able	F 498		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145045	A. BUILDING _____ B. WING _____	11/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 498	Continued From page 14 to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure the Certified Nurse Aide (CNA), E10 transferred R10 safely. This is for one of one residents in the sample of 19 residents who was transferred with a total mechanical lift. Findings include: The facility documents an incident involving E10 transferring R10 with a total mechanical lift on 11/3/11 at 7:30 pm. E9, the Nurse found R10 on the floor in his room. The incident investigation report indicated E10, Certified Nurse Aide (CNA) transferred R10 using a total mechanical lift by her self. In the process, E10 failed to connect the sling to the lift hooks. R10 fell three feet down to the floor from the sling while being lifted from his chair with the mechanical lift. On 11/17/11 at 1:30 pm, E10 states she usually transfers R10 by her self with the total mechanical lift, but she knows she has to have two staff present when transferring with a mechanical lift. E10 states R10's family some times assists her to transfer R10. On 11/3/11, R10's family was	F 498		

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F 498	Continued From page 15 present, but she was on the other side of the bed. E10 said, she did not connect the sling properly to the lift hooks, which resulted in R10 sliding from the sling head down to the floor. A review of E10's personnel file documents E10 twice was deficient in ensuring safety of a resident on (4/20/11) and when providing care on (3/25/11). On 11/8/11, the facility served a third and final written warning to E10 for lapse in safe transfer of R10 on 11/3/11.	F 498		