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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	166161	A. BUILDING _____ B. WING _____	C 09/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON SQUARE	600 MESSENGER ROAD KEOKUK, IA 52632

(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 000	INITIAL COMMENTS Correction Date 9/22/17 The following deficiencies relate to the annual health survey conducted in conjunction with complaint 70058-C, 70175-C, 70125-C, 69704-C, and 69556-C and facility reported incidents 69238-I and 69262-M. Complaints 70175-C, 70125-C, 69704-C, and 69556-C and facility reported incident 69238-I were not substantiated. Complaints 70058-C and 70125-C were substantiated. The findings for facility reported incident 69262-M will be sent to the facility at a later date under separate cover. See code of Federal Regulations (42 CFR) Part 483, Subpart B-C.	F 000		
F 314 SS=G	Amended 10/2/17 JKM, RN 483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and	F 314		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Susan Grant RN
TITLE: Administrator
(X6) DATE: 09/29/2017

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.

10/5/17

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F 314	Continued From page 1 (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and resident and staff interviews, the facility failed to provide Resident #2 with an appropriate pressure relieving cushion on the wheelchair seat to prevent the development of pressure ulcers and failed to reposition the resident frequently in the wheelchair to promote healing and failed to apply planned foam boots to Resident #9's feet and legs in order to promote healing of an ankle pressure sore. The sample consisted of 4 residents with pressure ulcers and the facility reported a census of 90 residents. Findings include: 1. Resident #2 had a MDS assessment with an assessment reference date of 6/15/17. The MDS identified a BIMS (Brief Interview for Mental Status) score of 15. A score of 15 indicated the resident had no cognitive problems. The assessment identified the resident as totally dependent on two staff members for bed mobility, transfers, dressing and personal hygiene. The assessment indicated the resident had functional limitations in range of motion of both arms, hands, legs and feet. The MDS listed Resident # 2 with diagnoses of anemia, hypertension (high blood pressure), neurogenic bladder, diabetes mellitus, quadriplegia (unable to move arms and legs), and depression.	F 314		

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F 314	Continued From page 2 The Braden Scale (for predicting pressure sore risk) indicated Resident #2 had a score of 13 on 6/19/17. A score of 13 identified the resident at a moderate risk for the development of pressure ulcers. The Care Plan dated 3/21/17 and updated on 6/21/17, identified a problem for the resident at risk for pressure ulcers and had a history of pressure areas. The approaches included and directed the staff to keep bony prominences from direct contact with one another, turn and reposition every two hours, avoid friction and shearing forces during transfers and position changes, pressure relieving mattress and cushion in the chair. The resident had a new motorized wheelchair and able to reposition self and can off load in chair. The staff are directed to encourage the resident to change positions, staff to provide treatment to abrasion to upper right buttock, resident cares to be completed within 30 minutes. Review of the Interdisciplinary Notes dated 05/23/17 at 9:30 am identified an area to the resident's buttock. The area measured 1.5 cm (centimeters) by 2.0 cm. The staff notified the family and physician of the area on the buttock. Review of the Wound/Skin Healing Record dated 5/23/17, indicated the resident had a Stage II pressure ulcer located on the right buttock that measured 1.5 by 2 cm and no depth. On 5/29/17 the Stage II wound measurement was identified as 3 by 3.5 cm and depth 0.1 cm. On 6/5/17 the Stage II wound measurement were 4.5 cm by 4.5 cm with depth undesirables. The resident was referred to the wound clinic.	F 314		

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F 314	Continued From page 3 On 6/13/17 the wound identified as unstageable and measured 4 cm by 4.7 cm. (no depth since unable to see wound bed). On 6/19/17 the unstageable wound measured 4 cm by 4.5 cm. On 6/26/17 wound is unstageable, measurements are 4.5 cm by 5 cm with depth 2.5 cm. On 7/3/17 wound unstageable and measured 5.4 cm by 4 cm with depth 2.7 cm. On 7/17 the unstageable wound measured 3.6 cm by 5.9 cm with depth 4.1 cm. On 7/17/17 wound is unstageable, measurements 2 cm by 5 cm with depth 4.9 cm. On 7/24/17 wound is unstageable, measurements 5 cm by 5.4 cm with depth of 4.9 cm. On 7/31/17 wound is unstageable, measurements 4 cm by 5 cm with depth of 6 cm. On 8/7/17 wound is unstageable, measurements 2.8 cm by 3.8 cm with depth 4 cm. On 8/14/17 wound is unstageable, measurements 5 cm by 8 cm with depth 6.3 cm Review of the Interdisciplinary Notes dated 5/31/17 indicated a new order received for treatment to the right buttock area. Review of the Interdisciplinary Notes dated	F 314		

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F 314	Continued From page 4 06/05/17 indicated the area to the buttocks worsening, reported to Resident #2 physicians and received new order to refer resident to the wound clinic. Resident's open area at old pressure injury site had worsened in the last week. Visible slough present in center of wound now unmeasurable depth. Spoke with resident regarding treatment when area was open more than a year ago and surgical repair with bed rest of a year. Discussed with resident the time he/she is up in wheelchair from approximately 10:30 am to 11:00 pm at night. Resident stated he/she repositioned self every two hours in wheelchair and the Roho Cushion (adjustable air-filled, wheelchair support to provide skin/soft tissue protection). Review of the operational manual of the Roho dated 04/2017 revealed warnings that included: Do not use an under-inflate or an over-inflated because the cushions benefits will be reduced or eliminated, resulting in an increased risk to skin and other soft tissue. Intended use included a weight limit of 250 pounds. The MDS with a reference date of 6/15/17 identified the resident's weight to be 284 pounds. Review of the physician History and Physical report, dated 6/19/17, indicated Resident #2 presented for evaluation of the right buttock wound. The resident noted the wound started approximately 4 to 5 weeks ago. The resident believed the wound to be pressure related, as there was an issue with his/her Roho cushion losing air. The Roho cushion was checked in the office today and found cushion to be low with release valve open. Resident educated on placing cushion so valve to the back of the chair to prevent accidental release of air. Resident	F 314		

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F 314	Continued From page 5 advised to fill cushion today upon returning to facility. Resident to contact wheelchair representative and to have them come to check cushion for any other causes of air loss, resident to follow-up in 3 weeks. Review of the Wound Center Notes dated 7/13/17 indicated Resident #2 returned for re-evaluation of right buttock wound. The resident had been placing towels in the wheelchair seat for pressure relief and keep pressure off of wound site. Resident averaged 8 hours in the wheelchair during most days. At last visit, the Roho cushion was noted to be deflated with release valve open. Education provided and to have cushion checked for leaks. Resident stated this was performed and that no leaks were identified. Nursing staff at the facility were advised to check cushion daily to insure it is inflated and the release valve is closed. Resident indicated the staff had checked the cushion daily and cushion noted to be inflated in office today. On 8/17/17 at 2:00 p.m. and 8/18/17, Resident #2 was interviewed and stated 3 weeks after the staff noted the wound on the right buttock, he/she along with Staff K, LPN (Licensed Practical Nurse) found the Roho cushion of the wheelchair to be flat. Resident #2 stated Staff K put air into the cushion at the time. Resident #2 stated he/she did not know how long the cushion was flat. Resident #2 stated he/she believed the flat Roho cushion is the cause of his/her current wound to the right buttock. Resident #2 stated the staff do not check the cushion in the wheelchair and he/she has to tell the staff when the Roho is empty. The resident stated he doesn't always know when the cushion is flat. The resident stated the staff are good about	F 314		

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F 314	Continued From page 6	F 314		

repositioning him/her and if not, then will ask and the staff will reposition the resident.

On 8/22/17 at 11:30 a.m. and on 8/25/17 at *:40 a.m., Staff K, LPN, stated he never found Resident #2's wheelchair Roho cushion to be completely flat but had found it to be low in air a couple times after his/her wound was noted. Staff K stated he put in more air. Staff K stated there are other residents with the same Roho cushion. Staff K stated he received no training regarding the Roho cushion but had looked up information on the Internet regarding the Roho cushion. Staff K stated Resident #2 stated he/she can reposition self in wheelchair by tilting the back of the wheelchair. Staff K reported Resident #2 did not have the ability to reposition self in wheelchair and staff did not assist him/her.

On 8/22/17 at 3:05 p.m., Staff L (nursing assistant) was interviewed and stated he had never attempted to reposition the resident in his/her wheelchair. Staff L stated he repositions the resident in bed every 2 hours or sooner if needed.

On 8/25/17 at 12:59 p.m., Staff M (nursing assistant) stated she had taken care of Resident #2 for a long time. Staff M stated the resident will tell you what he wants done. We now check his cushion every day and use a pump in his/her room if needs air. Staff M stated she had offered to reposition the resident in the wheelchair but the resident will refuse and says he/she can do it. Staff M stated after development of the wound, the resident requested a hand towel be rolled up and placed under the thigh [to relieve pressure]. Staff M stated she did not think reclining in the wheelchair would reposition the resident off of the

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F 314	Continued From page 7 buttocks. On 8/25/17 at 10:30 am, the Director of Nursing (DON) stated the wound clinic visit on 6/19/17 was a nursing judgement of the wound clinic regarding resident's wheelchair cushion to be checked daily. The DON stated Resident #2 can reposition self in the wheelchair by the remote control of the wheelchair. 2. Resident #9 had a MDS (Minimum Data Set) assessment with a reference date of 8/17/17. The MDS identified the resident had diagnosis including muscular dystrophy, and chronic respiratory failure, pneumonia, dysphagia (difficult to swallow). The MDS indicated the resident had a BIMS (Brief Interview for Mental Status) score of 7 out of 15. A score of 7 identified the resident had severe cognitive impairment. The MDS indicated the resident required extensive assistance with bed mobility and dependent with transfers, eating, toilet use and personal hygiene. The MDS identified the resident had 1 unstageable pressure ulcer. The MDS indicated the resident had a pressure reducing device on the bed, chair seat and a turning/repositioning program. The Care Plan, with a goal date of 8/23/17, identified a problem with a pressure ulcer and directed the staff to use heel protectors to relieve pressure on the heels as needed on 5/23/17. A review of the Admission Note dated 11/14/16 indicated the resident had a pressure area around the feeding tube and no other open areas. A review of the laboratory report from the comprehensive metabolic panel (blood test)	F 314		

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F 314	Continued From page 8 dated 6/26/17, identified an albumin level of 2.6 g/dl (grams per deciliter) (normal 3.5 to 5g/dl). The test measured the amount of protein in the blood. Observations of the resident lying in bed revealed the resident did not have foam boots on the following dates and times: On 8/21/17 at 10:35 a.m., at 1:24 p.m., at 1:47 p.m. after cares provided by Staff G, CNA and Staff H, CNA and after medication administered by Staff I, LPN. On 8/22/17 at 6:32 a.m., at 6:43 a.m. after Staff I suctioned the resident, at 6:52 a.m., after Staff J, respiratory therapist suctioned the resident, at 7:15 a.m. prior to Staff J changed the dressings to the tracheostomy, at 9:33 a.m., at 10:37 a.m., at 2:03 p.m. and 3:10 p.m. On 8/23/17 at 6:35 a.m., the resident laid in bed asleep and lying on back. The resident had a pillow under the calves of both legs; however, the pillow was flat with the resident's ankle positioned directly on the mattress. The resident had no foam boots on either foot. At 7:18 a.m., the resident continued without foam boots. The form titled Wound/Skin Healing Record described the right ankle as unstageable when identified on 6/19/17. The area measured 1.1 by 0.9. The wound had a purple/red color around the open area which measured 2.2 by 2.7. The last entry identified for the peri-wound area was 6/19/17. On 7/24/17 the area measured 1.1 by 1.1 cm (centimeters) and the resident experienced pain.	F 314		

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F 314	Continued From page 9 On 7/31/17 the area measured 1.3 by 1.3 cm and the resident did not experience pain. On 8/7/17, the area measured 1.5 by 1.2 cm and had pain. On 8/14/17 the wound measured 1.2 by 1.2 cm and depth 0.3 and unstageable. On 8/21/17 the wound measured 1.4 by 1.8 cm and showed deterioration. On 8/22/17 at 11:30 a.m., the ADON (Assistant Director of Nursing) reported the possible cause of the pressure sore could be attributed to large doses of Prednisone, newly diagnosis of diabetes, depression, refused to get up and due to the diagnosis of muscular dystrophy, the resident laid with legs in a frog leg position frequently. In an interview on 8/23/17 at 7:38 a.m. and 7:48 a.m., Staff C, RN reported the pressure ulcer may have been caused by the way the resident laid in bed and the resident should have heel protectors on while in bed. Staff C stated she sent the heel protectors to the laundry due to soiled and the resident should wear them when in bed. On 8/23/17 at 8:13 a.m., Staff E, CNA (certified nursing assistant) was interviewed and stated the staff were to ensure no pressure to the resident's right ankle. Staff E stated the staff needed to apply the foam boots while in bed and the boots were in the closet in the resident's room. Staff E stated the resident should have had them on last night and she picked up the boots from the laundry this morning. On 8/23/17 at 8:22 a.m. Staff F, CNA was interviewed and reported the staff should put the heel protectors on while the resident laid in bed	F 314		

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F 314	Continued From page 10 and the boots were in the laundry. Staff F stated the resident did not have an extra pair of boots. Staff F stated when the boots are in the laundry, the resident's ankle should be under a pillow and floated. On 8/23/17 at 1:49 p.m., the Director of Nursing reported the resident should have heel protectors on their feet while in bed and if the protectors needed to be washed, the staff should make sure to have another pair for the resident to wear or at least float the area. The Director of Nursing stated the aides do not carry a pocket Care Plan, but do have access to the Care Plan. There are Care Cards in the resident rooms that only address toileting and transferring and thought the Care Card did not address the need to put the heel protectors on. A review of the resident's Care Card revealed documentation that the resident needed assistance with positioning, required a Hoyer [mechanical lift] for transfer and the resident did not have alarms.	F 314		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or	F 329		

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F 329	Continued From page 11 (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to document non-pharmacological interventions prior to administering anti-anxiety medications given as needed for 2 of 7 residents reviewed in the standard sample (Residents #6 and #9). The facility reported a census of 90 residents. Findings include: 1. According to the Minimum Data Set (MDS)	F 329		

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F 329	Continued From page 12 assessment tool dated 8/17/17, Resident #9 had the following diagnoses: muscular dystrophy, anxiety disorder and chronic respiratory failure. It also identified the resident as severely cognitively impaired and totally dependent on staff for most activities of daily living. The care plan with the goal of 8/23/17 identified the problem of resident receiving antianxiety medication and directed staff : a. Pharmacy consultant review will occur quarterly b. Assess/record effectiveness of drug treatment c. Monitor and report signs of sedation hypotension or anticholinergic symptoms. Drug and dose reductions will occur as recommended by physician or pharmacist. A review of the medication administration records, physician orders had documentation of the following order for Lorazepam 0.5 milligrams (mg) one tablet every 6 hours PRN (as needed) with doses given on the following dates and times without documentation of non-pharmacological interventions implemented on the MAR or the nurse's notes: July 1 at 1:30 p.m., 4 at 1:00 p.m., 15 at 6:45 p.m., 17 at 9:30 a.m., 18 at 9:00 p.m., 19 at 8:00 p.m., 21 at 9:00 a.m., 24 at 5:30 a.m., 25 at 8:45 a.m., 28 at 2:00 p.m., and 30 at 8:30 p.m. August 1 at 9:00 a.m., 11:00 a.m., at 1:00 p.m., at 9:00 p.m., 3 at 6:30 p.m., 5 at 8:00 a.m., and 4:35 p.m., 7 at 7:45 a.m., 8 at 8:30 a.m. and 11:00 a.m., 11 at 9:05 a.m., 12 at 5:30 p.m., 13 at 8:00 p.m., 14 at 8:00 am., 16 at 6:20 p.m.	F 329		

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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
F 329	Continued From page 13 In an interview on 8/22/17 at 11:47 a.m., Staff B, LPN verified the numbers documented above as the times staff administered the medication. During an interview on 8/23/17 at 7:38 a.m., Staff C, RN reported that prior to administering PRN anti-anxiety medications, that staff should attempt interventions such as repositioning, asking the resident if he/she wanted to talk, one on one and if those interventions do not work, then administer the medication and chart the interventions on the back of the MAR. She also reviewed the yellow card stock sheet placed on the front of the medication abrade, which directed staff to apply 2 interventions before any anti-anxiety or hypnotic. The interventions listed had numbers assigned to each one. In an interview on 8/23/17 at 8:00 a.m., Staff D, LPN reported prior to administering PRN anti-anxiety medications, staff should chart interventions in the nurse's notes or the behavior symptoms tracking tool. During an interview on 8/23/17 at 1:49 p.m., the director of nursing reported she would expect staff, prior to administering PRN anti-anxiety medication, to find out why the resident is agitated, check if the resident needed assistance with toileting and if the resident had pain. If the interventions failed, would expect them to administer the medication and document the interventions on the MAR or in the nurse's notes. A review of the reminder sheet kept at the front of the MARs had documentation of the following: We are required to apply 2 interventions before administering any anxiolytic or hypnotic. Use the checklist below and document the number in the	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	C 09/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON SQUARE	500 MESSENGER ROAD KEOKUK, IA 52632

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F 329	Continued From page 14 PRN MAR 1. Assess pain 2. Offer toileting 3. Offer food/drink 4. Reposition/offer rest/ambulation 5. Massage/warm or cold packs 6. Music/TV/reading 7. 1:1 8. Remove to quiet area 9. Family call/pictures 10. Favorite blanket/stuffed animal/doll or personal item 11. Monitor VS, assess if disease related 12. Physician notification and ideas 13. Other (specify) 2. Resident # 6's MDS dated 6/15/17, listed diagnosis including, anxiety disorder and chronic obstructive pulmonary disease (COPD). The MDS also documented Resident # 6 is moderately cognitively impaired with short and long term memory problems. The Care Plan for Resident # 6 dated 6/21/17, lacked direction to staff to provide non-pharmacological interventions before administration of PRN Lorazepam. The Physician's Order Sheet (POS) dated 8/17, directed staff to administer Lorazepam 1 mg (1-2 tabs) every 4 hours PRN. Review of the MAR for Resident # 6 dated 5/17, listed Lorazepam 1 mg every 4 hours PRN administered on: 5/6, and 5/8. The Nurses Notes on 5/6, and 5/8 lack documentation of non-pharmacological intervention attempted before administration of	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 15 the PRN Lorazepam. Review of the MAR for Resident # 6 dated June 2017, listed Lorazepam 1 mg administered on 6/2 and 2 doses on 6/3. One additional dose administered during the month unclear date. Review of the Nurses Notes dated June 2017, lacked documentation of non-pharmacological intervention before administration of PRN Lorazepam. Review of the MAR dated 7/17, listed Lorazepam 1 mg every 4 hours as needed PRN administered on: 7/28. The Nurses Notes on 7/28/17, lack documentation of non-pharmacological intervention attempted before administration of the PRN Lorazepam. During an interview on 8/23/17 at 7:32 a.m., Staff D Licensed Practical Nurse (LPN) reported before administering an anti-anxiety medication the need to redirect, toileting, repositioning, feeding, call family the last resort is using anti-anxiety. The facility provided a policy titled Medication Administration dated 3/28/17, the policy lacked direction to provide non-pharmacological intervention before administration of PRN anti-anxiety.	F 329		

Lexington Square Healthcare & Rehabilitation Center

Department of Inspection & Appeals Plan of Correction

October 5, 2017

Disclaimer – This document shall be considered as the formal response to the CMS 2567 compiled from the annual recertification survey and investigation of facility reported incidents 69262-M and 69238-I and 70058-C, 705125-C, 70175-C, 69556-C AND 69704-C conducted in this facility from August 17 – September 5, 2017. This facility denies that the alleged facts as set forth constitute deficiencies under interpretations of Federal and State law. The preparation and /or execution of this Plan of Correction for these deficiencies does not constitute and should not be interpreted as admission nor an agreement by the facility for the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction for these deficiencies is prepared and/or executed solely because it is required by the provisions of Federal and State law.

F000 Credible Allegation of Compliance as of date Certain: September 22, 2017

F 314 TREATMENT/SERVICES TO PREVENT/HEAL PRESSURE SORES

SS = G

Without waiving the opening disclaimer, the facility states that with respect to Residents #2, #9 and all similarly situated residents that it is the policy of Lexington Square to ensure that residents receives care consistent with professional standards of practice, including the prevention of pressure ulcers (unless the individual's clinical condition demonstrates that they were unavoidable) and that those residents with pressure ulcers receive the necessary treatment and services to promote healing, prevent infection and prevent new ulcers from developing.

- In regards to Resident #2 – the ROHO cushion is at proper inflation and staff has been re-educated to check the inflation daily or as needed before resident is seated into his wheelchair.
- The restorative staff are now doing routine checks on all ROHO cushions in facility to assure all are functioning properly with proper inflation rate so as to prevent potential pressure while sitting.
- A second pair of heel protectors has been provided for Resident #9 so the assistive device would be available to relieve pressure from heels as per the care plan.
- Staff have been re-educated the importance of using assistive devices on residents as instructed on their care plans.
- The resident bedside care cards have been revised to document the need for any assistive device needed and will be updated as resident needs or care plan changes.

- Staff re-education was completed on September 22, 2017 by AMT Wound Management Nurse, entitled Skin Saver Points for the Bedside Caregiver.
- The Director of Nursing or designee will be responsible to complete periodic audits to ensure the resident care plan is being followed.
- Results of monitoring will be reviewed at the monthly QAPI meeting. Opportunities for improvement will be developed and implemented if indicated.

Because Lexington Square recognizes the significant problem of pressure ulcers and importance of preventive efforts, the Skin/Wound Management Interdisciplinary Team (IDT) has re-convened to review current practices in our facility and make recommendations as to improvements in prevention and treatment interventions for pressure ulcers and other wound management issues. We have partnered with American Medical Technologies and their certified wound nurse to make routine rounds on residents and provide recommendations as to prevention and treatment strategies. She provided staff education on September 22, 2017 on Skin Saver Points for the Bedside Caregiver and will continue to provide staff education as requested. In addition, Dr. Kulin Oza has joined the staff of Unity Point – Keokuk (formerly Keokuk Area Hospital). He is a surgeon with specialization in skin and wound management. He will serve on the IDT and make rounds on residents. Pressure Ulcer Prevention and Treatment will be the focus of our 2018 Performance Improvement Project (PIP) and we will monitor the effectiveness of our Skin / Wound Management Program to ensure quality improvements are maintained.

F329 DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS

SS = D

Without waiving the opening disclaimer, the facility states that with respect to Resident #6 and #9 and all similarly situated residents that it is the policy of Lexington Square to ensure that staff will provide the necessary non-pharmacological interventions and document the positive or negative outcome of interventions prior to the use of anti-anxiety medications.

- Nursing staff has been re-educated on importance of attempting at least three non-pharmacological interventions and documenting results on the Behavior Tracking Tool prior to administration of psychotropic medication.
- The care plan of any resident on psychotropic medications will have directions listed on the POC as to non-pharmacological interventions to attempt prior to med administration.
- The Medication Administration policy has been revised to include nursing instructions as to non-pharmacological interventions needing attempted prior to any administration on an anti-anxiety medication.
- Pharmacy Consultant and/or Director of Nursing or designee will validate documentation of interventions and outcome of use of anti-anxiety med administration by periodic random auditing weekly times four (4) weeks.
- Results of monitoring will be reviewed at the monthly QAPI meeting. Opportunities for improvement will be developed and implemented as necessary.