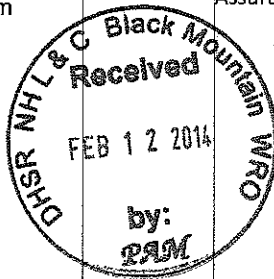


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/30/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345493	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/16/2014
NAME OF PROVIDER OR SUPPLIER HENDERSONVILLE HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 104 COLLEGE DRIVE FLAT ROCK, NC 28731	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272 SS=B	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:</p> <ul style="list-style-type: none"> Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. 	F 272	<p>Disclaimer Clause:</p> <p>Preparation and or execution of this plan does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and or executed solely because it is required by the provisions of the State and Federal law.</p> <p>Activity Assessments for Resident's # 146 and #100 were completed by the Activity Director. Preferences for these residents were gathered and documented in the activity notes.</p> <p>Other residents with moderately to severely impaired cognitive abilities, long and short term memory impairment and requiring extensive to total assistance for all activities of daily living have been identified by the Activity Director and their activities assessments reviewed for completion.</p> <p>Activity assessments will be completed by the Activity Director or designee for each resident with moderate to severe impaired cognitive abilities, long and short term memory impairment and requiring extensive to total assistance for all activities of daily living upon admission, quarterly and annually.</p> <p>Activity assessments for the above population of residents will be reviewed by the Activity Director or designee for completion monthly for four months with results being reported to the monthly Quality Assurance Performance Improvement committee.</p>	2/13/14



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *Administrator* (X6) DATE: *2-6-14*

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 272	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to comprehensively assess 2 of 3 residents sampled for activities. (Residents #46 and #100).</p> <p>The findings included:</p> <p>1. Resident #146 was readmitted to the facility on 04/23/13. Her diagnoses included senile dementia, dysphagia, history of falling, and depressive disorder.</p> <p>The Minimum Data Set (MDS), a significant change assessment dated 08/06/13 coded Resident #146 with long and short term memory impairment and severely impaired cognitive abilities. she was coded as having exhibited behaviors 4 to 6 times in the previous 7 days. She required extensive to total assistance for all activities of daily living skills and was receiving antianxiety and antidepressant medications. She was coded as sometimes being understood and sometimes understanding. Staff completed the preference section indicating she liked music favorite activities and religious activities. The MDS section for activities was completed by the Social Worker #1.</p> <p>Although the care area of activities triggered for an assessment, there was no assessment completed for activities. In addition there were no activity notes located in the medical record related to preferences.</p> <p>On 01/16/14 at 9:02 AM, the Activity Director (AD) stated that when a resident was due for an</p>	F 272			

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F 272	<p>Continued From page 2</p> <p>assessment, she completed an activity preference sheet with the resident or a family member. She stated she was fairly new when Resident #146's significant change assessment was completed and the SW #1 assisted with the assessments. The AD stated Resident #147 enjoyed music, eating in the dining room, getting her nails manicured and holding hands with staff.</p> <p>Interview with SW #1 on 01/16/14 at 10:01 AM revealed she had been assisting the new activity director with MDSs and assessments. She stated she was not sure why she did not complete an assessment related to activities to determine if a care plan would be developed. SW stated Resident #146 liked one on one interactions with staff and sat at the nursing station when tearful.</p> <p>2. Resident #100 was admitted to the facility on 04/02/12. Her diagnoses included acute renal failure, diverticulitis, Alzheimer's dementia, organic brain syndrome, dysphagia, and lower leg cellulitis.</p> <p>The annual Minimum Data Set (MDS) dated 03/19/13 coded her with long and short term memory impairment, moderately impaired decision making skills, and required extensive to total assistance for all activities of daily living.</p> <p>The care area assessment for the triggered area of Activities dated 03/18/13 stated "Family are in to visit each meal. No need to care plan at this time." The last Activity assessment in the medical record was dated 04/02/12.</p> <p>Interview on 01/16/14 at 9:02 AM with the Activity Director (AD) revealed she had only been in her</p>	F 272			

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F 272	Continued From page 3 position approximately 6 months. She stated normally she completed an Activity Evaluation with current likes and dislikes provided by family interview for those residents who could not speak for themselves. She did not complete the annual evaluation for Resident #100. The AD further stated Resident #100 rarely got out of bed and she normally visited with her every morning and spoke about breakfast and the weather. On 01/16/14 at 10:08 AM, the Social Worker (SW) confirmed she had completed the activity assessment and decision not to care plan activities. She was unable to explain why she did not comprehensively assess Resident #100's strengths and weaknesses and their impact on her ability and desire to attend activities. She stated she was thinking more socially in that family came all the time and she received socialization from them. She further stated Resident #100 did not come out of her room and she watched television. The SW was unable to state what type of television she preferred.	F 272			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to follow a physician's order for lab work for 1 of 3 sampled residents. (Resident #6). The findings included:	F 281	The Physician was notified regarding the lab for resident #6. An order was obtained on 1/15/14 to discontinue the order for the lab secondary to resident #6 being asymptomatic for C-Difficile. An audit was completed by the Unit Managers on all current residents' charts for physician orders for the past 30 days to determine if an order for laboratory testing was written. If an order for laboratory testing was written, the Unit Managers compared the order to the lab log to ensure the lab was transcribed correctly to the lab log, each lab was obtained as ordered, the Physician/Nurse Practitioner was notified, and appropriate follow up was completed.		

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F 281	<p>Continued From page 4</p> <p>Resident #6 was readmitted to the facility 01/02/14 after hospitalization for pneumonia and urinary tract infection. Physician orders on 01/03/14 for Resident #6 included Loperamide (medication to treat diarrhea) and to test the resident's stool for clostridium difficile (c diff).</p> <p>Nurses notes in the medical record of Resident #6 noted attempts were made to get a stool sample on 01/04/14 but the resident's stools were too watery to obtain a sample. On 01/05/14 a nurses note written by Nurse #6 included, "Loose stool X 1 specimen collected and ready for lab pick up for c diff testing."</p> <p>Review of the medical record revealed there was not a result from the lab for the testing of c diff from the sample collected on 01/05/14. On 01/15/14 at 6:00 PM the Director of Nursing (DON) stated she was not aware the test for c diff for Resident #6 had not been completed. The DON stated when the lab requisition had been completed the stool sample had been tested for occult blood, not c diff.</p> <p>On 01/16/14 at 08:30 AM the DON reported after talking to Nurse #6 and the staff member from the contract lab (that picked up the stool sample) she understood what happened. The DON stated Nurse #6 had placed the stool for Resident #6 in the lab refrigerator after the sample was obtained on 01/05/14. The DON stated the facility practice after obtaining a stool sample was to note the sample on the lab register. The lab register had data entry for the date, room number, patient's name, test requested, results, phlebotomist initials and comments. The DON stated after the noted information was entered on this sheet third</p>	F 281	<p>If any of the above mentioned items were not completed, the physician was notified and orders were obtained as necessary.</p> <p>The lab process was reviewed and revised by the Director of Nursing regarding transcription of lab orders, logging ordered labs, tracking completion of those orders, and notification of the physician.</p> <p>The licensed nurses will be in-serviced by the Director of Nursing or designee by 2/13/14 regarding the lab process, appropriate follow up on lab results, what to do if the lab results are not returned timely from the lab, and notification of the physician.</p> <p>All lab orders will be forwarded to the unit manager for completion of weekly auditing of the lab log to ensure all steps in the lab process are completed.</p> <p>The Director of nursing will present the results of those audits to the Quality Assurance Performance Improvement Committee monthly for four months for review and recommendations.</p> <p>The Corrective Action will be completed by</p>	2/13/2014	

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F 281	Continued From page 5 shift nursing staff would complete the lab requisition sheet. The DON stated when the phlebotomist came to the facility on 01/06/14 she reviewed the lab requisition sheets and obtained needed blood work as well as picked up any specimens to take to the lab. The DON stated on 01/06/14 an order had been written for a basic metabolic package (BMP) to be drawn on Resident #6. The DON noted on the 01/06/14 lab register the need for the BMP had been entered for Resident #6. A corresponding lab requisition slip had been completed on 01/06/14 for the need for a BMP for Resident #6. The DON stated Nurse #6 failed to note the c diff on the lab register for Resident #6 and, as a result, it was not included on the lab requisition. The DON stated Nurse #6 reported she was not aware she was supposed to enter this on the lab register. The DON stated she spoke with the phlebotomist that picked up the stool culture for Resident #6 on 01/06/14 and the phlebotomist stated she asked Nurse #8 what the stool culture was for and Nurse #8 told her occult blood. The phlebotomist reported she wrote "occult blood" on the lab requisition slip and lab register for Resident #6 and the stool was tested for occult blood, not c diff. The DON stated she spoke with Nurse #8 and she did not recall a conversation with the phlebotomist on 01/06/14 about the stool culture for Resident #6. Nurse #8 stated if she had been asked she would have checked physician orders in the medical record of Resident #6 to know what test had been ordered.	F 281			
F 309 SS=D	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	F 309	Physician was notified on 1/16/14 regarding the Senna S for resident #146. An order was obtained on 1/16/14 to continue the Senna S 2 tablets po twice a day for constipation.		

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F 309	<p>Continued From page 6</p> <p>or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to follow physician's orders related to the discontinuation of a laxative/stimulant medication for 1 of 5 residents (Resident #146) sampled for medication review and failed to remove a wound packing before a sitz bath for 1 of 5 residents (Resident #357) sampled for wound care.</p> <p>The findings included:</p> <ol style="list-style-type: none"> Resident #146 was most recently admitted to the facility on 04/23/13. Her diagnoses included dysphagia, a history of falls, senile dementia and depressive disorder. Her most recent Minimum Data Set, a quarterly dated 10/30/13, coded her as having severely impaired cognition. <p>Per the Medication Administration Records, Resident #146 had been receiving Senna S 2 tabs twice per day for constipation since readmission on 04/23/13. On 12/03/13 a physician's telephone order included the discontinuation of the Senna S and the start of Questran 1 packet 1 hour before or 4 hours after other medications every 4 hours up to 3 times per day as needed due to the resident experiencing diarrhea. Review of the Medication Administration Record (MAR) for December 2013 revealed the Senna S had been discontinued and</p>	F 309	<p>The nurse that hand wrote the order on the Physician Order Sheet (POS), (Nurse #4), was in-serviced by the Director of Nursing on 1/17/14 regarding the process for completing the end of month physician order and Medication Administration Record (MAR)/Treatment Administration Record (TAR) review for paper change over to include physical review of the medical record for new and discontinued orders during the previous month.</p> <p>The licensed nurses will be in-serviced by the Director of Nursing on or before 2/13/14 regarding the process for completing the end of month physician order and Medication Administration Record (MAR) and review for paper change over to include physical review of the medical record for new and discontinued orders during the previous month.</p> <p>The paper change over process was reviewed and revised as needed by the Director of Nursing to ensure all current medications and treatments are reflected accurately on the MARs and TARs for the upcoming month. At the end of each month, two Licensed Nurses will check the residents' Medical Record for new Physician Orders to ensure that the residents' medication and treatment changes are accurately transcribed to the printed Monthly MAR and TAR for each resident.</p> <p>The DON, and/or Designee will perform Monthly Audits of five charts from each unit for three months for accuracy of the residents' POS, MARs, and TARs. The Director of nursing will present the results of those audits to the Quality Assurance Performance Improvement Committee monthly for review and recommendations.</p> <p>The Corrective Action will be completed by</p>	2/13/14	

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F 309	<p>Continued From page 7</p> <p>not administered to Resident #146 after 12/03/13. On 12/30/13 another order was written for Dulcolax suppository every 3 days as needed for constipation per hospice protocol. The orders did not include the restart of routine Senna S.</p> <p>Review of the printed monthly physician orders and MARs, provided by the pharmacy for January 2014, revealed a hand written addition to each for Senna S 2 tabs twice daily for constipation. The MAR revealed that Senna S had been given twice daily from 01/01/14 through 01/15/14 and once on 01/16/14. Review of physician telephone orders revealed no order for the restart of this medication.</p> <p>On 01/16/14 at 1:17 PM, Nurse #2 stated that any time there was a new physician 's order, nurses were to change the MAR and send a copy of the order to the pharmacy. At the end of each month, two nurses checked the physician's orders to ensure accuracy. She confirmed Resident #146 was receiving Senna S 2 tabs twice per day and she could not find a physician order in the medical record to restart the Senna S.</p> <p>The Director of Nursing (DON) stated during interview on 01/16/14 at 1:23 PM that when telephone orders were received, the nurse was expected to fax a copy of the order to pharmacy and change the MAR. Each month, the pharmacy preprinted and sent the facility the next month's physician order sheet and new MAR. Once received, two nurses were assigned to double check the orders and MARs with any orders received since the last month's pharmacy order sheet and MAR to ensure accuracy of the newly printed order sheet and MAR. The DON further identified that Nurse #3 completed the first</p>	F 309	<p>The Nurse Practitioner was notified on 1/14/14 and the order was changed for the dressing to be changed after the sitz bath and the dressing is now changed per these orders. Nurse Assistant (NA) #1 and Nurse #5 were in-serviced on 1/15/14 regarding removing packing prior to performing a sitz bath. There are no other residents with ordered sitz baths. An audit will be completed on or before 2/13/14 on all residents' charts with wound treatment orders to ensure all treatments needing packing and/or dressing to be removed prior to a bath, shower, sitz bath, etc., are indicated on the nursing assistant care card to facilitate communication with the licensed nurses.</p> <p>The nursing assistants will be in-serviced by the Director of Nursing or designee on or before 2/13/14 regarding notifying the licensed nurses before showers, baths, or sitz baths are performed on residents with dressings, so the dressing and or packing can be removed as indicated.</p> <p>The licensed nurses will be in-serviced by the Director of Nursing on or before 2/13/14 regarding removing packing prior to performing a sitz bath and communication with the Nursing Assistants to better time treatments with baths, showers, sitz baths, etc.</p> <p>All wound treatment orders will be forwarded to the unit managers to be taken to the clinical meeting to be reviewed by the administrative clinical team and the care card can be updated with the wound treatment.</p> <p>Each unit manager will randomly audit five wound treatments weekly for three months to ensure packing and/or dressing is removed prior to baths, showers and sitz baths as indicated.</p> <p>The Director of nursing will present the results of those audits to the Quality Assurance Performance Improvement Committee monthly for review and recommendations.</p> <p>The Corrective Action will be completed by</p>	2/13/14

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F 309	<p>Continued From page 8</p> <p>check and Nurse #4 completed the final check. The DON further stated that one of the nurses hand wrote the Senna S onto the preprinted order sheet and MAR.</p> <p>An attempt to contact Nurse #3 via phone on 01/16/14 at 1:39 PM was unsuccessful.</p> <p>Nurse #4 was interviewed by phone on 01/16/14 at 1:40 PM. Nurse #4 stated that during the month to month physician sheet and MAR review, if there was a discrepancy, she would normally check with the nurse practitioner and write a clarification order. Nurse #4 stated she completed the end of month reviews but could not recall any specifics related to Resident #146's review or any changes that were made.</p> <p>2. Resident #357 was admitted to the facility on 01/02/14 with a peri-rectal abscess which had required surgery.</p> <p>There was no Minimum Data Set for this resident. During interview on 01/13/14 at 3:03 PM, the resident was noted to be alert with some short term memory loss.</p> <p>Review of physician orders revealed: *On 01/09/14 a telephone order was to change the sitz bath (water immersion to decrease inflammation and pain) to twice a day. *On 01/14/14 a telephone order stated to pack the peri-rectal wound with 1/4th inch iodoform gauze and change twice per day after the sitz bath. *On 01/15/14 a telephone order included to irrigate the peri-rectal wound with normal saline prior to packing twice a day.</p>	F 309		

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F 309	<p>Continued From page 9</p> <p>On 01/15/14 at 1:30 PM Resident #357 stated she had her sitz bath early this morning. Immediately following this conversation, Nurse Aide (NA) #1 assisted Resident #357 onto the bed from her chair. Nurse #5 was observed providing the irrigation and wound care of the peri-rectal area. Nurse #5 stated the wound care was usually done soon after the sitz bath but not today. Resident #357 was observed with wound packing in place prior to the irrigation.</p> <p>On 01/15/14 at 4:32 PM, NA #1 stated that either she or the nurse placed Resident #357 on the sitz bath usually in the morning or after breakfast according to the resident's preference. NA #1 stated she removed a cover dressing to the wound and she stated she did not see packing or remove any packing from the wound. She further stated that if she saw packing she would remove it.</p> <p>Nurse #5 was interviewed on 01/15/14 at 4:39 PM. Nurse #5 stated that normally the sitz bath and irrigation and packing were completed one after the other, with the nurses help, however, sometimes staff were busy and the nurse aides removed the packing prior to the sitz bath. Nurse #5 stated that she obtained an order to irrigate the wound with normal saline so that the wound would be cleaned well before the packing if, like today the sitz bath was completed much earlier than the wound packing. Nurse #5 stated she was surprised to see the packing still in the wound at the time she went to irrigate it since it should have been removed prior to the sitz bath.</p> <p>On 01/15/13 at 5:29 PM, the Director of Nursing stated the sitz bath was more for comfort and the irrigation was to clean the wound. She confirmed</p>	F 309			

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NAME OF PROVIDER OR SUPPLIER HENDERSONVILLE HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 104 COLLEGE DRIVE FLAT ROCK, NC 28731	
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F 309	Continued From page 10	F 309		
F 329 SS=D	<p>that the nurse aide should get the nurse to remove the packing prior to the sitz bath.</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>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.</p> <p>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 drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to assess clinical indication for use of an anti-anxiety medication for 1 of 5 sampled residents. (Resident #135).</p>	F 329	<p>The Ativan for resident #135 was changed from routine to Ativan 0.25mg p.o. t.i.d. prn anxiety and is only receiving the medication when needed for symptoms of increased anxiety.</p> <p>An audit will be completed by the pharmacy consultant or designee on or before 2/13/14 on all residents receiving psychoactive medications to ensure appropriate indications and diagnoses are present. If no indication or diagnosis is present, the physician will be notified and orders obtained as necessary.</p> <p>A risk/benefit evaluation form will be implemented by 2/13/14 to ensure appropriate indications and diagnoses are present prior to introducing a psychoactive medication to a residents' drug regimen.</p> <p>The licensed nurses, social workers and physician will be in-serviced by the Director of Nursing or designee regarding completing the risk/benefit form prior to introducing a psychoactive medication to a residents' drug regimen.</p> <p>All residents on psychoactive medications will be audit/reviewed in the monthly behavior committee meeting to ensure appropriate indications, diagnoses, behavioral interventions, and gradual dose reductions are completed as appropriate.</p> <p>The Director of nursing will present the results of those audits to the Quality Assurance Performance Improvement Committee monthly for four months for review and recommendations.</p> <p>The Corrective Action will be completed by</p>	2/13/14

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F 329	<p>Continued From page 11</p> <p>The findings included:</p> <p>Resident #135 was admitted to the facility 03/07/12 with diagnoses which included dementia and depression.</p> <p>Review of physician orders and the Medication Administration Review (MAR) records of Resident #135 noted an order for Ativan (an anti-anxiety medication) 0.25 milligrams every eight hours as needed (PRN) for anxiety/agitation. Review of the October 2013, November 2013 and December 2013 MARs noted the PRN Ativan had not been administered to Resident #135. The October 2013, November 2013 and December 2013 behavior monitoring sheets for Resident #135 did not indicate any instances of anxiety.</p> <p>Review of the physician communication book noted an entry dated 12/04/13 regarding Resident #135 with a request, "Can anti-anxiety medications be routine due to increased anxiety with transfers with physical therapy staff. On 12/05/13 a physician's order was written in the medical record of Resident #135 for Ativan 0.25 milligrams three times a day. There was not a corresponding physician/nurse practitioner progress note to indicate the reason for initiation of routine Ativan for Resident #135. A nurse's note dated 12/05/13 in the medical record of Resident #135 noted the order to start Ativan but did not address the indication for use.</p> <p>Review of the medical record of Resident #135 noted the following documentation: -Resident #135 was seen by the physician on 12/03/13. This physician progress note mentioned that Ativan was ordered PRN for anxiety. The physician's assessment of Resident</p>	F 329		

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F 329	<p>Continued From page 12</p> <p>#135's "mood and affect" noted "no depression, anxiety or agitation."</p> <p>-The 24 hour nurses report book was reviewed and on 12/04/13 and 12/05/13 there were no concerns related to Resident #135.</p> <p>-Nurses notes in the medical record of Resident #135 did not mention any issues with anxiety November-December 2013.</p> <p>- At Risk Interdisciplinary Notes in the medical record of Resident #135 dated 12/04/13 and 12/12/13 did not address any issues with anxiety.</p> <p>-A Social Worker progress note dated 12/20/13 did not mention any issues with anxiety.</p> <p>-A quarterly Minimum Data Set (MDS) for Resident #135 dated 12/09/13 assessed no signs of delirium, no issues with mood and no behaviors. This MDS assessed Resident #135 with severe impairment of cognition.</p> <p>-The care plan for Resident #135 was updated 12/23/13. The care plan did not identify any issues with anxiety. The care plan did include a problem area of: falls related to recurrent falls, unsteady gait and decreased mobility.</p> <p>On 01/16/14 at 08:50 AM Nurse #1 stated she recalled that either a physical therapist or occupational therapist (OT) had suggested the Ativan when they were working with Resident #135 due to fears the resident had of falling. Nurse #1 stated Resident #135 had fractured her ankle several months prior and ever since then the resident had a fear of falling. Nurse #1 stated she was not sure if Resident #135 was still being seen by therapists.</p> <p>Review of therapy service progress notes revealed Resident #135 had not been seen by a physical therapist for several months prior to</p>	F 329		
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F 329	<p>Continued From page 13</p> <p>12/04/13. Resident #135 was seen by occupational therapists from 11/22/13-12/12/13. Discharge plans on 12/12/13 by the Occupational Therapist noted, "Staff training completed, OT recommending use of Sara lift or assist of two people for all transfers." "Fall risk, personal alarm at all times." The Nursing Assistant Care Guide book indicated that effective 12/11/13 Resident #135 should be lifted with a Sara lift or two person assist related to a history of a fracture.</p> <p>On 01/16/14 at 02:00 P.M. Nurse Aide #2 stated she had worked with Resident #135 for the past several months. Nurse Aide #2 stated she used the Sara lift when transferring Resident #135 and as long as she explained to Resident #135 what she was doing, the resident transferred without difficulty. Nurse Aide #2 stated she never had difficulty transferring Resident #135 in the past several months.</p> <p>On 01/16/14 at 03:30 PM the Occupational Therapist that worked with Resident #135 stated that since fracturing her ankle the resident appeared to be afraid of falling during transfers. The Occupational Therapist stated Resident #135 did much better with transfers when she had consistent staff assisting her and when a consistent method of transferring was used. The Occupational Therapist stated this is why the Sara lift was recommended for use with transfers for Resident #135.</p> <p>On 01/16/14 at 03:40 PM the Certified Occupational Therapy Assistant (COTA) that primarily worked with Resident #135 stated there had been a time during OT therapy that Resident #135 was anxious with transfers due to an</p>	F 329		

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F 329	<p>Continued From page 14</p> <p>apparent fear of falling. The COTA stated she mentioned this to Nurse #1 and Nurse #1 stated she would talk to the physician/nurse practitioner about the concern and possible use of anti-anxiety medication. The COTA stated at that time (when she spoke to Nurse #1) in therapy they were primarily transferring Resident #135 with two staff and then decided to try the Sara lift. The COTA stated Resident #135 did much better with the Sara lift and her fear of falling was greatly reduced. The COTA stated by the end of therapy services Resident #135 was doing so well with the Sara lift it was recommended as the primary mode of transfer. The COTA stated she felt it reduced any fears of falling Resident #135 had to the point anti-anxiety medication was no longer a consideration.</p> <p>On 01/16/14 at 10:51 AM the Family Nurse Practitioner (FNP) that wrote the 12/05/13 order for routine Ativan for Resident #135 stated she did so in response to the therapist request. The FNP stated she did not realize PRN Ativan had been available and not used for Resident #135 prior to the request on 12/04/13. The FNP stated in light of the falls risk for Resident #135 it might have been good to initially try the PRN Ativan or now attempt to wean her off the routine Ativan.</p> <p>On 1/16/14 at 10:25 AM the facility Director of Nursing stated she understood the concern and did not have any explanation for use of routine Ativan for Resident #135.</p>	F 329		