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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation in this survey, event ID # F37111	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on medical record review, observations, and staff interviews the facility failed to systematically reduce or attempt to use less restrictive alternatives to a soft lap belt restraint for one (1) of two (2) residents reviewed for restraints. Resident #3 The findings are: Resident #3 was admitted to the facility 10/24/2010 with the diagnoses: dementia, hypertension, and history of cerebrovascular accident. The most recent Minimum Data Sheet (MDS) revealed that Resident #3 was cognitively impaired and needed extensive assistance with activities of daily living. The MDS also revealed that a restraint was used daily while Resident #3 was in a chair. A review of Resident #3's care plan dated 05/17/2011 revealed Resident #3 used a soft belt restraint while in her wheel chair due to the diagnoses of dementia with poor safety	F 221		8/18/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/15/2011

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F 221	Continued From page 1	F 221		

awareness and unsteady gait. Interventions included were to review the restraint quarterly for elimination of restraint or decrease to a less restrictive device.

A physician's order dated 05/25/2011 read "soft belt when out of bed in wheel chair related to poor safety awareness secondary to dementia."

A quarterly restraint assessment completed 05/17/2011 revealed the medical condition which impacted the use of a restraint was an unsteady gait with a history of a fall related to an injury. On 05/11/2011 thru 05/13/2011 a "daily review" of the soft belt restraint was done. Each day during the review the soft belt restraint was removed by a restorative nursing assistant. Each time the restraint was removed Resident #3 attempted to stand and the soft belt restraint was reapplied. No less restrictive interventions were documented as having been attempted.

An observation was made on 07/20/2011 at 8:30 a.m. of Resident #3 in the dining room eating breakfast. Resident #3 was wearing her soft lap belt restraint while sitting in her wheel chair.

An observation was made on 07/20/2011 at 10:44 a.m. of Resident #3 in the activity room wearing her soft lap belt restraint while sitting in her wheel chair.

An interview was conducted on 07/21/2011 at 9:56 a.m. with Nursing Assistant (NA) #1. She reported that Resident #3 has always had a belt restraint. She wore the belt restraint to keep her from standing up.

An interview was conducted on 07/21/2011 at

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F 221	Continued From page 2 10:00 a.m.with restorative NA #2. She reported that Resident #3 had a restraint because she tries to stand up and leans over in wheel chair and tries to pick things up. She reported that restorative nursing assistants do trials and take residents' restraints off and watch how they will act without a restraint. She further reported that if the resident tried to stand up the restraint is reapplied. An interview was conducted on 07/21/2011 at 10:55 a.m. with Licensed Nurse (LN) #1. LN #1 reported that with trial reduction the resident's restraint is taken completely off. The resident is them monitored to see if they get up, lean forward or if they slide down in their chair. This is done for three consecutive days. LN #1 further reported that if the resident is constantly trying to get up unassisted then the restraint is reapplied. An interview was conducted on 07/21/2011 at 1:30 p.m. with the Director of Nursing (DON). The DON reported that Resident #3 was admitted with the soft belt restraint from another facility in October of 2010. She further reported that it is the care planning team and MDS nurses' responsibility to review and attempt restraint reduction if possible. The DON reported that it was her expectation that less restrictive interventions would have been attempted.	F 221		
F 226 SS=C	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226		8/18/11

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F 226	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on administrative interview and review of the facility policy, the facility failed to include 1 of 7 components (Protection) in the development of the facility's policy and procedures regarding abuse and neglect. Findings include: On 07/20/2011, review of the undated facility abuse policy revealed it lacked the Protection component of how the resident would be protected during an abuse investigation. Review of an alleged abuse investigation (dated 06/11/2011) completed by the facility revealed the investigation was in compliance with the regulatory requirements and included a description of how the resident was protected. On 07/21/2011 at 2:08 p.m., the Administrator, Assistant Administrator #1 and Assistant Administrator #2 were interviewed about the facility Abuse Policy and the missing component about protection. The Administrator and Assistant Administrator #1 indicated it was the most current policy. Assistant Administrator #2 reviewed the facility's computerized policies but was unable to find anything more current. They were unable to provide an Abuse Policy that included the Protection component.	F 226		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities	F 311		8/18/11

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specified in paragraph (a)(1) of this section.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interviews and record review, the facility failed to provide a dining table at a height to maintain independence in eating for one (1) of twenty (20) sampled residents (Resident #14).

The findings are:

Resident #14 was admitted to the facility on 10/05/2010 with diagnoses which included Dementia and Osteoarthritis. Resident #14's most recent quarterly Minimum Data Set dated 05/20/2011 assessed moderately impaired cognition with tray set up required for independent eating.

Continuous observation on 07/21/2011 from 7:53 a.m. to 8:20 a.m. of the breakfast meal revealed Resident #14's shoulders at table height while seated in a wheelchair. Resident #14 reached up and over the table and meal tray edge and brought the milk up and over to her lap. Resident #14 consumed 100% of the milk and rested the glass on her lap between sips. After placing the empty milk glass over the tray edge in front of the orange juice, Resident #14 reached up and attempted to obtain the orange juice. After two minutes, Resident #14 reached up over the table edge and pushed the empty milk glass toward the orange juice glass. After three pushes of the empty glass to the orange juice, Resident #14 placed both hands in her lap. Observation of Resident #14's breakfast meal revealed consumption of approximately 25% of grits in

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addition to 100% of the milk.

Observation on 07/21/2011 at 8:21 a.m. revealed Resident #14 nodded yes in response to the Director of Nursing's (DON) offer of assistance with the breakfast meal. At 8:22 a.m., NA #3 began to feed Resident #14.

Interview with NA #3 on 07/21/2011 at 8:25 a.m. revealed Resident #14 ate at the same table every meal. NA #3 explained Resident #14 was independent in eating but required help at times. She thought help was needed because Resident #14 became tired during the meal and had difficulty reaching the food.

Interview with NA #4 on 07/21/2011 at 8:30 a.m. revealed Resident #14 required eating assistance since a move from the other section of the dining room. NA #4 reported Resident #14 began meals independently then required total assistance.

Interview with the DON on 07/21/2011 at 8:40 a.m. revealed Resident #14's position at the dining table was too low for independent eating.

Interview with Licensed Nurse (LN) #1, the Restorative Nurse, on 07/21/2011 at 8:55 a.m. revealed the table height changed when Resident #14 moved to another section in the dining room. She could not remember when the dining room seating change occurred "but it was awhile ago." LN #1 explained she tried an over the bed table for Resident #14's use in the dining room which lowered to a height for Resident #14 to eat independently. She explained Resident #14 did not like the over the bed table. LN #1 reported she did not refer Resident #14 for a therapy referral for positioning or change the dining table

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F 311	Continued From page 6 height. Interview with the Occupational Therapist on 07/21/2011 at 9:45 a.m. revealed residents referred for positioning evaluations received wheelchair and table height assessments to ensure proper height to maintain independence with eating.	F 311		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on medical record review, observations, and staff interviews the facility failed to rinse the soap from a resident's body after performing incontinence care for one (1) of eight (8) residents observed for incontinence care. Resident #3 The findings are: Resident #3 was admitted to the facility 10/02/2011 with the diagnoses dementia, hypertension, and history of cerebrovascular accident. The most recent Minimum Data set dated 05/10/2011 revealed Resident #3 was cognitively impaired and needed extensive assistance with toileting. Resident #3 was also coded as continent of bowel with occasional incidences of urinary incontinence.	F 312		8/18/11

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Further review of Resident #3's medical record revealed that a physician's order was written 06/01/2011 for a urinalysis with culture and sensitivity due to burning and frequency. Physician orders were written on both 06/09/2011 and 06/14/2011 for urinalysis to be done. On 06/20/2011 a physician's order was written for a urology consult.

A review of Resident #3's care plan dated 05/17/2011 revealed a problem entitled urinary incontinence with interventions that included resident would be taken to the bathroom every two hours.

A review of the facility policy entitled Incontinent Care Procedure (undated) revealed that the purpose of providing incontinence care is to keep skin clean, dry, and free from irritation and odor.

An observation was made on 07/20/2011 at 12:55 p.m. of Nursing Assistant (NA) #1 and NA #2 performing incontinence care on Resident #3. NA #1 and NA #2 transferred Resident #3 to the toilet using a gait belt. After Resident #3 used the bathroom, NA #1 and NA #2 cleaned Resident #3's peri-area using body gel soap, rinsed and dried the resident. Resident #3 then reported she needed to use the bathroom again. After Resident #3 used the bathroom NA #1 cleaned Resident #3's peri-area using a generous portion of body gel soap. NA #1 then dried Resident #3 peri-area and pulled up her pants.

An interview was conducted on 07/20/2011 at 1:20 p.m. with NA#1 and NA #2. When asked, NA #2 read the bottle of soap and reported that the body gel shampoo was to be rinsed thoroughly.

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F 312	Continued From page 8 NA #1 reported she should have rinsed Resident #3's peri-area after cleaning her with thebody gel soap. An interview was conducted on 07/20/2011 at 4:40 p.m. with the Director of Nursing (DON). The DON reported it is her expectation that the NAs should have rinsed the gel soap off of Resident #3 after cleaning her.	F 312		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 431		8/18/11

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Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and manufacturer's recommendations, the facility failed to remove a bottle of expired Lorazepam (a benzodiazepine) from use in a medication refrigerator located in one of one medication rooms.

The findings are:

Resident #28 was admitted to the facility on 05/09/2008 with diagnoses including Congestive Heart Failure, Diabetes and Anxiety. Review of the most recent annual Minimum Data Set (MDS) dated 04/15/2011 revealed Resident #28 was usually understood, usually understands and was cognitively intact with daily decision making.

Review of the manufacturer's recommendation documented on the product insert for liquid Lorazapam Intensol revealed instructions to discard opened bottle after ninety (90) days of opening.

On 07/19/2011 at 4:55 p.m. the medication refrigerator in the medication room was observed to contain an opened thirty (30) millimeter multi-use bottle of Lorazepam oral concentrate. The medication was stored in the locked section of the refrigerator and labeled for Resident #28's

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use. There were no labels indicating the date the bottle was opened on the packaging or the medication bottle. The pharmacy issue date on the product label was 08/26/2010.

Review of a form used by the facility for signing out dosages of controlled medications indicated an initial dose of the Lorazapam was given to Resident #28 on 09/07/2010. Resident #28 also received additional doses on 10/11/2010, 10/13/2010 and 01/26/2011.

On 07/20/2011 at 1:12 p.m. the Director of Nursing (DON) was interviewed and confirmed the Lorazapam was indicated for Resident #28. She further stated the Lorazapam was opened on the date the first dose was given which was 09/07/2010. During the interview the DON indicated the medication nurses are responsible for documenting open dates on multi-use medications and monitoring for expiration dates. The DON further revealed she would expect the medication nurses to read the package insert information and directions regarding expiration dates especially when a medication is not frequently used.

Interview with the consulting pharmacist on 07/19/2011 at 2:15 p.m. revealed the medication nurses open, date and administer the medications from multi-dose containers. He further stated he would expect the medication nurses to refer to the package insert for storage information.