



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7012 3050 0001 2125 5952

November 21, 2014

Rick L. Holloway, Administrator
Kindred Nursing & Rehabilitation - Caldwell
210 Cleveland Boulevard
Caldwell, ID 83605-3622

FILE COPY

Provider #: 135014

Dear Mr. Holloway:

On **November 4, 2014**, a Complaint Investigation survey was conducted at Kindred Nursing & Rehabilitation - Caldwell by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

After each deficiency has been answered and dated, the administrator should sign both the Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces

Rick L. Holloway, Administrator
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provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 4, 2014**. Failure to submit an acceptable PoC by **December 4, 2014**, may result in the imposition of civil monetary penalties by **December 24, 2014**.

The components of a Plan of Correction, as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained.
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

This agency is required to notify CMS Region X of the results of this survey. We are recommending that CMS impose the following remedy:

Denial of payment for new admissions effective as soon as notice requirements can be met. [42 CFR §488.417(a)]

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **May 4, 2015**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative

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remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Lorene Kayser, L.S.W., Q.I.D.P. or David Scott, R.N., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

go to the middle of the page to **Information Letters** section and click on **State** and select the following:

- BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **December 4, 2014**. If your request for informal dispute resolution is received after **December 4, 2014**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Lorene Kayser, L.S.W., Q.I.D.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626.

Sincerely,



LORENE KAYSER, L.S.W., Q.I.D.P., Supervisor
Long Term Care

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

PRINTED: 11/21/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/04/2014
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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHABILITATION - CALDWELL	STREET ADDRESS, CITY, STATE, ZIP CODE 210 CLEVELAND BOULEVARD CALDWELL, ID 83605
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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	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during a complaint survey of your facility.</p> <p>The surveyors conducting the survey were: Rebecca Thomas, RN, Team Coordinator Nina Sanderson, LSW</p> <p>The survey team entered the facility on 11/3/14 and exited on 11/4/14</p> <p>Survey Definitions: ADL = Activities of Daily Living BID = Twice daily BIMS = Brief Interview for Mental Status cm = Centimeters CNA = Certified Nurse Aide DDCO = Director of Divisional Clinical Operations DON/DNS = Director of Nursing Dx = Diagnosis LN = Licensed Nurse LSW = Licensed Social Worker MAR = Medication Administration Record MDS = Minimum Data Set assessment PO = Per Oral PRN = As Needed PT = Physican Therapy TID = Three times daily s/sx = Signs and symptoms w/c = wheelchair</p>	F 000	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kindred Nursing and Rehabilitation - Caldwell does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p>	
F 225 SS=E	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have</p>	F 225	<p>F225 ABUSE/INVESTIGATION</p> <p>1. Residents #1, 4, and 5 had their falls re-evaluated by the Interdisciplinary Team (IDT) to establish root cause. Resident care plans were adjusted as indicated for fall prevention.</p>	12/8/14

RECEIVED
11-11-14
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Rita L. Holman</i>	TITLE Executive Director	(X6) DATE 12/1/14
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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.

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F 225	<p>Continued From page 1</p> <p>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 or licensing authorities.</p> <p>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).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of investigations, record review and staff interview, it was determined the facility failed to ensure investigations were thoroughly investigated and reported to the State Survey</p>	F 225	<p>2. The IDT reviewed other residents with multiple falls over the past 6 months and any resident who has fallen in the last 30 days to establish root cause. Resident care plans were adjusted as indicated for fall prevention.</p> <p>3. The Staff Development Coordinator (SDC) and Executive Director (ED) has re-educated staff regarding the investigative process, to include but no limited to,</p> <ul style="list-style-type: none"> • Thorough investigation of falls by analysis of blood pressure, medication side effects, environmental issues, and other factors which may have contributed to the fall. • Documentation of the data collected will be noted on the "Post Fall Investigation." • Interviews will include signatures of individuals providing the information. • Root cause will be identified by the Licensed Nurse (LN) with a plan of care established for prevention of future falls. • The physician will be updated by the LN as to contributing factors of the fall. Adjustments to care plans and orders will be made as directed by the physician. Physicians will address risks and benefits of medications and their side effects as needed, and if it may contribute to falls. 		

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F 225	<p>Continued From page 2</p> <p>Agency - Bureau of Facility Standards (BFS) timely. This was true for 3 of 9 (#s 1,4, and 5) residents reviewed for accidents. This failure resulted in a lack of sufficient information being available on which to base corrective action decisions. Findings included:</p> <p>The facility's Policy and Procedure on Conducting an Investigation, dated 6/30/06, documented the following Rationale: "Federal regulation requires a center have evidence that all allegations of abuse, neglect and exploitation/misappropriation, including injuries of unknown source, are thoroughly investigated. In addition, the center must take action to prevent further potential abuse while the investigation is in progress." The Summary Report of the Center's Findings and Conclusions section documented the following: *Upon the conclusion of the investigation, prepare a summary report of the findings and conclusions; and, *Submit the findings to the State Survey Agency within 5 working days of the initial incident or per state regulations, if applicable.</p> <p>Please see F-323 as it relates to falls and accidents.</p> <p>1. Resident #5 fell 5 times in the facility between 9/5/14 and 10/2/14. The investigations for each incident did not include data or did not include an analysis of the data as follows: *9/5/14. The facilities PFI (Post Fall Investigation) form documented the resident fell at 5:50 AM. The last time the resident's BP (blood pressure) was evaluated was on 9/2/14 at 9:55 PM and was not evaluated after the resident fell. The resident was on three antihypertensive medications and a antiparkinson's medication which has a drug-drug</p>	F 225	<ul style="list-style-type: none"> The IDT will review and validate effectiveness of the post fall prevention plan the next business day and again within 7 days of the fall during daily clinical review. <p>The District Director of Clinical Operations (DDCO) has re-educated the ED and IDT regarding reportable event requirements and timeliness of reporting.</p> <p>4. Medical Records and/or her designee will evaluate 25 percent of the incident reports for the next 60 days to validate thorough investigation with completion of the post fall investigation, identification of contributing factors, determination of a root cause resulting in care plan updates as indicated. The audit will be documented on the PI monitor beginning the week of December 8, 2014.</p> <p>The DDCO will review no less than four post fall investigations per month to verify the quality of investigation, appropriateness of interventions, and timeliness of follow up to prevent further incidents. The report of these audits will be provided to the PI committee monthly.</p> <p>Any concerns will be addressed immediately and discussed with the IDT as indicated. The results will be reported to the PI Committee. After 60 days, the PI committee will have the authority to adjust the number of incident reports to be reviewed when the requirements of this citation are met.</p>		

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F 225	Continued From page 3 interaction with antihypertensive medications and can cause additive hypotensive effects. Additionally, the resident was on Seroquel, an antipsychotic which also has a drug-drug interaction with antihypertensives. (Please see F-329 as it relates to unnecessary medications.) However, Section J, which asked which medications might contribute to falls, was blank. No documentation was found which investigated a root cause analysis or that BP could be a contributing factor. *9/15/14. A PFI form documented the resident fell out of bed at 3:00 AM. The resident's most recent BP was taken at 2:34 AM which was documented as 150/100. However, no documentation was found the facility addressed the resident's high BP. The form did not include contributing medications or recent changes of antihypertensive and antiparkinson medications. No documentation was found which investigated a root cause analysis or that BP could be a contributing factor. *9/19/14. A PFI form documented the resident fell twice during the same event at 6:15 PM, while walking with a LN and CNA and became weak and after he was in bed got tangled in linens and partially rolled out of bed. The form did not include the signature of the CNA who was interviewed for the first event. The most recent BP was on 9/18/14 at 5:00 AM. The form did not include contributing medications which could have been a factor, include BP was being monitored or include a BP before or after the event or documentation which investigated a root cause analysis. *9/23/14. A PFI form documented the resident fell at 6:15 AM. The resident was walking with a CNA and was eased to the floor on his knees. The resident's most recent BP was on 9/18/14 at	F 225			

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F 225	<p>Continued From page 4</p> <p>5:00 AM. The BP had not been taken since the resident's last fall on 9/19/14. Again, the form did not include contributing medications which could have been a factor, include BP was being monitored or include a BP before or after the event or documentation which investigated a root cause analysis.</p> <p>*10/2/14. A PFI form documented the resident fell at 2:55 AM. The form did not include a description of the fall in the Verbal Fall Description, only that the resident was in bed asleep, was check on at 2:35 AM and was on 15 minute checks. The interviews documented the resident was found on the floor on his hands and knees, his bed was wet, and a adult brief was near the bed on the floor. The form documented a BP of 110/66 after the fall and a contributing psychoactive medication was given at 10:00 PM. However, the form was blank, in Section B, where it asked for a description of the position the patient was found in and position of limbs. Additionally, the form did document the resident had vision and hearing impairment but had no corrective devices. No documentation was found which investigated a root cause analysis, however, the form did document in the comment section, "Resident was incontinent but it would not let me type in the 2a spot (referring to the form) provided."</p> <p>Additionally, Resident #5 had an injury of unknown origin which was documented on 10/11/14 at 10:12 AM in a Physician's Order progress note. LN #3 documented, "NO [new order] noted for left wrist and hand x-ray r/t Guarding and not using left hand. Has approximately 2.0 x 1.0 cm bony protrusion of the 4th metatarsal [sic] just below the wrist."</p> <p>On 10/11/14, the Final X-Ray Report,</p>	F 225		

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F 225	<p>Continued From page 5</p> <p>documented, "Fracture of distal left 5th metacarpal with mild angulation and mild callus formation."</p> <p>A Resident Fracture Report, undated, for the 10/11/14 Incident, was received at the BFS on 10/28/14 at 3:22 PM. The Investigation and Conclusion section of the report documented, "It is unknown when [the resident] suffered the fracture." The report failed to determine how a resident who was on 1:1 supervision with 15 minute checks experienced a fracture of the 5th metacarpal.</p> <p>On examination of Resident's #5 medical record, it could not be determined when the fracture actually occurred. Please see F-323 for details. The Resident Fracture Report was received at the BFS 12 working days after the fracture was discovered. This injury of unknown origin was not reported to the BFS Hotline within 24 hours as required by BFS Informational Letter 2014-04.</p> <p>On 11/4/14 at 1:15 PM, the DNS was asked about the root cause analysis for each of the aforementioned falls, the DNS stated, "I try to." When asked if the medication changes had been considered as a contributing factor to falls, the DNS did not respond.</p> <p>On 11/4/14 at 3:20 PM, the Administrator was interviewed regarding the facility's Fall Investigation Evaluations and the lack of a root cause analysis. The Administrator stated, "The form is relatively new and doesn't give good opportunity for analysis."</p> <p>2. Resident #4 fell 14 times in the facility between 7/9/14 and 11/1/14. Please see F 323 for details.</p>	F 225			

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F 225	<p>Continued From page 6</p> <p>The investigations for each incident did not include data, or did not include an analysis of the data, as follows:</p> <p>*7/9/14. The facility's Post Fall Investigation (PFI) form documented the resident slid to the floor from sitting at the edge of her bed at 11:50 AM. The resident's July 2014 MAR documented she was on Lisinopril for hypertension, which was to be held if her systolic blood pressure was less than 110. However, there was no blood pressure value documented until 4:23 that afternoon, which was documented as being taken when the resident was in a lying position. There was no documentation of orthostatic blood pressures, and this information was not analyzed as a contributing factor to the resident's fall.</p> <p>*7/26/14. A PFI form documented the resident fell from a standing position at 11:30 AM. The resident's most recent blood pressure value was documented on 7/24/14. There were no orthostatic blood pressures documented. Additionally, the resident had been started on the medication Tegretol, with adverse effects which may contribute to falls, on 7/21/14. The addition of this medication was not analyzed as a contributing factor to the fall.</p> <p>*7/29/14 at 3:00 PM. A PFI documented the resident again fell from a standing position. Orthostatic blood pressures were not documented or analyzed, nor was the addition of Tegretol.</p> <p>*7/30/14 at 6:00 AM and 9/4/14 at 6:30 AM. PFIs documented the resident fell from bed. Orthostatic blood pressures were not documented or analyzed.</p> <p>*9/22/14 at 3:30 PM, a PFI documented a resident fell while ambulating. Her orthostatic blood pressures were not checked or evaluated. Additionally, in the ten days leading up to this fall,</p>	F 225		
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F 225	<p>Continued From page 7</p> <p>the resident had received IM Haldol and IM Zyprexa in the same day (9/12/14); tried on Ambien (9/8/14) which was discontinued (9/15/14) due to possible adverse effects; and had her Seroquel dose increased twice (9/15/14 and 9/22/14). None of these medication changes were analyzed as a possible contributing factor to the resident's fall.</p> <p>*10/11/14 at 3:00 AM, a PFI documented the resident fell trying to take herself to the bathroom. Orthostatic blood pressures were not documented. The plan to prevent further falls documented the resident was to be offered the toilet throughout the night. However, on 10/14/14, when a PFI documented the resident fell at 5:55 AM while again trying to toilet herself, the facility did not analyze why the plan put in place after the 10/11/14 fall had not been carried out successfully.</p> <p>*10/19/14 at 2:50 PM, a PFI documented the resident fell while trying to get to the bathroom. Orthostatic blood pressures were not documented or analyzed. Additionally, on 10/18/14 the resident had received a dose of Geodon. The potential impact of this medication on the resident's fall was not analyzed.</p> <p>*On 10/22/14, the resident's NN documented she had multiple medication changes, which included the addition of 2 antipsychotic medications, an increase in her mood stabilizer, and an increase in her antidepressant. PFIs documented the resident fell on 10/22/14, 10/28/14, 10/29/14, and 11/1/14. The investigation of these falls did not include an analysis of these medication changes.</p> <p>On 11/4/14 at 9:15 AM, the DNS stated the facility had considered blood pressures as a potential factor in some of her falls, but this was not evaluated by the physician until 10/28/14. Please</p>	F 225			

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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHABILITATION - CALDWELL			STREET ADDRESS, CITY, STATE, ZIP CODE 210 CLEVELAND BOULEVARD CALDWELL, ID 83605		
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F 225	<p>Continued From page 8</p> <p>see F 323 for details. The DNS stated the facility had not considered the impact of the resident's psychotropic medications as a factor in her falls. Please see F 329 for details.</p> <p>On 11/4/14 at 3:10 PM, the Administrator was informed of these concerns. The facility offered no further information.</p> <p>3. Resident #1 fell 4 times in the facility between 7/3/14 and 9/21/14. Please see F 323 for details. The investigations did not include data, or an analysis of the data, as follows:</p> <p>*7/3/14. A PFI documented the resident was to have new shoes. on 7/7/14 the IDT review of the event documented the facility informed the resident's wife he would require new orthotic shoes, so as to fit over a brace he wore on his left leg. The facility did not document they followed up on this issue, and did not know when, if, or how the resident was obtaining the appropriate footwear. The facility first became aware the resident had obtained those shoes on 9/14/14, when the resident fell when staff was assisting him to remove those shoes.</p> <p>*9/14/14. A PFI documented the resident fell at 12:20 PM, but the physician and family had been notified of the fall at 12:00 noon, twenty minutes before the resident fell. Additionally, the resident's range of motion was not assessed as part of the investigation. The resident fell again within 3 hours, and was later found to have a tibial fracture and a torn meniscus. The PFI did not document orthostatic blood pressures were obtained. The PFI documented the resident had a change in his Zyprexa dose within 2 weeks prior the fall, but no other medication changes. However, the resident was started on the hypnotic medication Restoril on 9/5/14, 9 days</p>	F 225			

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F 225	Continued From page 9 before the fall. Please see F 329 for details. *9/14/14. A PFI at 3:05 PM documented the resident fell. The investigation did not include data on the resident's orthostatic blood pressures. *9/21/14. A PFI documented the resident fell at 6:30 AM, after being awakened by a housekeeper putting his clean laundry away in his closet. The investigation did not include documentation the facility had reconsidered the housekeeping assignments so laundry was put away after the residents were already up. Additionally, orthostatic blood pressures were not documented. On 11/4/14 at 3:50 PM, the Administrator was informed of thses findings. The facility provided no further information.	F 225			
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must 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 facility incident report review, record review and staff interview, it was determined the facility failed to ensure timely diagnostic work-ups and treatments for injuries residents received from falls in the facility. This was true for 2 of 9 residents (#s 1 and 4) sampled for falls. Resident	F 309	F309 QUALITY OF CARE 1. Resident #4 was re-evaluated and currently is not complaining of back pain. Resident #1 had arthroscopic repair of his meniscus on 11/19/14 and experienced no complications. Orthopedic follow-up appointments are scheduled. 2. The IDT reviewed other residents for change in function after a fall, scheduling of referral/consultations/diagnostics, timely implementation of adaptive equipment, and other physician directed interventions as indicated. Adjustments were made as indicated.	12/8/14	

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F 309	<p>Continued From page 10</p> <p># 4 was harmed when she experienced new onset of back pain conjunction with a fall, but did not have x-rays determining she had fractures until more than a month later. Resident #1 was harmed when he experienced acute knee pain following a fall in September, but did not receive an orthopedic consult for almost a month. Additionally, the orthopedist ordered a procedure to address the injury discovered, but the procedure was not scheduled for yet another month. Findings included:</p> <p>1. Resident #4 was admitted to the facility on 12/3/10, and re-admitted on 6/24/14 with multiple diagnoses which included recent large bowel obstruction, Type II diabetes mellitus, chronic kidney disease, organic brain syndrome, and alcohol-induced dementia.</p> <p>Resident #4's current falls care plan documented a history of chronic left hip and back pain related to a left hip replacement on 5/30/14. There was no documentation the resident had a history of compression fractures.</p> <p>Resident #4's Admission MDS, dated 7/1/14, coded: *Moderately impaired cognitive skills; *Supervision after set-up for ambulation; *Extensive assistance of 2 for toileting; *Limited assistance of 1 for dressing; *Frequent pain of 7 out of 10, which required medications but no non-pharmacological interventions.</p> <p>Resident #4 experienced 14 falls in the facility between 7/9/14 and 11/1/14, including falls on 7/9/14, 7/26/14, and 7/29/14. Please see F 323 for details.</p>	F 309	<p>3. The SDC and/or Director of Nursing (DON) has re-educated LN staff regarding change of condition post fall, to include but not limited to, appropriate assessments to identify change in function, new/change in pain care directives updates, and timely inclusion of reports in the clinical record.</p> <p>The IDT will validate timely diagnostic work-ups and treatment for injuries post fall during daily clinical review.</p> <p>4. The ED and/or designee will audit two post fall investigations weekly for 8 weeks to verify timely diagnostics, physician review, and appropriate treatment. The audit will be documented on the PI monitor beginning the week of December 8.</p> <p>The DDCO will validate the clinical review process through review of four post fall investigations monthly. Review will include review of change in function, documentation of treatments, and the resident response to treatment. The results of these audits will be reported to the PI Committee monthly.</p> <p>Any concerns will be addressed immediately and discussed with the IDT as indicated. The results will be reported to the PI Committee. After 60 days, the PI Committee will have the authority to adjust the number of incident reports to be reviewed when the requirements of this citation are met.</p>	

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F 309	<p>Continued From page 11</p> <p>Resident #4's MAR for July 2014 documented she received Oxycodone HCl/Acetaminophen 10/325 mg tablets 1-3 times per day. The resident had abdominal surgery on 6/20/14, thus the majority of her pain complaints were documented as abdominal pain. The MAR did document "back and abdominal pain" on 7/15/14 at 4:45 AM, "rib/back pain" on 7/20/14 at 1:15 AM, and pain in the lower back on 7/26/14.</p> <p>On 7/16/14, the resident was discharged from Physical Therapy (PT) and Occupational Therapy (OT). The PT and OT discharge summaries documented the resident was "modified independent" (resident completing more than 50 percent of the task, requiring adaptive equipment, or needing reminders for safety) with ambulation up to 400 feet, bed mobility if a "log roll" technique was used, transfers, dressing/undressing, and toileting.</p> <p>On 7/29/14 at 3:00 PM, a facility Post Fall Investigation (PFI) documented the resident fell while trying to sit in a chair in the dining room. A corresponding Nurse's Note (NN) documented the resident hit her head on a doorframe and complained of back pain. The resident was medicated with 50 mg Ultram.</p> <p>On 7/29/14 at 8:19 PM, a NN documented the resident's physician was updated regarding continued complaints of back pain. The physician's response was documented as a new order for ice three times daily for the resident's back, and that an x-ray would be considered if the resident's pain continued the next day. This was also documented on a pain assessment completed at 10:48 PM.</p>	F 309			

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F 309	Continued From page 12 On 7/30/14 at 5:40 AM, Resident #4's NN documented, "Res[ident] was ambulating to the bathroom at the start of shift and was walking very slowly and complaining of lower back pain related to her fall in the dining room..." No updates to the resident's pain care plan were made on 7/29/14 or 7/30/14. Resident # 4's MAR documented she received either Percocet, Oxycodone, and/or Ultram for complaints of back pain at least once daily from 7/29/14 through 8/11/14, 8/13/14 through 8/21/14, 8/24/14 through 8/27/14, 8/30/14, 8/31/14, 9/2/14 through 9/17/14, and 9/19/14. There was no documentation until 9/14/14 that the physician was notified of these continued complaints, or that an x-ray had been considered as documented in the 7/29/14 NN. Back pain was documented in the NN as well, including an entry on 9/4/14, when the resident experienced a fall and complained of 6/10 back pain (on a pain rating scale of 1-10). On 9/11/14, the NN documented 10/10 back pain. On 9/14/14, a NN documented the resident's physician was notified of continued complaints of flank pain. On 9/15/14, the NN documented a correlation between back pain and increased behaviors. Additionally, the NN documented decreased functional abilities for this resident. Beginning on 9/4/14, after a fall, the resident continued to complain of back pain, required the use of a wheelchair at times (9/4/14, 9/8/14, and 9/12/14), and when ambulating displayed an unsteady gait (9/5/14 and 9/10/14). On 9/18/14, a physician's progress note documented, "...Her main complaint today is her	F 309		

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F 309	<p>Continued From page 13</p> <p>chronic low back pain, it is located in the lumbosacral region. She noted that she took a fall, but she cannot tell me when or where that happened...The patient will have a lumbosacral spine film. She has not had any x-rays recently. It is difficult with her history to know when and how she fell as she is quite confused today..." A CT urogram of her pelvic region was also ordered.</p> <p>There was a 53 day delay between the time the resident's 7/29/14 fall and onset of back pain, and the time an x-ray was ordered to ascertain whether there was an injury to that area.</p> <p>On 9/19/14, a Final X-Ray Report for Resident #4 documented osteoporotic compression of T12, L2, and L4 vertebrae of undetermined age.</p> <p>On 9/20/14, a NN documented the physician was aware of the new diagnosis of compression fractures, and ordered Miacalcin spray (osteoporosis medication) daily. The NN also documented the physician wanted to be kept updated on the resident's pain.</p> <p>On 9/22/14 at 11:49 AM, the NN documented the resident continued to complain of back pain. At 3:12 that afternoon, the resident experienced another fall, this time complaining of "slight pain" to her right side and hip.</p> <p>On 9/29/14, the abdominal and pelvic CT results documented, "Multiple new compression fractures as compared to 6/20/14... the compression fractures are the likely etiology of the patient's back pain..." There was no documented response from the physician regarding these results. At the time the survey was conducted, there was no documentation the</p>	F 309		

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F 309	<p>Continued From page 14</p> <p>resident had been evaluated by a physician following the diagnosis of her fractures.</p> <p>On 11/4/14, when asked, the DNS stated she did not know why the x-ray had not been completed after the 7/29/14 fall when the resident's complaints of back pain continued; how pain from the fractures had been ruled out as a cause of her behavioral and functional changes; or whether the resident would benefit from further evaluation of her fractures to determine whether any precautions or limitations would be warranted to promote healing of her injuries. It could not be determined when the resident's status would be evaluated again to ensure healing was proceeding as expected. The DNS agreed there was a delay between the onset of the resident's complaints of back pain and x-rays being obtained.</p> <p>Resident #4 was harmed when she fell on 7/29/14 and began to complain of back pain. Although the facility documented the physician planned to obtain an x-ray of the resident's back if her pain complaints continued, this was not done. The resident continued to complain of back pain, x-rays were obtained on 9/19/14, and compression fractures were discovered. The facility did not ascertain what limitations or precautions were needed to ensure the injury healed as planned, nor was there a plan documented to ascertain if the injury had healed.</p> <p>On 11/4/14 at 3:20 PM, the Administrator, DNS, and DDCO were informed of these findings. The facility offered no further information.</p> <p>2. Resident #1 was admitted to the facility on 1/11/11 and readmitted on 6/26/14. His diagnoses</p>	F 309		

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F 309	<p>Continued From page 15 included embolic/ischemic stroke resulting in left sided hemiparesis, depression and anxiety, and vascular dementia.</p> <p>Please see F 323 for the resident's MDS data.</p> <p>*On 7/3/14 a PFI documented the resident fell. The PI recommendations after the fall documented the resident needed new shoes. Please see F 323 for details.</p> <p>On 11/4/14 at 12:35 PM, when asked, the DNS stated the resident's shoes had not been fastened properly when he fell, and the facility determined the resident would need new, special order orthotic shoes to fit over a brace he wore on his left leg. The DNS stated the facility let the resident's wife know of this need, but did not know for sure when the resident was fitted for, or received, his new shoes. The DNS stated the resident's wife had taken care of the matter, and did not believe the facility was involved with ensuring the resident obtained the necessary footwear identified to prevent further falls.</p> <p>*On 9/14/14 at 12:20 PM, a PFI documented the resident fell while trying to take off his new orthotic shoes, which he had just received. A NN following this fall documented the resident complained his right wrist was tender. It was not documented the resident's range of motion was assessed.</p> <p>On 11/4/14 at 12:35 PM, when asked, the DNS could not explain why the resident had just received his shoes at the time of the 9/14/14 fall, when the facility identified after his fall over two months prior the need for new shoes. The DNS stated she would have expected to see</p>	F 309			

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F 309	<p>Continued From page 16</p> <p>documentation the resident's range of motion was assessed after his fall, and could not explain why that had not been done.</p> <p>*On 9/14/14 at 3:05 PM a PFI documented the resident had another fall, this time complaining of left knee pain and right wrist weakness as contributing factors. A NN documented resident's range of motion was "good" in all his extremities but the left. At 7:47 PM, a NN documented the resident complained of right thumb pain. On 9/15/14 at 7:21 AM, a NN documented the resident had complained of left knee pain throughout the night. At 10:48 AM, a request was sent to a physician for an order for a left knee x-ray. The order was provided at 11:15 AM. At 12:12 PM, a request was made to add a x-ray of the left forearm and wrist. The x-ray results were documented as received by the facility on 9/15/14 at 1:19 PM, 25 hours after the first fall. The x-ray results documented no some abnormalities to the left knee, but the left wrist and forearm were normal. The x-ray results did not document the resident's right hand, wrist, or thumb had been assessed.</p> <p>On 11/4/14 at 12:35 PM, when asked, the DNS could not explain why there had been a delay after the resident fell and complained of pain, and orders were requested for x-rays. It could not be determined why the left forearm and wrist had been x-rayed when the resident's complaints of pain were on the right. As of the 11/4/14 interview, no diagnostic work-up had been done on the resident's right wrist, thumb, or hand.</p> <p>*On 9/17/14 at 10:50 AM, an IDT Event Review note documented the resident was evaluated by PT and the physician on 9/16/14 due to his falls.</p>	F 309		

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F 309	<p>Continued From page 17</p> <p>The PT evaluation documented the resident complained of 9/10 pain (on a pain scale of 1-10) in the left knee, needed 75% assistance with transfers, and could not ambulate. A progress note documenting the physician's assessment of the resident's falls and continued complaints of pain and functional changes, was not found in the resident's record.</p> <p>On 11/4/14 at 12:35 PM, when asked, the DNS stated the facility's medical director, a psychiatrist, had signed that he had seen the x-ray results on 9/16/14. However, the DNS stated if there was not a progress note from a physician documenting a physical assessment of the resident, it could not be determined that the resident was actually seen and evaluated by a physician on that date.</p> <p>*On 9/21/14 at 6:00 AM, a PFI documented another fall for the resident. The PI recommendations documented the resident was to use a wheelchair with staff assistance until the resident's knee could be evaluated, and the facility would request the resident's primary care physician to order an orthopedic consult.</p> <p>On 9/23/14, a progress note from the resident's primary care physician documented the resident had a fall on 9/15/14. [NOTE: The resident actually fell twice, on 9/14/14]. This was the first documented physician's assessment since the resident's two falls on 9/14/14 and the fall on 9/21/14. The physician documented the resident's left knee continued to feel weak, "gave out" when he was not expecting it, would "pop", and felt unstable. The physician's assessment was documented as, "Fall with some knee injury, now with buckling of the knee in a patient with</p>	F 309		

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F 309	<p>Continued From page 18</p> <p>hemiparesis." The progress note documented the resident should have an orthopedic consult to see if an MRI needed to be done, and an order for the consult was written. There was no documentation as to what the nature of the knee injury was. There was no documentation to instruct the staff as to any limitations or restrictions for the resident to protect from further injury while awaiting the orthopedic consultation, specifically with transfers and ambulation.</p> <p>On 11/4/14 at 12:35 PM, when asked the DNS stated the delay between the fall on 9/21/14 and the physician's visit on 9/23/14 was because the fall took place on a Sunday and the physician made her next visit to the facility on a Tuesday. The DNS stated the facility did not think to question this because the resident had already had a x-ray of the left knee, which did not show a fracture. The DNS agreed the resident's symptoms of "popping" and "buckling" were concerning. It could not be determined if the resident would have benefited from a second x-ray after falling and complaining again of knee pain on 9/21/14, six days after the x-ray was obtained.</p> <p>The facility documented they faxed a referral sheet to the orthopedic physician on 9/25/14. There was no documentation as to why the referral was not provided to the orthopedic physician for 2 days after the order for the referral was written. The documentation provided by the facility did not include any clinical information provided to the orthopedist, other than the resident had a fall with a knee injury, which needed to be diagnosed and treated.</p> <p>On 10/9/14, two weeks after the primary care</p>	F 309		

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F 309	<p>Continued From page 19</p> <p>physician ordered the consultation, and orthopedic progress note documented the resident presented in the office with left knee pain from an injury fall approximately three weeks prior. The injury was described as a "twisting" injury. The progress note documented the resident was given a Cortisone shot in the physician's office, but if the pain did not improve over the next 1-2 days the resident would require an MRI to rule out a torn meniscus.</p> <p>There were no entries in the resident's record at the facility that this appointment had taken place, nor that the resident would need to be monitored for the effectiveness of the injection or follow up with the orthopedic physician if relief was not noted within 1-2 days. There was no documentation as to whether the resident had an MRI. In fact, between 10/10/14 and 10/15/14 there were no entries in the resident's NN.</p> <p>On 10/15/14 at 9:08 PM, a NN documented the facility was contacted by the orthopedic physician, verbally informing the facility of MRI results and ordered the resident to be non-weight bearing through his left leg, and that he would need a follow-up appointment as soon as possible. On 10/16/14 at 9:14 AM, a NN documented the resident's wife had scheduled the follow up appointment for 10/21/14. The facility did not have a copy of the MRI results at the time of the survey on 11/4/14. After requested by the survey team, the facility contacted the orthopedist and obtained a copy of the MRI, which documented the resident had a nondisplaced fracture of the lateral tibial plateau, possible small superficial medial meniscal tear and a mild lateral tilt of the patella.</p>	F 309			

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F 309	<p>Continued From page 20</p> <p>On 10/21/14 at 9:45 PM, a NN documented the resident had returned from an orthopedic appointment that day, and the orthopedist's office would be scheduling an arthroscopy. The NN documented if the facility had not received confirmation of an appointment being scheduled within a week, the facility should contact the orthopedist's office to schedule the procedure. No further documentation regarding this issue was noted. It could not be determined if the appointment had been scheduled within a week, as ordered by the orthopedist; and/or the facility had made contact if the appointment had not been scheduled.</p> <p>On 11/4/14 at 12:35 PM, the DNS stated she did not know if the appointment for the arthroscopy had yet been scheduled, but she would check on it. At 3:05 PM, the DNS provided a hand-written sticky note which documented the procedure was scheduled for 11/19/14 at 8:45 AM, almost a month after the physician ordered the procedure be scheduled. When asked when the appointment had been made, the DNS did not respond.</p> <p>The facility failed to facilitate a resident receiving orthotic shoes in a timely manner, or assisting the resident to adapt to the use of those shoes to prevent falls. The resident experienced further falls, and was harmed when the facility failed to ensure he was evaluated by a physician after falling multiple times. The resident experienced an increase in his discomfort and a decline in his function. Once the resident was evaluated, the facility failed to ensure follow-up diagnostic evaluations and treatment plans were implemented timely, and that the resident was protected from further injury while awaiting these</p>	F 309			

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F 309	Continued From page 21 evaluations. Further, it could not be determined an appointment for a treatment determined to be necessary to facilitate healing of the resident's injuries, alleviate his pain, and enable him to return to his prior level of functioning was scheduled timely by the facility.	F 309		
F 323 SS=G	On 11/4/14 at 3:50 PM, the Administrator was informed of these findings. The facility offered no further information. 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 review of fall investigations, record review and staff interview, it was determined the facility failed to ensure the safety of residents from falls and accidents. This was true for 5 of 9 (#s 1,4,5,7 & 9) sampled residents. *Resident #1 was harmed when he fell and sustained a left lateral tibial plateau fracture and torn meniscus. *Resident #4 was harmed when she fell 14 times in a 4 month period, experienced increased pain and decreased function, and was later diagnosed with 3 compression fractures. *Resident #5 was harmed when he fell five times and sustained a left hand fracture of the 5th	F 323	F323 ACCIDENT/INCIDENT INVESTIGATION 1. Residents #1, 4, 5, 7, and 9 had their falls re-evaluated by the IDT to establish root cause. Resident care plans were adjusted as indicated for fall prevention. 2. The IDT reviewed other residents with multiple falls in the last 6 months and any resident who has fallen in the last 30 days to establish root cause. Resident care plans were adjusted as indicated for fall prevention. 3. The SDC and/or DON has re-educated staff regarding the prevention of accidents and incidents, to include but not limited to: • Development of a fall prevention plan on admission and with resident change of condition to include review of medication risk factors, room changes, sleep pattern hygiene, medical condition, and physician directives for blood pressure parameters as indicated.	12/8/14

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F 323	<p>Continued From page 22</p> <p>metacarpal with unknown origin. *Resident #7 fell due to lack of 1:1 supervision. *Resident #9 fell two times with one witnessed fall and one unwitnessed fall.</p> <p>Findings included:</p> <p>1. Resident #4 was originally admitted to the facility on 12/3/10, and most recently admitted on 6/24/14 with multiple diagnoses which included recent large bowel obstruction, Type II diabetes mellitus, chronic kidney disease, organic brain syndrome, and alcohol-induced dementia.</p> <p>Resident #4's Admission MDS, dated 7/1/14, coded: *BIMS of 8, indicating moderately impaired cognitive skills; *Delusions; *Verbal behavioral symptoms 1-3 days out of the past 7 days; *Behavioral symptoms did not impact the resident, others, or disrupt the social environment of the facility; *Supervision after set-up for ambulation; *Extensive assistance of 2 for toileting; *Limited assistance of 1 for dressing; *Frequent pain of 7 out of 10, which required medications but no non-pharmacological interventions; and *Falls in the past month, but no falls for 2-6 months prior to that.</p> <p>Resident #4's current fall care plan documented the resident had falls, and was at increased risk for further falls due to poor balance, impaired perception of her body position, confusion, visual deficits, gait, balance impairment, incontinence, and psychotropic medication use. Interventions in</p>	F 323	<ul style="list-style-type: none"> • Thorough completion of the "Post Fall Investigation" with identification of root cause and updates to the plan of care to prevent future falls. • The daily clinical review process will include review of post fall events for quality of investigation, root cause identification, and care plan updates. In addition, re-evaluation of plan effectiveness will occur within 7 days of the fall. Plans will be adjusted as indicated. • The DDCO has re-educated the ED and ITD regarding the IDT responsibility for fall prevention, post fall investigation, and post fall follow up and role as care oversight committee. <p>4. The Case Management Coordinator (CMC), ED, and/or designee will evaluate the thoroughness of two post fall investigations each week for 8 weeks for analysis of medication use and impact on fall risk, signed interviews, evidence of logical root cause, plan addresses root cause, and review occurs to validate plan effectiveness within 7 days of fall. The audit will be documented on the PI monitor beginning the week of December 8. Any concerns will be addressed immediately and discussed with the IDT as indicated. The results will be reported to the PI Committee. After 60 days, the PI committee will have the authority to adjust the number of incident reports to be reviewed when the requirements of this citation are met.</p>	

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F 323	<p>Continued From page 23</p> <p>place beginning 6/3/14 included ensuring the call light was in reach and encouraging the resident to use her four-wheeled walker when ambulating, as well as PT to evaluate and treat as needed. On 6/24/14, an intervention to verbally instruct her when seating or transferring her, using one-step instructions was added. The 6/24/14 intervention was the only new fall intervention put in place for this resident when she returned to the facility following a surgical procedure to remove a large bowel obstruction. There was no documentation for additional supervision for the resident who was acutely ill and confused. The resident fell 14 times between 7/9/14 and 11/1/14.</p> <p>The following documents were reviewed for each of the resident's falls: Nursing Progress Notes (NN), Post Fall Investigations (PFI), Interdisciplinary Team Event Reviews (IDT) care plan updates (CP), Physician's progress notes (MDPN), Morse Fall Risk Scale (MFRS), Weights and Vitals Summary for Blood Pressure (BP), MARs, and the 2015 Nursing Drug Handbook (NDH).</p> <p>Fall #1. On 7/9/14 at 11:50 AM, a NN documented the resident slid out of bed trying to scratch her abdomen; the PFI documented the fall occurred when the resident was sitting at the edge of her bed; and witness statements documented she was attempting to dress herself and scratch her abdomen. The PI (Performance Improvement) Recommendations documented the resident would wear non-skid socks or shoes at all times. The resident's CP was updated to monitor for gait changes, but did not include an update for non-skid socks. On 7/16/14, seven days after the fall, an IDT review in the resident's NN documented the resident had agreed to wear</p>	F 323			

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F 323	<p>Continued From page 24</p> <p>non-skid socks. When asked on 11/4/14 at 9:15 AM, the DNS stated she had determined the root cause to be the lack of appropriate footwear, based on an interview with the resident the day following the fall. The DNS stated she had not documented the interview anywhere, and could not explain how other factors, such as as the amount of assistance offered for dressing, or the cause of the itching on the resident's abdomen had been ruled out. The DNS stated the facility did not incorporate increased assistance or supervision to the resident's CP following this fall.</p> <p>On 7/9/14, a Morse Fall Risk Scale was completed for Resident #4 with a score of 85, indicating the resident was at high risk for falls. The fall risk scale was repeated on 7/26/14, 7/29/14, 7/30/14, 9/4/14, and 9/22/14. The resident remained in the high risk for falls category for each of these assessments. The "Risk Variables" were documented as a history of falls, the need for a walker when ambulating, the resident's tendency to overestimate or forget limitations, the use of multiple medications, diagnoses of dementia and diabetes, confusion, weakness, depression, and occasional incontinence.</p> <p>On 7/16/14, the resident was discharged from Physical Therapy (PT) and Occupational Therapy (OT). The PT and OT discharge summaries documented the resident was "modified independent" (resident completing more than 50 percent of the task, requiring adaptive equipment, or needing reminders for safety) with ambulation up to 400 feet, bed mobility if a "log roll" technique was used, transfers, dressing/undressing, and toileting.</p>	F 323			

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F 323	<p>Continued From page 25</p> <p>On 7/21/14 at 6:03 PM, the NN documented the resident was started on the medication Tegretol 200 mg twice per day for a new diagnosis of bipolar disorder, and that her dose of Wellbutrin was increased from 75 mg twice daily to 150 mg twice daily. The NDH documented potential adverse reactions for both medications as dizziness, ataxia (impaired gait), and syncope.</p> <p>Fall #2. On 7/26/14 at 11:30 AM, a PFI for Resident #4 documented a second fall. The NN documented the resident abandoned her walker in the dining room, ambulated to a "side table" to pick dead leaves off of a plant, lost her balance, and fell. The PFI documented PI Recommendations of closed toe, closed heeled non-skid shoes, and to remind the resident to use her walker.</p> <p>On 7/29/14 at 10:04 AM, an IDT Event Review in Resident's #4's NN documented the resident was forgetful and required reminders to use her walker. [NOTE: This intervention was added to the resident's care plan on 6/3/14, therefore should have been implemented when the resident abandoned her walker to approach the plants on the side table.] The NN documented the resident's preference to wear Croc-type shoes, with a plan that social services would talk to the resident about using different shoes. The intervention of "solid grip tennis shoes" was added to the resident's care plan on 10/14/14, however the resident did not receive the tennis shoes until 10/27/14. The event review did not document whether the addition of Tegretol and increased Wellbutrin just 5 days prior had been evaluated as a contributing factor to the resident's fall. No interventions for increased supervision or assistance were added to the resident's care</p>	F 323		

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F 323	<p>Continued From page 26 plan.</p> <p>When asked on 11/4/14 at 9:15 AM, the DNS and DDCO stated the facility provided the resident with non-skid socks, but not different shoes. The DDCO confirmed the documentation related to the fall did not address if adverse effects of the medication changes had been considered and ruled out as a causative factor.</p> <p>Fall #3. On 7/29/14 at 3:30 PM a NN documented the resident fell in the dining room while trying to get into a chair. The resident complained of new onset of back pain and was medicated with Ultram. At 8:19 PM the physician was notified of continued back pain. The NN documented the physician ordered ice to be placed to the resident's back three times daily, and a x-ray be obtained if the complaints of pain continued the next day. The FSI documented maintenance to examine/repair "leg sliders" on the bottom of the dining room chair legs, as the chair the resident was using had worn sliders. The resident's MAR documented complaints of back pain which continued throughout the remainder of July, August, and September 2014. See F 309 for details.</p> <p>When asked on 11/4/14 at 9:15 AM, the DNS stated the root cause of this fall was related to worn down small plastic attachments on the bottom of the dining room chair legs, which made it difficult to slide the chairs across the floor. The facility inspected and replaced the worn parts to correct the problem. Additionally, the DNS was asked why the x-ray had not been obtained for this resident when her complaints of back pain continued. The DNS stated she did not know.</p>	F 323			

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F 323	<p>Continued From page 27</p> <p>Fall #4. On 7/30/14 at 6:00 AM, a PFI documented the resident fell from her bed, stating the mattress was slick. The NN documented the resident continued to complain of back pain from her fall the previous day. The facility documented they changed her bed from a bariatric bed to a "regular" bed with bolsters, however it was not added to the resident's care plan until 8/17/14.</p> <p>An 8/1/14 IDT Event Review NN documented an unknown family member reported a history of the resident sliding to the floor to get attention. It was unclear how the family member had determined this to be a deliberate behavior, how often it occurred, what may trigger the behavior, or what interventions may be helpful if the behavior occurred. The care plan was not updated with this information until 10/20/14, after the resident had fallen 6 more times.</p> <p>On 11/4/14 at 9:15 AM, the DNS stated the resident had been on a bariatric air bed at the time of her re-admission to the facility, and was changed to a standard hospital bed with bolsters to define the edge of the bed after the 7/30/14 fall. The DNS could not explain why the root cause of the resident's back pain had not been identified and addressed.</p> <p>Fall #5. On 9/4/14 at 6:30 AM, a PFI documented the resident fell getting out of bed. A NN documented the resident was wearing poorly fitting non-skid socks. On 9/4/14 at 11:17 PM, and again on 9/5/14 at 9:49 AM, the NN documented the resident was now using a wheelchair for mobility, however the wheelchair was not added to the resident's care plan until 10/31/14. The PI recommendations documented non-skid strips on the floor at bedside, and staff was to ensure the</p>	F 323		

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F 323	<p>Continued From page 28</p> <p>resident was wearing "fitted" non-skid socks. The PI recommendations were added to the care plan on 9/4/14. This was the third of her 5 falls attributed in part to improper footwear. The resident continued to complain of back pain after this fall.</p> <p>On 11/4/14 at 9:15 AM, the DNS confirmed the resident was wearing poorly fitted non-skid socks at the time of the fall, and the IDT concluded staff was to ensure the resident had "fitted" non-skid socks. No explanation was offered as to how the facility had addressed the resident's ongoing complaints of back pain.</p> <p>From 9/4/14 to 9/19/14, Resident #4's NN documented multiple changes in her health and behavioral status, including continued complaints of back pain, at times at an intensity of 10 out of 10; a UTI; an increase in her Seroquel dose on 9/8/14 and 9/15/14; the addition of Ambien on 9/8/14; an increase in her Tegretol dose on 9/15/14; and new orders for "as needed" Haldol and Benadryl on 9/12/14. Please see F 329 for details. On 9/19/14, Resident #4's NNs documented new orders to increase her diabetic medication (causing the potential for low blood glucose levels), increase her anti-hypertensive medication Lisinopril (increasing her risk for hypotensive episodes), and initiate a routine dose for Ultram, in addition to her "as needed" dose. Additionally, there was an order for a lumbar sacral spine x-rays.</p> <p>The resident's Final X-Ray Report dated 9/20/14 documented the resident had osteoporotic compression fractures of T12, L2, and L4 vertebrae, of undetermined age. It could not be determined from the documentation if the</p>	F 323		

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F 323	<p>Continued From page 29</p> <p>resident required further diagnostic work-up, or if there was a need for precautions and/or limitations related to the fractures.</p> <p>On 11/4/14 at 9:30 AM, the DNS stated she did not know why the resident's back had not been x-rayed between the onset of her complaints of back pain following her 7/29/14 fall, and the time the x-ray was completed on 9/19/14. The DNS was unable to provide evidence the resident had received increased supervision following any of her falls or medication changes, and was unaware whether there was to be any further diagnostic work-up or treatment needed for the fractures. The DNS stated she did not believe the fractures could be attributed to the 7/29/14 fall, as the resident had a history of compression fractures. The DNS was unable to provide documentation related to the resident's history of fractures, and was unable to explain why that would negate the facility's responsibility for providing adequate assistance and supervision to prevent falls for this resident.</p> <p>On 9/22/14 at 11:49 AM, the NN documented the resident had been having back pain, and was scheduled for a CT urogram the following day due to continued UTIs.</p> <p>Fall #6. On 9/22/14 at 3:30 PM, the PFI documented the resident fell trying to ambulate from a chair in her room to look for a stuffed dog. The NN documented the resident had recently been moved to a new room and was trying to find her things. The PI Recommendations included moving the resident to a "high traffic" room (near the nurse's station); encouraging the resident to participate in activities; providing staff assistance when the resident was "looking for things;" and</p>	F 323			

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F 323	<p>Continued From page 30</p> <p>wear non-skid socks. No new interventions were documented on the resident's care plan. On 9/25/14 an IDT review documented the resident had been "more manic," noncompliant, and a history of putting herself on the floor.</p> <p>On 9/29/14, the results of the resident's CT urogram documented, "Multiple new compression fractures...the compression fractures are likely the etiology (cause) of the resident's back pain."</p> <p>On 11/4/14 at 9:15 AM, the DNS stated after the 9/22/14 fall, the facility determined the resident had a long history of putting herself on the floor to get attention, therefore it was unclear if this event was a fall. The DNS stated she had been sitting in her office at the time of the fall, and did not hear a "thud" therefore she determined the resident had placed herself on the floor, and had not "technically" fallen. When asked, the DNS stated the facility's process for acclimating a resident to a new room was to show the resident their new room, introduce them to their roommate, explain the reason for the room change, and monitor if they liked the room. The process did not involve increased supervision, or ongoing orientation for the resident to identify placement of his or her things. Additionally, the DNS was asked if the multiple medication changes were considered and ruled out during the investigative process, the DNS was unable to explain.</p> <p>Fall #7. On 10/11/14 at 3:00 AM, the PFI documented the resident had fallen in her room after taking herself to the restroom. The PI Recommendations documented the resident was to be offered assistance to the toilet "every round" at night, and this was added to the resident's care</p>	F 323			

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F 323	<p>Continued From page 31</p> <p>plan. The NN documented the resident was reminded to use her call light to ask for assistance. It could not be determined how the facility assessed the cognitively impaired resident was able to remember to ask for assistance at night.</p> <p>Fall #8. On 10/14/14 at 5:55 AM, the PFI documented, the resident fell in her room, wearing no pants, no incontinence brief, or shoes. Additionally, the resident was incontinent and was attempting to retrieve a new brief from the closet when she fell. The form documented the resident "self toilets," even though the new intervention from her fall on 10/11/14 documented the resident was to be offered assistance toileting at night. The PI Recommendations documented a physical therapy referral was requested for the resident, and the alarmed mat was to be removed; however this was the first documentation of an alarmed mat for the resident and it was not on the care plan. Additionally, the physician was to evaluate her blood pressures.</p> <p>On 10/16/14 at 8:40 AM, an IDT event review documented the resident did not consistently understand or agree with her limitations and would at times argue or laugh when reminded. The event review documented the resident fell on 10/11/14, and had been assisted by staff to use the bathroom at night since that time, and had not fallen since. However, the resident fell on 10/14/14 while taking herself to the toilet at night.</p> <p>On 11/4/14 at 9:15 AM, the DNS stated the resident was now working with PT, and the physician had evaluated her blood pressures on 10/28/14. The DNS could not explain the delay in these interventions being implemented.</p>	F 323			

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F 323	<p>Continued From page 32</p> <p>On 10/18/14 at 10:00 AM, the NN documented the resident received 30 mg of Geodon IM due to threatening staff, and at 2:14 PM the resident had been sleeping most of the time since the medication was given.</p> <p>Fall #9. On 10/19/14 at 2:50 PM, the PFI documented the resident objected to a staff member helping her to ambulate back to bed from the bathroom, and the resident fell backwards. The PI Recommendations documented the facility's medical director (a psychiatrist) was to review the resident.</p> <p>On 10/20/14 at 3:20 PM, an IDT event review documented the resident had some low blood pressures, however, no BP values were given. The facility documented the physician would review the resident's BPs at the "next visit." The IDT review referred to the fall on 10/14/14 and documented, "She has not been to therapy since July will refer back to PT to work on balance..."</p> <p>At 3:48 PM second IDT event review documented the resident had called out for help, a CNA approached her to steady her by reaching for the resident's belt loop, at which point the resident objected to the care provided and fell backwards.</p> <p>On 11/4/14 at 9:15 AM, the DNS was unable to explain why the resident's blood pressures had not been reviewed. Additionally, PT was recommended after the fall on 10/14/14, however had not started until after the fall on 10/19/14. The DNS confirmed the belt loop would not be the preferred method of preventing a fall. The DNS said she did not think a CNA grabbing the resident by the belt loop would cause resistive behavior.</p>	F 323			

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F 323	Continued From page 33 Fall #10. On 10/20/14 at 4:55 PM, the PFI documented a CNA observed the resident, "on the floor on her bottom pushing herself around the floor on her bottom with her hands." The PI Recommendations documented the primary physician was to review the resident, however the documentation did not identify what specifically the physician was to review. A NN documented the resident was encouraged to use a wheelchair, but refused. On 10/20/14 at 7:14 PM, the NN documented the new orders for Geodon 20 mg IM every 8 hours as needed, increase her dosages of Wellbutrin and Tegretol, add Abilify, and continue her Seroquel at a lower dose. On 10/21/14, the resident was evaluated by PT and the evaluation documented the resident had deteriorated in her abilities to move herself around in bed, walk, transfer, and had decreased balance after she was discharged from services on 7/16/14. On 11/4/14, when asked, the DNS stated the facility requested the physician evaluate the resident for her BP medications. The DNS offered no explanation as to why this evaluation had not occurred. The DNS was asked and was unable to explain if or how the facility had increased monitoring of the resident following the multiple psychotropic medication changes made on 10/20/14. Fall #11. On 10/22/14 at 7:20 AM, a PFI documented the resident was found in a seated position in the hallway with her walker behind her. A NN documented the resident was calm,	F 323		

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F 323	<p>Continued From page 34</p> <p>changed her story twice, and complained of pain, however, pain medications were not administered related to concerns it would cause the resident to be even more unsteady. The PI Recommendation documented to have the primary physician evaluate the resident. No new interventions were implemented to ensure the resident's safety while waiting for the physician's evaluation.</p> <p>On 11/4/14 at 9:15 AM, the DNS stated the facility wanted the physician to review the resident's blood pressures. The DNS stated the facility had determined the resident had fallen deliberately, based on her demeanor at the time of the fall, inconsistencies in her story, and the resident's son stating this had been a previous history for her. The DNS was unable to explain why the resident had not been treated for pain when she asked for pain medications, or how further injury was ruled out.</p> <p>On 10/28/14 the physician reviewed the resident's blood pressures, and increased her blood pressure medication.</p> <p>Fall # 12. On 10/28/14 at 8:15 PM, a PFI documented the resident was ambulating in the hallway, started to sway, and was lowered to the floor. The PI Recommendations for this fall were, "Family conference to discuss discharge and fall prevention to accomplish this," and, "...have asked Social Services to schedule a care conference...which includes safety compliance and more appropriate ways to get attention than being on the floor. She [the resident] needs to understand that with the meds she takes she is higher risk and we will explain the safety factors she needs to be aware of..."</p>	F 323		

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F 323	Continued From page 35 Fall #13. On 10/29/14 at 3:15 PM, a PFI documented the resident was standing near her bed holding onto her walker and fell to the floor, and the nurse had been in the room with the resident 2 minutes prior to the fall. The PI Recommendations documented the resident was to use a wheel chair instead of a walker for mobility, and if the resident was insistent on using her walker without staff, the walker was to be removed from the resident's reach. Additionally, the purchase of stable shoes was recommended. On 10/29/14 at 4:11 PM, a NN documented a care conference was held with the resident, two nurses, a social worker, and the Administrator. The plan was to remind the resident of her goal of transitioning to an assisted living; to use her call light; and to wear non-skid socks; and non-skid shoes were to be purchased for the resident. On 10/31/14, an IDT event review documented the facility purchased shoes for the resident. On 11/4/14 at 9:15 AM, when asked why the resident did not already have the non-skid shoes as an intervention for a fall on 7/29/14, the DNS stated the resident had refused to wear different shoes at the time the original intervention was identified. The refusals had not been documented. The DNS was unsure if the resident had other shoes available before the facility purchased them on 10/31/14. Fall #14. On 11/1/14 at 1:31 PM, a NN documented the resident fell attempting to take herself to the bathroom, less than an hour after she was reminded to call for help. The facility had not finished the investigation of this fall at the time	F 323			

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F 323	<p>Continued From page 36 of the survey.</p> <p>Resident #4 was harmed when she fell 14 times in a four month period, complained of new onset back pain, experienced a decline in her functional abilities, and suffered from 3 compression fractures in her back. The facility failed to determine the underlying causes for the resident's falls and did not implement interventions to include increased supervision. The facility did not monitor and evaluate the effectiveness of their interventions, or modify those interventions after the resident continued to fall.</p> <p>On 11/4/14 at 3:20 PM, the Administrator was informed of these findings. The Administrator stated, "I know the resident had a history of putting herself on the floor, but there were things I was told were done that were not done. There is no defense against the indefensible." The facility offered no further information.</p> <p>2. Resident #1 was admitted to the facility on 1/11/11 and readmitted on 6/26/14. His diagnoses included embolic/ischemic stroke resulting in left sided hemiparesis, depression and anxiety, and vascular dementia.</p> <p>On 7/2/14, the resident's change of condition MDS assessment coded: *Cognitively intact; *Impaired range of motion in one arm and one leg; *No mood indicators, including insomnia; *No behaviors; *Supervision for transfers, ambulation, and eating; *Limited assistance of 1 person for dressing, bed</p>	F 323			

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F 323	<p>Continued From page 37 mobility, and hygiene; *Continent of bladder; and *1 fall with minor injury since his previous MDS assessment on 3/30/14.</p> <p>No falls care plan was documented for the resident until 7/7/14.</p> <p>Fall #1. On 7/3/14 at 4:00 PM, a PFI documented the resident became dizzy and fell while ambulating from his room to the dining room. The PI Recommendations included new shoes for the resident. There was no documentation on the resident's care plan regarding footwear until 8/25/14.</p> <p>On 11/4/14 at 12:35 PM, when asked, the DNS stated the resident's shoes had not been fastened properly when he fell, and the facility determined the resident would need new, special order orthotic shoes to fit over a brace he wore on his left leg. The DNS stated the facility let the resident's wife know of this need, but did not know for sure when the resident was fitted for, or received, his new shoes.</p> <p>On 7/4/14, PT progress notes documented the resident was able to ambulate with a 2-wheeled walker and transfer with modified independence and supervision in crowded areas, but continued to be a fall risk. There were no concerns documented with range of motion in the resident's left knee or the resident's ability to bear weight through his lower extremities.</p> <p>On 7/7/14, the facility initiated a care plan for risk of falls due to diminished safety awareness and history of falls. Interventions included anticipate and meet the resident's needs; encourage use of</p>	F 323		

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F 323	<p>Continued From page 38</p> <p>the call light and prompt response to requests for assistance; encourage the use of a cane when ambulating; and monitor for gait changes. NOTE: Since the resident had left sided weakness from his stroke, he used his right hand to manage his cane.</p> <p>On 9/5/14, the resident was started on Restoril 30 mg at bedtime routinely for a diagnosis of insomnia. Per the 2015 Nursing Drug Handbook, adverse reactions for Restoril were documented as dizziness, disturbed coordination, confusion, vertigo, weakness, and fatigue. Please see F 329 for details.</p> <p>On 9/8/14, a progress note from the resident's psychiatrist documented, "...continues to be rather drowsy during the day. Nursing report that he tends to fall asleep even standing up...Review of his medication shows significant doses of methadone, which is likely the most prominent contributor of the sedation..." The note did not address the addition of a hypnotic medication for insomnia just three days prior, or the resident's methadone.</p> <p>Fall #2. On 9/14/14 at 12:20 PM, a PFI documented the resident fell while attempting to stand and put his shoes on. The description of the event documented the resident had received new orthotic shoes, and was trying to remove them while standing in the hallway. A CNA assisted the resident to remove his shoes, without having him sit, and he lost his balance and fell. The PI Recommendations were to educate the CNA to have the resident sit when assisting him with his footwear. The resident's record documented his right wrist was tender, but did not document an assessment of his range of</p>	F 323			

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F 323	<p>Continued From page 39</p> <p>motion for any of his extremities following this fall. The facility did not document increased supervision for the resident after he fell, even though he was complaining of tenderness in the extremity he used to manage his cane. The PFI did not document the addition of a hypnotic medication 9 days prior. The PFI documented the incident took place at 12:20 PM, but the physician and family were both notified at noon, twenty minutes before the event occurred.</p> <p>On 11/4/14 at 12:35 PM, when asked, the DNS stated the resident reported after he fell that he had received his new orthotic shoes, and was instructed to wear them for only an hour and a half at a time until they were broken in. The DNS stated the facility was unaware the resident had received his new shoes, and had not received instructions as to when and how they were to be applied from the orthotic shoe provider. The DNS agreed this was information the facility should have had, and the facility should have been evaluating the resident after he received the shoes. The DNS stated the resident told the facility he had been wearing the new shoes for the allotted time, and was trying to remove them while standing in the hallway. The resident did request assistance from a CNA who was in the room across the hall. The DNS stated it was a new CNA who did not realize the resident should sit when being assisted with footwear. The DNS stated the fall was determined to be the facility's fault, and the CNA was educated. The DNS could not determine, from the documentation on the PFI or in the NN, if the resident's range of motion had been assessed after this fall. The DNS could not determine which physician had been notified, when they were notified, or what the physician's response had been. The DNS was unable to</p>	F 323			

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F 323	<p>Continued From page 40</p> <p>determine what, if any, increased supervision was provided for the resident after his fall.</p> <p>Fall #3. On 9/14/14 at 3:05 PM, less than 3 hours after the previous fall, a PFI documented the resident fell again. The description of the fall documented, "My knee was sore from earlier fall. [Left] knee buckled. Also with [increased] weakness in [right] hand which he holds cane with." The PI Recommendations from this fall documented the resident was to use a wheelchair until a PT evaluation could be obtained, and staff to assist with ambulation until "back to baseline." At 3:48 PM, the resident's NN documented, "... [complains of] pain left knee 4 [out of] 10...Also stated his right hand felt weaker. [Range of motion] good in all extremities but left..." The PFI documented the physician was notified of the fall at 4:00 PM, but did not document whether the notification included the resident's complaints that his knee buckled and was painful, or that his right wrist was weak and tender. The form did not document which physician was notified. The form did not document whether the physician was notified in person, by telephone, or via fax. There was no response from the physician documented on either the PFI or in the NN at the time of the fall.</p> <p>There was no documentation as to how the resident was being transferred by staff after his second fall on 9/14/14.</p> <p>On 9/14/14 at 7:47 PM, the NN documented the resident complained of right thumb pain, and was given pain medication.</p> <p>On 9/14/14, the resident's care plan was updated to include "actual falls" as a focus area.</p>	F 323		

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F 323	<p>Continued From page 41</p> <p>Interventions included, "All dressing including putting on jacket and shoes while sitting down due to left sided weakness and poor balance," and to monitor for pain, bruises and change in mental status for 72 hours due to new onset confusion, sleepiness, and agitation.</p> <p>On 9/15/14 at 7:21 AM, the NN documented that throughout the night, the resident had complained of 8 out of 10 pain in his left knee, and would not put weight on his leg. The NN documented pain medication was given, but did not document the physician was notified of these developments.</p> <p>On 9/15/14 at 10:48 AM, the NN documented the physician was updated on the resident's falls and complaints of pain. The NN documented the resident reported tenderness in the left medial knee and radiated to his posterior knee. An x-ray to the left knee was requested.</p> <p>On 9/15/14 at 11:15 AM the facility documented the medical director (a psychiatrist) ordered an x-ray to the left knee. At 12:12 PM, the facility requested, and an order was provided, for a x-ray of the left wrist and forearm. There was no documentation as to why the left forearm and wrist were being x-rayed in light of the resident's complaints of pain to his right wrist and thumb.</p> <p>On 9/15/14, a Final X-Ray Report for the resident's left forearm documented the results were normal. The Final X-Ray Report for the resident's left knee documented no fracture was seen, but mild osteoporosis and mild osteoarthritis were present. No new orders or other instructions were documented. It could not be determined whether the resident's primary care physician had been made aware of any of</p>	F 323			

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F 323	<p>Continued From page 42</p> <p>the resident's falls, or complaints of tenderness, weakness, or pain after the falls.</p> <p>On 9/16/14 a PT Plan of Care documented the resident had 9/10 pain in his left knee and 6/10 pain to his right wrist which had a severe effect on his function; impaired ROM and strength in his left leg; needed maximum (75%) assistance for transfers, and was unable to ambulate.</p> <p>On 9/17/14 at 10:50 AM, an IDT Event Review progress note documented the physician and PT had evaluated the resident on 9/16/14, and staff was assisting the resident to ambulate. There was no documentation present regarding the results of the physician's evaluation of the resident. It could not be determined how the staff was assisting the resident to ambulate, given the PT Plan of Care documented the resident was unable to ambulate.</p> <p>There was no documentation in the NN regarding the resident's mobility, pain, or what type of increased supervision or assistance were being provided between 9/17/14 and 9/21/14. There were no entries in the NN for 9/18/14 or 9/20/14.</p> <p>On 11/4/14 at 12:35 PM, when asked, the DNS stated she could not determine which physician had been notified of the resident's fall, nor when the physician was made aware of the resident's weakness or increased pain. The DNS could not find documentation the resident had been physically examined by a physician after having two falls in one day. The DNS stated the resident had a negative x-ray and was evaluated by PT, so the facility felt comfortable they had ruled out significant injury and the resident would return to his baseline status with PT.</p>	F 323			

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F 323	<p>Continued From page 43</p> <p>Fall #4. On 9/21/14 at 6:30 AM, a PFI documented there resident fell in his room. The event description documented housekeeping staff had been in the resident's room putting away his laundry, after which the resident tried to stand from bed. A NN documented the resident complained of pain in his left shoulder, left knee, and left hip. The PFI documented a progress note was faxed to the physician; however it was not clear which physician was faxed, and there was no confirmation or response documented from the physician. The PI Recommendations documented the facility would request a physician's order for an orthopedic evaluation, and the resident would use a wheelchair with staff assistance until this evaluation took place. There was no documentation that the facility considered re-scheduling the time laundry was put away in resident rooms. There was no evaluation documented regarding the resident's new complaints of pain in his left shoulder and hip, or ongoing complaints of pain in his left knee. Even though the facility documented the resident was to use a wheelchair with staff assistance for mobility, there was no documentation as to how the facility evaluated the resident's transfer status or educated staff as to how to transfer the resident safely. It was unclear how the facility could make such a determination without further diagnostic work-up of the resident's pain complaints.</p> <p>On 9/22/14 at 7:31 PM a NN documented the resident had increased general weakness and his legs had been buckling. This was also documented on 9/23/14 at 4:55 AM and 4:47 PM.</p> <p>On 9/23/14 a physician's progress note</p>	F 323		

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F 323	<p>Continued From page 44</p> <p>documented, "Patient seen today at the nursing home in followup of a fall." This note was the first documentation since the resident's falls on 9/14/14 and 9/21/14 that the resident was seen and evaluated by a physician. The progress note further documented, "His left side is [already] weak so if the knee is going to give out or buckle, this would be a big problem for him as he is ambulatory. Today when I see the patient, he tells me that he pain is improving but the knee just feels weak and will give out when he is not expecting it. He feels like it pops and is unstable...He notes that his collarbone hurts a little bit and he has had a history of fractures there...Assessment...Fall with some knee injury, now with buckling of the knee in a patient with left hemiparesis...at this time, I am going to have him go to Orthopedics, so that he can have further evaluation of his knee...Patient is dependent on that knee being strong enough for ambulation...so this is a big mobility issue and want to make sure that we do what we can to keep him mobile."</p> <p>On 11/4/14 at 12:35, when asked, the DNS stated she had asked the housekeeping staff to not deliver laundry so early in the mornings, but had not documented that anywhere. The DNS was uncertain whether that change had taken place since the resident's fall. When reviewing the documentation in place in the resident's record, the DNS could not determine what injury the physician had determined the resident received in the fall. The DNS and DDCO could not find documentation in the resident's record, at that time, that the orthopedic appointment had taken place, or what the results of the appointment were. On 11/4/14 at 3:30 PM, the facility provided information from 2 orthopedic physician visits, and results from the resident's MRI.</p>	F 323		

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F 323	<p>Continued From page 45</p> <p>On 10/9/14, a progress note from the orthopedic physician documented, "The patient comes in today for left knee pain following a falling injury about 3 weeks ago...twisting injury on the left knee...may be experiencing pain due to arthritis in the knee and/or a torn meniscus..." The resident received a Cortisone Kenalog injection. The physician documented if the resident did not show improvement within 1-2 days, an MRI would need to be scheduled.</p> <p>There was no documentation in the resident's record that the resident was monitored over the next 1-2 days as directed by the orthopedic physician. On 11/4/14 at 12:35 PM, when asked, the DNS stated this was because the facility did not know the appointment had taken place, or what the results were. There was no documentation in the resident's record at the facility regarding the outcome of the injection, or whether an MRI was scheduled. Please see F 309 for details regarding this delay.</p> <p>On 10/15/14, an MRI study of the resident's left knee documented a nondisplaced fracture of the lateral tibial plateau, a possible medial meniscal tear, and a mild lateral tilt of the patella. On 10/15/14 at 9:08 PM, a NN documented the facility was contacted by the orthopedic physician, verbally informing the facility of the MRI results and ordered the resident to be non-weight bearing through his left leg, and that he would need a follow-up appointment as soon as possible.</p> <p>On 10/21/14 at 9:45 PM, a NN documented the resident had returned from an orthopedic appointment that day, and the orthopedist's office</p>	F 323			

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F 323	<p>Continued From page 46</p> <p>would be scheduling an appointment for an arthroscopy.</p> <p>On 11/4/14, at the request of the survey team, the facility obtained a 10/21/14 orthopedic progress note which documented the resident would require a left knee arthroscopy for debridement of the meniscal tear.</p> <p>Resident #1 was harmed when he fell in the facility on 3 occasions within the month of September, after the facility had both provided cares in such a way as to cause the resident to fall, then failed to provide increased supervision and assistance in a way to prevent further falls and injuries from falls. When assessed by an orthopedic physician, the resident was found to have a tibial fracture, and a meniscal tear requiring surgical intervention. Throughout this process, the resident experienced increased pain and a decrease in his functional abilities.</p> <p>On 11/4/14 at 3:50 PM, the Administrator was informed of these findings. The facility offered no further information.</p> <p>3. Resident #5 was admitted to the facility on 8/6/14 and readmitted on 9/25/14 with diagnoses of Lewy Bodies dementia, paralysis agitans, generalized anxiety, and post-traumatic stress disorder (PTSD).</p> <p>The resident's Admission MDS, dated 8/13/14, documented the resident was cognitively intact and required 2 person extensive assist for bed mobility, transfer and toileting.</p> <p>The resident's current care plan, dated 8/6/14, documented focus areas of falls r/t confusion,</p>	F 323			

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F 323	<p>Continued From page 47</p> <p>wandering, gait/balance problems, incontinence and diminished safety awareness. Interventions included, "Anticipate and meet the resident needs such as toileting, drink, food, to walk or stretch, verbally interact with others."</p> <p>Fall #1. A Post Fall Evaluation, dated 9/5/14 at 5:50 AM, documented, "CNA heard thud and found [resident name] laying [sic] flat on floor between bed and bathroom with pants around ankles." The resident stated he was pulling up his pants after using the restroom. The PI recommendations included PT was to evaluate toileting, staff were to assist with increased agitation and the physician would review medications.</p> <p>A Berg Balance Scale, dated 9/7/14, documented a score of 28/56 which indicated the resident was at moderate risk for falls. On 9/8/14 the resident was evaluated and certified to receive PT from 9/8/14 to 10/19/14.</p> <p>A Physician Telephone Order, dated 9/8/14, documented: "Decrease Propranolol to 60 mg PO BID; Klonopin 0.5 mg Q [every] AM and PM; Klonopin 2 mg Q HS [hour of sleep]; DC [Discontinue] Propranolol ER; and, Sinemet 10/100 mg 2 tabs TID PO."</p> <p>A Physician's Order, dated 9/11/14, documented: "Decrease Sinemet to 10/100 mg one tab PO TID; Increase Seroquel to 200 mg PO Q HS; and, Restoril 15 mg PO Q HS...insomnia."</p> <p>A Nurse Progress Note (NN), dated 9/13/14, documented, "Walking with CNA per weak gait to</p>	F 323		

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F 323	<p>Continued From page 48</p> <p>room and knees buckled and CNA helped him ease onto the bed. No injuries or c/o pain...Will continue to assist with ambulation when weak and have PT evaluate." Additionally, on 9/14/14, a NN documented the resident had digressed from independent transfer to 2 person assist with ADLs and transfers.</p> <p>Fall #2. A Post-Fall Investigation (PFI), dated 9/15/14 at 3:00 AM documented LN #1 heard a thump, went to check on the resident and found him on his hands and knees on the floor with the blanket wrapped around his feet and lower legs. The PI recommendations included the physician would review, staff was to assist with toileting at night, and PT would evaluate.</p> <p>On 9/16/14 the resident's physician documented the resident had frequent falls and was at high risk for falls due to poor memory and impulsivity.</p> <p>A NN, dated 9/17/14 documented that on 9/15/14 the resident was more restless, exit seeking, not sleeping as well, and was started on Restoril. Additionally, staff were to assist with toileting at night and to remind him to use his urinal.</p> <p>The resident's care plan for urinary tract infection documented an intervention, with a start date of 9/17/14, for "Staff to assist to bathroom in the NOC [night]."</p> <p>The care plan for potential for complications associated with urinary incontinence, initiated on 8/7/14, already documented the intervention, "Prompted voiding plan. Offer toileting or urinal q 2 hrs and prn." A care plan for the focus of urge and mixed bladder incontinence r/t dementia, initiated on 8/16/14, documented an intervention,</p>	F 323			

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F 323	<p>Continued From page 49 dated 9/17/14, for staff to remind the resident to toilet every 2 hours and assist as needed.</p> <p>Falls #3. A PFI, dated 9/19/14 at 6:15 PM, documented the resident fell twice during the same event. The resident fell while walking with the nurse and CNA to his room when his knees buckled and he went down on his knees by the bed with assistance. The second fall occurred when staff helped the resident into his bed and he got tangled in the linen and "partially" rolled out of bed. The PI recommended 1:1 supervision; however, the resident's care plan did not include an intervention for 1:1 supervision until after a fall on 9/23/14.</p> <p>A NN, dated 9/21/14, documented, "Resident has been both non-compliant and compliant with cares. Resident continues to exit seek and is still very unsteady on his feet and requires a lot of assistance with cares. Resident will be given a 1:1 during AM shift. Resident given PRN Klonopin."</p> <p>A NN, dated 9/22/14, documented the resident was placed on a Resident at Risk review. The resident continued to obsess about leaving, was exit seeking and was hard to direct. He had declined physically and his cognition had declined rapidly. The resident was unaware of abilities and required PRNs frequently. Additionally, a NN, for the same date, documented, "1:1 per impulsiveness and higher risk of fall today. Primarily using w/c for mobility."</p> <p>On 9/22/14 a Physician Telephone Order documented the following: "Seroquel 50 mg Q AM & PM, 200 mg PO Q HS; Decrease Propranolol to 40 mg PO BID."</p>	F 323			

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F 323	<p>Continued From page 50</p> <p>On 9/22/14 at 6:00 PM, the MAR documented the resident received an injection of Zyprexa 10 mg with a decrease in behaviors.</p> <p>Fall #4. A PFI report, dated 9/23/14 at 6:15 AM, documented the resident was walking to the bathroom with a gait belt on, started to fall and was assisted to the floor without injury. The PI recommendations documented staff were to use a w/c when the resident was given a PRN medication. The Comment section of the computerized PFI, documented the resident was increasingly having more falls without injury and the facility would continue 1:1 supervision and use a w/c for mobility.</p> <p>The resident's physician documented on 9/23/14, "Patient has fallen multiple times...has a poor attention span...quite poor balance...has Parkinson symptoms, so he is quite slow in his gait, and he remains a high fall risk...he is on multiple medications that might cause difficulties."</p> <p>A NN, dated 9/23/14, documented a Morse Fall Risk Scale was completed with a score of 80.0 which indicated the resident was a high fall risk.</p> <p>An IDT progress note, dated 9/24/14, documented the resident had a rapid decline in his cognition, his confusion had gotten worse and he required 1:1 staffing. The resident was sent to the ER for sudden chest pain on 9/21/14 and he had a PE [Pulmonary Embolis].</p> <p>An IDT Review progress note, dated 9/25/14, documented the resident returned to the facility with a steady gait, was confused and agitated requiring PRN meds for his anxiety. He had 1:1</p>	F 323		

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F 323	<p>Continued From page 51</p> <p>supervision and staff would ambulate with him or use the wheelchair if given a PRN medication.</p> <p>On 9/25/14 at 2:00 PM, the MAR documented the resident was given an injection of Zyprexa 10 mg for an increase in anxiety.</p> <p>On 9/25/14 at 10:21 PM, a progress note documented, "Unsteady on feet, tires easily. No prn's needed after 2 pm..."</p> <p>A NN, dated 9/26/14, documented Resident #5 had a "resident to resident" episode with his roommate and was given Zyprexa IM. Additionally, a NN, for the same date, documented, the resident was found on top of his roommate, was shaking him and was being hit in the face. Resident #5 sustained a small 2 cm laceration under his left eye. The resident's physician's ordered multiple psychotropic medications. Please see F-329 for details.</p> <p>A progress note, dated 9/27/14, documented the resident had no further signs of aggression, was adjusting well to his new room and had 1:1 supervision.</p> <p>The resident's care plan for urinary tract infection, with a start date of 9/25/14, documented an intervention for staff to use a wheelchair when a PRN medication for agitation or anxiety was given and to provide "1:1 supervision am and pm."</p> <p>Fall #5. A PFI report, dated 10/2/14 at 2:55 AM, did not include a description of the fall but documented the resident had been asleep in bed, was checked on at 2:35 AM, was sound asleep and had been on 15 minute checks. LN #2 documented, "When I returned from lunch I</p>	F 323			

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F 323	<p>Continued From page 52</p> <p>noticed resident's Attend [adult brief] on floor. I walked into resident's room and he was kneeling on floor on his hands and knees. Resident's bed was wet and TV and DVD player were both on the floor." The PI recommendations documented to continue 15 minute checks at night and to take the resident to the toilet at least one time at night.</p> <p>The resident's care plan for falls documented an intervention, dated 10/3/14, to provide 1:1 supervision when awake.</p> <p>The ADL care plan documented a toilet use intervention, with a start date of 8/8/14 and revised on 10/30/14, the resident "Requires 1 to 2 staff participation to use toilet." However, record review documented only 1 staff member toileted the resident, not 2 staff members, as directed in the care plan.</p> <p>NOTE: This was the resident's 4th fall which occurred between 2:55 AM and 6:15 AM. Documentation could not be found for increased supervision during this period of time, just 15 minute checks at night. Additionally, documentation could not be found which supported the PI recommendation to toilet the resident at least 1 time at night.</p> <p>A NN, dated 10/6/14, documented, "Resident does require 2 person assist when transferring. He has been using w/c at this time and is totally dependent with cares..."</p> <p>An LSW note, dated 10/6/14, documented the resident was in his room due to his PTSD and was having a difficult time with his roommate. The resident's physician would review his medications and adjust the treatment plan</p>	F 323		

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F 323	<p>Continued From page 53 accordingly.</p> <p>Additionally, on 10/6/14, a progress note by the LSW, regarding a care plan conference at the family request documented, "Family member asked about therapy...He is in a w/c for his own safety. His 1:1 frequently walking his 1:1 staff as he is wanting and willing. Wife is stating that his left side is weak and he is struggling to lift his arm. She feels this is different. Wife noted to staff that she felt he was favoring his left arm today...Family likes the pvt [private room]. SW reminded them that are (sic) goal was to get him the point were (sic) he can be with a roommate and that he does not require a 1:1. He has had two resident to resident altercations. The current plan is to provide adequate supervision to prevent such altercations."</p> <p>A NN, dated 10/8/14, by LN #4, documented, "CNA stated left hand was weak. Pt [patient] tends not to use it lately at times but when RN played a game with him (arm wrestling) with Lt [left hand] he used Lt arm and hand. Squeezed hard and beat RN at arm wrestling."</p> <p>A progress note, dated 10/10/14, for an IDT Event Review documented the resident was found on the floor on 10/2/14 beside his bed and his bed was wet. Staff would get him up in the night to use the toilet in order to help decrease incontinence and prevent him from attempting to get up on his own.</p> <p>The resident's care plan for falls documented an intervention with a start date of 10/10/14, "15 min checks at night. Toilet him at least one time in the night." Additionally, the 9/25/14 intervention of "1:1 supervision am and pm" was revised on</p>	F 323			

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F 323	<p>Continued From page 54 10/10/14.</p> <p>A NN, by RN #2, dated 10/11/14, documented, "Resident's L[left] hand/wrist bruised and decreased in ROM. Upon assessment Resident states he does have pain. PRN Tylenol given from Standing Order. Will advise Dr. Brown and possibly obtain an X-ray. Ice and Elevation PRN. Will continue to monitor PRN."</p> <p>A Physician's Order progress note written by LN #3 on 10/11/14 documented, "NO [new order] noted for left wrist and hand x-ray r/t Guarding and not using left hand. Has approximately 2.0 x 1.0 cm bony protrusion of the 4th metatarsal [sic] just below the wrist...Does not wince or indicate pain during palpation but does point to wedding band as it is now tighter per edema as CNA reports he has been dangling it and NOC nurse observed it as well."</p> <p>A Physician's Order progress note written by LN #3 on 10/11/14 documented, "NO noted @ 1:15 PM to transfer to [name of local hospital] ER via non-emergency transport per FX [fracture] of left metacarpal with mild angulation."</p> <p>A 10/11/14 the Final X-Ray Report documented, "Fracture of distal left 5th metacarpal with mild angulation and mild callus formation."</p> <p>A Physician's Order progress note by RN #4, dated 10/11/14, documented, "Returned fom [sic] ER with soft cast on Lt arm due to fx [fracture] metacarpal bone. Will need to make appt. for F/U with ortho surgeon ASAP."</p> <p>A Resident Fracture Report, undated, for the 10/11/14 Incident, was received at the Bureau of</p>	F 323			

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F 323	<p>Continued From page 55</p> <p>Facility Standards (BFS) on 10/28/14 at 3:22 PM. The report documented in the Summary of Event, "A CNA reported to the charge nurse on this date that [name of resident] had bruising and decreased ROM in his left hand and wrist. The charge nurse examined him and noted a bony protrusion of the 5th metacarpal immediately distal to the wrist..."The Pertinent History documented, "He requires supervision and setup help only with all ADLs. His BIMS is 9, and is generally easy to understand and able to make his needs known...He also takes a closed fist and will bang on the wall or table. This behavior does not appear to be related to actually needing anything, but simply perceived stress."</p> <p>The Investigation and Conclusion section of the report documented, "It is unknown when [the resident] suffered the fracture, as the most recent fall he had was 9 days prior to the identification of the fracture...Six days after the two incidents on 10/2/14, he verbalized 'weakness' in his left hand but not pain...It is therefore determined that [the resident]fractured his hand when striking the wall with the external portion of a closed fist at some time in the past 2-4 weeks. The angulation occurred sometime on the evening of the 10th or early morning of the 11th when he again struck a solid surface."</p> <p>NOTE: The 10/6/14 NN documented the resident "required 2 person assist when transferring...and is totally dependent with cares," was not reflected in the resident's ADL self care performance deficit care plan. No documentation was found in the resident's medical record, before the fracture occurred, the resident would bang on the wall or table. In addition, no interventions were found in the care plan which addressed this behavior. The</p>	F 323			

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F 323	<p>Continued From page 56</p> <p>report failed to determine how a resident who was on 1:1 supervision with 15 minute checks experienced a fracture of the 5th metacarpal. The Resident Fracture Report was received at the BFS 12 working days after the fracture was discovered. This injury of unknown origin was not reported to the BFS Hotline within 24 hours as required by BFS Informational Letter 2014-04.</p> <p>September and October 2014 Monthly Behavior Monitoring Flowsheets did not document the resident had behaviors of hitting or punching.</p> <p>On 10/14/14 the resident was seen by his physician who documented in the Nursing Home Visit, "He had a fall on 10/02/14, was not noted to have any injuries. At some point he developed some weakness of the left upper extremity. I believe this was on Saturday 10/11/14. The nurse had called me and told me that he had increased swelling to the hand a a nodular area and it was thought possibly he had a fractured hand...There was no problem noted until Saturday and now the staff is telling me that it was more that he had no grip strength and he was not moving his hand, and it was more flaccid...Of note, the patient does tend to bang on the wall with his fist. This could have caused a fracture at some point or could have caused some angulation of a recent fracture." The Neurologic examination documented, "...face is symmetrical. He has no tone and no strength at all in his left hand. He will not try to do any strength testing...The patient does have a fairly mobile distal left 5th metacarpal. You can tell that it is broken." The Assessment documented, "I suspect stroke." The Plan documented, "I am going to have them try to continue to use the left hand splint as much as possible for 2 weeks as it appears that the</p>	F 323			

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F 323	<p>Continued From page 57</p> <p>patient's x-ray is most likely approximately 2 weeks ago. This could have happened with the fall on the 2nd and then possibly had some reinjury, as the patient supposedly was making a fist and hitting the wall...With his hand weakness, at this time he cannot use his hand...The patient will have a repeat x-ray of his hand in 2 weeks for further followup to see how it is healing."</p> <p>On 10/16/14 the resident was seen by his physician who documented in the Nursing Home Visit, "The patient will wear the hand splint for another 2 weeks and I am going to get a repeat hand x-ray in 2 weeks to make sure the area is healing...The patient is on Zyprexa 5 mg twice a day for his psychosis. This may worsen his Parkinson's type symptoms or be some of the cause but [name of physician] is following very careful to only prescribe what he needs."</p> <p>On 10/17/14 at 10:21 PM, six days after the fracture, a progress note for an IDT Event Review documented, "He has been observed by staff to punch the wall with a closed fist hitting it with the outer [sic] aspect of his hand. He has also been observed doing this in the dining room hitting the table in the same manner...We turned his bed so he is unable to hit the wall. 1:1 have been informed of the behavior of hitting when he is angry to help divert that behavior and minimize injury."</p> <p>The resident's care plan for fractured left hand 5 metatarsal (sic) initiated on 10/12/14 documented, "Medicate for pain PRN and wear soft cast and sling until DC'd [discontinued]." On 10/17/14 an intervention documented, "Keep bed turned away from outside wall to prevent hitting the wall with his hand."</p>	F 323			

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F 323	Continued From page 58 On 10/20/14, 9 days after the fracture, the resident was seen by an orthopedic surgeon who documented in the history of present illness, "Reportedly had a fall a few weeks ago...Also has noticed decreased range of motion of the wrist including lack of extension at the wrist. This is going over the last couple weeks as well." The focused examination documented, "patient has a wrist drop of his left wrist. Unable to fully extend his wrist. Also unable to fully extend his fingers." The plan documented, "Appears he does have a wrist drop probably radial nerve injury or compression. At this point he has full flexion of his fingers and he has no pain no palpation over his fracture site...We discussed not going to cast and letting him moves [sic] fingers." On 10/23/14 at 1:37 PM, the resident's left hand was x-rayed which documented in the findings, "Old fracture of the fifth metacarpal. Mild degenerative changes at the DIP [distal interphalangeal joint or end joint of the finger] and PIP joints [proximal interphalangeal joint, used for lateral stability]." On 10/23/14 at 2:07 PM, a CT Head without Contrast documented in the findings, "There is no evidence of acute cortical infarction, intracranial hemorrhage, mass effect or edema." The conclusion documented, "No acute intracranial abnormality." On 10/31/14 an Evaluation Summary progress note documented, "Resident has been declining gradually over past month, requires extensive assist for transfers, walks seldom, spends most of shift in wheelchair."	F 323		

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F 323	<p>Continued From page 59</p> <p>On 11/4/14 at 1:15 PM, the DNS was interviewed regarding the resident's multiple falls and asked about the PI recommendation of staff to assist with agitation, the DNS stated, "I don't see on the care plan an intervention for staff to assist with increased agitation." When asked about the 9/13 and 14 incidents where the resident had weakness, confusion and knees buckled, the DNS stated, "I described the fall to him (meaning PT), he had been evaluated and they were waiting for authorization from the VA (Veteran's Administration). The DDCO stated, "He was being seen by PT and progress notes are in place." Regarding the 9/15 fall and the PI recommendation for staff to assist with toileting at night, the DNS stated, "Our routine is to check on residents every 2 hours, wake and ask if they need to use the bathroom." The DNS was asked when 1:1 staffing was initiated and if that included night shift. The DNS stated, "He did not have a 1:1 on nights, only day and evening shift. Prior to 9/19 he had a 1:1 on a PRN basis. The DNS was asked about medication changes with regard to duplicate therapy of antipsychotics, benzodiazepines and antihypertensive medication BID and HS and if this could be a contributing factor to falls in the AM. The DNS did not respond.</p> <p>When asked about the 10/2 fall and the PI recommendation to continue 15 minute checks, the DNS stated, "The toileting every 2 hours at night didn't work, it agitated the resident so we changed to toileting just once at night, but we checked on him every 15 minutes. If he was asleep we didn't wake him except just once per night."</p> <p>The DNS was asked about the 10/6 Behavior</p>	F 323		

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F 323	<p>Continued From page 60</p> <p>progress note when the resident's wife expressed concern about her husband's left side weakness and struggling to lift his arm, that this was different. The DNS stated, "I'll have to ask the nurse who wrote it, I wasn't aware that had happened." When asked if anything had been done regarding the wife's concerns, the DNS stated, "This input was by social services, I'd have to ask them. [Identified physiciatrist], two social workers, the resident's wife and two sons were present."</p> <p>When asked about the 10/8 progress note where the CNA stated the left hand was weak and what was done with this information, the DNS stated, "I was not aware a CNA had stated the left hand was weak." The surveyor expressed concern to the DNS that 2 days after the wife had noticed the resident was struggling to lift his arm and was favoring his left arm the CNA had reported the left hand was weak. The DNS stated, "I know, I would have to ask the nurse and the social worker." When asked if the 5th metacarpal fracture to the resident's left hand could have happened when wrestling with LN #4, the DNS stated, "I wonder." When asked if there was documentation of the resident banging his fist on the wall, the DNS stated, "No, just CNA interviews...I have never personally seen it."</p> <p>On 11/4/14 at 3:05 PM, The Administrator was asked if he was aware of the care conference on 10/6 and stated, "Just now when the DDCO and DNS told me." The surveyor expressed concern that a CNA reported on 10/8 the resident's left hand was weak and that a LN had the resident arm wrestle. The Administrator stated, "It's not something I would do, not anybody should do. I read the note, I did not interview staff. There</p>	F 323			

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F 323	<p>Continued From page 61</p> <p>wasn't any bruising, displacement until the AM...When I talked to everyone on 10/11 there wasn't an acute event, no injury or reason to think anything new had happened. The only thing I can think of is that some time during the night, he hit something."</p> <p>On 11/4/14 at 4:20 PM, LN #4 was interviewed in the presence of the Administrator regarding the 10/8 progress note regarding the resident's left hand weakness. LN #4 stated the resident, "Sometimes it would hang down, sometimes he would use it." When asked if the arm was flaccid (hanging loosely or limply), LN #4 stated, "I was trying to figure out if he would use it or not. Just played a little game with him, a guy thing, and I just put my hand up and told him to wrestle and he pushed it right down. I didn't grab it or anything." When asked about the statement, "Squeezed hard," LN #4 stated, "Did I write that? Oh my Gxx (expletive)." The surveyor asked LN #4 if she was aware of the 10/6 documentation where the wife stated his left side was weak and he was struggling to lift his arm and how the facility communicates this kind of information. LN #4 stated, "There is a 24 hour report." The Administrator stated, "There is a communication tab on PCC (Point Click Care - electronic charting)." LN #4 then stated, "I don't remember if I looked at that, wasn't real plain." The surveyor asked LN #4 when she first noticed the resident's left hand was weak, LN #4 stated, "After I went to see him to check on him, he was in the dining room." The surveyor expressed concern with LN #4's assessment of hand and wrist. LN #4 stated, "He was able to use it normally for him. At that time we didn't, we just thought it was a behavior or something...it didn't seem abnormal at the time." When asked about the resident's visit to</p>	F 323		

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F 323	<p>Continued From page 62</p> <p>the ER on 10/11 and if she had noticed any difference with his left hand between the 8th and the 11th, LN #4 stated, "I don't remember."</p> <p>Resident #5 was a moderate to high fall risk and continued to experience an increase in falls. The facility failed to assess if medications contributed to the residents increase in falls. (Please see F-329 as it relates to unnecessary meds.) The facility failed to assess the resident had an increase in early morning falls and did not increase supervision during this time. The resident was harmed when the facility failed to identify an injury of unknown origin when he was on 1:1 supervision and 15 minute checks at night. Additionally, there is conflicting information as to when the fracture actually occurred.</p> <p>4. Resident #7 was admitted to the facility on 3/4/14 with multiple diagnoses which included Lewy Bodies dementia, psychosis and epilepsy with recurrent seizures.</p> <p>Resident #7's fall risk care plan documented the following interventions: *Start date of 8/4/14 and revised on 9/1/14, "Ambulate and Transfer with 1 assist with gait belt." *Start date of 8/7/14 and revised on 8/11/14, "1:1 supervision when awake or PRN bowel care given."</p> <p>The resident's ADL care plan, initiated on 3/4/14, documented the resident required the assistance of 1 staff member with transfers.</p> <p>On 10/29/14 at 1:11 PM, a NN documented, "Resident fell at 7:55 AM this morning...1:1 educated on proper pt [patient] care."</p>	F 323			

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F 323	Continued From page 63 A PFI for the 10/29/14 fall documented the resident was sitting in the Dining Room, was done eating, got up and started walking. CNA #5 documented, "I heard a loud noise and res[ident] was on knees. Res was in front of stool." CNA #6 documented, "I heard a loud sound and looked at res. He was laying on left side on floor. Res was trying to get up." The PI recommendation documented, "Staff Counseling." The computerized portion of the PFI documented, "Res was found in dinning [sic] room approximately 1 foot away from chair. Res was found on his knees with hands on sides." Staff Assistance Being Given at Time of Fall section documented, "Patient alone - unattended at the time." The Comment section documented the resident got up to walk around impulsively, appeared to have lost his balance and fell onto his knees. When the resident fell, he scraped his hand against a chair. On 10/31/14 at 10:49 AM, a progress note documented, "[Name of resident] has dementia. He has a 1:1 with him when he is awake due to his impulsivity, constant walking and unsteady gait. He is unable to be redirected. While seated in the dining room he got up quickly and fell, the 1:1 was not close enough to assist him. The CNA was counseled on positioning close and responsibilities of 1:1 supervision." On 10/31/14 at 1:36 PM, a NN documented, "Rsd. requires 1:1 monitoring due to impulsiveness and wandering. Rsd. ambulates in the hall with 1:1 at bedside." On 11/4/14 at 2:15 PM, the DNS explained the	F 323		

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F 323	<p>Continued From page 64</p> <p>circumstances surrounding the event. She stated, "The resident had a 1:1 who went on break and another staff member said they would watch him, then didn't, so they were counseled." When the surveyor asked if this fall was due to staff failure, the DNS stated, "Yes." The DNS later stated, "[Name of resident] has been with us long enough for us all to know that we need to hold on to him." The DNS provided the Performance Improvement Forms for CNA #5 and #6 which documented the counseling given to both staff members along with the expected level of performance.</p> <p>The facility failed to implement 1:1 supervision for Resident #7 as documented in the care plan and the resident fell in the dining room.</p> <p>5. Resident #9 was admitted to the facility on 8/16/12 and on 9/26/12 with multiple diagnoses which included schizoaffective disorder, mood disorder, dementia with behaviors, anxiety, and convulsions.</p> <p>On 9/13/14 at 10:05 AM, an Evaluation Summary progress note documented a score of 75.0 on the Morse Fall Risk Scale, indicating the resident was a high fall risk.</p> <p>Fall #1. A PFI report, dated 9/13/14 at 10:05 AM, for Resident #9 documented, "I was rocking, I don't know what happened." Investigation interviews included statements from two CNAs. CNA #7's statement said, "Res was rocking back and forth in w/c. Leaned forward in chair, leaned forward again and went face down on knees. Her eyes were closed." The witness description was not signed. CNA #8's statement said: "Heard a loud sound and went to help. Res was on hands</p>	F 323			

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F 323	<p>Continued From page 65</p> <p>and knees face down looking at the floor." The witness description was not signed. The PFI documented, "...Knees slightly pink. Otherwise no injuries noted."</p> <p>PI recommendations documented the resident's physician would review medications, and staff would be with her and talk to her when she was rocking.</p> <p>Resident #9's fall care plan documented an intervention, with a start date of 9/13/14, "Cue [name of resident] to verbalize anxiety and not to rocking [sic] in w/c."</p> <p>On 10/6/14 the resident's physician ordered an increase in Wellbutrin XL from 150 mg daily to 300 mg daily for the diagnosis of schizoaffective disorder.</p> <p>Fall #2. A PFI, dated 10/30/14 at 6:00 AM, documented, "Res was laying in bed dressed with TED hose on feet." An Investigation interview by CNA #9 documented, "Res got up to the toilet at 0500 [5:00 AM] and voided and then requested to get dressed and then lay back in bed." PI recommendations documented, "Day shift to place TED hose on then shoes just before transfer to W/C." The computerized PFI documented the resident, "put call light on and upon entering room found res[ident] sitting on the floor with legs out in front leaning against her bed in low position. Res said she was trying to reach her Kleenex. TED hose on feet. No injury noted."</p> <p>On 11/4/14 at 2:20 PM, the DNS stated, "When [name of resident] hears her voices, she tends to rock. We sit and talk with her." When asked about the PI recommendation for staff to be with</p>	F 323		

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F 323	Continued From page 66 the resident and talk to her when she was rocking being different from the care plan intervention to cue the resident to verbalize anxiety and not to rock in w/c, the DNS stated, "Yes." Regarding the 10/30/14 fall, the surveyor expressed concern a resident was dressed, TED hose placed on her lower extremities and then put back to bed without grip socks. When asked what the staff should have done, the DNS stated, "Not put her TED'S on until ready to put her shoes on and get her up for the day."	F 323			
F 329 SS=G	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 329	<u>F329</u> UNNECESSARY DRUGS 1. The medication regimen for residents #1, 4, and 5 were reviewed by their attending physician to address adequate indications for medication use, justification for duplicate therapy, and parameters for monitoring. Risks and benefits were addressed and medications were adjusted as indicated. 2. Residents receiving psychotropic and/or antihypertensive medications were reviewed by the pharmacist and the physician to address adequate indications for medication use, justification for duplicate therapy, and parameters for monitoring. Attending and consulting physicians have coordinated care.	12/8/14	

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F 329	<p>Continued From page 67 drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure adequate indications for use, justification for duplicate therapy, and monitoring for psychotropic medications; justification for duplicate therapy for antihypertensive medications; coordination between prescribing physicians; and adequate monitoring for antihypertensive medications. This was true for 3 of 9 sampled residents (#s 1, 4, and 5). *Resident #4 was harmed when she experienced multiple falls in conjunction with the administration of multiple psychotropic medications, when other causes of behavioral changes had not been ruled out. Resident #4 also received an antihypertensive medication without her blood pressures being monitored as ordered. *Resident #1 was harmed when he received routine hypnotic medication after he had been identified to become so drowsy he would fall asleep standing up, and experienced multiple falls. *Resident #5 had potential for harm when he received multiple antihypertensives, antipsychotics, and benzodiazapines without clear clinical indication. Findings included:</p> <p>Federal Guidance at F-329, specifically regarding the use of anti-psychotic medications in elderly residents, documented, "Before initiating or</p>	F 329	<p>3. The SDC and/or DON has educated nursing staff regarding evaluation of unnecessary drugs, to include but not limited to:</p> <ul style="list-style-type: none"> • Medications that increase the risk of falls and process for documentation of those side effects on the Medication Administration Record (MAR). • Behavior management programs to include medication with appropriate diagnosis and indication of a behavior that causes harm to the resident or other residents, individualized non-drug interventions, monitoring of medication side effects, validation of parameters for physician notification, and analysis of behavioral log documentation. • The medication change process is initiated to rule out medical issues prior to change in psychotropic medication. If multiple drug changes occur simultaneously, the physician documentation will reflect the necessity by depicting risks and benefits. Nursing staff to monitor medication changes for adverse side effects to include those that may increase the risk for falls. • IDT coordination of care will include, but not be limited to, sleep hygiene practices, life history impact, room orientation process, use of PRN medications, and completion/accuracy of behavior monitors. 	

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F 329	<p>Continued From page 68</p> <p>increasing an antipsychotic medication for enduring conditions, the target behavior must be clearly and specifically identified and documented. Monitoring must ensure that the behavioral symptoms are...not due to a medical condition or problem...and not due to environmental stressors alone...and not due to psychological stressors alone...and persistent...when dosing an antipsychotic, the treatment should be at the lowest possible dose to improve the target symptoms being monitored...when monitoring antipsychotics, it is important to not only evaluate ongoing effectiveness and potential adverse consequences...after initiating or increasing the dose of an antipsychotic medication, the behavioral symptoms must be evaluated periodically...to determine the effectiveness of the antipsychotic and the potential for reducing or discontinuing the dose based on target symptoms..."</p> <p>Federal Guidance at F-329, specifically regarding duplicate therapy "refers to multiple medications of the same pharmacological class/category or any medication therapy that substantially duplicates a particular effect of another medication that the individual is taking."</p> <p>1. Resident #4 was originally admitted to the facility on 12/3/10, and most recently admitted on 6/24/14 with multiple diagnoses which included recent large bowel obstruction, Type II diabetes mellitus, chronic kidney disease, organic brain syndrome, and alcohol-induced dementia.</p> <p>Please see F 323 for Resident #4's most recent MDS data.</p> <p>According to the resident's 6/24/14 Admission</p>	F 329			

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F 329	<p>Continued From page 69</p> <p>physician's orders and the July 2014 MAR, Resident #4's received Glimepiride 2 mg daily for diabetes, Lisinopril 20 mg daily for hypertension, Seroquel XR 150 mg daily for recurrent depression with psychosis, Wellbutrin HCl 75 mg twice daily for depression, Percocet 10/325 mg every 4 hours as needed, and Ultram 50 mg every 6 hours as needed for generalized pain.</p> <p>According to the 2015 Nursing Drug Handbook (NDH), Seroquel had a Black Box Warning, "Drug isn't indicated for use in elderly patients with dementia-related psychosis because of increased risk of death from CV (cardiovascular) disease or infection." Adverse effects were documented as dizziness and agitation. Wellbutrin had a Black Box Warning, "Drug may increase hostility, agitation, and depressed mood." Adverse effects were documented as insomnia, delusions, and syncope.</p> <p>The resident's MAR from 7/1/14 through 9/18/14 documented the resident's Lisinopril was to be held if her systolic blood pressure was less than 110. The medication was administered daily, however there was no documentation her blood pressure was taken in conjunction with the administration of this medication.</p> <p>The resident had multiple Monthly Behavior Monitoring Flowsheets (MBMF) for each month. When asked on 11/4/14 at 9:15 AM, the DNS stated there was one of the flow sheets for the LN to fill out, and one for the CNAs. The forms documented a pre-printed list of generic interventions to be attempted if a target behavior occurred, which were not specific to the resident. The forms for the LN and CNA did not document the same behaviors, and the behaviors on each</p>	F 329	<ul style="list-style-type: none"> Weekly behavior meeting will include physician review of pharmaceutical changes, impact of medication changes, additional changes in resident behaviors and/or new admissions with psychotropic medications. Licensed nurse leadership team will evaluate non-drug interventions with the IDT prior to the request for medication changes from the physician. <p>The pharmacist, attending physician, and psychiatric neurologist have been re-educated and participate in the PI Committee to monitor practices for appropriate use of medications and quality documentation of medication use, to include but not limited to, psychoactive and antihypertensive medications and the impact on falls.</p> <p>4. The DON and/or designee will audit two resident charts per week for 8 weeks to validate:</p> <ul style="list-style-type: none"> Documented behaviors have failed non-drug interventions prior to a change in psychotropic medications. Evidence the physician has performed a risk and benefit analysis for each medication and addition of multiple drug therapy. Behavior is clearly identified that is harmful to the resident or other residents, and is being monitored for effectiveness with treatment. 	

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F 329	<p>Continued From page 70 of these forms varied from month to month. Many of the flow sheets had holes in the documentation. It was not clear which of the behaviors being monitored had been identified by the physician as the target behavior for the use of antipsychotic medication.</p> <p>On 7/1/14, the resident's nurses's notes (NN) documented the resident was awakened when the staff were providing cares to the resident's roommate, began yelling, tried to unplug her roommate's television and turn off the lights in the room. The physician was notified, and ordered Zyprexa Zydis 10 mg every 6 hours as needed for psychosis. It was not clear from the documentation how the resident reacting to awakening to find other people interacting in her private living space was determined to be "psychosis" which required the use of an antipsychotic medication. There was no documentation regarding the risks and benefits of using two antipsychotic medications for this resident.</p> <p>According to the 2015 NDH, Zyprexa Zydis had a Black Box Warning, "Drug may increase risk for CV or infection-related death in elderly patients with dementia. Olanzapine [Zyprexa] isn't approved to treat patients with dementia-related psychosis." Adverse reactions were documented as insomnia, abnormal gait, and orthostatic hypotension. At this point, the resident had orders for 3 psychotropic medications with Black Box Warnings, all of which had adverse reactions of agitation and falls.</p> <p>For July 2014, the target behaviors for Resident #4 were documented as refusing medication, isolation, verbal aggression, exit seeking, and</p>	F 329	<p>The audit will be documented on the PI monitor beginning the week of December 8, 2014.</p> <p>Medical Records will audit documentation on one resident fall per week to identify analysis of medication occurred, the impact of resident fall, and resident plan of care is updated as indicated. The audit will be documented on the PI monitor beginning the week of December 8, 2014. She will report her findings to the PI Committee on a monthly basis.</p> <p>Any concerns will be addressed immediately and discussed with the IDT as indicated. After 60 days, the PI committee will have the authority to adjust the number of incident reports to be reviewed with the requirements of this citation are met.</p>	

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F 329	<p>Continued From page 71 becoming argumentative.</p> <p>On 7/21/14, the resident's Wellbutrin was changed to 150 mg of an extended release form once per day (same overall dosage), and Tegretol 200 mg twice per day for a diagnosis of bipolar disorder was initiated. There was documentation on the resident's MBMFs of "verbal aggression" on evening shift 7/20/14 through 7/22/14. On one of those occasions, the only documented intervention was that the room temperature was changed, on the other two occasions the documented intervention was medication, though the form instructed medication should not be the first choice as a behavioral intervention. The NN documented on 7/19/14 the resident had been pleasant and cooperative with cares. On 7/21/14 the NN documented she was "impulsive" with "mood swings," hence the need for the addition of the Tegretol as a "mood stabilizer." It could not be determined from the documentation how persistent the resident's behaviors were, what individualized approaches had been made to alter them, nor how they presented a danger to the resident or others. Also not clear from the documentation regarding the addition of Tegretol was when the resident was diagnosed with bipolar disorder, what standardized diagnostic tool had been used to arrive at this diagnosis, and how the resident's previous diagnosis of dementia impacted the validity of a new diagnosis of bipolar disorder.</p> <p>According to the 2015 NDH, adverse reactions for Tegretol were documented as ataxia (impaired gait), dizziness, confusion, and syncope; and each dose of the medication could remain in the resident's system for 50 to 130 hours (approximately 5 1/2 days).</p>	F 329		

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F 329	<p>Continued From page 72</p> <p>The resident fell on 7/26/14, 7/29/14, and 7/30/14. There was no documentation the addition of Tegretol was ruled out as a causative factor in the resident's falls. After the resident's fall on 7/29/14 she began to, and continued to, complain of back pain. She was later diagnosed with vertebral fractures. Please see F 323 and F 309 for details.</p> <p>The resident's MBMFs documented target behaviors for the month of August 2014 as "repetitive", delusions with paranoia, verbal aggression, physical aggression, argumentative, "very confused," refusing bathing, refusing ADL assistance, and anger towards others. It was not clear why the target behaviors had changed since the previous month, which behavior was the target behaviors for either of her antipsychotics, her antidepressant, or her mood stabilizer. There were many blanks on the MBMFs.</p> <p>On 8/25/14 at 5:45 AM, the resident's NN documented she was awake most of the night, with multiple trips to the bathroom. The NN documented the resident identified trouble sleeping at night due to a long history of working the night shift. The NN documented the facility would obtain a urine sample to rule out the presence of a urinary tract infection (UTI). On that same date at 1:58 PM, there was an entry from a social worker which documented, "...appears to have some delusional thinking and manifests this by trying to help others as she did when she was a nurse..." On 8/26/14, the resident's care plan was updated to include an intervention, "...She would like to be retired. When she is helping others as if she were the staff, remind her that she is not working this shift and to let you do the</p>	F 329		

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F 329	<p>Continued From page 73</p> <p>work..." There was no documentation of coordination between nursing and social services to reconcile these two perspectives on the resident's current behaviors.</p> <p>The NN documented a urine sample was collected on 8/26/14, but was contaminated. On 8/27/14 a urine analysis showed positive results for a UTI. On 8/29/14, the resident was started on Macrobid for 10 days.</p> <p>The resident's MBMFs for September 2014 documented target behaviors of fluctuating confusion, refusing ADLs, anger towards others, refusing bathing, physically and verbally aggressive, argumentative with others, exit seeking. There were duplicates of some of the forms, and the values documented on those forms did not match. Additionally, many areas of the forms were blank. It could not be determined how the information documented on these forms could help determine the resident's behavioral patterns or the effectiveness of interventions attempted.</p> <p>On 9/5/14, while the resident was still being treated for a UTI, a NN documented the resident was to be started on a "sleep study", which was clarified by the DNS during an interview on 11/4/14 at 9:15 AM as documentation of how many hours the resident slept every shift. The monitor documented the resident slept a total of ten hours on 9/1/14 and 9/2/14, nine hours on 9/3/14, five hours on 9/4/14, seven hours on 9/5/14 and 9/6/14, nine hours on 9/7/14 and 9/8/14. While there were some dates where few hours of sleep were documented on night shift, the facility had established the resident had worked as a night shift nurse for many years.</p>	F 329			

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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHABILITATION - CALDWELL			STREET ADDRESS, CITY, STATE, ZIP CODE 210 CLEVELAND BOULEVARD CALDWELL, ID 83605		
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F 329	<p>Continued From page 74</p> <p>There was no documentation of what her normal sleeping patterns were and what the facility had done to recognize and adapt her daily routines accordingly. There was no documentation that the resident's goal was to change her sleep/wake patterns. There was also no documentation of any sleep hygiene interventions to adjust those patterns before sleep medication was used.</p> <p>On 9/8/14 at 2:45 AM, a NN documented the resident had been awake off and on through the night, and was refusing to sit or lay down due to back pain. The note further documented, "Resident was given PRN (as needed) Percocet and also PRN Zyprexa for increased confusion, agitation and anxiety...although every hour [resident] feels she needs to use the bathroom...transferred with the wheelchair..."</p> <p>When asked on 11/4/14 at 9:15 AM, the DNS agreed pain and increased confusion were not indications for use for Zyprexa. On that date, which was the last day the resident was receiving the antibiotic for her UTI, her Seroquel dose was increased to 200 mg daily, and Ambien 5 mg at bedtime as needed was started. The resident was documented to continue to use the wheelchair that day.</p> <p>The resident's MAR documented she received the Ambien from 9/9/14 through 9/11/14. On 9/9/14, the NN documented the resident had a room change. There was no documentation the psychosocial stressors of her room change were assessed and addressed prior to the hypnotic medication being administered. On 9/10/14, the NN documented the resident was attempting to climb out of bed, and was given Ambien. The MAR documented the Ambien was given at 10:45 PM. There was no documentation that her</p>	F 329			

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F 329	<p>Continued From page 75</p> <p>room change or pain had been assessed and addressed before the hypnotic medication was given. The NN documented the resident was still not sleeping at 12:30 AM on 9/11/14, when the MAR documented she was then given Percocet for back pain, which was helpful and the resident then slept. The resident's MAR documented she was given a dose of Ambien on 9/11/14 at 8:20 PM, and at 10:00 PM she was asleep. There was no additional documentation regarding the Ambien use for 9/11/14.</p> <p>According to the 2015 NDH, adverse reactions for Ambien were documented as amnesia, dizziness, and nervousness.</p> <p>On 9/12/14 at 1:06 AM, the NN documented the resident was awake and trying to wake her roommate by throwing toiletries at her. The physician was notified and issued a one-time dose of Zyprexa 10 mg IM. At 5:00 AM, the NN documented the resident was scheduled to have a repeat UA following the treatment of her UTI, and that staff had noted her behaviors to worsen since the Ambien was started. At 10:11 AM, the resident was noted to be intrusively wandering, confused, and running into walls with her wheelchair. There was no documentation to rule out whether the resident's behavior may be related to the increase in her Seroquel dose, the use of Ambien, the dose of IM Zyprexa, or a continued UTI. The physician was notified, and issued an order for 10 mg Haldol and 50 mg Benadryl to be administered together. At 11:25 AM the resident was noted to be sleeping soundly. Within the 24 hour period of 9/12/14, the resident received two doses of Percocet, either one or two tabs (exact dose not documented), 10 mg Zyprexa, 10 mg Haldol, 50 mg Benadryl, and</p>	F 329			

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F 329	<p>Continued From page 76 200 mg Seroquel.</p> <p>According to the 2015 NDH, Haldol had a Black Box Warning, "Elderly patients with dementia-related psychosis treated with atypical or conventional antipsychotics are at increased risk for death. Antipsychotics aren't approved for the treatment of dementia-related psychosis."</p> <p>Though no further behavioral concerns were documented over the next 3 days, on 9/15/14 the Ambien was discontinued and her Seroquel dose was again increased to 400 mg daily, which was double the previous dose.</p> <p>On 9/19/14 at 3:40 AM, the physician ordered an increase in the resident's antihypertensive medication Lisinopril, even though her blood pressure values had not been monitored with the administration of the current dose as ordered; an increase in her diabetic medication Glimpiride; and a routine dose of the pain medication Ultram in addition to her "as needed" dose.</p> <p>On 9/20/14 it was confirmed the resident had three compression fractures in her vertebrae at undetermined stages of healing.</p> <p>On 9/21/14 at 9:20 PM, the NN documented the resident was "quite manic," yelling, crying, and angry. She was given PRN Zyprexa at 4:30 PM, which was documented as minimally effective. There was no documentation of pain from her fractures being considered and ruled out as a factor in this behavioral change, nor any of her recent medication changes. 9/21/14 was the first day for the month of September the resident did not receive Percocet for back pain.</p>	F 329		

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F 329	<p>Continued From page 77</p> <p>On 9/22/14 at 11:49 AM, the resident's Seroquel was increased, with the continuing with a 200 mg dose daily and adding another 400 mg. At 3:12 PM, the resident was ambulating with her walker, lost her balance, and fell over her walker. Please see F 323 for details. Her recent medication changes were not documented as considered and ruled out as causative factors. There was no documentation of follow-up being completed regarding her UTI, in terms of a repeat urinalysis.</p> <p>The resident had 2 MBMF records for the month of October 2014. One of the records documented either blanks or zeroes for the number of behavioral occurrences. During an interview on 11/4/14 at 9:15 AM, the DNS identified this as the form the LN filled out. The target behaviors for October were documented as bipolar mood swings, psychosis, and depression. The LN's MBMF documented one instance of "bipolar mood swings" on night shift on 10/16/14, and one instance of depression on day shift 10/16/14 and 10/17/14. No interventions or outcome were documented on the LN's MBMF.</p> <p>On 10/18/14 at 9:53 AM, a NN documented the resident woke up screaming, continued to scream while being assisted to the bathroom, activated the bathroom call light repeatedly, and cursed at staff when they responded. The physician was notified, and at 10:00 AM, the resident received one-time dose of Geodon 20 mg IM. At 2:14 PM, the NN documented the LN was unable to obtain an orthostatic blood pressure from the resident because she was too drowsy.</p> <p>The 2015 NDH documented a Black Box Warning for Geodon, "In elderly patients with dementia-related psychosis, drug isn't indicated</p>	F 329			

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F 329	<p>Continued From page 78</p> <p>for use because of increased risk of death from CV events or infection." Adverse reactions were documented as dizziness, anxiety, insomnia, and orthostatic hypotension.</p> <p>On 10/19/14 at 2:50 PM, the resident fell. The NN documented the resident lost her balance and fell backwards, with a CNA at her side. The resident fell from bed on 10/20/14 at 4:55 PM. See F 323 for details.</p> <p>On 10/20/14, the resident's morning dose of Seroquel was discontinued, but the bedtime dose continued. Abilify 10 mg was added in place of the morning dose of Seroquel. Additionally, the Wellbutrin dose was doubled to 300 mg daily, and the Tegretol dose was increased to 300 mg twice daily. An ongoing order for Geodon 20 mg every 8 hours as needed for psychosis was started.</p> <p>According to the 2015 NDH, Abilify had a Black Box Warning, "Elderly patients with dementia-related psychosis treated with atypical antipsychotics are at increased risk for death. Abilify isn't approved for the treatment of patients with dementia-related psychosis." Adverse reactions were documented as anxiety, insomnia, dizziness, nervousness, hostility, manic behavior, confusion, abnormal gait, and restlessness. Additionally, the NDH documented a drug-to-drug interaction with Abilify and antihypertensives, as the use of Abilify may enhance their effect, causing hypotension. The NDH advised blood pressures be monitored with the use of the drug. The NDH also documented a dose of Abilify could remain in a patient's system for over 6 days.</p> <p>The resident's medications now included four antipsychotics (Seroquel, Abilify, Geodon, and</p>	F 329		

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F 329	<p>Continued From page 79</p> <p>Zyprexa), a mood stabilizer (Tegretol), and an anti-depressant (Wellbutrin). Four of these medications were either added or increased in dosage on the same day. Five of the medications carried a Black Box Warning. There was no documentation as to why the resident required multiple antipsychotic medications, or why multiple medication doses were adjusted on the same day.</p> <p>The resident fell on 10/22/14 at 7:20 AM, 10/28/14 at 8:15 PM, 10/29/14 at 3:15 PM, and 11/1/14 at 12:20 PM. There was no documented evaluation of the effects of her multiple psychotropic medication changes as a factor in any of these falls.</p> <p>On 11/4/14 at 9:15 AM, when asked, the DNS stated: *No specific target behavior corresponding to the use of each of the resident's psychotropic medications was identified. The DNS stated the resident did become agitated, and was believed to have a behavior of, "putting herself on the floor to get attention." Please see F 323 for details. *Some of the resident's medication changes were made by her primary care physician, some were made by the facility's medical director (a psychiatrist). The DNS stated she did not know of any formal dialogue between the two providers regarding this resident, and as a rule such an interaction would not happen for any resident. *The resident was diagnosed with bipolar disorder on 7/21/14, when the facility received the order for the resident to start taking Tegretol. The DNS did not know what diagnostic tool the physician had used to arrive at that diagnosis. The DNS could not provide research or documentation from the physician regarding a</p>	F 329			

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F 329	<p>Continued From page 80</p> <p>resident being diagnosed as bipolar after already being diagnosed with dementia.</p> <p>*The DNS agreed it was not a "best practice" to make multiple psychotropic medication changes in a single day, as it was difficult to monitor both effectiveness, and adverse effects of these medications when this occurred.</p> <p>*The facility had discovered at some point that the resident had been a night shift RN for at least seventeen years. However, since the resident was felt not to be sleeping at night, the facility felt putting the resident on Ambien to help her sleep at night was justified. The DNS could not explain how the facility had incorporated the resident's past history into her plan of care, other than the single additional intervention to her care plan on 8/26/14.</p> <p>*The DNS could not explain how root causes of the resident's behavioral changes, such as pain, UTIs, or room changes, had been ruled out before making psychotropic medication changes.</p> <p>Resident #4 was harmed when the facility initiated multiple psychotropic medications, including antipsychotics and mood stabilizers, without first investigating the root cause of her behavioral changes. Many of these medications carried Black Box Warnings and had documented adverse effects, which were not assessed as the resident began to have behavioral changes, falls, decline in her functional abilities, and confusion. The target symptoms for the use of these medications were not clearly identified or monitored, and individualized non-pharmacological interventions consistent with the resident's personal history and preferences were not developed or implemented. The resident experienced fourteen falls with injuries which included fractured vertebrae, increased pain</p>	F 329		

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F 329	<p>Continued From page 81</p> <p>which was at times treated with psychotropic medications, and a decline in her functional status as these medication changes evolved. The resident's polypharmacy was not identified as a possible root cause of these changes, nor investigated and ruled out.</p> <p>On 11/4/14 at 3:10 PM, the Administrator was informed of these findings. The Administrator indicated he had been led to believe some of these factors had been investigated, although there was no documentation to confirm that. The Administrator stated, "There is no defense for the indefensible." The facility offered no further information.</p> <p>2. Resident #1 was admitted to the facility on 1/11/11 and readmitted on 6/26/14. His diagnoses included embolic/ischemic stroke resulting in left hemiparesis, depression and anxiety, and vascular dementia.</p> <p>Please see F 323 for Resident #1's MDS data.</p> <p>Resident #1's MARs from 7/1/14 through 9/5/14 documented an order for Ambien 5 mg at bedtime as needed for insomnia. The resident's care plan did not document a focus area, goals, or interventions for insomnia during this timeframe. The MARs documented the resident received the medication on 4 occasions in July, but not at all in August or September.</p> <p>The resident's NN for from 7/1/14 through 9/5/14 did not document any concerns with the resident sleeping patterns.</p> <p>On 9/5/14 at 5:59 PM, Resident #1's NNs documented, "New order to discontinue Ambien,</p>	F 329			

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F 329	<p>Continued From page 82</p> <p>begin Restoril 30 mg [by mouth at bedtime]." There was no documentation as to why the resident was started on a routine hypnotic medication, when he had not used the "as needed" hypnotic available to him for over a month.</p> <p>The 2015 NDH for Restoril documented, "...Indications and dosages...Elderly or debilitated patients: 7.5 mg [by mouth] at bedtime until individual response is determined." Each dose of the medication was documented to take over 17 hours to clear from the resident's system. Adverse reactions included drowsiness, dizziness, lethargy, disturbed coordination, daytime sedation, confusion, nightmares, vertigo, weakness, nervousness, and blurred vision.</p> <p>On 9/5/14, the resident's care plan was updated with a focus area of, "Impaired Sleep Pattern [related to]: Inability to fall asleep." Interventions included the use of medication, helping the resident to find a calm and quiet environment, offering music, limiting caffeine and fluids before bedtime, offering warm milk, and offering a banana or high carbohydrate snack. It could not be determined how the facility was to provide both a quiet environment and music, and both limit fluids and offer warm milk.</p> <p>Resident #1's NN on 9/7/14 at 6:13 AM documented the resident was awake at the beginning of night shift (10:00 PM), but was assisted to bed due to being on a new sleep medication.</p> <p>The NN for night shift on 9/8/14 and 9/9/14 documented the resident awakened occasionally throughout those nights, but had to be put back in</p>	F 329		

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F 329	<p>Continued From page 83 bed due to his new sleeping medication.</p> <p>On 9/8/14, a progress note from the resident's psychiatrist documented, "...continues to be rather drowsy during the day. Nursing reports that he tends to fall asleep even standing up, at times he falls asleep at meals and at various other inconvenient times...Review of his medication shows significant doses of methadone, which is likely the most prominent contributor of the sedation..." The progress note did not document the recent addition of Restoril as a possible contributing factor to the resident's drowsiness, and the psychiatrist did not make changes in that medication. Additionally, even though the psychiatrist had identified the resident's methadone as a possible contributing factor, there was no documented change in the methadone dose, and no documentation the psychiatrist communicated this concern to the resident's primary care physician.</p> <p>On 9/11/14, a progress note from the resident's primary care physician documented, "The patient is an elderly male...quite debilitated. Today when I see him, he is sleeping soundly in his room. He does have episodes where he becomes extremely sleepy and sleeps quite soundly. Today, he did not awaken for the examination..." The progress note documented a diagnosis of vertigo. The progress note did not address whether the addition of Restoril was a necessary treatment for this resident, in terms of his sleepiness, or whether that medication was having an impact on the resident's sleeping patterns.</p> <p>The resident fell twice on 9/14/14, and again on 9/21/14. The resident was later diagnosed with a</p>	F 329			

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F 329	<p>Continued From page 84</p> <p>left tibial fracture, and a left torn meniscus. Please see F 323 for details.</p> <p>The resident continued on the dose of Restoril at the time the survey was conducted.</p> <p>On 11/4/14 at 12:35 PM, when asked, the DNS stated she had talked to the physician about using methadone for this resident, but the physician felt it was the best medication and wanted to continue it. When asked, the DNS stated the she was not sure why the psychiatrist had ordered the Restoril for the resident. The DNS agreed if the resident had not been using the "as needed" sleep medication, and there were no changes in sleep patterns documented, it did not make sense to start a routine sleep medication.</p> <p>Resident #1 was harmed when he began to receive hypnotic medication without indication for its use. The resident was seen by two physicians, each of whom noted the resident's excessive drowsiness, but neither of whom considered the effects of the hypnotic use. The resident experienced three falls within 16 days of the initiation of this medication, and sustained injuries which required surgical intervention.</p> <p>On 11/4/14 at 3:50 PM, the Administrator was informed of these findings. The facility offered no further information.</p> <p>3. Resident #5 was admitted to the facility on 8/6/14 and readmitted on 9/25/14 with diagnoses of Lewy Bodies dementia, paralysis agitans (Parkinson's disease), generalized anxiety, and post-traumatic stress disorder (PTSD).</p>	F 329			

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F 329	<p>Continued From page 85</p> <p>The resident's Admission MDS, dated 8/13/14, documented the resident was cognitively intact and required 2 person extensive assistance for bed mobility, transfer and toileting. The resident did not have delusions, manifest behavioral symptoms, reject care by caregivers or exhibit wandering behaviors.</p> <p>According to the Physician's Orders for September 2014 (Recapitulation Orders), the resident received Propranolol HCL 120 mg daily in the morning and 60 mg at bedtime for generalized anxiety, Klonopin 2 mg daily at bedtime and 1 mg PRN every 6 HR for generalized anxiety, Prazosin HCL 4 mg daily at bedtime for posttraumatic stress disorder, Seroquel 100 mg daily at bedtime for dementia with Lewy Bodies, Lisinopril 60 mg daily for hypertension, and to notify the physician if the resident's B/P was greater than 170/95 or less than 90/50.</p> <p>According to the 2015 NDH: *Propranolol had adverse reactions of lightheadedness, dizziness and insomnia. Additionally, there was a caution which documented, "Elderly patients may experience enhanced adverse reactions." *Klonopin had adverse reactions of confusion, glassy-eyed appearance, insomnia, psychosis, agitation, anxiety, hostility, irritability, nervousness, abnormal coordination, dizziness, ataxia (lack of muscle control during voluntary movement), and sleep disturbances. *Lisinopril had adverse reactions of dizziness, headache, and fatigue. *Prazosin had adverse reactions of dizziness, drowsiness, weakness and orthostatic hypotension. The drug-drug interactions listed</p>	F 329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/04/2014
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHABILITATION - CALDWELL			STREET ADDRESS, CITY, STATE, ZIP CODE 210 CLEVELAND BOULEVARD CALDWELL, ID 83605	
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F 329	<p>Continued From page 86</p> <p>Propranolol which could increase the risk of orthostatic hypotension, and directed to help the patient stand slowly until effects are known. Additionally, the NDH directed to use Prazosin cautiously in patients receiving other antihypertensives, to monitor blood pressure, and pulse rate frequently and elderly patients could be more sensitive to the drug's hypotensive effects. *Seroquel and Zyprexa had drug to drug interactions with antihypertensives which could increase effects of those medications, and cautioned to monitor blood pressure.</p> <p>Resident #5 was on three antihypertensive medications in addition to multiple psychotropic medications.</p> <p>It could not be determined from the physician's order how frequently the blood pressure was to be monitored. The resident's MAR documented the residents orthostatic blood pressure was monitored once per month. Therefore, it was impossible to determine whether the resident was experiencing adverse effects from the use of multiple antihypertensive medications.</p> <p>On 9/5/14 the resident fell, (see F-323). The facility requested the physician review the medications as a result.</p> <p>A NN on 9/7/14 and 9/8/14 documented the resident had been confused, agitated, irritable, nervous, dizzy and had abnormal coordination.</p> <p>A Physician Telephone Order on 9/8/14 documented an increase of Klonopin 0.5 mg BID and to decrease the Propranolol to 60 mg BID. It could not be determined why the physician increased the resident's Klonopin, considering the</p>	F 329		

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

PRINTED: 11/21/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/04/2014
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHABILITATION - CALDWELL			STREET ADDRESS, CITY, STATE, ZIP CODE 210 CLEVELAND BOULEVARD CALDWELL, ID 83605	
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F 329	<p>Continued From page 87</p> <p>adverse effects of this medication were agitation, irritability and nervousness.</p> <p>A Physician's Order on 9/11/14 documented to increase Seroquel to 200 mg at bedtime (double the previous dose) and added Restoril 15 mg at bedtime for insomnia. The 2015 NDH for Restoril included a nursing consideration to reduce doses in elderly patients as these patients may be more sensitive to the drug's adverse CNS effects. Additionally, the adverse reactions for Restoril included dizziness, lethargy, disturbed coordination, confusion, weakness, headache, fatigue, and anxiety.</p> <p>No documentation was found which indicated the facility had used resident specific non-pharmaceutical approaches for resident behaviors. There was no documentation of how persistently the resident was experiencing hallucinations, delusions or psychosis; or how they were harmful to the resident or others. It could not be determined what the therapeutic goals were or how the effectiveness of the medication changes would be monitored. The monitoring of the resident's total hours of sleep was already in place and documented the resident had experienced only one day where he slept less than 6 hours prior to the 9/11/14 order for Restoril.</p> <p>A NN on 9/13/14 documented the resident was walking to his room with a CNA, became weak and his knees buckled. On 9/14/14 a NN documented the resident experienced a change in condition due to weakness and confusion, and digressed from independent transfer to 2 person assist with ADLs and transfers. On 9/15/14 the resident fell. There was no documentation that</p>	F 329		

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F 329	<p>Continued From page 88</p> <p>the resident's medication use was ruled out as a contributing factor to these changes.</p> <p>On 9/16/14 a NN documented a new order to do orthostatic BP and pulse for days so those values could be reviewed by the physician. However, no documentation was found that this was done or that the physician reviewed the blood pressures and pulse readings.</p> <p>On 9/19/14 there was documentation of a new telephone order for Zyprexa 10 mg IM (intramuscular) every 12 hours as needed for psychosis with agitation features. The first documentation the resident received Zyprexa was on 9/21/14 at 8:15 PM. It could not be determined from the resident's record why he required the addition of a second antipsychotic medication.</p> <p>On 9/22/14 a new physicians order documented to increase the resident's Seroquel by adding a 50 mg dosage twice daily, and to continue 200 mg at bedtime. The resident's Propranolol dose was decreased to 40 mg twice daily. It could not be determined from the resident's medical record why Seroquel was increased, or how underlying acute medical issues had been ruled out if behavioral changes had in fact occurred.</p> <p>At this time, the resident continued to receive two antipsychotic medications, two Benzodiazepine medications and three antihypertensive medications.</p> <p>A PFI documented the resident fell again on 9/23/14 at 6:15 AM.</p> <p>On 9/25/14, a NN documented, "On 9/23 [name of resident] was ambulating with CNA and</p>	F 329			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHABILITATION - CALDWELL			STREET ADDRESS, CITY, STATE, ZIP CODE 210 CLEVELAND BOULEVARD CALDWELL, ID 83605	
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F 329	<p>Continued From page 89</p> <p>became weak so the CNA lowered him to the floor...He was sent to the ER later that day and was admitted with PE [Pulmonary Embolis]. He has returned today...is confused and agitated."</p> <p>On 9/25/14, when the resident returned from the acute care hospital, his Klonopin, Restoril, Propranolol, and Prazosin remained at the same dosage. His Lisinopril was decreased from 60 mg to 40 mg daily. His MAR documented Seroquel 50 mg twice daily on 9/25/14, with the previous dose of 200 mg at bedtime started on 9/26/14.</p> <p>On 9/26/14, the MAR documented the discontinuation of Seroquel 50 mg twice daily. On that same date, Zyprexa 5 mg twice daily was started. It could not be determined why these medication changes were made the day after the resident returned from the hospital and while he was recovering from an acute illness.</p> <p>A PFI documented the resident fell again on 10/2/14 at 2:55 AM.</p> <p>On 11/4/14 at 1:15 PM, the DNS was asked about the medication changes related to duplicate therapy for the classes of antipsychotics, benzodiazepines and antihypertensive medications, and the reasons for the multiple psychotropic medication changes the resident had. The DNS did not respond, and the facility did not provide that information.</p> <p>On 11/4/14 at 3:50 PM, the Administrator was informed of these concerns and the facility offered no further information.</p>	F 329		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001100	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/04/2014
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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHABILITATION - CALI	STREET ADDRESS, CITY, STATE, ZIP CODE 210 CLEVELAND BOULEVARD CALDWELL, ID 83605
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C 000	16.03.02 INITIAL COMMENTS The following deficiencies were cited during a complaint survey of your facility. The surveyors conducting the survey were: Rebecca Thomas, RN, Team Coordinator Nina Sanderson, LSW	C 000		
C 147	02.100,05,g Prohibited Uses of Chemical Restraints g. Chemical restraints shall not be used as punishment, for convenience of the staff, or in quantities that interfere with the ongoing normal functions of the patient/resident. They shall be used only to the extent necessary for professionally accepted patient care management and must be ordered in writing by the attending physician. This Rule is not met as evidenced by: Please see F 329 as it pertains to unnecessary medications.	C 147	Please refer to the 2567 as it relates to F329 RECEIVED DEC 31 2014 FACILITY STANDARDS	12/8/14
C 175	02.100,12,f Immediate Investigation of Incident/Injury f. Immediate investigation of the cause of the incident or accident shall be instituted by the facility administrator and any corrective measures indicated shall be adopted. This Rule is not met as evidenced by: Please refer to F-225 as it relates to investigation of accidents.	C 175	Please refer to the 2567 as it relates to F225	12/8/14
C 784	02.200,03,b Resident Needs Identified	C 784	Please refer to the 2567 as it relates to F309	12/8/14

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Heidi L. Walker</i>	TITLE Executive Director	(X6) DATE 12/01/14
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001100	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/04/2014
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHABILITATION - CALI		STREET ADDRESS, CITY, STATE, ZIP CODE 210 CLEVELAND BOULEVARD CALDWELL, ID 83606		
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C 784	Continued From page 1 b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Please see F 309 as it pertains to delay in treatment.	C 784		
C 790	02.200,03,b,vi Protection from Injury/Accidents vi. Protection from accident or injury; This Rule is not met as evidenced by: Please see F 323 as it pertains to falls, and falls with injury.	C 790	please refer to the 2567 as it relates to F 323	12/8/14
C 893	02.203,02,g,v Incidents/Accidents Reports v. Any incident or accident occurring while the patient/resident is in the facility. This Rule is not met as evidenced by: Please refer to F-323 as it relates to accidents and injuries of unknown origin.	C 893	Please refer to the 2567 as it relates to F 323	



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

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BUREAU OF FACILITY STANDARDS
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Boise, ID 83720-0009
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December 11, 2014

FILE COPY

Rick L. Holloway, Administrator
Kindred Nursing & Rehabilitation - Caldwell
210 Cleveland Boulevard
Caldwell, ID 83605-3622

Provider #: 135014

Dear Mr. Holloway:

On **November 4, 2014**, a Complaint Investigation survey was conducted at Kindred Nursing & Rehabilitation - Caldwell. Becky Thomas, R.N. and Nina Sanderson, L.S.W. conducted the complaint investigation.

The survey team completed the following tasks while conducting this investigation:

- The records of nine residents having falls in the facility were reviewed, which included the identified resident.
- Staff interviews were conducted.
- Facility's policies and procedures were reviewed for incident investigations.
- Facility's incident reports were reviewed from July through October.
- Records from consulting physicians and laboratory results were reviewed.

The complaint allegations, findings and conclusions are as follows:

Complaint #6709

ALLEGATION #1:

The complainant reported an identified resident fell while being assisted with his shoes.

FINDINGS #1:

An incident report confirmed the resident fell while being assisted by a staff member to put on his shoes.

This portion of the allegation was substantiated and cited at F225, F323 and F329.

CONCLUSIONS:

Substantiated. Federal and State deficiencies related to the allegation are cited.

ALLEGATION #2:

The complainant stated an identified resident received a physician's referral for an orthopedic consult on September 23, 2014. However, the facility waited until October 7, 2014, to schedule the appointment, and the resident did not actually see the orthopedist until October 9, 2014. The orthopedist provided the resident with an injection for pain but instructed that if the injection was not effective an MRI would be required.

FINDINGS #2:

The identified resident's record contained an order from his primary care physician on September 23, 2014, for an orthopedic consultation. The facility had documentation revealing the orthopedist's office was made aware of the referral on September 25, 2014, and again on October 1, 2014. However, it could not be determined when the actual appointment was scheduled or what clinical information the orthopedic office received, in order to ensure the resident's appointment was prioritized as needed. Additionally, the facility did not document that it was aware that the October 9, 2014, appointment took place, or that the resident needed to be monitored for the effectiveness of the injection. The first documentation in the facility's record of the resident's orthopedic appointments was on the evening of October 15, 2014, when the orthopedist called the facility with new orders based on the outcome of the resident's MRI.

This portion of the complaint was substantiated and cited at F309.

CONCLUSIONS:

Substantiated. Federal and State deficiencies related to the allegation are cited.

ALLEGATION #3:

The complainant stated an identified resident sustained a fracture to his left lateral tibial plateau and a right torn meniscus. The complainant reported the injuries caused the resident pain,

Rick L. Holloway, Administrator
December 11, 2014
Page 3 of 3

functional decline and would require surgical intervention to repair.

FINDINGS #3:

An MRI study of the resident's left knee was completed on October 15, 2014. The resident was diagnosed with a non-displaced fracture of the lateral tibial plateau and a medial meniscal tear. During an office visit with the orthopedist on October 21, 2014, a treatment plan was developed that included an arthroscopy, which is a surgical procedure.

This portion of the complaint was substantiated and cited at F309 and F323.

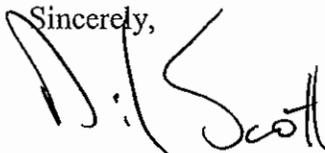
CONCLUSIONS:

Substantiated. Federal and State deficiencies related to the allegation are cited.

Based on the findings of the complaint investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this complaint's findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact Lorene Kayser, L.S.W., Q.I.D.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in black ink that reads "David Scott". The signature is written in a cursive style with a large initial "D" and "S".

DAVID SCOTT, R.N., Supervisor
Long Term Care

DS/dmj