STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING ______ B. WING ______	09/24/2013

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F 279	Continued From page 24	F 279	Continued From page 24	

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Resident #194 was observed on September 20, 2013 at approximately 2:45 PM sitting in a wheelchair proximal to the nursing station. Exposed wounds were observed on his/her right arm. The dressing bandage was observed loosely hanging around his/her right wrist and drainage was noted on the resident ' s clothing.

A face-to-face interview was conducted with Employee#8 on September 20, 2013 at approximately 3PM, he/she was asked why the resident did not have a dressing on his/her wounds, he /she stated "[Resident #194] refused to have his/her dressing changed this morning as scheduled by the wound care nurse and that he/she is often resistant to care ...the charge nurse and responsible party were made aware."

A review of the physician ' s order sheet dated September 10, 2013 revealed the resident ' s diagnoses included Disquamative skin disorder and hemorrhagic blisters of the skin.

The Medication and treatment administration record for September 2013 revealed wound treatments to the affected area(s) [right arm] were scheduled at twice daily at 10AM and 6PM.

A review of Resident #194 ' s comprehensive care plan lacked evidence of goals and approaches to manage behaviors of resistance of care.

Employee #8 acknowledged the findings on September 20, 2013 at approximately 4:30 PM. The record was reviewed on September 20, 2013.

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F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for four (4) of 40 sampled residents, it was determined that facility staff failed to review and revise care plans: for one (1) resident with an indwelling catheter; one (1) resident who required PROM [Passive Range of Motion] prior to application of splint devices and one (1) resident who required the use a gel cushion for pressure redistribution. Resident's #93, #121, and #182. The findings include:	F 280		

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F 280	Continued From page 26 1. Facility staff failed to review and revise a care plan with goals and approaches for Resident #93 who had an indwelling catheter A review of the resident ' s admission record dated March 7, 2013 revealed that he /she was readmitted to facility `with diagnosis of Seizure Disorder, DVT [Deep Vein Thrombosis], CVA [Cerebral Vascular Accident], Psychosis, Pressure Ulcer, Anemia, Diabetes Mellitus and Senile Dementia A review of the Physician's order sheet dated May 21, 2013 revealed an order that directed "Change indwelling foley catheter now with18FR [french] secondary to foley catheter leaking." A review of the comprehensive care plan for Resident #93 revealed a care plan, " Problem: Functional Incontinence, [secondary to] decreased bladder capacity. " The care plan was last updated September 12, 2012. The facility staff failed to update [since September 2012] the care plan related to the use of the indwelling catheter. A face-to-face interview was conducted on September 19, 2013 with Employee #9 at approximately 10:50AM. He/she acknowledged the findings after reviewing the care plan. The record was reviewed September 19, 2013. 2. Facility staff failed to review and revise a care plan for Resident #121 who was to receive PROM [passive range of motion] prior to the application of splints.	F 280	Continued From page 26 **#1.** (1). Resident #93 care plan was updated to indicate use of a Foley on 9/20/13. (2). Resident #121 was updated to include PROM before the splint application on. (3.) Resident #182 care plan is unable to be amended due to the resident no longer resides at this facility. 2. A 100% review of all resident's assessments and care plans were conducted to ensure each care plan contains goals and approaches that reflect the resident's current and potential care needs. 3. The MDS staff will conduct monthly review of care plan completion and report the findings to the DON/ADON. 4. The DON/designee will report to the Quality Assessment and Performance Improvement Committee (QAPI) the findings, problems identified and interventions based on the results of the audit. The QAPI Committee will determine the need for additional audits and frequency of further monitoring and follow up.	9/20/13 9/23/13 10/10/13 Monthly Monthly & Ongoing

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F 280	Continued From page 27	F 280	Continued From page 27	

A review of the residents care plan indicated a problem " Requires Supportive Devices " right ankle boot. The care plan was last updated July 6, 2013.

Review of the medical record revealed an Interim Order Form dated and signed August 26, 2013 at 3:00 PM, which indicated: apply Left elbow splint, Left hand splint, Left ankle boot and bilateral knee splints, perform gentle PROM [Passive Range of Motion] to BUE [Bilateral Upper Extremities] and BLE [Bilateral Lower Extremities before application of splints.

Review of the " Restorative Charting Review " revealed the resident received PROM for the months of August and September 2013.

The supportive devices care plan lacked evidence of approaches that included passive range of motion prior to the implementation of splints as prescribed.

A face-to-face interview was conducted on September 20, 2013 at approximately 2:30 PM with Employee #10. After review of the care plans he/she acknowledged the care plan was not updated to include PROM to be performed prior to application of the splints.

3. Facility staff failed to review and revise Resident #182' s care plan to include a prescribed pressure redistribution strategy for the use of a gel cushion while seated in a geriatric chair.

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F 280	Continued From page 28 Physician ' s orders signed and dated August 8, 2013 at 3:05 PM indicated " Resident to use gel cushion when out of bed to geri-chair for pressure relief for sacral ulcer. " A review of the medical record wound assessment sheets dated September 18, 2013 revealed that the resident had a left buttock shear skin impairment measuring 3.1x1.2x0.2cm. A review of Resident #182 ' s care plan last revised on September 18, 2013 lacked evidence of revisions to the altered skin integrity care plan include the use of a gel cushion when out of bed to geri chair for pressure relief of the sacral ulcer. " A face-to-face interview was conducted with Employees #10 and #19, on September 19, 2013 at approximately 3:05 PM. After review of the care plans, both acknowledged that the care plan was not revised to include goals and interventions to use the gel cushion. The record was reviewed September 19, 2013.	F 280	Continued From page 28	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 40 sampled residents, it was	F 282		

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F 282	Continued From page 29 determined that facility staff failed to ensure that services were provided in accordance with the written plan of care for Resident #23 who did not undergo a rehabilitation screen following a fall without injury. The findings include: Facility staff failed to implement measures to ensure that Resident #23 was evaluated by the Rehabilitation Department for an evaluation and/or treatment after sustaining a fall without injury. A review of the resident ' s clinical record revealed that the resident sustained a fall on September 8, 2013 at 3:15AM. No injury was noted. According to documentation recorded on the Incident Report form dated September 8, 2013 the staff responded to the resident ' s room and found the resident lying on the floor mat at the bedside. A review of Resident #23 ' s comprehensive care plan revealed that the fall prevention care plan was updated September 8, 2013. Listed among the interventions on the care plan was a referral to the Rehabilitation Department for a post fall evaluation. A face-to-face interview was conducted with Employee #8 at approximately 10:00AM on September 20, 2013. In response to a request to review the rehabilitation assessment, Employee #8 retrieved the referral for rehabilitative services and stated, " I thought I had sent it after the fall. "	F 282	Continued From page 29 1. A rehab screen was initiated for Resident #23. It was conducted on 9/19/13. 2. A 100% review of resident falls was conducted to ensure the required services are provided. 3. The RN Charge Nurse/Nurse Supervisor/ Unit Manager will initiate the Rehab screen for each resident who sustains falls. 4. The Director of Nursing/ADON will report to the QAPI Committee the findings, problems, interventions and corrective plans monthly x3. The QAPI Committee will review the results and determine the need for further review or new process development.	9/19/13 10/21/13 Ongoing Monthly & Ongoing

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F 282	Continued From page 30 Facility staff failed to provide services for Resident #23 in accordance with the comprehensive plan of care to ensure the resident was assessed by rehabilitation post fall. The record was reviewed on September 20, 2013.	F 282	Continued From page 30	
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 or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for one (1) of 40 sampled residents, it was determined that facility staff failed to ensure that residents received 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 as evidenced by a failure to follow physician's orders for the utilization of a pressure redistribution device while seated in a chair for Resident #182. The findings include: 1. Facility staff failed to follow physician's orders to utilize a pressure redistribution device, a gel cushion, while Resident #182 was seated in a	F 309	1. Resident #182 gel cushion was corrected immediately.	9/19/13

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F 309	Continued From page 31 geriatric [recliner] chair. A review of Resident #182 ' s medical record revealed physician ' s orders signed and dated August 8, 2013 at 3:05 PM that directed, " Resident to use gel cushion when out of bed to geriatric chair for pressure relief of sacral ulcer. " Review of the medical record wound assessment sheet dated September 18, 2013 identified that the resident had a left buttock shear skin impairment measuring 3.1x1.2x0.2cm. An observation was made on September 19, 2013 at approximately 3:05 PM. The resident was in the dining area engaged in an activity, resting in a semi-fowlers [45 degree angle] position in a geriatric chair. There was no evidence that a gel cushion was applied to the geriatric chair as ordered. The observation was made in the presence of Employees #10, #19, #20. Employee #20 acknowledged that the resident should have been on a gel cushion. A face-to-face interview was conducted with Employees #10 and 19. A query was made regarding the use of a gel cushion for Resident #182. Employees #10 and 19 acknowledged that the resident was not on the gel cushion. Employee #10 then stated that "[the resident's name] usually is, and that the CNA [Certified Nursing Assistant] must have just changed [him/her] and forgot to replace the cushion." Facility staff failed to follow the physician ' s order to place the resident on a gel cushion when up in a geriatric chair secondary to a stage 2 sacral ulcer. The record lacked evidence of	F 309	Continued From page 31 2. A 100% review of all residents with positioning devices was conducted. 3. The restorative aide will be given a listing of all residents with assistive devices. The RN Charge Nurse/Team Leader will conduct a random daily audit check to ensure proper placement of these devices. The audit tool result will be collected daily. A monthly report will be provided to DON 4. The Director of Nursing/ADON will report to the QAPI Committee the findings, problems, interventions and corrective plans monthly x3. The QAPI Committee will review the results and determine the need for further review or new process development.	10/29/13 Daily & Monthly Monthly & Ongoing

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F 309	Continued From page 32 worsening of the skin impairment. The record was reviewed September 19, 2013.	F 309	Continued From page 32	
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 an observation, record review and staff interview for one (1) of 40 sampled residents, it was determined that facility staff failed to provide the necessary care and services to maintain good grooming and personal hygiene for Resident #P1. The findings include: On September 19, 2013 at approximately 4:00 PM Resident #P1 was observed lying in bed with lengthy nails that were soiled beneath the nail beds. A review of Resident #P1's Minimum Data Set (MDS) dated June 26, 2013 revealed that the resident was coded as cognitively impaired under Section C [Cognitive Patterns] and was totally dependent for ADLs (activities of daily living) under Section G0110 J [Personal Hygiene]. Employee #8 that was present in the resident ' s room was asked to observed the resident ' s nails. The employee observed the nails and	F 312	1. Resident #P1 nails were cleaned immediately.	9/19/13
			2. A random check of 30 residents was conducted through out the facility weekly for grooming.	Daily
			3. All staff was re-educated on providing ADL care and personal hygiene.	12/5/13
			3B. The Nurse Supervisor will conduct random audits of resident care such as grooming, clean attire, hair care daily. These results will be reported to the DON/designee.	Daily
			4. The Director of Nursing/ADON will report to the QAPI Committee the findings, problems, interventions and corrective plans monthly x3. The QAPI Committee will review the results and determine the need for further review or new process development.	Monthly & Ongoing

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F 312	Continued From page 33 stated, " We will take care of them [the resident's finger nails]. " The facility staff failed to carry out activities of daily living to maintain good grooming for Resident #P1.	F 312	Continued From page 33	
F 313 SS=D	483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by:	F 313		
	Based on observation, record review and staff interview for one (1) of 40 sampled residents, it was determined that facility staff failed to ensure that Resident #153 received assistive devices when it was determined the resident ' s vision was impaired.		1. Resident # 153 was evaluated by the eye doctor on 10/26/13	10/26/13
			2. A 100% review of residents' charts was conducted to ensure that all residents received their annual eye exams.	11/6/13
	The findings include: A review of admission Minimum Data Set [MDS] Assessment Reference Date (ADR) December 19, 2012 revealed that Resident #153 was coded as " 1 " visually impaired .under section B [Hearing, Speech, and Vision] B1000.		3. The Unit Manager/Unit Clerk will continue to audit monthly the clinical records to ensure compliance with annual eye exams. These results will be reported to the Director of Nursing/ADON.	Monthly

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F 313	Continued From page 34 A review of the quarterly [MDS] with (ADR) August 23, 2013 revealed that under section B [Hearing, Speech, and Vision] B1000 Resident #153 was coded as " 1 " indicating the resident was "visually impaired." The clinical record revealed an authorization Form for " Senior Vision Services "signed and dated by Resident #153 on May 22, 2013. A review of current physician ' s orders dated August 31, 2013 directed " Ophthalmology [consult] prn. " The original date of the order was December 19, 2012. A telephone interview was conducted with Employee #23 on September 20, 2013 at approximately 3:00 PM, when questioned regarding the prescribed ophthalmology evaluation for Resident #153; he/she stated "the resident signed the consent in May 2013. The appointment was scheduled in August 2013, but was cancelled by Senior Vision Services to be rescheduled, date undetermined." There was no evidence that facility staff followed through with the physician's order for Ophthalmology consultation. Approximately nine (9) months lapsed from the time the resident was assessed with visual impairment in the absence of corrective visual aids and/or appliances (December 2012) and this review of the clinical record. Observations of the resident during the survey period lacked evidence that the resident utilized corrective lenses or other visual aids.	F 313	Continued From page 34 4. The Director of Nursing/ADON will report to the QAPI Committee the findings, problems, interventions and corrective plans monthly x3. The QAPI Committee will review the results and determine the need for further review or new process development.	Monthly & Ongoing

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F 313	Continued From page 35 There was no evidence that facility staff progressively implemented measures to ensure Resident #153 received assistive devices to manage impaired vision. A face-to-face interview was conducted with Employee #8 on September 20, 2013 at approximately 3:00 PM. He/she acknowledged the findings. The record was reviewed on September 20, 2013	F 313	Continued From page 35	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations made during a tour of the Dietary Department on September 18, 2013 at approximately 12:30 PM, it was determined that the facility failed to provide an environment that is free from accident hazards as evidenced by hot water temperatures from the eyewash sink in the main kitchen that exceeded acceptable range. The findings include: 1. Water temperature from the eyewash sink in the main kitchen was as high as 155 degrees Fahrenheit (F).	F 323	**#1** 1. The water supply for eyewash was disconnected on the day of the survey. The eyewash in the main kitchen has been replaced with a brand new eyewash bowl that has cold water only.	9/18/13 11/22/13

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F 323	Continued From page 36 A face-to-face interview with Employee #14 was conducted on September 18, 2013 at approximately 1:30 PM. He/she revealed that the hot water from the eyewash sink is coming straight from the boiler room and is usually as high as 155 degrees F. He/she suggested that the hot water supply to the eyewash sink be turned off. Employee #14 shut off the hot water supply to the eyewash sink and the water temperature dropped to approximately 75 degrees F. No residents or employees were affected by the elevated water temperatures from the eyewash sink. The observation was made in the presence of Employee #12 who confirmed the findings.	F 323	Continued From page 36 2. All areas have been reviewed to identify those areas that may be affected, needing eyewash stations. 3. Maintenance staff will check the eyewash stations weekly and report results to the Director. This process of checking eyewash stations also will be incorporated in the Daily Environment of Care Rounds by Department Directors and Managers. Results of the rounds will be provided to the Food Service Director, Administrator, and Nurse Managers and others directors. 4. The Director(s) will present the results of the daily and weekly checks to the QAPI Committee monthly. The committee will make a determination based on the analysis of the results of the process, as to the pattern of continuous monitoring.	11/24/13 12/2/13 & Daily & Weekly Monthly & Ongoing
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced	F 325		

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F 325	Continued From page 37 by: Based on record review and staff interview for two (2) of 40 sampled residents, it was determined that facility staff failed to verify a significant weight variance for one (1) resident and to accurately assess a weight for one (1) resident. Residents #65 and #186. The findings include: According to the facility ' s " Weight Policy " Revised 7/29/10, stipulates: Procedure: 4. If the weight difference from the previous month is +/-5 pounds, the resident must be re-weighed by two members on the team for verification. 5. The dietitian will evaluate all weight variations to assess if change is significant.. 8. Admissions should be weighed on admission and then weighed again within 72 hours to verify accuracy of initial weight. 1. Facility staff failed to verify a significant weight variance for Resident #65. This was a closed record review. Resident #65 was admitted to the facility on May 20, 2013 for skilled [Physical Therapy and Occupational Therapy] post hospitalization and was discharged home on June 18, 2013 with home health services.	F 325	Continued From page 37 1. Resident #65 was discharged and the weight is unable to be done at this time. (1a) Resident #186 admission weight cannot be changed at this time. However, resident #186 monthly weights 143 + or – 3 lbs. constantly from Aug.-Oct.	
			2. A 100% review of all the new admissions from September-November 2013 was conducted to ensure all 72 hour weights were conducted.	11/27/13
			3. The Unit Manager/Charge Nurses will monitor the completion of the 72 hour weight process for new admissions monthly. These audit results will be reported to the dietician and the DON/designee.	Monthly
			4. The DON will report this information to the Quality Assessment and Performance Improvement Committee (QAPI) monthly. Based on the results of the audit the QAPI Committee will determine the need and frequency for continued monitoring and further follow up.	Monthly & Ongoing

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The physician's history and physical note dated May 21, 2013 revealed that the resident ' s diagnoses included: Chronic Obstructive Pulmonary Disease (Status Post Exacerbation), Systolic and Diastolic Heart Failure, Status Post Left Knee Orthopedic Surgery and Debility."

The discharge assessment Minimum Data Set (MDS) with an ARD (Assessment Reference Date) of June 18, 2013, coded the resident in Section K (Swallowing/Nutritional Status) with " no or unknown weight loss in the last month.

A nutrition progress note dated May 23, 2013 at 9:36 AM read; " Problem: Weight Fluctuation related to Disease Process. No significant weight loss. "

The resident ' s weight (in pounds) was documented as follows:

May 21, 2013 - 199.5 (admission)

June 1, 2013- 166 (no re-weigh)

The clinical record lacked evidence that Resident #65 was re-weighed within 72 hours of admission in accordance with facility policy. Additionally, there was no evidence that the significant weight variance of 33.5 pounds within one (1) month was verified by a re-weight with two team members as stipulated in facilty policy.

A face-to-face interview was conducted with

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Employees #10 and #11 on September 19, 2013 at approximately 11:30 AM. Both acknowledged the aforementioned findings. The clinical record was reviewed on September 19, 2013.

Facility staff failed to verify a significant weight variance.

2. Facility staff failed to conduct reweight verification at the time of admission as per facility policy for Resident #186. Successive weight assessments revealed a significant weight variance of approximately 13 pounds lost over 10 days post admission.

The resident was admitted to the facility on June 26, 2013. His/her admission weight was documented as 148lb. On July 5, 2013 (10 days after admission), the resident ' s weight was documented as 135lbs [13lb less than on admission]. On July 11, 2013 [six days after the July 5, weight] the resident ' s weight was documented as 137lb. This weight was classified as a reweight.

The clinical record lacked evidence that Resident #186 was re-weighed within 72 hours of admission in accordance with facility's aforementioned policy [Item #8]. Additionally, there was no evidence that the resident's significant weight variance of 13lb was verified by a reweight by two members on the team as stipulated in the facility's policy [Item #4].

The resident was referred to the dietician on July 11, 2013 and placed on "Ensure Plus Tid (three times a day), encourage PO (oral) intake and weekly weights for a significant weight loss of

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F 325	Continued From page 40 eight percent (8 %)." A review of the resident ' s discharge record from an area hospital [assessed prior to June 26, 2013] revealed that the discharge weight was 128lb. A face-to-face interview was conducted with Employee #8 at approximately 3:00 PM on September 20, 2013. In response to a query regarding the accuracy of the resident ' s weight, the employee stated, " The resident said [he/she] has not lost any weight. He/she said [his/her] weight has always been around 120lb and [he/her] has never weighed 140lb. " Facility staff failed verify Resident #186's admission weight within 72 hours of admission as per facility policy. The resident was subsequently assessed with significant weight loss. The record was reviewed September 20, 2013.	F 325	Continued From page 40	
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced	F 328		

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by:

Based on clinical record review and staff interview for one (1) of 40 sampled residents, it was determined that facility staff failed to ensure Resident #160's pulse oximetry was monitored according to physician's orders.

The findings include:

A physician ' s order dated August 15, 2013 at 3:00 PM directed " Continue oxygen 3-4 liters/minute via trach mask at 28 % to keep oxygen level greater than 95%. "

The quarterly MDS (Minimum Data Set) with an Assessment Reference Date (ARD) dated July 26, 2013 was coded under Section O (Special Treatments and Programs) as requiring oxygen therapy and tracheostomy care.

A review of the Medication/Treatment Administration Record (MAR/TAR) for the months of June through September 2013 revealed that Resident #160 was scheduled to receive oxygen saturation assessments via pulse oximetry every shift. The spaces allotted on the MAR/TAR for pulse oximetry testing were labeled " N, D, E " [night, day and evening].

The MAR/TAR records for the months of June through September 2013 lacked evidence that pulse oximetry assessments were conducted on the following dates, as evidenced by blank spaces in the allotted spaces for pulse oximetry testing:

June 11, 2013 - night shift
July 7, 2013 - night shift

F 328 Continued From page 41

1. The dates observed for missing pulse oximetry values for resident #160 cannot be corrected at this time. All values for resident #160 has been entered since 9/14/13. — 9/14/13

2. A 100% review of residents on oxygen therapy has been conducted. — 12/2/13

3. All licensed nursing staff have been re-educated on the documentation process for pulse oximetry; and completed the O2 competency skills evaluation and documentation review. — 11/25/13

4. The Unit Manager/designee will monitor weekly and report findings to the Director of Nursing and Assistant Director of Nursing who will report monthly to the QAPI Committee the findings and problems identified with a corrective action plan for three months. The QAPI Committee will determine the need for further follow up. — Monthly & Ongoing

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F 328	Continued From page 42 July 8, 2013 - night shift July 9, 2013 - night shift July 10, 2013 - night shift September 14, 2013- night shift A review of the clinical record lacked evidence that Resident #160 ' s pulse oximetry was monitored as prescribed. A face-to-face interview was conducted with Employees #10 and #26 on September 20, 2013 at approximately 3:30 PM. After reviewing the clinical record; both acknowledged the aforementioned findings. The clinical record was reviewed on September 20, 2013.	F 328	Continued From page 42	
F 329 SS=D	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		

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F 329	Continued From page 43 drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 40 sampled residents, it was determined that the physician failed to provide an " indication " for prescribing Lasix for Resident #23. The findings include: A review of the resident ' s Medication Administration Record (MAR) revealed that the resident was receiving Lasix 40mg by mouth daily. No indication was documented for the use of the Lasix. Review of the Physician ' s Order Sheet (POS) revealed an order which was written and signed on September 16, 2013 and directed, " Lasix 40mg PO (milligrams orally) qd (every day). A face-to-face interview was conducted with Employee #8 on September 19, 2013 at approximately 4:00 PM. The employee reviewed the POS and acknowledged that no reason was indicated for the use of the medication. The employee added, " The resident has been on the medication for a long time. " The record was reviewed on September 19, 2013. The physician failed to provide an indication for the Resident #23 ' s use of Lasix.	F 329	Continued From page 43	
			1. The Medication Administration Record and Physician Order Sheet were updated with an indication for Lasix for resident #23.	9/21/13
			2. A 100% review of all physician orders was conducted.	9/30/13
			3. The Nurse Supervisor will monitor and review the physician orders written per each shift. The night shift charge/team leader nurses will conduct a 24 hour chart audit of the physician orders and provide the results to the ADON for compilation of the monthly report to the DON.	Daily
			4. The Director Nursing will report monthly x3 to the QAPI Committee the findings, problems identified and corrective actions taken. The QAPI Committee will determine further monitoring and frequency of the audits.	Monthly & Ongoing
F 371	483.35(i) FOOD PROCURE,	F 371		